Public Board of Directors Meeting

Schedule	Thursday 2 March 2023, 10:15 — 13:00 GMT
Venue	Forum 1A/B, Learning Centre, Huddersfield Royal Infirmary
Organiser	Kathy Bray

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b) Quality Committee
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- Finance and Performance Committee November 2022

- Quality Committee 14 November 2022
- Workforce Committee 7 December 2023
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Partnership papers: Kirklees Health and Care Partnership Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)
and Calderdale Cares Partnership Meeting papers - Calderdale Cares Partnership
To Note

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27. Date and time of next meeting
Date: Thursday 4 May 2023
Time: 10 am
Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

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1. Welcome and Introductions
Andrea Dauris (Item 18)
Louise Croxall – Chief Nurse Information Officer (item 6)
Chloe Gough - Matron Emergency Care - CRH (Item 6)

Invited Public Governors:
Peter Bamber
Veronica Woolin
Stephen Baines
Isaac Dziya
To Note

2. Apologies for absence:

To Note

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 12 January 2023

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 12 January 2023 at 10:00 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	Acting 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	Interim Chief Operating Officer
Robert Birkett	Chief Digital Information Officer
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary
Dr Shiva Deep Sukumar	Guardian of Safe Working Hours
Andrea Gillespie	Freedom to Speak Up Guardian (Item 08/23b)
Diane Tinker	Director of Midwifery and Women's Services (Item 11/23)
Tahira Naeem	Clinical Director for Women's Services (Item 11/23)
Susan Johnson	Urgent Community Response Team (Item 06/23)
Jo Banks	Urgent Community Response Team (Item 06/23)
Amber Ballard	Urgent Community Response Team (Item 06/23)
Nicola Hosty	Assistant Director of Human Resources (Item 09/23)
Christopher Button	Lead Cancer Nurse (Item 09/23)
Zebi Deluce	Physiotherapist - Paediatric Community Child Health (Item 09/23)
Corinna Hampshire	Matron, General Surgery (Item 09/23)
Amy Campbell	Head of Communications
Deborah Melia	Corporate Governance Manager *(minutes)*

OBSERVERS

Stephen Baines	Public Elected Governor
Christine Mills	Public Elected Governor
Gina Choy	Public Elected Governor

01/23 **Welcome and Introductions**

The Chair welcomed everyone to the Board of Directors meeting held in public, in particular Jo Banks and Amber Ballard from the Urgent Community Response Team, Nikki Hosty, Christopher Button, Zebi Deluce and Corinna Hampshire to present the Diversity and Inclusion Update. Amy Campbell, Head of Communications was also welcomed to the meeting as was Rob Aitchison attending his first Board meeting.

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The Chair also welcomed invited governors, Stephen Baines, Christine Mills and Gina Choy as observers to the meeting.

The Chair congratulated Robert Birkett on his recent appointment as Chief Digital Information Officer.

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

02/23 Apologies for absence

Apologies for absence were received from Victoria Pickles, Director of Corporate Affairs and Peter Bell, public governor.

03/23 Declaration of Interests

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

04/23 Minutes of the previous meeting held on 10 November 2022

The minutes of the previous meeting held on 10 November 2022 were approved as a correct record subject to the following addition to the Digital Health Strategy (item 150/22):

'AN raised the need for more rigorous analysis of which projects have and have not been delivered against planned and ad-hoc projects over the year.'

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 10 November 2022 subject to the above amendments.

05/23 Matters Arising and Action Log

The Chair updated the Board on progress of the actions. The log has been updated and other actions are on the meeting agenda.

No further actions or matters arising to note.

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

06/23 Virtual Ward Patient Story

The Deputy Chief Executive introduced Jo Banks and Amber Ballard, Specialist Practitioners from the Urgent Community Response Team and congratulated them on the great work they are doing through the virtual ward, which has been set up at pace and is really making a difference to patient care.

Jo and Amber shared Enid's story which illustrated how her unplanned patient care journey was positively impacted by the service provided by the virtual ward team. Enid attended A&E and soon after was stepped down to the 'Virtual Ward' for continued medical and social care before being discharged home where she was allocated a Virtual Ward Specialist Practitioner.

