Public Board of Directors Meeting - 4.5.23

Schedule	Thursday 4 May 2023, 10:00 — 12:45 BST
Venue	Forum Rooms 1a and 1b, Learning Centre, Huddersfield Royal Infirmary
Organiser	Kathy Bray

Agenda

10:00	1. Welcome and Introductions: Invited Public Governors: Christine Mills Gina Choy Brian Moore To Note - Presented by Helen Hirst	1
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Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

To Note - Presented by Helen Hirst

1. Welcome and Introductions:

Invited Public Governors:

Christine Mills

Gina Choy

Brian Moore

To Note

Presented by Helen Hirst

2. Apologies for absence: Denise Sterling, Peter Wilkinson

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Note

Presented by Helen Hirst

STANDING ITEMS

4. Minutes of the previous meeting held on 2 March 2023

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 2 March 2023 at 10:15 am, Forum Room 1A / 1B, Sub-Basement, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
Robert Aitchison	Deputy Chief Executive
David Birkenhead	Medical Director
Lindsay Rudge	Chief Nurse
Suzanne Dunkley	Director of Workforce and Organisational Development (OD)
Kirsty Archer	Joint Director of Finance
Tim Busby **(TB)**	Non-Executive Director
Nigel Broadbent **(NB)**	Non-Executive Director
Peter Wilkinson **(PW)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director
Andy Nelson **(AN)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director

IN ATTENDANCE

Anna Basford	Deputy Chief Executive / Director of Transformation and Partnerships
Jonathan Hammond	Chief Operating Officer
Robert Birkett	Chief Digital and Information Officer
Victoria Pickles	Director of Corporate Affairs
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary*(minutes)*
Louise Croxall	Chief Nurse Information Officer (Item 27/23)
Chloe Gough	Matron Emergency Care (Item 27/23)
Rachel Crossley	Public Health Registrar

OBSERVERS

Robert Markless	Public Elected Governor
Stephen Baines	Public Elected Governor
Danielle Booth	Membership Officer

22/23 Welcome and Introductions

The Chair welcomed everyone to the Board of Directors meeting held in public, in particular Louise Croxall – Chief Nurse Information Officer and Chloe Gough - Matron Emergency Care - CRH to present the Patient Story 'Improving patient outcomes through digital'.

The Chair also welcomed invited governors, Stephen Baines, and Robert Markless as observers to the meeting.

The Chair welcomed the Chief Nurse to her first official Board meeting in post.

The Board meeting took place face to face. The agenda and papers were made available on the Trust website.

23/23 Apologies for absence

There were no apologies for absence.

24/23 Declaration of Interests

There were no declarations of interest, and the Board were reminded by the Chair to declare at any point in the agenda.

25/23 Minutes of the previous meeting held on 12 January 2023

The minutes of the previous meeting held on 12 January 2023 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 12 January 2023.

26/23 Matters Arising and Action Log

The Chair noted that all actions on the action log were complete.

Action 120/22 1.9.22. – Integrated Performance Report (IPR) - KH queried if this action was on track and whether the revised IPR will be presented at the May Board meeting. The Director of Corporate Affairs confirmed the action was on track, with a draft IPR in development and engagement process planned, including "Making Data Count" training for Board members in March.

Action 11/23 12.1.23. Maternity Incentive Scheme (MIS) Submission – the Chief Executive confirmed, in response to a query from TB, that the Trust had met all the MIS standards.

There were no matters arising to note.

OUTCOME: The Board **NOTED** progress on the action log.

27/23 Patient Story - 'Improving patient outcomes through digital'.

The Chief Digital and Information Officer introduced the digital patient story, which was presented by Louise Croxall, Chief Nurse Information Officer and Chloe Gough, Matron Emergency Care CRH. He noted the patient story linked to the Digital Health Strategy update presented to the Board in November 2022 and demonstrated how digital developments were aligned to patient care and improve patient outcomes.

The Chief Nurse Information Officer explained the purpose of Nerve Centre, an electronic system which uses a hand held device to help colleagues detect early patient deterioration, frequency of observations and prompts action which feeds into the Electronic Patient Record (EPR). Nerve Centre had not been implemented into the Emergency Department (ED) until last autumn. She shared the story of a patient with respiratory disease, prior to the use of Nerve Centre in ED, where there had been a poor outcome when the patient attended ED and the frequency of observations had been an issue. A serious incident investigation into the patient's care recommended the implementation of Nerve Centre in both EDs to support staff in detecting deterioration of patients. A project team subsequently implemented Nerve Centre in the EDs, aligning it with ED pathways, which has improved quality and safety for patients.

The Matron for Emergency Care provided details of how Nerve Centre works in practice in ED and has been beneficial, especially given the high number of ED attendances. She referred to the development and use of a digital checklist used when caring for patients

in cubicles and noted that Nerve Centre was now used in the waiting areas by Healthcare Assistants, with escalation to the nurse in charge as needed. Work has also taken place with ambulance staff and Nerve Centre has been used for cohorts of patients following arrival by ambulance. She described the benefits including greater efficiency and real time data, increased compliance with sepsis recognition and treatment, and quality and safety benefits, hourly observations and earlier detection of deterioration with better patient outcomes and a reduction in incidents. The team continue to seek to drive improvements.

The team had worked closely with a Trust in Nottingham which had used Nerve Centre in ED for a longer period and learned from their experience.

The Chair thanked the presenters for their enthusiasm, energy and leadership and positive comments on this digital development were made by Board members, particularly considering ED operational pressures.

Discussion took place on:

- Implementation issues – there had been an issue with duplication when inputting data to trigger hourly observations which had been worked through using the experience of the Trust in Nottingham, there was close monitoring of the 25 handheld devices in each ED supported by use of the asset tracking system.

- Next steps would be to add prompts for alerts to x-rays, ultrasound, and CT scans.

- Learning from making changes in a busy department for sharing with other teams –having a clear narrative for colleagues of the reason for the change (preventing incidents and improving patient safety), visibility, senior nursing engagement, project management. and information.

- Communicating and sharing the work undertaken more widely - close working with Nerve Centre was noted, the Trust has offered to host site visits and this digital development has been promoted with Cerner specialist interest groups nationally.

- Measurable benefits – it was noted that nursing colleagues can access real time data via an enhanced dashboard on Knowledge Portal+, with further work needed in relation to data to evidence improvements made.

- Impact on colleagues – improvements made in efficiency and education and empowerment of healthcare assistants, visual check of patients which builds better relationships with staff.

The Chair commented on how external communication regarding this improvement could help attract workforce and promote the Trust's digital reputation

OUTCOME: The Board **NOTED** the Patient Story - 'Improving patient outcomes through digital' and thanked Louise Croxall and Chloe Gough for the presentation and their dedication, leadership and enthusiasm for this work.

28/23 Chair's Report

The Chair presented the Chair's report detailing activities since the last meeting within the Trust, local systems, regionally and nationally.

KH echoed the Chair's congratulations to all colleagues who have worked with positivity through challenging times.

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

29/23 Chief Executive's Report

The Chief Executive presented this report which detailed progress in relation to local and national agendas and an update against his leadership responsibilities.

In addition to the content of the written report, the following was noted in relation to the three day 72 hour junior doctor industrial action in mid-March:

- Detailed planning, preparations, and communication in place including Trust command and control arrangements, Executive Director involvement and work with system partners including primary care in place to mitigate the industrial action.

- The industrial action will impact on elective work, though the Trust will continue to treat priority patients where possible.

- There are no derogations negotiated for the planned strike action. Patient safety remains a priority, re-skilling of colleagues was taking place with support from colleagues across a range of professional groups to help provide safe care.

- Financial impact due to clinical colleagues working differently.

Discussion took place in response to a question from DS on ensuring that medical fit patients are discharged. The Chief Operating Officer commented that there remain significant capacity challenges in social care. There are good relationships with partners with clear actions and meetings with partners will continue.

OUTCOME: The Board **NOTED** the Chief Executives Report

30/23 Progress Update against the Trust's Health and Inequalities

The Deputy Chief Executive (RA), together with Rachel Crossley, Public Health Registrar presented the first update on progress against the actions in the Health and Inequalities Strategy 2022-24 approved by the Board in November 2022. A Plan on a Page for the Strategy was presented as requested by the Board. This set out the vision across the following four areas: connecting with our communities and partners, equitable access and prioritisation, lived experience and outcomes and diverse and inclusive workforce. The presentation summarised progress and next steps in each of these four areas. Non-Executive Directors welcomed the Plan on a Page summarising the strategy.

The key elements highlighted, in addition to work in relation to people with Learning Disabilities and learning from the care navigator role, were:

- Connecting with our communities and partners – meetings have been held jointly with Calderdale and Kirklees Local Authorities to discuss and align our strategic partnership approach to inequalities

- Equitable access and prioritisation - development of a Trust vulnerabilities matrix through working closely with information and clinical colleagues, which takes a more holistic approach to patient prioritisation and delivery of care for patients in P3 and P4 categories. This will be trialled during the coming months in gynaecology and evaluated prior to roll out.

The Chair commented the purpose of the vulnerability matrix was to reduce inequality and create equality.

Key points of discussion were:

- Benefit in sharing this work with governors at a future Board / Council of Governors session as governors are keen to avoid digital exclusion; the heath inequalities work could be illustrated with a patient story (VP)
- Assurance was given that this work does not supersede clinical prioritisation work
- There is work to do on how accessible information impacts on health inequalities (VP)
- Whether previous actions to address access and health inequalities continue to narrow the gap (PW) – the Deputy Chief Executive responded that the Trust has maintained the gains made 18 months ago and there are plans to include an update of this information in a future IPR report
- The importance of building in measures of lived experience and clear visuals (KH) – the Deputy Chief Executive supported sharing patient stories from projects in future.
- AN queried whether connections with the voluntary / community sector / charities are improving so the Trust can help them. The Deputy Chief Executive advised learning has been the need for support at a strategic level and connections at community level. The Public Health Registrar commented that progress was being made and closer working with local councils supports this.
- DS questioned future work in this area and discussion took place on maintaining the pace of work without input from a Public Health expert, whose time with the Trust was ending. The Deputy Chief Executive thanked the Public Health Registrar for the impact of her work. He noted an infrastructure was in place, expertise had been passed on to the team and there is a need to consider how strategically the Trust secures Public Health input going forwards

  The Chair thanked the Public Health Registrar for her leadership on health inequalities, noted the links between this report and the Public Sector Equality Duty report on the agenda and thanked the presenters for the report.

OUTCOME: The Board **RECEIVED** the Health Inequalities Update.

31/23 Annual Strategic Plan – Progress Report - Strategic Objectives – 2021/2023

The Deputy Chief Executive / Director of Transformation and Partnerships presented an update on progress against the annual strategic plan for the period ending December 2022, noting a final year report to 31 March 2023 will be presented to the Board at its May meeting.

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. The report details the progress against delivery of the objective, together with an outcome measure and assurance route and the risk score for the relevant Board Assurance Framework risk that relates to the objective.

This report highlighted that of the 19 objectives none were rated red or amber, 18 were rated green and one has been completed.

The Chair commented that she had had sight of progress with all objectives via Board papers.

OUTCOME: The Board **NOTED** the progress of the Annual Strategic Plan 2021/2023.

32/23 Strategy - 2023-2028 5 Year Strategy and 1 Year Strategy 2023-2024

The Deputy Chief Executive / Director of Transformation and Partnerships presented the refreshed and re-formatted five year strategy for 2023 – 28 which was supported by a one year strategy for April 2023 to March 2024. The change to the format of the presentation marks the new challenges and strategic opportunities, building on the Trust's current position.

The Deputy Chief Executive / Director of Transformation and Partnerships noted this review of the Trust's strategic plans builds on and refreshes our previous strategy and follows discussion with Board members at Board development sessions. It was also noted the strategy had been informed by significant engagement with colleagues, governors and partner organisations and is aligned to the West Yorkshire Integrated Care System and Calderdale and Kirklees Place Strategies. Some minor changes to wording to improve the readability of the strategy were being made following comments from governors.

The refreshed five year and one year strategic plans set out the Trust ambitions across the following four goals:

1. To transform patient care and population health outcomes
2. To provide the best quality and safety of care
3. To be the best place to work, supporting a workforce for the future
4. To be sustainable in our use of financial and environmental resources

A full progress report against year one of the 2023/24 plan will be brought to the Board.

The Chair and other Non-Executive Director colleagues congratulated the Deputy Chief Executive / Director of Transformation and Partnerships on this work and the clear presentation of the strategy. The support of the Director of Corporate Affairs and communications team was acknowledged. It was noted that the embeddedness of the strategy once it has been communicated throughout the Trust will be a test of its effectiveness. AN commented on the need for the measures of progress to be sharp.

The Chair asked governors for comments. Stephen Baines, lead governor noted he was impressed by the continuous drive for change and the impact of the digital development in the patient story which will be a major improvement for patients waiting in ED. Robert Markless advised that governors have had opportunity to input to the strategy and would welcome the strategy being formally shared with governors at a future meeting, as they can help share the key messages with community forums.

The Chair thanked the Deputy Chief Executive / Director of Transformation and Partnerships and the Director of Corporate Affairs for this work.

OUTCOME: The Board **APPROVED** the CHFT's Five Year Plan for 2023 - 28 and One Year (2023-24) Strategic Plans.

33/23 Quality Committee Chair's Highlight Report

DS presented the Chair's highlight report from the Quality Committee meeting of 16 January 2023 and drew attention to the Director of Infection Control Report for quarter 3 2023/24 in the papers. The contents of the report were reviewed and noted by the Board.

OUTCOME: The Board **NOTED** the update of the Quality Committee Chair Highlight Report.

34/23 Quality Report

The Medical Director gave feedback on a CQC engagement meeting and service review of surgery and the Intensive Care Unit (ICU) on 1 March 2023, which the Chief Nurse and Director of Corporate Affairs attended which was well received. There was positive feedback on the Same Day Emergency Care model and surgical pathways and comments were made that these approaches could be shared with wider audiences.

The Chief Nurse advised that the Never Events detailed were discussed with the CQC at this engagement meeting. The Chair queried whether there were any themes across the Never Events and was assured that there was not and that two incidents declared as Never Events may not fit with the Never Event framework.

It was noted that a CQC maternity inspection is due to take place before May.

The Medical Director highlighted work on the embeddedness of "must do" and "should do" actions from the 2018 CQC inspection. He gave an update on the three quality account priorities (recognition and timely treatment of sepsis, reducing the number of hospital acquired infections and reducing waiting times for individuals in ED), noting progress with the latter two had been challenging. It was reported that the number of patients awaiting clinical validation had reduced and a refreshed process was in place. It was noted that key mortality metrics had improved, and that crude mortality was stable, with the Trust being 48th nationally and in the second quartile. Close monitoring of

mortality metrics will continue, with caution noted given high mortality rates in December 2022.

The improvement in complaints performance was noted with cross divisional support to the Medicine division acknowledged.

TB queried the increase in patient safety incidents and asked if this was a concern. The Chief Nurse responded that incidents are regularly reviewed, and further analysis is underway to better understand the categories.

AN suggested a RAG rating for each slide would be helpful. He queried how improvements could be made in two areas: pressure ulcers and nutrition. In relation to pressure ulcers the Chief Nurse responded that there is a different acuity in deconditioned patients and that work was underway looking at the metrics for nutrition. She advised that different approaches to these quality and safety matters, such as the social movement approach used in the John's carers campaign, were being considered.

The Medical Director also gave feedback on a recent visit by the Chief Coroner who was interested in seeing work within surgery looking at how we manage patients and untoward events and had commented that the Trust's innovative approach could be shared with a wider audience.

The Chair queried if the Quality Committee looks at the impact of long waits for treatment. It was noted that an audit is reviewing waits during the peaks of operational pressures (December 2022 and January 2023 when the Trust was at OPEL 4) to assess whether any patients came to harm. The Chief Operating Officer also commented that in addition to increased demand from patients, the acuity of patients had impacted on lengths of stay.

OUTCOME: The Board **NOTED** the Quality Report.

35/23 Finance and Performance Chair Highlighted Report

AN presented this highlight report with an update from the Finance and Performance Committee meetings held on 7 and 28 February 2023.The contents of the report were reviewed and noted by the Board.

OUTCOME: The Board **NOTED** the update of the Finance and Performance Chair Highlight Report.

36/23 Month 10 Finance Report

The Director of Finance presented the month 10 finance report. The reported 2022/23 year end forecast was in line with the planned deficit of £17.35m with mitigation from additional non recurrent funding, technical flexibilities, and system support, with a mitigation gap of approximately £1m to be identified. Full delivery of a challenging £20m efficiency target and the Trust elective activity plan was assumed in the forecast.

The month 10 finance report confirmed that year to date the Trust is reporting a £20.4m deficit, a £3.48m adverse variance from plan. The in month position is a deficit of £2.33m, a £0.69m adverse variance. The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate

staffing costs. These pressures remained high in early January, with OPEL 4 status, but dropped back to OPEL 3 mid-month, with some surge capacity now closed.

TB commented that the financial position seemed better than expected and asked what had been the main change that helped. The Director of Finance advised that non recurrent funding and redistribution of funding had helped, which demonstrated good partnership working, but could not be relied on in future years.

OUTCOME: The Board **NOTED** the Month 10 Finance Report and the financial position for the Trust as at January 2023.

37/23 Workforce Committee Chair Highlight Report

KH presented the highlight report from the meeting of the Committee held on 14 February 2023, the content of which the Board reviewed and noted.

In addition to the report the Chair noted the Committee continues to focus on the challenging position for medical, nursing and midwifery staff and progress with leadership development.

The Chair advised that a national strategic workforce plan was imminent and asked what work has taken place at the Committee regarding retention. KH advised the Committee had reviewed reasons for leaving which identified promotion, work/life balance and earlier retirement as factors and the Director of Workforce and OD added that staff turnover is comparatively good. The Chief Nurse advised that the Trust has been part of a nursing and midwifery national retention programme. The Chief Executive added that our offer to staff is not articulated as retention activity in reports.

OUTCOME: The Board **NOTED** the Workforce Committee Chair Highlight Report.

Robert Markless left the meeting.

38/32 Integrated Performance Report (IPR) – December and January 2023

The Chair asked if the Chief Operating Officer would like to highlight any further information within the Integrated Performance Report not covered by the previous Committee highlight reports. The Chief Operating Officer highlighted the following:

- ED performance had improved in January but was more challenging again in February, which impacted waiting times in ED and led to challenging bed occupancy rates of 98/99%.
- Improvement in ambulance handovers in ED given the challenges in December 2022
- Cancer performance has seen a slight dip, with areas of focus identified such as colorectal, theatre and clinic capacity and a focused approach to pathways
- Recovery – aim is to hit the 104% 2022/23 year-end target, currently at 103.9%
- Excellent feedback from a Getting It Right First Time (GIRFT) elective hub visit by Professor Sir Tim Briggs with the surgery team

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance for January 2023.

39/23 Safeguarding Update – Adults and Children – Executive Summary

The Chief Nurse presented the report which detailed the key activity of the Safeguarding Team from April to September 2022. An Executive summary presentation was included within the Board papers. The key points highlighted by the Chief Nurse included:

- Partnership working by the Safeguarding team
- Maintenance of safeguarding training compliance
- An audit of cases reviewing heath providers responses to domestic violence to identify areas for improvement
- Work on Mental Capacity Act and Deprivation of Liberty Safeguards, an area of CQC focus with further preparatory work for the implementation of Liberty Protection Safeguards
- Review of discharge incidents
- Ongoing work with bereavement for children
- Oversight arrangements for looked after children out of area

KH queried training compliance for Mental Health Act Receipt and Scrutiny and Safeguarding Supervision flagged as red. The Chief Nurse advised that the training was provided by South West Yorkshire Partnership Foundation Trust and there had been a gap in the delivery alongside new starters requiring the training but assured the Board that the Trust had trained cover over the 24 hour period. Safeguarding supervision has been below 90% during the reporting period. There is a plan in place to address the gap in supervision compliance.

OUTCOME: The Board **NOTED** the key highlights of the Safeguarding report for April to September 2022.

40/23 Public Sector Equality Duty (PSED) Annual Report

The Director of Workforce and OD presented the Public Sector Equality Duty report for 2022 which highlighted the activities the Trust has been working on to address the need of patients and colleagues who fall under the protected characteristics of the Equality Act 2010.

The Chair commented that there was a good level of detail regarding workforce equality but that she felt that there was further work to do to capture the work in relation to patients, given the health inequalities work in the Trust. She also suggested that mitigations for areas where we are not making the progress we would hope for could be added.

It was noted that the report is retrospective for the calendar year 2022 and some work, such as engagement with families on the new Rainbow Child Development Centre, had not yet concluded. It was agreed that the Chief Nurse would co-ordinate the addition of further relevant examples relating to patient engagement prior to publication.

The Director of Corporate Affairs suggested that this information could be captured during the year, with a skeleton report being presented to the Workforce Committee and Quality Committee, which KH agreed to.

ACTION: Chief Nurse to co-ordinate the addition of further examples of patient engagement in the Public Sector Equality Duty Act Annual Report for 2022.

ACTION: Workforce & Quality Committees to receive periodic updates throughout the year in relation to PSED.

OUTCOME: The Board **APPROVED** the Public Sector Equality Duty (PSED) Annual Report, subject to the addition of further information in relation to patients prior to publication.

41/23 Audit and Risk Committee Chair Highlight Report

NB presented the Chair's highlight report from the Audit and Risk Committee meeting of 31 January 2023. The contents of the report were reviewed and noted by the Board, including the recommendation to the Board of the updated Board Assurance Framework, Standing Orders, Standing Financial Instructions and Scheme of Delegation, all of which were on the Board meeting agenda as they required Board approval.

NB noted two limited assurance reports had been shared with the Committee (quality governance and sickness absence) and highlighted the importance of completing overdue recommendations from internal audit reports by 31 March 2023.

NB also advised that as Committee Chair, he attends Audit and Risk Committee meetings of the Integrated Care System looking at risks at Place level and consistency across Boards.

The Company Secretary advised that there is progress with overdue recommendations, and this is being closely monitored, with an update on this from internal audit to the Weekly Executive Board on 16 March 2023.

OUTCOME: The Board **NOTED** the Audit and Risk Committee Chair Highlight Report

42/23 Board Assurance Framework

The Company Secretary presented the final update of the Board Assurance Framework (BAF) for the financial year 2022/23 noting a total of 22 risks to the current strategic objectives. The BAF has been reviewed by the Audit and Risk Committee on 31 January 2023 and was recommended to the Board for approval.

The top three risks noted related to the reconfiguration programme (risk 1/19), nursing workforce (risk 10a/19) and long term financial sustainability. The Chair asked Board members if they recognised the top three risks in the BAF as the top three risks and members confirmed they did. PW welcomed inclusion of the top 3 risks in the report.

The reduction in the risk score for the health and safety risk (risk 16/19) was approved.

Plans to refresh the BAF in 2023/24 and align risks with the refreshed five year and one year strategy were noted as well as discussions in Committees regarding changes to some risks. The Director of Corporate Affairs, noting that the BAF drives Board agendas, commented that the refresh in 2023/24 would look carefully at certain risks which could

be removed, for example the commercial risk, clinical strategy risk and seven day service risk.

The Chair noted that the paper provided positive evidence of continuous review of the content of the BAF.

OUTCOME: The Board **APPROVED** the Board Assurance Framework and noted reduced risk score for the health and safety risk 16/19..

43/23 **High Level Risk Report**

The Director of Corporate Affairs presented the paper and highlighted risk themes in relation to the Trust's four strategic goals detailed in the report (transforming care, keeping the base safe, workforce and sustainability), noting these reflected the key areas of challenge. Themes included single consultant specialties being vulnerable, access to theatres in a timely way, equipment and workforce.

The report details 58 risks on the risk register, with full risk report available in the papers. It was noted that work was continuing with divisional colleagues to review and refine risk identification, management, and mitigation processes. It was noted there was some duplication in the current risks and risk scoring needed moderating as part of this work, together with scrutiny at an appropriate divisional level.

NB commented that some risks could be consolidated, for example staffing risks and it would be helpful to review how the Risk Group operates and moderates the risk scores. The Director of Corporate Affairs advised that this will be covered in the risk management deep dive presentation to the Audit and Risk Committee in April.

AN queried whether the wrong actions to mitigate risks had been identified for some risks as progress had been made, but risk scores had not reduced. He commented on the challenge for the Risk Group in reviewing this volume of risks and whether there was appropriate representation from divisions at meetings of the Risk Group. It was noted that these were all relevant points and the Chief Operating Officer advised that colleagues benefit from guidance.

OUTCOME: The Board **APPROVED** the high-level risk report and noted the ongoing work to strengthen the management of risks.

44/23 **Charitable Funds Committee Chair Highlight Report**

The Chair presented this highlight report from the Charitable Funds meeting of 15 February 2023. The Board reviewed the report, the contents of which were noted.

The Chair highlighted a Charity walk event between the two hospital sites that was planned which she invited Board members to consider joining.

OUTCOME: The Board **NOTED** the Charitable Funds Chair highlight report.

45/23 **GOVERNANCE REPORT**

The Company Secretary presented the report and asked the Board to approve the:

- Standing Orders
- Standing Financial Instructions

- Scheme of Delegation
- Board of Directors Terms of Reference
- Delegation to the Audit and Risk Committee for the approval of the 2022/23 Accounts and Annual Report
- Delegation to the Quality Committee for the approval of the 2022/23 Quality Accounts
- Board of Directors workplan for 2023/24

The Company Secretary noted that a detailed review of the suite of key governance documents for the Trust had been completed, as required every two years, and required Board approval. These linked documents included a review of:

- the Standing Orders, which regulate how the Trust conducts business
- Standing Financial Instructions (SFIs) which detail financial responsibilities, policies and procedures and
- Scheme of Delegation which sets out the formally delegated responsibilities of the Trust's functions, duties and powers to Directors and Officers of the Trust.

The Audit and Risk Committee had reviewed the proposed amendments at its meeting on 31 January 2023 and recommended these to the Board for approval. Key changes were noted in the cover sheet. It was noted that further work on the presentation of authorisation limits (an appendix to the SFIs) will take place and be presented to the Board on 7 September 2023 for ratification.

AN highlighted that reference had been made in the Standing Orders to local partner system and delegation arrangements but not in the Scheme of Delegation. Following discussion, it was agreed to include similar information with the Scheme of Delegation.

ACTION: Company Secretary to amend the Scheme of Delegation in relation to delegation.

The Board Terms of Reference have also been reviewed and are presented to the Board for approval. These describe the role and work of the Board and updates relate to legislative changes and alignment with changes to Standing Orders.

Delegation was sought for the approval of the 2022/23 annual report and accounts by the Audit and Risk Committee and the quality accounts by the Quality Committee, as the national deadlines of 30 June 2023 did not align with Board meeting dates.

The Board APPROVED

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation, subject to the amendment discussed
- Board terms of reference
- Delegation to the Audit and Risk Committee for the approval of the 2022/23 Accounts and Annual Report
- Delegation to the Quality Committee for the approval of the 2022/23 Quality Accounts
- Board of Directors workplan for 2023/24

The Board NOTED

- Use of the Trust Seal

- Board of Directors Declarations of Interest
- Fit and Proper Persons Self-Declarations Register and an assurance that all Directors are and satisfy the Fit and Proper persons requirements

46/23 Review of Board Sub-Committee Terms of Reference

The following Board Sub-committee Terms of Reference were presented for approval
a) Finance and Performance Committee
b) Quality Committee

AN highlighted a difference between the two terms of reference in relation to Non-Executive Director quoracy requirements. The Company Secretary agreed to review this and amend for consistency.

ACTION: Company Secretary to review consistency of terms of reference and amend for consistency.

OUTCOME: The Board APPROVED the Terms of Reference of the Finance and Performance and Quality Committee, subject to review of the matter highlighted.

47/23 Items for Review Room

- Director of Infection, Prevention and Control (DIPC) Q3 Report
- High Level Risk Report
- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership

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

- Finance and Performance Committee November 2022
- Quality Committee 14 November 2022
- Workforce Committee 7 December 2023
- Charitable Funds Committee 15 February

AN commented that the minutes in Review Room did not look to be up to date. The Company Secretary agreed to review this for all Committee minutes and advise on whether minutes could be added retrospectively.

OUTCOME: The Board **RECEIVED** the items listed above which were available in the Review room.

48/23 Date and time of next meeting

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at 1.25 pm.

Date: Thursday 4 May 2023
Time: 10 am

Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

5. Matters Arising and Action Log

For Review

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 06.03.23

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
2.03.23. 47/23	**Minutes in Review Room**	Company Secretary	Review timeliness of minutes in the review room and consider if these can be added retrospectively. Review of all Board Committee minutes shared, "catch-up" of minutes for 4 May Board. Schedule of Board Committee minutes for the year to Board agreed with PAs to ensure timely minutes at Board meetings.	31.03.23.		4.5.23.
2.03.23. 46.23	**Terms of Reference Quality Committee and Finance and Performance Committee** Consistency of Quoracy for Non-Executive Directors	Company Secretary	Non-Executive Director quoracy requirement of two per Committee F&P terms of reference updated accordingly.	10.03.23.		12.4.23.
2.03.23. 45/23	**Scheme of Delegation (SoD) / Standing Orders (SO)** Add section from Standing Orders into Scheme of Delegation and minor amends to Standing Orders	Company Secretary	Add to SoD section on working with partners from SOs. Minor amend to SO re: Deputy Chief Executive	10.03.23.		6.3.23.
2.03.23. 40/23	**PSED Annual report 2023**	Director of Workforce and OD / Chief Nurse / Director of Corporate Affairs	Amend Workforce Committee Quality Committee workplans to receive periodic updates throughout the year to inform Public Sector Equality Duty Act Report for 2023	3.05.23.		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 06.03.23

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
2.03.23. 40/23	**Public Sector Equality Duty (PSED) Annual Report 2022**	Chief Nurse	Co-ordinate the addition of further examples of patient engagement to the report.	01.03.23.		
01.09.22 120/22	**Integrated Performance Report – Recommendation** Director of Corporate Affairs to share alongside the current performance metrics a recommendation of metrics monitored at future Board meetings that focus on priorities and key risks.	Director of Corporate Affairs	Board Development – 6 October 2022	04.05.23		
10.11.22. 149/22 a	**Panorama Programme: Mental Health / Learning Disabilities Trust Response** Further discussion at a Board Development Session	Chief Nurse		30.06.23		

6. Staff Story: Alternative Workforce Models Maternity

To Note

Presented by Lindsay Rudge

7. Chair’s Report

To Note

Presented by Helen Hirst

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	4 May 2022
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None

Purpose of the Report

To update the Board on the actions and activity of the Chair.

Key Points to Note

The enclosed report details information on key issues and activities the Trust Chair has been involved in over recent months within the Trust, with local system partners and regional and national work.

EQIA – Equality Impact Assessment

The attached paper is for information only and does not disadvantage individuals or groups negatively.

Recommendation

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

Chair's Report to the Board

This report provides information about key issues and activities I have been involved in over the past couple of months within the Trust, within local systems, regionally and nationally. These present me with opportunities to better understand the excellent work colleagues across the Trust do, the innovation and quality improvement that happens in services routinely, and the challenges faced by our teams. It also helps to develop my understanding of where our Trust contributes to and is impacted by wider system working and decision making. This helps set the context for the discussions and decisions we make during Board meetings.

1. Trust activities

I have enjoyed meeting with prospective governors ahead of the now concluded election process. It is so positive that many people, from diverse backgrounds are interested in supporting the Trust. Some chose not to proceed this time but instead are being active members and involving themselves in Trust activities. On 20 April 2023 at our Council of Governors meeting we heard about the outcomes of our recent governor elections. Congratulations to those who were elected this time who we will formally welcome at our Annual Members Meeting on 25 July 2023; I really look forward to getting to know the new governors. They are:

Public Governors	
Lindley and the Valleys	Pam Robinson
North and Central Halifax	Kathleen Wileman Anthony Wilkinson
Skircoat and Lower Calder Valley	Diane Cothey Lorraine Wolfenden
South Huddersfield	John Richardson
North Kirklees	Hollie Hampshaw

Staff Governors	
Nurses / Midwives	Emma Karim
AHPs/Healthcare Scientists/Pharmacists	Jonathan Drury

Since my last report to the Board, I have had the pleasure of attending a few events and visiting colleagues during and after Easter to hand out some Easter Eggs and other goodies. It was impressive to see a full endoscopy clinic running on Easter Sunday afternoon! Thank you to James Teal and Stevie Cheeseman from Workforce and OD for coming with me and making sure I didn't get lost.

Events have included:

A talk by Major General Tim Hodgetts, Master General of the Army Medical Services organised by Neeraj Bhasin, Deputy Medical Director as part of a programme of events for the senior medical workforce.

International Women's Day event organised by colleagues in Workforce and OD around the theme of Inspire to Grow

Inaugural Leadership Conference, also organised by Workforce and OD where, as well has hearing from Brendan Brown, Anna Basford, Rob Aitcheson, myself and Lucy Cole

(WYAAT Programme Director) we were joined by Peter Anderton from Art of Brilliance who gave ideas to create a workplace that buzzes and were treated to an exclusive interview of Lisa Farrand, the producer and police officer who worked on Happy Valley and advised on policing matters. Vicky Pickles took the interviewers chair and did a great job.

As well as Easter visits, I have met with the League of Friends at Calderdale Royal Hospital, colleagues at Todmorden Health Centre, the Rainbow Hub and The Health Informatics Service at Elland.

The Board have held two short Board development events – one on making data count and the other on our health and safety responsibilities. The Council of Governors met last week and we said good bye and thank you to Lesley Warner who is standing down as a councillor and therefore as a stakeholder governor. We are arranging a thank you lunch for all the governors who are leaving this time and those who have left over the last year.

Finally, I was involved in the interviews for the Chief Operating Officer and am delighted that Jonny Hammond was successful in his application – congratulations Jonny.

Health and Care System

There have been two Calderdale Cares Partnership Board meetings/ development events since my last report. At the development event we reviewed our first nine months in operation, our strengths and areas for improvement and considered how to improve the public voice in our working. At the last Board meeting we discussed a scrutiny review of primary care as well as our routine business. This was John Mullaly's last meeting as chair. The recruitment process for his replacement is ongoing.

West Yorkshire Partnership Board held a development session followed by the Board meeting at the beginning of March where the three main agenda items were tackling health inequalities, the Five Year Strategy for the Partnership and the Climate Change Strategy. The full meeting is available to watch on the West Yorkshire Partnership website.

I attended the monthly partnership meeting for West Yorkshire trust chairs, local authority leaders, health and wellbeing board chairs, ICB place committee chairs and ICB non-executive members and presented on the impact of One Culture of Care.

This week was the quarterly meeting of West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common discussing the WYAAT strategy as well as 2023/24 plans. The meeting was followed by a tour of the new pathology laboratory which is currently being fitted out and should be operational by the Summer.

Other system/ partner meetings and events include Yorkshire and Humber Chairs; West Yorkshire Organisation Development Network event; informal get together of Chairs across Calderdale, Kirklees and Wakefield; external assessor on Mid Yorkshire Hospitals Non-Executive Director recruitment; and one to ones with Mark Hindmarsh, Director of Integration and Strategy for Kirklees and Tim Swift, Leader of Calderdale Council

National/other

I attended the NHS Providers national Chairs and Chief Executives Network event in London at the end of March where the main focus was 23/24 planning, Equality, Diversity and Inclusion and Workforce. A Good Governance Institute event, attended by a number of our NEDs, held on line considered how trusts balance the books within the ICS context. I

am enrolled on a national chair's development programme and module 4 (final) fell in this period where we covered working with governors.

Helen Hirst
Chair
26 April 2023

8. Chief Executive’s Report

To Note

Presented by Brendan Brown

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	**2 March 2023**
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**Chief Executive's Report**
Author:	**Victoria Pickles, Director of Corporate Affairs**
Sponsor:	**Brendan Brown, Chief Executive**
Previous Forums:	**None**

Actions Requested:

- Consider this report as assurance and progress against both the local and national agenda, and the Trust's strategic priorities.

Purpose of the Report

This report provides a focused update on the Trust's response to specific elements of its service delivery and the evolving health and care landscape.

Key Points to Note

- The context and environment within which we operate remains challenging
- We have maintained good performance across our range of measures and recognised as national leaders in cancer and elective care performance
- The health and wellbeing of our colleagues remains paramount and the staff survey results show us where we need to focus our attention
- The financial position both within the Trust, regionally and nationally remains a concern
- The national and local NHS architecture is under review. Our partners in the West Yorkshire Integrated Care Board, and at a local Kirklees and Calderdale Place level are experiencing significant change – which we continue to support

EQIA – Equality Impact Assessment

There are no differential equality impacts resulting from these areas of work at this point.

Recommendation

The Board is requested to receive this paper as assurance and progress against both the local and national agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
25 April 2023

1. Introduction

1.1. This report aims to provide strategic and delivery context to the items for discussion on the agenda of this Board meeting. It sets out the key challenges and activities happening within the Trust and our partnership arrangements, within the current dynamic national agenda, against each of our strategic objectives.

1.2. In my last report I described the environment within which we are operating as being challenging and it certainly feels no different as I write this month's report. We are in a pre-election period, and indeed on the day we meet, local people will be going to the polls. The political, social, and economic environment remains complex and impacts on how we operate as a Trust and the discussions and decisions we will have and make at this meeting.

1.3. There are colleagues in the Trust who have families affected by the ongoing war in Ukraine and by the recent events in the Sudan. Inflation has continued to rise, impacting on the cost-of-living and how people subsequently feel and indeed live. This is one of the drivers of the continuing industrial action both within the NHS and other public services. Strike action is also taking place abroad which may impact on our colleagues' ability to take the leave they have planned. The financial position of the Trust and of the West Yorkshire system remains unclear and at the point of writing we do not have an approved financial plan. The increased number of bank holidays during April and May, coupled with the strike action, mean that our emergency departments have remained under sustained pressure. Today's agenda items will enable discussion on key elements of our clinical, operational and financial planning, and consider the implications for our patients and colleagues.

1.4. Against this backdrop of challenges, there remains plenty to be positive about both inside and outside the Trust and this report describes some of our successes and achievements for our patients, our colleagues, and our communities. We have also delivered all elements of our strategic plan for 2022/23 as seen in the update report on the agenda for this meeting.

1.5. It is important that we consider all this context as we discuss the items on the agenda at this meeting.

2. Keeping the base safe – quality and safety of care.

2.1. Over the last two months, although we have seen high attendances at our emergency departments, we have continued to focus on patients experience and ensuring people have been seen and treated as safely and as timely as possible. Our performance against the new emergency care standard has improved. We remain one of the best performing trusts nationally for cancer performance, and for elective care, achieving both the 104 and 78 week waits ahead of the national deadline.

2.2. Our community services have also been extremely busy, managing high caseloads of patients in their homes as well as running the virtual ward and community emergency response services.

2.3. Colleagues will see from the Integrated Performance Report, which shows the data for the end of 2022/23 financial year, that we have continued to perform well across several metrics. At the next meeting, the Board will receive the new format of the performance report using statistical process control which will help identify our key areas of focus moving forward.

2.4. On 30 March 2023 NHS England published its three-year delivery plan for maternity and neonatal services. The plan (a copy of the summary is available here) sets out a series of actions for trusts, ICBs and NHS England in order to improve the safety and quality of maternity and neonatal services. It sets out the twelve priority actions for trusts and systems for the next three years, across four themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures

We are undertaking a review of our current maternity improvement plan against these priority actions and will present the assessment to the Quality Committee prior to receiving for a discussion here at Board.

2.5. Ensuring that we have a robust and effective risk management system is a key part of keeping the base safe. The revised risk management policy is included on the agenda of this meeting for ratification following approval at the Audit and Risk Committee. As part of these changes, I will use this report to ensure that, as a Board we are clearly sighted on the top three risks affecting the organisation. These are: medical and nursing staffing across the Trust; the challenging financial position; and progress with the transformation and reconfiguration of our services. All of these risks are on the agenda today for discussion.

2.6. The new provider licence came into force on 1 April 2023. The NHS provider licence forms part of the oversight arrangements for NHS providers. It was first introduced in 2013 and has since been held by all NHS foundation trusts, as well as independent sector providers, unless exempt. NHS trusts have been exempt until now, but changes brought by the Health and Care Act 2022 require them to be licenced too from 1 April 2023. The new provider licence aims to: support effective system working; enhance the oversight of key services provided by the independent sector; address climate change; and make several necessary technical amendments.

2.7. The COVID Inquiry has begun, and the first public hearings are likely to take place in June. It is important to recognise that the commentary around these messages can be distressing for colleagues, families and our local people and we will need to be mindful of this as the various hearings take place. Direct NHS evidence will be heard as part of module three, due to commence in 2024.

2.8. A single point of contact service for Calderdale Community District Nursing teams is proving to be an invaluable support for the District Nursing teams within Calderdale. The team of seven are based at Beechwood Health Centre and handle around 900 calls between Monday and Friday each week from patients, families, carers, and other Health Professionals.

2.9. Hearing the views of those who use our services is important and we have been focusing our attention on parts of our community whose voices sometimes get missed. Our Youth Forum

has returned, with a group of seven young patients invited to share their views and ideas on the services we provide, this time focussing on the emergency department. They were all able to open up and tell us about their experiences, which provides useful learning for us.

2.10. This month we also saw the return of PAT (Pets as Therapy) Volunteers. These hospital visits can aid a patient's recovery and rehabilitation and help improve mental health and wellbeing. Visits are provided for patients at CRH, HRI and Acre Mills.

3. Transforming services and population outcomes

3.1. Over the last month there has been a significant national focus on the new structures within the NHS, their efficiency and effectiveness and what further development is required. This has resulted in several reports and publications. As a partner organisation at both place and West Yorkshire level, it is important that we are aware of these and their potential impact on future configurations of the partnership.

3.2. The Rt Hon Patricia Hewitt's review into integrated care systems (ICSs) has been published. It was commissioned by the Chancellor, Rt Hon Jeremy Hunt, in November 2022, to look at the role and powers of ICSs. The review was conducted with significant engagement with leaders from across the health and care system. The Report makes recommendations to maximise the opportunities ICSs bring to population health and wellbeing and provides a helpful overview of the issues hindering progress and placing burden on system players.

Key recommendations include:

- Reducing the number of targets set at a national level.
- Developing "high accountability and responsibility partnerships" for more mature ICSs.
- More investment in prevention, including increasing the public health grant allocation.
- Reducing the use of short-term funding pots.
- Reviewing the entire NHS capital regime.

A full briefing on the review and link to the full review document is available here.

3.3. On 3 March 2023, NHSE announced that ICBs will be required to reduce their running costs by 20% by 1 April 2024, with an additional 10% by April 2025, a total of 30%. The national requirement is a reduction in the size of the running cost budget. As part of the Partnership, we will have a role to play in supporting ICB colleagues in this work and looking for solutions to ensure that work can continue across West Yorkshire while supporting this ask. The first phase will be completed by summer 2023. This will set out options for the future operating model, with an expectation that providers and collaboratives will pick up more functions in places and across West Yorkshire. In addition, there is a move to transfer functions and resources to ICBs, including commissioning for Pharmacy, Dentistry and Optometry services. This will take place by July 2023.

3.4. NHS West Yorkshire Integrated Care Partnership (WYICP) has published its Five-Year Strategy following engagement undertaken with the public and partners. It has been built from the five places' health and wellbeing strategies and engagement with Health and Wellbeing Boards. In developing our own Five-Year Strategic Plan, we took account of the NHS WY ICP Strategy and there is a clear alignment between the two documents. The WY ICP plan is available on their website.

3.5. This month, NHS England has also published the findings of its review of delivery and continuous improvement in the NHS, and launched its new approach to improvement, NHS Impact. The review was commissioned to consider how the NHS can continue to deliver against its immediate priorities while also continually improving services over the long-term.

The review's findings were:

- NHS England's structures do not currently enable a focus on a small number of shared priorities for improvement.
- NHS England needs to engage differently with clinicians and operational managers to enable improvement-led delivery.
- Improvement approaches are embedded in many NHS organisations, but some providers and systems need more support.
- Improvement methodologies are an important element of building improvement approaches, but their deployment should be based on priorities for improvement.
- There is more scope for NHS England to provide tailored support to organisations and systems facing greater challenges.
- NHS England can do more to provide practice support to enable organisations to focus on improvement, including aligning regulatory incentives.

In response, NHS England has agreed three actions:

- To establish a national improvement board, which will agree national priorities for improvement-led delivery.
- To launch a single, shared 'NHS improvement approach' – which will be developed through NHS Impact.
- To co-design and establish a Leadership for Improvement programme.

Along with the review, NHS England is highlighting several improvement guides related to urgent and emergency care and elective care, along with primary care, which you may find useful. Trusts are not being asked to take any specific action at this point, however, as NHS England develops an improvement approach through NHS Impact, Trusts will be asked to introduce an organisational improvement approach aligned with NHS Impact.

The five principles of NHS Impact are:

- Building a shared purpose and vision of improvement.
- Investing in people and culture.
- Developing leadership behaviours that support improvement.
- Building improvement capability and capacity.
- Embedding improvement into management systems and processes.

3.6. Strong collaboration between providers forms the bedrock of statutory integrated care systems. Provider collaboratives mark a definitive policy move from competition towards collaboration and, while they have been established for some time locally, they are still in their infancy in many parts of the NHS. The NHS Confederation and NHS Providers surveyed leaders to evaluate the evolution of provider collaboratives, giving the first national picture of how they are progressing, the state of relationships with partners and ICBs, where there have been successes and where support may be needed. The findings are analysed in a report here, which cites our West Yorkshire Association of Acute Trusts as being one of the most advanced acute collaborations.

3.7. The Health Informatics Service (THIS), have been revealed as finalists in four categories of the HSJ Digital Awards 2023. Two of the categories are linked to the work that THIS colleagues have supported alongside Nurse Consultant for Learning Disabilities, Amanda Mckie. The Covid-19 pandemic highlighted several of the inequalities in health outcomes, experience, and access, so the Reducing Health Inequalities Through Digital and Generating Impact in Population Health Through categories recognise the work to prioritise waiting lists, specifically for our learning disability patients – which resulted in them all being prioritised, with none left waiting for treatment or care.

The Supporting Elective Recovery Through Digital nomination came about from the work the EPR team did to build information in Cerner to support the prioritisation of waiting lists – and is no doubt part of the reason we were recently accredited as one of eight surgical hubs in the UK.

And the fourth category Optimising Clinical Pathways Through Digital, showcases the work to link Cerner EPR to the Pharmacy EMIS system. This has saved around 59 days a year for the pharmacy team who no longer need to follow a manual process, it's easier for our nursing teams and there are fewer transcription errors.

3.8. The Trust also welcomed colleagues from Sweden, who came to look at how we use our electronic patient record (EPR) to transform patient care. As one of the first to 'go-live' in a 'big bang' approach with EPR back in 2017, CHFT is now one of the leading, most digitally mature trusts in the north of England. Oracle/Cerner, the supplier of our EPR technology, invited the delegation from the health and social care system in the Skåne region of Sweden to HRI, where they are currently embarking on their Oracle/Cerner journey and have been signposted to CHFT as a great organisation to learn from. They are interested in the reality of our roll-out – what we learned, and what went well.

3.9. Our reconfiguration plans continue. In April we held the official opening of our Rainbow Hub Child Development Centre. Halifax Panthers' star and Wheelchair Rugby League World Cup winner, Rob Hawkins, cut the ribbon at the event which included patients and their families plus other local partners viewing the state-of-the-art sensory room, moving 'floorscapes' in reception, which change to touch, and moving 'ceilingscapes' in treatment rooms, on which parents can upload family videos from their phones for children to watch.

3.10. The Rainbow Hub also has co-located a number of paediatric specialties on to one site meaning we can now provide a 'one stop shop' for children with complex needs. This was evident with a recent patient who attended their play session with the Rainbow Team. During the session, their Occupational Therapist joined them to review the patient, identified the need for a new specialised chair and due to the location of the new Hub in Elland, the team were able to fit the chair during the same appointment. During the session, the child's

nasogastric tube came out and the Community Nursing team were able to attend to reinsert it as well as support the child's parents with training. This is a great example of how estates reconfiguration is about so much more than new buildings. It is about true transformation of services to create a better patient experience and more effective and efficient service provision.

3.11. Other estates developments continue as planned. Calderdale Council has approved the planning permission for the construction of the learning and development centre at Calderdale. The emergency department development at Huddersfield Royal Infirmary is on track with an open event for local residents being planned for the summer.

4. **Inclusive workforce and local employment**

4.1. Board members will be aware that, as referenced at the start of this report, strike action across the public sector continues. Junior Doctors within the Trust took industrial action over the Easter period. As I write, the Royal College of Nursing is planning two days of strike action in neighbouring trusts from 30 April to 2 May after voting to reject the pay deal. While we are not directly affected, this latest industrial action is planned to be without derogations, meaning that, unlike previously, nursing colleagues will not be required to provide cover in emergency departments and Intensive Care Units. We have been working with partner trusts, which are affected by the industrial action, and we are mindful of the consequential impact the action may have on our services over the Bank Holiday period.

4.2. The Society of Radiographers also voted to reject the pay offer and we await further information as to any further action they plan to take.

4.3. The Royal College of Midwives meanwhile has voted to accept the pay deal alongside Unison. Other unions including Unite, GMB and the Chartered Society of Physiotherapists are due to announce their ballot results over the coming days (prior to the scheduled Board meeting).

4.4. Throughout this, our priority remains the safety of our patients, and the health and wellbeing of our colleagues. This is a national issue, and it is important that we respect the decision of any colleague whether or not they chose to take industrial action, as well as supporting partners across the system to ensure that patient care remains as safe and effective as possible.

4.5. Last month the NHS National Staff Survey results were announced. Our own results show a positive incremental improvement on the previous year's survey. The paper on the agenda for discussion at this meeting sets out the key results and our response led by our One Culture of Care approach, focussing on learning, development, and teamwork.

4.6. Leadership was a key theme from the staff survey and this week we held our first Leadership Conference with around eighty colleagues in leadership positions from across clinical and corporate divisions.

4.7. Recruitment and retention across a range of areas remains challenging and it is important that we look at different ways of bringing new people into the Trust, retaining and motivating our existing colleagues as well as looking at different workforce models. There are lots of

examples of how we are doing this, and the Board will hear more about that at the start of the meeting. Some examples include:

- Welcoming student nurses and allied health professionals from the University of Huddersfield as part of a pioneering new programme of digital placements;
- Following a successful pilot of placements for Learning Disability Nursing Students, we have had our first cohort of Mental Health Nursing Students with one student commenting their second day: "we are learning so much about One Culture of Care and the integration of physical and mental health care needs for patients at CHFT". Having mental health students at the Trust helps them learn and practice physical health skills, whilst helping us meet the ongoing mental health needs of people in our care.
- Six colleagues in the community healthcare division will start their degree apprenticeships later this year, as the division continues to develop its workforce.
- We have included staff nurses as part of our midwifery team to provide the non-midwife care to mums and their babies on our maternity unit.

4.8. A joint celebration event for the International Day of the Midwife and Nurses' Day is planned for next month. The event for nurses, midwives and AHPs will be on Friday 12 May at HRI. The theme this year is the difference nursing makes.

4.9. This week saw National Cancer Clinical Nurse Specialist Day, which aims to raise the profile and showcase the amazing work of Cancer Clinical Nurses Specialists (CNS). Clinical Nurse Specialists are senior nurses who have completed postgraduate qualifications and acquired specialist knowledge to support cancer patients. They hold regular clinics to support patients through their cancer diagnosis, treatments, and follow-up care. The Trust has a team of around fifty clinical nurse specialists undertaking varied and complex roles.

4.10. April also saw the latest Wellbeing Festival with the theme of Stress Awareness. Supported by Andy's Man Club the event focused on "it's okay to talk".

4.11. We have been encouraging colleagues to apply to join the latest tranche of the WYICB's award-winning leadership development programme aimed at colleagues from ethnic minority communities who are working within health and care. The programme aims to increase the diversity of our leaders within health and care roles across the area. Twenty individuals have either completed or are currently undertaking the programme since 2020. The programme's participants have gone on to have great success. Within six months of completion, nine of the eleven cohort one participants were either promoted or moved to a job of their choice.

5. **Financial, economic, and environmental sustainability**

5.1. Board members will see from the papers for this meeting that we met our financial plan for 2022/23. This is a fantastic achievement; in the context I have previously described and with a significant efficiency programme and I would like to thank colleagues across the Trust for their hard work to enable us to reach this position.

5.2. It is recognised nationally that 2023/24 will be even more challenging and as I write this report, the Trust does not have an agreed financial plan. We have been working with colleagues within other acute trusts across West Yorkshire and within the ICB to get to an

agreed position. It is likely that this will also have a significant cost efficiency ask. The Director of Finance will provide a more detailed update on this at the meeting.

5.3. Our Deputy Chief Executive / Director of Strategy and Transformation has been working with Kirklees Council and the University of Huddersfield to look at how we ensure that the work we do and our role as an anchor partner creates true social value for our local area. Those colleagues that have seen the most recent Foundations for the Future Stakeholder Briefing will have seen that we have had a real commitment to generating social value through our significant estates development through using local suppliers and creating jobs and training placements for local people. This work is continuing and is a key part of our social and economic contribution to our local places. You can read more about what we have been doing here.

6. Recommendations

6.1. The Board is requested to receive this paper as assurance and progress against both the local and national agenda, and as an update against leadership responsibilities within the CEO portfolio.

STRATEGY : TRANSFORMING AND IMPROVING PATIENT CARE

9. Annual Strategic Plan – Final Year End Progress Report

To Approve

Presented by Anna Basford and Rob Aitchison

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	**4 May 2023**
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**Annual Strategic Plan – Final Year End Progress Report**
Author:	**Anna Basford, Deputy Chief Executive (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 March 2023.

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. Each of the objectives has a named Director lead accountable and responsible for delivery.
This report details progress to deliver the objectives and also includes the Board Assurance Framework risk score that relates to the objective.
Significant progress has been made against all areas of the 2021-23 strategic objectives. This year-end report highlights that of the 19 objectives, 18 are rated green, and 1 has been closed.
In March 2023 the Trust Board approved a refreshed five year strategic plan and the one year strategic objectives for 2023-24. The refreshed five year and one year strategic plans describe the Trust's ambitions across the four goals:

- To transform patient care and population health outcomes
- To provide the best quality and safety of care
- To be the best place to work, supporting a workforce for the future
- To be sustainable in our use of financial and environmental resources

Quarterly updates on progress to implement the 2023-24 strategic objectives will be provided for the Trust Board.

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 requested to **NOTE** the assessment of progress against the 2021/23 strategic plan.

Calderdale and Huddersfield NHS Foundation Trust
2021-23 Strategic Plan – Progress Report for period ending March 2023

Purpose of Report

The purpose of this report is to provide an update on progress made against the Trust's 2021-23 strategic 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
0	is rated amber
18	are rated green
1	has been 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**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**
Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'.	**BLUE** Completed/ Closed	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. In March 2022 the Trust Board 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 and objective has been closed.	**Ensure learning from the Pandemic is embedded in the longer term strategies of the Trust.** **Lead: AB** Transformation Programme Board	Related BAF risk removed March 2022
Trust Board approval of reconfiguration business cases for HRI and CRH.	**GREEN** on track	The Full Business Case for the new Accident Emergency Department at Huddersfield Royal Infirmary was approved by NHSE in 2022 and the first stage of reconfiguration is underway with construction of the new A&E at HRI that is scheduled to open in September 2023. The Reconfiguration Outline Business Case (detailing the planned estate developments at HRI and CRH) was approved by NHSE and DHSC in 2022 and DHSC has confirmed allocation of capital funding for the developments. All necessary planning permissions for the developments at CRH have been granted by Calderdale Council. The first phase of enabling construction works at CRH will be	**NHSE and Treasury Approval of Reconfiguration Business Case** **Lead: AB** Transformation Programme Board , Trust Board ICS, NHSE, DHSC	20 BAF Risk 1/19 Reconfiguration

		the build of the new Multi-Storey Car Park and the new Learning and Development Centre. The second phase of work at CRH will then expand the hospital providing an additional 10 wards, two theatres and a new Accident and Emergency Department, including a specialist paediatric A&E Department. The Trust is progressing constructive dialogue with the Infrastructure Project Authority and DHSC to enable Treasury approval of the Reconfiguration OBC and commencement of construction at CRH during 2023-24. Delay in Treasury decision on the business case could impact on programme timescale and affordability. Regular updates and briefing on the reconfiguration programme is provided for stakeholders and detailed information about the Reconfiguration Programme is also available on the Trust's reconfiguration website https://future.cht.nhs.uk/home		
Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire.	**GREEN** on track	The Board approved clinical strategy is supporting discussions within WYAAT and the ICS on the development of WY service strategies 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. A South Sector implementation	**Clear plans agreed with partners to implement improved, resilient and innovative service models in Calderdale and Kirklees and across West Yorkshire** **Lead: DB** Weekly Executive Board Quality Committee Trust Board	12 BAF risk 01/20 Clinical Strategy

		manager has been appointed and DB is chairing an implementation Board. The Pathology Partnership between LTHT, CHFT and MYHT (NPP) has been established and both an oversight Board and operational groups have been established. DB has been appointed as the SRO for the program. A single Laboratory Information management system has been purchased and is being implemented across the network as a single instance overseen by a Digital Implementation Board. There have been delays in implementation, however Bradford is now live with histopathology, and plans are in place for Blood sciences and Microbiology. Modifications to the system have resolved concerns in relation to the blood transfusion module and implementation will now commence. LTHT are on track to go live in the Summer, followed by Harrogate. CHFT will go live in 2024. A WYAAT diagnostics board is established to oversee progress of both Pathology and Radiology networks and Community Diagnostic hubs. Work is ongoing to develop a business case to establish a Bariatric surgery hub, for patient within WYAAT and further afield. Monthly Place based meetings have been established in Calderdale and a partnership working group between CHFT and MYHT.		
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. The Trust is now connected to a CHFT instance within Microsoft Azure (Cloud) by	**Continued progress towards strategic objectives to include key milestones for data integration, ERP Optimisation and delivery of key capital**	12 BAF risk 02/20 Digital Strategy

		resilient network connections from both hospital sites. • There is continued progress of a data science approach to help improve services and outcomes both at Trust and Place level. Working with system partners including the universities to progress this approach and building further on recent work around waiting list validation and Health Inequalities (Learning disabilities) • Scan for Safety has come to an end as a programme however, work continues with the technology under the digital plan in supporting wider trust strategies such as Reconfiguration. • Capital funding for 23/24 is limited however we continue to submit bids for central funding enabling the trust to further invest in digital technology, Patient Portal and RPA being good examples. • Continued support of Trust Reconfiguration activities including the outputs from innovation workshops and digital target operating model sessions. Engagement with vendors on strategic planning and implementation of physical infrastructure. • EPR Team structured to support steps towards optimisation through trust aligned pieces of work with a focus on 'getting the basics right' (e.g. Clinical Documentation). In relation to this, nursing documentation optimisation is now underway and making a difference. • Collaboration with partners continues with successful outcomes including becoming an Oracle/Cerner reference site in the north as well as a number of initiatives	**projects including Reconfiguration** **Lead: RB** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.	

		with the Universities such as digital nursing placements. • Digital Governance at Divisional Level is now established but continues to take time to become fully embed. Technical/project management support assigned to each divisional board to provide specialist knowledge.		
Use population health data to inform actions to address health inequalities in the communities we serve.	**GREEN** on track	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. Through the Access Delivery Group further work is being progressed to ensure a greater level of scrutiny is in place for oversight of elective waiting lists. A Health Inequalities strategy has been developed to further enable the Trust to address health inequalities within the communities we serve Work is being undertaken to develop a "Health inequalities vulnerability index" to identify patients at increased risk of experiencing inequalities and take a holistic approach to prioritisation and care. People with learning disabilities were prioritised under the reset and recovery programme, with all known people with a	**To see a sustained improvement in the waiting time differential. To reduce the incidence of harm as result of waiting for treatment.** **Lead: LR** Weekly Executive Board Board of Directors Access Delivery Group Learning Improvement Review Board Health Inequalities Oversight Group (England)	12 BAF risk 07/20 Health Inequalities

		learning disability on existing waiting lists having their surgery. There has been continued work with partners on Outpatient Transformation. This includes remote appointments project, and implementation of patient-initiated follow-up (PIFU) pathways. Specific actions relating to digital inclusion, and the development of referral information required to identify where reasonable adjustments may be needed to enable equitable access have been progressed. We have created a new service called BLOSM within our emergency departments to tackle health inequalities and engage with vulnerable service users attending ED (BLOSM stands for Bridging the Gap, Leading a change in culture, Overcoming adversity, Supporting Vulnerable People, Motivating Independence and Confidence) Further work has been undertaken on the matrix of vulnerability to support ongoing prioritisation for people accessing planned care services. In relation to ensuring equitable waiting times across the wider Health Inequality agenda significant progress has been made in the management of patients and is monitored by the access delivery group. The waiting time for patients with a Learning Disability has continued to decrease. Maternity services has established a working group to progress actions to address health inequalities. The service have developed specialised roles that are supporting women who are impacted by mental health and/or substance misuse, to improve and impact on their health outcomes.		

Goal: Keeping the base safe				
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**
Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleague's safety.	**GREEN** on track	We are continuing to work with all partners and communities to support increased population uptake of the Covid-19 and flu vaccines. The Trust is ensuring national guidance in relation to IPC measures are implemented. There has been re-launch of the health and well-being risk assessments. The trust has continued to develop and refine its Health and Well being provision to meet the needs of colleagues and has a seasonal Health And Well Being strategy on place for Autumn and Winter2022/23. The strategy contains 4 key areas - Mental, Financial, Physical and Social. CHFT has a programme of Wellbeing Festivals which are an opportunity for colleagues to catch up on the Trust's wellbeing offers and feedback to shape the future of the support the Trust offers too. Average wait times for a management referral appointment with an Occupational Health Nurse Practitioner have reduced from 6-8 weeks (Summer 2022) to 2 weeks (as of February 2023). In the 12 month period 1 February 2022 to 31 January 2023 we have completed 809 Health and Wellbeing Risk Assessments. 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. The trust has reviewed its	**Staff accessing HWB assessments receive timely and effective outcomes**. **Lead: LR** Weekly Executive Board Trust Board Workforce committee	16 BAF risk 05/20 Recovery

		recovery plans to ensure it meets the national performance targets in place for 2022/23 The trust has continued to progress this work in the reporting period.		
Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**GREEN** on track	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. Significant work has been put in place to ensure optimum state of readiness for future CQC assessment across a number of services. Maternity Services has had an external Ockenden Assurance review and met all 7 immediate essential actions (IEA).Children and Young People services has undertaken an internal review with the NHSE/I regional transformation lead providing external scrutiny. We have continued to share overviews of specific services to support the relationship meetings with CQC including End of Life Care, Surgical and Critical Care services. The trust has reviewed the Must do and Should do actions from its previous inspection. Further work is being undertaken to support the Well Led Domain. The trust is currently supporting the	**Maintain the Good rating, achieve some outstanding ratings.** **Lead: LR** Quality Committee Weekly Executive Board	12 BAF risk 04/20 CQC rating

		transition to the new CQC single inspection framework. The Trust has continued to work with CQC during the reporting period and is undertaking work to underpin partnership service models and how this will be regulated within the new framework. The Trust is awaiting its Maternity Services CQC inspection as part of the national CQC programme.		
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 is embedded and plans in place for the schedule of assessments. These align to our J20 programme. The observe and act has transitioned into face to face as part of the recovery from the pandemic – feedback is embedded into action plans in the areas reviewed. 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 have appointed a Nurse Consultant for Mental Health to address the unique needs of this group pf service users. Further work is being undertaken to ensure shared learning from incidents and complaints. The trust is working towards the implementation of the new national Patient Safety Incident Response Framework (PSIRF). The trust has launched its Keep Carers Caring strategy and has relaunched Johns Campaign following feedback from patients	**To see an improvement in the feedback from service users as part of the Observe and Act process.** **Lead: LR** Quality Committee Weekly Executive Board	12 BAF risk 04/19 Patient and Public Involvement

		and families. Feedback has been positive in regard to the changes made. Observe and act continues to form part of our local accreditation system across ward teams and feedback has been positive from patients engaging in the process.		
Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery.	**GREEN** on track	The Trust achieved the national targets in relation to no over 104 week and no over 78 week waits by the end of the financial year. In addition, the volume of over 52 week waits reduced significantly and compares favourable regionally and nationally. The Trust continues to achieve cancer access standards ensuring that people who have an urgent referral from their GP for suspected cancer receive the timely treatment they need. The Trust's performance on the Accident and Emergency 4 hour waiting time standard continues to perform better than most Trusts despite increasing demand on services. This is also the case for over 12 hour waits which from February data showed the trust to be in the top 10% or organisations for low number of 12 hour length of stay. The trust also continues to perform well in relation to timely ambulance handover.	**Achieve key performance metrics for urgent and emergency care and elective recovery** **Lead: JH** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group	16 BAF risk 05/20 Recovery
Deliver the actions in the Trust's Health and Safety Plan.	**GREEN** on track	The health and safety management system is making good progress 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.	**Implement actions in the Health and Safety Plan** **Lead: SD** Quality Committee Trust Board	6 BAF risk 16/19 Health and Safety

		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 Home working display screen equipment assessment tool has been revised and planned for sharing to all relevant colleagues.		
Goal: A workforce fit for the future				
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**
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	Our recruitment strategy 2022/2023 was agreed in April 2022 and an action plan underpins this to monitor progress through Workforce Committee. To deliver the strategy we continue to focus on:- • the national target of 0 vacancies through the Healthcare Support Worker Programme. A task and finish group is underway to further progress delivery of new to care across the Trust. • Continued progress on reducing registered nurse vacancies and expanding recruitment events across the Trust. • Enhanced international nurse recruitment including further cohorts in 2023. • Extension of international recruitment to a limited number of AHP roles is underway for 2023.	**Improved vacancy rate overall. Improved vacancy rate for N&M and M&D staff groups. Turnover below 10% Stability above 90%** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention

		• Increase in substantive medical workforce numbers particularly in key hot spot areas including Emergency Medicine, Anaesthetics and Radiology. In addition, progressive work continues on a range of activities with external partners to develop employability and employment programmes accessible to people in our local communities. Turnover has remained at an average of 8.27% during 2022-3		
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	Progress has been made with regard to the following:- • People Strategy refreshed with talent management as 1 of 6 core themes. • Talent management framework established capturing a holistic approach including key themes recruitment, retention, reward and recognition, engagement and involvement, development, performance management and succession planning/pipeline management. • Talent development toolkit developed to support colleagues and their managers. • Appraisal season for 2023/2024 identified for April to December 2023 with a move to a 3-month season running from April to June by 2025/2026. • 'Development for All' programme and brochure produced and published. • Widening Participation and Apprenticeships offer a robust entry level pathway pipeline to employment. • Empower and Stepping into Leadership Programmes provide colleagues with the	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention

		tools they require to enable their career aspirations • Offering access to externally provided leadership development programmes by NHS North East and Yorkshire, NHS Leadership Academy and WYAAT. • Refreshing an internal 'management fundamentals' programme for leaders/managers • Building a 'new to manager' learning programme. • Partnering with Calderdale and Kirklees Colleges to create a Health Academy supporting T-Level health care and non-clinical learners aged 16 to 18. Learners will complete clinical placements and access apprenticeship opportunities on completion. • Our Work Together Get Results returned in January 2023. with colleagues feeding back '(this is the) best thing I've done in the Trust'.		
Revise our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams through Recovery and beyond	**GREEN** on track	• facilitates embedding essential leadership behaviours in support of One Culture of Care • Introduction of a 'taught' leadership development programme with opportunities for networking and shared coaching/problem solving. This is supported by the leadership development e-platform that comprises a library of leadership and management resources • Participation in an NHS England/Improvement pilot of a Team and Engagement Development (TED) tool. TED is an evidence-based diagnostic, structured around key features of highly	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention

		engaged and high performing teams. TED contains a team development toolkit to help teams develop and maintain high performance. There are resources linked to the areas measured by the diagnostic to provide specific guidance and development tools. TED aims to improve individual engagement, team engagement and team working. • Equality, Diversity and Inclusion Awareness and Education Programme launches by 31 July 2023. Refreshed Management Fundamentals programme to be launched by 31 May 2023.		
Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of our local communities.	**GREEN** on track	inclusive recruitment is a fundamental part of our recruitment strategy. Implementation stages were undertaken for a values based applicant screening tool in December 2023 with roll out planned for 2023/4. The trial of the screening tool in sample areas has been moved to Q2 of 2023/24. Further work is to be completed to review/refresh our recruitment approach from advertising stage to post-employment in 2023.	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention
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	Our 2021 staff survey health and wellbeing response scores endorsed the Trust's approach to colleague health and wellbeing. There was a 10% increase in colleague perception that the Trust is interested in and takes positive action in relation to their wellbeing. Our focus in facilitating access into individualised services, for example the internal Listening Ear service and CareFirst, our external employee assistance programme provider remains. We maintained our above average health and wellbeing score in the 2022 staff survey.	**Improved National Staff Survey scores** **Lead: SD** Workforce Committee	12 BAF risk 1/22 Health and Well Being

		Our internal colleague psychology service has been strengthened with an appointment to a Psychologist role which will be supported through additional investment by a newly created Assistant Psychologist position in the near future. The team will review our existing Friendly Ear service provision, support group psychological interventions and offer a small amount of 'low-intensity' 1:1s. Over the winter months specific focus has been placed on:- • Financial Wellbeing through education and guidance resources and cost of living including clothes and food 'top up' shops. • Developing a 'trauma informed workforce'. • Scheduling a quarterly programme of colleague health and wellbeing festivals in 2023. • Menopause accreditation • provision of 'safe spaces' offering refreshments and shelter for colleagues struggling with bills, home life and loneliness. The Trust's menopause support community launched in August 2022 now has 91 members has helped colleagues stay in work, improve their health, access medical advice/treatment and reduced stigma and social isolation. The Trust partnered with West Yorkshire and Harrogate Mental Health Hub and the regional suicide prevention service to raise		

		awareness and understanding of suicide risk and prevention in the workplace. The Trust has had support from clinical psychologists and suicide prevention experts to help develop its approach to suicide prevention in the workplace. 183 colleagues at the Trust have signed up to a mindfulness community. The service offers two 30 minute online mindfulness sessions a week designed to support wellbeing. In addition, mindfulness is included in the apprenticeship induction programme. Focused bespoke wellbeing support has been offered to high intensity clinical areas including ED, ICU, and Respiratory. The Trust has secured £65k funding from Calderdale and Kirklees Places to implement an 'in house' fast track MSK physiotherapy service for colleagues with musculoskeletal problems.		
Goal: Sustainability				
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**
Deliver the regulator approved financial plan.	**GREEN** on track	The Trust delivered the financial plan for 2021/22 with a £40k surplus on a control total basis. For 2022/23 a deficit plan of £17.35m was submitted and agreed with ICS. Subject to confirmation by the external audit process, the Trust has delivered the year end financial position in line with the 2022/23 planned deficit of £17.35m. In support of this the Trust has reported delivery of the full efficiency requirement of £20m	**No intervention from NHSEI or ICS.** **Lead: GB** Reported to Finance & Performance Committee Monthly regulator discussions	16 BAF risk 07/19 Compliance

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. 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. The plan for 2022/23 is a deficit plan which would score 3 on the finance use of resource metrics and not meet all the CQC actions required (one of which was to deliver financial balance). NHSE have not recommenced active formal monitoring of the use of resources score in 22/23 having paused this during the Covid pandemic. However internal monitoring demonstrates that the Trust has achieved an overall score of 3 in line with the planned level. Whilst one metric was lower than planned as the agency expenditure ceiling was exceeded, the achievement of the overall planned deficit position maintains the overall score at level 3.	**Completion of all CQC actions except financial balance. Finance Use of Resource score of 3 as per plan** **Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions	16 BAF risk 07/19 Compliance
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 Programme Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the bi-monthly Green Planning sub-group Chaired by Andy Nelson. The Green Plan is a Board approved document which is submitted at ICS level. Some of the key progress this year include: • We received around 1000 responses to our new travel survey which went out for consultation in February 2023. We are	**Strong working relationships with partners on the climate emergency. Delivery of our Green plan and Travel plan** **Lead: SS** Transformation Programme Board Trust Board	8 BAF risk 06/20 Climate Action

		collating the responses and will update the travel plan accordingly. • The Trusts Green Plan and Sustainability Action Plan outlines individual actions across 11 key themes. In total there are 203 interventions proposed. 148 of these actions are designated as complete. We are also developing a calendar of sustainability engagement events for 2023/24. • Audit Yorkshire – Sustainability audit gave significant assurance and confirmed that CHFT is demonstrating a commitment to minimising its adverse impact on the environment. • CHS can now provide in house Carbon Literacy Training for staff. • A heat decarbonisation plan with actions has been developed for both hospital sites • 94% of CHS fleet currently ultra-low emissions vehicles • 100% of our energy is bought from green sources • a Travel Plan has been adopted by the Trust to support more active travel. The Travel Plan outlines 47 individual actions across 4 key themes and 41 out of the 47 actions are designated as complete. • 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 along with new shower and locker facilities • a Biodiversity Management Plan has been developed covering our estate. Since		

		November 2022, over 600 trees have been planted at HRI CHS is an active member of Kirklees climate commission and Calderdale Councils climate action plan group.		
Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** on track	Following the legislative changes set out in the Health and Care Bill that was enacted on 1st July 2022 the West Yorkshire Health and Care Partnership (ICS) has established a West Yorkshire Integrated Care Board (ICB) and local place based sub-committees of the ICB in Calderdale and Kirklees. The Trust has confirmed senior leadership capacity to support the new place based ICB working arrangements. Trust Board development workshops have been held to discuss partnership working and the role of the Trust as an 'anchor partner' to support and enable integrated working in local Places. This has informed refresh of the Trust's corporate 5 year strategy that was approved by the Trust Board in March 2023. The Trust continues to collaborate as a member of the West Yorkshire Association of Acute Trusts (WYAAT) to develop and implement new ways of working across hospital Trusts in West Yorkshire, this includes developments related to: • clinical support services - imaging, pharmacy, pathology, digital developments such as scan for safety • corporate services - workforce, procurement • clinical service models - vascular and non-surgical oncology	**Strong working relations with partners with clear system minded rationale for decisions to deliver improved population health, tackle inequalities, enhance productivity and efficiency, and support social value generation and economic development.** **Lead: AB** Trust Board WYAAT Committee in Common Calderdale and Kirklees subcommittees of ICB System Leadership Meetings with NHSE and WY ICS	16 BAF risk 8/19 Performance Targets

		The Trust is working closely with partners to provide ‘mutual aid’ and enable service recovery and resilience.		