The Virtual Wards collaboration with local health partners such as Pharmacists, Local Care Direct, GP, Home Care Agency, and Palliative Care, District Nurses ensured

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continuity of care for Enid in her home environment where she felt most comfortable and avoided the need for visits to A&E.

The Chair thanked Jo and Amber for sharing Enid's story and commented that it was encouraging to see the proactivity of partnerships created throughout the patient's care journey.

The Chief Executive and AN asked Jo and Amber what Enid's care journey would have looked like without the involvement with The Virtual Ward. Jo indicated that Enid would have remained in hospital for a period before being discharged where she would have received social care but would not have had the same level of interventional medical care which would have likely resulted in a further attendance to A&E. Having a specialist practitioner allocated to Enid ensured that support was continued within the community at home with her family being involved in conversations relating to her care.

AN added that the Virtual Ward is a good use of resource.

DS thanked Jo and Amber for sharing the patient's story and the positive impact it had on the patient's needs and quality of life at the end stage of her life and asked about the volume of patients utilising the service. Jo confirmed that they have just finished the pilot phase, which was five patients per site, with numbers increasing to nine by site, with referrals are being received via various avenues such as GPs or via rehabilitation services.

The Interim Chief Operating Officer asked what support would be required from the Board moving forward. Amber expressed that having a consultant available via telephone for advice would be beneficial and pharmacy support for intravenous antibiotics at home and medication advice.

The Chief Nurse emphasised this as a great example of transformation outside of the hospital and the expansion of professional roles.

CM felt that the service was of great importance in supporting older patients and their families.

OUTCOME: The Board **NOTED** the Virtual Ward Patient Story and thanked the Urgent Community Response Team for their excellent presentation

07/23 Chair's Report

The Chair updated the Board on her activity since the last meeting. She used this opportunity to thank everyone at the Trust for all their hard work in the challenging operational times over the last couple of months, including our Interim Chief Operating Officer and Directors.

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

08/23 Chief Executive's Report

a) The Chief Executive commented on the challenging operational context, both externally and internally within the Trust. The key points highlighted were:

- The context in which we are operating is challenging both externally and internally within the Trust, with the Board leading and supporting the organisation through

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this. Having reached the highest operational level OPEL 4 at points, this has now reduced to OPEL level 3

- Industrial action continues within the NHS and other public services. While we are not directly affected, we do need to consider the impact on our Trust.
- Pressures on health and social care have been reported through Trust data and media over recent weeks. He thanked Amy Campbell, Head of Communications for managing the communications in the media and noted the Trust has participated in national level discussions about pressures
- Nationally the Hewitt Review closed for comment on 9 January 2023. The Director of Corporate Affairs has led the Trust response to this national piece of work on the effectiveness of Integrated Care Boards (ICBs). A copy of the West Yorkshire ICB response is available on their website and references the issue in relation to progressing the capital decisions for the Trust.
- At a West Yorkshire level, a proposed five-year strategy has been developed which the Trust has commented and is actively promoting the consultation on the Strategy through our stakeholder and public communication channels.

The Interim Chief Operating Officer commented on the recent operational pressures which mirrored those of our neighbouring Trusts. The driver was high ED attendances, with an increase in the acuity of patients in the last two months (Covid, Flu). This has led to a high number of admissions and bed occupancy with an increase in the number of escalation beds. The focus was on treating the most unwell patients within 60 minutes. This impacted on length of stay for other patients, and our 4 hour and 12-hour position deteriorated. Ambulance handover delays increased with 5.1% patients waiting greater than 30 minutes in December, with an improvement in January 2023. The Trust has several internal command arrangements and there are actions at Place level to manage high demand and these will remain under review.