10. Annual Plan 2023/2024 revised plan

To Approve

Presented by Kirsty Archer and Gary Boothby

INTEGRATED PERFORMANCE

11. Finance and Performance Chair Highlight Report

For Assurance

Presented by Andy Nelson

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	4th and 26th April 2023
Date of Board meeting this report is to be presented:	4th May 2023

ACKNOWLEDGE

- Continued strong performance in Cancer as noted recently in the Guardian where we were 1 of only 3 trusts nationally to regularly achieve the 14-day and 62-day referral to treatment targets
- Recovery performance remains strong and we have met the 2022/23 target for Zero 78- and 104-week waiters and 52-week waiters compared with the external plan. Against our internal target of zero 52-week waiters at year end we had just 131 patients. We also met the 104% activity target for planned inpatient spells and exceeded the target for outpatient first attendances. CHFT clearly best performer in West Yorkshire ICB – a real credit to all involved
- We are reporting a £17.34m deficit for the 2022/23 year (excluding the impact of Revaluations, Impairments and Donated Assets); a £0.01m favourable variance to plan
- There has been an improvement in our mortality measures with HSMR now reporting lower than the expected range at 96.8 and SHMI within the expected range at 104.7

ASSURE

- The committee had a presentation of the Urgent and Emergency Care Recovery Plan with a focus on reducing Length of Stay and improved pathways in Same Day Emergency Care
- The Treasury Management annual report for 2022/23 showed we have maintained a good cash balance, paid invoices over 90% of the time and bar two specific debt issues managed our aged debt well
- We underspent our capital plan for 2022/23 by £11.2m primarily due a reduction in planned expenditure on Reconfiguration. The committee were assured that the Capital Management Group and Business Case Approval Group tightly manage our capital expenditure at a scheme level

AWARE

- Diagnostics performance still good overall but issues in Neurophysiology and Echocardiography for which there are clear action plans
- Transfer of Care (TOC) numbers remain a concern being consistently over 100 – the Urgent and Emergency Care Recovery Plan is key to cracking this problem and has set a target of 50 TOC patients by July of this year
- Backlog volume of ASIs and Follow-Up appointments which have increased recently remain a concern and is now a key area of focus in our relaunched Elective Transformation Programme
- F&P received updates on the draft 23/24 financial plan which as of the 26th April committee meeting had not been finalised and agreed but was expected to be agreed by the May Board meeting. This is likely to show a further challenge to the plan previously discussed at Board. The committee noted the challenging nature of the plan but were encouraged by the progress made to date in developing the Cost Improvement Plan with 87% of schemes now at a gateway stage and 74% of schemes being recurrent

- The committee also had a paper on Productivity which compared inflation adjusted performance in 2019/20 to the plans for 2023/24. This shows our spend is a little higher than peers but that activity is materially better. However, the national productivity measurement tool still generates a productivity improvement opportunity for CHFT of 8.1%. Against this we believe we can show actions are being taken not least in a number of our CIP schemes.

ONE CULTURE OF CARE

One Culture of Care considered as part of the performance and finance reports. Senior member of WOD now attends F&P on a regular basis plus WOD representation in deep dives. This allowed the committee to check in on workforce performance (such as sickness levels) and well-being and whether any further actions can be taken given the significant operational pressures staff are facing.

CHFT continues to reduce its elective backlog faster than all Trusts across WYAAT

As of 21/04/2023	0<18			18>26			26>40			40>52			52>78			78>104			>104			Total		
Provider	Dec-21	Feb-23	^v %	Dec-21	Feb-23	^v %	Dec-21	Feb-23	^v %	Dec-21	Feb-23	^v %	Dec-21	Feb-23	^v %	Dec-21	Feb-23	^v %	Dec-21	Feb-23	^v %	Dec-21	Jan-23	^v %
Leeds	54,434	57,432	↑ 6%	9,770	11,657	↑ 19%	6,526	12,295	↑ 88%	2,079	6,042	↑ 191%	2,079	3,899	↑ 88%	831	128	↓ -85%	480	7	↓ -99%	76,199	91,460	↑ 20%
Mid Yorks	26,143	32,256	↑ 23%	4,453	7,524	↑ 69%	3,320	7,803	↑ 135%	998	3,462	↑ 247%	639	1,373	↑ ####	118	14	↓ -88%	-	-	↑ 200%	35,671	52,432	↑ 47%
Bradford	21,722	26,580	↑ 22%	6,364	6,352	↓ 0%	6,072	4,517	↓ -26%	763	1,395	↑ 83%	611	584	↓ -4%	336	8	↓ -98%	154	-	↓ -100%	36,022	39,436	↑ 9%
Calderdale	19,089	22,678	↑ 19%	5,039	5,792	↑ 15%	6,328	4,087	↓ -35%	2,029	1,337	↓ -34%	2,444	131	↓ -95%	636	-	↓ -100%	106	-	↓ -100%	35,671	34,025	↓ -5%
Harrogate	15,551	15,587	↑ 0%	2,904	3,656	↑ 26%	2,328	3,295	↑ 42%	911	1,279	↑ 40%	877	1,156	↑ 32%	203	-	↓ -100%	45	-	↓ -100%	22,819	24,973	↑ 9%
Airedale	7,913	9,296	↑ 17%	995	2,048	↑ 106%	656	2,105	↑ 221%	219	951	↑ 334%	306	567	↑ 85%	107	-	↓ -100%	12		↓ -100%	10,208	14,967	↑ 47%
Total	144,852	163,829	↑ 13%	29,525	37,029	↑ 25%	25,230	34,102	↑ 35%	6,999	14,466	↑ 107%	6,956	7,710	↑ 11%	2,231	150	↓ -93%	797	7	↓ -99%	216,590	257,293	↑ 19%

12. Month 12 Financial Summary

For Assurance

Presented by Kirsty Archer and Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 4th April 2023
Meeting:	Board of Directors
Title:	Month 12 Finance Report
Author:	Philippa Russell – Acting Deputy Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance / Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance & Performance Committee

Actions Requested:

To receive – to discuss in depth, noting the implications for the Board or Trust without formal approval

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 12 (March 2023)

Key Points to Note

Year-End Summary

The Trust is reporting a £17.34m deficit, (excluding the impact of Revaluations, Impairments and Donated Assets), a £0.01m favourable variance from plan. The in-month position is a surplus of £4.64m, a £3.61m favourable variance. The Trust continued to incur higher than planned costs due to inflationary pressures and additional capacity requirements. In addition, costs were incurred in month due to the Doctors Strike and the Trust was asked to include in the position the cost of the proposed Agenda for Change (AfC) pay award (22/23). Whilst national funding has been provided, this is not sufficient and does not cover staff on local pay scales, a £0.50m adverse impact. These pressures were offset by additional funding from System partners to support operational and inflationary pressures; higher than planned vacancies and technical benefits including the Joint Venture revaluation and profit.

- £12.73m of Elective Recovery Funding (ERF) has been received, £0.40m lower than planned. National confirmation has now been received that there will be no claw back of ERF for 2022/23, but £0.40m has been returned to Kirklees ICB to support Independent Sector expenditure pressures at Place.
- The Trust has been allocated block funding of £7.3m for the year to support Covid-19 costs by the Integrated Care System (ICS) and have also been allocated funding for Covid-19 costs that are considered to be outside of the System Envelope: Vaccinations and Covid-19 Testing. Requirements for additional funding for testing have reduced significantly as national procurement has expanded and the Autumn vaccination programme was funded differently, on a fixed cost per vaccine basis.
- The Trust has incurred costs relating to Covid-19 of £15.23m, (excluding costs outside of System Envelope), £6.27m higher than planned. Covid-19 activity remained higher than planned throughout the year and is one of a number of factors driving additional

staffing costs and consumables, with extra capacity opened over and above the planned level.
- The Trust has delivered efficiency savings of £20.00m, as planned.
- Agency expenditure in 2022/23 was £14.35m, £7.45m higher than planned. The Integrated Care Board set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has exceeded that ceiling by some margin.
- Total planned inpatient activity, for the purpose of Elective Recovery, was 99.6% of the activity planned, (104.0% of 19/20 activity levels).

Key Variances

- Income is £49.73m above the plan but includes two material nationally agreed funding adjustments: £12.77m funding for the 6.3% pension contribution that is paid for centrally and a £10.84m contribution towards the proposed AfC additional Pay Award. The Trust has also received additional Tariff based funding (£6.06m) to support changes to pay (pay award / National Insurance changes); additional Integrated Care Board (ICB) funding to support increased bed capacity and Depreciation; and income from other local Trusts to support Vascular Services and Non-Surgical Oncology. In addition, £2.3m of Covid-19 funded has been reallocated year to date to support operational pressures. Higher than planned NHS Clinical income is offset to some extent by lower than planned funding for 'outside of envelope' Covid-19 due to a reduction in testing costs now that most testing consumables have moved to a national procurement mechanism. Higher than planned Education & Training income includes £2.37m for hosted GP trainees.

- Pay costs were £36.63m higher than the planned level in 2022/23 including: higher than planned pay award for which arrears were paid in Month 6, partially offset by a change to National Insurance, (net increase £6.92m); the AfC additional non-consolidated pay offer in M12 at a cost of £11.36m; £12.77m for the 6.3% pension contribution that is paid for centrally. Excluding these nationally driven elements described above, the underlying pay position is a year to date adverse variance of £5.58m. The cost of additional capacity; higher than planned Agency and Bank premium rates and the impact of Strike Action, have been partially offset by a combination of vacancies in FSS and Community Divisions and lower than planned Elective Recovery costs.

- Non-pay operating expenditure is £15.93m higher than planned year to date with pressure on consumable costs due to additional capacity requirements, higher than planned insourcing / outsourcing costs associated with Elective Recovery and inflationary pressures in particular on utilities and the PFI contract.

Attachment: Month 12 Finance Report

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to receive the Finance Report and note the financial position for the Trust as at 31st March 2023.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Mar 2023 - Month 12

KEY METRICS

	M12				YTD (MAR 2023)				Forecast 22/23			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	£1.13	£4.74	£3.61		(£17.35)	(£17.33)	£0.01		(£17.35)	(£17.33)	£0.01	
Agency Expenditure (vs Ceiling)	(£0.64)	(£1.35)	(£0.71)		(£6.90)	(£14.35)	(£7.45)		(£6.90)	(£14.35)	(£7.45)	
Capital	£4.50	£10.67	(£6.17)		£41.99	£31.26	£10.73		£41.99	£31.26	£10.73	
Cash	£19.26	£24.63	£5.37		£19.26	£24.63	£5.37		£19.26	£24.63	£5.37	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	92.1%	-3%		95.0%	91.4%	-4%					
CIP	£2.11	£2.31	£0.19		£20.00	£20.00	£0.00		£20.00	£20.00	£0.00	
Use of Resource Metric	2	2			3	3			3	3		

Year-End Summary

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Total Group Financial Overview as at 31st Mar 2023 - Month 12

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M12

CLINICAL ACTIVITY

	M12 Plan	M12 Actual	Var
Elective	5,774	4,664	(1,110)
Non-Elective	58,361	53,818	(4,543)
Daycase	50,176	51,073	897
Outpatient	436,084	453,885	17,801
A&E	170,928	173,831	2,903
Other NHS Non-Tariff	1,867,647	1,996,299	128,652
Total	**2,588,970**	**2,733,570**	**144,600**

TOTAL GROUP: INCOME AND EXPENDITURE

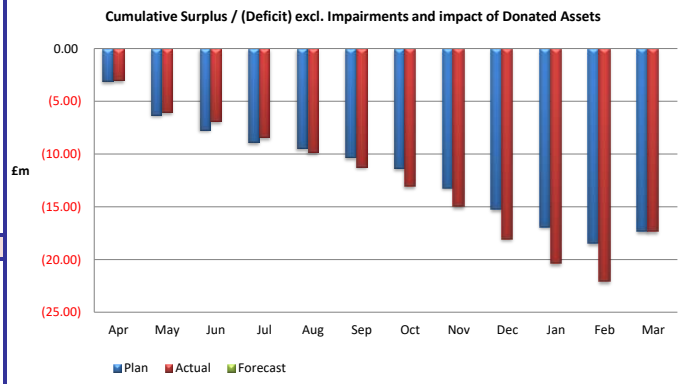
	M12 Plan	M12 Actual	Var
	£m	£m	£m
Elective	£23.08	£18.12	(£4.96)
Non Elective	£123.29	£122.73	(£0.56)
Daycase	£35.10	£36.61	£1.51
Outpatients	£40.60	£44.93	£4.33
A & E	£28.76	£30.59	£1.83
Other-NHS Clinical	£180.77	£226.31	£45.54
CQUIN	£0.00	£0.00	£0.00
Other Income	£53.66	£55.71	£2.05
Total Income	**£485.26**	**£535.00**	**£49.73**
Pay	(£318.79)	(£355.42)	(£36.63)
Drug Costs	(£45.79)	(£45.40)	£0.40
Clinical Support	(£34.28)	(£33.71)	£0.57
Other Costs	(£57.19)	(£73.79)	(£16.60)
PFI Costs	(£14.31)	(£14.61)	(£0.30)
Total Expenditure	**(£470.36)**	**(£522.92)**	**(£52.56)**
EBITDA	**£14.90**	**£12.07**	**(£2.83)**
Non Operating Expenditure	(£32.25)	(£29.41)	£2.84
Surplus / (Deficit) Adjusted*	**(£17.35)**	**(£17.33)**	**£0.01**

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

DIVISIONS: INCOME AND EXPENDITURE

	M12 Plan	M12 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.29)	(£101.48)	£0.80
Medical	(£124.34)	(£132.86)	(£8.52)
Families & Specialist Services	(£89.56)	(£87.15)	£2.41
Community	(£27.88)	(£27.06)	£0.82
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£53.58)	(£54.55)	(£0.97)
THIS	£1.25	£1.25	(£0.00)
PMU	£2.39	£1.57	(£0.82)
CHS LTD	£0.54	£0.22	(£0.32)
Central Inc/Technical Accounts	£374.02	£383.46	£9.43
Reserves	£2.09	(£0.75)	(£2.84)
Surplus / (Deficit)	**(£17.35)**	**(£17.33)**	**£0.01**

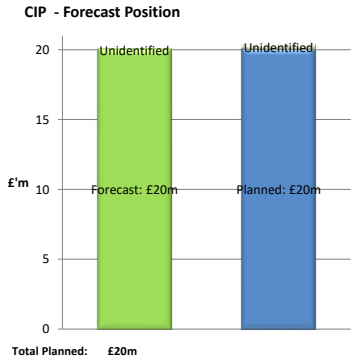
TOTAL GROUP SURPLUS / (DEFICIT)

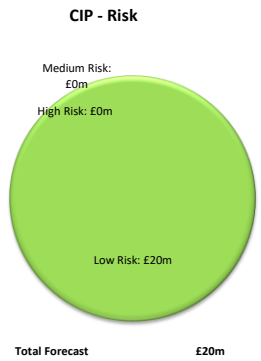


KEY METRICS

	Year To Date			Year End: Forecast			
	M12 Plan	M12 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£17.35)	(£17.33)	£0.01	(£17.35)	(£17.33)	£0.01	
Capital	£41.99	£31.26	£10.73	£41.99	£31.26	£10.73	
Cash	£19.26	£24.63	£5.37	£19.26	£24.63	£5.37	
Invoices Paid within 30 days (BPPC)	95%	91%	-4%				
CIP	£20.00	£20.00	£0.00	£20.00	£20.00	£0.00	
	Plan	**Actual**		**Plan**	**Forecast**		
Use of Resource Metric	3	3		3	3		

COST IMPROVEMENT PROGRAMME (CIP)





YEAR END 22/23

CLINICAL ACTIVITY

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	Plan	Forecast	Var
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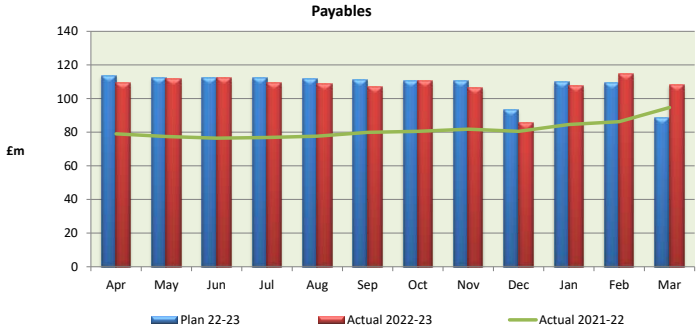
Reserves	£2.09	(£0.75)	(£2.84)
Surplus / (Deficit)	**(£17.35)**	**(£17.33)**	**£0.01**

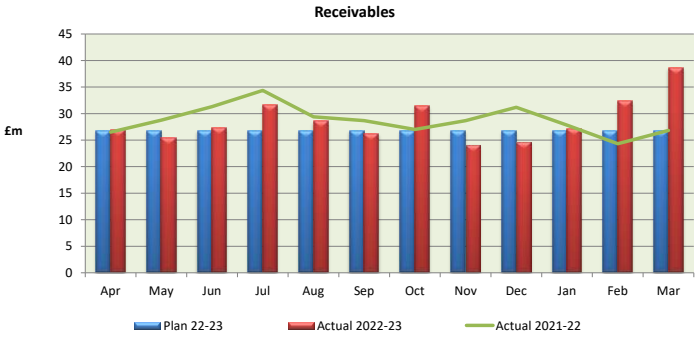
Total Group Financial Overview as at 31st Mar 2023 - Month 12

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

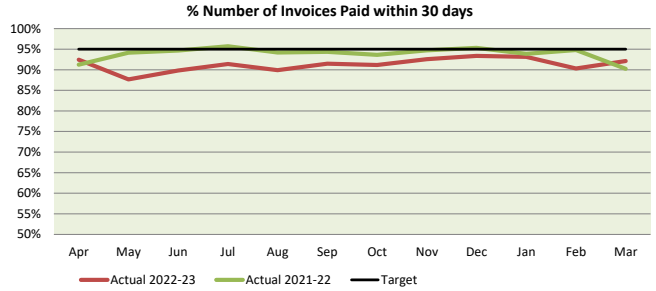
WORKING CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Payables (excl. Current Loans)	(£88.46)	(£108.24)	£19.78	
Receivables	£26.70	£38.65	(£11.95)	



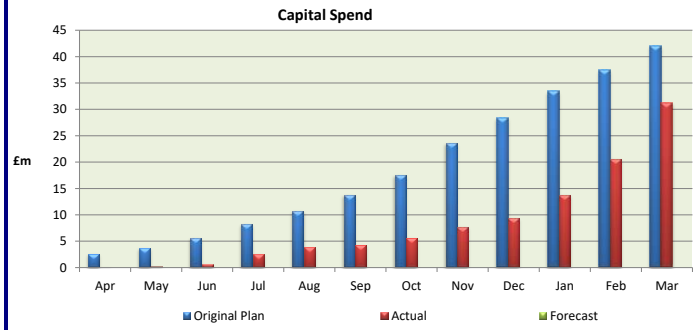


BETTER PAYMENT PRACTICE CODE



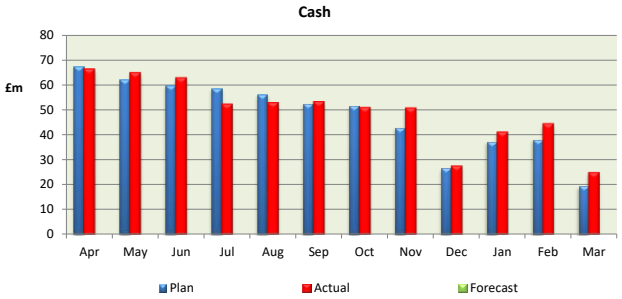
CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Capital	£41.99	£31.26	£10.73	

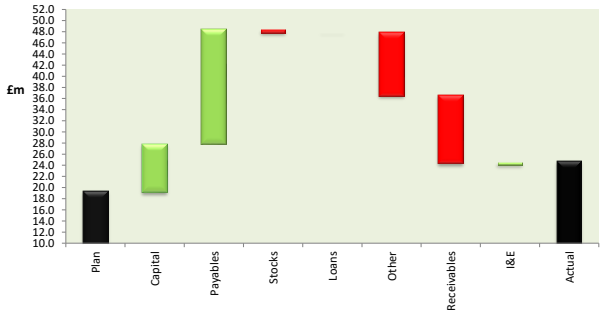


CASH

	M12 Plan £m	M12 Actual £m	Var £m	M12
Cash	£19.26	£24.63	£5.37	
Loans (Cumulative)	£15.46	£15.46	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is reporting a £17.34m deficit, (excluding the impact of Revaluations, Impairments and Donated Assets), a £0.01m favourable variance from plan.
- The Trust continued to incur higher than planned costs due to inflationary pressures and additional capacity requirements. In addition, costs were incurred in month due to the Doctors Strike and the Trust was asked to include in the position the cost of the proposed AfC pay award (22/23). Whilst national funding has been provided, this is not sufficient and does not cover staff on local pay scales, a £0.50m adverse impact. These pressures were offset by additional funding from System partners to support operational and inflationary pressures; higher than planned vacancies and technical benefits including the Joint Venture revaluation and profit.
- £12.73m of Elective Recovery Funding (ERF) has been received, £0.40m lower than planned, but no claw back is expected.
- Total planned inpatient activity for the purposes of Elective recovery was 99.6% of the activity planned year to date, (104.0% of 19/20 activity levels).
- Year to date the Trust has incurred costs relating to Covid-19 of £15.23m, (excluding testing and vaccination costs funded outside of System envelope), £6.27m higher than planned.
- Capital expenditure is lower than planned at £31.26m against a planned £41.99m.
- The Trust has delivered efficiency savings of £20.00m as planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with 1 metric (agency trajectory) away from plan.

NOTES

- The Trust has a cash balance of £24.63m, £5.37m higher than planned.
- The Capital underspend of £10.73m is due to reduction in expenditure on PDC funded Reconfiguration and leases, offset to some extent by an increase in forecast donated assets (funded through charitable funds) and additional PDC funded expenditure on Endoscopy equipment, Diagnostics Digital Capability and Front Line digitisation.
- The total loan balance is £15.46m as planned. The Trust has not required any revenue support in this financial year, but plans for 2023/24 would currently drive a future borrowing requirement.

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

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

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

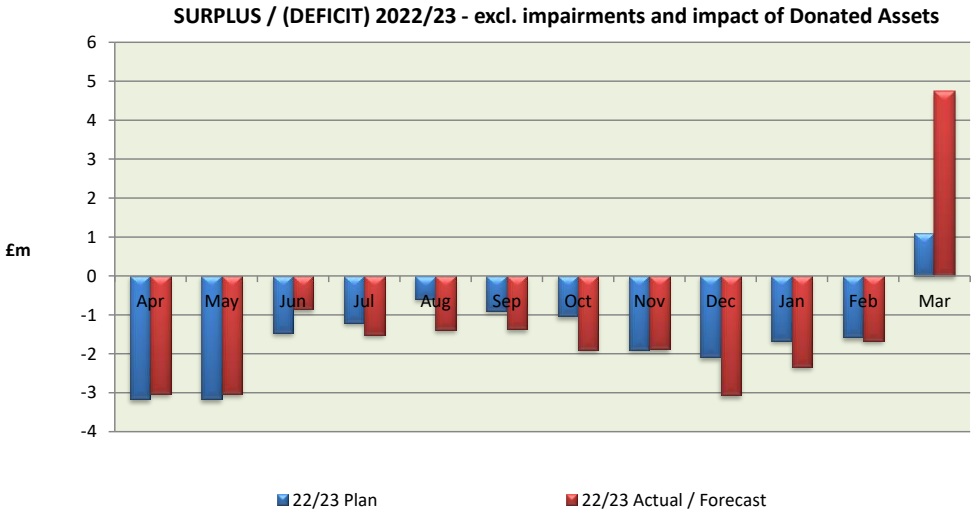
YEAR END POSITION 22/23

22/23 Year-End Position (31 Mar 23)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£485.349	£536.460	£51.111	
Pay expenditure	(£318.788)	(£355.421)	(£36.633)	
Non Pay Expenditure	(£151.575)	(£168.555)	(£16.980)	
Non Operating Costs	(£32.677)	(£22.542)	£10.135	
Total Trust Surplus / (Deficit)	**(£17.692)**	**(£10.058)**	**£7.634**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.000	(£7.410)	(£7.410)	
Donated Asset depreciation	£0.429	£0.543	£0.114	
Donated Asset income (including Covid equipment)	(£0.084)	(£0.548)	(£0.464)	
Net impact of donated consumables (PPE etc)	£0.000	£0.139	£0.139	
Gain on Disposal	£0.000	£0.000	£0.000	
Adjusted Financial Performance	**(£17.347)**	**(£17.335)**	**£0.012**	

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

MONTHLY SURPLUS / (DEFICIT)



NHSE reported position:

The year-end financial performance from a regulatory perspective has been described throughout this report. The total reported Trust year end position as reported in the annual accounts is a £10.06m deficit, a £7.63m favourable variance from plan. This includes a number of items that are excluded for the purposes of monitoring financial performance. The table to the left shows these accounting adjustments. Excluding these elements, the Trust delivered a £17.34m deficit, a £0.01m favourable variance from plan.

COVID-19 & Recovery

Covid-19 Expenditure YTD MAR 2023	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	903	0	903
Remote management of patients	201	0	201
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	73	73
Segregation of patient pathways	12,151	577	12,728
Existing workforce additional shifts	209	0	209
Decontamination	0	6	6
Backfill for higher sickness absence	0	0	0
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	0	0
Sick pay at full pay (all staff types)	0	0	0
Enhanced PTS	0	393	393
COVID-19 virus testing - rt-PCR virus testing	200	85	286
COVID-19 virus testing - Rapid / point of care testing - all other locally procured devices	40	0	40
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	0	0	0
COVID-19 - Vaccination Programme - Vaccine centres	96	0	96
NIHR SIREN testing - antibody testing only	18	4	21
Total Reported to NHSI	**13,819**	**1,138**	**14,957**
COVID-19 - Vaccination Programme - Vaccine centres (Locally Funded)	54	0	54
COVID-19 - Vaccination Programme - Provider/ Hospital hubs (Locally funded)	84	0	84
PPE - locally procured	0	-16	-16
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	579	0	579
Support for stay at home models	0	29	29
Internal and external communication costs	0	-1	-1
Grand Total	**14,536**	**1,151**	**15,687**

Recovery Costs YTD MAR 2023	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	11	6,908	6,920
Additional Staffing - Medical	2,533	0	2,533
Additional Staffing - Nursing	510	0	510
Additional Staffing - Other	1,198	0	1,198
Non Pay	0	2,389	2,389
Enhanced Payment Model - Medical	0	0	0
Enhanced Payment Model - Nursing	956	0	956
Total	**5,209**	**9,298**	**14,507**

Covid-19 Costs

Year to date the Trust has incurred £15.69m 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 £15.23m versus a plan of £8.97m, an adverse variance of £6.27m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and contributing to the requirement for additional Medical capacity, although it is becoming increasingly difficult to separately identify the impact of Covid-19 from other operational impacts on capacity, (e.g. Flu). Outside of envelope costs are highlighted in the table to the left and total £0.44m year to date.

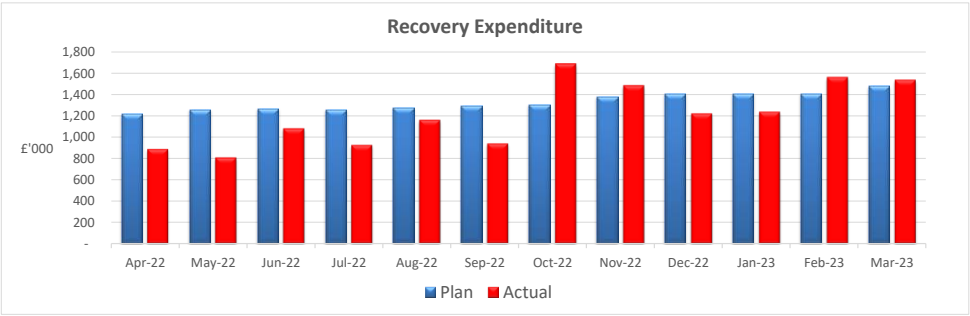
The Autumn Covid-19 vaccination programme is now complete and funding has been provided on a fixed cost per vaccine basis.

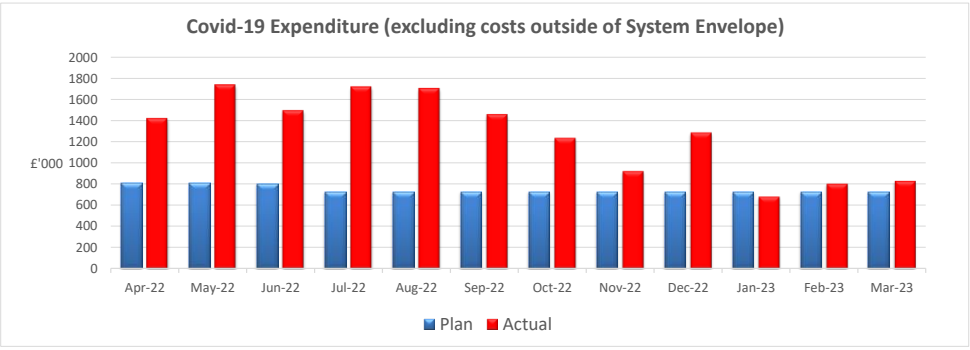
Covid-19 Funding

The Trust was allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £6.00m for the year (£5.50m year to date). A further £2.3m of additional funding has been allocated in Quarter 4, to support operational pressures.

Recovery

- Year to date Recovery costs are £14.51m, £1.47m lower than planned.
- Trust successfully delivered the required 104% of 19/20 activity.
- £11.72m of Elective Recovery Funding (ERF) has been received and national confirmation given that there will be no claw back this year based on performance. £0.40m of the planned ERF was returned as agreed to the Integrated Care Board (ICB) to support Independent Sector overspends in Kirklees Place.





13. Quality Committee Chair’s Highlight Report

- Director of Infection Prevention Control (DIPC) Q4 Report (Review Room)

To Approve

Presented by Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	Monday, 20th February 2023 Monday, 20th March 2023 Monday, 17th April 2023
Date of Board meeting this report is to be presented:	4th May 2023

ACKNOWLEDGE

- QC noted the timeline for Quality account completion and submission.
- Terms of Reference for QC subgroups circulated for ratification as part of recommendations from the quality structure internal audit.
- Patient Story presentation on the carer experience and the successful implementation of John's Campaign.
- Quality and Safety Strategy due at QC deferred so that further work can undertaken to align with the 5 year strategy and 1 year plan .
- Trust Patient Safety and Quality Board (PSQB) – report from Surgical PSQB a number of initiatives underway; ophthalmology department raising awareness of eye conditions providing insight into falls risks and prevention. Plans to roll this out trustwide.

ASSURE

- CQC Children and Young People Survey and action plan, significant progress has been made. Areas highlighted for ongoing improvement includes age-appropriate play, distraction, and activities (risk register 8262)
- Comprehensive Getting It Right First Time (GIRFT) report received, a new team is being established and refreshed reporting system which will enable improved tracking of the benefits of GIRFT across the Trust as the programme continues to expand . Committee informed that GIRFT will play a central part in recovery and transformation of services.
- Board Assurance Framework (BAF) Risks reviewed :
  - *7-day services* – the annual audit of key standards for 7-day services provide assurance that CHFT is compliant.
  - *Compliance with Quality and Safety standards* - assurance measures outlined and actions taken to complete internal audit recommendations noted. QC supports the proposed reduction of risk score from 12 to 15.
  - *CQC* - noted actions and the ongoing work of the CQC committee the risk score remains the same.

- Learning from death Q2 report, 31% of deaths have been reviewed using the initial screening tool not yet achieving the 50% target this is expected to be achieved. The quality care scores improved in Q2; further review underway to understand the higher poor care scores in Q1.
- The Lead Medical Examiner reported on the service and its ongoing development and expansion. The divisions support of the process of scrutiny has contributed to the high percentage of deaths that have been scrutinised. Planning underway for the roll out to the community.
- Maternity update – Improving position with the Maternity Transformation plan with more actions completed in February. Review undertaken of December 2022 postpartum haemorrhage and all cases had been managed appropriately. Review of delay in emergency caesarean section found that delays were due to ensuring adequate analgesia and no harm identified in any case.
  - The CQC annual maternity survey 2022 was mainly positive, and an action plan will be developed with Maternity Voices Partnership (MVP).
  - April results of the audit into neonatal death 2022 was presented and prematurity was the overall cause of death, committee noted the assurance provided within the report.
- Q3 Infection Prevention Control (IPC) report – C.diff action plan in place all cases reviewed, Covid remains a challenge for the Trust. The IPC team are active undertaking audits. The IPC Board Assurance Framework self assessment has been completed and the Trust rated reasonable assurance . Implementation of the new National Standards of Cleanliness (2021) has begun Overall the Trust is performing reasonably well in comparison to peers.
- Safeguarding Biannual Report provided assurance that statutory responsibilities are being met and progress is being made on the key priorities. It was reported that a challenge is colleagues understanding of the Mental Capacity Act. Audit results were a concern and work is planned over the next few months to address this.
- Report presented on patient incidents and harm, the data related to medication errors, falls and pressure ulcers. On average in 2022/23, 2.9% of patients were discharged with harm, for patients with a length of stay (LOS) of 35+ days - 33.7% of patients were discharged with harm. Data also showed that 44% of harm occurred within the first 6 days. Committee discussed the importance of reducing LOS and further analysis of the data was requested to better understand the link between LOS and harm.
- Integrated Performance Report - There was a Never event in January. Improving position with Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio now at national average. Significant pressures continue in the stroke service with staffing issues. A plan in place for dementia screening to be undertaken using a multi professional approach of nurses and therapists from April 2023.

- QC discussed the Quality Account Priorities agreed for 2023-2024 and the priority Commissioning for Quality and Innovation (CQUINs) that have some alignment to the quality priorities. Further information to be received on the expected outcomes.
- In depth update received on the work of the Follow Up Task and Finish Group, good progress has been made on the recommendations and going forward actions will be monitored through business as usual.

AWARE

- Action plans in place for Stroke, Fractured neck of femur, and dementia screening however sustained improvement not yet being achieved.

14. Quality Report

To Note

Presented by Lindsay Rudge and David Birkenhead

Date of Meeting:	**Thursday, 4 May 2023**
Meeting:	**Board of Directors**
Title:	**Quality Report (Reporting period February to March 2023)**
Author:	**Kim Smith – Assistant Director of Quality and Safety Sharon Cundy – Head of Quality and Safety**
Sponsoring Directors:	**Lindsay Rudge - Chief Nurse Dr David Birkenhead - Medical Director**
Previous Forums:	**None**

Actions Requested - To note

Purpose of the Report

The purpose of this report is to provide the Trust with ongoing oversight of the Quality agenda and the emerging issues for consideration.

It is to ensure that the Board of Directors is provided with a level of assurance around key quality and patient experience outcomes.

To provide high level updates on the Trust's preparedness for relevant regulatory scrutiny.

Key Points to Note

See separate PowerPoint Executive Summary

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 will be well placed to respond positively to external scrutiny from the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission.

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.

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 Board of Directors on the developments and progress against the Quality Strategy and improvement work that has been carried out and continues to be carried out every day.

This report provides assurance that as a Trust we are working towards the Outstanding CQC rating, the question for any Trust committee should be one of 'Am I assured and am I confident that we know where the risks lie'. Through the transparent reporting and the robustness of the reports we seek to give the Board the clarity and assurance required.

This report provides an update on assurances against several quality measures for the period February to March 2023: and progress updates for the Quality Account Priorities and the Focussed Quality Account Priorities for 2022/2023.

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.

Contents

2. Care Quality Commission (CQC)

Due to operational pressures and planning of the Junior Doctor Industrial Strike Action the March 2023 CQC Group was stood down, however updates and papers for the meeting were received in line with the Group work plan.

An update of the 'Must Do' & 'Should Do' actions which were issued post the 2018 CQC Inspection were due to be presented at the March 2023 CQC Group.

The position remains unchanged since the initial review in January 2023.

Prior to the review the action position had remained the same since June 2021 and prior to the review the Trust had 8 'MD Actions' & 54 'SD Actions' embedded with 1 'MD Action' outstanding.

In summary the current overall position of the 2018 CQC actions as of March 2023 is:

Progressing	Completed	Embedded
1 x MD Action	5 x MD Actions	4 x MD Actions
6 x SD Actions	3 x SD Actions	44 x SD Actions

Actions which are no longer in an embedded position are in relation to 3 key areas:

Theme	Action Reference	Comments	Next Steps
Staffing	MD8, SD9, SD25, SD28	Core service leads were able to describe current mitigations re staff requirements which are currently in place. Staffing levels are monitored daily. Nationally recruitment is an issue therefore will not be able to meet staffing requirements at present. CQC Group agreed staffing is a long-term issue but to reopen the actions for ongoing monitoring.	Long Term Actions – Review in 6 Months
Finance	MD1, SD37, SD38, SD39	The Trust continues to operate with a planned and underlying deficit position and plan towards financial sustainability. CQC Group agreed to reopen actions for ongoing monitoring.	Long Term Actions – Review in 6 Months
Further Assurance Needed	MD2, MD4, MD16(SD), MD17 (SD), SD5, SD7, SD26	Further assurance is needed before actions can be evidenced as embedded. Actions reopened and core services leads to present assurance to CQC Group in March 2023 with the hope of closing actions.	To Review in 2 Months

The CQC Group continues to have full oversight and scrutiny where actions have been reopened which were previously reported as embedded. The group will support core services in ensuring actions are progressing. Actions which were due to be completed in March will be monitored closely and presented at the May 2023 CQC Group.

All reopened actions are being closely monitored at divisional level with regular progress and assurance reporting to the CQC Group.

CQC Road Map:

A full plan in line with the CHFT CQC Road Map is in production and will be aligned with the CQC Group workplan from May 2023. This will include:

- Identified CQC Road Map Leads
- CQC Trust Wide Areas of Focus
- Initiation of Well-Led Self Assessments in line with the revised CQC Quality Statements at Divisional Senior Leadership Level and Executive Board.
- Commencement of 'CQC New Way of Inspecting' workshops which will be presented across the Trusts Committees and Divisional Meetings. The aim is to raise awareness of how CQC will inspected in the future.

Engagement Meetings:

A planned Onsite CQC Engagement Visit took place on 01st March 2023. This visit focused on Surgical and Critical Care Core Services, an overview of services was presented to CQC followed by a walk around of Surgical SDEC, Ward 10, Theatres, and ICU.

A presentation was presented to CQC by the Surgical and Critical Care Teams and gave an overview of the following:

- Divisional Team Structure
- Surgical Division Workforce
- Divisional Strategy
- Surgical Pathways
- Full overview of SDEC, SAU, Operating Services, ICU and Elective Recovery. This included current performance, service developments, innovations and celebrating success'
- Risks and Challenges including current position of Never Event investigations

The visits had positive feedback from the CQC inspectors which included:

"Staff clearly work together as teams"

"The new ICU was 100% improved and had a really nice feel and was bright and spacious"

"From experience SAUs are usually crowded and busy but the HRI SAU was not overcrowded and was a calm well manged environment"

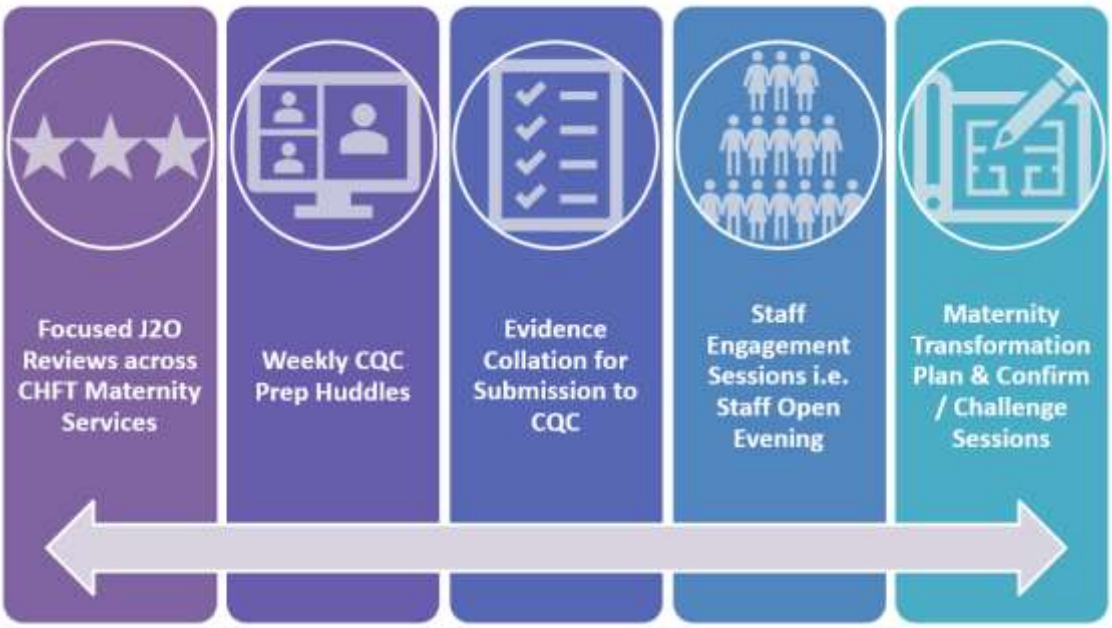
"SDEC is a well-established embedded department which is clearly well led"

Planned Onsite Visits:

- The trust currently has no planned onsite CQC Engagement visit scheduled. From conversation at the 1st March visit is likely the next onsite visit will be May / June 2023, but this is still to be confirmed.
- A planned CQC Engagement call will take place on 18th April 2023 between the Community CQC Relationship Manager and the CHFT Community Senior Leadership team as per the quarterly catch up schedule.

Maternity Services Inspection:

The Trust has not yet been inspected by the CQC Maternity Team this will be undertaken before May 2023. This is part of a planned programme in which all Maternity centres across the country will be inspected. Intel suggests that CHFT will be inspected around May 2023. Continuous planning with Maternity Services is ongoing, this includes:



The current WYAAT position in line with the CQC Maternity Inspection rolling programme, is detailed below:

A piece of work has been undertaken to identify emerging trends from inspection which have already taken place as part of the rolling programme, these trends have provided a focus for the service:

CQC Strategy:

CQC will continue to implement their new approach in phases, making sure each phase is properly implemented before moving to the next.

From **spring** CQC will focus on:

- Making sure the technology they need is in place and that they're able to test it with providers
- Being confident that their new regulatory approach is ready to launch.

In **summer** CQC will launch the new online provider portal. They'll do this is in stages and provide support and guidance. In the first stage:

- Providers will be able to submit statutory notifications
- CQC will improve how the enforcement process works.

Towards the **end of 2023** CQC will gradually start to carry out assessments in the new way. This means using the new assessment framework.

3. Patient Experience, Participation and Equalities

In March 2022, the Trust agreed its Carers Strategy within the Patient Experience Group (PEG). It is intended to ensure that carers and the role they have in caring for someone is valued, they are involved in a way they wish to be involved and are supported in their role. The Carers Strategy fits with the Trust's vision of delivering compassionate care that puts our patients and community first.

Our vision is for all our staff to be carer aware and understand carers' rights. We will recognise, value, involve and support the role carers play in working with us to deliver patient-centred care. We will also recognise, value, and support the role of carers when they are patients themselves or are our colleagues.

In June 2022, the Trust launched the 'Carers Lanyard Pilot' within the Emergency Department at Huddersfield Royal Infirmary. This was part of a wider initiative with Healthwatch-Kirklees and other local organisations to use in healthcare settings. The original idea came from an unpaid carer who said she was often questioned about why she was attending appointments with the person she cares for. Like many of the carers the Trust has engaged with, she felt her role was not recognised, which made her feel unsupported.

By triangulating feedback through PALS, complaints, Friends and Family Tests (FFT) and Healthwatch Intelligence Reports it was recognised that we needed to go beyond the lanyard to ensure carers truly felt supported and involved in decisions about the care and treatment of their loved ones.

As a direct result of this the decision was made to re-launch John's Campaign across the Trust. Typically, John's Campaign recognises the valuable role carers have in the reassurance and dignity of people living with dementia.

Our approach to Keeping Carers Caring

Following engagement with local carer organisations, relatives, carers, and staff we have adopted the principles of John's Campaign and extended the criteria as an all age, all carer approach.

This was achieved through the creation of a Keep Carers Caring Action Group. Membership of the group included a carer who had complained to the Trust about our lack of provision for

carers, staff from Medicine, Corporate, Quality, Learning Disabilities, Communications and Frailty.

Using a co-design approach, the group created a menu of resources available to carers, with quality measures to monitor the difference these make. The resources were selected based on feedback. The aim is to make carers feel welcomed, seen, heard, and involved in decisions, whilst in a safe environment.

The group initially met on a weekly basis to rollout the pilot. This has now been reduced and the group now meet on bi-monthly basis, with quality updates being provided within divisional Patient Safety Quality Board meetings and the Patient Experience Group.

A direct outcome of the group was the creation of Carers pack, which has been hand delivered across our hospital sites by members of the Keep Carers Caring Action Group and additional senior staff.

An audio version of the Carers Information Leaflet was also created. This is available on the Trust website. This was agreed as good practice by our Visual Impairment user group.

Since January an additional 2000 carer's lanyards have also been distributed across our hospitals to help carers feel seen.

Delivering the message to staff

Initially details of Keep Carers Caring and John's Campaign were shared through the Friday Leadership Meeting. In January 2023, once the Keep Carers Caring action group was able to share their carer packs and details of the offer to carers, a personal approach was taken to deliver the packs by hand. This allowed staff who don't attend the Leadership Meeting to ask questions and hear more about John's Campaign from a member of the action group.

Members of the Keep Caring Action Group and volunteers continue to re-visit wards and outpatient clinics to remind staff the importance of continuing to identify hidden carers.

Some teams have requested additional information about the campaign, and this has been provided within their team meetings. The End-of-Life Team have also requested that John's Campaign training is provided within the induction of their End-of-Life Champions. This will commence from April 2023.

Staff have been encouraged to share their views of Keep Carers Caring and John's Campaign. This has been shared within a weekly briefing and through screen savers.
Progress updates are provided through the Leadership Meeting, divisional PSQB's and the Patient Experience Group.
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A Patient Story

The Trust has been committed to learning from the experiences of carers using various platforms. It was decided that a patient story would be a useful resource to helping staff and volunteers understand the human factors behind supporting carers.

The Trust supported one of our complainants to share their experiences to help identify where improvements can be made. The story captures the experiences from the carer point of view and helps the audience put themselves in their shoes, whilst enabling them to focus on what matters the most to the carer.

The story was filmed by the Medical Illustration Team and shared through CHFT News.

To date the story has received over 200 views, and has been shared with audience through:

- Preceptorship Induction
- Quality Committee
- Patient Experience Group
- Community Matrons Meeting

https://chft-news.cht.nhs.uk/issue/chft-news-issue-5-6march2023/article/inspirational-video-supports-keep-carers-caringcampaign27aff0ad8703?utm_source=self&utm_medium=email

CHFT Working Carers

Through the drive to keeping carers caring, and the launch of John's Campaign it has helped staff not only identify hidden carers, but also self-identify as working carers. The Trust has provided support for its working carers for some time now. But with a 600% increase in staff accessing this support since January 2023, this is a significant development.

CHFT has a Working Carer Passport scheme. This is designed to make it easier for staff with caring roles to talk about the flexibility and support they need. Staff who use a Carer passport report benefits such as:

- Understanding and support reduces stress within the workplace
- It improves health and wellbeing and feelings of being able to cope
- It can improve staff retention and morale

There is also an established Working Carer peer support group which is popular.

How we make carers feel welcome in our hospitals

Across our hospitals we have posters welcoming carers. Each of our wards and outpatient areas displays a 'Carers Pledge'. This outlines the commitment the individual team working within that area has made to driving improvements for carers.

To help make life a little bit easier for carers supporting our patients, anyone with a carer's lanyard is able to park at our hospitals for free when supporting a patient to an outpatient appointment, or whilst visiting them as an inpatient. As 43% of the carers we identified do not live with the person they care for, it is anticipated that this will be a welcomed gesture.

69% of the carers told us that they have benefited from the free car parking. This has been of particular value to carers attending multiple outpatient appointments and those visiting for prolonged periods of time.

Carers want to be involved:

Removing the barriers to visiting for carers has proven extremely popular. Carers have told us that not only has this increased the length of time to stay with the person they provide care for, but they can also plan to visit outside of peak visiting times, which makes finding a car parking space easier, and reduces congestion around the hospital.

Opening visiting has given carers the opportunity to be more involved in looking after the person they care for. Not only in terms of practical support such as assisting with personal cares, nutrition and hydration, but also supporting the cared for person in terms of their emotional wellbeing through engagement and stimulation.

68% of carers that have been reached are within working age. This could mean that juggling working and visiting the cared for person has been made easier. Potentially this could also mean a working carer would be less likely to need to access paid or unpaid carers leave if they can still visit outside typical visiting hours, which are currently 2-8pm.

Carers want to be heard:

Shared decision making is key to providing personalised care. Within the initial engagement of carers, they shared that this was important to them. They wanted to be more involved in decisions about the health and care of the person they care for, where this is appropriate. As a Trust we regard shared decision making as:

- Patients and carers understand the care, treatment, and support options available, including risks.
- Patients and carers can make decisions about their preferred course of action, based on good quality information alongside their personal preference.
- It is a process in which clinicians and individuals work together

The “See who I am” document has also been updated and reintroduced to carers. This helps our staff work with carers to identify essential information such as individual preferences, characteristics, support needs and life history. This is used as a guide to person centred care planning

270 carers were asked if they felt they had been actively involved in discussions about the care and treatment of the person they care for:

- 73% Said they had, and this made them feel assured about the care and treatment provided
- 5% They had, but didn’t understand what was being said
- 19% They hadn’t, but they would have liked to
- 2% Said they hadn’t, but it didn’t bother them
- 1% said they were unable to remember if they had

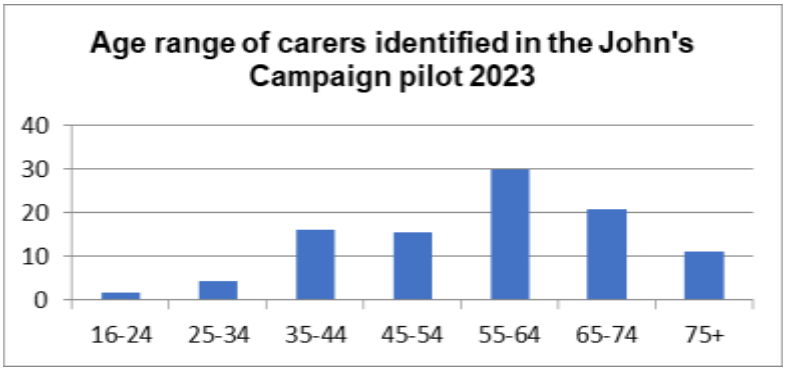
This is an encouraging start to involving carers more in vital discussions. As the Trust increases its awareness of the value in supporting carers, it is anticipated that more carers will be involved in key discussions.

This feedback will be shared within the Consent Group and evaluated within the baseline assessment tool for shared decision making (NICE guidance NG197).

The learning will also be used within End-of-Life Group and help influence the Patient Experience Strategy for 2023/2025

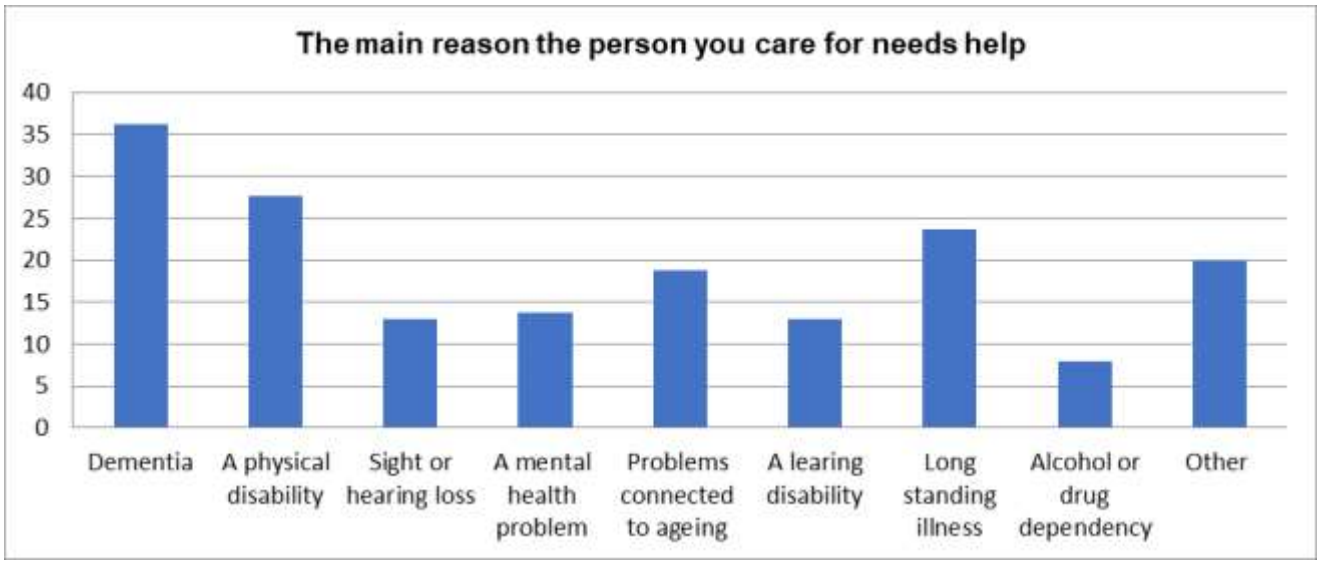
All age, all carer approach:

The Trust is committed to delivering carer support that takes an all age, all carer approach. This can be demonstrated through the findings of the carer profiling. Each carer who is provided with a lanyard is asked to complete a carers survey which is done through a quality call. 100% of the carers identified within the pilot were happy to complete this.



Whilst it is encouraging to see a reach across all ages (16-75+ years) it is recognised that moving forward the Trust should do more to identify young carers. They often have to face their caring responsibilities with challenges of being young, with the responsibilities of being an adult.

As a young person caring can also be extremely isolating. They are often harder to identify and are less likely to seek support as they are often too embarrassed to ask for help. Often young carers don't get identified until there is a crisis.



Through the carers survey 12 different health conditions were identified as the reason carers provided additional support. 36% of carers explained that this was due to a dementia diagnosis, with 28% a physical disability and 24% a long-standing illness.

It is not surprising that dementia has been the reason most of the carers identified provide a caring role. In many ways they are easier to identify. On a national level, John's Campaign is more traditionally associated at carers looking after someone with a dementia diagnosis. Staff may therefore associate the Trust's carers provision more towards someone providing care for someone with dementia.

Caring for someone with a dementia diagnosis can be a challenging experience. It is common for carers to feel frustrated and guilty. Many carers feel they're not doing a good job.

It can also be particularly tiring, especially as their condition progresses. Within the Carer Information Booklet carers can find details of how where to go for a Carers Assessment, this is vital information as it can help carers get access to support, they are entitled to, such as respite care and benefits advice.

20% of the carers who completed the survey identified themselves as having a disability. It is important that they do not neglect their own health and wellbeing. Often the needs of the carer become secondary to the person they provide care for. Caring for someone can result in significantly poorer health and quality of life outcomes. Which can in turn affect a carer's effectiveness and potentially lead to the admission of the cared for person to hospital.

*The survey has been altered, so from April 2023, carers will be asked to explain what 'other' means, so the Trust can have a greater understanding of the different types of caring roles that are being provided.

Signposting:

Almost 100 newly identified carers have now been signposted to local carers organisations as a direct outcome of John's Campaign. This has been largely down to explaining to carers through our quality calls what support, information and advice is available within their local community.

We have also increased a visual presence within Calderdale Royal Hospital and Huddersfield Royal Infirmary with monthly carers stands which have been delivered in conjunction with Carers Count and Community Plus. Since January the Trust has hosted 9 stands. Not only been well received by patients and carers but hospital staff too.

The Trust has measures in place to understand what support referred carers are accessing. The most popular sessions to have been accessed relate to:

- Emergency care planning
- Accessing respite care
- Understanding benefits and financial support

When asked about how easy carers had found accessing information and advice about carers support:

- 40% said they had not tried to find any
- 31% said it was difficult or very difficult to find
- 29% said it was very easy or easy to find.

The most common reasons for carers not looking for information was due to the face they didn't identify themselves as a carer., just as a person looking after someone close to them. These hidden carers are often the most in need of support because they don't know they should even be looking for help.

Many carers simply didn't know what help is out there, or only know a small part of what is available.

Pride can also play a part. It can sometimes be hard to ask for help, many of the carers told us they didn't like to admit that they needed help or were struggling.

As the next stage of the roll-out is within the community, it is recognised that increasing the number of care awareness stands should be considered across further healthcare settings.

Sharing the message:

The approach to identify hidden carers has been slightly different than typical campaigns. We have worked with existing carer networks within the community to help share details of commitment to Keeping Carers Caring, which is our long-term sustainable improvement.

- Involving People Network
- Calderdale Carers Strategy Group
- Dementia Hub
- Community Links

The Trust took part in the Carers' Strategy Development Workshop, which was hosted by the ICB, Calderdale Council and VSI Alliance.

The Trust was also invited to present at the Calderdale Family Voices Conference and the Calderdale Cares Carers' Strategy Launch both of which were well attended by local carer organisations, Public Health, and carers.

On the 20th April 2023 the Trust will be providing an on our commitment to carers to the Kirklees Carers Strategy Group.

We have also been approached by Bradford Teaching Hospitals NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust to provide them with details about our approach to supporting carers.

Equality Delivery System (EDS-2)

Keep Carers Caring initiative has been selected to be showcased within the Trusts EDS-2 review.

The aim of EDS2 is to improve services for people who belong to vulnerable and protected groups by assessing health inequalities and provide better working environments, free of discrimination, for people who use and work in the Trust. The implementation of EDS2 supports our strategic objectives to promote equality throughout the planning, developing and delivery of our services, whilst appreciating and respecting the diversity of our local community and workforce.

The Trust is required to undertake a self-assessment. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined.

Learning

With every Carers Lanyard the Trust has provided, the carer has been follow-up with a quality call. During the call carers are asked a series of questions so we can build a profile of the carers being identified, and also gather key intelligence to help understand the current experiences of carers within the Trust.

Asking for feedback is just half of the picture. We also need to act on what we hear.
Since January 270 carers have completed our Carer Survey and shared their views about the Trust. On average, each call has taken 20 minutes, which equates to 90 hours of carer feedback.

What carers said the Trust is doing well:

- **Carers like the lanyard: it has prevented many carers having to explain why they are attending appointments with the cared for person.**
- **Improved involvement in discussions and decision making**
- **The see who I am document: Carers feel more confident knowing that staff on the ward know what the patient's likes and dislikes are**
- **Opening visiting has made a significant difference to carers. Carers have reported feeling less worried, anxious and concerned about what is happening.**
- **Carers feel more supported and valued in the caring role**
- **Having a meal with the person you care for is valued. It's normalising behaviour that would happen if the cared for person was at home**

What carers said the Trust could improve:

- **Greater understanding as to what carers can do on the ward. Carers have felt that they are "getting in the way" at times**
- **Attitude of staff. Carers have said that although the signs around the hospitals say the Trust welcomes carers, that is not always the case on the wards**
- **Communication is inconsistent particularly around visiting. Wards, mainly at Calderdale are not allowing carers to visit outside of usual visiting hours**
- **Carers feel that communication with Dementia patients is poor and at time rude and dismissive**
- **Parent Carers felt that the hospital should be more child friendly in outpatient areas**
- **Parent Carers would like staff to be more understanding of children with a learning disability**
- **Carers would like a central resource to be able to find carers support activities and services, particularly for holistic health and wellbeing**

Friends & Family Test Improvements:

We have listened to feedback from patients and staff about our process for capturing Friends & Family test responses. The decision was made to bring the planned improvements forward so that capturing the information can commence within April 2023, so reporting is consistent throughout 2023/2024.

- Patients found our online system for responding difficult and timely
- The FFT cards were difficult to read
- Cards only gave limited space for providing feedback

- Equality monitoring options were limited and out of touch with the diverse community we serve
- Capturing learning disability data was inconsistent across the Trust
- Staff within community did not have capacity to be inputting responses

What have we done?

- Designed a format that uses both sides of the card to collect feedback
- Increased the space for providing feedback
- Increased the ethnicity monitoring options from 6 to 17 categories
- Improved the space to record details of a physical, mental health condition or disability. This information will be captured and monitored across all divisions
- The online form has been developed on Microsoft Forms and looks consistent across all platforms
- Mapping of divisional information has been undertaken, with branching reducing the length of time it takes to complete the Friends & Family Test
- Created business cards with QR codes for community staff to provide patients a direct link to the online form
- Patient and carers are also given the option to name a staff member who they would like to be recognised for delivering compassionate care.
- Children and young people are asked if there is a member of staff who made them feel safe and well looked after

Learning

The Trust is currently undertaking a three-phase approach to understand how we can learn not only when mistakes happen, but when things go well too.

We have gathered feedback from young people and adult service users. The next phase is to ask staff about their understanding of learning, and how they would like to receive it.

Often when staff are asked to demonstrate the learning, they reflect on the communication tools they would use to share learning, not what we have actually understood from the learning itself.

Throughout February 24 local young people (aged 16-18) and 63 adult patients, who attended Calderdale Royal Hospital, Huddersfield Royal Infirmary and Acre Mill were asked about their understanding of 'learning'. They were also asked what CHFT could do to share how we have made improvements

Adult patients regarded learning as:

- Discovering something new
- Extending your knowledge
- Asking questions and thinking about the answers
- Giving something new a go
- Talking and discussing
- It is not something you already know

Young people said:

- Gaining knowledge of our environment and understanding how we interact in it
- Gathering information to get a better understanding
- Using Personal experiences to change behaviours

When we asked patients how they felt we should share learning with them they said:

- Don't call it learning
- Show examples of how learning has made a difference
- Make it easy to access - Learning may be happening, but as a member of the public it is hard to see
- Just putting information on a website isn't enough

Key recommendations were suggested:

- Change the language from "Lessoned learned" to "What we are doing differently"
- Introduce a "Delivering Differently" roadshows across the health economy, not only in hospital settings, but within the community too
- Provide visible examples
- Use interactive posters in the areas where changes have happened (QR codes that link to videos/soundbites explaining what has changed). This may also help share examples of changes we are making to patients for whom English is not their first language.

Once the feedback has been triangulated, a guide on 'What is learning' will be produced. This will help support the reduction of complaints, incidents, and risks within the Trust.

4. PALS and Complaints Service

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**	A Standard Operating Procedure has been approved and shared with the Divisions. This is to ensure the Trust is working in line with a standardised process across all Divisions. Weekly meetings are on-going with Divisions and are helpful in identifying any issues and discussing concerns. The Trust's overall performance has slightly decreased to 88% on average, however weekly scrutiny is on-going to highlight any areas of concern. Given the operational pressures recently, performance is positive.
2. Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/quality priority	**REASONABLE Assurance**	Work is on-going to embed learning and the process surrounding this. Support is being offered to Divisions regarding the quality of complaint responses. A Trust wide Learning forum is being considered to share learning across all strands of governance, including complaints

<u>Patient Advice and Liaison Service (PALS) & Complaints team to undertake quality improvements:</u>

- Fully align the work of the Making Complaints Collaborative to ensure it is delivering against the national complaints regulations and the emergent Parliamentary and Health Service Ombudsman (PHSO) standards.
- Support a trust wide / user led approach to 'Making Complaints Count'.
- Review existing processes, policy and operating procedures as needed to be assured of compliance and that operations are fully supported. This has been done and standard operating procedures have been drafted for both PALS & Complaints.

Progress against key objectives
Complaints and Patient Advice and Liaison Service (PALS) Performance Summary

	Feb 2023	Mar 2023
Complaints received	29	37
Complaints closed	21	36
Complaints closed outside of target timeframe	2	5
% of complaints closed within target timeframe	**90%**	**86%**
Complaints reopened	7	8
PALS contacts received	151	170
Compliments logged	17	14
PHSO complaints received	1	0
PHSO complaints closed	0	2
*Complaints under investigation with PHSO (total)	12	10

- Backlog of compliments to be logged by the PALS Team which is why the numbers reported are low.

5. 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

There continues to be growing demand around claims and inquests, with an increase in portfolio size of around 20% for claims and 45% for inquests since July 2022. The portfolio size has increased from 170 to 205 (Claims) and 79 to 115 (Inquests).

There are approximately 18 incident investigations linked to an open claims/inquest and 3 mortality reviews linked to a legal process.

A weekly task list is also being provided by panel solicitors to highlight any impending deadlines and cases which need to be prioritised. This is being reviewed twice weekly to progress matters as swiftly as possible.

Internal audit of the Trust's Inquest Portfolio

Monthly audits completed so far have indicated an average of 63% compliance with the Legal SOP. This is being monitored and feedback via monthly 1-1's.

A fortnightly inquest dashboard report (and inquest timetable) continues to be provided to the Assistant Director of Quality & Safety, Divisional Leads and Quality Governance Leads for awareness.

Medical records disclosure

A Task & Finish Group is ongoing to set up a unified Trust SOP/process to ensure consistency and avoid duplication across the Trust.

Recent Data

This report covers the period **1 February – 31 March 2023**

Healthcare Advisory

Statement requests for Family/Court of Protection- 4
Statement requests for Police- 0
Court Attendance- 0 (1 hearing vacated)

It should be noted there has been an increase in the number of rejected/unsafe Deprivation of Liberty Safeguards (DoLS) applications. Sarah Mather (Head of Legal Services), Alison Edwards (Head of Safeguarding) and Ian Noonan (Mental Health Nurse Consultant) will be

meeting with the team at SWYPFT to explore further training around receipt of DoLS paperwork and scrutiny.

Clinical Negligence

- **180** active clinical negligence claims
- **18** new clinical negligence claims were received
- **2** clinical negligence claims have been concluded

Employers' and Public Liability (EL/PL) Claims

- **25** active EL/PL claims- **10 open PL/ 15 EL open active**
- **1** new EL & **1** new PL claim received
- **3 E**L claims were concluded
- **1 P**L claim was concluded

Inquests

- **115 active inquests**
- 5 x high, 19 x moderate, 42 x low and 42 x minimal risk inquests (7 x inquests to be risk assessed)

  Medicine- 86 in total consisting of High-Risk x 3, Moderate Risk x 11, Low Risk x 34, Minimal Risk x 33, TBC x 6
  SAS- 22 in total consisting of High-Risk x 2, Moderate Risk x 7, Low Risk x 7, Minimal Risk x 8, TBC x 1
  FSS- 3 in total consisting of High-Risk x 0, Moderate Risk x 1, Low Risk x 1, Minimal Risk x 1
  Community- N/A

- **20** inquests were opened
- **16** inquest files were closed with no adverse findings.

Legal Service Learning - Sharing Learning from Inquests and Clinical Negligence Claims

The review of the GIRFT Litigation Data Pack continues with around 280 cases yet to be reviewed for medicine and surgery.
The Legal Services Team continue to deliver education and learning at General Surgery, O&G, Anaesthetics/Critical Care and Paediatrics Clinical Governance forums. Further invites have been received from Ophthalmology, Radiology and ED PSQB. The Legal Services Team will continue to attend these meetings every quarter to deliver a portfolio update and bite size learning on healthcare/regulatory law and have offered this engagement across the Divisions.

6. Incidents

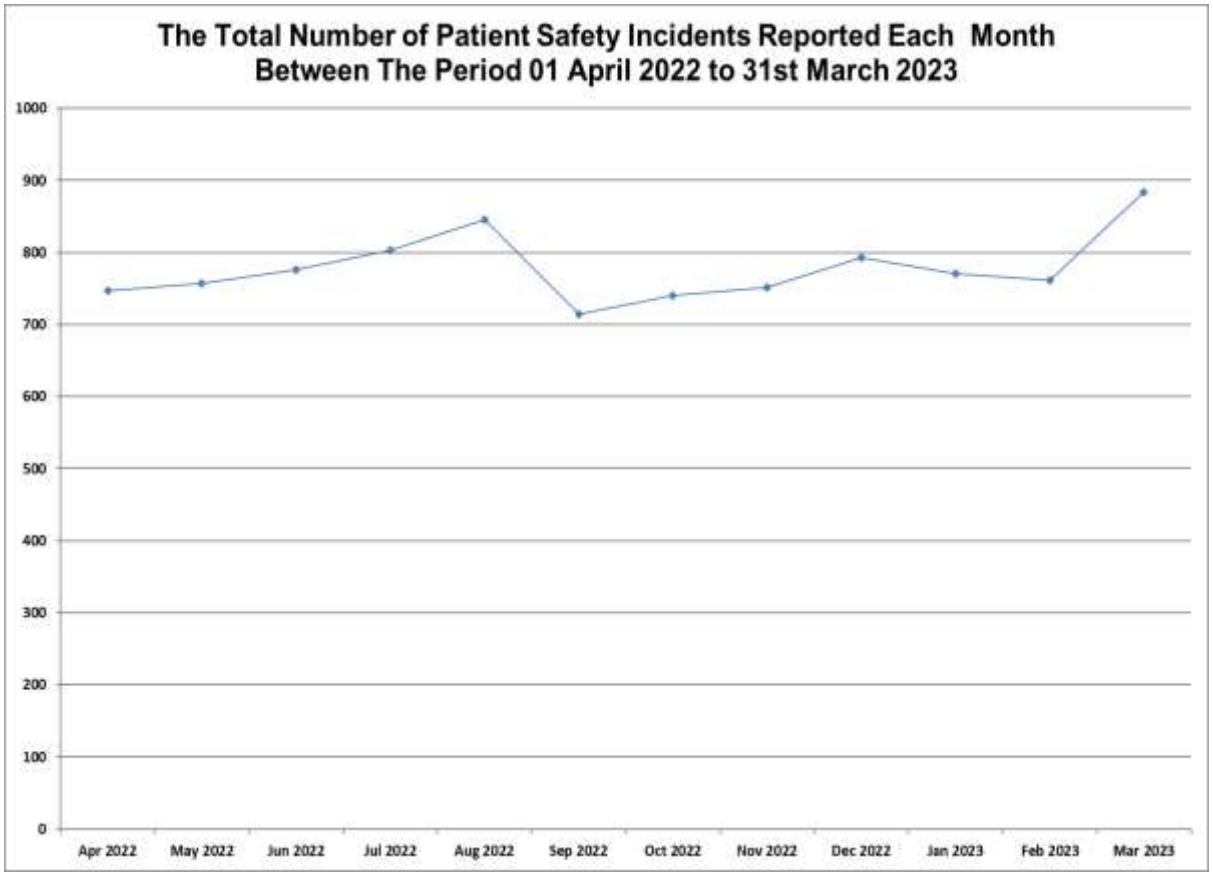
Below is a summary of patient safety incidents and incidents with severe harm or death, for the rolling year 01 April 2022 to 31 March 2022, and number of serious incidents (SIs) reported by month.

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 resulting in severe harm or death	Serious Incidents by the month externally reported on StEIS
Apr 2022	747	3	2
May 2022	757	10	4
Jun 2022	776	3	1
Jul 2022	803	11	5
Aug 2022	845	11	5
Sept 2022	715	7	2
Oct 2022	740	8	4
Nov 2022	751	12	4
Dec 2022	793	16	9
Jan 2023	770	7	4
Feb 2023	761	7	0
Mar 2023	884	9	1
Total Over rolling 12 Months	**9342**	**104**	**41**

The number of patient safety incidents reported in March 2023 is slightly above average. The average for the rolling 12 months is 778 patient safety incidents per month. Please note that due to operational demands within the Risk Management Team, not all incidents reported during the period of March 2023 have yet been reviewed by the team. Once reviewed the figures for incident reported during the period of March 2022 may reduce.

When analysing the data for February and March 2023, there were no trends, patterns, or concerns to indicate over/under reporting for this period.



Over the last 12 rolling months there has been a total of 104 incidents reported where the level of harm has been recorded as severe or catastrophic harm. Of the 104 incidents, the most frequently reported type of incident to cause, severe harm, or catastrophic harm/ or death is Assessment, treatment and diagnosis failed, with 64 incidents reported over the last 12 months.

There were 10 incidents reported over the last 12 months in relation to Appointment/Admission/Transfer/Discharge that had resulted in severe harm or death to the patient. Of the 10 incidents there were 3 incidents reported due to breakdown in referral process, and a further 2 incidents reported due to unsafe discharge of patient causing harm to the patient.

A further breakdown of the data did not indicate any trends or patterns for concerns.

The table below shows the incidents by category (reported between 01 April 2022 to 31 March 2023), with level of harm either severe or catastrophic/death harm only.

Incidents by Category with Level of Harm either Severe/Catastrophic/Death	**Severe harm**	**Catastrophic or Death**	**Total**
Assessment/Treatment/Diagnosis	23	41	**64**
Appointment/Admission/Transfer/Discharge	5	5	**10**
Infection Control	2	6	**8**
Slips, trips and falls	2	5	**7**
Investigations (Scans/Tests/Results)	3	1	**4**
Maternity Incidents	1	2	**3**
Medication	1	1	**2**
Safeguarding Adults	1	1	**2**
Abuse/Self-Harm	1	0	**1**
Medical Device	1	0	**1**
Pressure Ulcers/Moisture Associated Skin Damage (MASD)	1	0	**1**
Safeguarding Children	0	1	**1**
Total	**41**	**63**	**104**

Over the 12-month rolling period between 01 April 2022 to 31 March 2023, the most frequently and common type of incident reported during this period, **(regardless of the level of harm),** is Slips, Trips and Falls, with 1872 incidents reported in the 12-month rolling period. This is closely followed by Pressure Ulcers / Moisture Associated Skin Damage (MASD) with 1744 incidents and Appointment / Admission / Transfer / Discharge with 1289 reported incidents.

On analysis of all the incidents reported during the period 01 April 2022 and 31 March 2023, there are no trends or patterns that can be identified with the numbers reported during that period. 95.5% of incidents reported during 01 April 2022 to 31 March 2023 resulted in either no harm or minimal harm to patient.

February and March 2023 Data:

During the month of February 2023 and March 2023, a total of 1651 patient safety incidents were reported on Datix.

For the last period (December 2022 and January 2023), there was a total of 1583 patient safety incidents reported for that period.

February 2023 and March 2023 has seen a slight increase in the number of incidents reported when compared to the last report. There was a total of 68 more incidents recorded during this period when compared to the previous period.

The average number for patient safety incidents reported each month is 778 incidents per month, 94.2% of all patient safety incidents reported in both February 2023 and March 2023 resulted in either no harm or minor harm to the patient.

The **Top 10** most common type of incidents reported between the period 01 February 2023 and 31 March 2023 are shown below:

TOP 10 Incidents ONLY Reported During February 2023 and March 2023	**Feb 2023**	**Mar 2023**	**Total**
Safeguarding Children	1	2	3
Medical Device	2	8	10
Safeguarding Adults	7	3	10
Blood Transfusion Related Issues	3	8	11
Infrastructure/Resources/Staffing	6	9	15
Abuse/Self-Harm	12	15	27
Health and Safety/Sharps/Security	17	17	34
Infection Control	20	23	43
Investigations (Scans/Tests/Results)	29	16	45
Confidentiality/Communication/Consent/IG	25	32	57
Total	**122**	**133**	**255**

As with the previous Quality Report (for the period, December 2022, and January 2023), Slip Trips and Falls and Pressure Ulcers/Moisture Associated Skin Damage (MASD) continue to be the most frequent type of incidents reported during February 2023 and March 2023.

All Slips, Trips and falls incidents reported during the period of February 2023 and March 2023 have been an analysed and there are no trends or pattens identified.

The majority of Slip Trips and Fall, incidents resulted either in no harm or low harm, where the fall was unwitnessed.

Never Events

Between 01 April 2022 and 31 March 2023 (rolling 12 months) the Trust has reported 5 Never events.

The Table below shows the current stages of the ongoing Never event investigations

ID	Date Reported	Division	Subcategory	Description	Current Progress
220339	05/01/2023	Medical Division	Treatment/procedure - inappropriate/ wrong (Never event)	Wrongly placed NG	Currently under investigation within 60 working days.
219465	13/12/2022	Surgical & Anaesthetics Services Division	Wrong site surgery (Never event)	Wrong side block.	Currently under investigation. Over 60 working days. extension agreed.
215192	17/08/2022	Surgical & Anaesthetics Services Division	Wrong site surgery (Never event	Wrong lens implant	Currently under investigation. Over 60 working days. extension agreed.
211996	10/06/2022	Medical Division	Prescribing wrong dose or Strength (Never event)	Patient prescribed 15mg Twice in one day instead of 10mg twice a week. -	Report signed of at SI Panel and submitted to Integrated Care Board for review and approval.
213644	22/07/2022	Surgical & Anaesthetics Services Division	Wrong site surgery (Never event)	Pt had biopsy of 3 lesions of which one was a melanoma in situ. This was done in dermatology department. Referral sent to maxillofacial team for wider excision. The surgeon did a wider excision of the benign lesion and not the insitu lesion.	Currently Over 60 working days. Extension agreed. Investigator contacting consultant from another Trust for their option / policy / procedures

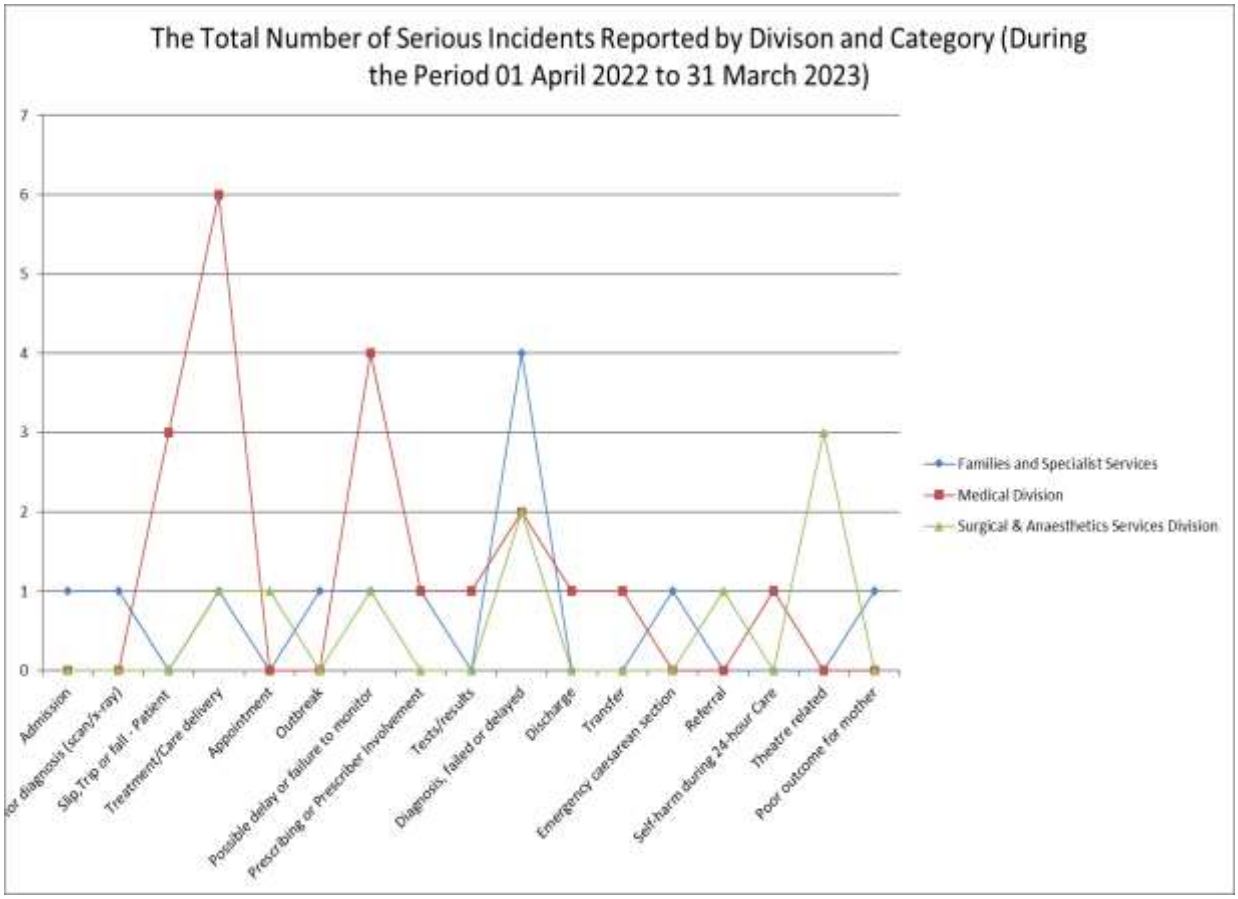
The last Never Event reported by the Trust was in reported during the month of January 2023., This was in relation to a wrongly placed NG Tube.

*** Datix ID 215192 was initially reported in August 2022, however there was differing opinions if this incident should be classed as a never event, therefore the incident was not declared as a never event at the time but treated as a serious incident investigation. After extensive discussion between the ICB and the medical directorate, the Trust has agreed that this incident met the criteria for never event and incident was declared a Never Event in November 2022.

Serious Incidents (reported from 1st April 2022 to 31st March 2023)

For the rolling 12 months, between 01 April 2022 to 31 March 2023, there has been a total 41 Serious Incidents declared on Strategic Executive Information System (StEIS) that are either under investigation or the investigation has been completed and closed. The 41 SI's have been recorded across 3 divisions: Families and Specialist Services **(12),** Medical Division **(20)** and Surgical & Anaesthetics Services Division (**9)**

The graph below shows the number of serious incidents reported by category and division:



The top two most frequently (and common) reported category for a serious Incidents over the last 12 rolling months (from 01st April 2022 to 31 March 2023) are Diagnosis/Failed or Delayed (8) and Treatment and Care Delivery (8)

When analysing serious incidents recorded under the category of Diagnosis/Failed, there were a total of 6 serious incidents that were in relation to Missed Cancer/Delayed Diagnosis.

For serious incidents recorded under the category Treatment and Care delivery, there was a total of 6 serious incidents in which the correct treatment or procedure was not followed resulting in severe or catastrophic harm/death to patient.

Current Progress of SI Investigations:

As of 01 April 2023, the Trust has 25 serious incident investigation that are **currently** on going and under investigation. The 25 ongoing serious incident investigation are across 3 division: families and specialist services (8), Medical division (12) and surgical and anaesthetic division (5)

The below table shows the 25 serious incidents investigations that are currently under investigation:

Serious Incident Investigations on going by Category and Division	Families and Specialist Services	Medical Division	Surgical & Anaesthetics Services Division	**Total**
Admission	1	0	0	**1**
Images for diagnosis (scan/x-ray)	1	0	0	**1**
Slip, Trip or fall - Patient	0	2	0	**2**
Treatment/Care delivery	0	4	0	**4**
Appointment	0	0	1	**1**
Possible delay or failure to monitor	1	2	1	**4**
Prescribing or Prescriber Involvement	1	0	0	**1**
Tests/results	0	1	0	**1**
Diagnosis, failed or delayed	2	1	1	**4**
Discharge	0	1	0	**1**
Transfer	0	1	0	**1**
Emergency caesarean section	1	0	0	**1**
Theatre related	0	0	2	**2**
Poor outcome for mother	1	0	0	**1**
Total	**8**	**12**	**5**	**25**

Summary of Progress with Serious Incident Actions

The Risk Management Team continue to have oversight of all serious incident investigations and are working closely with the divisions and clinical teams to support and ensure a consistent process is followed across the Trust. Services are reminded to complete all actions in a timely manner, with robust evidence to support this for completeness. From April 2023 the Risk Management Team will be sending all open actions for red and orange incidents to the triumvirate team monthly in order that the leads for each division can have oversight of their open and outstanding actions.

Serious incidents reported between 01 February 2023 and 31 March 2023

During the period between 01st February 2023 to 31st March 2023, there has been 1 incident that has been declared as serious incident and reported onto the StEIS system. Below is a table showing serious incidents reported during the period February 2023 and 31 March 2023:

SI Category by Month declared	Feb 2023	Mar 2023	Total
Diagnosis, failed or delayed	0	1	1
Total	**0**	**1**	**1**

Serious Incidents Closed by Integrated Care Board (ICB) during 01st February 2023 and 31st March 2023.

There was a total of 2 serious incident investigation reports that were approved and closed by the ICB during the month of February 2023 and March 2023 A brief detail of these incidents can be found in the below table:

Datix ID	Division	Category	Brief Description	Conclusion	Date Closed by ICB
206431	Families and Specialist Services	Diagnosis, failed or delayed	Patient had been complaining of abdominal pain. CT organised by GP which was reported by outsourcing company as normal. Patient returned in November 2022 with pain extending to right side as well. CT scan has shown primary pancreatic cancer in the tail and multiple metastases.	The pancreatic cancer was missed due to human error in that the reporting Radiologist failed to identify the same.	21/02/2023
211996 (NEVER EVENT)	Medical Division	Prescribing Wrong Dose or Strength	Patient prescribed Methotrexate 10mg Twice in same day instead twice a week.	The Prescriber decided to prescribe methotrexate which was not appropriate due to the patient having a clinical infection which was being treated with an intravenous penicillin. The incorrect closure of outpatient episodes led to incorrect information being visible to the prescriber about the patient in the current 'Document Medication by history section of EPR	24/03/2023

Learning from Serious Incidents

A total of 9 serious incident investigations were completed and submitted to the Integrated Care Board for approval and closure during the month of February 2023 and March 2023. Upon completion of 4 serious investigation report, the findings and lessons learned indicated that all correct procedures, pathways, policies were followed and the outcome to the patient would have been the same, regardless of if something different was done/carry out. Therefore, the Risk Management Team have made a request to the ICB, to have these 4 serious incidents de-logged from an SI but to remain as an orange investigation.

The table below gives a breakdown of the serious incident's investigations completed during the month of February 2023 and March 2023 and have been sent for approval and closure to ICB.

Incident Summary	Learning Need and Organisational Learning
215835: PHSO received Findings leading to recommendations: Failure to provide all appropriate treatment. Failure to communicate seriousness of condition. Failure to support the family after patients' death.	Action plan devised Medical Division Clinical Director, Endoscopy Matron with support from Head of Risk. Action plan to be shared with Family and staff by the Clinical Director and Head of Complaints.
200657: At ERCP, Patient sustained trauma to her oesophagus and died the following day from haemothorax	**De-log request made to ICB following completion of SI investigation:** The investigation has identified that the patient had died of unfortunate complication Post ERCP, and all guidance and policy relating to ERCP had been followed. Post procedure care was appropriate and relevant actions taken in a timely manner. The post procedure form was completed advising ward of post procedure instructions.
202514: 38+2 Patient telephoned Maternity Assessment Centre (MAC) for advice. She was having contractions (30 seconds) and feeling fetal movements. She was advised to wait for contractions 40 seconds and 2-3 minutes apart. Patient had called back within the hour to describe more frequent contractions and a sudden onset of a different abdominal pain and was advised to attend hospital. Upon arrival no heartbeat present. Still born baby born.	**De-log request made to ICB following completion of SI investigation:** SI Panel recognised the learning in respect of telephone advice, but that different advice would have not prevented unanticipated placental abruption. It was acceptable that the woman could have stayed at home with the contractions described in the initial telephone call but that the advice was too prescriptive.
208823: Delayed diagnosis- cancer	**De-log request made to ICB following completion of SI investigation:** The delay in diagnosis of prostate cancer was caused by a long wait for a CT scan. This was in turn due to the wrong level of urgency being assigned to the request, an existing lengthy waiting

	list, breakdowns in equipment, and an extended Christmas holiday period. The delay was compounded by the fact that the original treatment plan put in place by Doctor A was not followed by staff on Medical SDEC.
209312: Hospital Acquired Pressure Ulcer Category 4	**De-log request made to ICB following completion of SI investigation:** This investigation has established that the likely root cause for the category 4 right ischial tuberosity pressure ulcer was multi-factorial. A key feature in the findings is that Patient found the progression of her disability and physical limitations challenging. There were instances where Patient declined both pressure area care advice and offer of support from cares. There was no adverse effect on the patient the outcome would have been the same. Through prolonged periods of sitting out of bed creating mechanical forces on vulnerable, sometimes moist skin, played a significant part in the formation of the pressure damage.
215334: Patient was admitted to hospital following a heart attack. The next day the patient was found on floor in the ward. Patient had a suspected Fall.	Patients should be offered the use of anti-slip yellow socks every night and the risk of not wearing them should be clearly articulated. • Patients who fall should have their intentional round increased to hourly • Staff should be aware that a deterioration in a patient's GCS within 2 hours of a fall requires an urgent medical review and that a CT head should take place within an hour of the change in GCS.
218512: Patient with complex mental health issues was admitted to hospital with suspected overdosed. During her inpatient stay, the patient had been attempting self-harm, wrapping cords around her neck, and had locked herself in the bathroom. She subsequently obtained a quantity of paracetamol and took an intentional overdose leading to prolonged tonic-clonic seizure and status epilepticus	Medicines must be managed in accordance with The Medicines Code to prevent harm to vulnerable patients. Consider taking blood samples in patients found in possession of medicines where they have made self-harm attempts prior to confirm whether they have ingested some, even where the patient may deny having taken them.
218755: Patient admitted to ward 3 on November 2022, Patient known who has direct access to the ward due to a medical background of Maple Syrup Urine Disease (MSUD). During the episode of care, he was given the wrong fluids and specialist metabolic feed, this led to an increase in leucine levels which are toxic to his brain. He became confused and disorientated, eventually dropping conscious level.	Awareness that dietary products can result in harm if not used as intended • Awareness that dietary products are not governed by the same labelling requirements as medicines and that there may be potential confusion with products with similar names. • Importance of dietary specialists being involved in the care of patients with complex/metabolic disorders • Importance of dietary specialists being involved in the procurement process by Pharmacy of any new nutritional products.

He was intubated and transferred to PICU (Paediatric Intensive Care Unit) at Sheffield	• Awareness there is a clear process for accessing medicines out of hours which is located on the intranet
211346: Patient due to have an angiogram patient taking warfarin for AF, warfarin stopped 5 days prior to procedure patient had a stroke and died on the stroke unit .	• Patients who are taking anti -coagulation therapy a require risk assessment as per Trust guidance on pre-operative anticoagulation prior to any interventional procedure • When a Trust policy is launched it should be communicated and adopted by all relevant departments • Nursing staff should only work within their scope of practice supported by local policies and protocols

Quality Priority (2022-2023)

Recognition and timely treatment of Sepsis

Executive Lead

Dr Elizabeth Loney

Operational Leads

Dr Rob Moisey
Paula McDonagh

Reporting

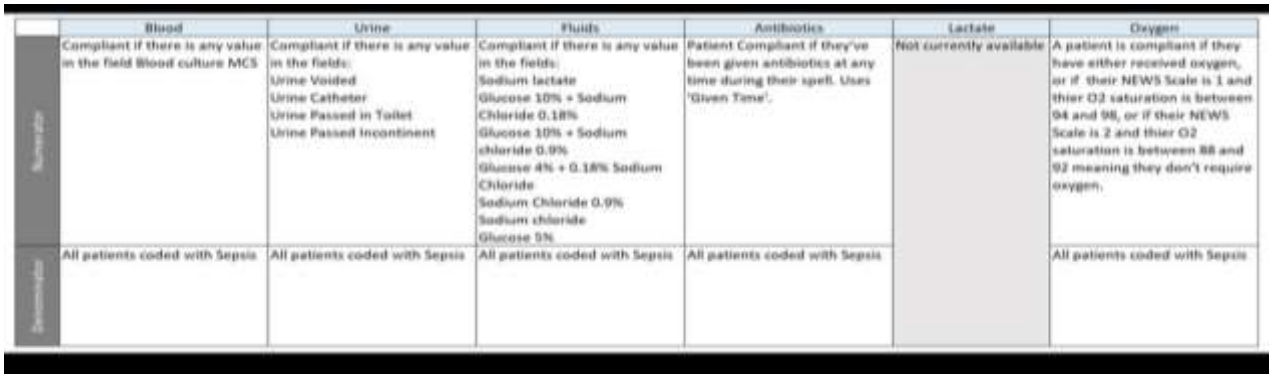
- Sepsis Collaborative
- Care of the Acutely Ill Patient (CAIP) Programme
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 Percentage of adult patients that triggered in ED for red flag Sepsis that had antibiotics administered within 1 hour of trigger	**Red flag patients ED, patients who have triggered one or more red flags at each site** **Feb 2023 – 65.9% March 2023- 47.6%** **All patients coded with sepsis ED** **Feb 2023 - 60.0% March 2023-65.8%** **External reporting compliance (within hour of clinical assessment) = 86%** **Current position** ▪ Compliance of antibiotics administered within 60 mins of earliest alert for red flag improved by 26.2% from in the month of February followed by a decrease of 18.3% in March. We know clinician and nurse staffing gaps have impacted review and treatment times. Staffing levels were near normal in the month of February. The staff at both sites remain committed to delivering sepsis treatment as quickly as possible. Most non-compliant severely septic patients receive their antibiotics within 85 minutes. ▪ New Reconstitution device for mixing IV Pip Tazocin being trialled in both Depts. Sepsis nurse liaising with Aseptic service manager and Jaqui Yuen in Procurement. ▪ ED consultant records a sepsis write back audit however this has been paused due to work absence from the Dept. Sepsis nurse seeking appropriate person to complete audit. This looks at red flag patients coded with sepsis who did not meet the 60minute antibiotic administration	Reasonable Assurance

What do we aim to achieve?	Update	Progress rating
	target. We can identify if the delay was due to doctor review, nurse administration or Triage delay, this allows us to feedback finding for improvement at both nursing and doctor handovers. This a useful process to monitor causes of delays which we know are overcrowding and staffing issues. Additionally, we feedback to the Patient Flow Team so support can be given where possible to free cubicles for deteriorating patients. ▪ Nerve centre went live in October 2022.This system calibrates when observations are due based on the previous NEWS2 score. Sicker patients will be escalated through the nerve centre to the medics, Outreach/HOOP teams. This is a very positive step to support deteriorating sepsis patients reviews and treatment plans. It will not replace verbal communication alerts but add a structured layer of patient assessment/alert through baseline observations. ▪ Allocated ED shift sepsis nurse who oversees time critical assessments and treatment is mostly no longer available due to changes in the ED work force models at both sites, however the Depts do try to allocate this role on a late shift. ▪ ED sepsis champion, clinician and nurse feeding back audit results. ▪ Sepsis info boards in central areas, compliance noted on boards, so staff have site of %s. ▪ Sepsis trolleys in use, another has been located which will be used in HRI rapid assessment as patients with sepsis are treated here, this will give the nurse immediate access to all treatment items should a patient deteriorate, and a treatment cubicle not be available. ▪ Compliance data now available site specific, no significant difference noted in last 2 months. ▪ Option within EPR for nurses to record time of antibiotic given retrospectively…. in Resus only. ▪ NICE are expected to publish new guidance for sepsis recognition, treatment and management of patients in June 2023. Once available the sepsis collaborative will discuss and action an agreed assessment/screening process involving key clinicians and group members. **<u>Risks and mitigations</u>** ▪ Use of sepsis/high risk phone variable, Nerve centre have confirmed that call facility on Zebra device will be complex to set up therefore we are now working towards using call facility in teams on this device. ▪ Further discussions regarding signing for antibiotics on time as ‘given’ in Resus have taken place, all staff now aware that gold standard for drug signing must be maintained.	

What do we aim to achieve?	Update	Progress rating
	▪ Staffing shortages and overcrowding have been negatively impacting patient reviews and treatment times Use of flexible workforce continues to assist unfilled shifts for both RNs and clinicians. Also, the ED coordinators risk assesses staffing cross site and move staff between the two hospitals to support safety of patient care. Nurse in charge using safe care to flag any staffing and care issues, this will then be actioned at site staffing meetings. ▪ Absence of the ED shift sepsis nurse may impact treatment times. ▪ Absence of premade IV Pip Tazocin may also impact treatment times. **Next steps:** -Seek update on call facility set up in Teams -Sepsis nurse to attend reinstated ED PSQB meetings. -Sepsis write back findings to be routinely communicated at ED handovers. -Trust sepsis nurse to advise on numbers of sepsis trolleys required for New ED HRI -Trust sepsis nurse to maintain networking with Bradford Trust. The Trust measures treatment within 60 mins from Dr review, there is no specific Red flag data available, their compliance is equal to CHFT at 86% -Work underway to improve EPR sepsis screening methods in line with national guidance (being updated in June 2023). **<u>Successes</u>** ▪ Introduction of CHFT Sepsis Press which is sent out bimonthly, this supports messages, information, training and audit findings. Staff are invited to contribute, and we also share a ward/Dept success story and patient story. Collaboration with other workstreams is highlighted in the press too. ▪ ED sepsis champions in place ▪ Sepsis boards highlighting data, information in both EDs	

What do we aim to achieve?	Update		Progress rating
	▪ Sepsis essential training now on all eligible staff ESR accounts from July 2022. ▪ Continued use of existing sepsis trolleys in format of sepsis 6. ▪ Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan. ▪ Trust sepsis nurse attending new starter induction programmes. ▪ Consistent positive engagement from staff in EDs regarding the sepsis improvement work.		
Aim 2 BUFALO Bundle Total Compliance (%)	**February 2023** **March 2023** (Total BUFALO target = 60% and > 90% target for each element)		
Blood Cultures	83.3%	85.1%	**Reasonable**
Urine output	63.3%	63.8%	**Reasonable**
Fluids	97.8%	100.0%	**Substantial**
Antibiotics	97.8%	100.0%	**Substantial**
Lactate (waiting adding to EPR)	90.0%	90.4%	**Substantial**
Oxygen	96.7%	93.6%	**Substantial**
TOTAL	**57.8%**	**56.4%**	
Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**<u>Current position</u>** ▪ Blood culture compliance improving. ▪ Urine output remains around 63%. ▪ Fluids, antibiotics, and oxygen remain good at > 90% ▪ Lactate compliance good at over 90%. ▪ Total % compliance has shown steady improvement. In order for full compliance the data measures if the patient has had all elements of the sepsis care bundle completed, if not it is classed as a fail. ▪ Blood culture 3Rs meeting with the EDs and the acute floors has taken place, issues raised regarding obtaining blood cultures are: - supply of blood culture bottles, cultures not routinely taken at night on the acute floors, mostly doctors taking cultures, it is seen as more of a medical task. Patients can be moved before senior review task are actioned. There is sometimes patient reluctance if has had blood samples taken earlier in the day.		

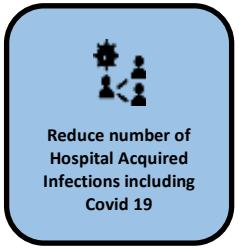
What do we aim to achieve?	Update	Progress rating
	▪ Blood culture volume rates are averaging 4/5 ml when should be 10ml. Contamination rates are in line with other organisations regionally ▪ Sepsis collaborative reviewing new blood culture guidance on our current position. ▪ Urine output measurement is very basic therefore not representing good data collection (see below). However, once the POCT testing work has been completed for urine, it should be possible to measure the data in more detail. ▪ IV fluids, Oxygen and antibiotics are consistently over 95% ▪ Sepsis nurse met with ED head Nurse to discuss compliance rates. Very positive meeting with active engagement regarding improving treatment times for ED. Additionally support provided to initiate the communication regarding patients with Red Flag sepsis having 2 sets of blood cultures taken.  **<u>Risks and mitigation's</u>** ▪ Sepsis nurse continuing communicate process for blood culture taking at both sites, also using sepsis press to deliver message. Poster drops taken place. ED and acute floor consultants reminding their teams. Agreed at sepsis collaborative that registered nurses who perform venepuncture skills should be trained to take blood cultures (some years ago, this was stopped). The IV therapy working group have now reconvened and have met to discuss training needs. Further meeting led by Jo Middleton planned on the 18/4/23 to progress the work.	

	Blood	Urine	Fluids	Antibiotics	Lactate	Oxygen
	Compliant if there is any value in the field Blood culture MCS	Compliant if there is any value in the fields: Urine Voided Urine Catheter Urine Passed in Toilet Urine Passed Incontinent	Compliant if there is any value in the fields: Sodium lactate Glucose 10% + Sodium Chloride 0.18% Glucose 10% + Sodium chloride 0.9% Glucose 4% + 0.18% Sodium Chloride Sodium Chloride 0.9% Sodium chloride Glucose 5%	Patient Compliant if they've been given antibiotics at any time during their spell. Uses 'Given Time'.	Not currently available	A patient is compliant if they have either received oxygen, or if their NEWS Scale is 1 and thier O2 saturation is between 94 and 98, or if their NEWS Scale is 2 and thier O2 saturation is between 88 and 92 meaning they don't require oxygen.
	All patients coded with Sepsis	All patients coded with Sepsis	All patients coded with Sepsis	All patients coded with Sepsis		All patients coded with Sepsis

What do we aim to achieve?	Update	Progress rating
	▪ POCT work for urine has remained static, no update available regarding fluid balance being added to nerve centre. Unable to change measurement criteria until this work is completed. Sepsis and Renal nurse will continue to communicate good fluid balance recording in EPR. ▪ Clinical Lead and sepsis nurse reminding clinicians that all elements of sepsis 6 care bundle should be completed. One issue identified is that if the patient does not require oxygen when assessed, there is a tendency to leave the box blank rather than indicating 'No', this is sometimes left blank in case the patient goes on to require oxygen. Clinicians are being reminded they can submit another entry if this is the case. **Next steps** ▪ Continue to communicate blood culture requirements for Red flag septic patients. ▪ Trial of order of blood culture test when IV antibiotic prescribed through EPR (Jim Harris and ED Consultant testing this) ▪ Sepsis nurse to liaise with renal nurse regarding improving fluid balance compliance (Hydration tool due to be added to EPR).	
Aim 3 Sepsis ESR Training Compliance (75%)	Business intelligence have now provided the training numbers. **Overall Compliance has now reached 78%** **Current Position** ▪ Sepsis nurse has agreed eligible clinicians and registered nurses and approves new position list. ▪ Sepsis training went live on all eligible staff ESR accounts on the 25/7/22. ▪ Data of compliance to be reported by informatics in December, delay due to staff absence. ▪ Sepsis nurse continuing face to face training for new RN starters. ▪ Sepsis nurse supporting community educator with online and face to face training.	Substantial

What do we aim to achieve?	Update	Progress rating
	Risks and mitigations ▪ Issues self-declaring that training completed identified, this has been actioned with further communication. ▪ Both Training packages were unable to support questions for knowledge Test due to specific Tech person no longer being in post. Other methods of testing knowledge were explored but were not suitable. This requires attention if the post is reinstated. ▪ Sepsis nurse has trained 450 staff prior to going on ESR, these staff have been asked to self-declare. **Successes** ▪ CHFT essential sepsis training now on all eligible staff ESR accounts. ▪ Community sepsis training reviewed and on ESR. ▪ Trust sepsis nurse support ED education leads and community education lead. Also attends new starter inductions and apprentice training programme both in Hospital and Community which has been well received. **Next steps** ▪ Sepsis nurse to continue ward visits to remind all eligible staff to complete their training. ▪ Sepsis nurse to share progress with Yorkshire Sepsis Network members as per previous interest. Members of the network have provided positive feedback on our commitment and processes in improving sepsis recognition and treatment. ▪ Continue attending CHFT new starter induction training monthly to deliver sepsis Presentation. ▪ Sepsis nurse attending new learning disability nurse training programme monthly from November 2022 to discuss sepsis and provide education. ▪ Continue supporting patients post severe sepsis with signposting information and discussing recovering from sepsis so they are informed and understand the complexities of recovery	

Quality Priority (2022-2023)



Reduce the number of Hospital-acquired infections including COVID-19

Executive Lead

Dr David Birkenhead

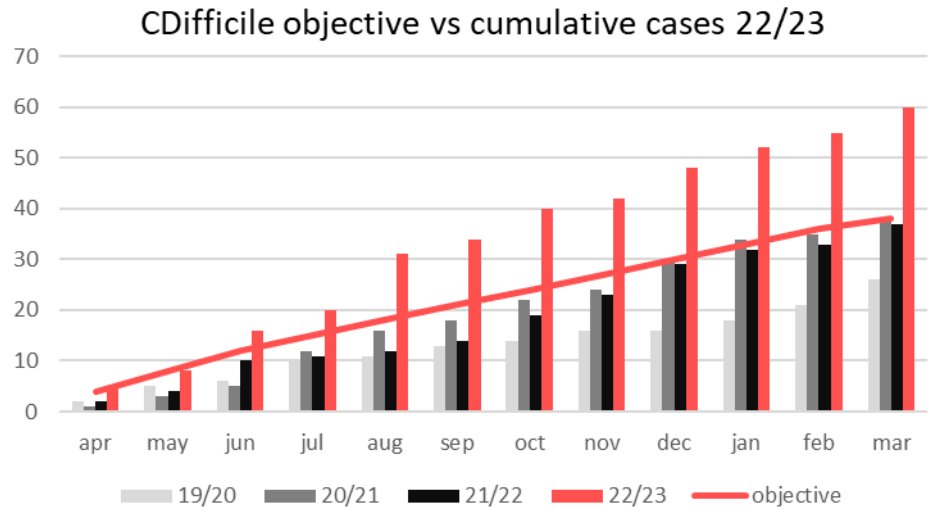
Operational Leads

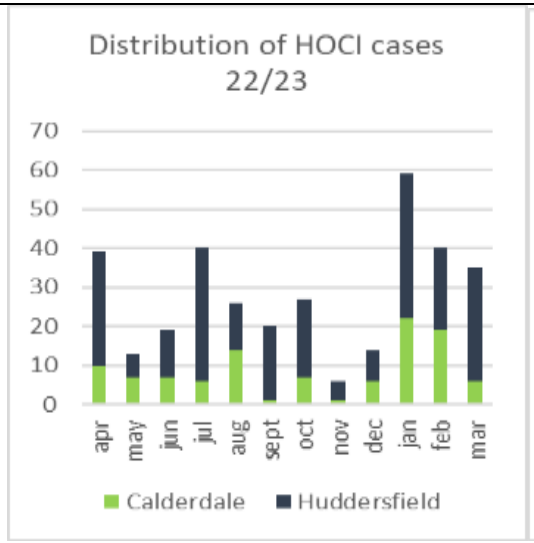
Dr Vivek Nayak
Gillian Manojlovic

Reporting

- Infection Control Performance Board
- Infection Control Committee
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 COVID 19 in patient testing compliance (%)	The schedule of in-patient testing had been suspended after the last report. As of 10/10/22, all admissions are tested on arrival, but no further testing is carried out unless symptoms occur. **This element is no longer reported in KP+.** **Testing changes have been instigated as of 01/04/23 and no asymptomatic patients are tested unless for discharge to a care home or if required pre-operatively.**	Limited Assurance limited
Aim 2 Number of c. diff: Trust-assigned (not to breach the 22/23 objective of 38 cases)	The number of C.difficile infections is monitored nationally, reported via the UKSHA HCAI data capture system. The number of C.difficile infections have increased over the past 2 years and this increase is not limited to CHFT but is being seen across many NHS Trusts. In response the Trust has implemented an improvement plan including a programme of HPV deep cleaning, C.difficile wards rounds, antimicrobial ward rounds and a review of the investigation process for cases. The first 6 months data reviewed and risks of acquisition of C-Diff are as per known norms (Older age/antibiotics/hospital stay/PPIs etc). NHSEI have carried out a support visit in March, with positive feedback. This will further inform the improvement plan. **At year end there have been 60 cases reported including 22 community onset, healthcare associated cases. This over the trajectory for the year.**	Reasonable Assurance

		
Aim 3 Number of Hospital Onset Covid-19 Infections (surveillance)	Hospital Onset Covid-19 infection (HOCI) increases and decreases in line with that seen in the wider population. This data provides an overview of the numbers of HOCI year to date. The Covid-19 control measures were changed in June 22 in line with national guidelines. The cessation of admission testing was reversed in October due to the rising numbers of cases. Visiting restrictions were lifted in December prior to Christmas and have not been reinstated. Asymptomatic patient testing has once again been stopped (01/04/23). The HOCI incidence will continue to be monitored. The following charts show the full years data for definite and probable HOCI and the distribution across the two sites. This reflects the outbreaks experienced by predominantly the elderly medicine wards at HRI. The open nature of some of the ward environments makes outbreak control more of a challenge.	Substantial Assurance


Distribution of HOCI cases 22/23
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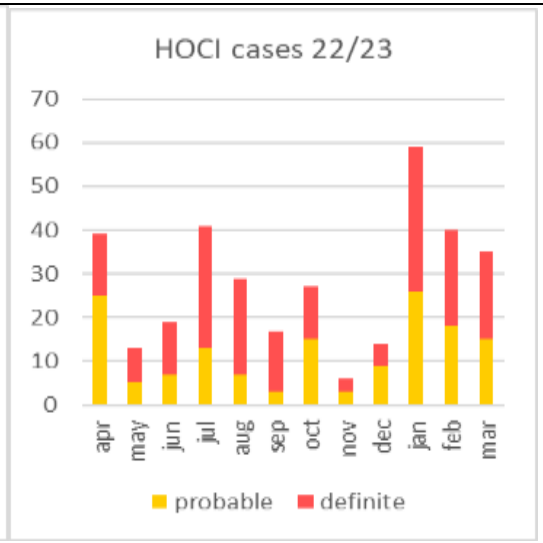
Huddersfield


HOCI cases 22/23
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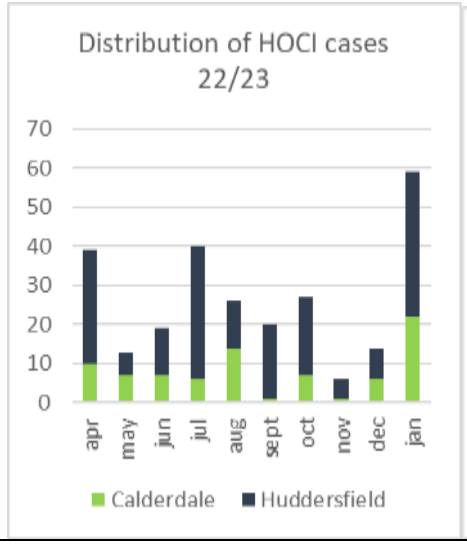
Distribution of HOCI cases 22/23
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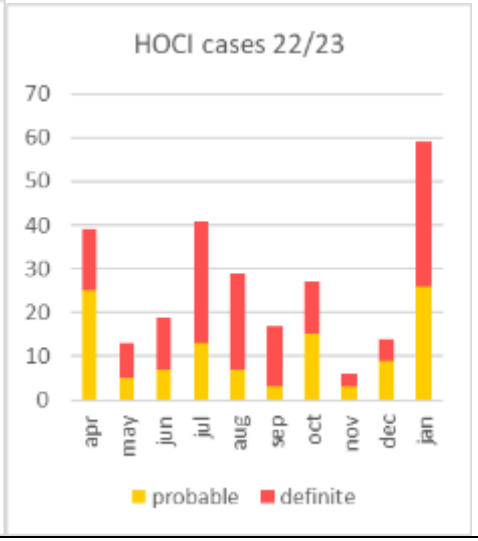
Calderdale
Huddersfield


HOCI cases 22/23
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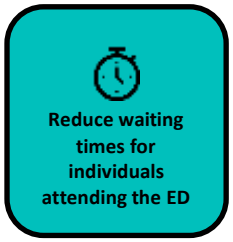
Quality Priority (2022-2023)



Reduce waiting times for individuals attending the Emergency Department

Executive Lead

Jonathan Hammond (Interim Chief Operating Officer)

Operational Leads

Jason Bushby
Dr Amjid Mohammed
Jayne Robinson

Reporting

- Medical Division PSQB
- Trust PSQB
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 Monitor 8 Hour A&E Breaches and ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards	>8 hour LOS: February 2023 = 1336 (+90 from previous month) March 2023 = 1858 (+522 from previous month) Overall attendances: February 2023 = 12,784 March 2023 = 14,419 Average LOS: February 2023 = 245.9 March 2023 = 260.1	Increased attendances of 1,635 from February to March resulting in an increased number of patients with an increased LOS above 8, 10 and 12 hours. Consistent increase in the use of the ED UCH: Jan 430 Feb 515 March 601 To reduce LOS for non-admitted low acuity patients. This also indicates a consistent increase in the number of lower acuity patient accessing the ED, potentially due to industrial action.
Aim 2 Monitor 10 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local	>10 hour LOS: February 2023 = 696 (+104 from previous month) March 2023 = 1079 (+383 from previous month)	Additional HCA for the waiting room to monitor patients with a LOS >4 hours.

standards		Senior medic (ST6+) added supernumerary in aid of decision making and front door turnaround, however this clinical is often re-routed to assist within ED Majors due to number of attendances, resulting in loss of senior medical decision maker at the ED front door.
Aim 3 Monitor 12 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards	>12 hour LOS: February 2023 = 372 (+70 from previous month) March 2023 = 632 (+260 from previous month)	Still monitoring and capturing and reporting DTAS's.

Focused Quality Priority (2022-2023)

Reducing the number of falls resulting in harm

Executive Lead

Lindsay Rudge

Operational Leads

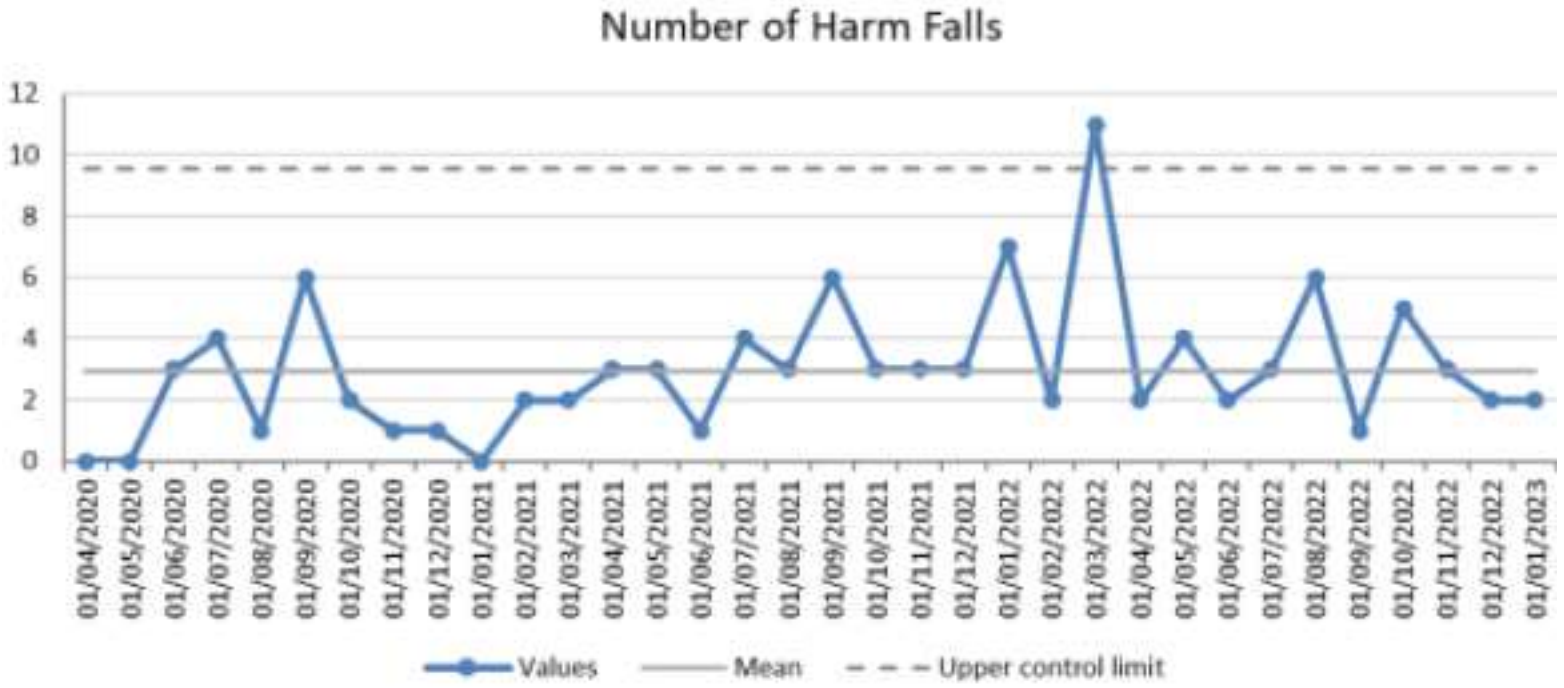
Dr Abhijit Chakraborty
Lauren Green
Helen Hodgson

Reporting

- Falls Collaborative
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 Monitor the total number of falls and implement actions to reduce these	Falls dashboard updated monthly and fed back through the Falls Collaborative. Total number of falls have reduced recently. Adding in time of day to falls dashboard to identify any themes. Acute floors have carried out a significant amount of work and have reduced their number of falls with great success. Falls KPIs are being reviewed by Falls Collaborative to ensure correct and appropriate data is being collected. This will be ratified at next Falls Collaborative. Task and finish group has been created by Matron Keaskin with a view to review the FISH Tool this will be reviewed at the next Falls Collaborative. Chart to be created identifying what interventions have been successful over last 18 months – action plan will be developed at next falls collaborative.	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
Aim 2 Monitor the total number of Number of falls resulting in harm and implement actions to reduce these	Falls dashboard updated monthly and fed back through the Falls Collaborative. Total number of falls have reduced recently. Adding in time of day to falls dashboard to identify any themes. Acute floors have carried out a significant amount of work and have reduced their number of falls with great success. Falls KPIs are being reviewed by Falls Collaborative to ensure correct and appropriate data is being collected. This will be ratified at next Falls Collaborative. Task and finish group has been created by Matron Keaskin with a view to review the FISH Tool this will be reviewed at the next Falls Collaborative. Chart to be created identifying what interventions have been successful over last 18 months – action plan will be developed at next falls collaborative.	**Reasonable Assurance**
Aim 3 Ensure all adult inpatients will receive a falls risk assessment on admission/ transfer to the ward (ward assurance)	This is consistently around 75% - QI work will need to be completed to improve compliance. Need to identify reasons why assessments are not being completed and a task and finish group will be established to support with the improvement work. This will be the focus for the May Falls Collaborative.	**Reasonable Assurance**


Number of Harm Falls
12
10
8
6
4
2
0
01/04/2020
01/05/2020
01/06/2020
01/07/2020
01/08/2020
01/09/2020
01/10/2020
01/11/2020
01/12/2020
01/01/2021
01/02/2021
01/03/2021
01/04/2021
01/05/2021
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01/07/2022
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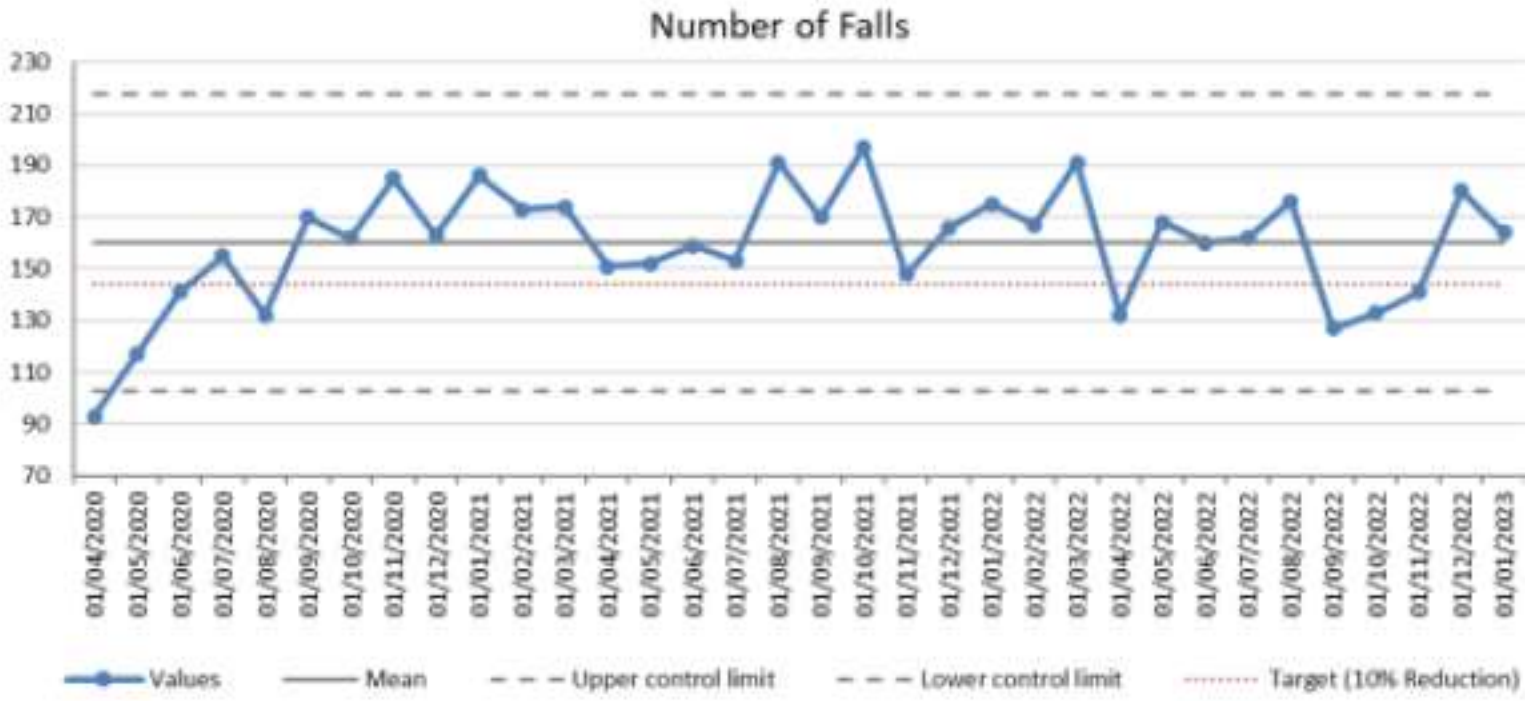
01/01/2023
Values
Mean
Upper control limit


Number of Falls
230
210
190
170
150
130
110
90
70
01/04/2020
01/05/2020
01/06/2020
01/07/2020
01/08/2020
01/09/2020
01/10/2020
01/11/2020
01/12/2020
01/01/2021
01/02/2021
01/03/2021
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01/02/2022
01/03/2022
01/04/2022
01/05/2022
01/06/2022
01/07/2022
01/08/2022
01/09/2022
01/10/2022
01/11/2022
01/12/2022
01/01/2023
Values
Mean
Upper control limit
Lower control limit
Target (10% Reduction)

	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
1. All adult inpatients will receive a falls risk assessment on admission/ transfer to the ward?	71.5%	74.3%	74.2%	71.5%	79.8%	74.9%	81.7%	76.7%	54.3%	76.0%	75.4%	75.9%
2. Care plans to minimise falls will be evident (met) for all patients assessed as 2 or above on FRA?	92.2%	92.0%	89.9%	90.7%	93.5%	91.6%	93.1%	91.5%	72.8%	88.6%	89.1%	88.4%
3. A bed rail assessment will be undertaken on all those patients identified as 2 or above on FRA?	70.0%	72.6%	71.5%	70.6%	78.6%	71.3%	79.4%	73.3%	69.5%	70.8%	70.4%	69.3%
4. All patients have an intentional rounding completed at least every 4 hours.	6.9%	6.5%	6.8%	6.7%	6.2%	6.4%	7.5%	6.3%	6.9%	7.3%	6.5%	7.2%
5. All patients have a manual handling assessment completed on admission/ transfer to the ward?	40.7%	41.1%	40.9%	42.8%	50.8%	46.3%	53.8%	47.2%	57.9%	47.3%	44.7%	44.2%
Total for Falls Assessment Section	50.9%	52.2%	51.9%	51.6%	58.5%	53.3%	60.2%	54.3%	47.9%	54.2%	53.5%	53.4%

Focused Quality Priority (2022-2023)

Increase the quality of clinical documentation across CHFT

Executive Lead

Dr David Birkenhead

Operational Leads

Louise Croxall
Jonathan Cowley

Reporting

- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 Optimise the Clinical Record by improving the workflows and making it easier to achieve the Must do's	Demonstrations are taking place of the new admission workflow and the feedback so far from the nursing staff has been very positive. Volunteers have been requested to help improve care plans and task and finish groups will be set up.	**Substantial Assurance**
Aim 2 Making sure assessments are achieved within a timely manner on admission and throughout the hospital stay as needed.	This connects with work mentioned above. All ward Assurance data now feeding from the correct place.	**Reasonable assurance**
Aim 3 Implement the hospital white board across the trust to assist in completion of accurate documentation and assessments	Change facilitators have been recruited and start 17th April 2023. Permanent screens have been installed in SAU, Acute floor at HRI and ward 5 HRI. Quote obtained for CRH. Project boards have been rescheduled and engagement with the clinical areas is currently underway.	**Substantial Assurance**
Aim 4 Improve overall performance on documentation by assisting ward managers and matrons to access information and report figures monthly into their quality boards.	Awaiting a meeting to finalise dashboard and how this will feed all information in so ward managers and above have one source of the truth.	**Reasonable Assurance**

Focused Quality Priority (2022-2023)

Clinical Prioritisation (deferred care pathways)

Executive Lead

Dr David Birkenhead

Operational Leads

Divisional Directors
Directors of Operation
Kimberley Scholes

Reporting

- Recovery Framework Board
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 Number of validations in month	**Current situation -** Pre Covid the total list size was 62k and now stands at 83k. The number of overdue patients pre covid was 10k and now stands at 26k. Of the patients that are overdue 17k are on an open RTT pathway **Admin Validation -** Cancelled appointment with Requests (CAWR), Incomplete Orders (IO's)and the Holding (82k patients, pre COVID 62k) list all require admin validation when 12 weeks overdue. This removes approximately 50%of IO's and 20%of the CAWR and Holding list. Over 212k admin validations have been completed. **Clinical Validation -** Clinical review and a Priority rating applied, P1 = 2 weeks, P2=6 weeks, P3=12 weeks, P4=clinician determined, P5=discharge, PIFU. **April Update: The holding list now stands at 87k with 27k patients overdue their follow up appointment. We continue to admin validate all patients at 12 weeks prior to clinical validation and prioritisation.**	**Limited Assurance**

Aim 2 Number of prioritisations in month	Patients will be prioritised for clinical validation, commencing with patients on the IO's list >90days, currently 3511 patients, a total of 5788 patients require validation in this cohort. This will be followed by the Holding list >90 days, currently 5246 patients, a total of 9190 patients require validation in this cohort. Performance will be monitored through PSQBs with reports into Divisional PRMs. **April Update: Patients are being prioritised for clinical validation, commencing with patients on the incomplete orders list >90days. There are currently 3413 patients in this cohort and of this a third (1,160) sit in just 2 specialities Colorectal and Neurology. The total outstanding clinical validation stands at 13k. Performance will now be monitored through the Access Delivery Group.**	**Limited Assurance**

Focused Quality Priority (2022-2023)

Reduction in the number of CHFT-acquired pressure ulcers

Executive Lead

Lindsay Rudge

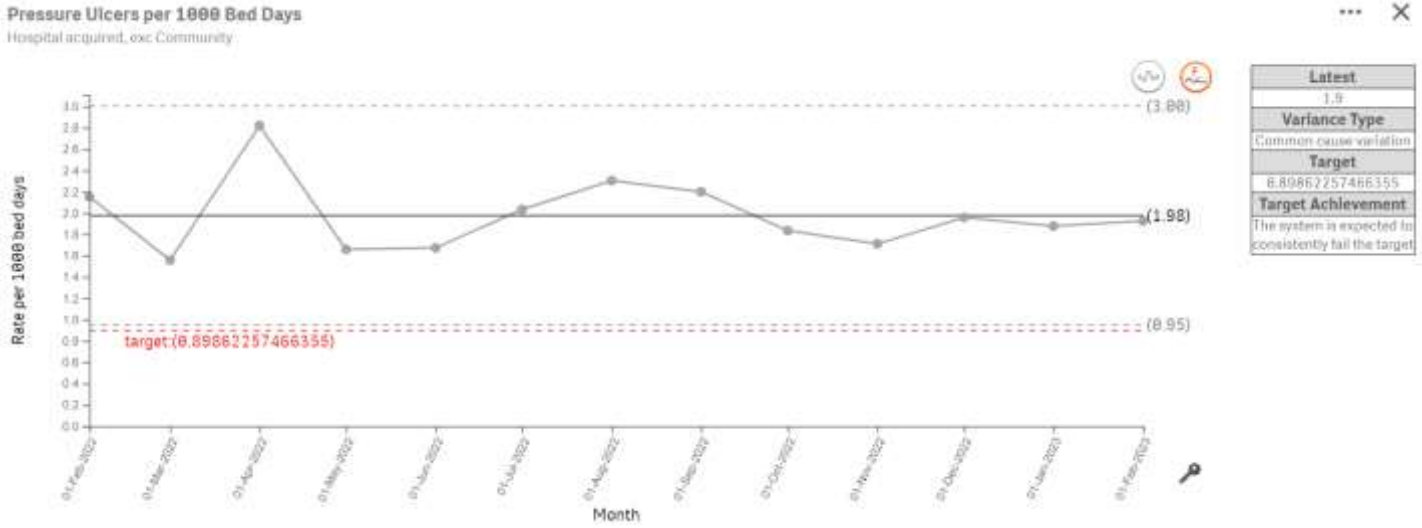
Operational Lead

Judy Harker

Reporting

- Pressure Ulcer Collaborative
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 10% reduction in the incidence of hospital acquired pressure ulcers per 1,000 bed days	**Hospital acquired pressure ulcers per 1,000 bed days** The graph below demonstrates that the incidence of hospital acquired pressure ulcers is consistently above the target. It is very challenging for Pressure Ulcer Collaborative to achieve any sustained reduction in pressure ulcers. High numbers of complex patients, long trolley waits, high numbers of patients being admitted following a long lie. Larger than average numbers of pressure ulcers deteriorating rapidly. An increase in very complex younger patients presenting with extensive tissue damage. Significant staffing challenges in acute and community settings	**Limited Assurance**

What do we aim to achieve?	Update	Progress rating
	 **Numbers of CHFT acquired pressure ulcers by division** The table below shows a stable picture with respect to numbers of pressure ulcers per month. The divisional breakdown is also stable with the majority occuring in division of community services which is a decrease for this division. It has been identified that many pressure ulcers reoroted by FSS/Plaster room/orthopaedic clinic sit accross several divisions.	

What do we aim to achieve?	Update	Progress rating

Division | Month

	YTD	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Jan-2023	Feb-2023
Trust Total	**1248**	**80**	**79**	**103**	**100**	**92**	**99**	**104**	**99**	**91**	**80**	**98**	**111**	**94**
-	**4**	-	-	-	-	-	-	-	-	-	-	-	1	3
Community	**727**	41	48	49	68	60	59	58	56	53	63	54	68	50
FSS	**3**	-	-	-	-	-	-	-	1	-	-	2	-	-
Medicine	**349**	26	21	43	28	28	26	34	29	25	24	23	28	30
Other	**5**	-	-	-	-	-	-	-	-	-	-	1	1	3
Surgical	**160**	13	10	11	12	12	14	12	13	13	11	18	13	8

Categories of CHFT Acquired Pressure ulcer

A noticeable reductions of category 2 pressure ulcers from January – February with a recognition that many reported are Moisture Associated Skin Damage (MASD).

Category 4 pressure ulcers remain a concern with 5 identified in January 2023. 1 patient developing 3 category 4 pressure ulcers, which were existing pressure ulcers that have naturally debrided from an unstageable pressure ulcer.

A reduction in the number of patients with pressure ulcers as we are seeing more patients with multiple reported pressure ulcers due to their complex needs.

What do we aim to achieve?	Update	Progress rating

Values | Month

	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Jan-2023	Feb-2023
Total number of CHFT acquired pressure ulcers	80	79	103	100	92	99	104	99	91	98	98	111	94
Category 2	49	47	39	48	39	47	50	52	32	39	44	53	30
Category 3	2	1	0	0	3	0	0	0	0	2	1	2	1
Category 4	0	3	1	2	0	0	1	3	1	6	2	5	0
DTI's	20	19	46	32	39	33	43	32	34	41	40	33	38
Unstageables	9	9	17	18	11	19	10	12	24	10	11	18	25
Number of patients with a Pressure Ulcer	69	70	76	78	79	85	84	82	81	81	78	94	73

Medical Device Related Pressure ulcers

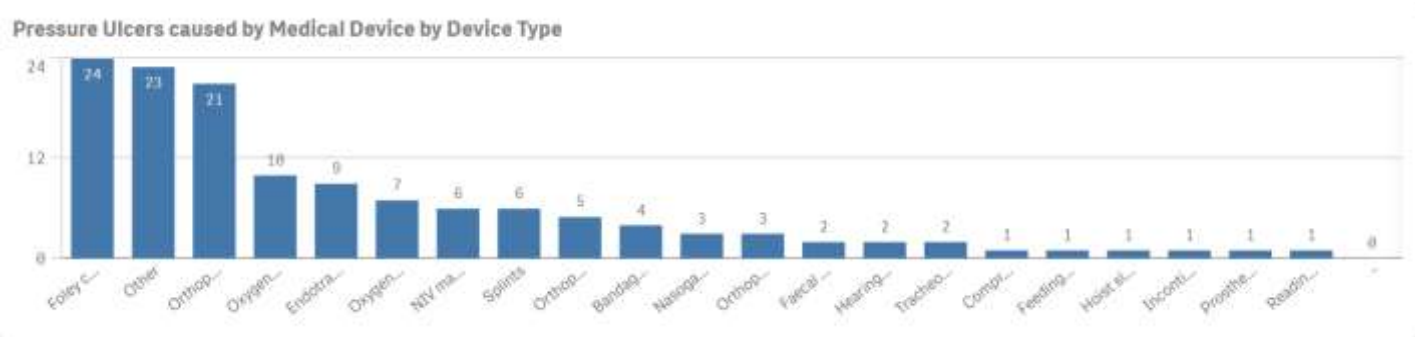
Devices causing skin damage has reduced since december with 5 reported in Januay and 0 reported in February. The Trust is moving to a new pressure ulcer risk assessment tool which includes the presence of medical devices which should help alert staff to this clinical risk. A few previoulsy reported plaster related pressrue ulcer incidents have been investigated and transferred to other community care settings due to a failure to follow advice provided by the outpatient department & specialist services.

Medical device related incidents althogh reported by FSS have been found to have omissions stretching across 4 divisions.

Catheter remain the most frequested reported MDRPU due to a low usage of anchor devices.

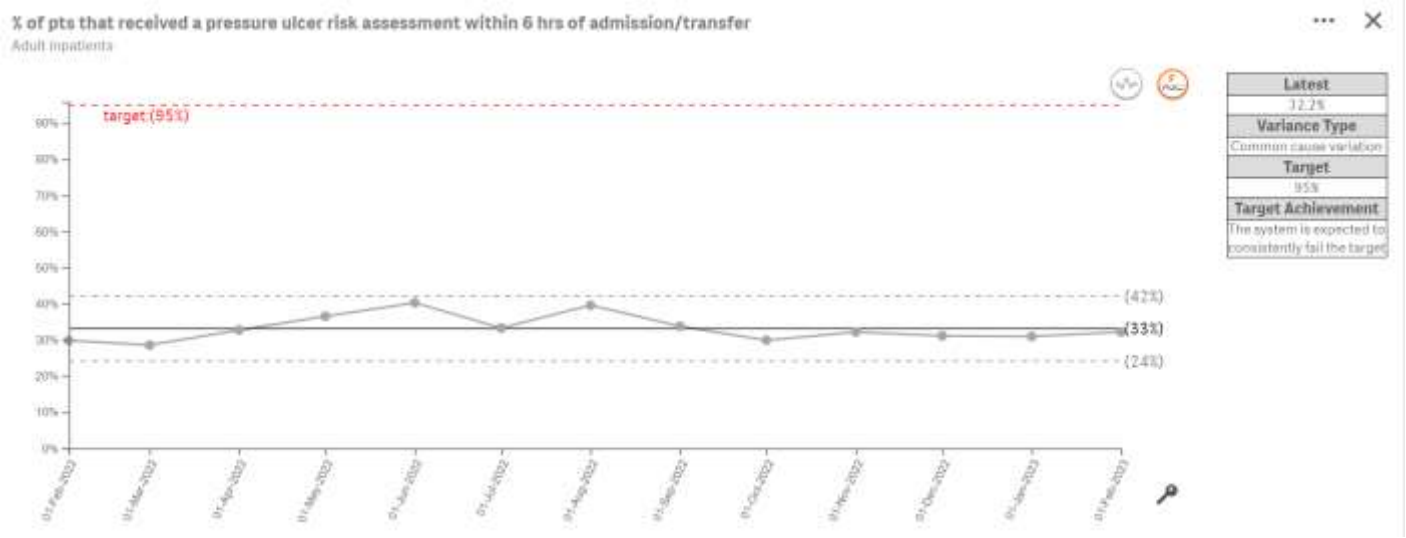
Values | Month

	Totals	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Jan-2023	Feb-2023
Total number of CHFT acquired pressure ulcers	133	8	5	9	11	11	18	14	16	10	16	10	5	0
Category 2	88	6	5	6	8	6	10	8	10	4	10	6	1	0
Category 3	1	0	0	0	0	1	0	0	0	0	0	0	0	0
Category 4	1	0	0	0	0	0	0	0	0	0	0	1	0	0
DTI's and Unstageables	51	2	0	3	3	4	8	6	6	6	6	3	4	0

What do we aim to achieve?	Update	Progress rating
	 **Improvement Work** Presence of Tissue Viability Nurses on wards at weekends and bank holidays since July 2022. Improved response times to referrals of patients with complex pressure damage. Plan for early 2023 to review terms of reference and relaunch Pressure Ulcer Collaborative. New SOP written for pressure ulcer risk assessment in hospital setting. **CQUIN12: Assessment and documentation of pressure ulcer risk:** Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. New pressure ulcer care plan written for community SystmOne. Review of catheter anchor devices to be led by the bladder & bowel team. New moisture associated skin damage care plan written for community SystmOne.	

What do we aim to achieve?	Update	Progress rating
	New lateral tilt bariatric mattresses now available in hospital setting (previously only available in community). New End of Life section to be added to KP+ so that proportion of patients developing pressure damage / skin changes in last days of life can be measured. Ongoing work with new Datix Manager to review thematic analysis of causal omissions and contributory factors. Dark skin toned wound models used in pressure ulcer education. Skin tone assessments now established in Tissue Viability Nurse assessments. Successful bid to purchase 60 new Pure air 8 air mattress to replace old stock of 40 Trios mattress with an additional 20 which will be in the trust by early April 2023. Collaborative work with Trust Decontamination team to explore increasing availability of air mattresses out of hours. Orthopaedic Cast awareness resource pack developed by Tissue viability and to be shared with wards. Links with ED to develop work already started to improve recognition of risk, categorisation, documentation and initiation of interventions required prior to ward transfer.	

What do we aim to achieve?	Update	Progress rating
Aim 2 **2a.** 95% of inpatients receive a pressure ulcer risk assessment within 6 hrs of admission/transfer	2a. The graph shows no sustained improvement in risk assessment. Risk assessment highlighted on aSSKINg care bundle action cards. Message of the month action cards has highlighted importance of risk assessment. The Trust will renew its focus on risk assessment when launching new risk assessment tool, PURPOSE T. This new pressure ulcer risk assessment tool and a suite of care plans have been built for Cerner. The tool is already available for use on SystmOne. Implementation is due in the coming months. Pressure ulcer risk assessments completed within <u>12 hours</u>: August 2022 – 57% September 2022 – 55% October 2022 – 54% Pressure ulcer risk assessments completed within <u>6 hours</u>: November 2022 – 32.2% December 2022 – 31.2% January 2023 31.2% February 2023 32.2% (a 30-minute buffer is allowed)	**Limited Assurance**

What do we aim to achieve?	Update	Progress rating
2b. 95% of patients have a PU risk assessment within 7 days of admission to DN caseload	 2b. SystmOne record review indicates that for September 2022, 58% of patients had a Waterlow pressure ulcer risk assessment completed within 7 days of being admitted onto a community nursing caseload. This KPI continues to be measured via manual data cleansing. Further work ongoing to support measurement.	**Limited Assurance**
Aim 3 95% of relevant staff will have completed Pressure Ulcer Prevention training	87.87% of staff have completed React to Red Training as of 1st April 2023. Data available on KP+. Training provided to all Pressure Ulcer Collaborative members on how to review the information. Good evidence of divisions targeting key wards to improve performance. Best performing divisions remain to be community and SAS showing 91% compliance with pressure ulcer training. Medicine 81% and FSS 86%. Medical staff continue to have a low number of completed training – communications have been sent to the medical education team to review this and identify what the barriers are to completing this. Induction training session for PU prevention has been extended with the plan to signs this off as the initial	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	mandatory PU prevention training. Additional virtual and ward-based training continues to be provided to support staff. Face to face training has recommenced. Joint venture with BTHT to build e-learning for pressure ulcer risk assessment tool (PURPOSE T). Completion due later this year.	

Focused Quality Priority (2022-2023)

Nutrition and Hydration for inpatient adult and paediatric patients

Executive Lead

Lindsay Rudge

Operational Leads

Vanessa Dickinson
Jonathan Wood
Dr Mohamed Yousif

Reporting

- Nutrition Operational Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
QP1 . % of adult patients that received a MUST assessment within 24 hours admission/ transfer to the ward	Independent study taken place to determine accurate figures for MUST training, results demonstrate: - The MUST assessment was fully completed for 15/30 (50%) reviewed patients. [Results by site: HRI (7), CRH (8)]. - However, only 8/15 (53%) of the completed MUST assessments were completed within 24 hours of the patient's admission, meaning that only 27% of the reviewed patients had the MUST assessment completed in line with the Foundation Trust's policy. This is an improvement on the IT figure of 19.4% but shows we still have a long way to go. Nutrition CNS audit of 10patients off each ward over 2-month period. Vast discrepancy. Some wards 0% compliance, others much higher. Overall, HRI compliance 21.2%, CRH 32%. Work is being carried out via the operational group to cascade the need down to the wards through the safety huddle. Work needs to be instigated with the acute admissions wards and clinical educators to see any major impact. Presented to ward managers meeting as reminder of importance of completing MUST within 24 hours of admission. Encouraging Matrons to complete manual trawl of 2 pts notes per week to determine if MUST is being completed.	**Limited Assurance**

What do we aim to achieve?	Update	Progress rating
QP2 % of patients with a MUST score of 2 or above that were referred to a dietician	100%. We know this to be accurate representation due to it being an automated response. Quality of the referral needs to be investigated. Dietitians report approx. 50% have inaccurate data	**Limited Assurance**
QP3. % of patients (>LoS 8hrs) that had a completed fluid balance chart	No longer a required aim for all admissions to have a fluid balance chart. Renal team report 75% of their referrals have a fluid balance chart commenced (up from 62%) Hydration tool planned for ESR via Renal CNS.	**Limited Assurance**

Focused Quality Priority (2022-2023)

Making Complaints Count

Executive Lead

Lindsay Rudge

Operational Lead

Emma Catterall

Reporting

- Making Complaints Count Collaborative
- Patient Experience and Caring Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 % of Complaints Closed within agreed timescale	The Trust's performance relating to complaints closed within an agreed timescale is continuing to maintain an acceptable standard despite the operational pressures the Divisions are facing. 50 out of the 57 complaints closed in February and March 2023 were closed within agreed timeframes, which is 88%. Meetings continue to take place on a weekly basis with individual Divisions and these are working well to understand the current position and to escalate any blockages or issues Divisions are experiencing. Meetings continue to work well, are well attended and are pivotal for escalating issues in a timely fashion.	**Reasonable Assurance** Since these meetings have been implemented, communication between the divisions and the corporate team has been more effective. As the department moves towards full capacity, we remain optimistic that the complaints will be closed in the timescale agreed so that we align with our Trust policy, and this is now being reflected in our data.
Aim 2 Number of reopened complaints	The quality of complaint responses continues to be a priority for the department. A rota has been established within the Executive Team to approve and sign complaint responses to ensure that a varied oversight is achieved. 15 complaints were re-opened in in February and March 2023, which is higher than we would hope to see at 26% of the total number of complaints closed. This will continue to be monitored and any actions required will be identified as to why we are not getting this right first time.	Limited Assurance The department is striving to improve customer complaint responses effectively first-time round. The focus on the quality of complaint responses needs to remain alongside our focus on performance.

What do we aim to achieve?	**Update** (January 2023)	Progress rating
Aim 3 Number of concerns that escalate into complaints	Concerns raised relating to a current, on-going admission are continuing to be telephoned through to Matrons (instead of emailed) to request direct contact with the patient/their family, in an attempt to avoid these issues escalating further – this is still working well, and Matrons are being responsive.	**Reasonable Assurance** In this reporting time period, 6 concerns have escalated to a formal complaint. All 6 have been reviewed and were appropriate to be escalated to a formal complaint.

Focused Quality Priority (2022-2023)

End of Life Care

Executive Lead

Lindsay Rudge

Operational Leads

Gillian Sykes
Renee Comerford
Gemma Gordon

Reporting

- EoLC Steering Group
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 To monitor the number of patients referred to HSPCT who die or are discharged from hospital before an encounter with the team to identify themes and trends	The HSPCT commenced a 7-day service on 1st September 2022. October -139 referrals, 28% died or discharged before encounter. (CNS x2 and PCSW x1 on weekend) November - 133 referrals, 22% died or discharged before encounter (CNS x2 and PCSW x1 on weekend) December - 133 referrals, 20.3% died or discharged before encounter (CNS x1 and PCSW X1) January - 144 referrals, 19.4% died or discharged before encounter (CNS x1 and PCSW x1). Feb – 120 referrals, 18.3% died or discharged before encounter (CNS x1 only) In the early stages of the 7 days service, we found that having 2 CNSs on at the weekend depleted the midweek team and therefore missing vital face to face contact with patients.	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	There appears to a correlation between a reduction in staff presence and numbers of missed referrals. There has been little difference on a weekend since reducing the numbers of staff however we have had to significantly reduce our face-to-face contact during the weekend. From February with one CNS only with an urgent response approach, along with urgent advice and referral triages only. Weekend work for Support workers has temporarily been suspended. So that we can monitor effect in outcomes. We hope this approach will also help with sickness levels in the team. Consultant absence is also down since Mary's retirement, Jeena's sickness, and Hazel's maternity. Therefore, this may also affect our figures and outcomes. We have also lost a 1.0 CNS but hope to recruit X2 0.8 CNSs	
Aim 2 That 50% of patients seen in the frailty service identified at Rockwood 8 are offered the opportunity to create an advance care plan	**February/March 2023** Full reporting is still not available across the CHFT footprint. However, data available for Kirklees is starting to show an increase in the number of Advance Care Plans recorded on EPaCCS. Work ongoing to provide data for Calderdale locality The ACP post has been reviewed and is now on trac to support ACP for frail people being discharged from hospital. This post will sit within the virtual ward and UCR to increase number of ACP being offered to people in their own home Kirklees data - for S1 practices November 22 EPaCCS – 1459, ACP – 620 There is now staff in post in Kirklees (joint funded post with Locala	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	for 12 months) to identify early and complete ACP in acute trust and community. This funding has also just been agreed through an innovation bid in Calderdale ICB for 12 months	
Aim 3 Monitor and report the number of complaints, concerns and compliments related to end-of-life care to identify themes and trends to implement lessons learned	**February/March 2023** • The Quality Improvement manager for patient experience has presented the data obtained at the EOLC steering group and a 6-month plan developed. • In February the bereavement support team spent 1156 minutes on calls with the average time being 13 minutes (Calls lasted between 2-50 minutes). Listening and supporting our bereaved relatives and we are also able to raise complaints/compliments and concerns on Datix. • The team have trialled the Marigold sign that is put on patients' doors/ boards to highlight someone is dying – to ensure a respectful environment and care for end-of-life care patients and their families. The trial went well and has highlighted a few amendments needed. We will be launching this across site in April. • Increase in training/ in reach /support for staff in recognising dying/communications skills which was highlighted in the NACEL audit/complaints. In Feb/March 2023 131 staff have been trained – including 30 Junior Drs, 7 Consultants and 29 RN and 42 AHPs.	**Substantial Assurance**

Quality Account Priorities agreed for 2023-2024

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Responsive
Care of the acutely ill patient 	**Nutrition and Hydration** 	**Alternatives to Hospital Admission** 
Lead: Cath Briggs Senior Nurse – Corporate Nursing **Focus** Timely recognition and response to deteriorating patient **Outcomes:** To ensure patients who identify as deteriorating have a recorded NEWS2 score	**Lead:** Vanessa Dickinson Head of Nursing – Medicine Division **Focus:** Audit of compliance with the Malnutrition Universal Screening Tool **Outcomes:** To ensure that 80% of patients receive a Malnutrition Universal Screening Tool (MUST) assessment within 24 hours of admission/transfer to ward area	**Lead:** Renee Comeford Nurse Consultant for Older People and Head of the Acute Frailty Service **Focus:** Virtual Ward/ Rapid Response Team – numbers of patients referred **Outcomes:** To enable patients to receive the care and treatment they need in their own home, safely and conveniently, rather than being in hospital

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.