TB asked whether the reason for increase in pressures is seasonal. The Chief Executive confirmed that these pressures come from the seasonal variances of Winter (Covid, flu, streptococcus A) and patient acuity.

b) Freedom to Speak Up Mid-Year Report

Andrea Gillespie, Freedom to Speak Up (FTSU) Guardian, presented the 6 Month report for April to December 2022. The key points noted were:

- There has been a significant increase in the number and complexity of concerns raised by colleagues in Q1 and Q2 2022 reflective of pressures and a decrease in the number raised anonymously when compared with 2021 data.
- Themes included attitudes and behaviours, workforce levels and agency use and an expanding bed base
- The FTSU concerns are taking longer to process as they become more complex, and colleagues are requiring additional emotional support.
- Due to increased FTSU activity current resource is being reviewed and additional support being considered.
- The current FTSU priorities are review of resources and promotion of the FTSU service.
- NHS England is asking all Trust Boards to provide evidence re FTSU by the end of January 2024. This includes update of the local Freedom to Speak Up policy to reflect the new national policy template, the Trust's assessment of its Freedom to

Speak Up arrangements and assurance that the implementation of the latest Freedom to Speak Up improvement plan is on track.

The Chief Executive commented on the positive progress Andrea and the FTSU team have made.

DS commented she was pleased to see an increase in the number of ambassadors and asked how diverse the current group is. Andrea advised that there is a mix of FTSU ambassadors and that improvements in gathering information on protected characteristics have been made which will be presented at a future Board meeting.

DS asked how the Trust FTSU resources compares to other Trusts. Andrea advised the position was variable with many Trusts looking to increase their FTSU resource.

KH commented that the Workforce Committee reviews the reports which are a reflection of the culture within the Trust.
AN asked for clarity on whether a response is provided to the complainant and Andrea confirmed they do.

HH thanked Andrea and the FTSU ambassadors on behalf of the Board

OUTCOME: The Board **APPROVED** the Freedom to Speak 6 Month Report.

09/23 Workforce Equality, Diversity and Inclusion Update

Nikki Hosty, Assistant Director of Human Resources introduced Christopher Button, Zebi Deluce and Corinna Hampshire who shared their personal experiences, including past discrimination, their challenges, achievements, how they were supported through the equality networks (PRIDE, Race Equality Network, Empower Programme) and how this had impacted positively on their work to personalise care for patients and support colleagues. Information was shared on work that has taken place to widen participation from our local communities, broadening employability skills and confidence, with an ambition to do more in this area.

Nikki Hosty then provided an update on the paper which provides the Board with a progress update on the delivery of the Trust's workforce equality, diversity and inclusion (ED&I) strategy. The key points to note were:

- The Trust has a Board approved People Strategy in place that captures its commitment to equality, diversity and inclusion (ED&I).
- A 5-year workforce ED&I strategy was approved in 2019, currently in year 3 of the 5 year strategy.
- Significant activity has been initiated and is progressing to engage colleagues.
- The 2023/2024 focus will be 'embedding' activity with deliverables identified.
- Reporting ED&I progress is actioned via staff survey, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap analysis.
- The organisation has several sponsored, colleague-led, equality network groups.
- Intersectionality (Several protected characteristics) and changes experienced throughout people's lives.
- 80% of colleagues are patients and members of our community.
- Our approach is to celebrate difference, engage colleagues to learn about difference and tackle inequalities.

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- Our Workforce Equality, Diversity and Inclusion strategy is a fundamental element of our People Strategy and One Culture of Care.
- Our work on workforce health inequalities provides essential insight to drive engagement activity and is enabling us to widen participation in recruitment.
- Workforce demographics – the average age of the workforce is getting younger, number of people with a disability has increased, percentage of BAME colleagues is increasing and number of male colleagues is increasing.
- Strengths – the widening participation model and approach to apprenticeships supporting the ethos of ‘growing our own’ and supporting people from our local communities into work and employment. Refreshed values and behaviours with an enhanced focus on ‘putting people first’ and ‘inclusion’. The Care Club as an opportunity for colleagues/volunteers to gain more experience about how we provide care to our patients.
- Areas for development – Workplace behaviours. ED&I leader/manager/colleague education and awareness resources improved Board level representation to reflect our local communities.

Members of the Board thanked Nikki and her colleagues for sharing their update and personal experiences. The Board also congratulated the team on the progress made within the timescale.

GC commented that she would welcome input from some of the presenters to help Governors encourage more diversity in our membership

OUTCOME: The Board received the update and **ENDORSED** the approach to the Workforce Equality, Diversity and Inclusion Strategy.

10/23 **Quality Committee Chair’s Highlight Report**

DS drew attention to the Learning from Deaths Report for quarter 2 2022/23 in the review room. No questions were raised.

Items to acknowledge:

- Patient Story presentation on the Motor Neurone Disease support at CHFT, which has improved the quality of care for patients and developed from a pilot to a multidisciplinary service.

Items for assurance:

- Health and Safety Assurance report – Update on projects undertaken during 2022, with assurance received that comprehensive and robust systems are in place to ensure patient and employee safety and appropriate priorities identified for further improvement.
- Stroke Service update – Advanced Clinical Practitioners roles are having an impact on response times to patient interventions. Improvement work continues.
- Midwifery Services Report – Review undertaken in response to the East Kent report including the review of still birth and neonatal deaths. Quarterly audits completed with actions. Working with regional and national teams to set new targets for Maternity Continuity of Carer.
- Board Assurance Framework Risk 4/20 CQC rating reviewed, and risk score remains the same.
- Integrated Performance Report for September, Committee noted that a number of domains are showing an improvement.

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- Clinical Outcomes Group Minutes, escalated to Committee - ReSPECT programme to be rolled out early 2023, level 1 training to be available on ESR. A dashboard shows Hospital Standardised Mortality Ratios (HSMR) are the lowest since start of the pandemic.

Items for awareness:

- Calderdale Integrated Quality Framework for Place was presented by Debbie Winder Deputy Director of Quality. It was agreed that sharing of minutes and agendas will take place at this stage as ways of working are developed, including developing shared quality priorities.

OUTCOME: The Board **NOTED** the Quality Committee Chair's Highlight Report

11/23 Maternity Incentive Scheme submission

Diane Tinker, Director of Midwifery and Women's Services presented the Maternity Incentive Scheme paper with evidence of achievement against standards for Board approval prior to submission to NHS England and was supported by Tahira Naeem, Clinical Director for Women's Services.
The key points to note were:

- NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
- The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund, (approximately £1 million) and will also receive a share of any unallocated funds.
- Maternity Services have been working since the publication of the year 4 maternity incentive scheme to meet the ten safety standards. The full details of NHS Resolution's ten maternity safety actions and technical guidance is available in the Review Room, with summary information given below.
- A collation of evidence has been presented to a divisional panel on 14 December 2022 as a "check and challenge" approach to providing assurance. The panel were satisfied with the evidence provided.
- The panel agreed that the evidence demonstrated compliance with 9 out of the 10 safety actions. Appendix F2 contains the evidence table which supports the statement of compliance against each of the ten maternity incentive scheme safety actions.
- In order to be compliant with the outstanding action, action 6, ongoing work is required to meet one of the elements of Safety action 6 'Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?'.
- The process indicators for Element 1 of Safety action 6 are: percentage of women where Carbon Monoxide (CO) measurement at booking is recorded and percentage of women where CO measurement at 36 weeks is recorded.
- For each process indicator to be compliant a Trust must achieve an average of 80% over a four-month consecutive period with an evidencing position as of 2nd February 2023.
- Compliance has been achieved for the percentage of women where Carbon Monoxide (CO) measurement at booking process however, percentage of women

where CO measurement at 36 weeks the current reporting position is 73% October 2022 and 74% November 2022. Ongoing work is being undertaken to improve recording with a weekly meeting to review current position for December 2022 (which is above 88%) and January 2023, with the aim to be in a position to declare compliance by the time of submission.

The Director of Midwifery and Women's Services requested Board approval for sign off of the submission by the Chief Executive, which will take place on 1 February 2023, subject to the data confirming compliance for safety action 6.

The Chair congratulated the team on the nine areas where compliance has been achieved.

The Deputy Chief Executive expressed concern over the timescale to achieve compliance, the implications if not achieved and asked if there is any support required from the Board. The Director of Midwifery and Women's Services confirmed that the team is being well supported by Mark Butterworth and daily and weekly checks in relation to data are completed.

The Acting Director of Finance commented on the importance of the maternity incentive scheme monies to the financial position.

KH, Maternity Safety Champion confirmed a significant amount of work had been done in relation to these standards and supported the proposed submission as outlined.

The Board supported the decision for approval of the submission to the Chief Executive on the basis that all 10 out of 10 safety actions are evidenced as compliant. The Board was assured that compliance for action 6 would be able to be maintained.