Calderdale and Huddersfield NHS Foundation Trust

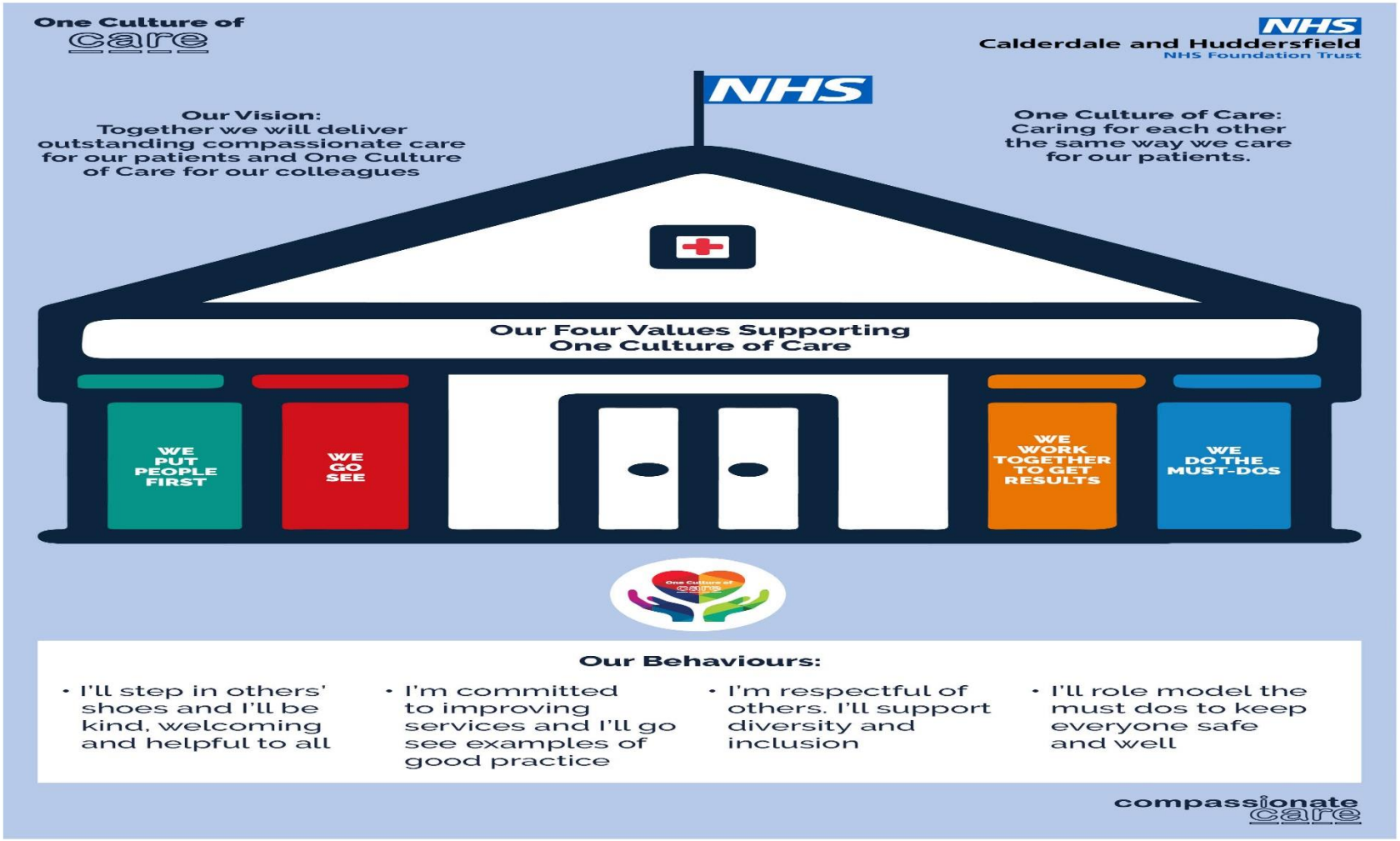
Quality Report

Executive Summary - Reporting Period February to March 2023

Quality & Safety Team

Calderdale and Huddersfield NHS Foundation Trust

Quality Report - Executive Summary - Reporting Period January 2023



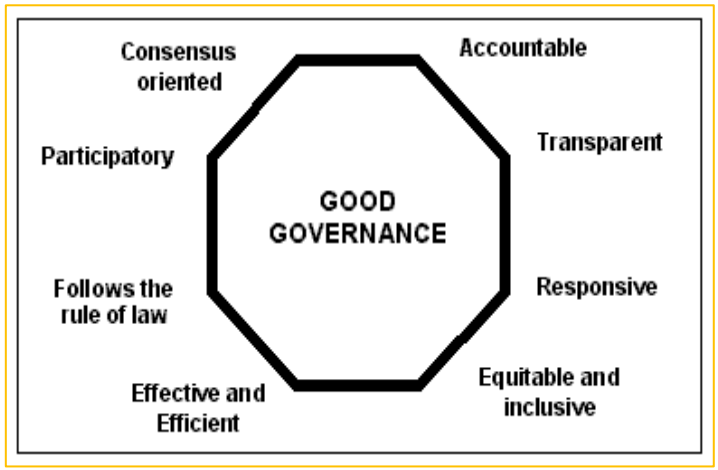
Purpose

The purpose of these slides are to provide key updates and assurance to the Quality Committee and Board of Directors in relation to the core quality work streams of the Trust.

It covers the period of February to March 2023 and provides assurance that the Trust has continued to maintain compliance with its statutory regulatory requirements, by implementing a number of proactive actions and adopting an innovative yet safe approach to quality governance.

The update will focus on key workstreams:

- Care Quality Commission (CQC)
- Patient Experience, Participation, Equalities
- Patient Advice & Complaints Service (PALS)
- Lessons Learnt from Serious Incidents
- Mortality & Morbidity



Quality Priorities

Quality Priorities are agreed each year to support the achievement of the long-term Quality Goals in our Trust Strategy.

The Trust has three key quality priorities with seven focussed quality priorities.

Examples of progress against the priorities are contained within the body of the report:

Quality Priorities

Recognition and timely treatment of Sepsis:

The sepsis collaborative has implemented multiple actions to improve overall concordance of antibiotic treatment through a multidisciplinary team approach. This includes focussed priority of timely patient assessment and treatment through improved communication networks, timely patient assessments, education and ensuring accurate data results.

- Compliance of antibiotics administered within 60 mins of earliest alert for red flag improved by 26.2% from in the month of February followed by a decrease of 18.3% in March. We know clinician and nurse staffing gaps have impacted review and treatment times. Staffing levels were near normal in the month of February. The staff at both sites remain committed to delivering sepsis treatment as quickly as possible. Most non-compliant severely septic patients receive their antibiotics within 85 minutes. Blood **cultures** – compliance continues to improve - The team continue to push compliance on blood cultures through medical and surgical clinician meetings.
- **Training** – Essential sepsis training now on all eligible staff ESR accounts. Trust sepsis nurse support ED education leads and community education lead. Also attends new starter inductions and apprentice training programme both in Hospital and Community which has been well received.

Quality Priorities

Recognition and timely treatment of Sepsis:

The Trust met the 50% target for the percentage of patients coded with sepsis that received all elements of the BUFALO bundle (blood cultures, urine output, fluids, antibiotic, lactate, oxygen)

In addition, the target of 80% for the administration of antibiotics within an hour of clinical assessment in the Emergency Department (ED) was achieved.. These priorities continue to be closely monitored with actions to increase compliance. Nerve centre went live in October 2022, this system calibrates when observations are due based on the previous NEWS2 score; this supports effective treatment plans for the deteriorating patient. Compliance with sepsis training continues and is now a live document with all eligible staff ESR accounts.

Quality Priorities

Reduce the number of Hospital-acquired infections including COVID-19:

The schedule of in-patient testing had been suspended after the last report. As of 10/10/22, all admissions are tested on arrival, but no further testing is carried out unless symptoms occur. This element is no longer reported in KP+.

Testing changes have been instigated as of 01/04/23 and no asymptomatic patients are tested unless for discharge to a care home or if required pre-operatively.

The number of C.difficile infections is monitored nationally, reported via the UKSHA HCAI data capture system. The number of C.difficile infections have increased over the past 2 years and this increase is not limited to CHFT but is being seen across many NHS Trusts.

At year end there have been 60 cases reported including 22 community onset, healthcare associated cases. This over the trajectory for the year.

Quality Priorities

Reduce waiting times for individuals attending the Emergency Department:

Aim 1 (Monitor 8 Hour Breaches):

>8 hour LOS:

February 2023 = 1336 (+90 from previous month)

March 2023 = 1858 (+522 from previous month)

Aim 2 (Monitor 10 Hour Breaches):

>10 hour LOS:

February 2023 = 696 (+104 from previous month)

March 2023 = 1079 (+383 from previous month)

Aim 3 (Monitor 12 Hour Breaches):

>12 hour LOS:

February 2023 = 372 (+70 from previous month)

March 2023 = 632 (+260 from previous month)

Actions:

Additional HCA for the waiting room to monitor patients with a LOS >4 hours.

Senior medic (ST6+) added supernumerary in aid of decision making at front door.

Focused Quality Priorities

Examples of progress against the priorities are shown below, with further details contained within the body of the report:

End of Life Care (EoLC) - The Hospital Specialist Palliative Care Team 7-day service continues. Full reporting is still not available across the CHFT footprint. However, data available for Kirklees is starting to show an increase in the number of Advance Care Plans recorded on EPaCCS. Work ongoing to provide data for Calderdale locality. Increase in training/ in reach /support for staff in recognising dying/communications skills which was highlighted in the NACEL audit/complaints.

Increase the quality of clinical documentation across CHFT - Demonstrations are taking place of the new admission workflow. Permanent white boards have been installed in SAU, Acute floor at HRI and ward 5 HRI. Quote obtained for CRH. Dashboard to be finalised to ensure all information have one source of truth.

Making Complaints Count - The Trust's performance relating to complaints closed within an agreed timescale is continuing to maintain an acceptable standard despite the operational pressures the Divisions are facing. 50 out of the 57 complaints closed in February and March 2023 were closed within agreed timeframes, which is 88%. 15 complaints were re-opened in in February and March 2023, which is higher than we would hope to see at 26% of the total number of complaints closed. This will continue to be monitored and any actions required will be identified as to why we are not getting this right first time.

Focused Quality Priorities

Examples of progress against the priorities are shown below, with further details contained within the body of the report:

Reducing the number of falls resulting in harm – Adding in time of day to falls dashboard to identify any themes. Acute floors have carried out a significant amount of work and have reduced their number of falls with great success. All adult inpatient receive a falls risk assessment on admission/transfer to the ward areas and this is consistently around 75%. Quality improvement work is currently underway to improve compliance and this will also be the focus at the May collaborative group.

Reduction in the number of CHFT-acquired pressure ulcers – Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. 87.87% of staff have completed React to Red Training as of 1st April 2023. Face to face training has recommenced. Joint venture with BTHT to build e-learning for pressure ulcer risk assessment tool (PURPOSE T). Completion due later this year.

Nutrition and hydration for inpatient adult and paediatric patients - Independent study findings on MUST training presented to ward managers to reinforce importance of completing MUST within 24 hours of admission. Matrons to complete regular spot check audits (2 x patient records per week) to determine if MUST is being completed efficiently. Fluid balance is no longer an aim for all admissions. Hydration tool planned for ESR via Renal CNS.

Focused Quality Priorities:
Clinical Prioritisation and Harm Review Out-Patients.

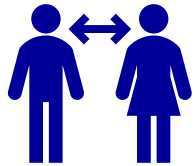
April Update: The holding list now stands at 87k with 27k patients overdue their follow up appointment. We continue to admin validate all patients at 12 weeks prior to clinical validation and prioritisation.

April Update: Patients are being prioritised for clinical validation, commencing with patients on the incomplete orders list >90days. There are currently 3413 patients in this cohort and of this a third (1,160) sit in just 2 specialities Colorectal and Neurology. The total outstanding clinical validation stands at 13k. Performance will now be monitored through the Access Delivery Group.

Quality Account Priorities agreed for 2023-2024

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Responsive
Care of the acutely ill patient 	**Nutrition and Hydration** 	**Alternatives to Hospital Admission** 
Lead: Cath Briggs Senior Nurse – Corporate Nursing **Focus** Timely recognition and response to deteriorating patient **Outcomes:** To ensure patients who identify as deteriorating have a recorded NEWS2 score	**Lead:** Vanessa Dickinson Head of Nursing – Medicine Division **Focus:** Audit of compliance with the Malnutrition Universal Screening Tool **Outcomes:** To ensure that 80% of patients receive a Malnutrition Universal Screening Tool (MUST) assessment within 24 hours of admission/transfer to ward area	**Lead:** Renee Comeford Nurse Consultant for Older People and Head of the Acute Frailty Service **Focus:** Virtual Ward/ Rapid Response Team – numbers of patients referred **Outcomes:** To enable patients to receive the care and treatment they need in their own home, safely and conveniently, rather than being in hospital

Care Quality Commission



Maternity Services Inspection:

- The Trust has not yet been inspected by the CQC Maternity Team this will be undertaken before May 2023. This is part of a planned programme in which all Maternity centres across the country will be inspected. Continuous planning with Maternity Services is ongoing

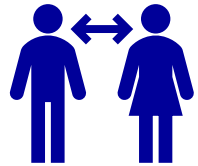
Engagement Meetings:

- A planned Onsite CQC Engagement Visit took place on 01st March 2023. This visit focused on Surgical and Critical Care Core Services, an overview of services was presented to CQC followed by a walk around of Surgical SDEC, Ward 10, Theatres, and ICU.
- A presentation was presented to CQC by the Surgical and Critical Care Teams

The visit had positive feedback from the CQC inspectors which included:

- Staff clearly work together as team
- The new ICU was 100% improved and had a really nice feel and was bright and spacious
- From experience SAUs are usually crowded and busy but the HRI SAU was not overcrowded and was a calm well manged environment
- SDEC is a well-established embedded department which is clearly well led

Care Quality Commission



CQC Strategy:

CQC will continue to implement their new approach in phases, making sure each phase is properly implemented before moving to the next.

From **spring** CQC will focus on:

- Making sure the technology they need is in place and that they're able to test it with providers
- Being confident that their new regulatory approach is ready to launch.

In **summer** CQC will launch the new online provider portal. They'll do this is in stages and provide support and guidance. In the first stage:

- Providers will be able to submit statutory notifications
- CQC will improve how the enforcement process works.

Towards the **end of 2023** CQC will gradually start to carry out assessments in the new way. This means using the new assessment framework.

Patient Experience, Participation, Equalities

Friends and Family Test

Microsoft Forms have now been developed to ensure data is captured robustly and this will now filter in to KP+. This will hopefully increase the number of online responses, improve the narrative where patients explain their experiences of the service, and staff who are delivering compassionate care are recognised

Commitment to Carers

Following engagement with local carer organisations, relatives, carers and staff we have adopted the principles of John's Campaign and extended the criteria as an all age, all carer approach.

CHFT has a Working Carer Passport scheme. This is designed to make it easier for staff with caring roles to talk about the flexibility and support they need.

Patient Experience, Participation, Equalities

Improving the experience of People with Visual Impairment

The Improving the experience of People with Visual Impairment Group aims to provide a forum to share lived experiences of those accessing Trust services whilst providing suggestions and solutions to help patients and service users maintain their independence.

You said, we did:

Patients want: Improved signage within the hospital and increased staff awareness of the reality of living with a visual impairment.

The Trust responded by:

Completing 'Walk around' sessions across Acre Mill, Calderdale Royal Hospital and Huddersfield Royal Infirmary with patient representatives to understand the reality for patients, carers and staff with a visual impairment

Improved the signage at Calderdale Royal Hospital with agreed funding for additional work on the ground floor

Improved the out of hours buzzer system at the main entrance doors, so it is now more recognisable and easier to use

Patient Advice and Complaints Service (PACS)

	Feb 2023	Mar 2023
Complaints received	29	37
Complaints closed	21	36
Complaints closed outside of target timeframe	2	5
% of complaints closed within target timeframe	90%	86%
Complaints reopened	7	8
PALS contacts received	151	170
Compliments logged	17	14
PHSO complaints received	1	0
PHSO complaints closed	0	2
*Complaints under investigation with PHSO (total)	12	10

- Backlog of compliments to be logged by the PALS team which is why the numbers reported are low

Risk Management (Incidents)

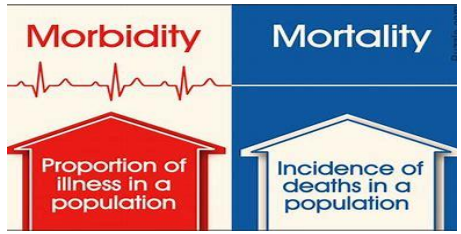
Never Events:

Between 01 April 2022 and 31 March 2023 (rolling 12 months) the Trust has reported 5 Never events.

Serious Incidents:

For the rolling 12 months, between 01 April 2022 to 31 March 2023, there has been a total 41 Serious Incidents declared on Strategic Executive Information System (StEIS) that are either under investigation or the investigation has been completed and closed. The 41 SI's have been recorded across 3 divisions: Families and Specialist Services **(12),** Medical Division **(20)** and Surgical & Anaesthetics Services Division (**9)**

Mortality and Morbidity



Monthly Mortality Update: March 2023

The HSMR figure shows a largely stable position of 100.19 to the end of December 2022, from 99.98 in November 2022.

Trust benchmarking for Crude mortality has remained stable at 44th position nationally (out of 123 Trusts), this is a similar position to the previous release, this remains in the 2nd quartile for national performance.

Latest SHMI release shows an improving position to 103.84 to the end of November 2022 from 104.66 up to the end of October 2022.

Legal Services

There continues to be growing demand around claims and inquests, with an increase in

portfolio size of around 20% for claims and 45% for inquests since July 2022. The portfolio size has increased from 170 to 205 (Claims) and 79 to 115 (Inquests).

The review of the GIRFT Litigation Data Pack continues with around 280 cases yet to be reviewed for medicine and surgery. Due to increased activity within Legal and leave, review of the cases has been put on hold.

A fortnightly inquest dashboard report (and inquest timetable) continues to be provided to the Assistant Director of Quality & Safety, Divisional Leads and Quality Governance Leads for awareness. This report is also reviewed as part of the Governance MICCI (Mortality Review, Inquests, Claims, Complaints, Investigations) meetings to triangulate with the Trust's investigation and review workstreams.

15. Workforce Committee Chair Highlight Report

For Assurance

Presented by Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and OD Committee
Committee Chair:	Karen Heaton.
Date(s) of meeting:	24 April 2023
Date of Board meeting this report is to be presented:	4 May 2023

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 24 April 2023.

- Failure to meet target for EST on Fire Safety remains a concern although it was noted there was a slight improvement in take up. An update report was requested for the next meeting together with a review of the balance required of face to face versus on- line training. The Committee agreed a targeted approach was to be made to those areas failing to meet the target , together with a review of the length and frequency of the module.
- IPR- concern remains over the level of short-term sickness absence. The number of recorded return-to-work interviews remains low whilst acknowledging this was no longer a target. Work is ongoing to improve the level of sickness absence with areas identified for support and action. Recruitment is much stronger and in particular in midwifery and nursing. Agency and bank costs remain high because of sickness absence, recruitment shortage areas and industrial action.
- Sponsors, buddies and Engagement Leads are in place to progress the actions identified from the Staff Survey.
- An update on the Pay Offer and Industrial action which provides a difficult employee relations landscape for the Government to navigate through successfully with some Trade Unions having accepted the pay offer whilst others have not. The Trust was managing to deliver services to patients during this difficult time.

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ASSURE

- The Committee received a detailed report covering the ESR annual assessment for 2022/23. The Committee were pleased to see that the Trust is a significant user of the functionality and is often cited as an exemplar user.
- The Board Assurance Framework covering Recruitment, Retention and Inclusive Leadership provided the Committee with assurance through the number of actions taking place . The score of 12 remains unchanged as these are set within the context of a challenging operational environment. The Committee requested a separate discussion on the actions being taken to support the retention of existing experienced staff.

AWARE

- Staffing levels continue to remain a challenge alongside turnover. Although recruitment has been going well and in particular international recruitment.
- The Committee has revised its workplan to include a themed approach with Divisions. There will be an additional meeting of the Committee in May to look more deeply at Diversity, Inclusion and Health Inequalities.

ONE CULTURE OF CARE

- One Culture of Care considered as part of the workforce reports and in discussions.

16. Audit and Risk Committee Chair Highlight Report

To Note

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date(s) of meeting:	25 April 2023
Date of Board meeting this report is to be presented:	4 May 2023

ACKNOWLEDGE

- Audit Yorkshire reported that good progress had been made with audit recommendations and that there were no outstanding responses to internal audit report recommendations as at 31 March 2023. There are currently 20 recommendations with revised target dates, some of which are due before Audit Yorkshire will provide their opinion for the 2022/23 accounts and therefore the responsible officers will be asked to ensure these are completed or updated.
- There was a significant improvement in the compliance with submission of declarations of interest by decision makers from 86% in 2021/22 to 93% in 2022/23.
- Audit Yorkshire also reported that the process for drawing up the Internal Audit Plan for 2023/24 had benefitted from the engagement of all senior management and therefore reflected a wide range of audits planned for this year. Audit and Risk Committee (ARC) approved the Internal Audit Plan for 2023/24.

ASSURE

- ARC also approved the Counter Fraud Plan for 2023/24 and thanked those people involved in communicating and ensuring checks are in place when fraud alerts are issued during the course of the year. A further report will be brought to the July Committee meeting highlighting the results of the staff survey on counter fraud including possible areas for additional counter fraud masterclasses.
- ARC approved the Committee's annual report for 2022/23 which will be shared at the July Board meeting. The draft Annual Governance Statement, and compliance with the Code of Governance to support the 2022/23 annual reporting process was also approved.
- The Trust's external auditors, KPMG, reported their draft risk assessment on the Trust's arrangements for securing Value For Money (VFM). At this stage, KPMG are reporting that they have not identified any significant weaknesses in the Trust's arrangements in relation to the required domains of financial sustainability, governance and economy, efficiency and effectiveness. On financial sustainability KPMG reported that this is still subject to further iterations (and savings) which may be required to the Trust's financial plan in agreeing the West Yorkshire Integrated Care System budget. The VFM assessment will therefore be updated prior to KPMG reporting as part of the financial statements for 2022/23.

AWARE

- ARC conducted a deep dive into the risk management arrangements within the organisation. The Head of Risk and Compliance reported on the issues which had been identified with the current arrangements and how these would be addressed and included within the new Risk Management Policy which was approved by the Committee and recommended to Board for approval. The Internal Audit Plan for 2023/24 includes a review of the Trust's risk management systems which will provide additional assurance on the revised arrangements and the actions being taken.
- A self-assessment has been undertaken of the effectiveness of ARC to understand where improvements might be made. In addition, the operation of the Committee has been appraised against the good practice guidance on audit committee effectiveness issued by the National Audit Office. As a result, further actions have been included within the action plan agreed by ARC, primarily in relation to skills mapping for the committee, the use of external skills/advice and how to gain assurance about key strategic risks such as cyber security, procurement etc. It was agreed that ARC would discuss at its next meeting which deep dives might be added to the existing work plan.
- The meeting concluded with reflections on how improvements had been made in producing the internal audit plan and reducing the number of overdue audit recommendations through greater and wider engagement throughout the organisation. It was agreed that these examples would be used to inform how the Committee considers other assurance processes.
- The next meeting of ARC will be an extraordinary meeting on 27 June 2023 to sign off the annual report and accounts as delegated by the Board.

ONE CULTURE OF CARE

- One Culture of Care was considered during various agenda items and reflected in the acknowledgements highlighted above.

17. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Date of Meeting:	Thursday 4th May 2023
Meeting:	Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance Kirsty Archer, Deputy Director of Finance Neeraj Bhasin, Deputy Medical Director Jo Middleton, Deputy Director of Nursing Kim Smith, Assistant Director of Quality Jason Eddleston, Deputy Director of Workforce and OD Helen Rees, Director of Operations, Medicine Division
Sponsoring Director:	Jonny Hammond, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee

Actions Requested: To note

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of March 2023.

Key Points to Note

The Trust has performed well in its key metrics during 2022/23 despite unprecedented levels of attendances at both emergency departments at various times throughout the year. We still managed to maintain key cancer metrics whilst in strategic gold command and control with mitigations in place to keep the organisation safe for patients. Cancer performance has been excellent throughout the year and has been recognised nationally in the media. From August 2022 to January 2023 month on month CHFT was the best performing acute/combined Trust in England for Cancer 62-day referral to treatment. In total best performing for 8 out of 11 months to February in 2022/23. Similarly for 14-day Referral to Date First Seen CHFT was the best performing acute/combined Trust in England for 6 out of 11 months to February in 2022/23.

Although the Trust missed the Emergency Care 4-hour standard during 2022/23, it has benchmarked extremely well nationally. For 8 out of 12 months in 2022/23 the Trust was placed in the top 10 best performing acute/combined Trusts for type 1 attendances with only one other Trust with greater attendances finishing above.

ED attendances for both hospital sites during 2022/23 continued to increase with an 11% rise in numbers attending compared to 2019/20. Along with increased attendances, acuity/dependency was significantly high and led to some very challenging operational issues which had an impact on the 4-hour ECS performance and increased numbers of patients waiting above 8 and 12 hours in both emergency departments. Although we saw an increase in ED attendances these have not translated into emergency admissions which were actually 10% below the same period in 2019. Overall acuity at Trust level for all non-elective admissions increased by 20% which impacted on bed pressures, length of stay etc.

At the start of the year we had some sustained periods in OPEL 2 however we then began to see increasing periods spent in OPEL 3 as the year progressed only dropping to OPEL 2 for a brief period in September. We also saw throughout April, May and June norovirus and this

caused several bouts of ward areas being closed particularly in elderly care. This caused issues across patient flow and required extra capacity to be opened.

For long periods there were approximately 100 patients on the Transfer of Care list due to capacity issues in social care packages of care and discharge to assess beds. This was partly driving an increase in medical outliers and occupancy levels. The numbers of patients on the Transfer of Care list peaked at 140 early in 2023.

December was a particularly challenging month in terms of performance with very high volumes of attendances seen in both ED departments, including children, with an increased proportion of very unwell patients where we saw an increase in respiratory illnesses with Flu numbers growing.

The OPEL position and increased attendances meant we had to open significant extra capacity across the organisation which gave us a pressure in terms of both medical and nursing staffing. This of course had an impact on length of stay and beds open and meant that we moved into OPEL 4 in late December and for the first week in January alongside all other Trusts in West Yorkshire.

Despite this, the time to treat the most clinically urgent remained good and the focus on minimising ambulance handover delays remained and we did manage to reduce our ambulance handover delays as we progressed into quarter 4.

During all these pressures and more recently the junior doctor strikes we continued to perform well on our Recovery Programme where our 104-week, 78-week and 52-week waits were amongst the best in the country.

We experienced extreme pressures on our services during the last week of March and went into Operational Pressures Escalation Level (OPEL) 4 for a few days.

In April pressures have reduced and we achieved the 76% ED target for 2023/24 several days in the first half of the month.

For our Stroke patients gaining access to a Stroke bed within 4 hours has been a constant issue however we have put an improvement plan in place.

Community services were also increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and LTC management.

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 for March 2023.

Calderdale and Huddersfield NHS Foundation Trust

Performance
March 2023

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.

ED attendances for both hospital sites declined slightly over the past quarter, with reductions in January compared to December, remaining lower in February before picking up again in March. Covid attendances dropped throughout November, December and January however Covid inpatient numbers remained high during the first few months of the year, with a high of 119 patients in February this then reduced during March and currently stands at 54 inpatients. The spike in Flu continued to reduce during this quarter with the significant reduction in January to minimal numbers. Along with increased attendances, acuity/dependency is still significantly high and has led to some very challenging operational issues, this has had an impact on the 4-hour ECS performance. The impact of the junior doctor strike in March resulted in a challenging period in mid- March. Between the middle of March and the end of March the Trust went into OPEL 4 and had a particularly challenging week, we saw all available extra capacity beds open and a high TOC list above 120, ED attendances were high and nurse staffing was in a challenging position. We stayed in OPEL 4 for a few days and have then remained in OPEL 3 since then, again main challenges are around a high TOC list, poor discharges and extra capacity beds open, giving us a pressure in terms of both medical and nursing staffing.

We have launched significant work programmes in the Trust focused on reduction in length of stay and improved use and pathways for our Same Day Emergency services.

The length of stay project is looking to reduce the overall bed occupancy level before making an impact on the overall bed capacity needed as well as targeting a reduction in TOC patients which will also reduce the demand for additional bed capacity.

We continue to focus on ambulance handovers and turnaround times to allow ambulances to respond to calls in the community, we now have a clear escalation process in place to support this, we have also refined this process following the ambulance strikes.

In March 2023, 37 formal **complaints** were closed – 33 of those were closed within agreed timeframes, which equates to 89% performance.

Since the last report was shared the number of open formal complaints has increased from 102 to 123, with 90% of these on schedule to be closed within timeframe.

With regard to **HSMR**, the current rolling position from April 2022, reporting to January 2023, is 96.8 which marks a very significant improvement and means CHFT lies positively below the expected range. For context, the national position is approximately 100. There has been a slight increase in coding for Specialist Palliative Care input/discharges, whilst this will contribute to an aspect of the improvement, it would not account for the full change.

With regard to **SHMI**, the current rolling position from April 2022, reporting to December 2022, is stable at 104.7 meaning CHFT lies within the expected range and is not an outlier. For context, the national position is tracking at 102.

The ‘crude mortality’ in March 2023 is 1.35%, lower than the equivalent measure in March 2022. This, again, supports a positive and expected position. With respect to crude mortality the Trust is sitting in an improved position of 40th out of 124 trusts.

Sepsis remains the main alerting condition. The sepsis team reviewed a cohort of notes to understand if there could be a more accurate initial diagnosis e.g. urinary tract infection/infective exacerbation of COPD, rather than a more generic first admission documentation of ‘sepsis’, as the generic description would drive up sepsis mortality indicators. The notes review showed there could be significantly more specific diagnoses which would reduce the alerting. Therefore, from February 2023 sepsis deaths will have some additional validation by members of the sepsis team to determine if a more definitive diagnosis could be coded and therefore improve accuracy of recording.

There is a reduced rate of red SHMI alerts, and where an alert comes in, there is a process for a clinical Structured Judgement Review to validate a documented pathology and identify any care concerns. This is more an internal assurance process to understand the mortality alert rather than an ability to retrospectively amend the data.

Coding reviews in all areas have been performed and the position is kept under review by the Mortality Surveillance Group, Clinical Outcomes Group and Care of the Acutely Ill Patient – the coding performance remains stable.

There was an increase in overall deaths in December 2022 and notable increase from the average number of monthly deaths in the Emergency Department. A review of these deaths is being undertaken to clarify that this is due to a spike in acute, co-morbid patients and not due to any issues with care delivery.

Within the Structured Judgement Reviewer cohort there is a vacancy and maternity leave absence. Whilst the majority are completed with 14 days of assignment, this is placing some additional pressure on the existing reviewers currently.

From a financial point of view, the full year position, subject to external audit review, is a £17.34m deficit, (excluding the impact of Revaluations, Impairments and Donated Assets), a £0.01m favourable variance from plan. The Trust continued to incur higher than planned costs due to inflationary pressures and additional capacity requirements. In addition, costs were incurred in month due to the Doctors’ Strike and the cost of the proposed Agenda for Change (AfC) pay award (2022/23). Whilst national funding has been provided, this is not sufficient and does not cover staff on local pay scales, a £0.50m adverse impact. These pressures were offset by additional funding from System partners to support operational and inflationary pressures; higher than planned vacancies and technical benefits including the Joint Venture revaluation and profit.

Agency expenditure in 2022/23 was £14.35m, £7.45m higher than planned. The Integrated Care Board set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has exceeded that ceiling by some margin. The Trust has however, successfully delivered efficiency savings of £20.00m, as planned.

Capital investments made in the year totalled £31.26m and the Trust closed the financial year with a cash balance of £24.63m, £5.37m higher than planned.

We remain vigilant in relation to colleague availability and the impact **sickness absence** has on our ability to deliver safe staffing. The rolling 12-month rate for non-Covid sickness is at 4.83% for the period ending 31st March 2023 against a target of 4.75%. The in-month March 2023 non-Covid sickness absence is at 4.55%, a reduction from 5.06% in February. The rolling 12-month rate including Covid related reasons is 5.62%, a reduction from 5.72% in February. The rate inclusive of Covid related absence reasons for March is 5.04%, a decrease from 5.51% in February.

Essential Safety Training (EST) core programme remains strong with 7 out of 10 elements above our 90% target, 3 are achieving the 95% 'stretch' target. Overall compliance increased to 93.82% from 93.2% in February, this represents a 6th increase in compliance month on month.

The 12-month turnover rate for all posts and staff groups is 8.07%, a decrease on the 8.7% position reported at the end of February.

The **Nursing and Midwifery** Workforce Steering Group is progressing work to understand the detail of the vacancy position and aligning this to the recruitment/training strategy in partnership with the local HEI, as well as high impact retention strategies.

Recent recruitment events secured 46 Students who are due to register as RN (Adult) nurses in September 2023 and 24 students who are due register as RN(Child) Nurses. This means there is now a pipeline of 71 newly qualified nurses for September.

To supplement this workforce pipeline, Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported as part of the recruitment strategy.

In addition, despite some small delays, the international recruitment project continues to progress well with 120 of the target 126 recruits from January 2022 to end March 2023 in employment. The remaining 6 will arrive in May 2023. CHFT was successful in a bid for funding from NHSE to support recruitment of a further 30 International Nurses to arrive before the end of November 2023.There are sufficient nurses in the pipeline to support this work which will also include working with the ICB and Global partnerships to support joint working to enable recruitment of nurses from Kerala.

The national benchmark for evaluating nursing care provision is Care Hours per Patient Day (CHPPD). Overall, for March 2023, the CHPPD was 7.9, giving a shortfall of 1.4 against a planned CHPPD of 9.3. This apparent widening of the gap between planned and actual results from an increase in the planned CHPPD which now includes shifts which are agreed to be above the recurrently funded workforce model, to provide care for patients in the additional capacity beds (e.g. Acute Floor and Stroke). The planned CHPPD now also includes the enhanced care support worker shifts required to care for patients requiring 1:1 care.

The actual CHPPD provided to patients, which is reported to NHSE, has remained steady since October 2022 between 7.9 and 8.1 CHPPD, this compares to the national and peer median of 8.1.

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. Both falls and pressure ulcer prevalence remain within normal variation in month.

The nurse staffing meetings have been reviewed to ensure that the ToR reflect the safer staffing requirements identified in the NQB standards and Developing Workforce Safeguards. The revised meetings will have oversight of operational pressures and mitigations and will monitor the impact of cost improvement plans to ensure that these remain on track and identify and mitigate any possible risks. The focus will be on the agency retraction plan as well as decision making around staffing for extra capacity areas with a plan to invite a matron from the central ops teams to support greater collaboration.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

March 2023

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Key Indicators

	21/22	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	Performance Range		
SAFE																			Green	Amber	Red
Never Events	2	0	0	0	1	0	1	1	1	0	0	0	0	1	1	0	**0**	**5**	0		>=1
CARING																			Green	Amber	Red
% Complaints closed within target timeframe	63.61%	70.73%	37.50%	44.44%	29.41%	27.08%	48.98%	28.57%	44.64%	55.32%	45.45%	49.12%	66.67%	78.05%	93.94%	86.96%	**89.19%**	**56.98%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	97.35%	97.10%	97.36%	96.36%	97.53%	97.17%	97.63%	98.24%	98.24%	98.40%	98.00%	97.94%	97.83%	98.35%	98.38%	**in arrears**	**97.94%**	>=90% / >=95% from September 21		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	92.16%	93.02%	93.20%	92.15%	93.71%	91.82%	92.24%	90.33%	92.13%	90.49%	91.88%	91.98%	92.44%	93.61%	93.24%	89.06%	**in arrears**	**91.76%**	>=90% / >=93% from September 21		<=79%
Friends and Family Test A & E Survey - % Positive Responses	82.76%	84.40%	86.40%	84.69%	76.52%	83.18%	81.09%	79.94%	79.63%	83.09%	84.64%	76.40%	80.20%	76.73%	83.94%	83.96%	**in arrears**	**81.18%**	>=80% / >=85% from September 21		<=69%
Friends & Family Test (Maternity) - % Positive Responses	94.64%	98.33%	92.30%	91.00%	95.12%	96.74%	97.92%	95.92%	93.09%	93.75%	93.33%	94.24%	93.24%	98.02%	92.63%	94.71%	**in arrears**	**94.80%**	>=90% / >=95% from September 21		<=79%
Friends and Family Test Community Survey - % Positive Responses	92.44%	93.68%	95.50%	91.21%	98.32%	94.79%	94.52%	88.96%	93.81%	95.34%	92.90%	96.86%	97.11%	87.05%	90.16%	95.50%	**in arrears**	**93.30%**	>=90% / >=95% from September 21		<=79%
EFFECTIVE																			Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	**0**	**2**	0		>=0
Preventable number of Clostridium Difficile Cases	5	1	1	0	0	2	1	1	1	0	0	0	0	0	0	0	**0**	**8**	<3		>=3
Local SHMI - Relative Risk (1 Yr Rolling Data)	106.36	106.36	104.79	104.38	104.58	105.39	107.98	107.85	108.15	106.05	105.86	104.66	103.84	104.78				**104.78**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	102.2	99.27	102.20	102.64	104.59	105.86	106.69	107.31	107.98	106.74	103.66	102.26	99.98	100.19	96.80			**96.80**	<=100	101 - 109	>=111
RESPONSIVE																			Green	Amber	Red
Emergency Care Standard 4 hours	78.99%	72.95%	75.70%	73.92%	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	75.44%	68.44%	66.37%	60.34%	70.85%	67.51%	**65.95%**	**70.14%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	36.71%	23.19%	16.67%	15.79%	25.45%	25.53%	28.81%	13.33%	24.60%	19.18%	33.30%	26.15%	31.30%	36.07%	30.56%	17.39%	**16.13%**	**24.97%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.38%	97.96%	98.39%	98.35%	97.56%	97.76%	98.46%	98.03%	97.76%	97.79%	96.19%	96.73%	98.28%	95.77%	98.50%	98.75%	**96.24%**	**97.52%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	96.00%	93.84%	97.25%	93.50%	96.92%	96.27%	98.20%	97.83%	100.00%	100.00%	98.56%	99.32%	98.20%	100.00%	97.93%	**95.97%**	**98.29%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.21%	99.37%	98.35%	99.39%	98.31%	97.58%	98.86%	99.00%	99.46%	97.85%	98.91%	99.03%	99.12%	98.88%	98.04%	98.77%	**98.21%**	**98.65%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	95.43%	100.00%	93.33%	96.55%	94.44%	96.00%	100.00%	100.00%	100.00%	96.97%	97.37%	97.30%	94.59%	100.00%	88.10%	93.33%	**93.75%**	**96.43%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.51%	100.00%	95.45%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.75%	98.86%	100.00%	98.67%	98.92%	100.00%	**100.00%**	**99.56%**	>=98%		<=97%
38 Day Referral to Tertiary	50.00%	37.93%	35.00%	66.67%	30.77%	55.17%	64.71%	40.74%	33.33%	24.00%	35.71%	54.55%	44.00%	84.21%	32.14%	61.11%	**45.45%**	**46.88%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	87.32%	89.59%	86.82%	89.71%	91.63%	87.70%	90.69%	85.32%	85.55%	86.09%	90.69%	92.28%	89.86%	88.80%	85.34%	**87.78%**	**88.53%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	59.47%	81.25%	62.50%	50.00%	96.30%	92.59%	73.68%	70.37%	87.88%	88.89%	88.89%	72.41%	82.35%	92.86%	58.62%		**90.00%**	**81.18%**	>=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	74.31%	76.82%	76.50%	83.12%	79.54%	77.76%	76.91%	74.06%	75.88%	73.65%	77.32%	78.05%	77.25%	76.77%	73.98%	79.82%	**78.69%**	**76.63%**	>=75%		<=70%
WORKFORCE																			Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m - Non-Covid related	4.83%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	4.88%	4.82%	4.77%	4.73%	**4.71%**	**4.73%**	**4.80%**	**4.73%**	**4.83%**	**4.83%**	-	<=4.75%	<5.25%	>=5.25%
Long Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	3.21%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	3.20%	3.15%	3.10%	3.06%	**3.06%**	**3.08%**	**3.09%**	**3.08%**	**3.10%**	**3.11%**	-	<=3.0%	<3.25%	>=3.25%
Short Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	1.62%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	1.69%	1.68%	1.67%	1.66%	**1.65%**	**1.65%**	**1.71%**	**1.65%**	**1.73%**	**1.71%**	-	<=1.75%	<2.00%	>=2.00%
Overall Essential Safety Compliance	92.90%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	92.61%	92.63%	91.89%	90.46%	**91.68%**	**92.38%**	**92.74%**	**92.76%**	**93.20%**	**93.82%**	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	82.43%	70.31%	72.91%	74.86%	82.43%	82.31%	81.50%	82.97%	83.79%	83.15%	82.47%	76.57%	76.57%	74.79%	75.86%	76.99%	**87.48%**	-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Non-Medical Staff	69.06%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	5.94%	9.36%	**17.18%**	48.64%	**59.23%**	**66.77%**	**74.47%**	**68.39%**	64.78%	**61.93%**	-	>=95%	>=90%	<90%
FINANCE																			Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	0.17	0.02	-0.06	-0.11	0.11	0.11	0.59	-0.34	**-0.83**	-0.51	-0.88	**-0.02**	**-1.01**	-0.69	-0.12	**3.61**	**0.01**			

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 and long waiters (52 weeks). • Ongoing comprehensive theatre staff engagement and workforce development programme. • Progressing installation of two new permanent MRI scanners which are being ramped and shimmed which is the process by which the main magnetic field is made more homogenous. • 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. • 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. • CMDU programme started 17th January in collaboration with Locala and Mid Yorkshire to reduce hospital attendances. This funding has now been extended for the whole of 2022/23. • Improving AHP workforce planning capability through extension of project roles to deliver outputs of initial review findings. • E-Job rollout almost complete for AHP and next for specialist nursing.
Weaknesses	• Bed pressures continue to be significant. • The staffing position continues to be extremely challenging across all divisions in particular among nursing teams. • Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists. • Disparity with availability of clinical educators into Therapy services to support staff retention and education.
Opportunities	• The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in. • 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. • Virtual wards - CKW working groups have been established for virtual wards to ensure pathways are streamlined across the CKW footprint. Initial focus pathways are Frailty and Respiratory. The first VW beds went live in November. • CHFT Community have agreed to work as a pilot site for developing a community currency tool with NHSE. • The Community division are currently working up a number of business cases with external partners to maximise some system money earmarked for innovation. In addition we are submitting a business case to Parkinson's UK for some pump primed funding to enhance the Calderdale Parkinson's service. • We have received ICB funding to undertake a diabetic foot screening project for 15 months, working closely with PCN colleagues. • Community have started conversations with the Medical division around optimising pathways and staffing, initial discussions are focussing on EoL/Palliative care. The next step will be to look at Diabetes. • IC Beds current provision extended for a further 12 months under the existing contract but on reduced beds (now 15 in total) and will be re looked at through 3CPB. • The school aged Immunisations tender has been released to start a new contract from 1st September 2023. Community division are looking at submitting a collaborative tender with Locala for CHFT to continue to provide this service.
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. • Deterioration of Head and Neck service in terms of consultant cover and Speech and Language Therapy, started some WYAAT conversations re: a regional response. • 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. • Significant cost pressure due to Private Ambulance costs over and above CCG YAS commissioned service. This service moved to the corporate division from May 2022. • Risk around long term funding of Virtual ward, this comes with 1 year pump priming, 1 year match funding and should be sustained through existing resource from 2024/25. Community are working in collaboration with other CHFT divisions as well as across CKW for longer-term efficiencies. • Risk around recruitment to virtual ward posts as initial plans support recruitment of circa 150 WTE posts across the West Yorkshire footprint. • We are still not clear on the match funding requirements for virtual ward in 2023/24, we continue to submit our forecast costs for 2022/23 and have submitted a plan for 2023/24 to NHSE and await further guidance. • 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. • There is currently an ongoing exercise to understand procurement options for Intermediate Care Beds in Calderdale. There is a significant risk to the stability of wider intermediate care provision and pathways the beds go out for open procurement.

104% Elective Recovery – Position to end of March

Point of Delivery	YTD Performance Against 2019/20 and 104% Target				Performance Against 2022/23 Plan				Gap to Achieve 104% Target		
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	2022/23 Plan - activity	2022/23 Plan - % of 2019/20 baseline	Variance - activity	Variance - % of 2019/20 baseline	104% Target	Actual	Gap
Daycase	48,300	51,073	2,773	105.7%	50,176	103.9%	897	**1.8%**	50,232	51,073	841
Elective	5,285	4,664	- 621	88.3%	5,774	109.3%	- 1,110	**-21.0%**	5,496	4,664	- 832
Sub-total Planned Inpatient	**53,585**	**55,737**	**2,152**	**104.0%**	**55,950**	**104.4%**	**-213**	**-0.4%**	**55,728**	**55,737**	**9**
Outpatient First Attendances*	**143,668**	**152,249**	**8,582**	**106.0%**	**152,668**	**106.3%**	**- 418**	**-0.3%**	**149,415**	**152,249**	**2,835**
Outpatient Follow-ups	270,804	302,181	31,377	111.6%	283,416	104.7%	18,765	6.9%			

* actual outpatient first activity includes an estimate of 546 attendances for Pioneer (ENT, Ophthalmology & Neurology) not yet input into EPR for Feb & Mar

- **Planned inpatient spells**
  - The Trust has delivered **104% of 2019/20 levels** and therefore achieved the 104% national volume target.
  - This has been achieved through increased day case activity (mainly Chemotherapy) offsetting a reduction in elective inpatients.
  - The Trust planned to deliver 104.4% of 2019/20 and is therefore only 0.4pp (213 spells) behind its plan.

- **Outpatient first attendances**
  - The Trust has delivered **106% of 2019/20 levels** and therefore exceeded the 104% national volume target.
  - The Trust planned to deliver 106.3% of 2019/20 levels and is therefore only 0.3pp (418 attendances) behind its plan.

- **Outpatient follow-up attendances**
  - The Trust has delivered 111.6% of 2019/20 levels. The national ambition was to reduce follow-ups by 25% but the Trust did not submit a plan to deliver this due to the size of follow-up backlog.
  - The Trust planned to deliver 104.7% of 2019/20 levels and is therefore 6.9pp (18,765 attendances) above its plan.
  - The overdue follow-up backlog has however increased from 25,105 to 25,872 over the past 12-months.

Summary

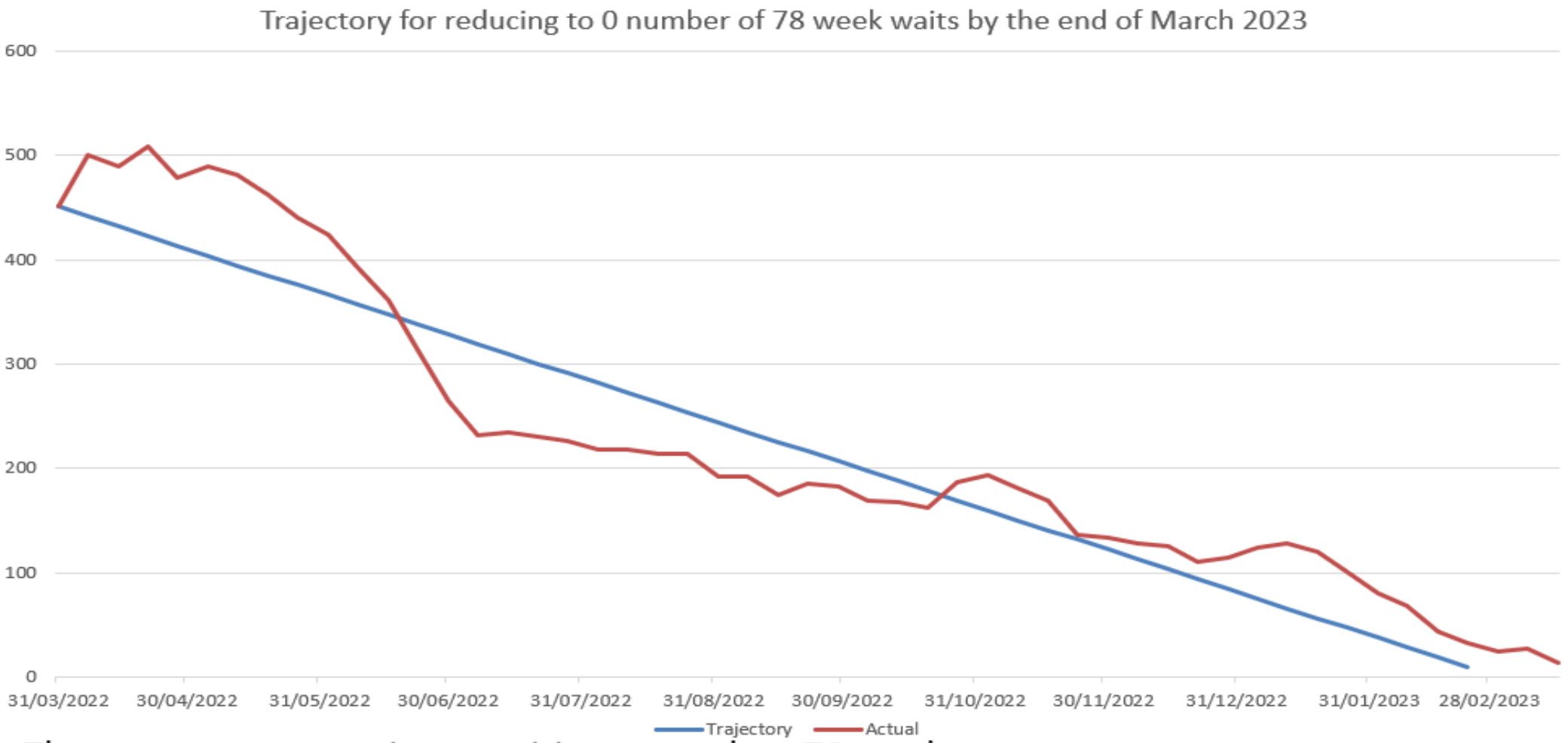
		As of 31/03/2023	Current Trajectory as	Variance to trajectory	Meeting Trajectory	Variance against trajectory			
						Medical	Surgical	FSS	Community
Elective Backlogs	104 Weeks RTT	0	0	0	Yes	0	0	0	-
	78 Weeks RTT	0	0	0	Yes	0	0	0	-
	52 Weeks RTT (External plan)	141	2053	-1912	Yes	-299	-1471	-142	-
	Total ASI's	13491	4563	8928	No	1567	6071	1178	112
	ASIs over 22 weeks	608	6	602	No	188	401	11	2
	Holding List overdue	25722	345	25377	No	13919	9701	1645	112

Current 104/78 week wait Position

- As of the 26th April , we currently have 0 patients waiting over 104 weeks or 78 weeks.
- Next longest waiting patient is currently at 77 weeks (has a TCI Date)

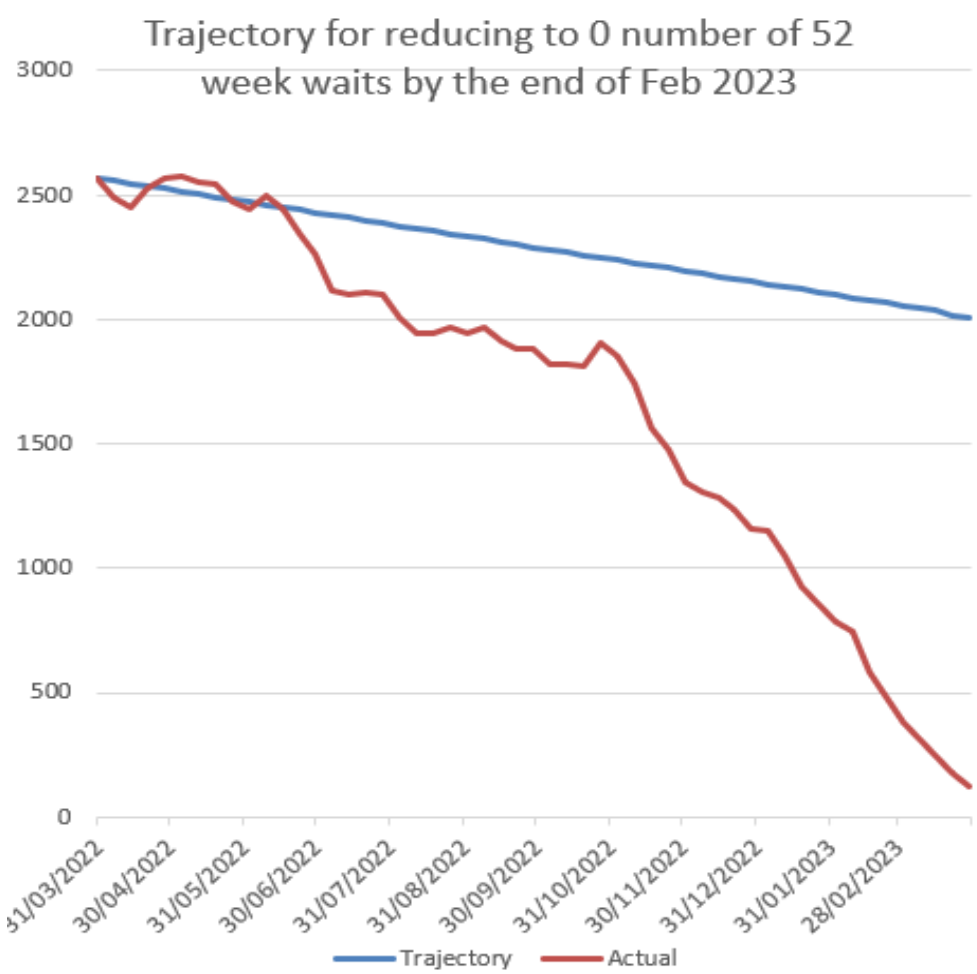
Specialty	Current total number of 78+ww	Current number of 78+ww patients on a non-admitted pathway	Current number of 78+ww who have a TCI date
ENT	1		1
General Surgery	1		1
Ophthalmology	1		1
Urology	1		1
Grand Total	4	0	4

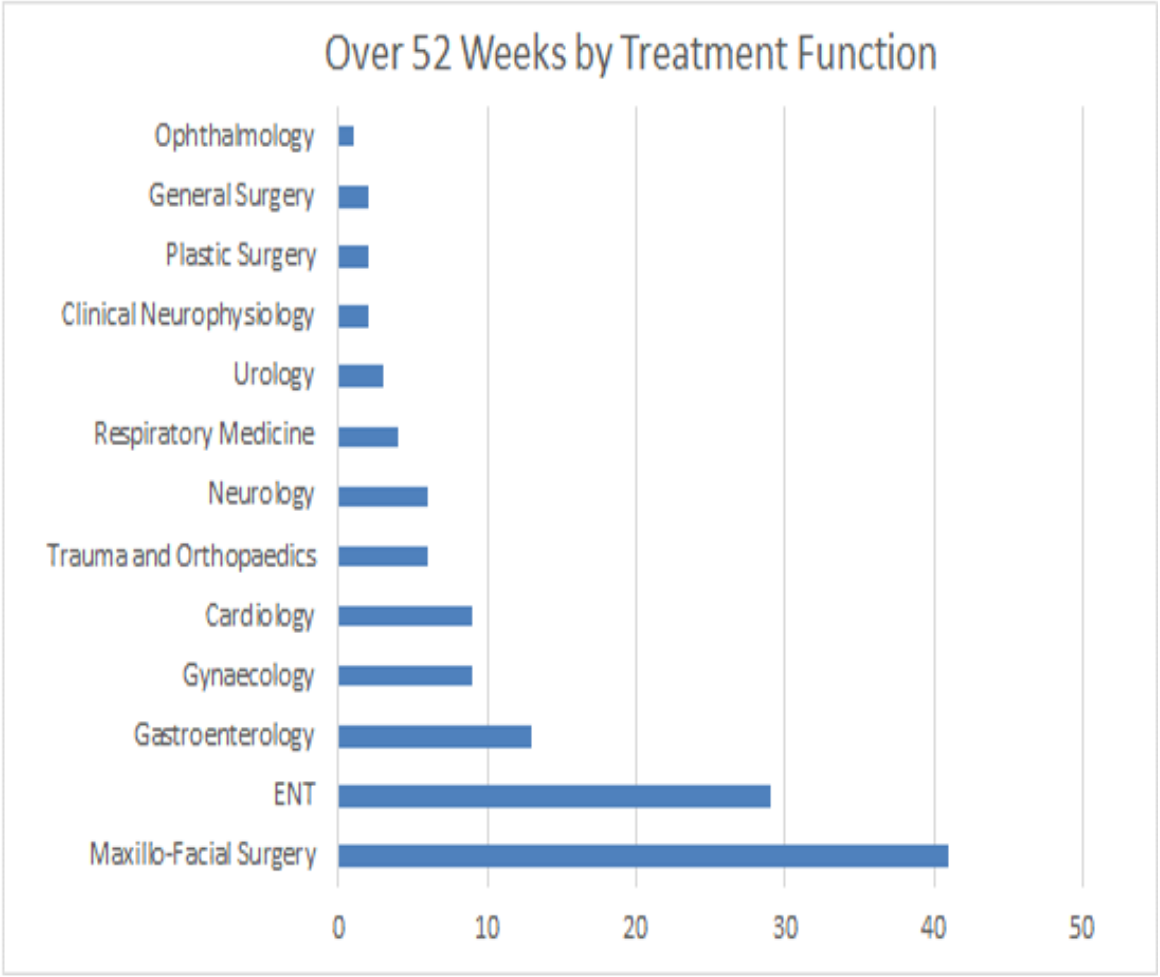
RTT – 78 Weeks



There are now no patients waiting more than 78 weeks

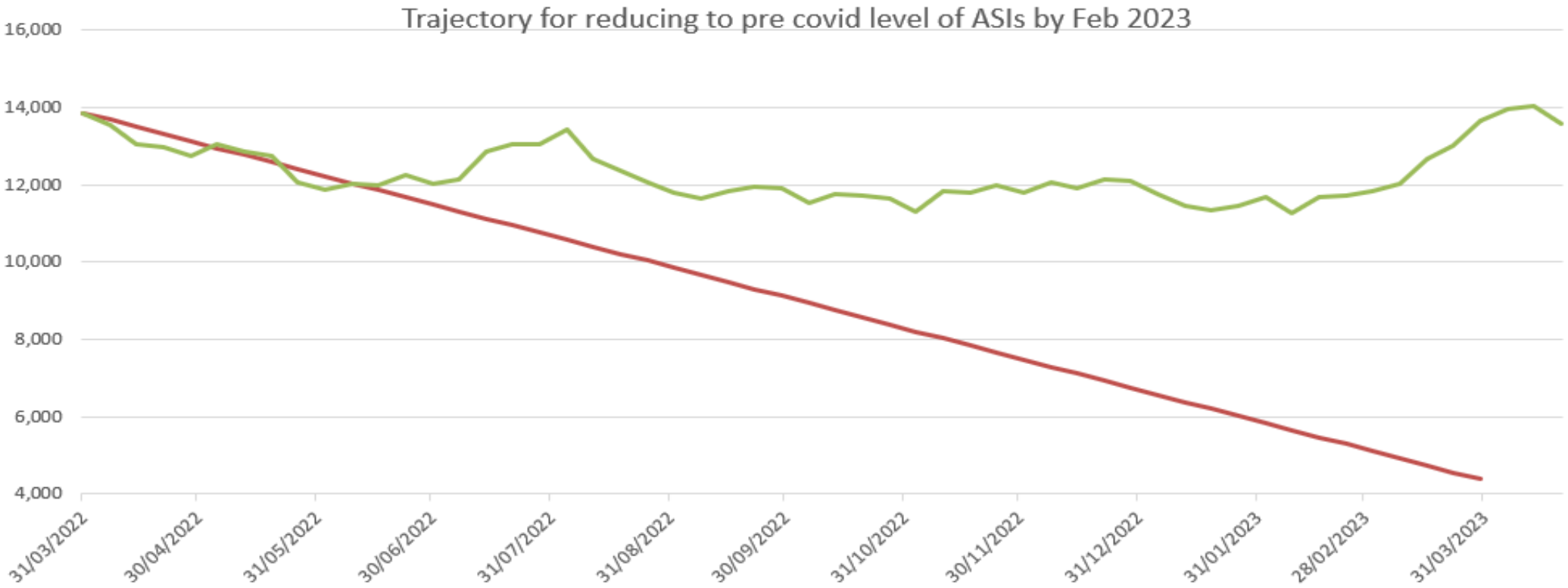
RTT – 52 Weeks





National expectation to be at zero by end of March 2025, on track to deliver NHS E/I trajectory.

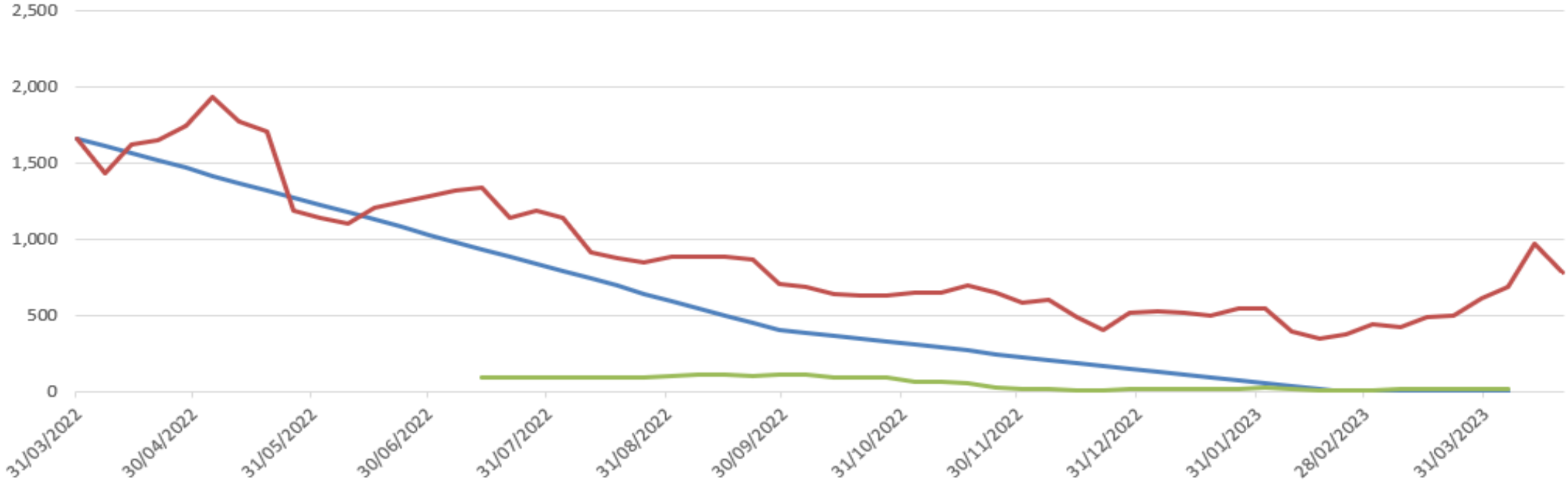
Outpatients – New (total ASIs)



- No external target and no requirement to report centrally. Internal target to get back to pre-covid levels.
- Current ASIs had reduced but increasing again particularly in ENT
- Risk of not addressing is on overall length of RTT pathways

Outpatients – New (ASI > 22 weeks)

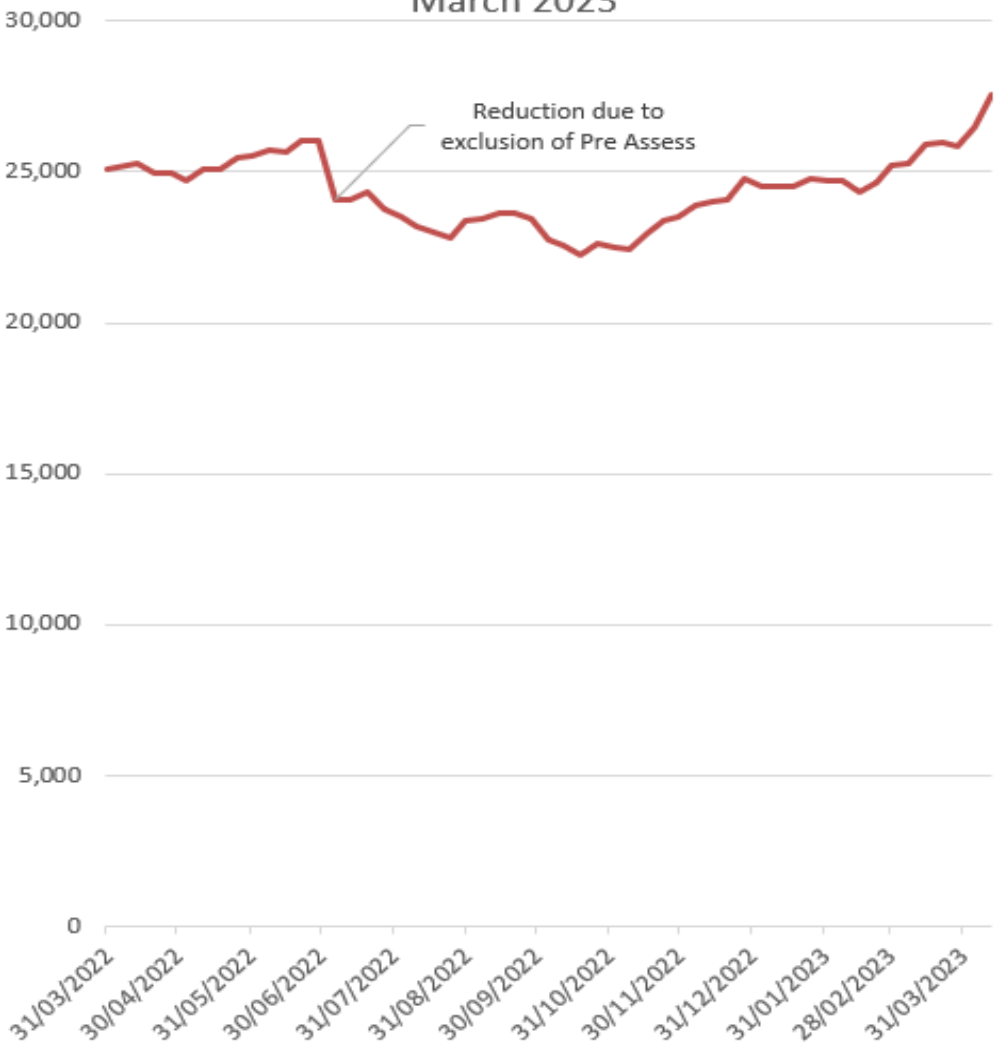
Trajectory for reducing to 0 number of ASI over 22 weeks by the end of March 2023



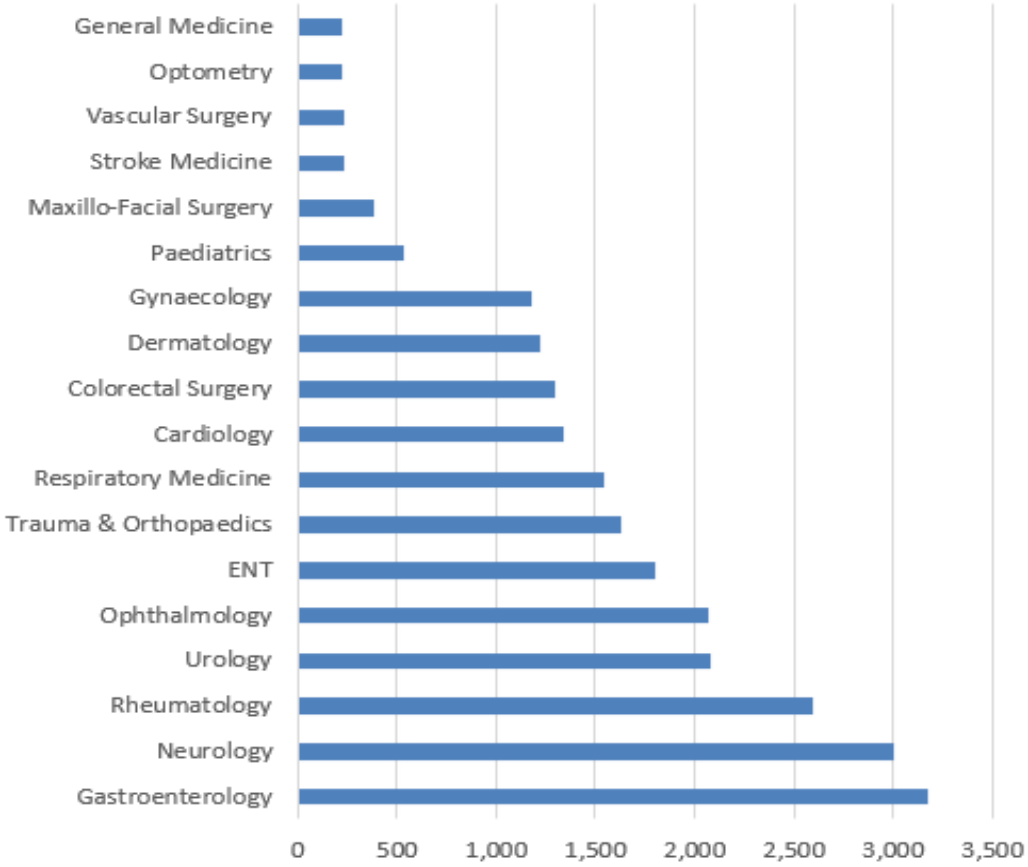
- Our trajectory is a locally set target that will help achieve a reduction in 52/78 week RTT Waits.
- Of the 785 Remaining ASIs over 22 weeks:
  - 157 in ENT
  - 188 in Max Fax
  - 56 in Colorectal
  - 104 in Neurology

Outpatients – Follow Up

Trajectory for reducing follow up backlog by March 2023



Number of Patients past see by date

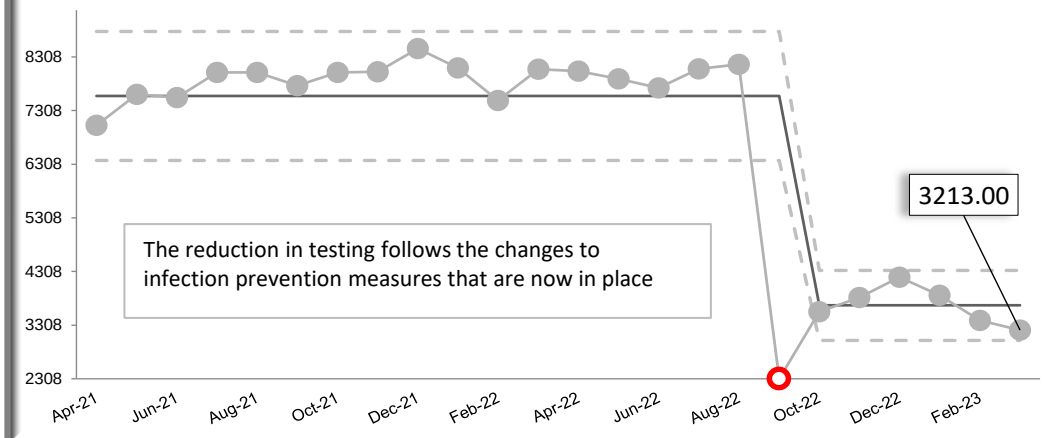


- No external target or requirement to report externally
- Internal target to reduce to 0

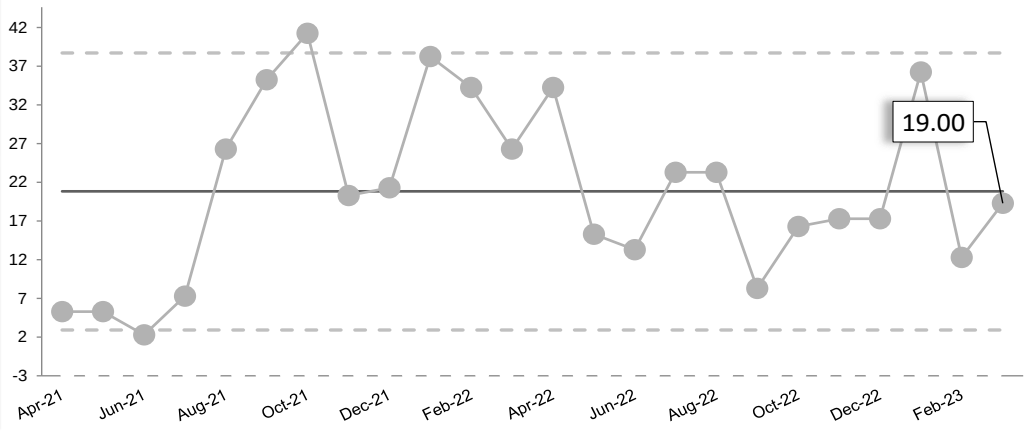
Covid-19 - Charts

Critical | Activity | On Target | Trend | Target Line | Average Line | Control Line | Last 6 Points Directional Flow | Last Data Point

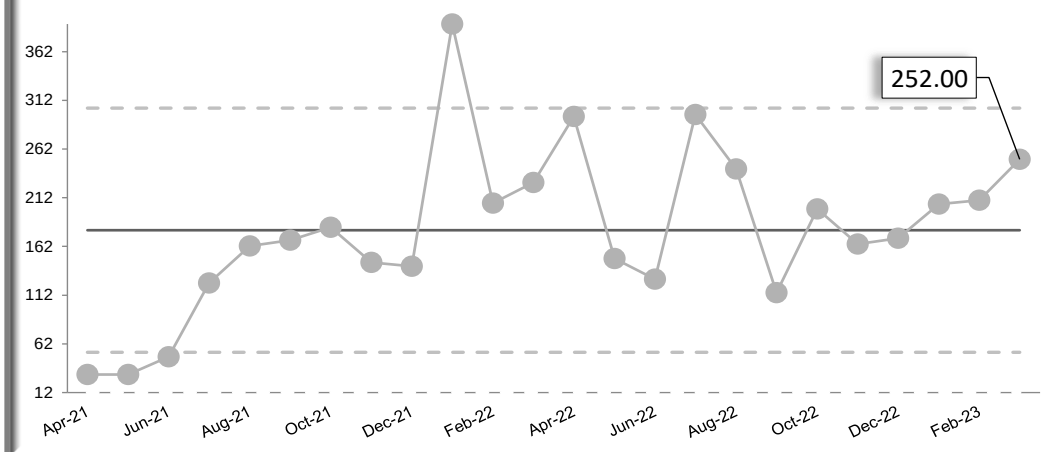
Number of Patients Tested for Covid-19



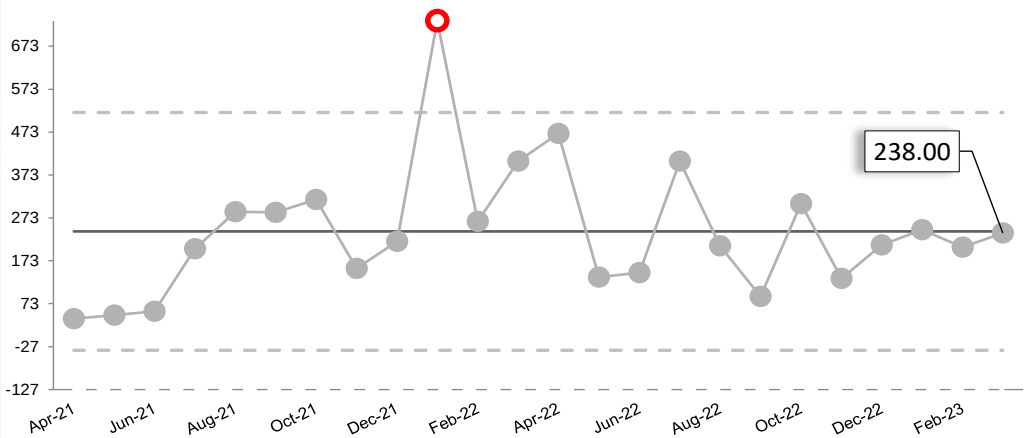
Number of Covid+ Deaths



Number of Covid+ Patients Discharged Well

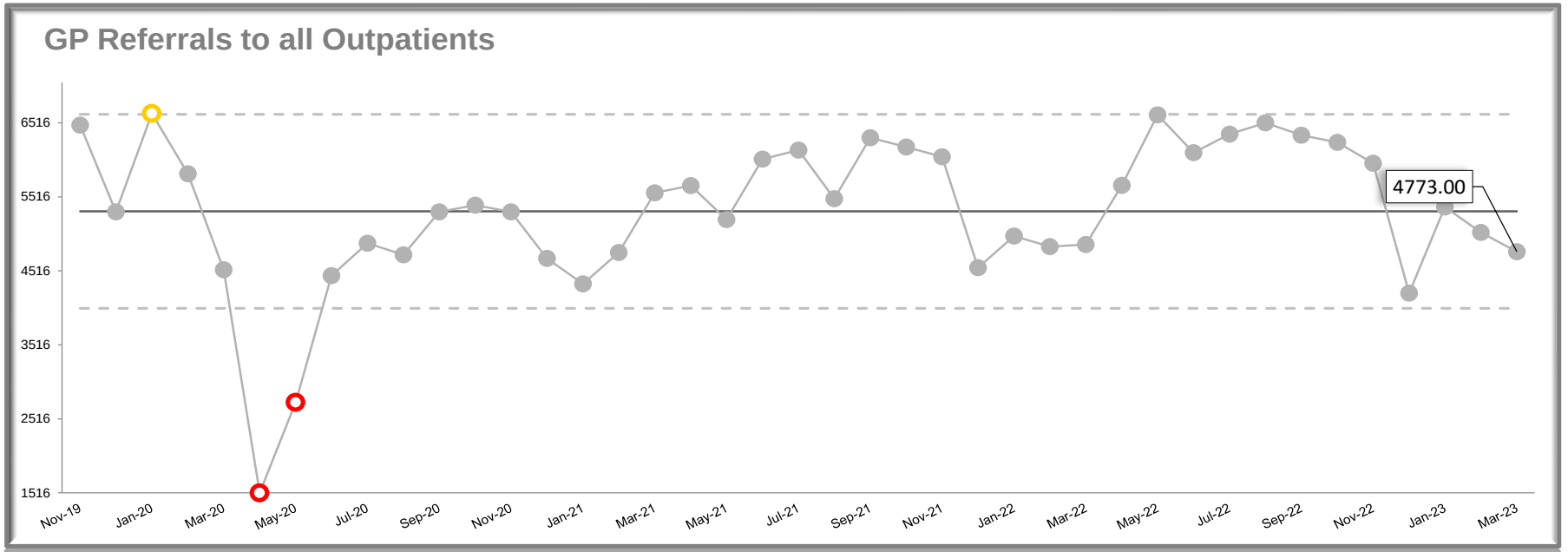


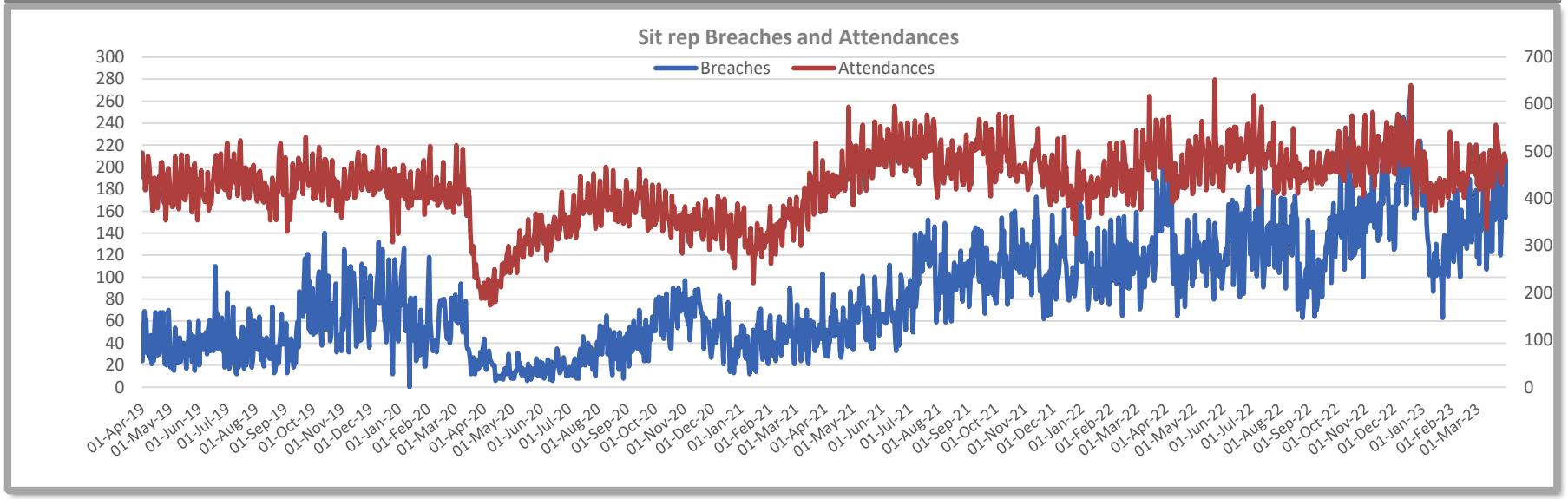
Number of New Covid+



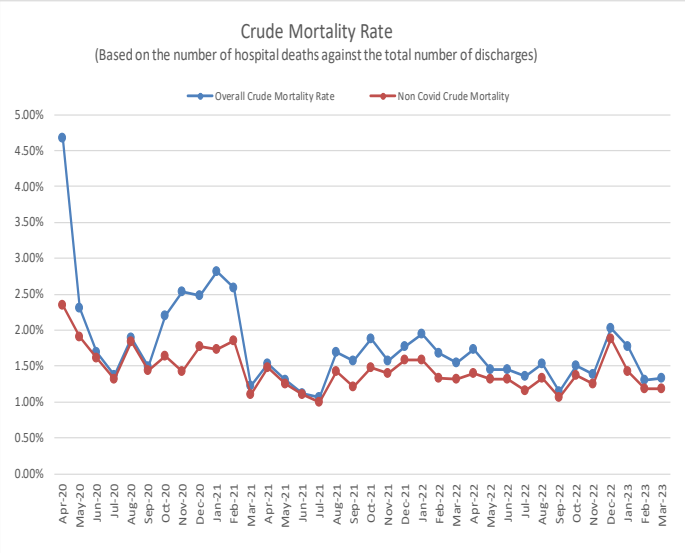
Capacity and Demand

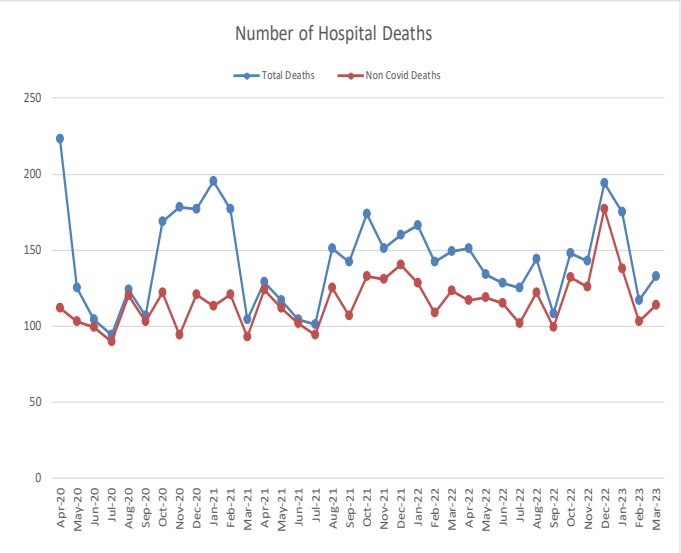
Critical Activity On Target Trend Target Line Average Line Control Line Last 6 Points Directional Flow Last Data Point

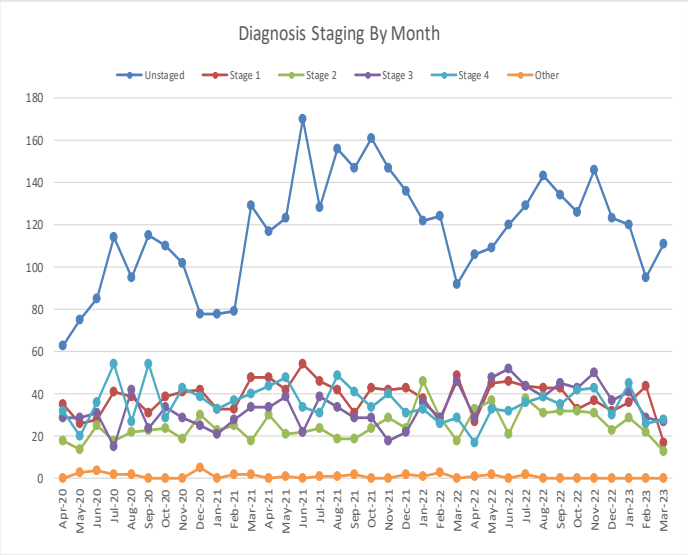


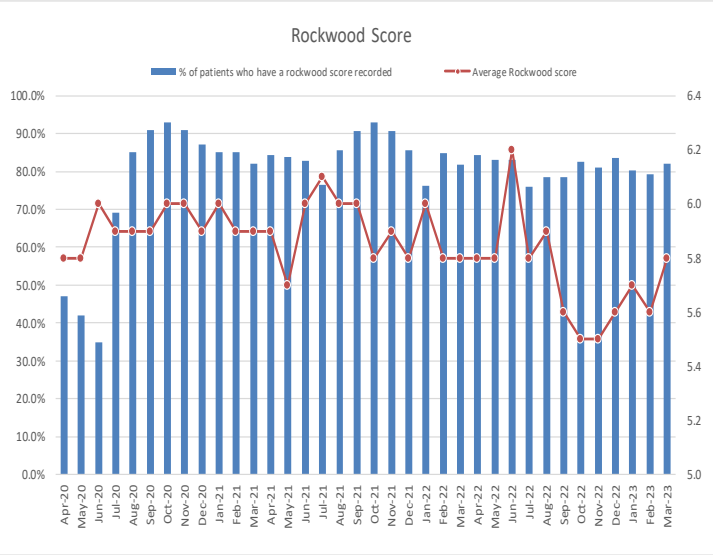


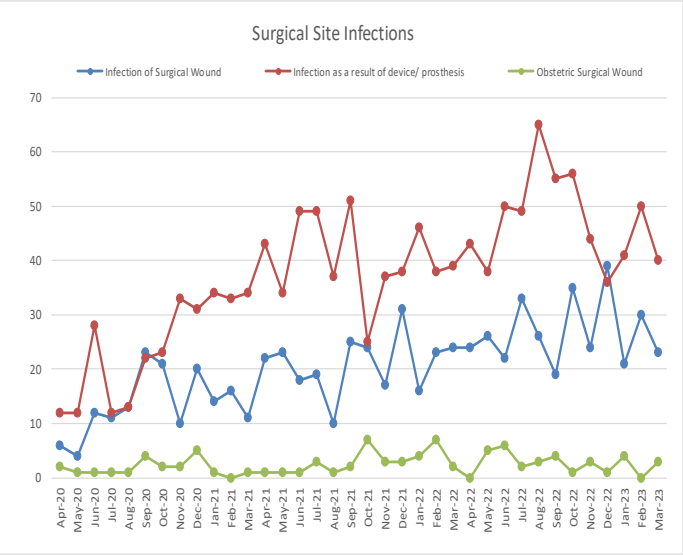
Outcome Measures







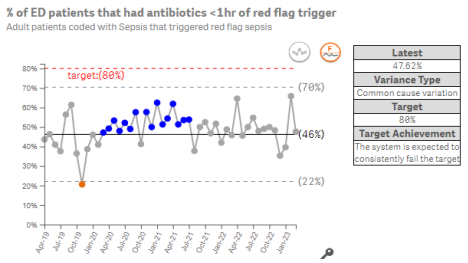


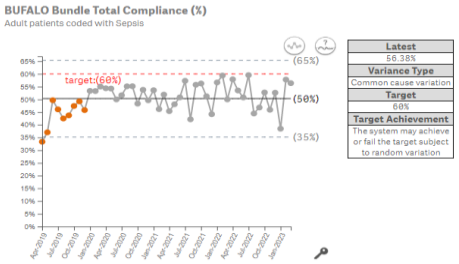


Graphs produced by the Quality Performance Team

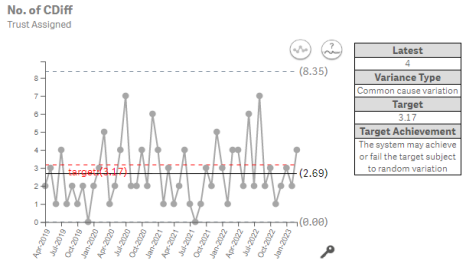
Quality Priorities - Quality Account Priorities

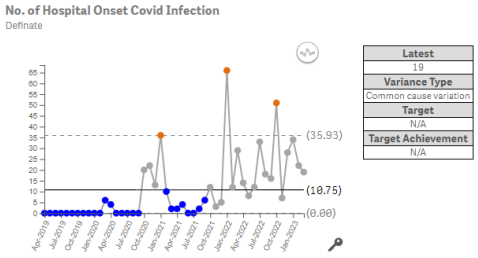
Priority 1
Recognition and timely treatment of Sepsis



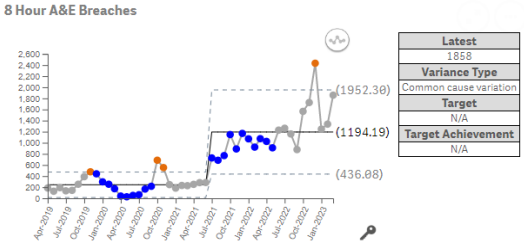


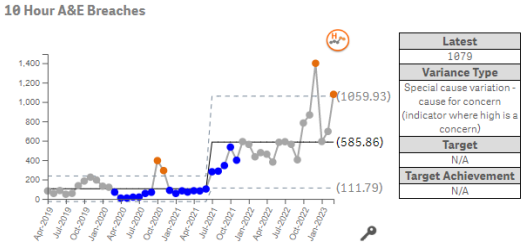
Priority 2
Reduce number of hospital acquired infections including COVID-19

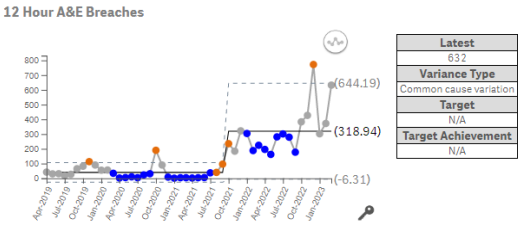




Priority 3
Reduce waiting times for individuals in the Emergency Department





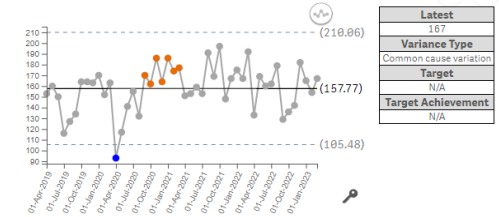


Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities

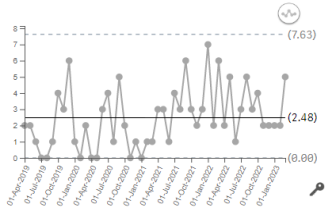
Priority 1
Reducing the number of falls resulting in harm

No. of Falls



Latest
167
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

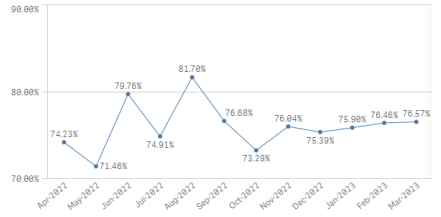
No. of Harm Falls



Latest
5
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

% of pts that had a falls risk assessment on adm/trans to the ward

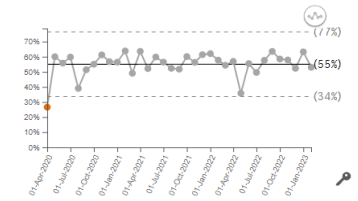
Adult Inpatients



Priority 2
End of Life Care

% of patients that had Last Days of Life Documentation (LDLD)

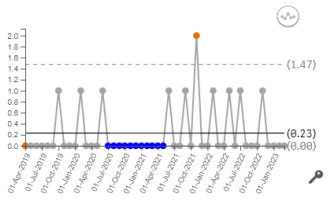
of those that died in hospital



Latest
52.99%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

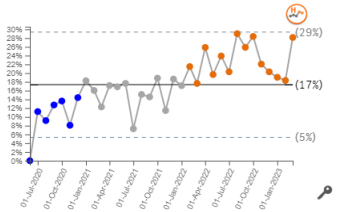
Number of complaints relating to end of life care

Where EOLC is in the subject (primary or secondary)



Latest
0
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

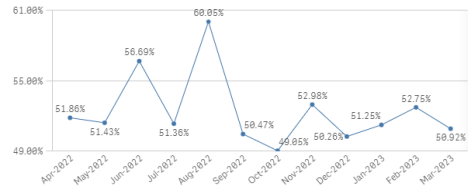
% of patients refered to HSPCT that died or were discharged before seen



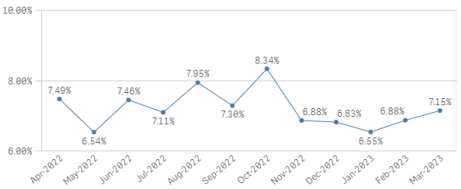
Latest
28.15%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Priority 3
Clinical Documentation

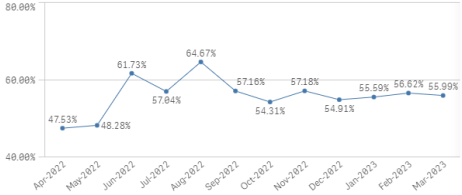
Ward Assurance Overall



Ward Assurance Elimination



Ward Assurance Pressure Ulcers



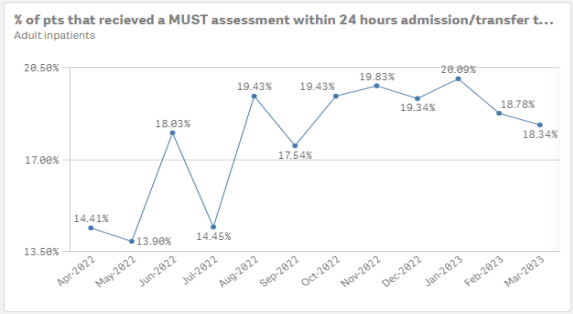
Priority 4
Clinical Prioritisation

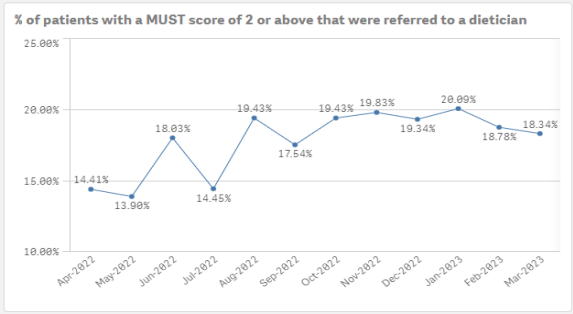
Not Available

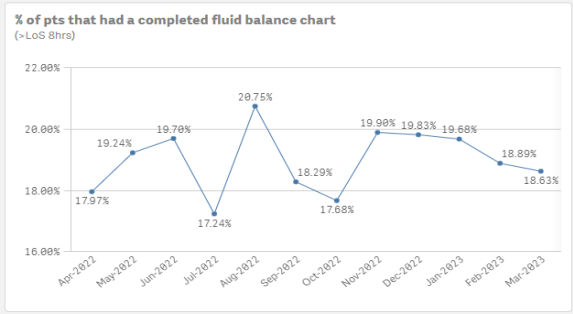
Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities

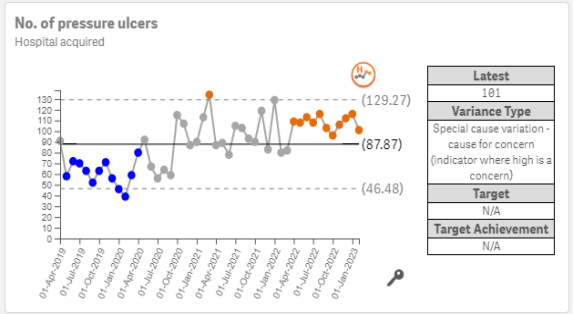
Priority 5
Nutrition and Hydration

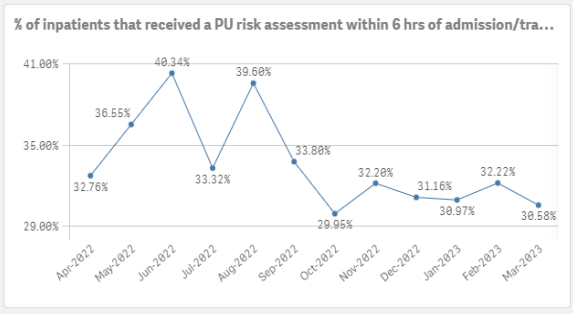




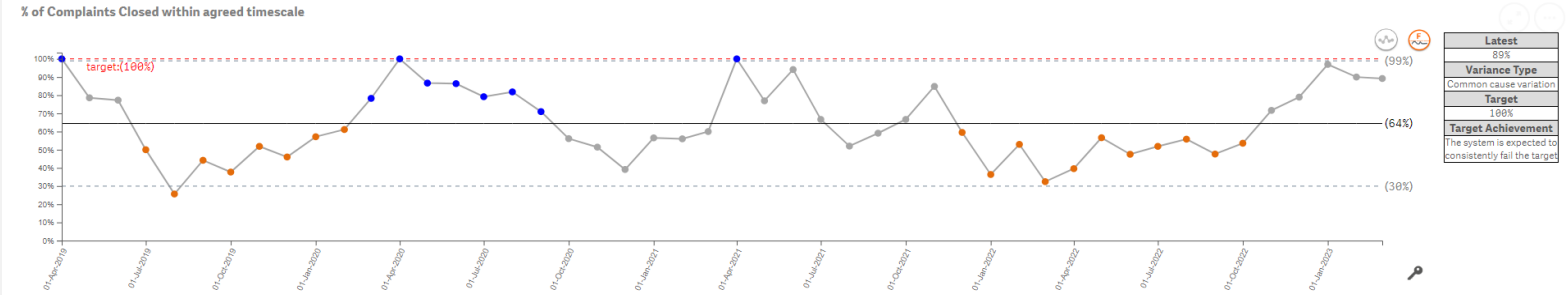


Priority 6
Reduction in the number of CHFT acquired pressure ulcers





Priority 7
Making complaints count



Graphs produced by the Quality Performance Team

CQUIN - Key Measures

Indicator Name	Description	Top 5	Target	Apr-22	May-22	Jun-22	Q1	Jul-22	Aug-22	Sep-22	Q2	Oct-22	Nov-22	Dec-22	Q3	Jan-23	Feb-23	Mar-23	Q4
CCG1: Flu vaccinations for frontline healthcare workers	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	N	Min 70%, Max 90%	Data collection starts in Q3				Data collection starts in Q3				50.2%			50.2%				
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	Y	Min 40%, Max 60%	57.00%			57.00%	59.00%			59.00%	63%			63%				
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	Y	Min 20%, Max 60%	100.0%	84.6%	75.0%	84.4%	100.0%	42.9%	100.0%	66.7%	100.0%	72.3%	100.0%	92.5%				
CCG4: Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	N	Min 55%, Max 65%	8.04%	4.84%	4.21%	5.60%	7.15%	7.24%	9.75%	8.00%	11.20%	16.10%	12.60%	13.40%				
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	N	Min 45%, Max 70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	N	Min 45%, Max 60%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	N	Min 0.5%, Max 1.5%	16.00%	15.70%	12.60%	14.90%	14.60%	15.50%	15.60%	15.20%	14.40%			14.40%				
CCG8: Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Y	Min 60%, Max 70%	83.33%	54.84%	96.30%	78.00%	88.00%	90.00%	88.89%	89.00%	78.00%			88.00%				
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	Y	Min 20%, Max 35%	12.90%	4.23%	3.77%	6.99%	4.29%	6.17%	1.75%	4.33%	7.25%	4.82%	1.79%	4.81%				
CCG14: Assessment, diagnosis and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	Y	Min 25%, Max 50%	28.40%			28.40%	43.50%			43.50%	35.82%			35.82%				

CQUIN - Key Measures

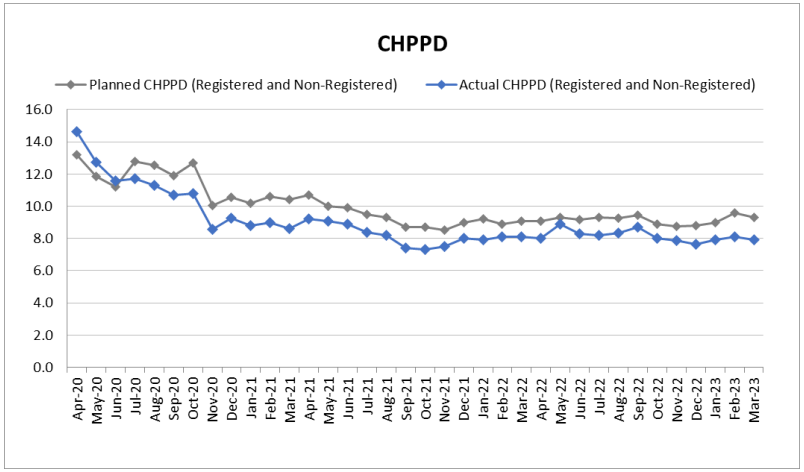
Indicator Name	Reality	Response	Result
CCG1: Flu vaccinations for frontline healthcare workers	In Q3 we achieved 50.02% compliance, which below the 90% target	CHFT rolled out a multi prong approach to vaccination for colleagues this year – for both flu and covid vaccinations. We set up alternating clinics at both main sites for the first 6 weeks and then implemented a 'roving clinic' to capture colleagues who may have struggled to leave their shift. This included covering colleagues at weekends and on the night shift.	Appetite for vaccinations was reduced this year, and we therefore kept the roving clinics operational for 3 weeks longer than planned
CCG4: Compliance with timed diagnostic pathways for cancer services	In Q3 we achieved 13.40% compliance, which is a small improvement from the previous quarters but still well below the 65% target.	This data is taken to a monthly collaborative meeting to assess current position. Assessment of the response of the 5 tumour sites is ongoing.	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	For the third quarter we are achieving 0.00%, this may be due to monitoring rather than an actual reflection of achievement	The low compliance is not a true reflection of current practice, there needs to be a means of recording the care bundle in EPR. This may be a quality improvement project for a junior doctor in the team.	Achieving 70% of patients with confirmed community acquired pneumonia to be managed
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	Performance for Q3 is 4.81% which is below the 35% target.	The low compliance may be due to monitoring rather than an actually reflection of data	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.
CCG14: Assessment, diagnosis and treatment of lower leg wounds	As of the third quarter we are achieving 35.82% compliance, which is below the target of 50%	Data collection framework is in place with a meeting in place every 4 weeks to sense check the data.	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.

Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

	Jan-23	Feb-23	Mar-23
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	84.0%	84.0%	81.9%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	93.8%	93.8%	88.2%

PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	9.0	9.6	9.3
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	7.9	8.1	7.9

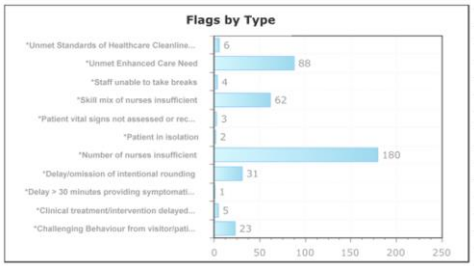


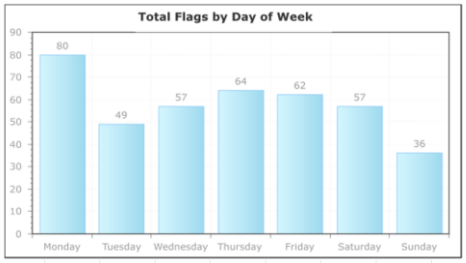
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide c are on inpatient wards. CHPPD is not a stand alone measure and is be used alongside clinical quality and safety outcome measures.

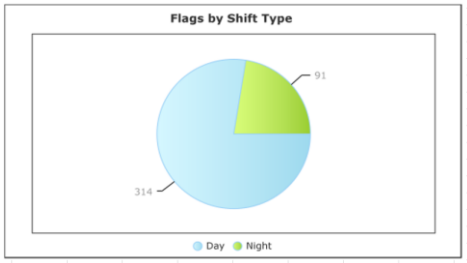
A review of March 2023 data indicates that the combined RN and non-registered clinical staff metrics resulted in all reporting clinical areas having fewer CHPPD than planned, with a total deficit of 1.4 CHPPD across the Trust. This apparent widening of the gap between planned an d actual results from the inclusion of those shifts which were planned but above the normal workforce model, to provide care for patients in the additi onal capacity beds (e.g. Acute Floor and Stroke). The planned CHPPD now also includes the enhanced support worker shifts required to care for patients requ iring 1:1 care. The impact of this change is also reflected in the recorded shift fill percentage, which is more representative of the clinical reality, wh ereas previous reports prior to February showed an apparent over staffing (<100%) in some areas.

A review of the nurse sensitive indicators demonstrates incidence of falls to be within normal variation. The apparent rise in pressure ulcers on the medical division SPC chart is as a result of reporting actual numbers, rather than prevalence per 1000 bed days. When prevale nce is calculated all nurse sensitive indicators fall within normal variance. The new style IPR from April 2023 will report prevalence rather than actual numbers for more consistent comparison.

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 usu al 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.

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)

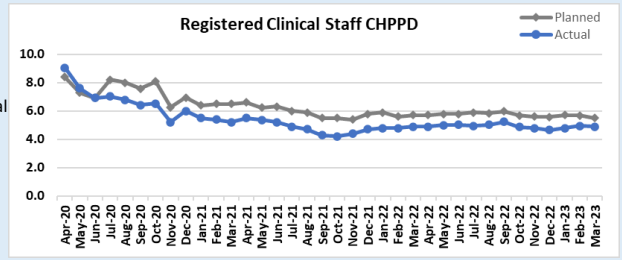
Aggregate Position | Trend | Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 5.5 for planned and 4.9 for actual for Registered Clinical Staff

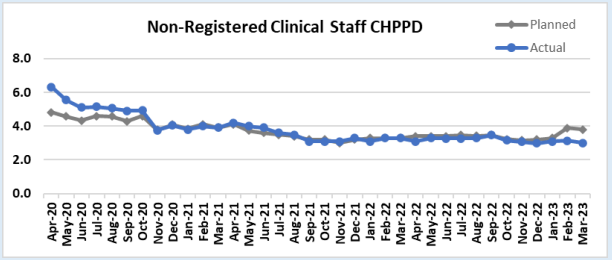


Overall there is a shortfall of 0.6 CHPPD against an overall requirement of 5.5 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse 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. When adjusted for prevalence, falls and pressure ulcer prevalence remain within normal variation in month.

Non Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.8 for planned and 3.0 for actual for Non Registered Clinical Staff



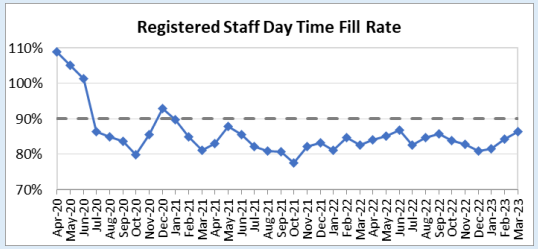
There was a shortfall in the planned CHPPD of 0.8 provided by non-registered clinical staff. This apparent step change between planned and actual from February represents the shortfall in availability to meet the 1:1 care allocation to patients who require that level of care. Previous reports have only included workforce model shifts in the 'planned' hours, whereas this report now also includes the 1:1 care requirements in the planned CHPPD.
The apparent significant drop in HCSW shift fill rates largely represents the unfilled 1:1 shifts not previously reported, and is more representative of the clinical reality.

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.

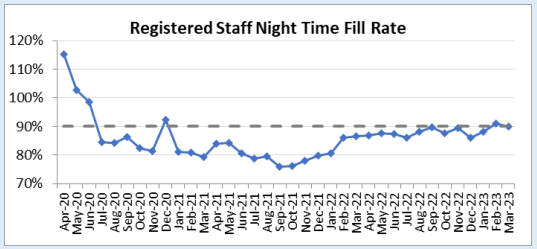
86.32% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

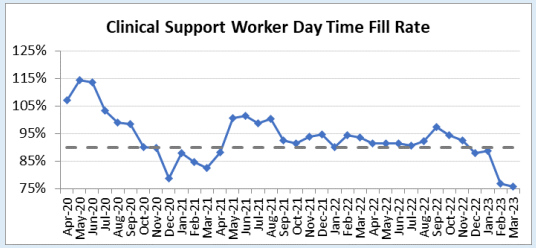
89.96% of expected Registered Clinical Staff hours were achieved for night shifts.



Non Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

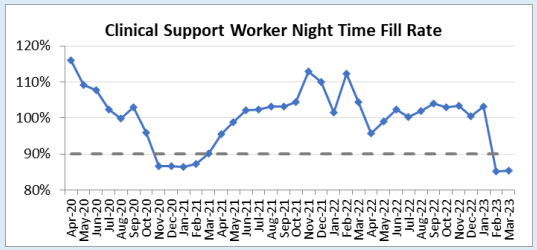
75.65% of expected Non Registered Clinical Staff hours were achieved for Day shifts.



Non Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

85.4% of expected Non Registered Clinical Staff hours were achieved for night shifts.

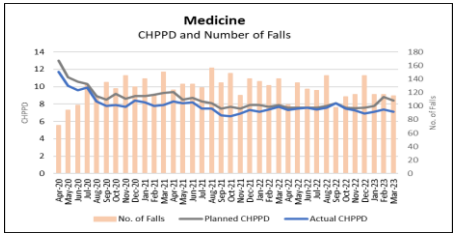


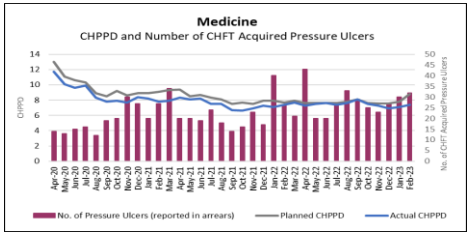
Hard Truths: Safe Staffing Levels (3)

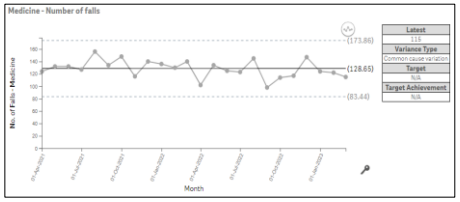
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

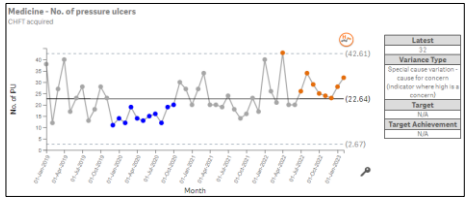
Ward	Average Fill Rates				CHPPD	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD
CRH ACUTE FLOOR	91.3%	81.0%	98.5%	90.7%	8.2	7.4
HRI ACUTE FLOOR	95.2%	83.5%	97.6%	86.6%	8.7	7.9
RESPIRATORY FLOOR	65.5%	74.2%	80.7%	81.7%	9.8	7.3
WARD 5	91.8%	60.9%	96.4%	73.2%	9.3	7.1
WARD 6	78.7%	94.0%	100.0%	95.5%	4.0	3.2
WARD 6C	78.6%	54.8%	98.2%	100.0%	13.4	11.9
WARD 6AB	83.0%	83.8%	100.6%	91.7%	6.6	5.9
WARD CCU	80.7%	43.5%	88.7%		8.6	7.0
STROKE FLOOR	91.5%	68.7%	93.9%	82.8%	7.6	6.5
WARD 12	98.9%	79.1%	66.7%	117.5%	8.3	7.0
WARD 15	99.8%	69.4%	91.4%	84.7%	9.2	7.8
WARD 17	85.1%	81.3%	88.6%	86.7%	7.4	6.5
WARD 18	90.3%	74.8%	92.3%	95.0%	10.5	9.5
WARD 20	96.9%	79.4%	93.7%	86.8%	7.4	6.5
Medicine	**85.47%**	**75.54%**	**91.83%**	**87.94%**	**8.4**	**7.1**
WARD 21	91.2%	89.4%	90.5%	90.3%	7.9	7.1
WARD 22	95.7%	88.3%	92.6%	84.7%	10.3	9.3
ICU	86.2%	68.7%	84.0%	51.3%	42.5	34.5
WARD 8A	72.6%	39.4%	70.9%	53.8%	15.1	9.0
WARD 8C	98.4%	76.7%	98.3%	96.8%	7.2	6.7
WARD 10	88.4%	85.3%	71.7%	78.1%	8.0	6.5
WARD 14	96.8%	72.5%	97.2%	85.7%	7.2	6.3
WARD 19	91.0%	80.7%	95.4%	87.0%	8.6	7.6
SAU HRI	97.9%	86.3%	99.4%	92.7%	8.2	7.8
Surgical	**90.3%**	**78.1%**	**88.3%**	**82.0%**	**10.7**	**9.1**
WARD LDRP	86.4%	71.3%	84.5%	100.0%	24.8	21.1
WARD NICU	80.0%	33.6%	87.3%	42.2%	17.9	13.9
WARD 3ABCD	87.4%	54.2%	92.6%	62.2%	11.9	9.9
WARD 4ABC	77.7%	81.0%	84.5%	80.4%	6.1	4.9
Ward 1D	99.0%	83.4%	99.1%	84.6%	9.7	9.0
FSS	**83.6%**	**63.4%**	**87.6%**	**74.1%**	**12.5**	**10.3**
TRUST	**86.32%**	**75.65%**	**89.96%**	**85.47%**	**9.3**	**7.9**

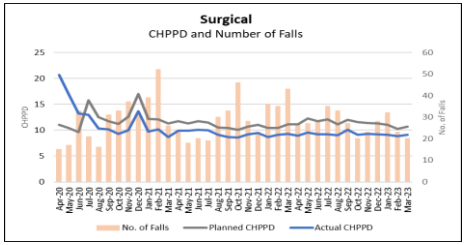
Nursing Quality Indicators

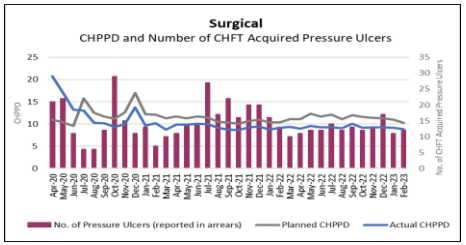


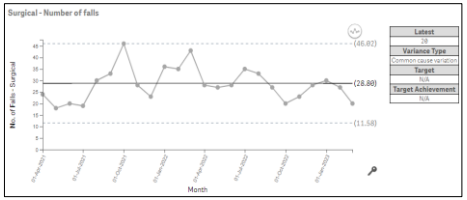


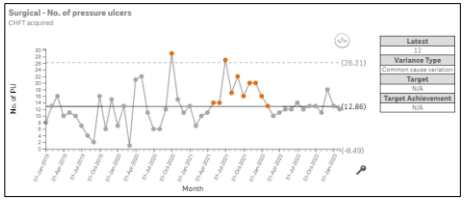












KEY: >100% | 100- 96% | 95-85% | <85%

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments to provide safe and compassionate care to patients.

On-going activity:
1. The dashboard aligns the workforce position to an agreed suite of nurse sensitive indicators and is reviewed weekly at the Monday Safer Staffing Meeting, for which terms of reference have been revised to include a greater focus on quality metrics.
2. The Nursing, Midwifery and AHP Workforce Steering Group is progressing work to understand the detail of the vacancy position and aligning this to the recruitment/training strategy in partnership with the local HEI, as well as high impact retention strategies.
3. A review of the current Nursing and Midwifery workforce plans is underway, supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment and retention strategies. The Safer Nursing Care Tool (Acuity/Dependency Scoring) is used on in-patient wards and the emergency departments to collect data to inform the next bi-annual review in May 2023.
4. The International recruitment project continues to progress. CHFT have been successful in a bid for funding from NHSE to support recruitment of a further 30 International Nurses to arrive before the end of November 2023. Work is commencing with the ICB and Global partnerships to support joint working to enable recruitment of nurses from Kerala.
5. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to assist the RN workforce recruitment strategy.
6.There is a strong commitment, with associated operational plans, to retract from Agency spending, commencing with the high cost agencies

Workforce Metrics

March 2023

Target:
Vacancies (NHSi submitted position) – 230.08 FTE

Workforce

Headcount	↑	6281
Actual FTE	↑	5577.46
Establishment FTE	↑	5985.53
Vacancies FTE	↓	408.07

Most Vacancies:
Nursing and Midwifery **(157.47FTE)**
Additional Clinical Services **(72.73 FTE)**
Admin & Clerical **(63.85 FTE)**

Target:
Overall - 4.75%
Long Term – 3.0%
Short Term – 1.75%

Non Covid- Sickness Absence

Rolling 12 month	↑	4.83%
In-month	↑	4.55%
FTE days lost per FTE (Rolling)	↑	20.52

Main Reason (in-month):
Anxiety, stress, and depression **(29.94%)**

Highest Staff Groups (in-month):
Estates & Ancillary **(10.68%)**
Additional Clinical Services **(7.42%)**

Target:
Rolling – 11.5%

Turnover

Rolling 12 month	↓	8.07%
In-month	↓	0. 44%
Leavers FTE	↑	32.68

Highest Staff Groups:
Estates & Ancillary **(12.19%)**
Administrative & Clerical **(10.31%)**
Add Prof Scientific and Technic **(10.22%)**

Target:
EST - 90%
Appraisal – 95%

Essential Safety Training & Appraisal

Overall EST Compliance	↑	93.82%
Appraisal Compliance*	↑	87.48%

*74.476% at the end of appraisal season 2022/2023.

Lowest EST Core Suite Elements:
Fire Safety **(87.73%)**
Data Security **(88.84%)**

Targets:
Advised by WYATT Streamlining
1 8 days
2 45 days
3 3 days

Recruitment

Vacancy approval to advert placement 1	↓	9.9
Interview to conditional offer 2	↑	1.9
Unconditional offer to acceptance 3	↓	1.9

Forecast Budget (YTD):
Substantive - £294.22M
Bank - £18.54M
Agency - £6.03M

Spend (YTD)

Substantive	£307.01M
Bank	£34.11M
Agency	£14.35M

Highest Agency Spend:
Medical and Dental **(£2.61M)**
Nursing and Midwifery **(£10.87M)**

All data correct as at 28 February 2023

Directorate Health Heatmap

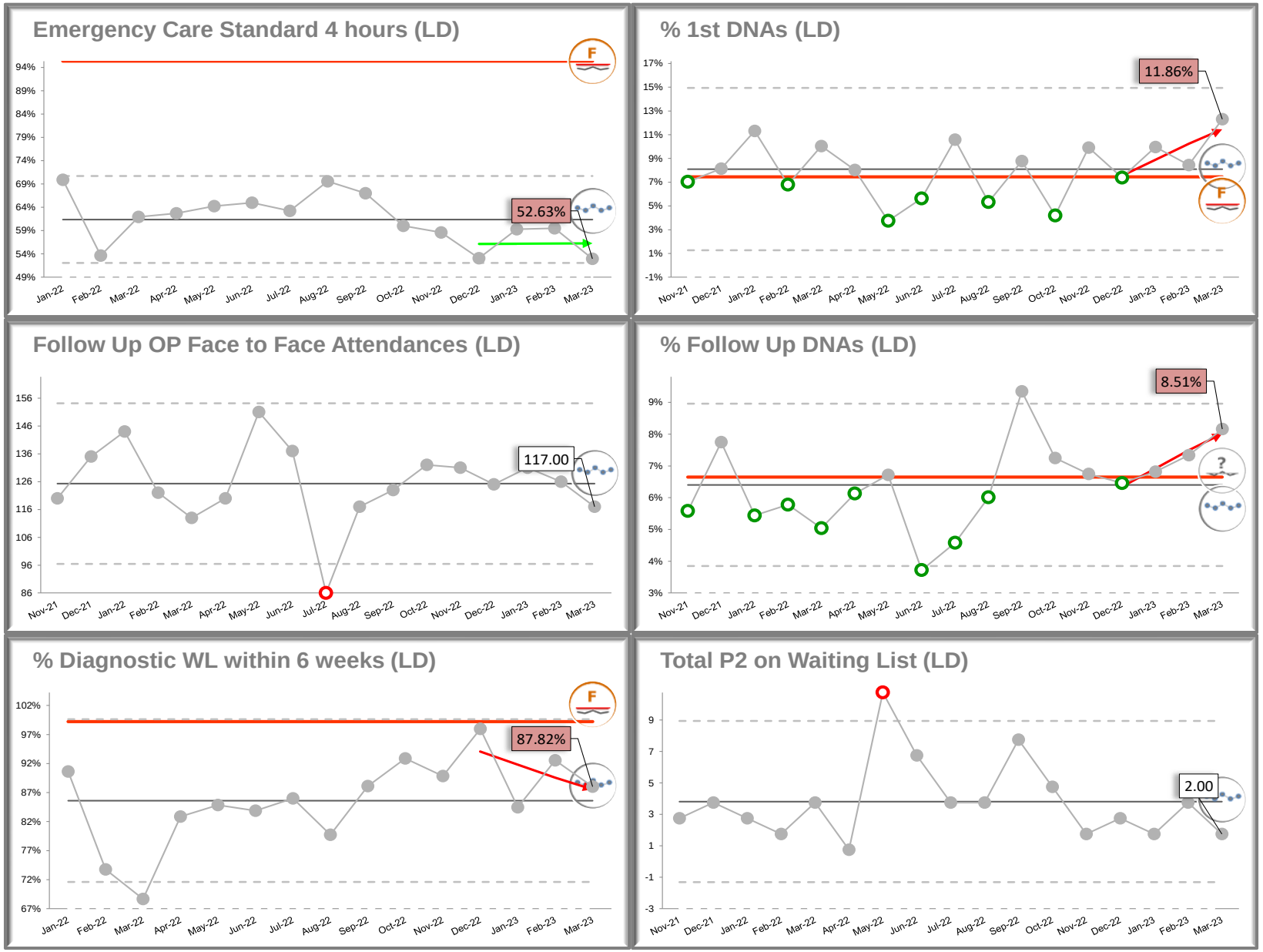
Directorate	Division	NHS SS Response Rate 2022	Engagement Score 2022	EST (Mar 2023)	AfC Appraisal 2022-23 (Mar 2023)	Sickness (Non-Covid) (12m) (Mar 2023)	Annual Leave Usage (Apr 2022 - Mar 2023)	Turnover (12m) (Mar 2023)	Vacancy Rate (Mar 2023)	Health Score
Workforce and Organisational Development	Corporate	87.1%	7.7	97.1%	95.7%	2.88%	90.8%	11.3%	-5.6%	94.4%
Finance	Corporate	86.7%	8.0	99.5%	97.6%	0.89%	90.2%	4.5%	-7.3%	88.9%
Information	Health Informatics	86.8%	7.6	98.7%	94.1%	2.22%	90.7%	3.1%	0.1%	88.9%
Community Therapies	Community	54.4%	6.8	95.4%	90.9%	3.91%	100.0%	9.6%	5.6%	83.3%
FSS Management	Families & Specialist Services	56.7%	7.8	93.8%	96.6%	4.71%	80.9%	5.2%	-1.3%	83.3%
Community Management	Community	66.7%	7.4	98.0%	89.6%	2.49%	95.8%	6.5%	0.0%	77.8%
Critical Care	Surgery & Anaesthetics	56.9%	6.7	98.0%	74.0%	8.10%	96.4%	4.8%	-6.1%	72.2%
Head & Neck	Surgery & Anaesthetics	42.4%	7.2	94.7%	91.3%	4.81%	76.3%	9.6%	6.2%	66.7%
Outpatients & Records Services	Families & Specialist Services	62.6%	6.5	98.7%	97.5%	5.03%	98.4%	13.2%	8.2%	66.7%
Quality	Corporate	62.2%	7.1	93.0%	59.2%	5.03%	90.5%	8.5%	-4.8%	66.7%
Radiology	Families & Specialist Services	44.8%	6.4	97.8%	92.4%	2.97%	55.1%	9.0%	9.5%	66.7%
Corporate & Operations	Health Informatics	68.2%	7.3	94.8%	90.6%	2.34%	82.9%	15.3%	9.1%	61.1%
Corporate Services	Corporate	71.6%	7.8	92.2%	64.9%	2.26%	65.8%	14.6%	-1.3%	61.1%
General Surgery	Surgery & Anaesthetics	37.1%	7.4	92.6%	90.0%	3.14%	77.5%	4.8%	4.3%	61.1%
Community Nursing	Community	34.7%	7.0	93.7%	84.6%	6.13%	98.8%	4.4%	-6.2%	55.6%
Medical Divisional Management	Medical	57.6%	7.0	91.9%	80.0%	7.09%	51.6%	5.4%	-1.2%	55.6%
Surgical Divisional Support	Surgery & Anaesthetics	73.3%	7.3	92.3%	71.0%	4.45%	48.3%	5.8%	9.8%	55.6%
Childrens	Families & Specialist Services	43.2%	6.9	92.0%	74.9%	4.11%	81.2%	6.1%	7.8%	50.0%
Pathology	Families & Specialist Services	40.8%	6.4	97.3%	91.0%	6.04%	93.3%	11.1%	8.3%	50.0%
Pharmacy	Families & Specialist Services	51.8%	6.8	97.0%	90.6%	3.99%	93.7%	15.4%	11.3%	50.0%
Surgical Medical Secretaries	Surgery & Anaesthetics	62.2%	6.7	97.7%	71.4%	5.93%	91.0%	9.2%	11.1%	50.0%
Medical Specialties	Medical	34.1%	6.4	91.0%	44.7%	4.58%	68.2%	8.6%	13.2%	44.4%
Integrated Medical Specialties	Medical	31.0%	6.7	91.8%	69.8%	4.91%	74.6%	7.4%	6.8%	38.9%
Operating Services	Surgery & Anaesthetics	33.8%	5.9	91.6%	79.4%	5.26%	77.6%	7.7%	-1.1%	38.9%
Womens	Families & Specialist Services	48.4%	6.6	94.4%	75.9%	5.38%	83.4%	7.4%	12.6%	38.9%
Pharmacy Manufacturing Unit	Pharmacy Manufacturing Unit	69.5%	5.9	96.8%	93.1%	5.55%	84.8%	23.2%	12.3%	33.3%
Resilience, Acute Flow and Transformation	Corporate	30.8%	6.1	93.2%	52.8%	8.66%	98.9%	8.5%	10.4%	33.3%
Service Delivery	Health Informatics	-	-	98.8%	85.7%	8.84%	66.8%	28.6%	-6.7%	33.3%
Acute Medical	Medical	29.6%	6.5	90.3%	71.2%	6.63%	81.3%	5.6%	14.2%	27.8%
Emergency Care	Medical	29.3%	6.2	90.5%	88.3%	5.15%	81.9%	3.5%	10.2%	27.8%
Orthopaedics	Surgery & Anaesthetics	26.5%	6.0	88.9%	66.0%	5.49%	64.8%	7.7%	7.9%	16.7%

LD - Key measures

	21/22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	Performance Range		
																Green	Amber	Red
Recovery																		
Total P2 on Waiting List (LD)	32	4	1	11	7	4	4	8	5	2	3	2	4	**2**	**2**	No target		
Total P3 on Waiting List (LD)	119	11	15	17	13	10	11	11	12	7	8	15	13	**10**	**10**	No target		
Total P4 on Waiting List (LD)	58	1	2	3	4	4	2	2	3	4	3	2	6	**8**	**8**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	61.62%	62.39%	63.93%	64.66%	62.89%	69.23%	66.67%	59.68%	58.27%	52.74%	58.97%	59.18%	**52.63%**	**60.56%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	54	50	48	55	41	35	37	35	33	35	21	22	**22**	**22**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	38	10	8	8	5	4	6	5	3	4	1	1	**0**	**0**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.6848	0.8266	84.64%	83.68%	85.80%	79.51%	87.90%	92.68%	89.63%	97.76%	84.24%	92.35%	**87.82%**	**86.89%**	>=99%		<=98%
Cancer																		
Two Week Wait for Referral to Date First Seen (LD)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<85%
31 Days From Diagnosis to First Treatment (LD)	100.00%	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	100.00%	100.00%	100.00%	not applicable	not applicable	not applicable	**not applicable**	**100.00%**	>=96%		<95%
31 Day Subsequent Surgery Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=94%		<93%
38 Day Referral to Tertiary (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=85%		<84%
62 Day GP Referral to Treatment (LD)	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**100.00%**	>=85%	81% - 84%	<80%
62 Day Referral From Screening to Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	not applicable	**not applicable**	**100.00%**	>=90%		<89%
Activity - Number of Attendances																		
New Outpatient Attendances - Face to Face (LD)	366	31	38	41	41	40	48	59	38	50	30	47	35	**22**	**489**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	18	11	20	15	9	13	16	18	14	17	15	18	**12**	**178**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	113	120	151	137	86	117	123	132	131	125	131	126	**117**	**1496**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	67	57	62	61	42	48	50	56	74	44	52	51	**51**	**648**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	9.59%	7.59%	3.30%	5.19%	10.14%	4.88%	8.33%	3.75%	9.47%	6.94%	9.52%	8.00%	**11.86%**	**7.31%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	5.39%	6.48%	7.07%	4.07%	4.93%	6.36%	9.70%	7.60%	7.10%	6.81%	7.17%	7.69%	**8.51%**	**7.01%**	<=7.0%	7.1% - 7.9%	>=8.0%

LD - Charts

Critical Activity On Target Trend Target Line Average Line Control Line Last 6 Points Directional Flow RAG Rated Last Data Point



WORKFORCE FIT FOR THE FUTURE

18. Staff Survey Results and Action Plan (In attendance:- Nikki Hosty, Diane Tinker, Sarah Wallwork)

For Assurance

Presented by Suzanne Dunkley

Date of Meeting:	Thursday 4 May 2023
Meeting:	Public Board of Directors
Title:	2022 Staff Survey Results
Authors:	Nikki Hosty, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee March 2023 Executive Board March 2023

Purpose of the Report

The report (via a slide deck presentation) provides the Board of Directors with feedback from the 2022 national staff survey and the Trust's survey response.

Key Points to Note

- The survey is aligned with the NHS People Promise
- CHFT outputs from the survey show a positive incremental improvement
- One Culture of Care is our guiding principle and drives our response
- Need continued focus on learning, development and teamwork with managers leading this approach
- Staff survey actions are principally leader and manager owned within our organisational structures
- Primary Board oversight for our response is through the Workforce Committee.

EQIA – Equality Impact Assessment

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

Recommendation

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

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NHS Foundation Trust

Staff Survey Results 2022
Board of Directors

4 May 2023

One Culture of care

We each have a voice that counts

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National Overview

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- Over 1.3 million NHS employees in England were invited to participate in the survey, 264 NHS organisations took part, including 215 trusts in England
- Since 2021, the survey questions have been aligned with the NHS People Promise, which sets out in the words of NHS staff the things that would most improve their working experience.
- Reporting has been updated to track progress against the seven People Promise elements and the themes of engagement and morale. The elements and themes are all scored on a 0-10 point scale, with 10 being the most positive. 2022 vs 2021 scores displayed below.
- The Staff Engagement theme score has stayed the same as in 2021 (6.8) and remains lower than in 2018-2020 (7.0)
- The Staff Engagement theme score has stayed the same as in 2021 (6.8) and remains lower than in 2018-2020 (7.0)
- CHFT is benchmarked against 124 Acute and Acute Community Trusts, the median response rate was 44%, the average engagement score was 6.8 and the average morale score was 6.7

	National 2022	National 2021
We are compassionate and inclusive	7.2 (=)	7.2
We are recognised and rewarded	5.8 (-0.1)	5.9
We each have a voice that counts	6.7 (=)	6.7
We are safe and healthy	5.9 (=)	5.9
We are always learning	5.4 (+0.1)	5.3
We work flexibly	6.1 (=)	6.1
We are a team	6.7 (+0.1)	6.6

Participation

636,348
staff responded
(648,594 in 2021)

593,977
online responses
(594,974 in 2021)

42,371
paper responses
(53,620 in 2021)

46%
response rate
(down from 48% in 2021)

Note: These are overall figures which include trusts and non-trust organisations.

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CHFT Overview

Calderdale and Huddersfield NHS Foundation Trust

44% response rate

-4% from 2021

2668 responses

-134 from 2021

6.8/10 engagement score

+0.1 from 2021

5.7/10 morale score

+0.1 from 2021

Positive Themes

- ***Learning opportunities, more colleagues accessing development***
- ***Support for career development***
- ***We are compassionate and inclusive***

Themes for Improvement

- Management Development
- Flexible working and better work life balance

Most Improved Scores Breakdown (Engagement)

Directorate	Score	Movement from 2021
FSS Management	7.8	+0.6
Head & Neck	7.2	+0.5
General Surgery	7.4	+0.5
Womens	6.6	+0.3

Lowest Scores Breakdown (Engagement)

Directorate	Score	Movement from 2021
Pharmacy Manufacturing Unit	5.9	-0.2
Operating Services	5.9	=
Orthopaedics	6	=
Corporate Central Operations	6.1	-0.1
Emergency Care	6.2	-0.1
Radiology	6.4	=

People Promise Elements & Themes

Calderdale and Huddersfield NHS Foundation Trust

	CHFT 22	SCC AVG 22	CHFT 21	SCC AVG 21
We are compassionate and inclusive	7.3 (+0.1)	7.2	7.2	7.2
We are recognised and rewarded	5.8 (+0.1)	5.7	5.7	5.8
We each have a voice that counts	6.8 (+0.1)	6.6	6.7	6.7
We are safe and healthy	5.9 (+0.1)	5.9	5.8	5.9
We are always learning	5.4 (+0.3)	5.4	5.1	5.2
We work flexibly	5.9 (+0.1)	6.0	5.8	5.9
We are a team	6.6 (+0.1)	6.6	6.5	6.6
Engagement	6.8 (+0.1)	6.8	6.7	6.8
Morale	5.7 (+0.1)	5.7	5.6	5.7

SCC = Survey Coordination Centre

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Equality, Diversity and Inclusion

Calderdale and Huddersfield NHS Foundation Trust

Age

Most engaged

66+ and **16-20** with 7.6 and 7.1 respectively.

Least engaged

21-30 with 6.7 (+0.2 from 2021)

Disability

Overall engagement score 0.4 points lower than colleagues that do no consider themselves to have a disability.

This is an improvement of +0.2 from the 2021 survey

Ethnicity

The engagement score for Black, Asian ethnic minority colleagues is 7.0 (same as 2021 score) and is 0.2 higher than for White colleagues.

Gender

The engagement score improved by 0.1 points for both Female and Male colleagues. Engagement for colleagues that stated they 'prefer not to say' stayed the same as 2021 at 5.7

Sexuality

LGBTQ+ colleagues score for a negative experience is 0.6 lower than the organisation overall (same difference as 2021)

Religion

Colleagues that have stated they 'prefer not to say' what their religion is, are the least engaged group at 6.1. Hindu colleagues are the most engaged 7.2

CHFT Positives

Calderdale and Huddersfield NHS Foundation Trust

74.2% of colleagues feel CHFT respects individual differences, 4.9% higher than the benchmark average

Since 2021, the most improved People Promise element is we are always learning improving by 0.3, Appraisals is a sub score of this element improving by 0.4

CHFT compassionate leadership sub score is 6.8 which improved by 0.1 from 2021

Our highest People Promise sub score for morale is diversity and equality scoring 8.3

Black, Asian and minority ethnic (BAME) colleagues score higher for both engagement (+0.2) and motivation (+0.5) compare to white colleagues

59.2% of colleagues feel CHFT acts fairly with regards to career progression/promotion, regardless of protected characteristics, this is 3.6% above the benchmark average

Our most engaged Divisions are Corporate 7.4 and The Health Informatics 7.4

Staff Survey 2022 Headlines

NHS
Calderdale and Huddersfield
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Top 5 scores vs Picker Average	CHFT	*Picker Avg
q18d. Feedback given on changes made following errors/near misses/incidents	64%	59%
q20. Feel organisation respects individual differences	74%	70%
q8a. Teams within the organisation work well together to achieve objectives	55%	51%
q18c. Organisation ensure errors/near misses/incidents do not repeat	70%	67%
q19b. Would feel confident that organisation would address concerns about unsafe clinical practice	59%	56%

Bottom 5 scores vs Picker Average	CHFT	Picker Avg
q13d. Last experience of physical violence reported	62%	69%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	41%	44%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	54%	58%
q4d. Satisfied with opportunities for flexible working patterns	50%	53%
q9f. Immediate manager works with me to understand problems	64%	67%

Most improved scores	CHFT 2022	CHFT 2021
q2a. Often/always look forward to going to work	52%	45%
q21a. Received appraisal in the past 12 months	83%	77%
q22d. Feel supported to develop my potential	55%	49%
q3f. Able to make improvements happen in my area of work	54%	49%
q7b. Team members often meet to discuss the team's effectiveness	56%	51%

Most declined scores	CHFT 2022	CHFT 2021
q4c. Satisfied with level of pay	27%	33%
q19a. Would feel secure raising concerns about unsafe clinical practice	74%	76%
q3h. Have adequate materials, supplies and equipment to do my work	54%	55%
q7d. Team members understand each other's roles	70%	72%

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*Picker are CHFTs independent survey provider

Tables are based on absolute % differences, not statistical significance

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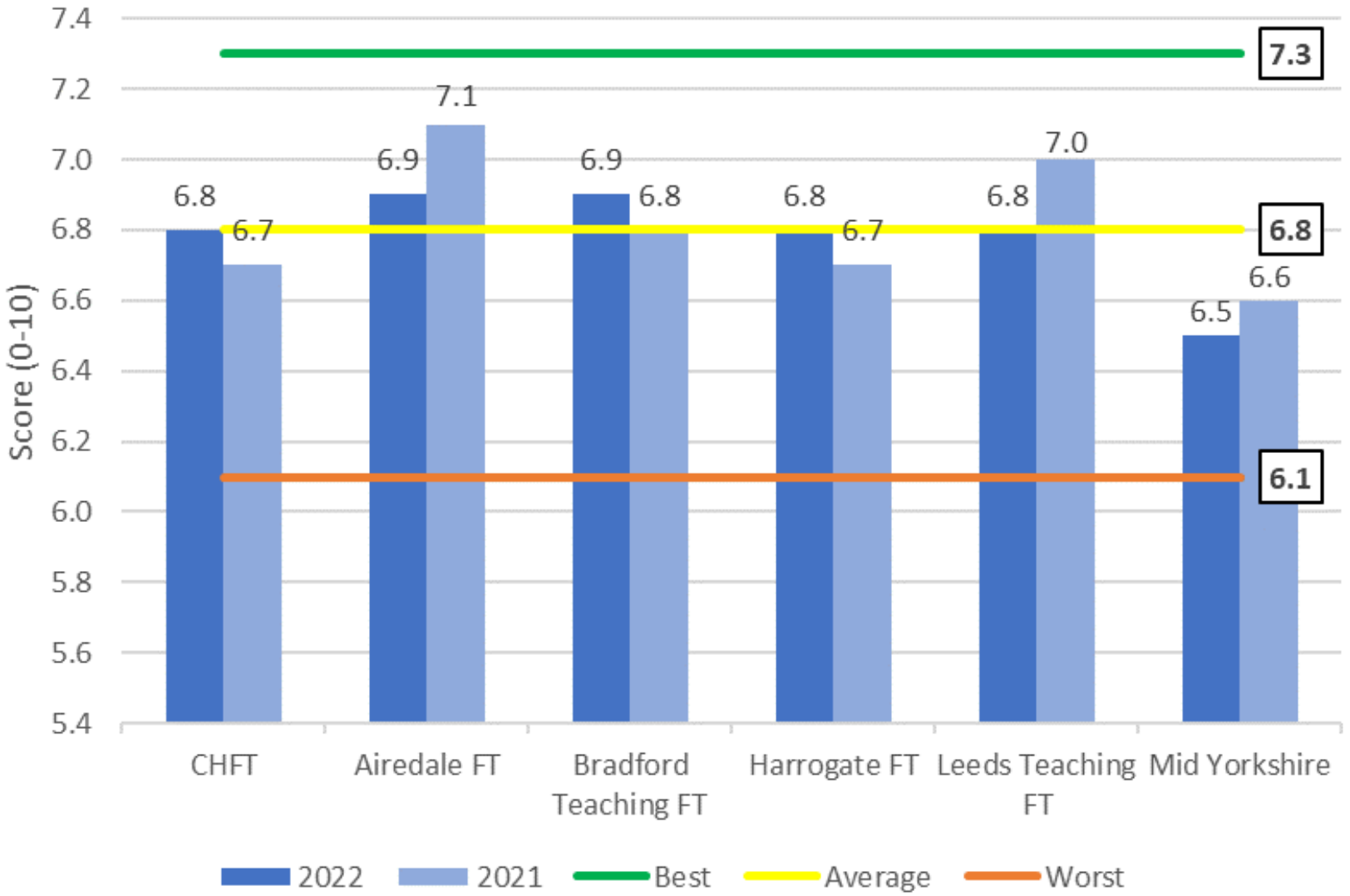
WYAAT Engagement Scores



West Yorkshire Association of Acute Trusts (WYAAT)

Staff Survey – Benchmark against NEY

Calderdale and Huddersfield NHS Foundation Trust

NEY People Promise Data

Element	NEY 2021	NEY 2022
We are compassionate and inclusive	7.3	7.3
We are recognised and rewarded	5.9	5.8
We each have a voice that counts	6.7	6.7
We are safe and healthy	6.0	6.0
We are always learning	5.4	5.4
We work flexibly	6.0	6.1
We are a team	6.6	6.7
Staff Engagement	6.8	6.8
Morale	5.8	5.8

People Promise Themes	CHFT 22	SSC AVG 22
We are compassionate and inclusive	7.3 (+0.1)	7.2 (=)
We are recognised and rewarded	5.8 (+0.1)	5.7 (-1)
We each have a voice that counts	6.8 (+0.1)	6.6 (-1)
We are safe and healthy	5.9 (+0.1)	5.9 (=)
We are always learning	5.4 (+0.3)	5.4 (+2)
We work flexibly	5.9 (+0.1)	6.0 (+1)
We are a team	6.6 (+0.1)	6.6 (=)

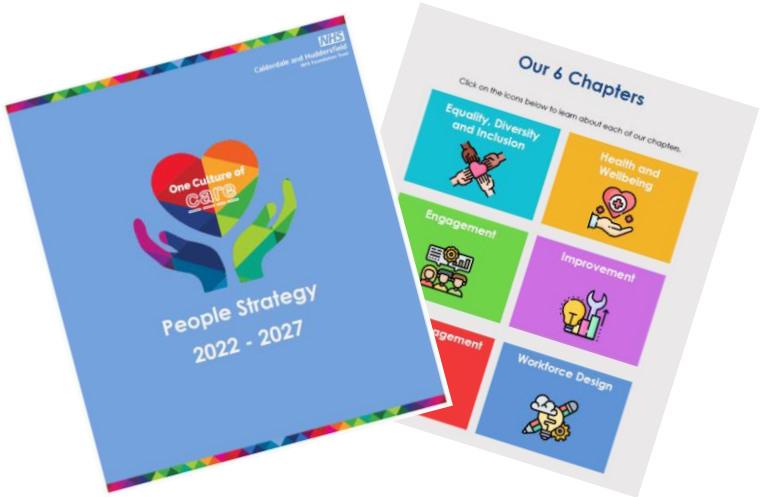
All our scores increased compared to NEY group only 2 elements increased.

What we have been focussing attention on in 2022

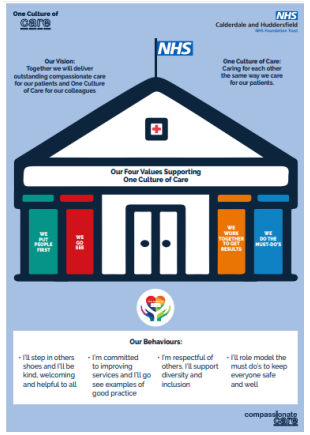
Calderdale and Huddersfield NHS Foundation Trust

Engagement goes from strength to strength with the Trust embracing OCOC.
Activity delivered 'with' rather than 'done to'.
OCOC is embedded in all people activities including a refreshed people strategy to respond to what colleagues were telling us.

- Call to arms – we're listening
- Bringing people together
- Refreshed People strategy
- Refreshed Values and Behaviours
- One Culture of Care Charters/Walls
- Succession Planning
- Leadership Development offer
- BIG CHuFT awards – showcasing our recognition and appreciation
- Appreciation Events
- Health and Wellbeing Festivals
- Equality Events
- Widening Participation offer
- Refreshed Appraisal
- OCOC embedded throughout the colleague journey



Refreshed People Strategy



Refreshed Values and Behaviours

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We Grow Our Own – CHFT Leadership Offer

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Talent Management

Calderdale and Huddersfield NHS Foundation Trust

Performance Management
- Appraisals
- Coaching and Mentoring

Development
- Development for All
- Leadership Development
- Future Leaders
- WTGR
- Level 5 & 7 Leadership Apprentices
- CPD Revalidation and EST

Engagement
- Health and Wellbeing Strategy
- OD Plan
- Staff Survey Plan
- Hot Houses
- Visibility Framework
- WTGR

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Recruitment
- Recruitment Strategy
- Values Based Recruitment
- Employment Access Points
- Induction
- Work Experience

Reward & Recognition
- CHuFT Awards
- Long Service Awards
- Appreciation Days
- Thank You Cards
- Benefits Package

Retention
- Benefits Package
- Appreciation Days
- Quality Conversations

Talent Pipeline / Succession Planning
- Talent Management Toolkit
- Shadowing Opportunities
- System BAME Fellowship
- Workforce Design Guides
- Coaching and Mentoring

Engagement – 2022 Staff Survey
Appraisal & Development

Calderdale and Huddersfield NHS Foundation Trust

Appraisal		CHFT 2022	CHFT 2021	Improvement
q21a	Received appraisal in the past 12 months	82.6%	77.1%	5.5%
q21b	Appraisal helped me improve how I do my job	20.4%	17.7%	2.7%
q21c	Appraisal helped me agree clear objectives for my work	30.4%	28.1%	2.3%
q21d	Appraisal left me feeling organisation values my work	33.5%	30.2%	3.3%

Development		CHFT 2022	CHF 2021	Improvement
q22a	Organisation offers me challenging work	70.6%	70.4%	0.2%
q22b	There are opportunities for me to develop my career in this organisation	52.0%	51.4%	0.6%
q22c	Have opportunities to improve my knowledge and skills	67.6%	63.8%	3.9%
q22d	Feel supported to develop my potential	54.9%	49.5%	5.4%
q22e	Able to access the right learning and development opportunities when I need to	55.8%	51.9%	3.9%

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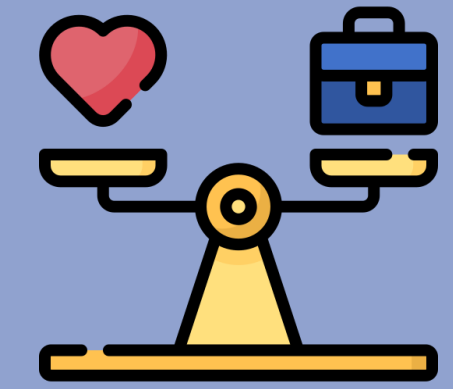
2023 High Impact Action Plan

Calderdale and Huddersfield NHS Foundation Trust

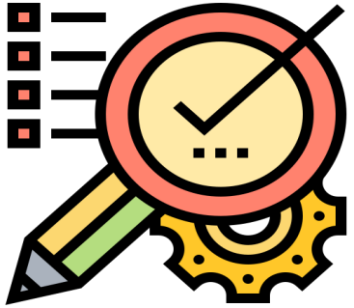
1. People Centred Leadership and Management Programme



2. Continue to evolve the Health and Wellbeing Offer

5. Hot spot management focus

4. Create a sense of togetherness across CHFT



3. Create a learning organisation, offering development opportunities for all

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Hot Spot Management

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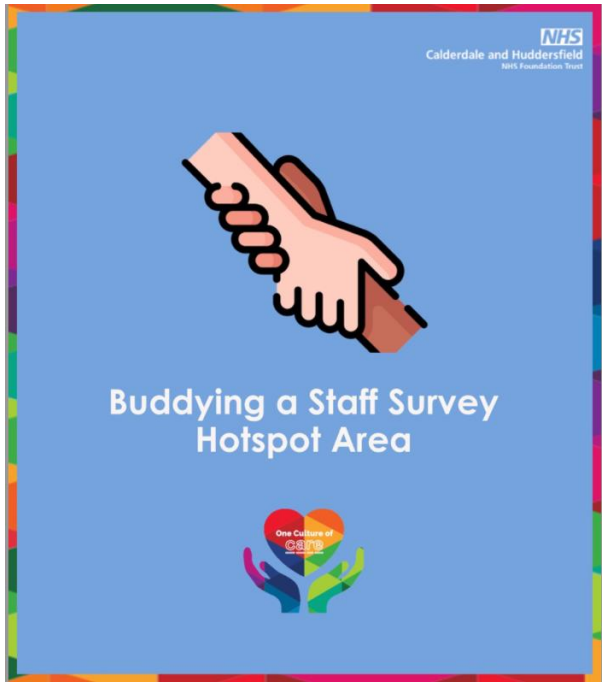
Staff Survey Hot Spot Management – Exec Buddies

Exec Buddy	Division	HRBP	Team
Gary Boothby and Kirsty Archer	Surgery	Alicia Webster	Operating Services (5.9 =) Orthopaedics (6 =) Surgical Divisional Support (7.3, down 0.5)
Lindsay Rudge and Vicky Pickles	Medicine	Lisa Whiteley	Emergency Care (6.2, down 0.1) Medical Divisional Management (7, down 0.4) Medical Specialties (6.4, lower than Trust AVG by 0.4)
Jonny Hammond David Birkenhead	FSS	Leigh-Anne Hardwick	Radiology (6.4 =) Pathology (6.4, lower than Trust AVG by 0.4)
Rob Birkett and Andrea McCourt	Community	Diane Marshall	Community Therapies (6.8, down 0.2)
Anna Basford	Corporate	Diane Marshall	Corporate Central Operations (6.1, down 0.1) Corporate Services (7.8, down 0.3)
Rob Aitchison	PMU	Diane Marshall	Pharmacy Manufacturing Unit (5.9, down 0.2)
Suzanne Dunkley	Cross Trust		High Impact Actions progress across Trust and specific support as requested by Directors for their buddy areas



So, in summary, your role as Buddy is to:

- Mentor and/or Coach the leaders and managers of the Hot Spot Area
- Support the development of a High Impact Action plan
- Share great ideas with other buddies
- Support the team to provide a progress update for Workforce Committee and Board in May
- Support the team to provide a progress update on delivered and embedded actions as part of the Trust wide communications and engagement plan for the launch of the 2023 staff survey

Hot Spot Management

- Executive Hot Spot Buddy
- Engagement Leads
- Action Plan Development
- Coaching, Supporting, Connecting
- Application of the Leadership Framework
- You Said / We Did campaign coordination
- Work Together Get Results/TED/One Culture of Care Charters
- Listening Events
- Dedicated Wellbeing Support

5. Hot spot management focus

Governance, Monitoring Progress and Gaining Assurance

Calderdale and Huddersfield NHS Foundation Trust

- Workforce Committee interrogation of progress against action plan
- Monthly discussion at divisional performance review meetings. Divisional Directors and Directors of Operations are responsible owners for making improvement for their staff survey results
- Shadow Board
- Engagement team collecting you said/we did output for the you said/we did promotional campaign
- Executive team visibility programme in line with key event ie Easter, Appreciation Events etc
- Team Engagement and Development diagnostic and work together/get results workshops analysis and performance reporting mechanism in place
- Care Club feedback

Board Response

- One Culture of Care – only show in town.
- Every Board member to be a sponsoring director for a hot spot area ie mentor, critical friend, working alongside the divisional teams and engagement leads
- Discuss progress at board meetings, what's working well/what's not working well and lean on each other for support.
- Share the message that the need to balance operational / financial challenges with the people experience challenge is more important now than ever
- Leadership conferences – this is a 'must do'. Call to arms. Work together to get results.