OUTCOME: The Board delegated the approval of the submission to the Chief Executive and **APPROVED** the Maternity Incentive Scheme submission based on the terms stated above.

12/23 Charitable Funds Committee Chair Highlight Report

The Chair asked the Board for any comments relating to the highlight report. No questions were raised.

NB highlighted to the Board that the Committee also agreed to review the Reserves Policy at the next Charitable Funds Committee meeting.

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

13/23 Finance and Performance Chair Highlighted Report

AN presented an update which included items raised in the meetings held on 6 December 2022 and 10 January 2023.

Items to acknowledge:

- Continued excellent performance in Cancer.
- Despite growing Emergency Department (ED) attendance CHFT continues to be the best performer in West Yorkshire – however, performance declined to 60% in December as pressures increased.

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- Recovery performance is still largely on track with strong achievement on 78- and 104-week waiters and 52-week waiters compared with the external plan and with Diagnostics overall performance now almost 97%.
- Improved complaints performance; currently have no complaints, with focus on quality of response and learning from complaints.

Items for assurance:

- Deep dive review of ED looking the drivers of reduced performance which include higher attendances and patient acuity, staffing challenges and space. The ED unit cost has increased by 27% driven by agency spend, Covid measures and higher staffing levels to improve flow and patient care.
- Review of forecasted Recovery Performance done for the remainder of the year to ensure overall 104% target is met and progress is maintained on long waiters.
- The Committee were assured that action plans and deep dives are in place to tackle areas where elective recovery performance is not hitting target – evidence of improving performance in a number of areas
- We remain on track to meet the efficiency target of £20m in 2022/23.
- Integrated Performance Report (IPR) and framework being refreshed to update for NHS performance and local performance metrics.

Items for awareness:

- Current trajectory is that theatre staffing will be fully established by mid-December – key to meeting elective recovery targets
- Stroke performance remains an issue and proposed stroke hub business case not approved.
- Backlog volume of appointment slot issues and Follow-Up appointments still a concern – will it lead to greater pressure on 52-week waits.
- At the end of month 8 the Trust is reporting a deficit position of £14.99m which is £1.78m adverse to plan (vs £0.88m at month 6). This is driven primarily by Covid/ED costs and agency spend and latterly paying enhanced rates for Bank work.
- Although the Trust continues to forecast a £17.35m for the year in line with the plan there is a risk that this will not be met. The finance team modelled some scenarios and the 'likely case' in November showed a further deficit against plan However, some further system monies, depreciation funding and active management of accruals have now seen this reduce from a £5.5m further deficit to a forecast deficit of £1.8m against plan. This assumes the current operational pressures continue but efficiencies are achieved and pay awards and elective recovery are fully funded. Winter is bringing further pressures and there is the potential impact of industrial action.
- Cash position strong primarily due to capital underspend. Forecast is to spend full capital plan but remains a risk this will not happen.

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

14/23 Integrated Performance Report (IPR) – November 2022

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The Chair asked the Interim Chief Operating Officer if he would like to highlight any further information within the Integrated Performance Report not covered by the previous highlight report. The Interim Chief Operating Officer highlighted the success the surgical division had in regard to adjusting the way of working within 12 hours to improve elective recovery.

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance for November 2022.

15/23 **Month 8 Financial Summary**

The month 8 Finance report confirmed that year to date the Trust is reporting a £14.99m deficit, a £1.78m adverse variance from plan. The in-month position is a deficit of £1.89m, a £0.02m adverse variance. The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate staffing costs, in particular the impact of the revised medical bank rates and high-cost agency staff.

The Acting Director of Finance added that we are heavily reliant this year on non-recurrent means in order to deliver this year's plan, which was re-emphasised by AN. She reiterated that the NHS England performance metric, Use of Resources (UOR) score stands at 4 which is reflective of fluctuation of metrics and the key drivers are agency spend against the ICB set trajectory and year to date variance to plan. The forecast is to return to a score of 3 in line with the plan.

TB asked if we could articulate the cost of the key drivers. AN advised this data can be collected and is complex.