Summary

- We have received a positive response from colleagues after a challenging period
- Appreciation and development opportunities were well received and we will continue to focus attention on and widen the reach of our development offers
- We need leaders who role model One Culture of Care and the values and behaviours and the application of the leadership framework and enhancing management development programmes will support that
- We all need to pull together as one team and create a sense of belonging
- We need to show visible praise and recognition for one another
- We can learn from one another and shout about our success with buddies supporting the hot spot areas

Please click on the link below to access the full 2022 staff survey scores from a national and local perspective

https://www.nhsstaffsurveys.com/results/

KEEPING THE BASE SAFE

19. Guardian of Safe Working Hours Quarterly Report and (Annual Report - Review Room)

To Note

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	4th May 2023
Meeting:	Board of Directors
Title:	Q4 - Quarter report (1 December 2022 to 28 February 2023) from the Guardian of Safe Working Hours, CHFT
Author:	Dr Shiva deep Sukumar
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

To provide an overview and assurance of the Trusts compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern

Key Points to Note

1. Exception reports
2. Information about cover arrangements for out of hours rota gaps
3. Junior doctors strike

EQIA – Equality Impact Assessment

The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 Contract irrespective of any protected characteristics.

Recommendation

None.
Please note the contents of the report

GOSWH Quarterly report – 04.05.2023

Introduction:

The purpose of this report is to give assurance to the board that the doctors in the training are safely rostered and that their working hours are compliant with the Junior doctor's contract 2016 and in accordance with the Junior Doctors terms and conditions of service (TCS).

The report includes the data from December 2022 to February 2023.

Executive summary:

The trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software.

Most of the exception reports were related to extra hours of working. One was related to service support. There weren't any ER related to missed educational opportunities during this period. Most ER were submitted by FY1 doctors. All the ERs were resolved and closed on the Allocate system.

All our junior doctor rotas are fully compliant with the 2016 TCs. Rota gaps remain a challenge, when/where Health Education England don't provide a trainee, however a number of Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

Background Data:

Number of doctors / dentists in training (total): 260

Admin support is provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed, and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Safety concern raised through Exception Report:

There were no exception reports highlighting any safety concern for the period between December 2022 to February 2023.

Work Schedule reviews:

There were no work schedule reviews during this period.

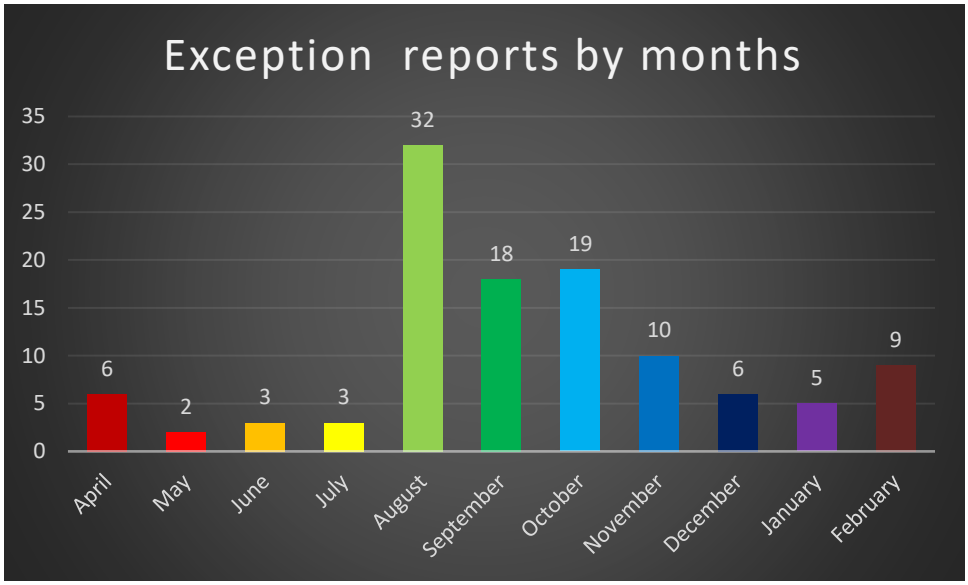
Exception reports details:

Total ER – 21

Distribution of exception reporting in relation to various reasons

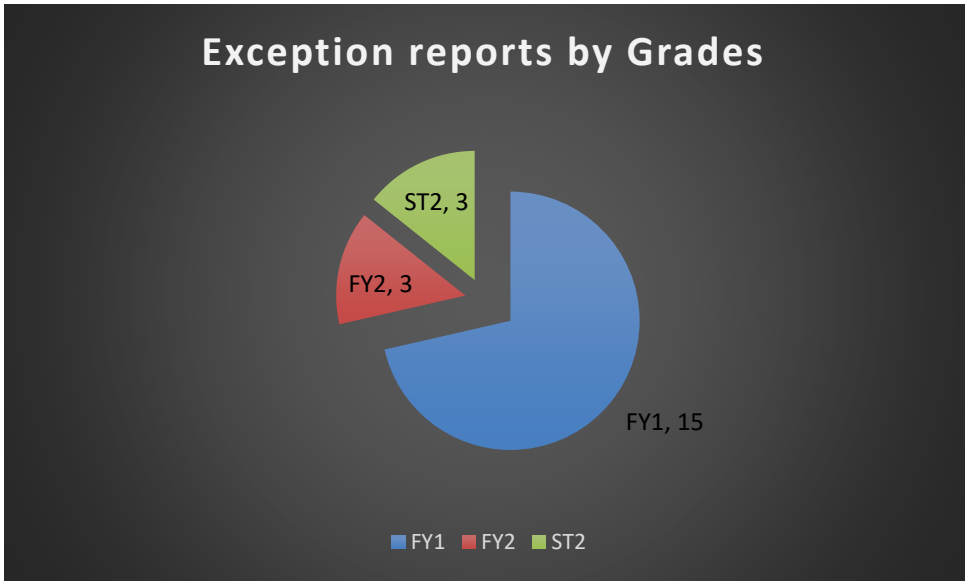
Out of these 21 reports, 20 were related to extra hours of working and 1 was related to service support.

Exception Reports from December 2022 to February 2023



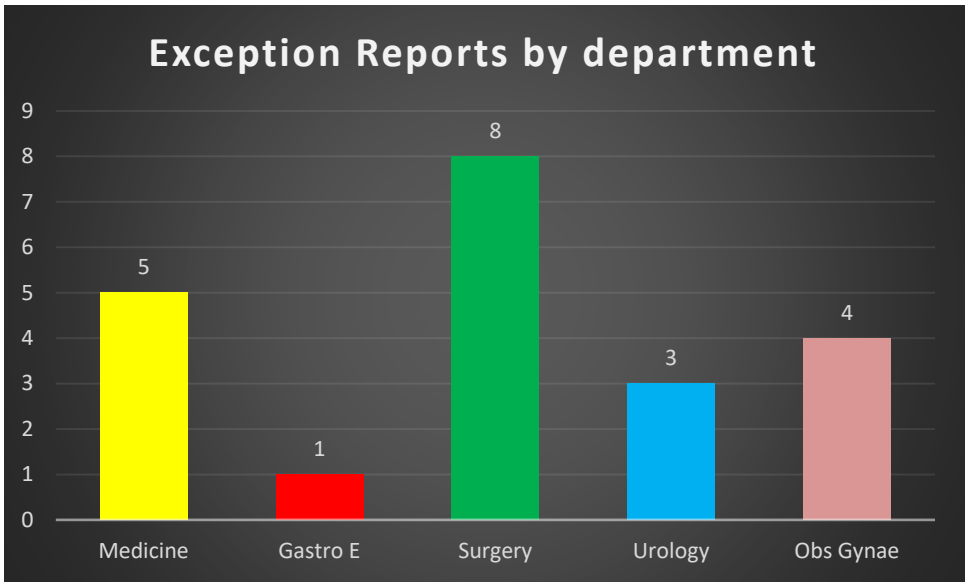
In total 21 reports were submitted. As we can see, the ER keeps decreasing from august 2022.

Exception report by Grades:



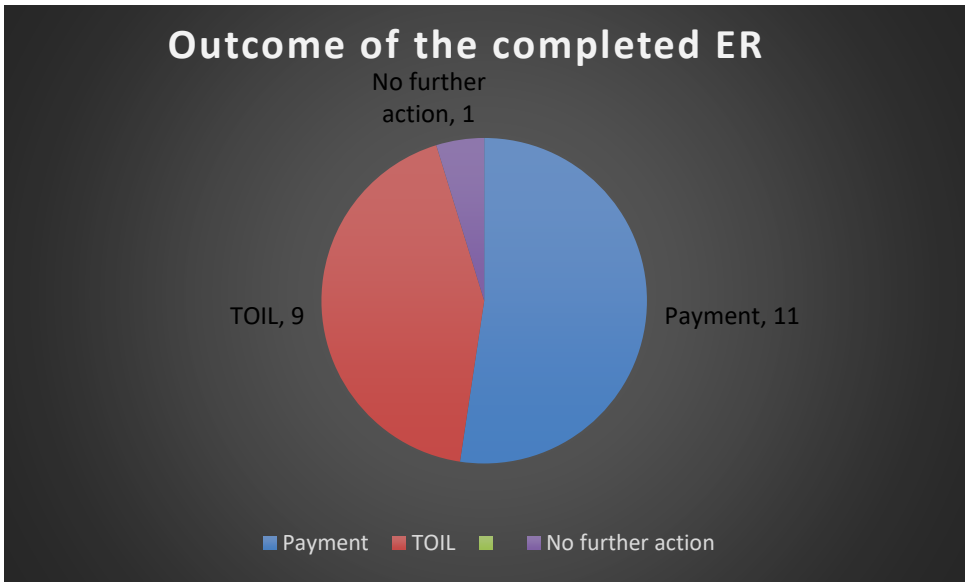
Most of the ER were from FY1 doctors. This is expected as the junior doctors are in the first year of working within the NHS and are still getting familiar with how the system works.

Exception reports by Departments:



We see that slightly more ER have been submitted in Surgery department. This has decreased when compared to the previous quarter.

Outcome of resolved exception reports:



All 21 ER were resolved and closed. Most were completed by payment and some by time off in lieu (TOIL).

Steps from last Board meeting:

In the last quarterly report, we discussed that there were a number of ER from within the general surgery department. I contacted the Divisional Director of Surgery and Anaesthesia and he provided assurance that the issues would be raised with his colleagues for awareness and to resolve issues, part particularly with those who are responsible for the rota. Since then, we see that the number of ER have decreased significantly in the surgery department.

Fines:

There haven't been any fines issued in last three months.

Other Salient ER investigation:

There was one ER submitted by a ST4 registrar from medicine department in the month of March. The doctor had to work in new hospital starting an out of hours on call without a formal induction and ID badge access. We investigated the concern raised and a remedial action plan has been put in place.

When the Trust has August, September and October changeover, the Trust will ensure that an induction is given at both sites and that badges are sorted for both sites.

Prior to the pandemic, the Registrars used to work a whole rota cycle at one site and then switch sites to start the on-call rota cycle there. This is going to be re-introduced.

Trainee Vacancies:

Data on Rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments.

As can be seen from the data held within ESR most of our training posts are filled currently.

	Dec-22			Jan-23			Feb-23		
Role	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE
Foundation Year 1	48.00	53.49	-5.49	48.00	53.49	-5.49	48.00	52.89	-4.89
Foundation Year 2	36.00	32.64	3.36	36.00	33.41	2.59	36.00	32.48	3.53
General Medical Practitioner	0.00	0.20	-0.20	0.00	0.20	-0.20	0.00	0.20	-0.20
Specialty Doctor	112.93	86.03	26.90	112.93	82.73	30.20	115.22	86.03	29.19
Specialty Registrar	140.76	134.21	6.55	139.76	134.71	5.05	139.76	135.58	4.19
GP Trainees - Trust Based (Specialty Registrar)	39.00	35.46	3.54	39.00	36.28	2.72	39.00	40.35	-1.35
Staff Grade (Closed to new entrants)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Trust Grade Doctor - Foundation Level	18.00	16.00	2.00	18.00	18.00	0.00	18.00	22.00	-4.00
Trust Grade Doctor - Specialty Registrar	26.94	36.62	-9.68	26.94	38.62	-11.68	26.94	35.62	-8.68
TOTAL	**422.63**	**395.65**	**26.98**	**421.63**	**398.44**	**23.19**	**423.92**	**406.14**	**17.78**

GP Trainees NOT based in the Trust have been excluded in this chart.
Details of GP Trainees Out in GP Surgeries:

Specialty GP Registrars
Dec22 - 83.40 FTE
Jan23 - 83.40 FTE
Feb23 - 78.98 FTE

Shifts covered by Bank and Agency:

Out of hours shifts on trainee rotas can arise for a number of reasons. As you can see from the table below, most shifts are filled with alternative cover.

Bank and Agency fill rates by division- December 2022 – February 2023			
	% Unfilled hours	% Filled Bank hours	% Filled Agency hours
FSS	8.17%	89.57%	2.26%
Medicine	13.08%	73.68%	13.24%
Surgery and Anaesthetics	9.83%	83.33%	6.84%

Industrial Action:

On Friday 24 February the British Medical Association confirmed that doctors in training along with locally employed doctors engaged on mirror terms and conditions would be undertaking industrial action for 72 hours commencing at 6.59am Monday 13 March through to 7am Thursday 16 March 2023. Additionally, the Hospital Consultants and Specialists Association confirmed strike action on Wednesday 15 March 2023.

The industrial action was confirmed as a full stoppage of work, with no derogations agreed locally or nationally during the strike period. In the event of a major unpredictable incident the Trust could call for doctors to return as long as the nationally agreed process was followed.

Whilst not obliged to inform the Trust about whether there was an intention to strike, many of our colleagues did let their operational management teams know so that plans could be put in place.

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

Additional strike action by the same eligible group happened for 4 days from Tuesday 11th April to Saturday 15th April 2023. The industrial action was again a full stoppage of work

Further details of the impact and how the industrial action was managed will be provided in the next Guardians report which covers March and April.

Other Updates:

Jeanette Clews has now resigned from the MEM role at CHFT and moved on to a new role at NHS Scotland.
We are in the process of recruiting for the role. In the interim Becky Colwill Deputy MEM is providing cover.

Post-Shift rest facilities:

It is challenging to always have rooms available due to reconfiguration and the removal of some of the buildings we may have used in the past. Gina Davies and her team do their upmost to monitor and provide rooms wherever possible.

A PDF giving information was formulated and been circulated to doctors in training and is held within the 'Doctors Toolbox' for reference. It is discussed at induction for the trainees as they tend to be less aware due to rotating frequently.

Regional GOSWH conferences and webinars:

I will be attending the two hours webinar on E-rostering delivered as part of enhancing junior doctors working lives (EJDWL) event hosted by NHS England on 25th April.

I will also be attending one day Yorkshire and the Humber Annual GOSWH meeting by HEE Health Education, England on 3rd May.

Summary:

The trainees here at CHFT all have Allocate accounts to enable them to raise an exception report if they work outside of their agreed rota, or there are any issues that they wish to escalate, including gaps in educational support.

The rotas that are in place are all fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed.

20. High Level Risk Report

To Approve

Presented by Victoria Pickles

Date of Meeting:	Thursday 4 May 2023
Meeting:	Public Board of Directors
Title:	High-Level Risk Report
Author:	Richard Dalton, Head of Risk and Compliance
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group

Purpose of the Report

The purpose of this report is to provide an overview of the risks scoring 15 or above.

Key Points to Note

Introduction
Since the last meeting the pilot work with SAS has supported the development of a separate risk policy that has been presented at Audit and Risk Committee on the 25/04/2023. A plan has been developed to review all risks scoring 15 and above by the end of May 2023 within the organisation, with further work to review all risks over the next six months. Training will be delivered to face to face for senior management teams and there is a plan to produce a training video for staff to access via the risk management intranet site.

Current risk process and position
The Trust manages and documents risk using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented on the electronic risk register, is considered in detail by the appropriate department and governance structure. All the appropriate information surrounding the risk is documented including all mitigating actions to ensure the safety of patients and staff is maintained. The Trust uses the information to learn and develop as an organisation. As such each risk has an action plan developed to manage the risk of the risk register. All risks are reviewed monthly at the Risk Group.

Currently there are 57 risks that rated as high (40) and very high (17). There has been 1 new risk added; 0 have had their risk score reduced; and 8 have had their risk score increased.

Each risk is aligned to one of the Trust's strategic objectives. Against each of these objectives the current risks scoring very high (20-25) are on the following themes:

- Transforming care:
  - The surgeons and theatre capacity to operate on patients that have suffered a fractured neck of femur within 36 hours of presenting to the hospital in 85% of all cases.
  - The capacity of the pharmacy department in relation to the British Oncology Pharmacy Association (BOPA) standards

- Keeping the base safe
  - There are several risks relating to staffing and vacancies in medical, nursing and therapy posts across a range of services including the emergency department, maternity,

paediatrics, and radiology. Risks describe the Trust's ability to meet the care hours per patient day and delays for induction of labour.
- Risks to meeting targets and waiting times including emergency care standard, Percutaneous Coronary Intervention (PCI) and angiogram waiting times, and national radiology targets.
- There is a risk to the Fluoroscopy service due to age of the equipment.
- There is a risk due the capacity available to validate outpatient appointments

Themes of risks scoring high (15-16) are:

- Sustainability
  - Financial plan; funding related to increasing activity to clear the backlog from covid as per the national target.

- Transforming care
  - Digital systems – both the use of and business continuity
  - The provision of play therapy to support the whole organisation
  - The workforce capacity within the ultrasound department to meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
  - Workforce capacity to meet the needs of individual care for the most vulnerable care
  - Medical cover for maternity assessment centre
  - Scanning capacity for rescanning within maternity

- Keeping the base safe
  - The number of referrals into services; appointment availability; level of unplanned and emergency care activity; demand on inpatient capacity; lack of theatre capacity to meet recovery plans; support for mental health patients; health inequalities because of the elective recovery and follow up back log.
  - The provision of plain film radiology due to age of equipment.
  - Point of care staffing capacity
  - Training requirements for staff in the use of digital services
  - The provision of pharmacy within ICU
  - The maintenance of the asset management log
  - Senior nursing leadership cover with children's/ neonatal services
  - Fire safety
  - Medication storage on ward 9

- Workforce
  - ICU well being of staff

These risks reflect the key areas of challenge reflected in the board agenda today and align to the strategic risks set out on the Board Assurance Framework.

Future development work
A deep dive of all risks has been completed within the organisation. The report has set out the actions to review all risks scoring 15 and above by the end of May 2023. The risks will be updated in line with the updated risk policy presented at Audit and Risk Committee on 25/04/2023 and on the agenda for this Board meeting. Alongside this, a new IT system is being reviewed to ensure new Patient Safety Incident Reporting Framework (PSIRF) requirements are met, whereby risks and serious incidents will be brought together so that learning can more easily be identified and shared.

EQIA – Equality Impact Assessment

Risks are assessed considering any impact on equality.

Recommendation

The Board is asked to **CONSIDER** and discuss the high-level risk report and note the ongoing work to strengthen the management of risks.

21. Fire Strategy 2021-2026

Presented by Jonathan Hammond

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	4 May 2023
Meeting:	Board of Directors
Title:	Fire Strategy
Author:	Keith Rawnsley, Trust Fire Officer
Sponsoring Director:	Jonny Hammond, Chief Operating Officer
Previous Forums:	Supporting Information has been shared with the Fire Committee during 2022/23

Purpose of the Report

The paper provides the Board with a progress report on the delivery of the Trust's Fire Strategy which was agreed by the Board in March 2021 and runs until 2026.

Key Points to Note

- The Trust Board has a Board approved five year Fire Strategy in place that captures the recommendations made by Mott MacDonald who produced the Strategy. This was approved in 2021 and to date is the second year of implementation. The Fire Strategy is available in the Review Room.
- Different priority scores have been agreed, so a more realistic outcomes are achievable.
- One hundred and one actions raised across all premises, 25 actions in progress, 75.25% completed
- Detailed reports of the external façade are being drawn up, for each building, this accounts for 10 of the outstanding actions, this is following on from the Grenfell Tower incident. The new fire safety regulations 2022, which came into force on the 23 January 2023, this required additional information to be made available for the Fire Service, which is being added to the façade information, hence causing a slight delay.
- Compartmentation, an audit of HRI and other Trust owned buildings is taking place to assess the work required. Once this information is available and costed this will then give the Trust information of what is required and where within the hospital.
- Whilst ICU (ward 1) was being refurbished an opportunity arose to improve the fire compartmentation and these works were completed.
- Design work and a feasibility study is in progress to address the lack of smoke clearance on the sub-basement of ward block 1.
- Work on the lifts at HRI has started.

- The Fire Strategy has been taken to the Health and Safety Committee and the disability group have also had opportunity to comment on the document
- The number of actions by site are detailed below with further. Some of the actions are not easily resolved and a detailed survey is underway in order to understand the extent of the compartmentation requirements Awareness of the compartmentation issues and taking opportunities to improve the standard when possible is noted on the risk register, risk reference 7413.

Site	Actions	Actions in Progress
Acre Mills Out Patients	10	1
Acre Mills Workforce Building	12	3
Beechwood Medical Centre	13	3
Broad Street Plaza	13	3
Unit 18 Records Store	4	1
CRH	8	4
Loan Store & THIS	2 complete	
HRI	11	6
Park Valley Mills	11	1
Huddersfield Pharmaceuticals Service	6	2
Spring Cottage Nursery	6	1

- Resolving requirements would then involve access (decanting areas) and financial support. Improvements have been made in relation to compartmentation, however risk of fire spread remains due to the legacy of the age of the building. Remaining issues with compartmentation will be fully understood once we have had the survey completed. The draft report is expected at the end of April 2023.

  To note, reconfiguration directly links to addressing legacy issues such as external cladding and decanting of wards to allow compartmentation work. Regular checks are completed on the existing cladding for structural purposes. If there are delays in reconfiguration capital build, there is an impact on resolving these issues.

  The smoke extraction survey and detailed design work to enable smoke extraction within the sub-basement HRI is complete (smoke venting was not required when the building was built). Proceeding with these works is also linked to progression of reconfiguration plans and so risk remains in relation to speed of fire spread within the sub-basement. There is potential for increased costs of resolving the above issues if there is a delay to the reconfiguration programme.

EQIA – Equality Impact Assessment

An Equality Impact Assessment has been completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.The equality impact for specific actions arising will be assessed, considered, and mitigated as appropriate.

Recommendation

The Board is asked to **NOTE** the content of the report and continue its support for the Fire Strategy implementation.

22. Risk Management Policy

To Approve

Presented by Victoria Pickles

Date of Meeting:	Thursday 4 May 2023
Meeting:	Public Board of Directors
Title:	Risk Management Policy
Author:	Richard Dalton, Head of Risk and Compliance
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group / Audit and Risk Committee

Purpose of the Report

The purpose of this report is to present the revised risk management policy for ratification by the Board.

Key Points to Note

The Trust previously had a Risk Management Policy and Strategy. It has been decided to separate these out into individual documents to make it easier for colleagues across the Trust.

The Policy, approved by the Audit and Risk Committee is presented to this meeting for ratification, as the Risk Management Policy is one of the documents reserved to the Board. The Strategy is in development and will go to the Audit and Risk Committee in July.

The Audit and Risk Committee asked for the following amendments to be made to the document in addition to those changes set out in the tracking on the front of the policy:

- Include reference to the five-year strategic plan and one year plan – included at p4
- Update the behaviours and objectives to reflect the revised versions – included at p4
- KPIs – update the metrics – have included an update as to how these will be monitored and reference to an update to these being managed within the risk management team – p21
- Update the governance chart – rather than including the governance chart within the document, have added the link to the document on the intranet so that this is being updated in one place – p8

Subject to these amendments, the Audit and Risk Committee approved the document for ratification by the Board.

EQIA – Equality Impact Assessment

The equality impact assessment for the policy is completed in section 17 of the policy.

Recommendation

The Board is asked to **RATIFY** the Risk Management Policy and **NOTE** that a separate Risk Management Strategy will be developed and brought to a future Board meeting.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Facilities Management

RISK MANAGEMENT POLICY

Version 6
2023 - 2024

Document Summary Table		
Unique Identifier Number		
Status	Final	
Version	6	
Implementation Date	May 2023	
Current/Last Review Dates	January 2022	
Next Formal Review	May 2024	
Sponsor	Director of Corporate Affairs	
Author	Assistant Director of Quality and Safety, Head of Risk and Compliance	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Audit and Risk Committee		April 2023
Executive Board		April 2023
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk Group	Assistant Director of Quality and Safety	March 2023
Divisional meetings	Assistant Directors of Nursing	March 2023
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 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 Risk Appetite Statement to September 2021 Version

	Change reference of high-level risk register to risks identified only by their scoring e.g. 15+ The creation of a separate risk policy and strategy Identification of a risk challenge meeting Terms of reference for risk challenge meeting Flow diagram for the process of managing risks

CONTENTS

1. Overview

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.

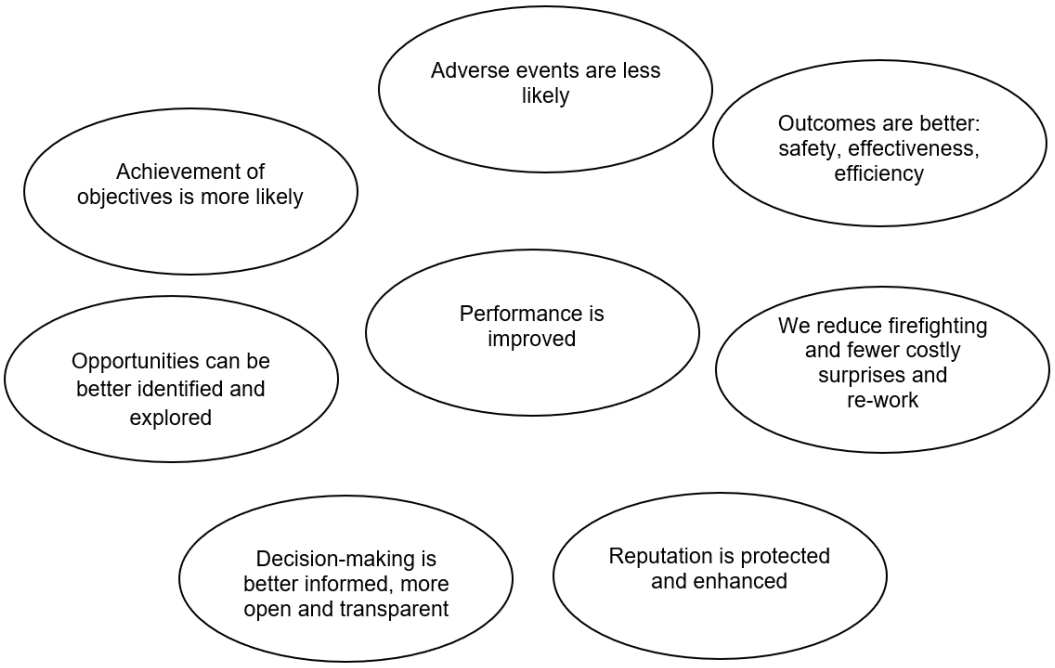
Risk Management is an integral part of CHFT's management activity and is a fundamental pillar in embedding high quality, sustainable services for the people CHFT serves. As a large and complex organisation delivering a range of services to a diverse population in a challenging and ever-changing health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

2. Benefits of Managing Risk

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



3. Scope

The 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 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

4. Vision and Statement of Intent

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

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

Our strategic objectives to deliver this aim are to:

- Transforming services and improving population outcomes
- Keeping the base safe – best quality and safety of care
- Inclusive workforce and local employer
- Financial, economic, and environmental sustainability

The five-year strategic plan and one-year strategic objectives have recently been reviewed and published on the Trust's website, which sets out in detail the key areas of work beneath these objectives. This policy sets out how the Trust will identify the risk to the delivery of these strategic objectives and the day to day running of the organisation.

The way we work

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

- We put patients and people first
- We go see
- We work together to get results
- We do the 'must dos'
- We care for ourselves and each other in the same way we care for our patients through 'one culture of care'

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.

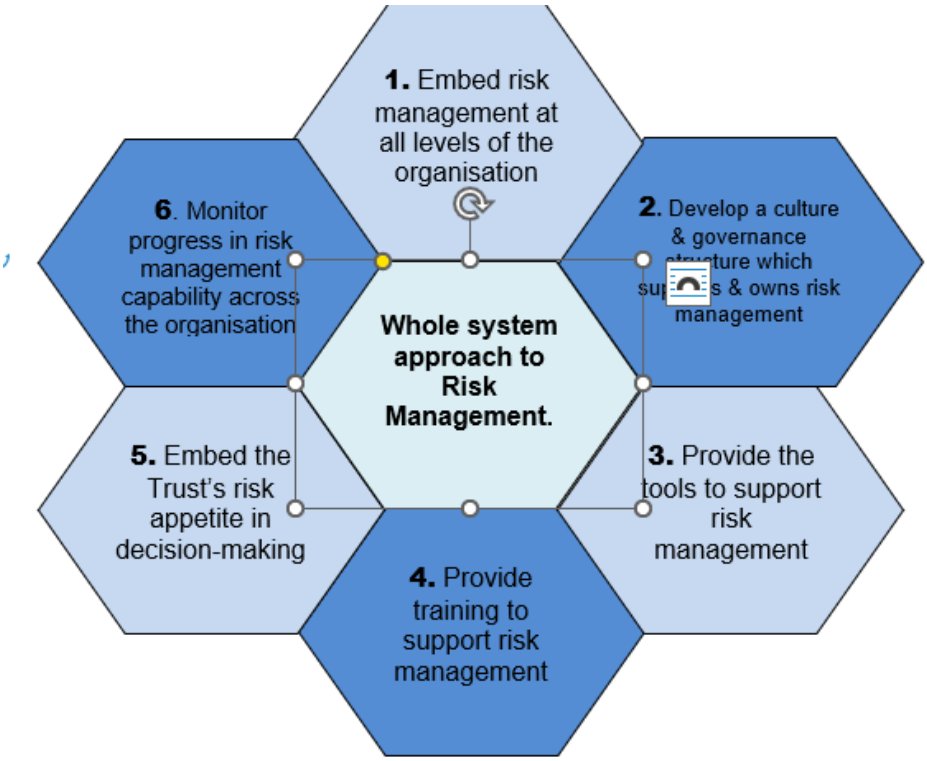
The process of risk management is an integral part of the Trust Board's system of internal control for identifying and managing risks which may threaten the ability of CHFT to meet its strategic objectives and its effectiveness is reviewed annually by internal and external auditors.

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 Risk Register provide a central record of how CHFT is managing its highest risks. (15 and above)

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 Policy

CHFT's Risk Management policy 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 Policy the following objectives have been devised and CHFT will endeavour to ensure that they are applied through its procedures and systems. CHFT will also ensure that it monitors compliance with its Risk Management 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. Risk Management

Definitions of Risk and Risk Management

A risk is an uncertain event or set of events that should it happen will influence 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 available on the Trust intranet CHFT Structure Charts - CHFT Intranet (cht.nhs.uk).

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 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 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
Chief Nurse 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. Director of corporate affairs facilitates the risk groups meetings.	• 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 responsibilities, 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
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
Chief Digital information officer The Chief digital information officer 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: -

- **Chief Nurse 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.

- **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 the management team includes an Associate Director of Nursing, 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, therapy service managers, Pharmacy, Heads of Nursing, matrons, ward managers, and all 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 several specialists employed by CHFT. Further details on these roles can be found in Appendix 3.

Role	Responsibility
Caldicott Guardian – Deputy Medical Director Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Director of Corporate Affairs Company Secretary	Strategic Risks Foundation Trust risks
Executive Director of Nursing director of midwifery	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Director 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, 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 Management and Investigation Group 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 the electronic risk management system and externally to the Health and Safety Executive (HSE) via the HSE link.

Incident investigation methodology (linked to PSIRF) used throughout CHFT provides 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, starting 2024.

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 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.

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 risks, (15 and above) 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 risks scoring 15 and above 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. All risks are recorded on the register system, using the risk grading matrix detailed at Appendix 6. Ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, risk type, division, directorate, and team. All risks are linked to strategic objectives.

It is the responsibility of each division to maintain and monitor their divisional risks and ensure risks with a current score of 15 and greater are reviewed at a divisional level and reported bi- monthly to the Risk Group for oversight, Risk scoring 15 and above are reported CHFT Board three times a year via Audit and Risk Committee

The flow chart in Appendix 8 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 several 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 risks 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 the division risk meeting – If meeting target/residual, only need reviewed at least every six months by division. – If not at target/residual risk, then reviewed at directorate meetings
8 - 12	Medium Risk	– New Medium Risks reviewed at divisional risk meeting which can either: approve, escalate or de-escalate and include explanation. – Existing medium risks reviewed every other month by the division.
15-16	High Risk	– Division to present to Risk Group and 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 – Monitor at each Risk Group meeting or by expectation at PRM /WEB
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 Risk Group, on behalf of the Audit and Risk Committee and Board, oversees the high scoring risks (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 the risks, 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 and notes organisational risks by exception

Risks from divisions are overseen and scrutinised through the divisional risk meeting. They are reviewed to ensure that risks within the division and their directorates are captured. Risks of a score of 15 or above are reviewed at a divisional level and reported bi - monthly to the Risk Group for oversight

The Executive Team will be informed by the divisional lead of any new risks scoring 15 or above arising outside of risk group reporting via WEB

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.

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 is reviewed at divisional risk 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.

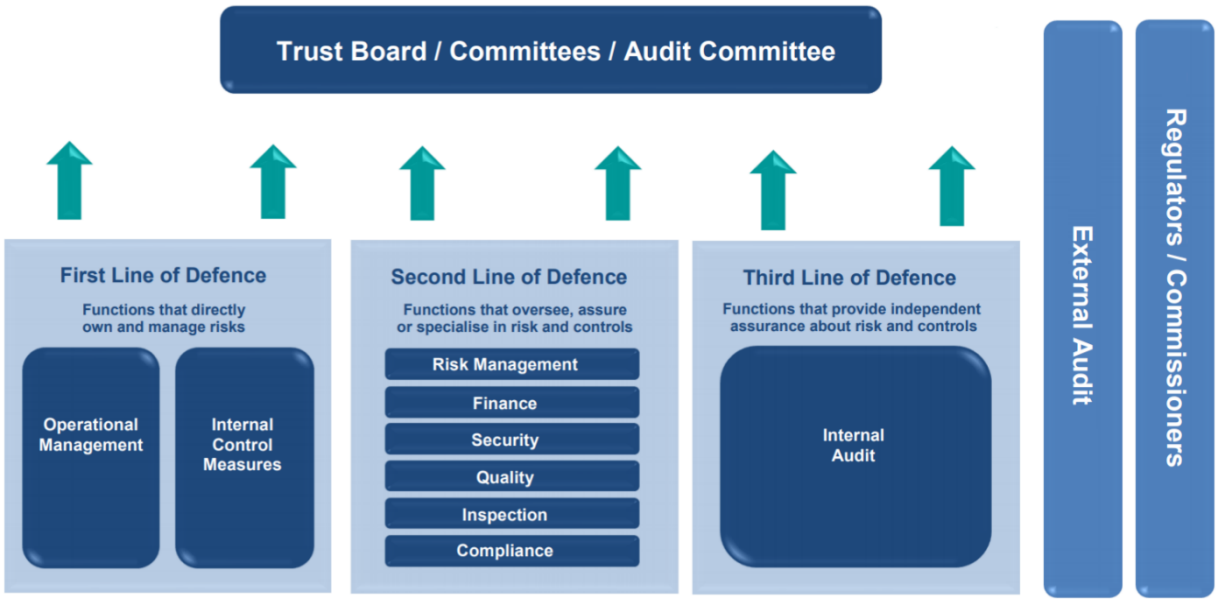
The first line of defence contains operational functions that directly own and manage risks. CHFT's first line of defence constitutes teams and managers in operational or service delivery functions and in support functions.

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. Risk Management Training

Risks may be identified pro-actively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled, and consistently documented the following risk management tools are in place:

a) Risk Register

The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training

Training is required to effectively manage risks in line with the process set out above. Regular Risk Register training sessions are offered monthly 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 as part of the Governance structure and formal meetings of Committees of the Board – Identified through Audit
- Risks of ≥15 are reviewed by the Risk Group, with risks of 12 also reviewed when requested by divisions – Identified through audit
- Local risk registers are in place, maintained and available for inspection at ward/departmental level – Identified through audit
- 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 – Identified through Audit

Compliance with the above process will be monitored by the Director of Corporate Affairs, Assistant Director of Quality and Safety and will be subject to audit and reported within an annual report submitted to the Audit and Risk Committee.

Further KPIs will be identified and managed through the Risk Management Team.

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 will review risks scoring 15 and above on the risk register 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 - April 2023

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

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.

Director of Corporate Affairs
The Director of Corporate Affairs 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
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 risks scoring 15 and above
- 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 4

Risk Register Guidance - Risk Description

Describing Risk and Assigning Controls

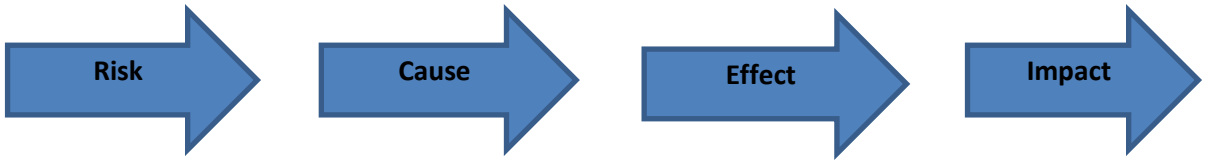
Risks are described in a clear, concise and consistent manner to ensure common understanding by all (including the public) with acronyms spelt out in the first instance. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of 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 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 5

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 6

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

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Staffing & Competence	Short term low staffing level (<1 day) – temporary disruption to patient care Minor competency related failure reduces service quality <1 day	On-going low staffing level - minor reduction in quality of patient care Unresolved trend relating to competency reducing service quality 75 % staff attendance at mandatory / key training	Ongoing low staffing resulting in moderate reduction in the quality of patient care Late delivery of key objective / service due to lack of staff Error due to ineffective training / competency 50% - 75% staff attendance at mandatory / key training	Loss of key staff Uncertain delivery of key objective / service due to lack of staff Serious error due to ineffective training and / or competency 25%-50% staff attendance at mandatory / key training	Loss of several key staff Non-delivery of key objective/service due to lack of staff Critical error leading to fatality due to lack of staff or insufficient training and / or competency Less than 25% attendance at mandatory / key training on an on-going basis
Business/ Service Interruption	Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	Short term disruption, of >8 hours, with minor impact	Loss / interruption of >1 day Disruption causing impact on patient care Non-permanent loss of ability to provide service	Loss / interruption of > 1 week. Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Temporary service closure	Permanent loss of core service / facility Disruption to facility leading to significant 'knock-on' effect across local health economy Extended service closure
Inspection/ Regulatory Compliance/ Statutory Duty	Inspection/ Regulatory Compliance/ Statutory Duty Small number of recommendations which focus on minor quality improvement issues Minimal breach of guidance / statutory duty Minor non-compliance with standards	Single failure to meet standards No audit trail to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	Challenging recommendations which can be addressed with appropriate action plans Single breach of statutory duty Non-compliance with > one core standard	Enforcement action Multiple breaches of statutory duty Improvement Notice Trust rating poor in National performance rating Major non-compliance with core standards	Multiple breaches of statutory duty Prosecution Severely critical report on compliance with national standards Zero performance rating Complete systems change required

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse Publicity / Reputation	Rumours Potential for public concern	Local Media – short term – minor effect on public attitudes / staff morale Elements of public expectation not being met	Local media – long term – moderate effect – impact on public perception of Trust & staff morale	National media <3 days – public confidence in organisation undermined Use of services affected	National / International adverse publicity >3 days. MP concerned (questions in the House) Total loss of public confidence
Financial	Small Financial loss < £1K	Loss <£1k - £50K	Loss of £50K - £500K	Loss of £500K - £1M	Loss > £5M
Fire Safety/ Security Management	Minor short term (<1day) shortfall in fire safety system. Security incident with no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) Security incident managed locally Controlled drug discrepancy – accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety Loss of vulnerable adult resulting in major injury or harm Major controlled drug incident involving a member of staff	Failure of multiple critical components of fire safety system (high risk patient area) Infant/young person abduction Loss of vulnerable adult resulting in death
Complaints/ Claims	Informal / locally resolved complaint Potential for settlement / litigation <£0.1 million	Overall treatment / service substandard Formal justified complaint (stage 1) Minor implications for patient safety Claim >£0.1 million	Justified complaint (stage 2) involving lack of appropriate care Potential for independent review Moderate implications for patient safety Claim(s) between £10K - £500K	Multiple justified complaints Findings of Inquest suggesting poor treatment or care Non-compliance with national standards implying significant risk to patient safety Claim(s) between £500K - £1M	Multiple justified complaints Single major claim Ombudsman inquiry Totally unsatisfactory level or quality of treatment / service Claims >£1M

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.

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:

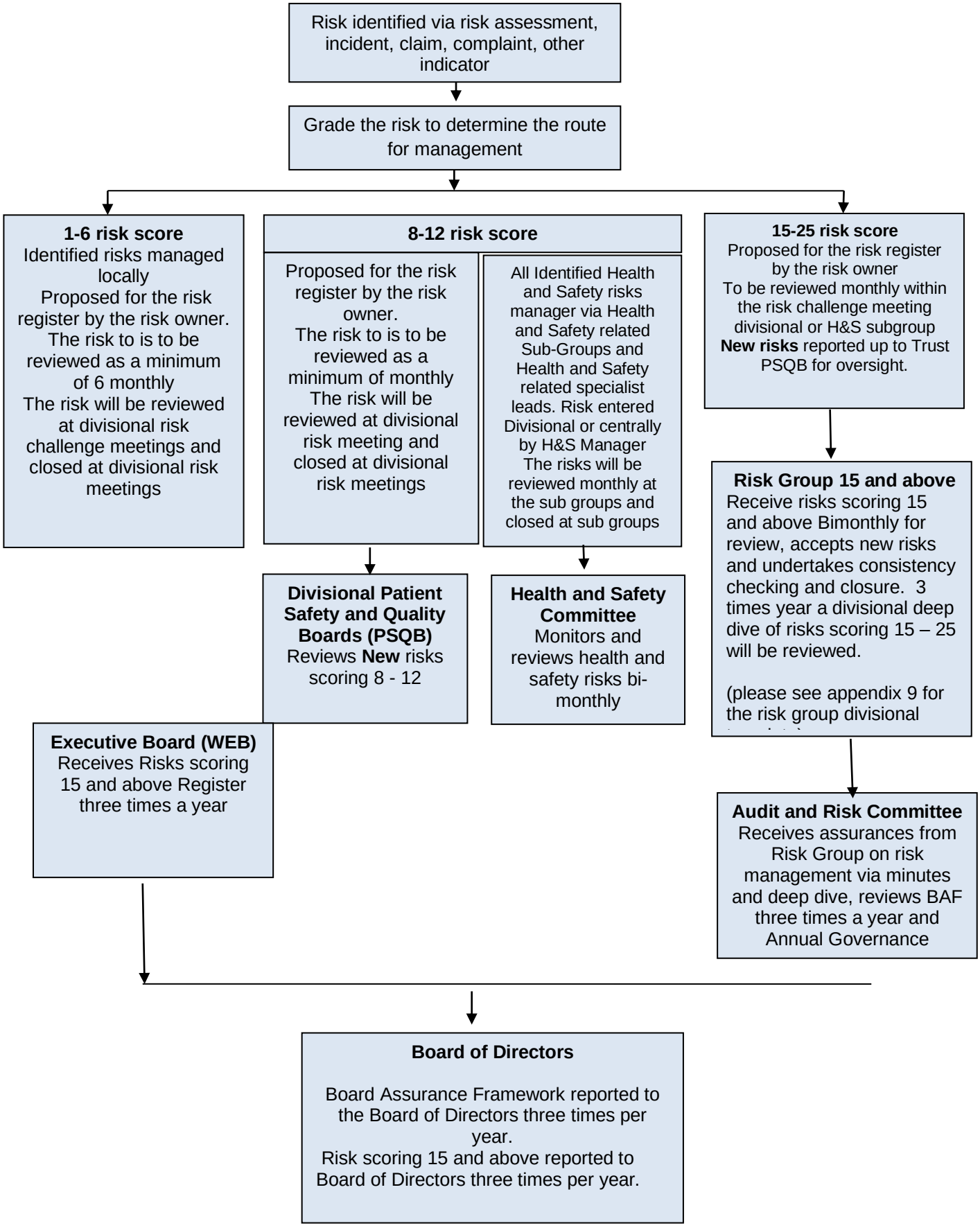
1 - 6	Low Risk
8 - 12	Medium Risk
15-16	High Risk
20 - 25	Very High

APPENDIX 7

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 8


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
Proposed for the risk register by the risk owner.
The risk to is to be reviewed as a minimum of 6 monthly
The risk will be reviewed at divisional risk challenge meetings and closed at divisional risk meetings
8-12 risk score
Proposed for the risk register by the risk owner.
The risk to is to be reviewed as a minimum of monthly
The risk will be reviewed at divisional risk meeting and closed at divisional risk meetings
All Identified Health and Safety risks manager via Health and Safety related Sub-Groups and Health and Safety related specialist leads. Risk entered Divisional or centrally by H&S Manager
The risks will be reviewed monthly at the sub groups and closed at sub groups
15-25 risk score
Proposed for the risk register by the risk owner
To be reviewed monthly within the risk challenge meeting divisional or H&S subgroup
New risks reported up to Trust PSQB for oversight.
Divisional Patient Safety and Quality Boards (PSQB)
Reviews New risks scoring 8 - 12
Health and Safety Committee
Monitors and reviews health and safety risks bi-monthly
Risk Group 15 and above
Receive risks scoring 15 and above Bimonthly for review, accepts new risks and undertakes consistency checking and closure. 3 times year a divisional deep dive of risks scoring 15 – 25 will be reviewed.
(please see appendix 9 for the risk group divisional
Executive Board (WEB)
Receives Risks scoring 15 and above 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.
Risk scoring 15 and above reported to Board of Directors three times per year.

Appendix 9

Risk Challenge Meetings TOR

Membership

- Clinical Director or deputy (with exception of community services)
- Associate director of Nursing or deputy
- Director of operations or deputy
- Assistant director of therapies or deputy (for community division only)
- Quality divisional lead
- (Risk Team on request)
- Risk owners

Frequency of meetings

Monthly or at least 8 times a year and can be held within other meetings for example PRN, PSQB.

Duties

- Review the description of risk matches the risk assessment
- Review the Gaps
- Review the Controls and mitigations
- Reviews and ensures there is evidence to support the risk
- Ensures there is measurable data to assess the impact of the risk score (number of times there has been an incident/ frequency or rating of the incident eg an SI)
- Review the action plan to deescalate the risk with designated points identified in the action plan when the risk score would be reduced.
- Ensures that appropriate escalation to trust PSQB and risk group if a new or escalating risk is identified
- Reviews the risk dashboard for compliance with review of risks in a timely manner
- Ensures there is appropriate evidence to close risks

23. Health and Safety Policy Annual Workplan and CHFT Health & Safety Policy

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	4th May 2023
Meeting:	Public Board of Directors
Title:	Health and Safety Annual Work plan, CHFT General Health and Safety Policy
Author:	Richard Hill, Head of Health and Safety
Sponsoring Director:	Suzanne Dunkley, Director of Workforce
Previous Forums:	CHFT Health and Safety Committee

To receive – to discuss for comment and approval.

Purpose of the Report

To inform Board members of the content of the annual health and safety work plan and to inform the Board members of the content of the CHFT General Health and Safety Policy

Key Points to Note

Approval of the H&S Policy by the Audit & Risk Committee on 31 January 2023.

The Annual Health and Safety Work Plan

- Provides 17 key actions being taken to maintain compliance across CHFT, also
- Provides timescales for the completion of the actions.

The CHFT General Health and Safety Policy

- Simpler and clearer descriptions of roles and responsibilities.
- Cross reference to the new CHFT health and safety dashboard.
- New risk added to the policy, equals Ligature hazards within clinical areas.
- New CEO signature added to the statement of intent

EQIA – Equality Impact Assessment

The Trust's approach to compliance plays a key role in reducing risk to all colleagues including those with additional needs . The Policy and Work Plan has been written to ensure they do not disadvantage individuals or groups negatively.

Recommendation

The Board is asked to receive the attached Annual Health and Safety Action Plan, CHFT General Health and Safety Policy.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Annual Health & Safety Work Plan - 2023 to 2024yr

Ref	Action	Progress	Up to April 23'	May-Aug 23'	Sept-Dec 23'	Jan-March 24'
1	To support the clinical teams to reduce the risk of patient ligature attempts. Ligature point risk assessments and ant-ligature training is needed	Crica of fifty risk assessments have been completed by ward managers. Circa 1000 front-line colleagues have been provided with training. Ligature release kits have been supplied across wards. This initiative is now finished. In terms of ligature risk across the community sites, having visited, it was realised that there is no resource to have supervision in place for patients using the toilets, although ligature release kits have been provided. Reviews to take place on annual basis	X			
2	To develop place-based health and safety risk assessments for all non-clinical areas.	Place based risk assessments have been completed in all clinical and non-clinical areas and a register is kept on file Review to take place annually or sooner if accidents/refurbishment/legislation changes.	X			
3	To develop a display screen workstation assessment and share with colleagues	The risk assessment tool is developed and ready and will now be shared with office relevant colleagues.	X			
4	To identify trends and patterns of incidents with view to putting in interventions	Sharps injuries project nearing completion, with engagement with IPC. An action plan has been produced and includes a review of the ANTT training, attendance at stakeholder meetings, poster developed. Roll out plan of the poster campaign planned. Daniels healthcare audit completed on sharps bins and four key messages agreed and to be shared in the poster, vial hard copies and intranet screen shot. Slips, trips, and falls compliance continues to be given a focus with some actions with Estates to ensure they review their current due diligence in place for cleaning and winter weather grounds. Moving and handling due diligence continues to be given focus with current measures working Reviews to take place across the year, including awareness campaigns	X X			
5	To complete the requirements of 2021 DGSA annual audit requirements which is conducted by an Authorised Engineer on behalf of CHFT in December 2021	The audit actions are on hold due to resource issues in CHS Ltd because 80% of actions are security/environmental/health and safety led by that team. Due to sickness/leavers, this project is on hold until CHS ltd seek a back-fill.		X		
6	To continue the development of the NHS workplace Health and Safety Standards, implementation into CHFT process and procedures	The work towards the standards is nearing completion and is circa 90% finished. Next steps will be something around audit/monitoring so the standard's requirements remain in place and can continue to be evidenced. Auditing program with the aim of continues assurance in place against the requirements of the key policies		X		
7	To ensure networking takes place with other Trusts. This achieved by attending networking meetings across the year	The Head of Health and Safety continues to attend meetings with other Trusts across the years and the sharing of best practice and updates.	X	X	X	X
8	COSHH work improvements need finishing with a focus now on the software database. Reviews to be carried out across the year, ensuring Superusers are still in post/review upskill new members	Earlier work has finished with ALCUMUS Ltd to clean-up the system . COSHH sub group starting April 2023 to work through reviews.	X		X	
9	Community buildings used by CHFT staff require attention in terms of seeking assurance from the GP practice managers/property owners they have the right compliance in place for gas, asbestos, legionella, electrical etc.	Site visits and photographs done, and a generic assessment completed for each site. Next steps are to seek assurance of building compliance from the practice managers/property owners incl. gas, legionella, electrical, etc .		X		
10	Audit of Pathology compliance	There is a need to complete audit of Pathology, and this is due to the nature/severity of risk re: Cat 3. Audit Yorkshire attending CHFT to complete review. Stephen Shepley / Jason Eddleston co-ordinating this piece of work.	X			
11	Planned meetings with Occupational Health and the sharing of accident/injury data and ideas around improvement plans	There is a need to get closer alignment around some of the injury data and synergies of working together, sharing new ideas .	X	X	X	X
12	Awareness campaigns across the year	There is a need to ensure awareness of key risks is maintained across the year, in the form of newsletters and includes involvement by the subject matter experts to help develop/promote .	X	X	X	X
13	Development of ISO-45001 into the due diligence measures	It is helpful to ensure the ISO and NHS Health and Safety Standards continue to complement each other because this offers an extra level of oversight/assurance.	X	X	X	X
14	Oversight of the NHS Workplace Health and Safety Standards monitoring/maintenance	It is necessary to ensure the standards continue to be maintained and effective, through oversight/monitoring	X	X	X	X
15	Continuation of attendance at the meetings and providing input/oversight	The Trust has a list of meetings with direct health and safety input and include CHFT health and safety committee meeting and the many sub meetings below that level.	X	X	X	X
16	Direct working with the SME's in monitoring accidents/injuries and maintaining oversight and intervention plans, to reduce accidents/injuries	Engagement is in place and Dashboard developed and will be used for the next 12 months, with updates to the CHFT health and safety committee.	X	X	X	X
17	Monitoring incidents and seeking improvements	Continuous monitoring of DATIX incidents and sharing them at CHFT health and safety committees, to help form decisions/improvements.	x	x	x	x

UNIQUE IDENTIFIER NO:
EQUIP NO:
Review Lead: Richard Hill, Head of Health and Safety
Review Date: 14th September 2022

Calderdale and Huddersfield NHS Foundation Trust

General Health & Safety Policy
Version 8

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

Document Summary Table		
Unique Reference Number	TBC	
Status	Waiting Ratification by the Board	
Version	8 of 8	
Implementation Date	TBC	
Current/Last Review Dates	May 2018, June 2020, September 2022	
Current Version	8	
Next Formal Review	August 2025	
Sponsor	Suzanne Dunkley, Board Executive Lead	
Author	Richard Hill Head of Health and Safety	
Where available	Intranet	
Target audience	CHFT Staff	
Ratifying Committee		
Board of Directors		4th May 2023
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
CHFT health and safety committee	Suzanne Dunkley	14th September 2022
Other Stakeholders Consulted		
Helen Senior, Staff-side Representative		
Does this document map to other Regulatory requirements		
Health & Safety at Work Act etc 1974 6-Pack Health and Safety Regulations Health and Safety Codes of Practice		
Document Version Control		
Version No.		
8	Simpler and clearer descriptions of roles and responsibilities. Cross reference to the new CHFT health and safety dashboard. New risk added to the policy which is ligature hazards within clinical areas. New CEO signature added to the statement of intent	
7	Included reference to the CHFT 4 Pillars and articulated their relationship with health and safety within the Trust. Added a page 'statement of intent' which is to be signed by CEO and displayed as a 1-page across areas of the Trust. This is standard best practice across all other organisations to have a 'statement of intent'. Added a reference to CHFT 5-year health and safety strategy 2021-2026.	

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

1.0 Introduction

This General Health and Safety Policy has been written to take account of the wide range of subjects across CHFT and provides the reader with an understanding of how those risks are being managed. It also includes a clear account of the roles and responsibilities so that those risks can be controlled so far as is reasonably practicable. When writing this policy it was benchmarked against the requirements of legislation which is the Health and Safety at Work Act etc 1974 and subordinate regulations.

2.0 Key Points and Summary

- Some of the details from this policy cross-references with the NHS Workplace Health and Safety Standards which are standards to explain how to meet the law in the best way and were written by the HSE and NHS.

- This policy introduces the use of a health and safety dashboard that provides the compliance data that is shared at every CHFT health and safety committee and helps form the decision-making process for future improvements.

- The roles and responsibilities section of this policy are written to ensure there are arrangements in place to meet regulatory requirements. This is supported by a number of sub-groups to help monitor compliance across the year.

- This policy also includes a 'statement of intent' that has the Chief Executive Officer signature. The statement provides the reader, the clearest indication that the health and safety of colleagues and others is given Board attention and that fact is something which is always received warmly by the HSE.

3.0 Aim

To ensure the risk of harm to colleagues, patients and others is reduce so far as is reasonably practicable, and the Trust has the right measures in place to protect its financial position against unwarranted attempts for compensation financial settlements and HSE fee for interventions.

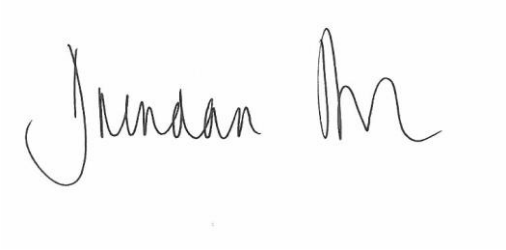
4.0 Purpose

The purpose of this policy is to inform the reader about what parts of the health and safety law which apply to CHFT, and how the Trust is meeting the requirements of legislation.

5.0 Statement of Intent

This statement of intent is a positive message to all colleagues that their safety and wellbeing continue to be a strong part of CHFTs commitment.

- An acceptance the Chief Executive Officer has final accountability and that Board members have leadership responsibility to champion/promote a positive health safety culture across the Trust.
- The Board continues to include within its strategy a focus upon a safe-base for every colleague and others.
- To continue and receive the health and safety annual report for Board consideration and comment.
- Ensuring sufficient financial resources, people and time continues to be in given to meet statutory compliance.
- To ensure continued, competent advice is provided to all colleagues.



Brendan Brown
Chief Executive for & on behalf of the Trust Board

6.0 Health and Safety Responsibilities

Chief Executive

- To ensure adequate measures including any financial resources and time is available to meet legislation requirements.
- To ensure compliance continues to form a part of CHFT Board Strategy.
- To ensure the Board continues to receive its annual health and safety report.
- To ensure the Trust continues to maintain every effort towards compliance through the appointment of competent advice.
- To ensure the appointment of a Director who will champion legislation.

Trust Directors

- To ensure sufficient time and resources is committed is given to meeting statutory compliance.
- To receive updates of compliance and give any reasonable support that is necessary.
- To ensure a representative is in attendance at the CHFT Health and Safety Committee.

Non-Executive Director - Health and Safety Champion

To receive assurance that CHFT is meeting regulatory compliance and there is a plan in place to achieve it.

Head of Health and Safety

- Develop and share a 5-year health and safety strategy which meets the requirements of health and safety legislation.
- To produce an annual health and safety plan and share it with key stakeholders.
- The produce key performance indicators that are specific, measurable and achievable.
- To ensure CHFT continue to meet the requirements of the NHS Workplace Health and Safety Standards.
- To ensure accidents are investigated and share any learning with relevant colleagues.
- To monitor incidents and identify trends and any patterns so improvements can be made.
- To provide advice on legislation requirements and how best to achieve it.
- To ensure compliance continues to maintain a profile by working directly with relevant stakeholders.
- To support Health Informatics Service and Huddersfield Pharmacy Specials in its compliance requirements.
- To work collaboratively with CHS Ltd, and Albany in meeting the regulatory requirements.
- To ensure the CHFT Health and Safety Committee is informed about compliance and provided with any emerging risks and changes in legislation.
- To attend health and safety sub-group meetings and provide direction and advice.

- To engage directly with the Staff-side Health and Safety Representatives on relevant matters.
- To develop, implement and monitor policies across the Trust.
- To act as the lead person for security management so that all the relevant measures are in place to protect colleagues.

General Managers

- To ensure there are available funds for any health and safety requirements that must meet legislation.
- To receive assurance from the Head of Health and Safety about health and safety compliance through sharing the Health and Safety Dashboard.
- To release Operation Managers to attend relevant meetings including the CHFT Health and Safety Committee Meetings.

Operations Managers

- To collaborate directly with the Head of Health and Safety on matters related to any compliance issues.
- To attend and inform the CHFT Health and Safety Committee about any divisional issues that need to be highlighted.
- To ensure their line managers complete DATIX incidents and the submission of any RIDDOR's to the HSE.
- To ensure their line managers complete the ESR health and safety training modules in line with timescales.
- To monitor the Health and Safety Dashboard and seek improvements, if necessary from the data shared by the Head of Health and Safety.

Line Managers

- Ensuring their team complete their ESR health and safety in the timescales required.
- Ensure incidents and near misses are recorded on DATIX as soon as possible.
- Reporting of any incident which is reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences to the HSE within 10 working days of notification.
- To ensure any relevant personal protective equipment is available for colleagues to wear.
- To ensure adequate supervision is given to colleagues.
- To collaborate with their Operation Manager on any improvements needed because of the Health and Safety Dashboard results.

Colleagues

- To ensure they complete the ESR health and safety training.
- To report accidents and any near misses to their line manager.
- To read and understand the health and safety policies available on the intranet.
- To continue and work in a safe manner, and where if necessary raise any issues with their line manager for escalation to the CHFT health and safety committee.
- To wear any necessary personal protective equipment needed for the activities being completed.

7.0 Accident Reporting

Accidents and near misses must be reported on DATIX as quickly as possible, so they can be investigated. All line managers have access to DATIX so these reports can be submitted. The incidents will be monitored by the Head of Health and Safety and support will be given upon the investigation. It is essential that the incident manager maintains an accurate record of DATIX and updating it, when necessary.

Some accidents may need to be reported to the HSE. These are the more serious accidents and any which is work related that leads to more than 7 working days off sick. For more information please refer to the intranet>non clinical>health and safety page. Please remember if the accident is reportable to the HSE, it must be done on the DATIX, within 10 workdays from notification of the incident.

8.0 First Aid

There is a requirement that all departments have local arrangements to respond to an injury. This means having a first aid box and access to receive first aid treatment. All clinical areas benefit from having a colleague who has received basic life support training. All the non-clinical departments, which are separated by distance do have first aid trained colleagues who have attended a 1-day emergency first aid course.

9.0 Consultation with S safety Representatives

CHFT is committed to ensuring consultation is provided to all colleagues, and this is done in partnership with the Staff-Side Union Health and Safety Representatives. Furthermore, CHFT Health and Safety Committee meetings happen bi-monthly. Finally, colleagues also benefit from access to the Trust intranet, health and safety page.

10.0 Working Sub-Groups

The following sub-groups provide a platform to discuss specific reguatory subjects and allow for discussion. These take place across the year and relevant meetings are in compliance with the Health Technical Memorandum requirements.

- Control of Substances Hazardous to Health Group
- Sharps Management Group
- Fire Safety Group Meeting
- Security and Resilience Group
- Ventilation Group
- Calderdale and Huddersfield Solutions Ltd Safety Group
- Joint Liaison Working Safety Group
- Electrical Group
- Water Quality Group
- Air Quality Group
- IPROG Meetings

11.0 Management of Contractors

The management of contractors is predominantly managed by CHS on behalf of the Trust, and this is arranged under a service level agreement. For a small number of contractor arrangements, these are controlled directly by the Head of Health and Safety. The key areas of assurance which is related to contractors is confirmation that they hold relevant risk assessments and method statements for the work intended, and that there is a contractor selection process applied.

12.0 Young Persons

The recruitment of colleagues under the age of 18 years old applies to apprentices who enter the workforce, and often for the first time. These are the clinical and non-clinical apprentices and CHFT ensure they have supervision and that a relevant risk assessment is completed. Enhanced training is also given to this cohort of colleagues which is delivered under a service level agreement by CHS.

13.0 Display Screen Equipment (DSE)

The use of display screen equipment is often an integral part of those colleagues who provide a level of desk-based support when gathering and sharing data and information on screen, which requires a higher level of concentration and time. This can include laptops, and desktop devices when colleagues often spend a hour or more each day continuous to input data onto the screens. CHFT understand there are associated risks from eye strain and upper musculoskeletal pains from long-term sitting and therefore provide a DSE assessment which helps inform colleagues about how best to sit correctly and reduce any risk of future pain. The DSE assessment is provided on the intranet>occupational health department. The assessment is an e-form, and the results are monitored by the Head of Health and Safety. The Trust has a long-term agreement with a local supplier of DSE equipment who are specialists and provide extra support.

14.0 Electrical Safety

CHFT have a service level agreement with partnership organisation to ensure the electrical systems and appliances continue to be in good order and safe to use. This includes all the portable appliances, and the fixed electrical wiring. The portable appliances are tested every year and the fixed electrical wiring inspection is completed every 5 years by qualified engineers. A HTM meeting is held across the year by the partnership organisation, when updates and assurances of compliance are given to CHFT.

15.0 Gas Safety

CHFT have a service level agreement with partnership organisations to ensure the natural gas supplied systems are inspected annually and certification is held on file.

16.0 Legionella Management

CHFT have a service level agreement with partnership organisations to ensure the water supply systems continue to be safe and free of harmful bacteria. This includes a schedule arrangement of water temperature inspection across the year and cleaning of the water systems. A HTM meeting is held across the year by the partnership organisation, when updates and assurances of compliance are given to CHFT.

17.0 Asbestos Management

CHFT have a service level agreement with partnership organisations to ensure areas where asbestos is contained is inspected and asbestos surveys are held on file which show the location and condition of the material. A HTM meeting is held across the year by the partnership organisation, when updates and assurances of compliance are given to CHFT.

18.0 Fire Safety

Fire safety across the estate is managed by CHFT fire safety team. For more information please read the Fire Safety Policy which is available on the Intranet.

19.0 Control of Substances Hazardous to Health (COSHH)

CHFT handle and use several thousand chemicals which have been subject to a risk assessment, and all of them come with a safety data sheet. Colleagues using and handling hazardous chemicals must wear protective equipment e.g. goggles, disposable gloves and if necessary respiratory protection. CHFT use SYPOL to hold the several thousand chemical risk assessments/safety data sheets, and a COSHH sub-group is held every 3 months to discuss and update any requirements including oversight of the SYPOL data.

20.0 Violence and Aggression

CHFT accept the risk to colleagues is present and has measures in place to reduce the risk of harm. CHFT has appointed security patrols, CCTV, investment in external lighting and access control systems. This is all supported by risk assessments and security audits which are completed across all the wards and departments. CHFT work directly with West Yorkshire Police Service and have invested in the appointment of a PCSO who povides advice and guidance around crime prevention. The Head of Health and Safety is the lead person for security management. For more information please read the Violence Prevention Reduction Policy which is on the intranet.

21.0 Moving and Handling

All colleagues receive training, and this is delivered by ESR training. Any moving and handling risk assessments are completed by Co-ordinators who also deliver on the job training to front-line colleagues. Where necessary moving and handling lifting aids are also provided under contract by a third party.

22.0 Medical Gases

The medical gas systems are managed under contract and inspections of these are carried out across the year by the partnership organisation, with records held on file. If any air monitoring is required then CHFT appoint a local air monitoring consultancy to complete the sampling and produce the results which are shared with the Medical Gas Committee which is a meeting that takes place several times across the year.

23.0 Personal Protective Equipment (PPE)

The wearing of personal protective equipment is mandatory for all clinical related work which presents a level of exposure to infection. Examples of PPE include the wearing of disposable surgical gloves, goggles, facemask, apron, protective footwear and lead gowns. PPE is given to all relevant colleagues by the Trust.

24.0 Pregnant Colleagues

Employees who are pregnant, breast feeding, have given birth within the last six months, or who have miscarried after 24 weeks of pregnancy must be given the opportunity to have completed a risk assessment with their line manager. A copy of the assessment is available from Workforce and Organisational Development and is part of the bundle of documents which are received on notification of the colleague's pregnancy. The aim of the assessment is to make a judgement of the health and safety hazards associated with their roles and responsibilities, and if necessarily make any necessary adjustments.

25.0 Safety Signage

Signage is displayed across the Trust to inform others of the rules in place to reduce/prevent the risk of injuries. The signage is colour coded which is an indication of the risk-type, for example yellow (caution), blue (mandatory) red (prohibition) green (safe condition) with equal symbols for visual impact. Additionally, the health and safety law poster are displayed and is informative upon the employer/employee expectations.

26.0 Inspections

Inspections are completed audits across the wards using the FLO audit tool. In the non-ward areas, the Contracts and Performance team also conduct inspections which are then shared with the relevant stakeholders.

27.0 Ligature Risk

All relevant areas of the wards have been inspected and risk assessments completed. This provides assurance that any ligature anchor point has been identified and where reasonably practical it has been removed. All relevant clinical colleagues have been given training on ligature risk and records are held on file.

28.0 Driver Risk Management

The Trust ensures that colleagues have the right documentation before being allowed to submit any travel expenses. This includes the vehicle MOT, insurance, and driving licence. This information is handled in partnership with another organisation. For further information please read the Transport Group Policy.

29.0 Radiation Compliance

Ionising and non-ionising radiation is a hazard which must be controlled. CHFT have appointed a Radiation Protection Advisor who gives advice on what is needed to meet the legislation. Meetings take place across the year when relevant stakeholders are given the opportunity to raise any issues and be updated on current regulations. Arrangements are in place to giver colleagues training, so they continue to be competent to deliver therapeutic treatment to patients without putting themselves or others at risk. Risk Assessments have been completed across the year and are available from the Radiation Protection Advisor or the Chief Medical Engineer Officer.

30.0 Stress Management

The Trust is committed to support the health and wellbeing of the workforce and to minimise the impact of work-related stress. For more information please read the Health and Wellbeing Policy.

31.0 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* (*to be added for new policies only). 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.

32.0 Financial impact

There is no financial impact.

33.0 Monitoring compliance

The Head of Health and Safety will be seeking assurance from the line manager that the measures explained within this policy continue to be effective. This will form part of a self-assessment tool which is shared with managers to complete. The results will be shared with the CHFT Health and Safety Committee and added to the end of year health and safety board report.

34.0 Associated documents

Relevant policies given on the intranet.

35.0 References

Health and Safety Executive Website Guidance Documents.

Appendix A – Board Strategic Plans

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)	

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

24. Governance Report

1) Compliance with Licence Conditions (and new provider licence Code ref)

2) Board of Director Attendance Register for the 2022/23 Annual Report

3) Trust Constitution

4) Scheme of Delegation

5) Board Workplan

To Approve

Presented by Andrea McCourt

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 May 2023
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

a) Compliance with the Trust's Provider Licence conditions
b) Board of Director Attendance Register 2022/23
c) Updates to the Trust Constitution
d) Scheme of Delegation
e) Board of Directors 2023-2024 Workplan

Key Points to Note

a) Self-certification of Compliance with Provider Licence Conditions

Each year NHS England (NHS E) requires all Foundation Trusts to complete a number of self-certifications to provide assurance that the Trust is compliant with the conditions of their NHS provider licence or provide explanatory text where this is not the case, have the required resources available if providing commissioner requested services and have complied with governance arrangements.

The purpose of this paper is to seek Board approval of the enclosed self–certification schedules for 2022/23 at Appendix S2 and S3. Self -certification relates to the following three conditions:

- *Compliance with governance requirements* - condition FT4 (8) relates to compliance with systems and processes for good governance and forward compliance with the governance condition for the 2023/24 financial year and any risks. Compliance is confirmed in Appendix S2.

- *Compliance with provider licence* - the Trust is confirming compliance with condition G6 (3) which relates to effective systems to ensure compliance with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, the Health and Social Care Act 2012, Health and Care Act 2022 and have regard to the NHS Constitution) - this is detailed at Appendix S3.

- *Available resources if providing commissioner requested services* - condition S7 (CoS7 (3)) relates to continuity of service and having the required resources available for the next 12 months. The Trust is confirming that it has a reasonable expectation that resources will be available for 2023/24 subject to the factors detailed in the return which is enclosed at Appendix S3. This is because the Trust remains in breach of its licence, for the availability of resources certification (CoS7) the Trust is declaring that it has a reasonable expectation to

have the required resources available (declaration 3b) and the factors relating to this are stated in the return. This is consistent with the response that the Trust has given over the previous financial years whilst in breach of the licence.

The self-certification documents confirms Trust compliance with governance (FT4) and the provider licence condition G6 (3).

Condition	Description	Internal Assurance Process
FT4 (8)	Compliance with systems and processes for good governance and forward compliance with the governance condition for the 2023/24 financial year and any risks.	Confirmed - compliance is confirmed in the attached Appendix S2. Evidence of compliance with Code of Governance reviewed at Audit and Risk Committee 25 April 2023. Governor training confirmed by lead governor on behalf of the Council of Governors
G6 (3)	Trust compliance with its NHS provider licence, NHS acts and NHS constitution in 2022/23.	Confirmed - see Appendix S3
G6 (4) Publication	Publication of condition G6(3) self certification	To be added to Trust website by 30 June 2023
Condition CoS7(3)	Continuity of Service and having the required resources available for the next 12 months for providing commissioner requested services	Narrative based on 2023/24 position and ongoing oversight of financial position by Finance and Performance Committee (see S3)

RECOMMENDATION: The Board is asked to **APPROVE** the content of the self-certification documents for the signature of declarations.

b) Board of Directors Attendance Register for the Annual Report and Accounts 2022/23

The attendance of Directors at Board of Directors meetings during 2022/23 is detailed within the annual report for 2022/23.

The Board of Directors attendance is attached at Appendix S4. Any changes to this should be notified to the Company Secretary.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors Attendance Register for 2022/23.

c) Updates to the Trust Constitution

Proposed amendment to the Trust Constitution
The Trust Constitution sets out the principles and processes that the Directors and Council of Governors follow, providing a corporate governance framework for the organisation. As situations change amendments can be made to the Constitution under section 44 of the Constitution. Any proposed amendments must be approved by more than half of the Council of Governors of the Trust voting approving the amendments and more than half of the members of the Board of Directors voting. approving the amendments.

The Council of Governors, at its meeting on 20 April 2023 approved the proposed updates to the Constitution and Standing Orders of the Council of Governors. These reflect the Health and Care Act 2022 (July 2022) and the NHS England Code of Governance for NHS Provider Trusts which came into effect on 1 April 2023. Updates are also included regarding members and governors in terms of applications, nominations, and tenure.

Summary Changes

- References to the Health and Social Care Act 2022 have been added
- Integrated Care Board/Partnership and System has been added
- References to Monitor, NHS Improvement and the Trust Development Authority have been removed and replaced with NHS England
- Purpose of a Foundation Trust has been updated (paragraph 4)
- Disqualification from membership has been updated (paragraph 8)
- Tenure for governors has been updated (paragraph 14)
- Disqualification and removal of governors has been updated (paragraph 16)
- Termination of office and removal of governors has been updated (paragraph 17)
- Duties of governors has been updated (paragraph 18)
- Board of Directors – general duty - updated (paragraph 23)
- Annex 2 Election Rules – Decisions as to the validity of nomination updated
- Annex 3 Further Provisions – Termination of membership updated
- Annex 5 Roles and Responsibilities of Governors updated
- Annex 6 Composition of the Council of Governors updated
- Annex 7 Standing Orders Council of Governors – updated for Health and Care Act 2022, deputy lead governor and nomenclature of Council Member changed to Governor

All updates proposed to the Trust Constitution can be found in the Review Room.

RECOMMENDATION
The Board is asked to **APPROVE** the updates to the Trust Constitution and Standing Orders of the Council of Governors as noted above.

d) Update to the Scheme of Delegation

The remit of the Chief Operating Officer role, which has recently been recruited to, now includes Health and Safety, which was previously within the remit of the Director of Workforce and Organisational Development.

Section 31 of the Scheme of Delegation (Appendix C) will be revised to show the Chief Operating Officer as the lead Director for the review of all statutory compliance legislation and Health and Safety requirements with effect from 4 May 2023.

RECOMMENDATION: The Board is asked to **APPROVE** the amendment to Section 31 of the detailed Scheme of Delegation regarding Health and Safety.

e) Board of Directors 2023-2024 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 2023/24 workplan at Appendix S5 is presented for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors workplan for 2023-2024.

EQIA – Equality Impact Assessment

The content of this report does not adversely affect people with protected characteristics.