The Chief Executive said further discussions around costings are to be had on how these are allocated.

OUTCOME: The Board **NOTED** the Month 8 Finance Report and the financial position for the Trust as at November 2022.

16/23 **Workforce Committee Chair Highlight Report**

KH presented the highlight report from the previous meeting held on 7 December 2022.

The key points noted were:

- Integrated Performance Report - concern remains over the level of short-term sickness absence and the number of return-to-work interviews remains below target with further work planned to improve this. The Committee received a paper on alternatives to return-to-work interviews and agreed to "remove the workforce target for return-to-work interviews as a Key Performance Indicator, but not the requirement to do them, as part of the performance report to Board.
- Fire safety and data security training completion levels are low, and action is underway to address these. The Fire Safety Manager will attend the next meeting of the Committee to present a revised training offer. Overall Essential Safety Training (EST) levels have fallen slightly. A review of all EST is currently underway to ensure we are identifying what is "essential" and this will be considered by the Education Committee.
- The Committee undertook a deep dive into Allied Health Professional (AHP) turnover and received a presentation on the role of the AHP manager. Turnover

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remains a concern with the majority of staff leaving seeking a better work life balance.

- A quarterly vacancy deep dive (quarter 2) was presented with a number of vacancies in hard to recruit roles across England. Medical Division is experiencing the highest number of vacancies.

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

17/23 Guardian of Safe Working Hours 1 October – 30 November 2022 Report

Dr Shiva Deep Sukumar, Guardian of Safe Working Hours (GOSHW) presented the Guardian of Safe Working Hours report which covers the period of 1 October 2022 to 30 November 2022.

The key points noted were:

- Current exception reports – Most of the exception reports were related to extra hours of working. Two were related to educational opportunities missed and most were submitted by FY1 doctors. No exception reports highlighted any safety concern. The decrease in exception reports is expected to continue, with most reports from within surgery.
- Sharps Reduction action plan: Dr Sukumar advised he had participated in meetings held by the head of health and safety regarding sharps incidents and plans to reduce the incidence. A suggestion was given to have awareness posters and to give handouts in welcome pack to the junior doctors when they join the trust.
- Attendance at regional GOSWH conferences and webinars: Opportunities to interact and take learning from other GOSWH.
- Information about cover arrangements for out of hours rota gaps
- Junior Doctors Forum – took place on 12 December 2022 where updates from the previous Board meeting were shared. It was noted that an August spike in reporting was due to junior doctors being new to the system.

The Chair voiced that it is great to see a decrease in exception reports and encouraged the networking between GOSWH regionally.

The Interim Chief Operating Officer questioned whether there had been any additional feedback from junior doctors due to the recent pressures. Dr Sukumar confirmed that there had not. The Interim Chief Operating Officer will contact Dr Sukumar to attend the next junior doctors meeting.

The Medical Director commented that certain specialties were more affected by rota gaps than others, e.g. Paediatrics and that alternative workforce was being used to support these.

The Deputy Chief Executive thanked Dr Sukumar in the fantastic work achieved in regards to the sharps reduction and involvement with the junior doctors so far. This was echoed by other members in attendance.

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours Report for the period of 1 October 2022 to 30 November 2022.

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18/23 **High Level Risk Report**

The Chief Nurse presented the paper on behalf of the Director of Corporate Affairs. The Chief Nurse highlighted that the risks within the report reflect the key areas of challenge These are summarised in the report.

The Chief Nurse updated the Board on the work being undertaken to understand the new Patient Safety Incident Response Framework (PSIRF), its implications and required actions, with learning from the early adopter sites. An NHS Providers PSIRF learning event for Boards has been shared and a Board development session on this will be held in April 2023.

NB asked if the description of the types of risks will be looked at within the review. The Chief Nurse responded all aspects, including the risk description of the risks, will be reviewed to ensure consistency.

OUTCOME: The Board **NOTED** the high-level risk report.

19/23 **Governance Report**

Extension to Policies and Governance Documents

The Board noted that a routine review of the policies and Trust governance documents listed in the paper was underway, with current documents due for review in January 2023. The reviewed documents are within the remit of, and will be presented to, the Audit and Risk Committee on 31 January 2023 for review and comment before being presented to the Board for approval on 2 March 2023 with the exception of the Risk Management Strategy and Policy which will be taken to the Board on 4 May 2023.