Recommendation

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

- content of the self-certification documents for the signature of declarations for 2022/23
- Board of Directors Attendance Register for 2022/23
- Updates to the Trust Constitution and Standing Orders of the Council of Governors
- Update to Section 31 of the Scheme of Delegation
- Board of Directors Workplan for 2023-2024

APPENDIX T1a

Corporate Governance Statement FT 4 -Self Certification Calderdale and Huddersfield NHS Foundation Trust 2022/23

Corporate Governance Statement	Response	Risks and Mitigating Actions
1. *The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.*	**Confirmed**	The Trust monitors and reviews its systems and processes to ensure they comply with good governance as detailed in the Annual Governance Statement. The Trust received a CQC good rating at a well-led inspection in April 2018, with a "requires improvement" rating for use of resources. The Trust has completed an externally commissioned a well-led development governance review and the Board of Directors continues to review its effectiveness as part of its development programme.
2. *The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time*	**Confirmed**	The Trust pays due regard to guidance issued by NHS England and liaises through national and regional networks. NHS England guidance is also noted through the Trust's external audit technical updated reported each quarter to the Audit and Risk Committee, with a similar report shared via internal auditors. Compliance with the Code of Governance is reviewed annually by the Audit and Risk Committee. The Trust has amended governance documentation in line with the Health and Care Act 2022 and has planned updates to the Constitution in Spring 2023 in line with NHS England's Code of Governance for NHS Provider Trusts effective from 1 April 2023.

APPENDIX T1a

3. *The Board is satisfied that the Licensee has established and implements:* *(a) Effective Board and Committee structures;* *(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and* *(c) Clear reporting lines and accountabilities throughout its organisation.*	**Confirmed**	The Trust has a robust Board and Board Committee governance structure which is reviewed annually and approved by the Board of Directors when changes are made. The governance structure is also depicted within the Trust Risk Management Strategy. Each Board Committee has a terms of reference reviewed annually, assesses effectiveness on an annual basis and develops an action plan.
4. *The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:* *(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;* *(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;* *(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;* *(d) For effective financial decision-making, management and control*	**Confirmed**	Board Committees give assurance to the Board that the Trust is operating effectively. These include Board Committees scrutinising the following matters: - finance and performance - quality - workforce - audit and risk The sub group reporting structure to Board Committees also provide comprehensive coverage of Trust business. This has been reviewed in year with changes made in relation to the management of elective recovery and Access, the Quality Governance structure and oversight of resources, with a change from an Effective Resources Group to a Turnaround Executive given the Trust's financial position. The Trust's wholly owned subsidiary, Calderdale Huddersfield Solutions Ltd. has its own governance structure and relationships and reporting to the Trust. The Trust declared no signifcant control issues in its 2022/23 annual governance statement and detailed the Trust's risk management

(including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); *(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;* *(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;* *(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and* *(h) To ensure compliance with all applicable legal requirements.*		framework and current strategic risks. The Board Assurance Framework and risk register are reviewed regularly by the Board and it's Committees. The Trust has a clear Standing Financial Instructions and Scheme of Delegation in place that determines the framework for financial decision-making, management and control. These were all reviewed and revised in year. Planning was in line with national guidance with collaboration with system partners.
5. *The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:* *(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;*	**Confirmed**	There is an effective objective setting and performance review process in place for Board members. Board succession planning is considered within the Nomination and Remuneration Committees. A fit and proper person declarations register is maintained and reported to the Board annually. Quality account priorities (agreed with governors) and other quality priorities have been agreed and reported, along with other quality metrics, to the Quality Committee and Board. A detailed quality report is presented to each Board meeting.

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; *(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;* *(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;* *(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and* *(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.*		The Trust has a Quality Strategy in place and engages in a wide range of quality improvement collaboratives to improve patient care. There is a robust quality impact assessment process in place for service changes.

6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	The Trust has in place a formal appointment process to the Board overseen by a Nomination and Remuneration Committees which ensures that appropriately qualified Board members are recruited and appointed, with appraisal processes in place to review existing Board members. These processes were used during the year to make appointments to the Board of Directors. A fit and proper person declarations register is maintained and reported to the Board.

Signed on behalf of the Board of Directors of Calderdale and Huddersfield NHS Foundation Trust

Signature

Name: Brendan Brown

Role: Chief Executive

Signature

Name: Helen Hirst

Chair

APPENDIX T1a

Training of Governors FT 4 -Self Certification Calderdale and Huddersfield NHS Foundation Trust 2022/23

Training of Governors	Response
The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

Signed on behalf of the Board of Directors of Calderdale and Huddersfield NHS Foundation Trust

Signature:

Name: Brendan Brown

Role: Chief Executive

Date: xx xxx 2023

Signature:

Name: Helen Hirst

Chair

xx xxx 2023

APPENDIX T1a

APPENDIX T1b

3 General Condition 6 Systems for Compliance with Licence Conditions and Continuity of services condition 7 - Availability of Resources

Self Certification Calderdale and Huddersfield NHS Foundation Trust 2022/23

1 & 2 General Condition 6 – Systems for compliance with Licence Conditions	Response
1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

Continuity of services condition 7 - Availability of Resources	Response
EITHER: 3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	
OR 3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	**Confirmed**
OR	

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3C In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Given the underlying deficit position and the planned deficit for 2023/24, the Trust has given this due consideration and notes the following:

Funding for the Trust's services will be received from commissioners in this period, embedding historic levels of Financial Recovery Funding (FRF). The Trust will work with partners across the Integrated Care System to manage elective recovery plans and access associated funding.

The 2023/24 financial plan submitted at the end of March 2023 described a deficit position which exceeds the cash holdings at the outset of the financial year. As such, the Trust will require cash support. This is expected to be accessed through the national mechanism allowing for Public Dividend Capital to be received to support and maintain cash flow.

Signed on behalf of the Board of Directors of Calderdale and Huddersfield NHS Foundation Trust

Signature **Signature**

Name: Brendan Brown **Name: Helen Hirst**

APPENDIX T1b

Role: Chief Executive	**Chair**
Date: xx xxxx 2023	**Date xx xxxx 2023**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Attendance	✓	Apologies	×

ATTENDANCE REGISTER – PUBLIC BOARD OF DIRECTORS
1 APRIL 2022 – 31 MARCH 2023

DIRECTOR	05.05.2022	07.07.2022	01.09.2022	10.11.2022	12.01.2023	02.03.2023	TOTAL
Philip Lewer (Chair)	✓						
Helen Hirst	✓	✓	✓	✓	✓	✓	**6 / 6**
Brendan Brown	✓	✓	✓	✓	✓	✓	**6 / 6**
Robert Aitchison						✓	**1 / 1**
David Birkenhead	✓	×	✓	✓	✓	✓	**5 / 6**
Lindsay Rudge		✓	✓	✓	✓	✓	**5 / 5**
Gary Boothby	✓	✓	×	×	×	x	**2 / 6**
Kirsty Archer			✓	✓	✓	✓	**4 / 4**
Suzanne Dunkley	✓	✓	✓	✓	✓	✓	**6 / 6**
Peter Wilkinson	✓	✓	✓	✓	✓	✓	**6 / 6**
Nigel Broadbent	✓	×	✓	✓	✓	✓	**5 / 6**
Tim Busby	✓	×	✓	✓	✓	✓	**5 / 6**
Andy Nelson	✓	✓	×	✓	✓	✓	**5 / 6**
Denise Sterling	✓	✓	✓	✓	✓	✓	**6 / 6**
Karen Heaton	✓	✓	✓	×	✓	✓	**5 / 6**
Anna Basford	✓	✓	✓	✓	✓	✓	**6 / 6**
Rob Birkett		×	✓	✓	✓	✓	**4 / 5**
Stuart Sugarman	✓	✓	✓	✓	✓	✓	**6 / 6**
Jonathan Hammond			✓	✓	✓	✓	**4 / 4**
Nicola Seanor	✓	✓	✓	×	×	x	**3 / 6**
Victoria Pickles		✓	✓	✓	×	✓	**4 / 5**
Richard Hopkin	✓	✓					**2 / 2**
Jim Rea	✓						**1 / 1**
Ellen Armistead	✓						**1 / 1**
Alastair Graham	✓						**1 / 1**
Jo Fawcus	✓	✓	×				**2 / 3**
Cornelle Parker	✓	✓					**2 / 2**

GOVERNORS	05.05.2022	07.07.2022	01.09.2022	10.11.2022	12.01.2023	02.03.2023	TOTAL
Christine Mills	✓	✓			✓	x	3
Robert Markless			×	✓		✓	2
Nicola Whitworth	✓						1
Peter Bamber		✓					1
Gina Choy		✓	✓	✓	✓		4
Veronica Woolin	✓						1
John Gledhill	✓	✓		✓			3
Alison Schofield							
Isaac Dziya	✓						1
Peter Bell	×						
Stephen Baines			✓	✓	✓	✓	4
Brian Moore			×	✓			1

UNIQUE IDENTIFIER NO: G-1C-2017
Review Date: April 2026
Review Lead: Company Secretary

CONSTITUTION OF THE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Version:	2.0 Review and update including: - Expenses clarification - References to Monitor / NHS Improvement - Typographical amends 2.1 Addition of partner governor May 2019 *3.0 April 2021* 14.1.5 An elected governor who completes the maximum 6 year tenure may stand for re-election after a period of 2 years has elapsed since the end of their tenure 14.3 removal of reserve register Annexe 1 - addition of Rest of England constituency *4.0 13 January 2022* 25.4 Change to NED eligibility criteria 5.0 July 2022 24.0 Change to the Board of Directors composition to increase the number of Non-Executive Directors to up to 7 and the number of Executive Directors to up to 7. 6 April 2023 Amendments to reflect the Health and Social Care Act 2022, the NHS England Code of Governance for Provider Trusts (October 2022), application for membership and nomination as a governor, voting for removal of a governor.
Approved by:	Council of Governors

Date approved:	Version 1 - 17 January 2017 Version 2 - 17 October 2019 Version 3 - 22 April 2021 Version 4 - 13 January 2022 Version 5 – 7 July 2022 Version 6 – April 2023
Date issued:	7 July 2022
Next Review date:	As required, as a minimum every three years (2024)

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CONSTITUTION FOR THE CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

1. Definitions

1.1. Unless otherwise stated words or expressions contained in this constitution bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022.

1.2. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3. Headings are for ease of reference only and are not to affect interpretation.

1.4. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.5. In this constitution:

The Accounting Officer	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
The 2006 Act	means the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.
The 2012 Act	is the Health and Social Care Act 2012.
The 2022 Act	means the Health and Social Care Act 2022
Annual Members' Meeting	is defined in paragraph 10 of the constitution.
Appointed Governor Member	means those Governors appointed by the Appointing Organisations;
Appointing Organisations	means those organisations named in this constitution who are entitled to appoint Governors;
Areas of the Trust	the areas specified in Annexe 1;
Authorisation	means an authorisation given by NHS England
Board of Directors	means the Board of Directors as constituted in accordance with this constitution;
Code of Governance	means the NHS England Code of Governance for NHS Provider Trusts (October 2022)
Director	means a member of the Board of Directors

Non-Executive Directors	means the Chair and non-executives on the Board of Directors;
Elected Governor"	means those Governors elected by the public constituency and the staff constituency;
Financial year	means: (a) a period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
Integrated Care Board	An Integrated Care Board is a statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Integrated Care Partnership	An Integrated Care Partnership is a formal partnership of organisations working together to improve the health and care of the whole population they serve
Integrated Care System	An Integrated Care System (ICS) is a statutory partnership of organisations who plan, buy and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups and independent care providers.
~~Monitor~~ NHS England	~~is the former name for the Trust's regulator, as provided by Section 61 of the 2012 Act~~; The Health and Social Care Act 2022 has merged Monitor and the Trust Development Authority into NHS England and is now the Trust's regulator
Local Authority Governor	means a Member of the Council of Governors appointed by one or more Local Authorities whose area includes the whole or part of the area of the Trust;
Member	means a Member of the Trust;
Council of Governors	means the Council of Governors as constituted by this constitution and referred to as the Board of Governors/ Council of Governors in the 2006 Act;
The NHS Trust	means Calderdale and Huddersfield NHS Foundation Trust t;

Other Partnership Governor	means a Member of the Council of Governors appointed by a Partnership Organisation other than a Primary Care Trust or Local Authority;
Public Constituency	means those individuals who live in an area specified as an area for any public constituency;
Public Governor	means a Member of the Council of Governors elected by the Members of the public constituency;
Secretary	means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary;
Staff Constituency	means those individuals who are eligible for Trust membership by reason of 8.5-8.9 of this Constitution are referred to collectively as the Staff Constituency;
Staff Governor	means a Member of the Council of Governors appointed by the Members of one of the classes of the constituency of the staff membership;
The Trust	means Calderdale & Huddersfield NHS Foundation Trust.

2. Name and status

2.1. The name of this Trust is “Calderdale and Huddersfield NHS Foundation Trust”.

3. Head Office and Website

3.1. The Trust’s head office for the purpose of this Constitution is at Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA, or any other address decided by the Council of Governors.

3.2. The Trust will maintain a website, the address of which is www.cht.nhs.uk or any other address decided by the Council of Governors.

4. Purpose

4.1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

4.2. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4.3. The Trust may provide goods and services for any purposes related to:-

4.3.1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
4.3.2. the promotion and protection of public health.

4.4. The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

4.5. The Trust should be led by an effective and diverse Board that is innovative and flexible and whose role it is to promote the long term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members, patients and the public.

5. Powers

5.1. The powers of the Trust are set out in the 2006 Act.

5.2. All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

5.3. Any of these powers may be delegated to a committee of directors or to an executive director.

5.4. The Trust may do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.

5.5. In particular it may:

5.5.1. acquire and dispose of property;
5.5.2. enter into contracts;
5.5.3. accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service);
5.5.4. employ staff.

5.6. Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.7. The Trust may borrow money for the purposes of or in connection with its functions, subject to the limit published by NHS England from time to time.

5.8. The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions. The investment may include investment by:

5.8.1. forming, or participating in forming bodies corporate;
5.8.2. otherwise acquiring membership of bodies corporate.

5.9. The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its function.

6. Membership and Constituencies

6.1. The Trust shall have members, each of whom shall be a member of one of the following constituencies:

6.1.1. A public constituency

6.1.2. A staff constituency

7. Members

7.1. The Members of the Trust are those individuals whose names are entered in the register of members. Every Member is either a Member of one of the public constituencies or a Member of the staff constituency.

7.2. Subject to this Constitution, Membership is open to any individual who:

7.2.1. is over 16 years of age;

7.2.2. is entitled under this Constitution to be a Member of the public constituencies, or staff constituency; and

7.2.3. completes or has completed a membership application form in whatever form the Council of Governors approves or specifies.

Public Membership

7.3. There are eight public constituencies corresponding to the areas served by the Trust as set out in Annexe 1. Members of each constituency are to be individuals:

7.3.1. who live in the relevant area of the Trust;

7.3.2. who are not eligible to be Members of the staff constituency; and

7.3.3. who are not Members of another public constituency.

7.4. The minimum number of members of each of the public constituencies is to be 50.

Staff Membership

7.5. There is one staff constituency for staff membership. It is to divide into four classes as follows with five seats:

7.5.1. doctors or dentists (x1);

7.5.2. Allied Health Professionals, Health Care Scientists or Pharmacists (x1);

7.5.3. Management, administration and clerical (x1);

7.5.4. Nurses and midwives (x2).

7.6. Members of the staff constituency are to be individuals:

7.6.1. who are employed under a contract of employment by the Trust and who either:

7.6.1.1. are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

7.6.1.2. who have been continuously employed by the Trust for at least 12 months; or

7.6.2. who are not so employed but who nevertheless exercise functions for the purposes of the Trust and have exercised the functions for the purposes of the Trust for at least 12 months.

7.7. Individuals entitled to be Members of the staff constituency are not eligible to be Members of the public constituency.

7.8. The Secretary is to decide to which class a staff member belongs.

7.9. The minimum number of members in each class of the staff membership is to be 20.

Automatic membership by default – Staff

7.10. An individual who is:

7.10.1. Eligible to become a member of the Staff Constituency, and

7.10.2. Invited by the Trust to become a member of the Staff Constituency,

Shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he / she informs the Trust that he / she does not wish to do so.

8. Disqualification from membership

8.1 When applying to be a member, an online literature review will be undertaken to check that there are no known concerns regarding an individual that would suggest the person would act in a manner detrimental to the interests of the Trust. This decision as to whether an individual is likely to act in a way detrimental to the interests of the Trust will be made by the Council of Governors (as per section 8.2 of the Trust Constitution).

8.2A person may not be a member of the Trust if, in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust.

9. Termination of membership

9.1. A Member shall cease to be a Member if:

9.1.1. they resign by notice to the Company Secretary;

9.1.2. they die;

9.1.3. they are disqualified from Membership by paragraph 7 and 8;

9.1.4. they cease to be entitled under this Constitution to be a Member of any of the public constituencies or the staff constituency.

9.2. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annexe 3 – Further Provisions.

10. Annual Members' Meetings

10.1. The Trust is to hold an annual meeting of its members. The Annual Members Meeting shall be open to members of the public.

10.2. Further provisions about the Annual Members' Meeting are set out in Annexe 4 – Annual Members' Meeting.

11. Council of Governors - composition

11.1. The Trust is to have a Council of Governors which shall comprise both elected and appointed governors.

11.2. The composition of the Council of Governors is specified in Appendix 6 – Composition of the Council of Governors.

11.3. The composition of the Council of Governors, subject to the 2006 Act, shall seek to ensure that:

11.3.1. the interests of the community served by the Trust are appropriately represented;

11.3.2. the level of representation of the public constituencies, the staff constituency and the partnership organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs.;

12. Council of Governors – elections of Governors

12.1. Public Governors are to be elected by Members of the public constituencies, and Staff Governors by Members of the staff constituency.

12.2. The Election procedures including the arrangements governing nominations, the advertisement of candidates, rules regarding canvassing voting, and the election of reserves to fill casual vacancies are to be determined by the election rules, set out in Annexe 2 – Election Rules.

13. Council of Governors - appointed Governors

13.1. Local Authority Governors

The Secretary, having consulted each Local Authority whose areas includes the whole or part of the area of the Trust is to adopt a process for agreeing the appointment of Local Authority Councils Member with those Local Authorities.

13.2. Partnership Governors

The Company Secretary, having consulted each partnership organisation is to adopt a process for agreeing the appointment of Partnership Governors with those partnership organisations.

14. Council of Governors - tenure for Governors

14.1. Elected Governors:

14.1.1. shall hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced;

14.1.2. subject to the next sub-paragraph are eligible for re-election after the end of that period;
14.1.3. may not hold office for more than six consecutive years or two terms;
14.1.4. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

14.2. An elected governor who completes the maximum 6 year tenure may not stand for re-election to ensure that they retain the objectivity and independence required to fulfil their roles. Appointed Governors:

14.2.1. shall hold office for a period of 3 years commencing immediately after the annual members meeting at which their appointment is announced;
14.2.2. subject to the next sub-paragraph are eligible for re-appointment after the end of that period;
14.2.3. may not hold office for longer than 6 consecutive years;
14.2.4. shall cease to hold office if the Appointing Organisation terminates their appointment.
14.2.5. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

15. Council of Governors - vacancies amongst Governors

15.1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

15.2. Where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.

15.3. Where the vacancy arises amongst the elected Governor, the Council of Governors shall be at liberty either:

15.3.1. to call an election within three months to fill the seat for the remainder of that term of office, or
15.3.2. where a vacancy arises within 6 months to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next annual election, at which time the seat will become vacant and subject to election for any unexpired period of the term of office.
15.3.3. If the vacancy arises during the last 6 months of office, the office will remain vacant until it is filled at the next scheduled election term

16. Council of Governors – disqualification and removal

16.1. A person may not become a Governorof the Trust, and if already holding such office will immediately cease to do so if:
16.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
16.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

16.1.3. they have within the preceding five years, been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.
16.1.4. they are a Director or Company Secretary of this Trust, a Director of another NHS Trust or a Governor or Non-Executive Director of another NHS Foundation Trust;
16.1.5. they are under 16 years of age;
16.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
16.1.7. their behaviour does not meet the Nolan principles / Standards of Public Life
16.1.8. they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

17. Council of Governors - termination of office and removal of Governors

17.1. A person holding office as a Governor shall immediately cease to do so if:
17.1.1. they resign by notice in writing to the Secretary;
17.1.2. they fail to attend two meetings in any 12 month period, unless the other Governors are satisfied that:
17.1.3. the absences were due to reasonable causes; and
17.1.4. they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.
17.1.5. in the case of an elected Governor, they cease to be a member of the constituency by whom they were elected;
17.1.6. in the case of an appointed Governor, the appointing organisation terminates the appointment;
17.1.7. they have failed to undertake any training which the Council of Governors requires all Governors to undertake;
17.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;
17.1.9. they refuse to sign a declaration in the form specified by the Council of Governors that they are a member of a specific public constituency and are not prevented from being a member of the Council of Governors. This does not apply to staff members;
17.1.10. they are removed from the Council of Governors under the following provisions.

17.2. A Governorr may be removed from the Council of Governors by a resolution approved by a 66% not less than three-quarters of the remaining Governors Members present and voting at a general meeting of the Council of Governors on the grounds that:
17.2.1. they have committed a serious breach of the code of conduct; or

17.2.2. they have acted in a manner detrimental to the interests of the Trust; and

17.2.3. the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.

Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable.

18. Council of Governors – duties of Governors

18.1. The general duties of the Council of Governors are:

18.1.1. to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;

18.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public

18.1.3. to form a rounded view of the interests of the "public at large" to support collaboration and system working; this includes the population of the West Yorkshire ICS ;

18.2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

18.3. The Council of Governors shall appoint at a general meeting one of its public members to be Lead Governor of the Council of Governors.

18.4. The specific roles and responsibilities of the Council of Governors are set out in Annexe 5 – Roles and Responsibilities.

19. Council of Governors – meetings of the Council of Governors

19.1. The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed with the provisions of paragraph 26 below) or, in his absence the Deputy Chair (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the Council of Governors.

19.2. Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

19.3. For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, the Council of Governors may require one or more of the directors to attend a meeting.

20. Council of Governors – standing orders

20.1. The standing orders for the practice and procedure of the Council of Governors and its meetings are included in a separate document which is attached at Annexe 8.

21. Council of Governors – conflicts of interest

21.1. If a Council of Governors has a pecuniary, personal or family interest, whether that interest is actual or potential, or whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the councillor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

21.2. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or the consideration of the matter in respect of which an interest has been disclosed. This should be in line with the NHS England guidance on Conflicts of Interest.

21.3. The Standing Orders for the Council of Governors are attached at Annexe 7.

22. Council of Governors - expenses

22.1. The Trust may pay travelling and other expenses to Governors at such rates as it decides. These are set out in the Standing Orders for the Council of Governors at Annexe 7 and are to be disclosed in the annual report.

22.2. Expenses claims must be submitted in line with the Trust's expenses policy.

22.3. Governors are not to receive remuneration.

23. Board of Directors – general duty

23.1. The business of the Trust is to be managed by the Board of Directors, who (subject to this Constitution) shall exercise all the powers of the Trust. The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust as to maximise the benefits for the members of the Trust as a whole and for the public.

23.2. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Directors are appointed or any vacancy on the Board of Directors.

23.3 The Trust will comply with the statutory requirements of the Code of Governance for NHS Provider Trusts issued by NHS England. Section A of this code details the principles and provisions relating to Board leadership and purpose.

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 7 other Non-Executive Directors;
- 24.2.3. up to 7 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.

25. Board of Directors – appointment and removal of the Chair, Deputy Chair and other 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 (SINED).

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 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.

25.6. 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.

26. Board of Directors – Senior Independent Director

26.1. The Board of Directors will appoint one Non-Executive Director to be the Senior Independent Director.

26.2. The Trust has a detailed job description for the Senior Independent Director. The main duties include:

26.2.1. Being available to members of the Foundation Trust and to the Council of Governors if they have concerns that contact through the usual channels of Chair, Chief Executive, Finance Director and Company Secretary has failed to resolve or where it would be inappropriate to use such channels. In addition to the duties described here the Senior Independent Director has the same duties as the other Non-Executive Directors.

26.2.2. A key role in supporting the Chair in leading the Board of Directors and acting as a sounding board and source of advice for the Chair. The Senior Independent Director also has a role in supporting the Chair as Chair of the Council of Governors.

26.2.3. While the Council of Governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on its behalf.

26.2.4. The Senior Independent Director should maintain regular contact with the Governors and attend meetings of the Council of Governors to obtain a clear understanding of Council of Governors views on the key strategic performance issues facing the Foundation Trust. The Senior Independent Director should also be available to Governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

26.2.5. In rare cases where there are concerns about the performance of the chair the Senior Independent Director should provide support and guidance to the Council of Governors in seeking to resolve concerns or in the absence of a resolution in taking formal action. Where the foundation Trust has appointed a lead Governor the Senior Independent Director should liaise with the Lead Governor in such circumstances.

26.2.6. In circumstances where the board is undergoing a period of stress the Senior Independent Director has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the Council of Governors regarding the chair's performance; where the relationship between the chair and the chief executive is either too close or not sufficiently harmonious, where the Foundation Trust's strategy is not supported by the whole Board or where key decisions are being made without reference to the Board or where succession planning is being ignored.

26.2.7. In the circumstances outlined above, the Senior Independent Director will work with the chair, other directors and/or Governors, to resolve significant issues.

27. Board of Directors – tenure of Non-Executive Directors

27.1. The Chair and the Non-Executive Directors are to be appointed for a period of three years.

27.2. The Chair and the Non-Executive Directors will serve for a maximum of two terms.

27.3. 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.

28. Board of Directors – appointment and removal of the Chief Executive and other executive directors

28.1. The Non-Executive Directors shall appoint or remove the Chief Executive.

28.2. The appointment of the Chief Executive requires the approval of the Council of Governors.

28.3. A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

29. Board of Directors – disqualification

29.1. A person may not become or continue as a Director of the Trust if:

- 29.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
- 29.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;
- 29.1.3. they have within the preceding five years been convicted in the British Islands of any offence, and a sentenced of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;
- 29.1.4. they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
- 29.1.5. they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- 29.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- 29.1.7. in the case of a Non-Executive Director they have failed to fulfil any training requirement established by the Board of Directors; or
- 29.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors and fit and proper persons test; or

30. Board of Directors - meetings

30.1. Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may

exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

30.2. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

30.3. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. Board of Directors – standing orders

31.1. The standing orders for the practice and procedure of the Board of Directors are attached at Annexe 8.

32. Board of Directors – conflicts of interest of directors

32.1. The duties that a director of the Trust has by virtue of being a director include in particular –

32.1.1. A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2. A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2. The duty referred to in sub-paragraph 31.1.1 is not infringed if –

32.2.1. The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2. The matter has been authorized in accordance with the constitution.

32.3. The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4. In sub-paragraph 31.1.2, “third party” means a person other than –

32.4.1. The Trust, or

32.4.2. A person acting on its behalf.

32.5. If a director of the Trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9. A director need not declare an interest –
- 32.9.1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
- 32.9.2. If, or to the extent that, the directors are already aware of it;
- 32.9.3. If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –
  - 32.9.3.1. By a meeting of the Board of Directors, or
  - 32.9.3.2. By a committee of the directors appointed for the purpose under the constitution.

32.10. Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and it shall be recorded in a register of interests and the Director in question:
- 32.10.1. shall not be present except with the permission of the Board of Directors in any discussion of the matter, and
- 32.10.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

32.11. Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors.

32.12. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Director or their spouse or partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust, including private healthcare organisations and other foundation Trusts.

32.13. The exceptions which shall not be treated as material interests are as follows:
- 32.13.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.

33. Board of Directors – remuneration and expenses

33.1. The Board of Directors shall appoint an executive remuneration committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and Executive Directors.

33.2. The remuneration and allowances, and the other terms and conditions of office, of the Chair and Non-Executive Directors shall be decided by the Council of Governors at a general meeting. The Council of Governors may take advice from independent pay advisors whose Terms of Reference will be established and ratified by the Board of Directors and the Council of Governors.

33.3. The remuneration and allowances for Directors are to be disclosed in the annual report.

34. Secretary

34.1. The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary shall be accountable to the Chief Executive and their functions shall include:

34.1.1. acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

34.1.2. summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

34.1.3. keeping the register of members and other registers and books required by this Constitution to be kept;

34.1.4. having charge of the Trust's seal;

34.1.5. publishing to members in an appropriate form information which they should have about the Trust's affairs;

34.1.6. preparing and sending to NHS England and any other statutory body all returns which are required to be made;

34.1.7. providing support to the Council of Governors and the Non-Executive Directors;

34.1.8. overseeing elections conducted under this Constitution;

34.1.9. offering advice to the Council of Governors and the Board of Directors on issues of governance and corporate responsibility.

34.2. Minutes of every members meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be included on the agenda of the next meeting.

35. Registers

35.1. The Trust is to have:

35.1.1. a Register of Members showing, in respect of each Member, the name of the member, the constituency to which they belong and, (where the Council of Governors has decided that the Membership of the Public, or Staff constituencies shall be sub-divided for election purposes) any sub-division of that constituency to which they belong;

35.1.2. a Register of Members of the Council of Governors;

35.1.3. a Register of Directors;

35.1.4. a Register of Interests of Governors

35.1.5. a Register of Interests of the Directors.

35.2. The Secretary shall add to the Register of Members any individual who becomes a Member of the Trust or remove from the Register of Members the name of any Member who ceases to be entitled to be a Member under the provisions of this Constitution.

36. Documents available for public inspection

36.1. The following documents of the Trust are to be available for inspection by members of the public. If the person requesting a copy or extract under this paragraph is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36.1.1. a copy of the current Constitution;

36.1.2. a copy of the current Authorisation;

36.1.3. a copy of the latest annual accounts and of any report of the auditor on them;
36.1.4. a copy of the report of any other auditor of the Trust's affairs appointed by the Council of Governors;
36.1.5. a copy of the latest annual report;
36.1.6. a copy of the latest information as to its forward planning;
36.1.7. a copy of the Trust's Membership Strategy;
36.1.8. a copy of any notice given under section 52 of the 2006 Act (NHS England's's notice to failing NHS Foundation Trust).
36.1.9. The register of Members shall be made available for inspection by members of the public. Article 2(b) of the Public Benefit Corporation (Register of Members) Regulations 2004 allows for members to request their details are not published as part of the Register of Members.

37. Auditors

37.1. The Trust is to have an auditor and is to provide the auditor.

37.2. The Council of Governors at a general meeting shall appoint or remove the Trust's auditors.

37.3. The auditor is to carry out his duties in accordance with Schedule 7 to the 2006 Act and in accordance with any directions given by NHS England standards, procedures and techniques to be adopted.

38. Audit and Risk Committee

38.1. The Trust shall establish a committee of Non-Executive Directors as an Audit and Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

39. Accounts

39.1. The Trust must keep proper accounts and proper records in relation to the accounts.

39.2. NHS England may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.

39.3. The accounts are to be audited by the Trust's auditor.

39.4. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

39.5. The following documents will be made available to the Auditor General for examination at their request:
39.5.1. the accounts;
39.5.2. any records relating to them; and
39.5.3. any report of the auditor on them.

39.6. The annual accounts, any report of the auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

39.7. The Trust shall:
39.7.1. lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and
39.7.2. once it has done so, send copies of those documents to NHS England.

40. Annual report, forward plans and non-NHS work

40.1. The Trust is to prepare an Annual Report and send it to NHS England.

40.2. The Trust is to give information as to its forward planning in respect of each financial year to NHS England. The document containing this information is to be prepared by the Directors, and in preparing the document the Board of Directors shall have regard to the views of the Council of Governors.

40.3. Each forward plan must include information about:-
40.3.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
40.3.2. the income it expects to receive from doing so.

40.4. Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 39.3.1 the Council of Governors must:-
40.4.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and
40.4.2. notify the directors of the Trust of its determination.

40.5. A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors voting to approve its implementation.

41. Indemnity

41.1. Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and the benefit of members of the Council of Governors and Board of Directors and the Secretary.

42. Seal

42.1. The Trust shall have a seal.

42.2. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

43. Dispute Resolution Procedures

43.1. Every unresolved dispute which arises out of this Constitution between the Trust and:

43.1.1. a Member; or

43.1.2. any person aggrieved who has ceased to be a Member within the six months prior to the date of the dispute; or

43.1.3. any person bringing a claim under this Constitution; or

43.1.4. an office-holder of the Trust;

is to be submitted to an arbitrator agreed by the parties. The arbitrator's decision will be binding and conclusive on all parties.

44. Amendment of the constitution

44.1. The Trust may make amendments of its Constitution only if:-

44.1.1. More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2. More than half of the members of the Board of Directors of the Trust voting approve the amendments.

44.2. Amendments made under paragraph 43.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3. Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)

44.3.1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

44.3.2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4. If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.5. Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers etc. and significant transactions

45.1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

45.2. The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

45.3. The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

46. Dissolution of the Trust

46.1. The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

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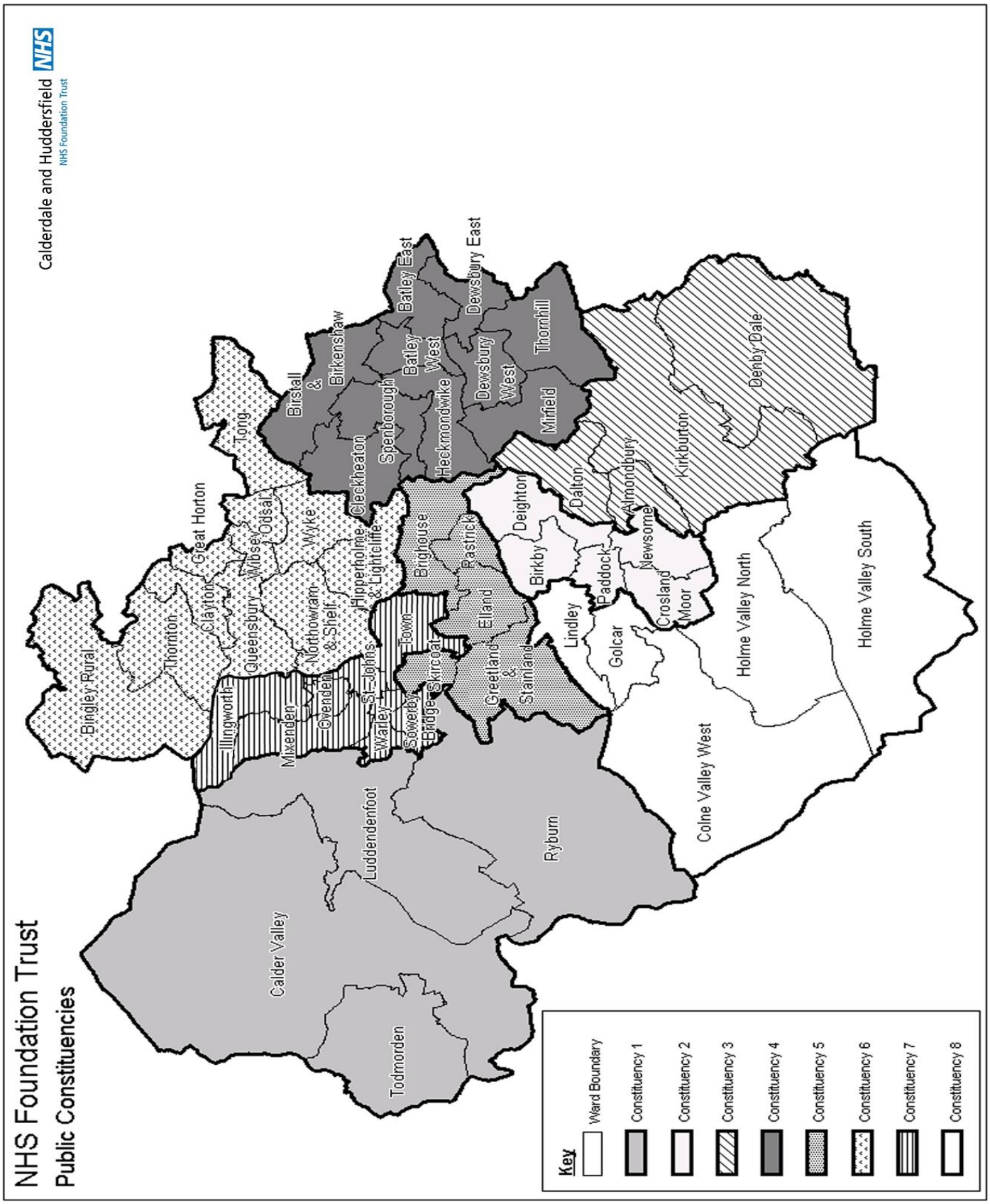
ANNEXE 1 – PUBLIC CONSTITUENCIES (See Map below and Rest of England)



Constituency	Wards	Population	Number of Governors to be elected
1	Todmorden	37,487	2
	Calder Valley		
	Luddendenfoot		
	Ryburn		
2	Birkby	62,501	2
	Deighton		
	Paddock		
	Crosland Moor		
	Newsome		
3	Dalton	56,161	2
	Almondbury		
	Kirkburton		
	Denby-Dale		
4	Cleckheaton	144,794	2
	Birstall & Birkenshaw		
	Spenborough		
	Heckmondwike		
	Batley West		
	Batley East		
	Mirfield		
	Dewsbury West		
	Dewsbury East		
	Thornhill		
5	Skircoat	47,727	2
	Greetland & Stainland		
	Elland		
	Rastrick		
	Brighouse		
6	Northowram & Shelf	150,326	2
	Hipperholme & Lightcliffe		
	Bingley Rural		
	Thornton		
	Clayton		
	Queensbury		
	Great Horton		
	Wibsey		
	Odsall		
	Wyke		
	Tong		
7	Illingworth & Mixenden	63,407	2
	Ovenden		
	Warley		
	Sowerby Bridge		
	St Johns		

Constituency	Wards	Population	Number of Governors to be elected
	Town		
8	Lindley	73,412	2
	Golcar		
	Colne Valley West		
	Holme Valley North		
	Holme Valley South		
9	**Rest of England** - any other electoral are England with the exception of the above		**2**

Note on Constituencies

Population data and indices of deprivation have been used to formulate the eight constituencies. Constituencies are as close as possible to one eighth of the population of Calderdale and Kirklees, though attempts to reflect Local Authority boundaries and areas of similar deprivation levels mean there is some variation. Constituencies 4 and 6 are noticeably larger because persons in these constituencies mostly use services provided by other NHS Trusts. Each Constituency comprises of several electoral areas for local government elections.

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Part 1 Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:
"corporation" means the public benefit corporation subject to this constitution;
"election" means an election by a constituency, or by a class within a constituency, to fill vacancy among one or more posts on the council of governors;
"the regulator" means the Independent Regulator for NHS foundation Trusts; and
"the 2006 Act" means the National Health Service Act 2006
"e-voting" means voting using either the internet, telephone or text message;
"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
"method of polling" means voting either by post, internet, text message or telephone
"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;
"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	**Not later than the fortieth day before the day of the close of the poll.**
Final day for delivery of nomination papers to returning officer	**Not later than the twenty eighth day before the day of the close of the poll.**
Publication of statement of nominated candidates	**Not later than the twenty seventh day before the day of the close of the poll.**
Final day for delivery of notices of withdrawals by candidates from election	**Not later than the twenty fifth day before the day of the close of the poll.**
Notice of the poll	**Not later than the fifteenth day before the day of the close of the poll.**
Close of the poll	**By 5.00pm on the final day of the election.**

Computation of time

3.1 In computing any period of time for the purposes of the timetable:
(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,
shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 Returning Officer

4.1 Subject to rule 66, the returning officer for an election is to be appointed by the corporation.
4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff
5.1 Subject to rule 66, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure
6.1 The corporation is to pay the returning officer:
(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation
7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 Stages

8. Notice of election
8.1 The returning officer is to publish a notice of the election stating:
(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates
9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination paper, and
(b) is to prepare a nomination paper for signature at the request of any member of the corporation,
but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

10. Candidate’s particulars
10.1 The nomination paper must state the candidate’s:
(a) full name,
(b) contact address in full, and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests
11.1 The nomination paper must state:
(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination paper must include a declaration made by the candidate:
(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Any member who chooses to nominate themselves for the role of governor must meet the Standards of Public Life (Nolan Principles) and sign a declaration at the point of nomination to confirm that they meet these principles of public life.

An online literature review will be undertaken of all members who wish to nominate themselves as a governor. Where this identifies any issues in relation to an individual meeting the standards of public life and / or acting in a way that is detrimental to the interests of the Trust, these concerns regarding a potential nomination will be notified to the Chair, Company Secretary and lead governor. If a recommendation is made that a nomination should not proceed then an extra-ordinary meeting of the Council of Governors should take place to consider the recommendation. The individual/member will be notified of the outcome of the Council of Governors. Consideration should also be given to formal removal of the member in question – see section 8.

14.2 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.3 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:
(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.4 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.5 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.6 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:
(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,
as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.
16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:
(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:
(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.
(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.
(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

Action to be taken before the poll

21. List of eligible voters

21.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

21.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

21.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

22. Notice of poll

22.1 The returning officer is to publish a notice of the poll stating:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19 (3).
(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located.
(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located,
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located,
(j) the address and final dates for applications for replacement voting information, and
(k) the contact details of the returning officer.

23. Issue of voting information by returning officer

23.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information:
(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:
(i) a ballot paper
(ii) information about each candidate standing for election, pursuant to rule 61 of these rules,
(iii) a covering envelope

(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
(i) instructions on how to vote
(ii) the eligible voters voter ID number
(iii) information about each candidate standing for election, pursuant to rule 61 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate.
(iv) contact details of the returning officer.

23.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

24. The covering envelope

24.1 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25. E-voting systems

25.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

25.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

25.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

25.4 The provision of the polling website and internet voting system, will:
(a) require a voter, to be permitted to vote, to enter his voter ID number;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote, and

(e) if their vote has been cast and recorded, provide the voter with confirmation

(f) prevent any voter voting after the close of poll.

25.5 The provision of a telephone voting facility and telephone voting system, will:
(a) require a voter to be permitted to vote, to enter his voter ID number;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

25.6 The provision of a text message voting facility and text messaging voting system, will:
(a) require a voter to be permitted to vote, to provide his voter ID number;

(b) prevent a voter voting for more candidates than he is entitled to at the election;

d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

The poll

26. Eligibility to vote
26.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance
27.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

27.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

28. Spoilt ballot papers
28.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

28.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

28.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless satisfied as to the voter’s identity.

28.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):
(a) is satisfied as to the voter’s identity, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement spoilt ballot paper.

29. Lost voting information
29.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

29.2 The returning officer may not issue replacement voting information for lost voting information unless they:
(a) are satisfied as to the voter’s identity,
(b) have no reason to doubt that the voter did not receive the original voting information.

29.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, and
(c) if applicable, the voter ID number of the voter.

30. Issue of replacement voting information
30.1 If a person applies for replacement voting information under rule 28 or 29, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 28.3 or 29.2, they are also satisfied that that person has not already voted in the election.

Polling by internet, telephone or text

31. Procedure for remote voting by internet
31.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information,

31.2 When prompted to do so, the voter must enter their voter ID number.

31.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

31.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

31.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

32. Voting procedure for remote voting by telephone
32.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

32.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

32.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

32.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

32.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

33. Voting procedure for remote voting by text message
33.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

33.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

33.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

34. Receipt of voting documents

34.1 Where the returning officer receives a:
(a) covering envelope, or
(b) any other envelope containing a ballot paper,
before the close of the poll, that officer is to open it as soon as is practicable; and rules 35 and 36 are to apply.

34.2 The returning officer may open any covering envelope for the purposes of rules 35 and 36, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

34.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers.

35. Validity of votes

35.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll.

35.2 Where the returning officer is satisfied that rule 35.1 has been fulfilled, the ballot paper is to be put aside for counting after the close of the poll.

35.3 Where the returning officer is not satisfied that rule 35.1 has been fulfilled, they should:
(a) mark the ballot paper “disqualified”,
(b) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and
(c) place the document or documents in a separate packet.

35.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or text voting record has been received by the returning officer before the close of the poll.

36. De-duplication of votes

36.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

36.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:
(a) only accept as duly returned the first vote received that contained the duplicated voter ID number
(b) mark as “disqualified” all other votes containing the duplicated voter ID number

36.3 Where a ballot paper is “disqualified” under this rule the returning officer shall:
(a) mark the ballot paper “disqualified”,
(b) record the unique identifier and voter id number on the ballot paper in a list (the “list of disqualified documents”); and
(c) place the ballot paper in a separate packet.

36.4 Where an internet, telephone or text voting record is “disqualified” under this rule the returning officer shall:
(a) mark the record as “disqualified”,
(b) record the voter ID number on the record in a list (the “list of disqualified documents”.
(c) disregard the record when counting the votes in accordance with these Rules.

37. Sealing of packets

37.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 35 and 36, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots
(d) the list of eligible voters, and
(e) complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

Part 6 Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

STV38. Interpretation of Part 6

STV38.1In Part 6 of these rules:
"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record.
"continuing candidate" means any candidate not deemed to be elected, and not excluded,
"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,
"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,
"mark" means a figure, an identifiable written word, or a mark such as "X",
"non-transferable vote" means a ballot:
(a) on which no second or subsequent preference is recorded for a continuing candidate,
or
(b) which is excluded by the returning officer under rule STV46,
"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,
"quota" means the number calculated in accordance with rule STV43,
"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus,
"stage of the count" means:
(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,
"transferred vote" means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred, and
"transfer value" means the value of a transferred vote calculated in accordance with rules STV44.4 or STV44.7.

39. Arrangements for counting of the votes

39.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

40. The count

40.1 The returning officer is to:
(a) count and record the number of votes that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

40.2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

40.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV41. Rejected ballot papers

STV41.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV41.2The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV41.3 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV41.1

FPP41. Rejected ballot papers

FPP41.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,
shall, subject to rules FPP41.2 and FPP41.3, be rejected and not counted.

FPP41.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP41.3 A ballot paper on which a vote is marked:
(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP41.4 The returning officer is to:
(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP41.2 and FPP 41.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP41.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:
(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,
and, where applicable, each heading must record the number of ballot papers rejected in part.

STV42. First stage
STV42.1 The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

STV42.2 The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

STV42.3 The returning officer is to also ascertain and record the number of valid ballots.

STV43. The quota
STV43.1 The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

STV43.2 The result, increased by one, of the division under rule STV43.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV43.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV44.1 to STV44.3 has been complied with.

STV44. Transfer of votes
STV44.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:
(a) according to next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.2 The returning officer is to count the number of ballots in each parcel referred to in rule

STV44.3 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.1(a) to the candidate for whom the next available preference is given on those papers.

STV44.4 The vote on each ballot transferred under rule STV44.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV44.5 Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:
(a) according to the next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.6 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.5(a) to the candidate for whom the next available preference is given on those ballots.

STV44.7 The vote on each ballot transferred under rule STV44.6 shall be at:
(a) a transfer value calculated as set out in rule STV44.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV44.8 Each transfer of a surplus constitutes a stage in the count.

STV44.9 Subject to rule STV44.10, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV44.10 Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:
(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV44.11 This rule does not apply at an election where there is only one vacancy.

STV45. Supplementary provisions on transfer

STV45.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballots of the candidate with the highest surplus shall be transferred first, and if:
(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

STV45.2 The returning officer shall, on each transfer of transferable ballots under rule STV44:
(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV45.3 All ballots transferred under rule STV44 or STV45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

STV45.4 Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule STV44 or STV45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV46. Exclusion of candidates
STV46.1 If:
(a) all transferable ballots which under the provisions of rule STV44 (including that rule as applied by rule STV46.11 and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV47, one or more vacancies remain to be filled,
the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV46.12 applies, the candidates with the then lowest votes).

STV46.2 The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule STV46.1 into two sub-parcels so that they are grouped as:
(a) ballots on which a next available preference is given, and
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV46.3 The returning officer shall, in accordance with this rule and rule STV45, transfer each sub-parcel of ballots referred to in rule STV46.2 to the candidate for whom the next available preference is given on those ballots.

STV46.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV46.5 If, subject to rule STV47, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been transferred to any candidate excluded under rule STV46.1 into sub- parcels according to their transfer value.

STV46.6 The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

STV46.7 The vote on each transferable ballot transferred under rule STV46.6 shall be at the value at which that vote was received by the candidate excluded under rule STV46.1.

STV46.8 Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV46.9 After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV46.1.

STV46.10 The returning officer shall after each stage of the count completed under this rule:
(a) record:
(i) the total value of votes, or
(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:
(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV46.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV44.5 to STV44.10 and rule STV45.

STV46.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV46.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV47. Filling of last vacancies
STV47.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV47.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV47.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV48. Order of election of candidates
STV48.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV44.10.

STV48.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV48.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV48.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP48. Equality of votes
FPP48.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 Final proceedings in contested and uncontested elections

FPP49. Declaration of result for contested elections
FPP49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:
(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who they have declared elected:
(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
(ii) in any other case, to the Chair of the corporation; and
(c) give public notice of the name of each candidate whom they have declared elected.

FPP49.2 The returning officer is to make:
(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP41.5,
available on request.

STV49. Declaration of result for contested elections
STV49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:
(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b) give notice of the name of each candidate who they have declared elected –
(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
(ii) in any other case, to the Chair of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

STV49.2 The returning officer is to make:
(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV41.1,
available on request.

50. Declaration of result for uncontested elections
50.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:
(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who they have declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who they have declared elected.

Part 8 Disposal of documents

51. Sealing up of documents relating to the poll

51.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:
(a) the counted ballot papers,
(b) the ballot papers endorsed with "rejected in part",
(c) the rejected ballot papers, and
(d) the statement of rejected ballot papers.
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.2 The returning officer must not open the sealed packets of:
(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots,
(d) the list of eligible voters, and
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.3 The returning officer must endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

52. Delivery of documents

52.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 51, the returning officer is to forward them to the chair of the corporation.

53. Forwarding of documents received after close of the poll

53.1 Where:
(a) any voting documents are received by the returning officer after the close of the poll,
or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voter information is made too late to enable new ballot papers to be issued,
The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

54. Retention and public inspection of documents

54.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

54.2 With the exception of the documents listed in rule 55.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

54.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so

55. Application for inspection of certain documents relating to an election

55.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing –
(a) any rejected ballot papers, including ballot papers rejected in part,
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers, or
(d) the list of eligible voters,
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

55.2 A person may apply to the Regulator to inspect any of the documents listed in rule 55.1, and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

55.3 The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –
(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening, and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

55.4 On an application to inspect any of the documents listed in rule 55.1:
(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –
(i) that their vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 Death of a candidate during a contested election

FPP56. Countermand or abandonment of poll on death of candidate
FPP56.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP56.2 Where a new election is ordered under rule FPP56.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP56.3 Where a poll is abandoned under rule FPP56.1(a), rules FPP56.4 to FPP56.7 are to apply.

FPP56.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 35 and 36, and is to make up separate sealed packets in accordance with rule 37.

FPP56.5 The returning officer is to:
(a) count and record the number of ballot papers that have been received, and
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.
(c) seal up the electronic copies of records that have been received referred to in rule 25 held in a device suitable for the purpose of storage.

FPP56.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP56.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP56.4 to FPP56.6, the returning officer is to deliver them to the Chair of the corporation, and rules 54 and 55 are to apply.

STV56. Countermand or abandonment of poll on death of candidate
STV56.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
(i) ballots which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
(ii) ballots which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV56.2 The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 51.1(a).

Part 10 Election expenses and publicity

57. Election expenses
57.1 Any expenses incurred, or payments made, for the purposes of an election which to the regulator under Part 11 of these rules.

58. Expenses and payments by candidates
58.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

59. Election expenses incurred by other persons
59.1 No person may:
(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

59.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 60 and 61.

Publicity

60. Publicity about election by the corporation
60.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

60.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 61, must be:
(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, the expense of the electoral prospects of one or more other candidates.

60.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

61. Information about candidates for inclusion with voting information

61.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 23 of these rules.

61.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a polling method, the numerical voting code, allocated by the returning officer, to each candidate, for the purpose of recording votes on the telephone voting facility or the text message voting facility, and
(c) a photograph of the candidate.

62. Meaning of "for the purposes of an election"

62.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

62.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11Questioning elections and the consequence of irregularities

63. Application to question an election

63.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

63.2 An application may only be made once the outcome of the election has been declared by the returning officer.

63.3 An application may only be made to the Regulator by:
(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

63.4 The application must:
(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the Regulator may require.

63.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

63.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

63.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

63.8 The determination by the person or persons nominated in accordance with rule 63.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

63.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 Miscellaneous

64. Secrecy

64.1 The following persons:
(a) the returning officer,
(b) the returning officer's staff,
must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
iv) the candidate(s) for whom any member has voted.

64.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

64.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

65. Prohibition of disclosure of vote

65.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

66. Disqualification

66.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:
(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

67. Delay in postal service through industrial action or unforeseen event

67.1 If industrial action, or some other unforeseen event, results in a delay in:
(a) the delivery of the documents in rule 23, or
(b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

UPDATED 11.04.23. -see version history (electronic voting)

ANNEX 3 – FURTHER PROVISIONS

(From paragraph 9.2)

Termination of Membership

1. A Member may be expelled by a resolution approved by not less than 66% of the full Council of Governors present and voting at a meeting of the Council of Governors – this may be either a public or an extra ordinary meeting as appropriate to the timeframe. The following procedure is to be adopted.

2. Any Member may complain to the Company Secretary that another Member has acted in a way detrimental to the interests of the Trust.

3. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each Member's point of view is heard and may either:

   3.1. dismiss the complaint and take no further action; or
   3.2. arrange for a resolution to expel the Member complained of to be considered at either a public or extra-ordinary meeting of the Council of Governors.

4. If a resolution to expel a Member is to be considered at either a public or extra-ordinary meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one week before the meeting with an invitation to answer the complaint and attend the meeting.

5. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

6. If the Member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

7. A person expelled from Membership will cease to be a Member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

8. No person who has been expelled from Membership is to be re-admitted except by a resolution carried by the votes of three quarters of the Council of Governors present and voting at a general meeting.

ANNEX 4 – ANNUAL MEMBERS' MEETING

(From paragraph 10.2)

1. All Members meetings, other than annual meetings, are called special members meetings.

2. Members' meetings are open to all members of the Trust, members of the Council of Governors and the Board of Directors, representatives of the Trust's financial auditors, but not to members of the public. The Council of Governors may invite representatives of the media, and any experts or advisors, whose attendance they consider to be in the best interests of the Trust to attend a members' meeting.

3. All Members meetings are to be convened by the Secretary by order of the Chair of the Council of Governors or upon a resolution of the Board of Directors.

4. The Council of Governors may decide where a members' meeting is to be held and may also for the benefit of Members:

   4.1. arrange for the annual members' meeting to be held in different venues each year;
   4.2. make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

5. At the Annual Members' Meeting the Council of Governors shall present to the Members:
   5.1. the annual accounts;
   5.2. any report of the auditor;
   5.3. any report of any other auditor of the Trust's affairs;
   5.4. forward planning information for the next financial year;
   5.5. a report on steps taken to secure that (taken as a whole) the actual membership of its constituencies is representative of those eligible for such membership;
   5.6. the progress of the Membership Strategy;
   5.7. any proposed changes to the policy for the composition of the Council of Governors and of the Non-Executive Directors.
   5.8. the results of the election and appointment of Council of Governors Members will be announced.

6. Notice of a Members' meeting is to be given:
   6.1. by notice on the Trust's website at least 14 clear days before the date of the meeting
   6.2. by notice emailed to all those members for whom we hold an email address
   6.3. included within the Trust's members newsletter
   6.4. be given to the Council of Governors and the Board of Directors, and to the auditors;

7. The notice of the member's meeting must:
   7.1. state whether the meeting is an annual or special members' meeting;
   7.2. give the time, date and place of the meeting; and
   7.3. indicate the business to be dealt with at the meeting.

8. It is the responsibility of the Council of Governors, the Company Chair of the meeting and the Secretary to ensure that at any members meeting:
   8.1. the issues to be decided are clearly explained;
   8.2. sufficient information is provided to members to enable rational discussion to take place;
   8.3. where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.

9. The Chair of the Trust or, in their absence, the Deputy-Chair or, in their absence, the Lead Governor is to chair Council of Governor meetings.

10. Subject to this Constitution, a resolution put to the vote at a members' meeting shall, except where a poll is demanded or directed, be decided upon by a show of hands.

11. On a show of hands or on a poll, every member present is to have one vote. On a poll, votes may be given either personally or by proxy under arrangements laid down by the Council of Governors, and every member is to have one vote. In case of an equality of votes the Chair shall decide the outcome.

12. Unless a poll is demanded, the result of any vote will be declared by the Chair and recorded in the minutes. The minutes will be conclusive evidence of the result of the vote.

13. A poll may be directed by the Chair or demanded either before or immediately after a vote by show of hands by not less than one-tenth of the members present at the meeting. A poll shall be taken immediately.

ANNEX 5 – ROLES AND RESPONSIBILITIES OF GOVERNORS

(from Your Statutory Duties – A reference guide for NHS foundation trust governors / Addendum to your statutory duties 2022)) NHS England » Addendum to your statutory duties – reference guide for NHS foundation trust governors

1. The roles and responsibilities of the Governors are:
   - 1.1. at a general meeting, to appoint or remove the Chair and the other Non-Executive Directors;
   - 1.2. at a general meeting, to approve an appointment (by the Non-Executive Directors) of the Chief Executive;
   - 1.3. at a general meeting, to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;
   - 1.4. at a general meeting, to appoint or remove the Trust's auditor;
   - 1.5. at a general meeting, to be presented with the annual accounts, any report of the auditor on them and the annual report;
   - 1.6. at a general meeting, to appoint or remove any auditor appointed to review and publish a report on any other aspect of the Trust's affairs;
   - 1.7. hold Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors;
   - 1.8. represent the interests of the members of the Trust as a whole and the interests of the public at large.
   - 1.9. to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning in respect of each financial year;
   - 1.10. to approve "significant transactions";
   - 1.11. to approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
   - 1.12. to respond as appropriate when consulted by the Board of Directors in accordance with this Constitution;
   - 1.13. to approve amendments to the Trust's Constitution
   - 1.14. Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions;
   - 1.15. to undertake such functions as the Board of Directors shall from time to time request;
   - 1.16. to prepare and from time to time to review the Trust's Membership Strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors.

2. If governors are acting outside of the context of a Council of Governors meeting they do so solely as individuals, i.e. outside their statutory role as a governor.

3. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Members of the Council of Governors are appointed or any vacancy on the Council of Governors.

ANNEX 6 – COMPOSITION OF THE COUNCIL OF GOVERNORS

(from paragraph 12.2)

1. The Council of Governors of the Trust is to comprise:
   1.1. up to 18 Public Governors from 9 public constituencies (2 members from each constituency) set out in Annexe 1

   1.2. up to six Staff Governors from 1 Staff Constituency from the following classes:
      1.2.1. doctors and dentists (1 member);
      1.2.2. Allied Health Professionals, Health Care Scientists and Pharmacists (1 member);
      1.2.3. Management, Administration and Clerical (1 Member);
      1.2.4. Ancillary Staff (1 Member);
      1.2.5. Nurses and Midwives (up to 2 members);

   1.3. Two Local Authority Governors, one to be appointed by each of: Calderdale Metropolitan Borough Council and Kirklees Metropolitan Council;

   1.4. Up to six Governors appointed by partnership organisations. The partnership organisations shall appoint a governor to represent their organisation on the Council of Governors. The partnership organisations are identified as:
      - Huddersfield University,
      - South West Yorkshire Partnership NHS Foundation Trust
      - Locala Community Interest Company
      - Calderdale Huddersfield Solutions Limited
      - Calderdale Cares Partnership / West Yorkshire Health and Care Partnership Kirklees Health and Care Partnership/ West Yorkshire Health and Partnership

ANNEX 7 – COUNCIL OF GOVERNORS – STANDING ORDERS

AS APPROVED AT COUNCIL OF GOVERNORS APRIL 2021

A Public Benefit Corporation

STANDING ORDERS

COUNCIL OF GOVERNORS

Version:	2.0 Review and update including: - Expenses clarification - References to NHS England / NHS Improvement - Typographical amends 2.1 Addition of partner governor May 2019 3 April 2021 Integrated car system references added Addition of period after which governors may stand for re-election
Approved by:	Council of Governors / Board of Directors
Date approved:	17 January 2017 Version 2 17 October 2019 Version 3 22 April 2021 Version 4 20 April 2023 Updates for Health and Care Act 2022 and change from Council Member to Governor
Date issued:	17 October 2019
Next Review date:	In conjunction with the constitution but as a minimum every three years (2026)

CONTENTS

INTERPRETATION

In these Standing Orders, the provisions relating to interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and, in addition:

"**The Act**" shall mean the National Health Service Act 2012.

"**Terms of Authorisation**" shall mean the Authorisation of the Trust issued by NHS England with any amendments for the time being in force.

"**Corporation**" means Calderdale & Huddersfield NHS Foundation Trust, which is a public benefit corporation.

"**Board of Directors**" shall mean the Board of Directors as constituted in accordance with the Trust's constitution.

"**Chair**" means the person appointed to be Chair of the Trust under the terms of the constitution.

"**Chief Executive**" shall mean the chief officer of the Trust.

"**Constitution**" shall mean the constitution attached to the Authorisation with any variations from time to time approved by NHS England.

"**Council of Governors**" shall mean the Council of Members as constituted in accordance with the corporation's constitution.

"**Council of Governors"** shall mean those persons elected or appointed to sit on the Trust's Council of Governors.

Deputy Lead Governor lead governor, act as deputy in the absence of the lead governor and share workload as required and act as a sounding board for the lead governor
"**Director**" shall mean a member of the Board of Directors as defined in section 13 of the constitution.

"Governor" shall mean a governor member of the Council of Governors as defined in section 12 of the constitution.

"**Lead Governor"** is the Public Council of Governor selected by the Council of Governors to act as a lead for the Council of Governors and to chair meetings in those circumstances where both the Chair and Deputy Chair have a conflict.
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Integrated Care System (ICS) - is the West Yorkshire Health and Care Partnership.

"**NHS England**" is the previous name of the Independent Regulator for NHS Foundation Trusts. This changed to NHS Improvement on 1 April 2016and NHS England on 1 July 2022

"**Motion**" means a formal proposition to be discussed and voted on during the course of a meeting.

~~"**NHS Improvement**" was the Independent Regulator for NHS Foundation Trusts which came into being on 1 April 2016 formed from Monitor and the NHS Trust Development Authority .~~

"**Officer**" means an employee of the Trust.

"**Deputy Chair**" means the Deputy Chair of the Trust pursuant to the terms of the constitution who will preside at meetings of the Council of Governors in the Chair's absence.

"**Secretary**" means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary to the Board of Directors.

SECTION A: CONDUCT OF MEETINGS

1. Admission of the Public and the Press

1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with 12.24 of the Constitution."

1.2. The Chair (or Deputy Chair) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the Council of Governors may resolve as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public in accordance with 12.24 of the Trust's Constitution."

1.3. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without prior agreement of the Council of Governors.

2. Calling and notice of meetings

2.1. The Council of Governors is to meet at least three times in each financial year. Meetings shall be determined at the first meeting of the Council of Governors or at such other times as the Council of Governors may determine and at such places as they may from time to time appoint. Meetings may be held virtually or in person.

2.2. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least **ten working** days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website.

2.3. Meetings of the Council of Governors may be called by the Secretary, by the Chair, by the Board of Directors or by eight Governors (including two appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request giving at least **ten working days'** notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or four Governors, whichever is the case, shall call such a meeting.

2.4. In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified on the notice.

2.5. All meetings of the Council of Governors are to be general meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The

Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting

2.6. The Council of Governors may invite the Chief Executive or through the Chief Executive any other member or members of the Board of Directors, or a representative of the Trust's auditors or other advisors to attend a meeting of the Council of Governors. The Chief Executive and any Executive of the Trust nominated by the Chief Executive shall have the right to attend any meeting of the Council of Governors provided that they shall not be present for any discussion of their individual relationship with the Trust

2.7. The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

2.8. All decisions taken in good faith at a meeting of the Council of Governors, or of any of its committees, shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

2.9. Following notice of the meeting (as set out in SO 2.3) an agenda for the meeting, specifying the business proposed to be transacted at it shall be sent to every Governor, , so as to be available to him/her at least **five working** days before the meeting.

2.10. The agendas will include all supporting papers available at the time of posting. Further supporting papers will be received no later than **three (3)** working days before the meeting.

2.11. Lack of service of the notice on any one person above shall not affect the validity of the meeting, but failure to serve such a notice on more than six Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3. Quorum

3.1. Ten Council of Governors members (including not less than six Public Governors, not less than two Staff Governors and not less than two Appointed Governors – in line with the Constitution) present in person or by proxy under arrangements approved by the Council of Governors shall form a quorum

4. Setting the agenda

4.1. A Governor desiring a matter to be included on an agenda shall make the request in writing to the Chair at least **ten working** days before the meeting. Requests made less than fourteen clear days before a meeting may be included on the agenda at the discretion of the Chair or the Secretary.

5. Chairing of meeting

5.1. The Chair of the Trust or, in his/her absence, the Deputy Chair will chair meetings of the Council of Governors.

5.2. The Lead Governor will be appointed from the Public Membership at a general meeting. He/she will act as Chair of the meeting should the Chair and the Deputy Chair be in conflict. The Deputy Chair will hold the casting vote when he/she is acting as Chair.

6. Notices of motion

6.1. A Governor desiring to move or amend a motion shall send a written notice thereof at least **ten working** days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to preceding provisions.

7. Withdrawal of motion or amendments

7.1. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

8. Motion to rescind a resolution

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8.1. Notice of motion to amend or rescind any resolution (or general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governors who give it and also the signature of four other Governors, of whom at least two shall be Public Governors. When any such motion has been disposed of by the Trust, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months, although the Chair may do so if he/she considers it appropriate.

9. Motions

9.1. The mover of a motion shall have the right of reply at the close of any discussions on the motion or any amendment thereto.

9.2. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

a) An amendment to the motion.

b) The adjournment of the discussion or the meeting.

c) That the meeting proceed to the next business. (*)

d) The appointment of an ad hoc committee to deal with a specific item of business.

e) That the motion be now put. (*)

1. [*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.]

9.3. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

10. Chair's ruling

10.1. The decision of the Chair of the meeting on the question of order, relevancy and regularity shall be final.

11. Voting

11.1. Questions arising at a meeting of the Council of Governors requiring a formal decision shall be decided by a majority of votes. In case of an equality of votes the Chair shall decide the outcome. No resolution of the Council of Governors shall be passed if it is unanimously opposed by all of the Public Governors.

11.2. All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request, or the Secretary deems it advisable or necessary.

11.3. If at least one third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

11.4. If a Governor so requests his vote shall be recorded by name upon any vote (other than by paper ballot).

11.5. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

12. Minutes

12.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting

12.2. No discussion shall take place upon the minutes, except upon their accuracy, or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

12.3. Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust Website (required by the Code of Practice of Openness in the NHS).

12.4. The names of the Governors' present at the meeting and those who gave apologies for each meeting shall be recorded in the minutes.

12.5. Council of Governor Members' must make every effort to attend meetings of the Council of Governors where appropriate and practicable. Where is it's not possible for a Governor to attend apologies should be sent to the Corporate Governance Manager no later than three working days prior to the meeting.

SECTION B: COMMITTEES

13. Appointment of Committees

13.1. Subject to paragraph 40 below and such directions as may be given by NHS England, the Council of Governors may and, if directed to do so, shall appoint committees of the Council of Governors, consisting wholly or partly of Governors. In all cases, each committee shall have a majority of Public Governors.

13.2. A committee appointed under SO 13.1 may, subject to such directions as may be given by NHS England or the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

13.3. These Standing Orders, as far as it is applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Council of Governors.

13.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

13.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Council of Governors.

13.6. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted. Where the Council of Governors determines that persons who are neither Governors, nor directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Council of Governors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS England (in line with SO 20).

13.7. Where the Council of Governors is required to appoint persons to a committee or to undertake statutory functions as required by NHS England, and where such appointments are to operate independently of the Council of Governors or the Board of Directors, such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his nominated officer or any directions or guidance issued by NHS England from time to time.

14. Confidentiality

14.1. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

14.2. A Governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

14.3. In relation to patient confidentiality, the provisions at paragraphs 42 and 43 above for disclosure of information by Governors or members of committees established by the Council of Governors shall not apply, and such information shall not be disclosed under any circumstances.

15. Appointment of the Chair, Deputy Chair and Non-Executive Directors

15.1. The Council of Governors shall appoint a Chair of the Trust. 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, also take on the role of SINED (Senior Independent Non-Executive Director). The Council of Governors shall ratify the appointment of the Vice Chair at a general meeting.

15.2. Non-Executive Directors are to be appointed by a sub-committee (not exceeding four persons) of the Council of Governors using the procedures set out under paragraph 13 of the constitution.

SECTION C: REGISTER AND DISCLOSURE OF INTERESTS

16. Register and disclosure of interests

16.1. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or the Secretary.

16.2. Any Governor who has a material interest in a matter as defined below and in the constitution shall declare such an interest to the Council of Governors and it shall be recorded in a register of interests and the Governor in question:

a) Shall not be present except with the permission of the Council of Governors in any discussion of the matter, and

b) Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

16.3. Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

16.4. At the time the interests are declared, they should be recorded in the minutes of the Council of Governors. Any changes in interests should be officially declared at the next meeting as appropriate following the change occurring.

16.5. It is the obligation of a Governor to inform the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register upon receipt within three working days.

16.6. The details of Governors' interests recorded in the register will be kept up to date by the Secretary, and reviewed at each meeting of the Council of Governors.

16.7. Subject to the requirements of the Public Benefit Corporation (Register of Members) Regulations 2006 and the Data Protection Act 1998, the register will be available for inspection by the public free of charge and will be published on the Trust's website.

16.8. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the register.

16.9. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Governor, or their spouse or partner, in any firm or business which, in connection with the matter, is trading with the trust, or is likely to be considered as a potential trading partner with the trust. The exceptions which shall not be treated as material interests are as follows:

a) Shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

b) An employment contract held by staff Governors;

c) A contract with their Integrated Care Board / Integrated Care System (ICS) held by a Place / ICS governor;

d) An employment contract with a Local Authority held by a Local Authority Governor;

e) An employment contract with any organization listed at paragraph 12.3.5 of the constitution.

16.10. If, in relation to 47, the Chair has a conflict of interest, the Deputy Chair will exercise the casting vote. If the Deputy Chair has a conflict of interest, the Deputy Chair will preside and exercise the casting vote, the nomination to be approved by a majority vote of those present at the meeting.

16.11. An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the Council of Governors Charter as specified by the Council of Governors as to the basis upon which they are entitled to vote as a member. The Constitution provides guidance. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

16.12. Members of the Council of Governors must meet the requirements of the Fit and Proper persons test as per section 4.1 of Section C of the Code of Governance for NHS Provider Trusts (Composition succession and evaluation)

SECTION D: TERMINATION OF OFFICE AND REMOVAL OF GOVERNOR

17. Termination of office

17.1. A person holding office as a Governor on the Council of Governors shall immediately cease to do so if:

a) They resign by notice in writing to the Secretary;

b) They fail to attend two meetings in any Financial Year, unless the other l Governors are satisfied that the absences were due to reasonable causes, and they will be able to start attending meetings of the trust again within such a period as they consider reasonable;

c) In the case of an elected Council Governor, they cease to be a Member of the constituency by whom they were elected;

d) In the case of an appointed Council Governor, the Appointing Organisation terminates the appointment;

e) They have failed to undertake any training which the Council of Governors requires all Governors to undertake;

f) They have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the Code of Conduct for Council of Governors Charter;

g) They refuse to sign a declaration in the form specified by the Council of Governors that they are a Member of a specific public constituency and are not prevented from being a Member of the Council of Governors. This does not apply to Staff Governors;

h) They are removed from the Council of Governors under the following provisions.

18. Removal of Governor

18.1. A Governor r may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting at a general meeting of the Council of Governors on the grounds that:

a) They have committed a serious breach of the Code of Conduct; or

b) They have acted in a manner detrimental to the interests of the Trust; and

c) The Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor.

18.2. Where a person has been elected or appointed to be a Governor and he/she becomes disqualified for appointment, under SO 17.1 above, he/she shall notify the Secretary in writing of such disqualification.

18.3. If it comes to the notice of the Secretary that a person elected or appointed to be a Governor may be disqualified, under SO 17.1 above, from holding that office and the Secretary has not received a notice, under paragraph 59, from that person, the Secretary will make such inquiries as he/she thinks fit and, if satisfied that the person may be so disqualified, the Secretary will advise the Chair so that the Chair can make a recommendation for disqualification to the Council of Governors. The recommendation will either be made to a general meeting or to a meeting called specifically for the purpose.

18.4. The Secretary shall give notice in writing to the person concerned that the Trust proposes to declare the person disqualified as a Governor. In this notice, the Secretary shall specify the grounds on which it appears to him/her that the person is disqualified and give that person a period of fourteen days in which to make representations, orally or in writing, on the proposed disqualification.

18.5. The Chair's recommendations and any representations by the Governor concerned shall be made to the Council of Governors. If no representations are received within the specified time, or the Council of Governors upholds the proposal to disqualify, the Secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect. On such declaration the person's tenure of office shall be terminated and he/she shall cease to act as a Governor.

18.6. A Governor whose tenure of office is terminated under paragraph 18 shall not be eligible to stand for re-election. ~~Any re-election would take into account time served as a Governor so that a maximum term would not exceed 6 years.~~

SECTION E: REMUNERATION AND PAYMENT OF EXPENSES

19. Remuneration

19.1. Governors are not to receive remuneration.

20. Payment of expenses

20.1. The return cost of travel from the Governor

a) The actual bus or rail fare using the most direct route.

b) Travel by private car or taxi at the Trust's usual pence per mile rate (currently 28p per mile) using the most direct route.

c) Necessary parking charges.

20.2. Governors claiming expenses may be required to provide tickets, receipts or other proof of expenditure alongside a completed and signed expenses form.

20.3. Expenses will be authorised through the Secretary's office and details of all expenses claimed by Governors will be recorded and published in the Trust's Annual Report and Accounts.

SECTION F: STANDARDS OF CONDUCT OF GOVERNORS

21. Policy

21.1. In relation to their conduct as a member of the Council of Governors, each Governor must comply with the same standards of business conduct as for NHS staff. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

22. Interest of Governors in contracts

22.1. If it comes to the knowledge of a Governor that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust, he/she shall, at once, give notice in writing to the Secretary of the fact that he/she has such an interest.

22.2. A Governor shall not solicit for any person any appointment in the Trust.

22.3. Informal discussions outside appointment committees, whether solicited or unsolicited, should be declared to the committee.

SECTION G: MISCELLANEOUS PROVISIONS

23. Suspension of Standing Orders

23.1. Standing Orders may be suspended at any general meeting provided that:

a) at least two-thirds of the Council of Governors are present, including at least six elected Governors and one appointed Governor, and

b) the Secretary does not advise against it, and

c) a majority of those present vote in favour.

23.2. But Standing Orders cannot be suspended if to do so would contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution.

23.3. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting and any matters discussed during the suspension of Standing Orders shall be recorded separately and made available to all members of the Council of Governors.

23.4. No formal business may be transacted while Standing Orders are suspended.

24. Variation and amendment of Standing Orders

24.1. Standing Orders may only be varied or amended if:

a) the proposed variation does not contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution;

b) unless proposed by the Chair or the Chief Executive or the Secretary, a notice of motion under paragraph 19 has been given;

c) at least two-thirds of the Council of Governors are present, including at least six elected Governors and one appointed Governor, and at least half of the Governors present vote in favour of amendment.

25. Review of Standing Orders

25.1. Standing Orders shall be reviewed bi-annually by the Council of Governors. The requirement for review shall extend to all and any documents having effect as if incorporated in Standing Orders.

Calderdale and Huddersfield
NHS Foundation Trust

ANNEXE 8 – BOARD OF DIRECTORS – STANDING ORDERS

UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: March 2025
Review Lead: Company Secretary

STANDING ORDERS

BOARD OF DIRECTORS

Directorate responsible for policy:	Chief Executive's Office
Version:	V6 - scheduled review, update for legislation and guidance, mandatory and non mandatory Committees and standards of public life Section 1.2 Composition of the Board of Directors increase to up to 7 Non-Executive Directors and up to 7 Executive Directors. Section1.1 addition of roles and responsibilities of Board of Directors Section 5.3 addition of section on Compliance with Fit and Proper Persons Regulations Section
Policy author:	Company Secretary
Responsible Committee:	Audit and Risk Committee
Date written:	April 2017
Date approved:	2 March 2023
Date issued:	6 March 2023
Date of latest review:	January 2023
Next review date:	March 2025 - or earlier if required by regulation or statutory changes

TRUST STANDING ORDERS

FOREWORD to Standing Orders

Within their terms of authorisation issued by the Regulator NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the need to agree Standing Orders (SOs) and schedules of Reservations of Powers to the Trust and Scheme of Delegation in accordance with their constitutions, their Terms of Authorisation and the requirements of the National Health Service Act 2006 ("the 2006 Act") and 2012 Act

These Standing Orders, together with the documents below which form part of these "extended" Standing Orders, are extremely important. They provide a regulatory and governance framework for high standards of personal conduct and corporate conduct of the Trust and support public service values of accountability, probity and openness.

The additional documents which form part of these "extended" Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust
- Schedule of Decisions reserved to the Board of the Trust Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

.

These documents provide a comprehensive business framework and set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

All Directors and all members of staff should be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, be familiar with the detailed provisions.

Failure to comply with standing orders is a disciplinary matter which could result in dismissal.

DEFINITIONS

These Standing Orders are subject to continuous review (and formally reviewed and approved by the Audit and Risk Committee and Board of Directors every 2 years) to ensure that they reflect the obligations to which the Foundation Trust is subject under the Health

and Social Care (Community Health and Standards) Act 2003, National Health Service Act, 2006 (the 2006 Act) and the Health and Social Care Act, 2012,(the 2012 Act) the Terms of Authorisation and the provisions of its Constitution.

For the avoidance of doubt nothing contained within these Standing Orders shall be construed in contravention of the Terms of Authorisation and in the event that there is such a contravention, the Terms of Authorisation, the 2006 Act, 2012 Act, the Health and Care Act 2022and the Constitution shall take precedence.

Whilst the nature of these Standing Orders is that they are subject to variation, no such variation shall contravene the Terms of Authorisation, the 2006 Act and the Constitution.

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders. In this the Chair should be advised by the Chief Executive, guided by the Company Secretary, and in the case of Standing Financial Instructions, the Director of Finance.

Any expression to which a meaning is given in the 2006 Act, 2012 Act or 2022 Act in the Regulations or Orders made under the Act shall have the same meaning in this interpretation and in addition:

Accounting Officer	means the NHS Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
Associate Non-Executive Director	means a development role for potential Non-Executive Directors who is not an Officer of the Trust with no voting rights and who is appointed by the Council of Governors.
Board of Directors	The Board of Directors as constituted in accordance with the Constitution.
Budget	A resource, expressed in financial terms, proposed by the Board and authorised by the Independent Regulator for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Chair (of the Board or Trust)	The person appointed in accordance with schedule 7 of the 2006 Act and under the terms of the Constitution to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable or is unable to act as Chair due to a conflict of interest.

Chief Executive	**The chief officer of the Trust**
Code of Governance	The Code of Governance for NHS provider trusts in its latest form as published at www.england.nhs.uk
Committee	A Committee created and appointed by the Board of Directors functioning as an internal Committee.
Committee members	Persons formally appointed by the Board of Directors to sit on or to chair specific Committees.
Committee in Common	A collective group or representation from organisations (i.e. the acute provider Trusts in West Yorkshire and Harrogate District), to perform a particular function or duty with the aim of promoting alignment between the organisations yet reserving to themselves their own decisions.
Company Secretary	A person appointed to act as Trust Secretary or Company Secretary for the purposes of the Code of Governance, to provide advice on corporate governance issues to the Board and Chair and monitor the Trust's compliance with the law, Standing Orders and regulatory guidance
Deputy Chair	The non-executive director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason or is unable to act due to a conflict of interest.
Director	A non-voting member of the Board who is an Officer of the Trust
Director of Finance	The chief finance officer of the Trust.
Elected governor member	Those governors Members elected by the public constituency and the staff constituency.
Executive Director	A voting member of the Board who is an Officer of the Trust
Funds held on Trust (Charitable Funds)	Those funds that the Trust as Corporate Trustee holds at the date of authorisation or receives on distribution by statutory instrument or chooses subsequently to accept. Such funds will be charitable.
Member	A member of the Trust Board unless otherwise stated.
Memorandum of Understanding (MoU)	A formal agreement between two or more parties. Companies and organisations can use MOUs to establish official partnerships. MOUs are not legally binding but they carry a degree of seriousness and mutual respect.
Motion	A formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
NHS England	Is responsible for the oversight of NHS Trusts
Non-Executive Director	A voting member of the Board who is not an Officer of the Trust
Nominated officer	An Officer charged with the responsibility for discharging specific tasks within the Constitution and the SOs and SFIs.
Officer	An employee of the Trust.
Schedule of Decisions reserved to	Document setting out those powers which only the Board can exercise

the Board	
Scheme of Delegation	Document setting out the detailed delegated levels of authority and responsibility.
SFIs	Standing Financial Instructions.
SINED	Senior Independent Non-Executive Director, the Non-Executive Director appointed to support the Chair in leading the Board of Directors and Council of Governors
SOs	Standing Orders.
Trust	Calderdale and Huddersfield NHS Foundation Trust.
Working Day	Means any day, other than a Saturday, Sunday or legal holiday
WYAAT	The West Yorkshire Association of Acute Trusts

INTRODUCTION

Statutory and Regulatory Framework

I. Calderdale and Huddersfield NHS Foundation Trust (the Trust) is a public benefit corporation which was established in 2006 under the National Health Service Act 2006 (as amended) ("the 2006 Act") and is governed by Acts of Parliament.

II. The principal place of business of the Trust is Trust Headquarters, Acre Mill Outpatients, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EB

III. The statutory functions conferred on the Trust are set out by Acts of Parliament, mainly the National Health Service Act 2006 and subsequent versions (i..e. Health and Social Care Act 2012 and the Health and Care Act 2022.) The functions of the Trust are conferred by this legislation. The Trust also has a constitution ("the Constitution") as required under the 2006 Act, which includes further provisions consistent with Schedule 7 in support of the governance arrangements within the Trust It should be noted that the Trust also has in place Standing Orders (SOs) which deal with the Council of Governors which may need to be referred to.

IV. The purpose of the Trust (as required by the 2006 Act) is to serve the community by the provision of goods and services for purposes related to the provision of health care in accordance with its statutory duties and the Terms of the Independent Regulator's Authorisation (the "Terms of Authorisation"). The Trust is to have all the powers of an NHS Foundation Trust as set out in the 2006 Act, subject to the Terms of Authorisation.

V. As a statutory body, the Trust has specified powers to contract in its own name and act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

VI. The Trust also has statutory powers under Section 28A of the NHS Act 1977 as amended by the 2006 Act to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

VII. The Trust will be bound by such other statutes and legal provisions which govern the conduct of its affairs. In addition to the statutory requirements NHS England will issue further requirements and guidance. Many of these are contained within the 2006 Act, 2012 Act and 2022 Act and on NHS England's website. Information is accessible locally via the Corporate Governance Manager.

VIII. Under its regulatory framework the Trust must adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

IX. The Code of Governance and the Trust Constitution, together with the NHS Provider Licence (and the NHS Foundation Trust Conditions), require that the Trust draws up a schedule of decisions reserved to the Board and publicises which types of decisions are to be taken by Board and by the Council, and ensure that management arrangements

are in place to enable responsibility to be clearly delegated to Committees of the Board and individual Directors.

X. The Code of Governance for NHS provider Trusts and the Trust Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Constitution requires a register of possible conflicts of interest of members of both the Board of Directors and the Council of Governors and how those possible conflicts are addressed.

XI. The Code of Governance sets out arrangements for public access to information on the NHS.

XII. Trust Boards are encouraged to operate an integrated governance framework to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. The Trust Board uses its Committee structures to take a holistic view of the Trust and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

Collaboration of services across West Yorkshire and the Integrated Care System

Since the introduction of statutory Integrated Care Boards in July 2022 all NHS Trusts providing acute hospital services have been mandated to be part of a provider collaborative. The West Yorkshire Association of Acute Trusts, part of West Yorkshire Health and Care Partnership, is the acute sector collaborative, which formalises previous voluntary partnership working that was in place across the region to impact on the delivery of efficient and sustainable healthcare services for patients across a footprint for the population of West Yorkshire and Harrogate District

Therefore the following Trusts:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust

will collaborate to oversee a comprehensive system-wide programme to deliver the objective of acute provider transformation. Collectively they will share obligations agreed by all Parties, set out in a Memorandum of Understanding (MOU) and hold each other to account via a Committee in Common, with all Parties agreeing to its Terms of Reference.

The Trust will also work with local Integrated Care Boards and system partners, having regard to the triple aim of better health for everyone, better care for all and efficient use of NHS resources.

PART 1 - THE TRUST AND BOARD OF DIRECTORS

CORPORATE ROLE OF THE TRUST

1. **Name and business of the Trust**

1.1 All business shall be conducted in the name of Calderdale and Huddersfield NHS Foundation Trust ("the Trust").

The roles and responsibilities of the Board of Directors to be carried out in accordance with the Constitution include:

1.1.1 to ensure compliance with the Constitution, mandatory obligations issued by NHS England and relevant statutory requirements;

1.1.2 to establish a set of values and standards of conduct with are consistent with the Nolan Principles governing standards in public life;

1.1.3 to ensure compliance with the Code of Governance for NHS provider trusts issued by NHS England and report on the Trust's governance arrangements annually;

1.1.4 to determine the vision and values of the Trust;

1.1.5 to determine the service and financial strategy of the Trust and to monitor the delivery of those strategies;

1.1.6 to ensure the financial viability of the Trust;

1.1.7 to ensure the clinical quality and safety through a system of clinical governance

1.1.8 to provide services in accordance with agreed contracts; to ensure that adequate systems are in place to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery; and

1.1.9 to ensure the Trust co-operates with other NHS bodies, Local Authorities and other stakeholders and relevant organisations with an interest in the health economy

1.1.10 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in the Constitution.

1.1.11 NHS Foundation Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2006 and subsequent versions.

1.1.12. All funds or property received in trust under section 22 of the 2003 Act shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by Directors acting on behalf of the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust. Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees under Chapter 5, section 51 of the 2006 Act. Accountability for charitable funds held on trust is in accordance with the relevant arrangements made by the Charity Commission and to the Secretary of State for Health.

1.1.13. The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Schedules of

Decision Reserved for the Trust Board and have effect as if incorporated into the Standing Orders. Those powers and decisions not reserved to the Board are delegated to Officers and other bodies as described in the Scheme of Delegation and have effect as if incorporated into these Standing Orders.

2. Composition of the Trust Board of Directors

2.1 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:

2.1.1. A Non-Executive Chair

2.1.2 Up to 7 other Non-Executive Directors (one appointee will act as the Deputy Chair and one the Senior Independent Non-Executive Director, the same appointee may be appointed to both roles))

2.1.3 Up to 7 Executive Directors which shall include:

- *the Chief Executive (the Chief Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *a medical or dental practitioner*
- *a registered nurse or midwife*

2.1.4. Other Directors may be appointed to the Board of Directors from time to time but shall have no voting rights.

2.1.5 The Non-Executive Directors and Chair together shall be equal to or greater than the total number of Executive Directors. In the case where the numbers are equal, in the instance of a vote, the Chair will have a casting vote.

2.1.6 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.

2.2 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.

2.3 Terms of Office of the Chair, Non-Executive Directors and Associate Non-Executive Directors

The provisions setting out the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office are contained in the Constitution, supplemented by the Code of Governance for NHS provider Trusts. The terms and conditions of the office are decided by the Council of Governors, informed by the Code of Governance for NHS provider Trusts.

The terms and conditions relating to the office of Associate Non-Executive Directors are decided by the Council of Governors.

2.4 Appointment of Deputy Chair
For the purpose of enabling the proceedings of the Board of Directors to be conducted in the absence of the Chair, the Directors of the Trust will appoint a Non-executive Director from amongst them to be Deputy Chair. This individual may, through agreement with the Chair take on the role of Senior Independent Non-Executive Director (SINED), as contained in 12.11 of the Constitution.

The appointment should be for a period which does not exceed the remainder of the term. Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy Chair in accordance with these Standing Orders.

2.5 Powers of Deputy Chair
Where the Chair has ceased to hold office or where he/she has been unable to perform his/her duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

2.6 Appointment of Senior Independent Director
The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director using the procedure set out in the Constitution.

Any appointment will be for such a period not exceeding the remainder of his/ her term as a Non-Executive Director agreed by the Council of Governors.

2.7 Appointment and Removal of Directors
The Chief Executive shall be appointed or removed by the Chair and the Non-Executive Directors. The appointment requires the approval of the Council of Governors.

A Committee consisting of the Chair, the Chief Executive and other Non-Executive Directors (as specified in the terms of reference) shall appoint or remove the other Executive Directors and non-voting Directors.

2.8 Appointment of Deputy Chief Executive
The Board may appoint an Executive Member as Deputy Chief Executive.

Any person so appointed may resign at any time from the office of Deputy Chief Executive by giving notice in writing to the Chief Executive. In the event of a resignation, the Board may appoint another Executive Member.

2.9.1 Joint Directors
Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly and shall count for the purpose of Standing Orders as one person.

Where the office of a Member of the Board is shared jointly by more than one person:

- Either or both of those persons may attend or take part in meetings of the Board
- If both are present at a meeting they should cast one vote if they agree
- In the case of disagreements, no vote should be cast and the presence of either or both of those persons should count as the presence of one person for the purposes of quorum.

2.10 Role of Directors
The Board will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal Directors. Their role as Directors on the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions in

accordance with the Code of Governance. The function and role of Directors is described within these Standing Orders and documents incorporated into these Standing Orders.

2.11 Executive Directors
Executive Directors shall exercise their authority within the terms of these Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

2.12 Chief Executive
The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under applicable financial directions and NHS England guidance and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

2.13 Director of Finance
The Director of Finance is responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems. He/she is responsible along with the Chief Executive for ensuring the discharge of obligations under applicable financial directions and NHS England guidance.

2.14 Non-Executive Directors
The Non-Executive Directors shall not be granted, nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as Directors of or when chairing a Committee of the Trust which has delegated powers.

2.15 Chair
The Chair is responsible for the operation of the Board and will chair all Board meetings when present.

The Chair has certain delegated executive powers.

The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the Council of Governors and the Nominations and Remuneration Committee over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive

The Chair shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions
The Chair will ensure that the designation of lead roles or appointments of Board Members as required by NHS England or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

2.16 Secretary
The Board of Directors shall appoint the Secretary of the Trust and subject to following good employment practice, may also remove that person. The Secretary may not be a Governor, or the Chief Executive or the Director of Finance. The Secretary shall be accountable to the Chief Executive and their functions shall be as listed in the Constitution.

PART 2. MEETINGS OF THE BOARD OF DIRECTORS

3.1 Admission of the Public and the Press

The public and representatives of the press shall be afforded facilities to attend all ordinary/formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The Chair shall give such directions, as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board's business shall be conducted without interruption and disruption and without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public (Section 1 (8) Public Bodies (Admission to Meetings) Act 1960).

Business proposed to be transacted when the press and public have been excluded from a meeting as provided for in Standing Order 2.1, shall be confidential to members of the Board.

Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of the proceedings as they take place without prior agreement of the Board of Directors.

The provisions of these Standing Orders relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to workshops or other meetings attended by members of the Trust Board.

3.2 Observers at Board meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and will change, alter or vary these terms and conditions as it deems fit.

3.3 Public questions

Members of the public wishing to submit questions to the Board of Directors meeting will be required to submit these in writing by close of play the day before the meeting. The Chair will have the discretion to accept questions at the meeting if appropriate. Questions / statements must not relate to any information defined as confidential under Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, unless the matter relates to a person's personal circumstances where that person has given their consent to it being raised at a public meeting. The Chair's ruling on the appropriateness of the question / statement is final. The Chair will reserve the right to respond to questions in writing if time does not permit these questions to be answered in the meeting.

3.4 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine.

Meetings of the Board of Directors may be called by the Secretary or by the Chair at any time.
Meetings may also be called by at least one-third of the directors who are eligible to vote, giving written notice to the Secretary specifying the business to be carried out. The Secretary should send a written notice to all Directors within seven days of receiving such a request. If the Chair or Secretary refuses to call a meeting after such a request one-third or more of Directors who are eligible to vote may forthwith call a meeting.

3.5 Notice of Meetings and Business to be Transacted

Before each meeting of the Board of Directors of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered by email or equivalent electronic means to every Director, or by post to the usual place of residence of such Director, so as to be available at least three working days before the meeting.

A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any Director shall not affect the validity of the meeting.

In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 2.6 (emergency motions).

Before each meeting of the NHS Foundation Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three working days before the meeting. (required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4) (a)

The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting

3.6 Chair of the Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent, the Deputy Chair shall preside. If the Chair and Deputy Chair are absent one of the other Non-Executive Directors in attendance, as chosen by the Board of Directors shall preside.

If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

The decision of the Chair of the meeting on questions of order, relevancy, and regularity (including procedure on handling motions and the Chair's interpretation of the Standing Orders shall be final. In this interpretation the Chair shall be advised by the Chief Executive and the Company Secretary and in the case of Standing Financial Instructions the Chair shall be advised by the Director of Finance.

3.7 Agenda and Supporting Papers

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

A Director who requires a matter to be included on an agenda should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 10 working days before a meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

The agenda will be sent to Directors and Governors five working days before the meeting. Supporting papers, whenever possible, shall accompany the agenda send to Directors, save in an emergency.

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors' meeting.

3.8 Annual Members' Meeting

The Trust will publicise and hold an annual members' meeting in accordance with its Constitution.

3.9 Notices of Motion

A Director of the Trust wishing to move or amend a motion should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than -7 working days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.10 Emergency Motion

Subject to the agreement of the Chair, a Director may give written notice of an emergency motion after the issue of the notice of the meeting and agenda up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision is final.

3.11 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding **six (6)** calendar months shall bear the signature of the director who gives it and also the signature of the majority of the other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chair to propose a motion to the same effect within **six (6)** months, however the Chair may do so if he/she considers it appropriate.

3.13 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(a) An amendment to the motion.
(b) The adjournment of the discussion or the meeting.
(c) That the meeting proceed to the next business. (*)
(d) The appointment of an ad hoc committee to deal with a specific item of business.
(e) That the motion be now put. (*)

(f) A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, advised by the Secretary, the amendment negates the substance of the motion.

3.14 Chair's Ruling

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting, on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

3.15 Voting

It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

Where it is necessary to take a vote to determine an issue, every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. No resolution of the Board of Directors shall be passed by a majority composed only of Executive Directors or Non-Executive Directors.

All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

Where the office of a Director who is eligible to vote is shared jointly be more than one person, see Standing Order 3.17 for voting rules.

Where necessary, a Director may be counted as present when available constantly for discussions through an audio or digital link and may take part in voting on an open basis.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust website (required by Code of Practice on Openness in the NHS). A record of items discussed in private will be maintained and approved by the Board of Directors.

3.17 Joint Directors

Where a post of Executive Director is shared by more than one person

a) Both persons shall be entitled to attend meetings of the Trust.
b) If both are present at a meeting, they should cast one vote if they agree.
c) In the case of disagreement between them no vote should be cast.
d) The presence of either or both of those persons shall count as one person for the purposes of SO 3.20 Quorum.

3.18 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by NHS England, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

A decision to suspend SOs shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

The Audit and Risk Committee shall review every decision to suspend SOs.

3.19 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.10 has been given; and
(b) upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting
(b) no fewer than half the total of the Trust's total Non-Executive Directors vote in favour of amendment; and
(c) at least two-thirds of the Directors are present at the meeting where the variation is being discussed; and
(d) the variation proposed does not contravene a statutory provision or provision of authorisation or of the Constitution.

3.20 Record of Attendance

The names of the Chair and Directors present at the meeting, and others invited by the Chair, shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual Directors. This will

include those who participate by telephone, video or computer link in accordance with these SOs.

If a Director is not present for the entirety of the meeting, the minutes shall record the items that were considered when they were present.

3.21 Quorum

No business shall be transacted unless six of the Directors are present (including three Executives and three Non-Executives are present), one of whom is the Chair or Deputy Chair and as such has a casting vote.

Any officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chair or a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SOs 5 he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least three Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

PART 3. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION AND COMMITTEES

Subject to a provision in the authorisation or the Constitution, the Board of Directors may delegate any of its functions to a committee or sub-committee, appointed by virtue of SO 4.2 below, or by a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the Board of Directors thinks fit.

4.1 Urgent Decisions

The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair acting jointly after having consulted at least two Non-executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.2 Delegation to Committees

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by internal committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

4.4 Schedule of Decisions Reserved to the Trust Board

The Chief Executive shall prepare a Schedule of Decisions reserved for the Trust Board identifying the matters for which approval is required by the Board of Directors.

The Chief Executive may periodically propose amendment to the Schedule of Decisions Reserved to the Trust Board which shall be considered and approved by the Board of Directors as indicated above; and shall update the schedule after each review.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other Executive Director to provide information and advice to the Board of Directors in accordance with any statutory requirements and the Terms of Authorisation.

The arrangements made by the Board of Directors as set out in the “Schedule of Decisions Reserved to the Trust Board shall have effect as if incorporated in these Standing Orders.

The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub-committee shall be subject to and qualified by the reserved matters contained in that schedule.

4.5 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee and Board of Directors for action or ratification. All members of the Board of Directors,

Membership Council and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

4.6 Scheme of Delegated Authorities

Standing Order (SO) 3 summaries the Board's powers to "arrange for the exercise of any of its functions by:

- an internal Committee or sub-Committee appointed by virtue of SO 4 Committees
- or by a Director or officer of the Trust,

in each case subject to such restrictions and conditions as the Board thinks fit or as NHS England may direct.

The Trust Board shall adopt a Scheme of Delegated Authorities covered in a separate document (Scheme of Delegation) and financial delegation in the Standing Financial Instructions. These documents have effect as if incorporated into the Standing Orders.

The Scheme of Delegated Authorities sets out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix A.

Subject to Standing Order 7.4 the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix A after each review.

The direct accountability, to the Trust Board, of the Chief Finance Officer and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

Wherever the title Chief Executive, Director of Finance or other Officer position is used in these Standing Orders, it will be deemed to include such other employees who have been duly authorised to deputise, such as an employee formally deputising into the post during a period of absence of the substantive post holder or to cover a vacant post, subject to such deputising arrangements being formally documented and signed off appropriately.

4.7 Appointment of Committees

Subject to the authorisation and the Constitution, the Board of Directors may appoint internal Committees of the Trust consisting wholly or partly of the Chair and Director of the Trust or wholly of persons who are not Directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

The Committees to be established by the Trust will consist of statutory, mandatory and non-mandatory Committees.

A Committee may appoint sub-committees consisting of wholly or partly of members of the Committee or wholly of persons who are not members of the Committee.

4.8 Joint Committees

The Trust may appoint a joint Committee by joining together with one or more other health or social care organisations consisting wholly or partly of the Chair and members of the Board of Directors or other health service bodies or wholly of persons who are not members of the Trust or other health bodies in question.

Any Committee or joint committee appointed under this SO may, subject to such directions as may be given by NHS England or the Board of Directors or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the Committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust Committee (whether or not they include Directors of the Trust).

4.9 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any internal Committees or sub-committee established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of the internal Committee as the context permits, and the term "Director" is to be read as a reference to a member of the internal Committee also as the context permits. There is no requirement to hold meetings of internal Committees established by the Trust in public.

4.10 Terms of Reference

Each such internal Committee or sub-committee shall have such terms of reference and powers. The Trust Board shall approve the terms of reference of each Board Committee. Committees and sub-committees shall be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to regular review by that Committee or sub-committee and the Trust Board as required

4.11 Delegation of powers by internal Committees to Sub-Committees

Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

4.12 Approval of Appointments to Internal Committees

The Board of Directors shall approve the appointments to each of the internal Committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither Directors nor officers, shall be appointed to an internal Committee, the terms of such appointment shall be determined by the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses subject to approval by the Council of Governors.

During a period of incapacity or temporary absence, Non-Executive Directors may nominate another named Non-Executive Director to attend a meeting of a Committee on their behalf. The status of the nominated Non-Executive Director shall be recorded in the minutes

4.13 Minutes

Minutes, or a representative summary of the issues considered, and decisions taken, of any Committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered, and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next Committee meeting to which it reports.

4.14 Appointments for statutory functions

Where the Trust is required to appoint persons to an internal Committee and/or to undertake statutory functions as required by NHS England and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and directions made by NHS England.

Statutory and Mandatory Committees

4.15 Mandatory Committees

Role of Audit and Risk Committee

In line with the Code of Governance, the Trust Board shall appoint a Committee of three independent Non-Executive Directors to undertake the role of an Audit & Risk Committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, guidance and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook.

The terms of reference of the Audit & Risk Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

The Council of Governors is responsible for the appointment of external auditors, working in conjunction with members of the Audit and Risk Committee.

Role of Nominations and Remuneration Committee of the Board of Directors

In line with the Code of Governance the Trust Board shall appoint a Committee to undertake the role of a remuneration and nominations Committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors, as well as advising the Trust Board on the terms of service of other senior officers and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

The terms of reference of the Nominations and Remuneration Committee of the Board of Directors shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

A separate Nomination and Remuneration Committee of the Council of Governors for Non-Executive Directors is in place as detailed in the Trust Constitution.

Charitable Funds Committee

The Trust Board, in line with its role as Corporate Trustee, shall appoint a Committee to be known as the Charitable Funds Committee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies in accordance with any statutory or other legal requirements or best practice required by the Charities Commission and Department of Health and Social Care.

The terms of reference of the Charitable Funds Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

4.16 Non-Mandatory Committees

The Trust Board shall appoint such additional non-mandatory Committees as it considers necessary to support the business and inform the decisions of the Trust Board

The terms of reference of these Committees shall have effect as if incorporated into these Standing Orders. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

The membership of these Committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the Committee and shall be subject to approval by the Board.

Committees established by the Board
The current non-mandatory internal Committees established by the Trust Board are:

- Finance and Performance Committee
- Quality Committee
- Workforce Committee
- Joint Liaison Committee
- Transformation Programme Board

- West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common

4.17 Appointment to the WYAAT Committee in Common

Membership of the Committee in Common will be defined in the Terms of Reference, which will be agreed or amended by all Parties. The Board of Calderdale and Huddersfield NHS Foundation Trust has not agreed to delegate any of its statutory functions to the Committee in Common. The scope of the Committee in Common will be responsible for leading the development of the WYAAT collaborative programme and the workstreams in accordance with the defined key principles, setting overall strategic direction in order to deliver the WYAAT collaborative programme.

The above are subject to change at the discretion of the Trust Board. Such other Committees may be established as required to discharge the Board's responsibilities and will have the same standing and be subject to the same standing orders.

4.18 Confidentiality

Proceedings in Committee meetings are confidential. There is no requirement for meetings of Trust Board Committees and sub-committees to be held in public, or for agenda or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

Committee members should normally regard matters dealt with or brought before the Committee as being subject to disclosure, unless stated otherwise by the Chair of the Committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

A member of a Committee, or observer of that Committee, shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or Committee shall resolve that it is confidential.

4.19 Election of Chair of Committee

Each Committee shall appoint a Chair; and may appoint a vice-Chair from its membership. The terms of reference of the Committee shall describe any specific rules regarding who the Chair should be. Meetings of the Committee will not be recognised as quorate, if the Chair, or vice Chair, or other suitably qualified, nominated member of the Committee is not present to undertake the role.

Each Committee shall review the appointment of its Chair, as part of the annual review of the Committee's role and effectiveness.

4.20 Special meetings of Committee

The Chief Executive shall require any Committee to hold a special meeting, on the request of the Chair, or on the request, in writing of any two members of that Committee.

PART 4

DUTIES AND OBLIGATIONS ON BOARD MEMEBRS, DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

5. DECLARATIONS OF INTERESTS, REGISTER OF INTERESTS AND COMPLIANCE WITH FIT AND PROPER PERSONS REGULATIONS

Schedule 7 of the 2006 Act, Section 13.20 of the Constitution and the Trust Policy on Conflicts of Interests and Standards of Business Conduct 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 (including the WYAAT Committee in Common). A register of these interests must be kept by the Trust.

Statutory requirements relating to pecuniary interests are detailed at SO 5.4

5.1 Declaration of Interests

All existing Directors should declare such interests. Any Board Directors/officers appointed subsequently should do so on appointment.

Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as relevant and material and which, for the avoidance of doubt should be included in the register are:

- Any directorship of a company;
- Any interest (excluding holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 2% of the total issued share capital or the value of such shareholding does not exceed £25,000) or position in any firm of company or business, which in connection with the matter, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust including private healthcare organisations and other foundation trusts;
- Any interest in an organisation providing health and social care services to the NHS;
- Position of authority in a charity or voluntary organization in the field of health or social care;
- Any affiliation to a special interest group campaigning on health or social care issues.

To the extent not covered above, any connection with an organisation, entity or company considering entering in to or having entered into financial arrangement with the NHS Foundation Trust, including but not limited to lenders or banks.

WYAAT Committee in Common – the Chair and Chief Executive of Calderdale and Huddersfield NHS Foundation Trust will adhere to declaring interests as described within the Conflict of Interests section 10 of the Memorandum of Understanding.

Reference should also be made to the NHS England *Code of Governance* and the Trust's Constitution and Policy on Conflicts of Interests and Standards of Business Conduct in determining whether other circumstances or relationship are likely to affect, or could appear to affect, the Director's judgement.

Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors.

At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting of the Board of Directors, if a conflict of interest is established the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an issue where a conflict is established. If there is a dispute as to where a conflict does exist a majority vote will resolve the issue with the Chair having the casting vote. If by inadvertence they do remain and vote, their vote shall not be counted. Declarations made during the course of a meeting should be recorded in the minutes.

There is no requirement in the Code of Accountability for the interest of Directors' spouses or partners to be declared. However, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly advisable (as are declaring the interests of other immediate family members and co-business partners). SO 5.4 (pecuniary interest), which is based on these regulations requires that the interests of spouses or partners (if living together) in contracts should be declared. Therefore the interests of spouses or cohabiting partners should also be regarded as relevant.

If Board Directors/officers have any doubt about the relevance of an interest, this should be discussed with the Chair or Company Secretary. Financial reporting standard 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of in interest. The interests of partner in professional partnerships including general medical practitioners should also be considered.

5.2 Register of Interests

The Company Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors and officers and is considered by the Board. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Board directors and officers, as defined in SO 5.1. The Register shall also contain the names of all members of the Board of Directors including those who have no interests.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and open to inspection via the Trust website.

5.3 Compliance with Fit and Proper Persons Regulations

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all Trusts to ensure that all Executive and Non-Executive Director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations ('FPPR'). The definition of Directors includes those in permanent, interim or associate roles, irrespective of their voting rights at Board meetings.

Individuals must be: of good character, have the necessary qualifications, competence, skills and experience for their role, have the appropriate level of physical and mental fitness, have not been party to any serious misconduct or mismanagement in the course of carrying on a regulated activity, and not be deemed unfit under the Regulation provisions

The regulations stipulate that Trusts must not appoint or have in place an Executive Director or a Non-Executive Director unless they meet the standards set out in the Regulations. The guidance issued by the CQC in January 2018 places ultimate responsibility on the Chair to discharge the requirements of the FPPR. The Chair must assure themselves that new applicants and existing post holders meet the fitness checks and do not meet any of the unfit criteria. Responsibility also falls on the Chair to decide whether an investigation is necessary and, at the end of the investigation, to consider whether the Director in questions remains fit and proper. The Chair will be notified by the CQC of any non-compliance with the FPPR and holds responsibility for making any decisions regarding action that needs to be taken.

5.4 Exclusion of the Chair and Directors in Proceedings on Account of Pecuniary Interest

Subject to the following provisions of this Standing Order, if the Chair or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and should withdraw so as not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability shall be removed.

The Board of Directors may exclude the Chair or a Director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chair or Director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 5.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

(b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of persons living together the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chair or Director shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he/she is is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chair or Director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a Committee or sub-committee of the Trust as it applies to the Board of Directors and applies to any member of any such Committee or sub-committee (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

5.5 Standards of Business Conduct

5.5.1. Policy

All members of staff must comply with the national guidance contained in the NHS England » Standards of Business Conduct Policy and Trust guidance in the Policy on Conflict of Interest and Standards of Business Conduct.

5.5.2 Standards of Public Life (Nolan Principles)

The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life.

These are:

• **Selflessness**: Holders of public office should act solely in terms of the public This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures. interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

• **Integrity**: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

• **Objectivity**: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

• **Accountability**: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

• **Openness**: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

• **Honesty**: Holders of public office should be truthful.

• **Leadership:** Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

The following provisions should be read in conjunction with this document.

5.5.3. Interest of Officers in Contracts
If it comes to the knowledge of a Board Director or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is him/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

An officer must also declare to the Chief Executive and declare in a register of interest any other employment or business or other relationship of his/hers, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

5.5.4 Canvassing of, and Recommendations by, Directors in Relation to Appointments
Canvassing of Board Directors or officers of the Trust or members of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

A Board Director or officer of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

Failure to declare any interest which may conflict with, or compromise, any employee's Trust duties and obligations in respect of the award, operation or administration of a Trust / NHS contract may result in a potential breach of the Bribery Act 2010 and necessitate further investigation by the Trust's counter fraud specialist.

5.5.5. Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Foundation Trust any such disclosure made.

Any alleged false representation contained on any application to the Trust, or failure to disclose any information when required to do so, may also result in investigation by the Trust's counter fraud specialist and / or NHS Counter Fraud Authority and possible prosecution under the Fraud Act 2006.

On appointment, Directors or officers (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Foundation Trust whether they are related to any other Director or holder of any office under the Trust.

Where the relationship of an officer or another Director to a Board Director of the Trust is disclosed, the Standing Order headed `Exclusion of Directors in proceedings on account of pecuniary interest' shall apply.

The key elements of the Trust's Standards of Business Conduct with which Directors and officers are required to comply are:

a. refuse gifts and hospitality above the value of £50.
b. declaration of Business interests.
c. decline offers of preferential treatment.
d. permission to undertake outside employment.
e. declaration of offers of commercial sponsorship.
f. declaration of rewards.
g. respect confidentiality of information.

The principles set out in this Standing Order may be expanded by the Trust's Standards of Business Conduct as from time to time approved by the Board of Directors.

5.

PART 5
CUSTODY OF SEAL AND SEALING OF DOCUMENTS

6.1 Custody of Seal

It is the responsibility of the Chief Executive to ensure that the Common Seal of the Trust is kept in a secure place.

6.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a Committee thereof or in accordance with any delegation by the Board of its power. The affixing of the Seal shall be attested and signed for by two Executive Directors (not from the originating department) or one Executive Director and the Company Secretary.

Before any building, engineering, property, or capital document is sealed the scheme must be approved and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department.)

Contracts for the purchase of goods and services shall be under seal where the aggregate contract value may be reasonably expected to exceed £500,000.

6.3 Register of Sealing

An entry of every sealing, including the name of the persons who have approved and authorised the document and attested the sealing shall be made and numbered consecutively in a register provided for that purpose.

A report of all sealings shall be made to the Board of Directors bi-annually. The report shall contain details of the seal number, the description of the document and the date of sealing. The book will be held by the Chief Executive or nominated officer.

The seal should only be used to execute deeds or where otherwise required by law. Where it is unclear whether the use of the seal is necessary, appropriate legal advice should by sought by the Company Secretary or Officer nominated by the Secretary.

6.4 Signature of Documents

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or any other Executive Director, unless any enactment otherwise requires or authorises. , or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or Committee or sub-committee to which the Board has delegated appropriate authority.

PART 6
MISCELLANEOUS

7.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Links to these policies shall be issued by email to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive e-copies where appropriate of SOs.

7.2 A copy of these Standing Orders will be held, with unrestricted access to all staff, on the Trust's intranet site

7.3 Documents having the standing of Standing Orders

Standing Financial Instructions and Scheme of Delegation shall have the effect as if incorporated into SOs.

7.4 Review of Standing Orders

Standing Orders and all documents having effect as if incorporated in Standing Orders shall normally be reviewed regularly by the Audit and Risk Committee on behalf of the Board of Directors before a recommendation is made to the Board for adoption.

7.5 Non-availability of the Chair / Deputy Chair and Chief Executive / Director of Finance.

Save as expressly provided in these standing orders if the Chair of the Trust is not available for whatever reason to transact the business of the Trust expressly or by implication delegated to him/her, then the Deputy Chair shall be empowered to act in his/her place and to exercise all the powers and duties of the Chair until the Chair is again available.

If the Deputy Chair is not available for whatever reason to transact the business of the Trust expressly or by implication delegated to him/her, then any two Non-Executive Directors shall be empowered to act in his/her place and to exercise all the powers and duties of the Deputy Chair in relation to that matter.

If the Chief Executive is not available for whatever reason, then any of the Chief Executive's powers and duties expressly or by implication under these Standing Orders may be exercised on his/her behalf by some other officer duly authorised by the Chief Executive in writing so to act.

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2025
Review Lead: Finance Director

Calderdale and Huddersfield
NHS Foundation Trust

SCHEME OF DELEGATION
AND
RESERVATION OF POWERS TO THE BOARD

FOR

Calderdale and Huddersfield NHS Foundation Trust

(Reviewed January 2023)

Version 4

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

Document Summary Table		
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Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Audit and Risk Committee	Non-Executive Director	31 January 2023
Other Stakeholders Consulted		
Deputy Director of Finance		

Does this document map to other Regulator requirements?	
NHS England	NHS England Code of Governance for NHS Provider Trusts

Document Version Control	
Version no	*Details of review/alterations, rational for document etc*
2	Update to align with revised Standing Financial Instructions and Director lead changes Addition of scheme of delegation for Mental Health Act 1983
3	Updates to respond to Covid-19 pandemic, non-material job title / organisational title changes
4	Routine review including incorporation of Covid-19 arrangements until further notice
5	Routine review, housekeeping, update for national guidance and legislation

CONTENTS

1.0 INTRODUCTION

This Scheme of Delegation (SoD) details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the Calderdale and Huddersfield NHS Foundation Trust (referred to as the "Trust"). They should be used in conjunction with the *Constitution, Standing Orders* and the *Standing Financial Instructions* which have been adopted by the Trust. The Trust's *Constitution* and the *Foundation Trust Code of Governance for NHS Provider Trusts* from the regulator (NHS England, formerly NHS Improvement and Monitor) requires such a formal document recording the exercise of delegated powers.

Standing Orders detail the statutory and legal framework for the Trust.

The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a Committee or sub-committee or by the Chair or a Director or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit". The purpose of this document is to detail how powers may be reserved to the Board - generally matters for which it is held accountable to the regulator , while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, even those delegated to the Chair, individual Committees and sub-Committees, individual Directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.1 The Purpose of the Board

The Board of Directors is a strategic unitary board that has regard to robust arrangements being in place that will deliver strong and highquality patient care and strong financial management. The appropriate role of the Board is to ensure that the governance mechanisms to meet these objectives are in place. This means that the Board takes the view that the experts it employs in each functional field should have the authority to present policies and procedural documents to the operational Executive Board which will give approval. The Board of Directors will be notified of policy and procedural changes for them to scrutinise if they wish but will not do this as part of the normal function of the Board of Directors Meetings.

1.2 Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to a Committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain on accountability to the Board.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer, the Chief Executive is accountable to the regulator for the funds entrusted to the Trust.

1.3 Caution over the Use of Delegated Powers

Powers are delegated to Directors and officers on the understanding that they would not exercise delegated powers in a matter, which, in their judgement was likely to be a cause for public concern.

1.4 Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

1.5 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a Director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, their delegated powers may be exercised by the designated Deputy Chief Executive. If both the Chief Executive and the Deputy Chief Executive are absent, the Chief Executive's delegated powers may be exercised by a nominated Executive Director acting in the Chief Executive's absence.

2.0 RESERVATION OF POWERS TO THE BOARD

Standing Order 1 (1.4) provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session." These powers and decisions are set out in this Schedule covering the following areas:

1. Structure and Governance of the Trust
2. Determination of Strategy and Policy
3. Direct Operational Decisions
4. Financial, Performance Reporting and Quality
5. Audit Arrangements

2.1 General Enabling Provision

The Board may determine any matter it wishes in full session within its statutory powers.

2.2 *Structure and Governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into Standing Order*

2.2.1 Approval of, including variations to:

a. Standing Orders (SOs)
b. , a schedule of matters reserved to the Board of Directors
c. Standing Financial Instructions (SFIs) for the regulation of its proceedings and business
d. a scheme of delegation of powers from the Board to officers including financial limits in delegations
e. suspension of Standing Orders

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2.2.3 Require and receive from Directors and officers, the declarations of any interests which may conflict with those of the Trust and consider the potential impact of the declared interests, determining the extent to which that Director may remain involved with the matter under consideration.

~~2.2.4 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.~~

2.2.4 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

2.2.5 Approval of the disciplinary procedure for officers of the Trust.

2.2.6 Approval of arrangements for dealing with and responding to complaints.

2.2.8 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to.

Moved to 2.3Moved to 2.3

2.2.11 Notification and ratification of any urgent decisions taken by the Chief Executive in accordance with SO 4.1.

2.2.12 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

2.3 Committee Appointments, Delegation of Functions and Reporting

2.3.1 The appointment and dismissal of Committees, including those which the Trust is required to esetablish by the Secretary of State for Health or other regulation and:.

a delegate functions from the Board to the Committees

b. delegate functions from the Board to a Director or officer of the Trust

c. approve the appointment of members of any Committee / sub-Committee of the Trust Board or the appointment of representatives on outside bodies

d. receive reports from Board Committees and take appropriate action in response to those reports

e. confirm the recommendations of the Committees which do not have executive decision-making powers

f. approve terms of reference and reporting arrangements of Committees

g. approve delegation of powers from Board Committees to sub-committees - Committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

2.3.2 The appointment, appraisal, disciplining and dismissal of executive directors (subject to SO2.7).

2.4 *Determination of Policy and Strategy*

2.4.1 Having regard to the strategic context that the Board has set for itself and the way it conducts the business of the Trust, it will only deal in determining strategic business. Therefore, policies will be approved by the Executive Board and reported to the next Board of Directors Meeting, with the exception of 2.4.2.

2.4. 2. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual Directors responsible for adopting and maintaining the policies.

2.5 Strategy and Business Plans and Budgets

2.5.1 Approve the Trust's strategic direction including definition of the strategic aims and objectives of the Trust and Trust strategy.

2.5.2 Approval of annual business plans.

2.5.3 Approval of annual budgets for the Trust.

6 *Direct Operational Decisions*

2.6.1 Acquisition, disposal or change of use of land and/or buildings of a significant nature (above £300,000.

2.6.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £1m.

2.7 *Financial, Performance and Quality Reporting Arrangements*

2.7.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors, Committees, Deputy / Asssociate Ddirectors and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS England (the regulator) , Care Quality Commission and the Charity Commission shall be reported, at least in summary, to the Trust.

2.7.2 Approval of the opening or closing of any bank or investment account.

2.7.3 Approval of any working capital facility arrangement entered into.

2.7.4 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

2.7.5 Consideration and approval of the Trust's Annual Report including the annual accounts.

2.7.6 Consideration and approval of the Trust's Quality Account

2.7.6 Delegated to Charitable Funds Committee.

2.8 ***Audit Arrangements***

2.8.1 To approve audit arrangements and to receive reports of the Audit and Risk Committee meetings and take appropriate action.

2.8.2 To receive and approve tha annual audit reports from the external auditor in respect of the Financial Accounts

2.8.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee.

2.8.3 To receive a report/minutes from the Audit and Risk Committee relating to the annual report received from the internal auditors and the agreement of action on any recommendations.

2.8.4 To endorse the Annual Governance Statement for inclusion in the Annual Report

3.0 DELEGATION OF POWERS

3.1 Delegation to Committees

The Board may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such Committees shall be that determined by the Board from time to time taking into account where necessary the requirements of the regulator and or the Charity Commissioners (including the need to appoint an Audit Committee, and a Remuneration and Terms of Service Committee). The Board shall determine the reporting requirements in respect of these Committees. In accordance with SO 42 Committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

4.0 SCHEME OF DELEGATION TO OFFICERS

4.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance (DoF) and other Directors. These responsibilities are summarised below.

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
General Data Protection Regulation Requirements	Chief Digital and Information Officer

Health and Safety Arrangements	Chief Executive

There are four schemes of delegation.

Appendix A: The “top level” scheme covers only matters delegated by the Board to Directors and certain other specific matters referred to in Standing Orders

Appendix B: The “top level” scheme covers only matters delegated by the Board to Directors and certain other specific matters referred to in Standing Financial Instructions

Appendix C: A detailed scheme of delegation including financial limits

4. Appendix D: Scheme of Delegation relating to Mental Health Act

APPENDIX A

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
Definitions	CHAIR	Final authority in interpretation of SOs.
2.12	CHIEF EXECUTIVE	Responsible for the overall performance of the executive functions of the Trust. Responsible for ensuring the discharge of obligations under applicable financial directions, the Regulator guidance and in line with the requirements of the NHS foundation trust accounting officer memorandum.
2.13	DIRECTOR OF FINANCE	Responsible for the provision of financial advice to the Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems.
2.15	CHAIR	Responsible for the operation of the Board of Directors
3.4	CHAIR	Calling meetings.
3.6	CHAIR	Chair all Board of Directors meetings and associated responsibilities.
3.15	CHAIR	Have second or casting vote
5.2	CE	Register(s) of interests.
6.1 /6.3	CE	Responsible for ensuring seal is kept in a safe place and a register of sealing is maintained.
6.2	CHAIR/CE OR DEPUTIES	Board delegated powers to seal documents and initial any amendments thereto.
~~10.1~~ 7.1	CHIEF EXECUTIVE	Ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and SFIs.
~~12.3a~~ 6.4.	CHAIR/CE/DEPUTIES DOF AND/OR NOMINATED OFFICERS	Board delegated powers to approve the signing ~~and sealing all building, engineering, property or capital documents and initial any amendments thereto.~~of documents the subject matter of which has been approved by the Board or Committee or sub-Committee to which the Board has delegated appropriate authority..
6.4	CE / NOMINATED OFFICER	~~Board delegated powers to approve building, engineering, property or capital documents and any amendments thereto.~~ Approve and sign all documents which will be necessary in legal proceedings .
6.4	CE/DOF/DEPUTIES OR	Approve and sign any contract, agreement or document not requiredested to be executed as a deed.

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
	HEAD OF PROCUREMENT	

APPENDIX B

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

Turquoise shading notes duties previously listed under SoD implied by Standing Orders

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	DIRECTOR OF FINANCE (DOF)	Responsible for: Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	DOF	Form and adequacy of financial records of all departments.
2.1.1	AUDIT & RISK COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF	Carry out all work to counter fraud and corruption in accordance with Directions on Fraud and Corruption and Bribery Act 2010
2.3.1	DOF	Monitor effectiveness of internal financial control, internal audit function and Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption.
2.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.5	AUDIT & RISK COMMITTEE	Ensure cost-effective external audit.
3.1.2	DOF	Submit budgets.

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

Turquoise shading notes duties previously listed under SoD implied by Standing Orders

SFI REF	DELEGATED TO	DUTIES DELEGATED
3.1.3	DOF	Monitor performance against budget, submit to Board financial estimates and forecasts.
3.2	CE	Delegate budget to budget holders and submit monitoring returns.
3.3	DOF	Devise and maintain systems of budgetary control and reporting.
4	DOF	Annual accounts and reports.
5	DOF	Banking arrangements.
6	DOF	Income systems.
7	CE	Ensure that procedures are in place to manage each contract on behalf of the Trust.
8	CE	Ensure adequate and appropriate business arrangements for the provision of patient services.
??		.
7.5.30	CE	Designate to Procurement team responsibility for receipt and custody of tenders on e-commercial portal
~~7.3.3~~	~~TWO SENIOR OFFICERS~~	~~Open tenders.~~
7.5.31	HEAD OF PROCUREMENT	Decide whether any late tenders should be considered.
7.3.8		Remove as approved supplier lists not permitted
7.1.1	CE	Best value for money is demonstrated for all services provided under contract or in-house.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

Turquoise shading notes duties previously listed under SoD implied by Standing Orders

SFI REF	DELEGATED TO	DUTIES DELEGATED
8	CE	Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.
9.1 – 9.2 9.4	BOARD NOMINATIONS & REMUNERATION COMMITTEE DIRECTOR/EMPLOYEE	Nominations and Remuneration Committee Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees. Staff, including agency staff, appointments.
9.5	DIRECTOR OF WORKFORCE AND OD	Payroll
9.8	CE	Ensure that procedures are in place to enter into contracts of employment, regarding staff, agency staff or consultancy service contracts.
10.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.3	DOF	Prompt payment of accounts.
10.2.5	CE	Authorise who may use and be issued with official orders.
10.2.7	DOF	Ensure that Standing Orders are compatible with requirements of NHS Improvement re building and engineering contracts.
11	DOF	Advise Board on borrowing and investment needs and prepare procedural instructions.
12.1	CE	Capital investment programme

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

Turquoise shading notes duties previously listed under SoD implied by Standing Orders

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.1.5	DoF	Monitoring the capital programme.
12.2.1	CE	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
12.3	CE	Maintenance of asset registers.
12	CE	Overall responsibility for fixed assets.
12.4.4	ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
13	DoF	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
14	DoF	Detailed procedures for the disposal of assets
14	DoF	Prepare procedures for recording and accounting for losses and special payments and informing NHS Improvement of all frauds and informing police in cases of suspected arson or theft.
15	DoF	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17	DoF	Shall ensure each fund held on trust is managed appropriately.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

Turquoise shading notes duties previously listed under SoD implied by Standing Orders

SFI REF	DELEGATED TO	DUTIES DELEGATED
17.9	CHARITABLE FUNDS COMMITTEE	On behalf of the Board as Corporate Trustee, consider the report from the Charity's auditor and review and approve the Annual Accounts and Trustees' report for charitable funds.
18	CE	Retention of document procedures
19	CE	Risk management programme
19.3	CE	Insurance arrangements

APPENDIX C

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST - DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.	**Management of Budgets** Responsibility of keeping expenditure within budgets		
a)	At individual budget level (Pay and Non-Pay and non-contracted income)	Budget Manager	SFIs Section 3
b)	For the totality of services covered in a division.	Divisional Director	
2.	**Maintenance / Operation of Bank Accounts**	Director of Finance	SFIS Section 5
3. **a)**	**Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment of Goods & Services** Non-Pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified in the Authorisation Limits in Appendix I of the SFIs		SFIs Section 10 and Appendix 1, Standing Orders section 9
4.	**Capital Schemes**		
a)	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations and the Trust tender process	Chief Executive or Director of Finance	SFIs Section 12 and Appendix 1
b)	Financial monitoring and reporting on all capital scheme expenditure	Director of Finance	

c)	Granting, extension and termination of leases for equipment	Director of Finance	
d)	Granting, extension and termination of leases for land and buildings	Director of Finance and Chief Executive	
e)	Approval of business case ▪ £2,500,000and over ▪ Between £2,000,000 and £2,500,000 ▪ Between 50,000 and £2,500,000 ▪ Less than £50,000	Board of Directors Trust Executive Board Chief Executive and Director of Finance Capital Investment Group	
5. **a)**	**Quotation, Tendering and Contract Procedures for Goods and Services** **Competitive Tenders** **Authorisation limits**	CHS Procurement Team	Refer to SFIs Section 7 Refer to the Authorisation Limits in Appendix 1 of the SFIs
b)	**Opening Tenders**	CHS Procurement Team	
i.	Receipt and custody of tenders prior to opening (where e-tendering portal being used)	CHS Procurement Team	
~~ii.~~	~~Receipt and custody of tenders prior to opening (where the paper-based system used)~~		N/A – no paper based tenders accepted
d)	**Waiving of Quotations and Tenders**		
. i.	Tenders – refer to paragraph 7.5.22 of the Standing Financial Instructions subject to the completion of the relevant	Director of Finance and Head of Procurement)	HoP will review the over threshold Waiver requests and

	Procurement form. Quotes – refer to paragraph 7.5.24 of the Standing Financial Instructions subject to the completion of the relevant Procurement form.	(reported to the Audit and Risk Committee) Head of Procurement	only submit to DoF if no other option is available. DoF will need to authorise due to breach of procurement regs. Removed the DoF from the under threshold quotes as the new procurement process we have implemented should give reassurance that any waiver is for genuine reasons as per the new Waiver exceptions in 7.5.26
6.	**Setting of Fees and Charges**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Appropriate Director	SFIs Section 6.2
b)	Price of NHS Contracts Charges for all NHS Contracts	Chief Executive or Director of Finance	SFIs Section [8]
7. a) b) c)	**Engagement of Management/Specialist Consultancy (non-medical)** ~~Management or Specialist Consultancy Where total commitment is less than £20,000~~ ~~Where total commitment is between £20,000 and £100,000.~~ ~~Where total commitment is above £100,000~~	~~Appropriate Director~~ ~~Two Executive Directors (one of whom must be the Chief Executive, Deputy Chief Executive or Director of Finance~~ ~~Chief Executive and Director of Finance~~	~~SFIs Section 9~~ Remove as this is covered by Section 7 of SFIs Tendering and Contract Procedure

c)	~~In accordance with NHS Improvement mandatory guidance the engagement, appointment or commissioning of any consultancy over £50,000~~	~~NHS Improvement~~	
d)	Engagement of Trust's Solicitors • Employment law matters • All other legal matters	All Directors and Company Secretary in liaison with Head of Procurement	
e)	Booking of Bank or Agency Staff • Nursing	Appropriate Director	
i.	Off framework	Executive Director	
ii	Above 50% wage	Executive Director Deputy Director of Nursing (via Nursing Daily staffing meeting)	
iii	Bank and Tier 1 Agency cap • Medical		
8.	**Expenditure on Charitable Funds** For authorisation limits please refer to Appendix 1 of the Standing Financial Instructions and to paragraph 17 for further guidance.	See SFIs - Appendix 1 which lists authorisation limits	SFIs Section 17
a)	Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Director of Finance	
b)	Letting of premises to non-NHS organisations.	Chief Executive/ Director of Finance	
c)	Letting of premises to other NHS Organisations	Chief Executive and Director of Finance	

d)	Approval of rent based on professional assessment	Director of Finance	
e)	Sales and purchase of land not exceeding £100	Chief Executive and Director of Finance of Director of Finance	
10.	**Condemning & Disposal**		
a)	Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (to be recorded in the appropriate Losses Register)		SFIs Section 14.1 and SFIs Appendix 2,
	i) all IT equipment with new price <£5,000	Director of Health Informatics	
	ii) all medical equipment with new price <£5,000	Divisional Director	
	iii) all mechanical and engineering plant <5,000	Chief Executive or Director of Finance	
	iv) all general equipment with new price <£5,000		
	v) all equipment with new price >£5,000		
11.	**Losses, Write-off & Compensation**		
a)	Losses and Cash due to theft, fraud, overpayment & others Up to £50,000	Chief Executive and Director of Finance	SFIs Section 14.2 and SFIs Appendix 2
b)	Fruitless Payments (including abandoned Capital Schemes) Up to £250,000	Chief Executive and Director of Finance	
c)	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other Up to £1,000 –Over £1,000	Chief Executive or Director of Finance Audit Committee	
d)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000	Chief Executive or Director of Finance	

e)	Extra Contractual payments to contractors Up to £50,000	Chief Executive or Director of Finance	
f)	Ex-gratia Payments Patients and staff for loss of personal effects Up to £2,500 £2,500 to £100,000	Assistant Director for Quality and Safety, Chief Executive or Director of Finance **AND** Medical Director or Director of Nursing	
g)	Payments or admissions of liability for personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to £10,000 for employer's liability and Up to £3,000 for public liability (to reflect the excess payment)	Assistant Director for Quality and Safety	
h)	Other, except cases of maladministration where there was no financial loss by claimant up to £50,000 **The following safeguards must have been made before payment can be made:** **a. For clinical negligence claims, the claim has been agreed with the NHS Resolution with the appropriate legal advice.** **b. For employee liability and public liability cases, that the claim has been agreed with the insurers with the appropriate legal advice.** **c. Where the level of expenditure is below that which requires either NHS Resolution or our insurers' approval, that legal advice supports the amount and payment of the claim.**	Chief Executive and Director of Finance	
12.	Reporting of Incidents to the Police		
a)	Where a criminal offence is suspected i) criminal offence of a violent nature ii) other than fraud	Duty Manager Appropriate Director	SFIs Section 2 & 14 Fraud Policy & Response Plan
b)	Where a fraud in involved	Director of Finance	

13. a)	**Petty Cash Disbursements** Expenditure up to £40 per item	 Manager / Authorised Signatory	 SFIs Section10
14. **a)** **b)**	**Receiving Hospitality, Gifts and Individual Corporate Sponsorship** Declaring the receipt of gifts and hospitality and/or individual sponsorships for inclusion in the Trust register. (Applies to both individual and collective hospitality / gifts / sponsorship received) In excess of £50.00 per item received. Approving the retention of gifts and receipt of hospitality/sponsorship • For Non-Executive Directors • For all employees	 Individual Staff Member Declaration required in Trust's Hospitality Register maintained by Company Secretary Chair Chief Executive	Refer to Conflicts of Interests and Standards of Business Policy
15.	**Implementation of Internal and External Audit Recommendations**	Director of Finance	SFIs Section 2
17.	**Investment of Funds (including Charitable & Endowment Funds)**	Director of Finance	SFIs Section 11 and 17 and authorisation limits at Appendix 1 of SFIs
18. a) b) d) e)	**Personnel, Pay and Expenses** Authority to fill funded post on the establishment with permanent staff. Authority to appoint staff to post not on the formal establishment. Regrading All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure. Establishments	 Director/ Divisional Director of Operations Director/Divisional Director of Operations Director of Workforce and Organisational Development/ Divisional Director Operations	

	i. Additional staff to the agreed establishment with specifically allocated finance.	Director/Divisional Director Operations	
	ii. Additional staff to the agreed establishment without specifically allocated finance.	Director/Divisional Director Operations	
f)	Pay		
	i. Authority to complete standing data forms effecting pay, new starters, variations and leavers.	Director of Workforce and Organisational Development/Divisional Director Operations	
	ii. Authority to complete and authorise positive reporting forms.	Line Manager	
	iii. Authority to authorise overtime.	Line Manager	
	iv. Authority to complete and authorise positive reporting forms.	Line Manager	
	v. Authority to authorise travel & subsistence expenses.	Line Manager	
g)	Leave		
	i. Approval of annual leave	Line Manager	See appropriate Trust Policy
	ii. Annual Leave – approval of carry forward of 5 days.	Line Manager	
	iii. Annual Leave – approval of carry over 5 days (to occur in exceptional circumstances only	Line Manager	
	iv.		
	v. Compassionate Leave up to 6 days.	Line Manager	
	vi. Special Leave arrangements • paternity leave • carers leave • adoption leave (to be applied in accordance with Trust Policy	Line Manager Line Manager Line Manager	

	vii. Leave without pay		
	viii. Medical Staff Leave of Absence • paid and unpaid	Clinical Director/General Manager/Line Manager Line Manager	
	ix. Time off in lieu	Line Manager	
	x. Maternity Leave – paid and unpaid		
h)	Sick Leave i. Extension of sick pay	Director of Workforce and Organisational Development/ Divisional Director Operations	
i)	Study Leave i. Study leave outside the UK	Divisional Director	
	ii. Medical staff study leave (UK)	Clinical Director/General Manager/Line Manager	
	iii. All other study leave (UK)	Line Manager	
j)	Removal Expenses Authorisation of payment of removal expenses	Director/Divisional Director Operations	
k)	Authorised Car & Mobile Phone Users		
	Requests for new posts to be authorised as car users.	Line Manager	
	Requests for new posts to be authorised as mobile telephone users.	Line Manager	
l)	Renewal of Fixed Term Contract	Line Manager	

m)	Redundancy	Director of Workforce and Organisational Development and Director of Finance	
n)	Dismissal inc. Ill Health	Director/Divisional Director Operations	
19.	**Authorisation of New Drugs**	Medicines Management Committee	
20.	**Authorisation of Sponsorship Deals**	Chief Executive, Medical Director	
21.	**Authorisation of Research Projects**	Chief Executive, Medical Director	
22.	**Authorisation of Clinical Trials**	Chief Executive, Medical Director & Deputy and Director of Operations	
23.	**Insurance Policies** **Risk management arrangements** Risk Management Strategy and Policy	Director of Finance Director of Corporate Affairs	SFIs Section 19
24.	**Patients & Relatives Complaints** a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico – Legal Complaints Co-ordination of their management	Director of Corporate Affairs Director of Nursing Medical Director	
25.	**Relationships with Press** a) Non-Emergency General Enquiries • Within Hours	Head of Communications	

	• Outside Hours b) Emergency • Within Hours • • Outside Hours	Head of Communications Chief Executive or Executive Director or Director of Corporate Affairs Head of Communications or On Call Director	
26.	**Infectious Diseases & Notifiable Outbreaks**	On Call Infection Control Team	
27.	**Extended Role Activities** Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	Director of Nursing	Nurse/Midwives Health Visitors Act Midwives Rules/Code of Professional Conduct
28.	**Patient Services** a) Variation of operating and clinic sessions within existing numbers • Outpatients • Theatres • Other b) All proposed changes in bed allocation and use • Temporary Change • Permanent Change	 General Manager General Manager General Manager Divisional Director Operations Chief Operating Officer and Divisional Director	
29.	**Facilities for staff not employed by the Trust to gain practical experience** Professional Recognition, Honorary Contracts, and Insurance of Medical Staff. Work experience students.	 Clinical Directors or Medical Staffing Manager or PGME Director as appropriate Departmental Managers / Personnel Officer	

30.	**Review of fire precautions**	Chief Operating Officer	Fire Safety Policy
31.	**Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations**	Director of Workforce and Organisational Development in conjunction with Director of Finance as appropriate	Health & Safety at Work
32.	**Review of Medicines Inspectorate Regulations**	Clinical Director of Pharmacy	
33.	**Review of compliance with environmental regulations, for example those relating to clean air and waste disposal**	Director of Workforce and Organisational Development, Director of Finance	
34.	**Review of Trust's compliance with the Data Protection Act**	Chief Digital and Information Officer	
35.	**Monitor proposals for contractual arrangements between the Trust and outside bodies**	Director of Transformation and Partnerships	
36.	**Review the Trust's compliance with the Access to Records Act**	Medical Records Manager	
37.	**Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" practices.**	Managing Director Digital Health	
38.	**The keeping of a Declaration of Interests Register**	Chief Executive/Company Secretary	SOs Section 6
39.	**Attestation of sealings in accordance with Standing Orders**	Company Secretary	SOs Section 12
40.	**The keeping of a Register of Sealings**	Company Secretary or Corporate Governance Manager	SOs Section 12
41.	**The keeping of the Hospitality Register**	Company Secretary	
42.	**Retention of Records**	Medical Records Manager	SFIs Section 18

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

APPENDIX D

43. Mental Health Act 1983: Scheme of Delegation by the Hospital Managers and Training

Director with responsibility: Director of Nursing **Operational Lead: Chief Operating Officer**

FUNCTIONS WHICH CANNOT BE DELEGATED TO OFFICERS OF THE TRUST

Function	Legislative Reference	Code of Practice Reference	Authorised Person / Committee
Review the Trust's operation of the Act, governance arrangements & varying this scheme of delegation		Chapter 37	Board of Directors

FUNCTIONS DELEGATED TO OTHER ORGANISATIONS

The Trust has a Service Level Agreement with South West Yorkshire Partnership Foundation Trust to act as hospital manager for the purpose of reviewing detentions under the Mental Health Act, and administration of the Mental Health Act	Section 23 MHA		South West Yorkshire Partnership Foundation Trust

FUNCTIONS DELEGATED TO OFFICERS

Recording admission for section 5(2) – Form H1	MHA sections 5(2) Regulation 4(1)(g)	Chapter 18: holding powers	H1 Part 1: Medical Practitioner in Charge of Patient or nominated deputy H1 Part 2: the designated authorised hospital manger which is the senior nurse in and out of hours who has received appropriate Mental Health Act receipt and scrutiny training
Formal Receipt and Scrutiny of statutory forms	MHA sections 5(2)	Chapter 18: holding powers	Head of Safeguarding
Provision of information on section 5(2) to patients and their nearest	MHA sections 5(2)	Chapter 2	Senior hospital nurse in and out of hours will provide relative letter 5(2) and the

relative			rights leaflet S5 (2).
Patient discharged from section 5(2) detention before the expiry of the 72 hours holding period (with clarity over start and finish times of the detention period)	MHA sections 5(2)	Chapter 18: 18.19, 18.20 & 18.35	Medical Practitioner in Charge of Patient or nominated deputy or Approved Mental Health Practitioner (AMHP)

TRAINING PROVISION

Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
MCA Level 3	Every three years	3½ hours	Face to face	Safeguarding team	Training team	Deputy Director of Nursing

*To be reviewed - Medical Staff also receive specific training in the use of the MHA at induction sessions, foundation year programme training and department specific sessions including Emergency Department.

PUBLIC BOARD WORKPLAN 2023-2024

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Date of agenda setting/Feedback to Execs	5 April 2023	31 May 2023	19 July 2023	11 Oct 2023	15 Nov 2023	10 Jan 2024
Date final reports required	21 April 2023	23 June 2023	25 August 2023	20 October 2023	29 December 2023	23 February 2024
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓	✓	✓	✓
Health Inequalities		✓		✓		✓
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 Chairs Highlight Report & Minutes		✓	✓		✓	
STRATEGY AND PLANNING						
Strategic Objectives – 1 year plan / 5 year strategy	✓ Year-end Quarterly Report	✓ *- 2023-2024 Strategic Objectives Progress Report*		✓		✓
Digital Health Strategy				✓		
Risk Management Strategy	✓RM Policy	RM Strategy				✓

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Annual Plan	✓ for 2023/24					✓
Capital Plan					✓	
Winter Plan				✓		
Green Plan (Climate Change)		✓ TBC				
QUALITY						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q3	✓Q4	✓Q1	✓Q2		✓Q3
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓ Q3 & Q4 & Annual Report	✓Q1	✓Q2		✓ Q3
Maternity Incentive Scheme					✓	
Safeguarding Adults and Children Annual / Bi-Annual Report		✓ Annual Report ✓ Annual Report			✓ Bi-annual	
Complaints Annual Report		✓				
WORKFORCE						
Staff Survey Results and Action Plan	✓		✓			✓
Health and Well-Being			✓			
Nursing and Midwifery Staffing Hard Truths Requirement		✓ Annual Report			✓ 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	
Public Sector Equality Duty (PSED) Annual Report						✓

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
GOVERNANCE & ASSURANCE						
Health and Safety Update (if required – routinely reports to ARC)	✓				✓	
Health and Safety Policy (May 2023)	✓					
Health and Safety Annual Report		✓				
Board Assurance Framework		✓ 1		✓ 2		✓ 3
Risk Appetite Statement			✓			
High Level Risk Register	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review (next review due March 2025 unless changes required beforehand)						
Non-Executive appointments				✓		✓
Annual review of NED roles				✓		
Board workplan	✓	✓	✓	✓	✓	✓
Board meeting dates		✓				
Use of Trust Seal		✓		✓		✓
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	✓ NRC	✓ Workforce	✓ARC ✓ TPB			✓QC ✓ NRC BOC
Constitutional changes (+as required)	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Strategy 2021-2026	✓ (B/f from March 2023 BOD)					✓

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Committee review and annual reports		✓				
Audit and Risk Committee Annual Report 2022/2023		✓				
Workforce Committee Annual Report 2022/23		✓				
Finance and Performance Committee Annual Report 2022/2023		✓				
Quality Committee Annual Report 2022/23		✓				
Transformation Programme Board Annual Report						
WYAAT Annual Report and Summary Annual Report					✓	
Kirklees ICB Committee Papers (Link)	✓	✓	✓	✓	✓	✓
Calderdale Cares Partnership Committee Papers (Link)	✓	✓	✓	✓	✓	✓

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

25. Review of Board Sub-Committee Terms of Reference

1) Nomination and Remuneration Committee (BOD)

To Approve

Calderdale and Huddersfield NHS Foundation Trust

NOMINATION AND REMUNERATION COMMITTEE (BOARD OF DIRECTORS)

TERMS OF REFERENCE

Version:	6 6 March 2023 5 10 November 2022 4 Board approved 3.3.22 3 Board approved 14.1.21. 2 Board approved 5.3.20. 1 Board approved 30.6.16.
6	Board of Directors
Date approved:	10 November 2022
Date issued:	10 November 2022
Review date:	March 2024

NOMINATIONS AND REMUNERATION COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Nominations and Remuneration Committee. The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

2.1 The Nominations and Remuneration Committee is constituted as a standing non-executive Committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

2.2 The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nominations and Remuneration Committee.

2.3 The Nominations and Remuneration Committee is authorised by the Board of Directors to instruct professional advisors and seek information where required to support decision making. The Committee may also request the attendance of individuals and authorities from both within and outside the Trust with relevant experience and expertise if it considers this necessary to the exercise its functions.

3. Purpose

3.1 To be responsible for identifying and appointing candidates to fill all NHS Foundation Trust Executive voting and non-voting Director positions on the Board, and Director roles within Calderdale and Huddersfield Solutions Ltd (CHS). When appointing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006. When appointing the other Executive Directors, the Committee shall be the committee described in Schedule 7, 17(4) of the Act.

3.2 To determine the remuneration and other conditions of service of voting and non-voting Director positions on the Board and the Director positions within CHS.

The Committee will:

3.2 Regularly review the structure, size, and composition (including the skills, knowledge, experience, and diversity) of the Board and make recommendations to the Board regarding any changes in Executive roles. When considering composition, the Committee will seek to reflect the Board's action plan to match the diverse composition of the overall workforce or community.

3.3 Consider and make plans for succession planning for the Chief Executive and other Executive Board Directors, taking into account the challenges and opportunities facing the Foundation Trust and the skills and expertise needed, to achieve the Strategy.

Consider and make plans for review and succession planning for the non-voting Director roles and Director roles for wholly owned subsidiaries established by the Board, taking into account the skills and expertise needed.

3.4 Keep the leadership needs of the Trust under review at Executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

3.5 Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

3.6 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the appointment. In identifying suitable candidates, the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria. The selection panel should include at least one external assessor from NHS England and / or a representative from a relevant ICB. (Code of Governance for NHS Providers Section C states FT should engage with NHS E to agree the approach)

3.7 Ensure that a proposed Executive voting and non-voting Director's other significant commitments (if applicable) are considered before appointment.

3.8 Be responsible for identifying and nominating a candidate for approval by the Board and the Council of Governors, in accordance with the Constitution, to fill the position of Chief Executive.

3.9 Ensure that proposed appointees comply with the Fit and Proper Persons Requirements and disclose any business interests that may result in a conflict of interest prior to appointment.

3.10 Consider any matter in line with Trust procedures relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Foundation Trust.

4. Remuneration role

4.1 Establish and keep under review a remuneration policy in respect of Executive voting and non-voting Directors of the Board.

4.2 Consult with the Chief Executive about proposals relating to the remuneration of Executive voting and non-voting Directors of the Board.

4.3 In accordance with all relevant laws, regulations, and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors and non-Board Directors including Director roles within wholly owned subsidiaries of the Trust, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses; and compensation payments.

4.4 In adhering to all relevant laws, regulations, and Trust policies:

- Establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the Trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors and non-Board Directors while ensuring that increases are not made where Trust or individual performance do not justify them.
- Be sensitive to pay and employment pay and conditions elsewhere in the Trust.

4.5 Monitor and assess the output of the evaluation of the performance of individual Directors and consider this output when reviewing changes to remuneration levels.

4.6 Advise on and oversee contractual arrangements for Executive Directors and non-Board Directors, including but not limited to termination payments (including redundancy), taking account of national guidance where appropriate, always ensuring that poor performance is not rewarded.

4.7 Delegate responsibility to the Chief Executive and Executive Director of Workforce and Organisational Development for the determination of the Trust's pay and reward strategy as it affects all other staff, working within national frameworks where required.

5. Membership and attendance

5.1 The membership of the committee shall consist of:

- The Trust Chair
- At least 3 other Non-Executive Directors on the Board (excluding the Chair of the Audit and Risk Committee)
- The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his terms of condition and remuneration.

5.2 The Trust Senior Independent Non-Executive Director shall chair the Committee.

5.3 A quorum shall be three members which must include either the Trust Chair or Trust Deputy Chair/Senior Independent Non-Executive Director. In the absence of the Trust Senior Independent Non-Executive Director, the Trust Chair will chair the meeting.

5.4 The Executive Director of Workforce and Organisational Development shall normally be invited to attend meetings in an advisory capacity but will withdraw from the meeting during any discussions regarding their remuneration and terms and conditions of service.

5.5 Other members of staff and external advisers may attend all or part of a meeting by invitation of the Committee Chair where required.

5.6 Members unable to attend should inform the Committee Secretary at least 7 days in advance of the meeting.

5.7 A register of attendance will be maintained, and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Company Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the Company Secretary in this regard include but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 5 working days of each meeting; and

- Maintaining a record of attendance.

7. Frequency of meetings

7.1 Meetings shall be held as required but at least annually in each financial year, and whenever there is a need to consider matters relating to the appointment of Executive Directors. A meeting of the Committee may be called by the Company Secretary at the request of the Chair.

8. Reporting

8.1 Formal minutes shall be taken of all Committee meetings and ratified by the Committee at its next meeting

8.2 The Committee Chair shall prepare a report of each Committee meeting for submission to the next Board of Directors meeting in confidence unless it would be inappropriate to do so.

8.3 The Committee shall receive and agree a description of the work of the Committee, its policies, and all Executive Director emoluments in order that these are accurately reported in the Trust's Annual Report.

9. Review

9.1 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually, with a prior review undertaken by the Committee before approval by the Board of Directors.

Date Approved by Nominations and Remuneration Committee: 14 March 2023

Review Date: March er 2024

26. Items for Review Room

1. Minutes of Board Committees

2. Finance and Performance Committee 6 December 2022, 10 January, 7 February, 28 February, 4 April 2023

3. Quality Committee 14 November 2022, 16 January, 20 February, 20 March 2023

4. Workforce Committee 14 February 2023

5. Audit and Risk Committee 31 January 2023

6. Partnership papers: Kirklees Health and Care Partnership Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)https://www.kirkleeshcp.co.uk/about-us/kirklees-icb-committee/kirklees-icb-committee-meetings/

and Calderdale Cares Partnership Meeting papers - Calderdale Cares Partnership https://www.calderdalecares.co.uk/about-us/meeting-papers/

To Note

27. Date and time of next meeting

Date: Thursday 6 July 2023

Time: 10 am

Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

To Note

Presented by Helen Hirst