- Standing Orders of the Board of Directors (last reviewed July 2022)
- Scheme of Delegation and reservation of Powers to the Board
- Standing Financial Instructions
- Risk Management Strategy and Policy (plan to take to Board 4 May 2023)

The Board was asked to extend the above documents from 1 February to 2 March 2023 except for the Risk Management Strategy and Policy which will be extended to 4 May 2023. Future review dates will then fall in March to allow for review by the Audit and Risk Committee in January.

Governance Structure

It was noted the updated governance structure is available in the Review Room.

Board Workplan

The Board workplan for the remaining meetings for 2023 and for 2023/24 is presented for information at Appendices N3 and N4.

Board Committee Meeting Schedule 2023-2024

The Board Committee Meeting Schedule from 1 April 2023 – 31 March 2024 is presented for information at Appendices N5. This is to ensure appropriate sequencing of the timing of Board Committee meetings with the Board of Directors meetings. This will

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allow for the most current up to date reports be fed up to the Board via the Chair highlight reports.

The Chair explained to the Board that all the Board meetings for this year will be held at Huddersfield Royal Infirmary due to room availability, cost of hiring rooms in the Calderdale area and the construction works taking place at Calderdale.

OUTCOME: The Board **NOTED** the Board workplan for 2022/23 and 2023/24, the Board Committee Meeting Schedule from 1 April 2023 – 31 March 2024 and the amendments to the Quality Committee sub-group reporting on the governance structure. The Board **APPROVED** the extension of policies and governance documents listed above to 2 March 2023 except for the Risk Management Strategy and Policy which will be extended to 4 May 2023.

20/23 Items for Review Room

- Learning from Deaths Q2 Report
- Health and Safety Annual Report
- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership
- WYAAT Annual Report and Summary Annual Report

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

- Finance and Performance Committee held on 1 November 2022.
- Quality Committee held on 12 September 2022 and 24 October 2022.
- Workforce Committee held on 11 October 2022
- Charitable Funds Committee held on 23 November 2022

The Chair invited Board members to raise any issues from the papers in the review room. None were raised.

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

21/23 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 approximately 12.35 pm.

Date: Thursday 2 March 2023
Time: 10 am (after the meeting, subsequently scheduled for 10.15 am)
Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

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5. Matters Arising and Action Log

For Review

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 01.03.23

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
12.01.23. 19/23	**Extension to Policies and Governance Documents**	Company Secretary	Board workplans for 2023 and 2023/24 amended to reflect revised dates for Board approval of extended governance documents and policies	16.2.23.		1.2.23.
12.01.23. 11/23	**Maternity Incentive Scheme Submission**	Chief Executive	Approval of the submission for the Maternity Incentive Scheme on behalf of the Board of Directors	1.2.23.		22.3.23
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		
151/22	**Health Inequalities Strategy and Update** Add in details of work within our communities to underpin the four action areas of the strategy.	Deputy Chief Executive	Health inequalities update included within March agenda – standing item at future meetings to update progress against strategy	02.03.23		02.03.23

6. Patient Story: ‘Improving patient outcomes through digital’

Chief Digital Information Officer with
Louise Croxall – Chief Nurse Information Officer
Chloe Gough - Matron Emergency Care - CRH

To Note

Presented by Robert Birkett

7. Chair's Report

To Note

Presented by Helen Hirst

Date of Meeting:	2 March 2023
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 am taking the opportunity over the first part of the year to visit CHuFT Award Winners to find out more about their successes and enable me to understand different areas of the Trust. I have visited six winners so far – Rebecca Beaumont who is the recruitment lead for healthcare support workers and was one of two winners of the Rising Apprentice category; Emma Kent, the other winner in this category, who is a Healthcare Assistant on Ward 21 (HRI); Rachel Garside, Matron and winner of the 'Must Do's' category; and Stevie Cheesman who is the Volunteer Co-Ordinator Project lead and won the 'Putting People First' category and the Urgent Community Response Team (including the virtual ward team).

I was pretty much blown away by everyone I met, for their enthusiasm, hard work and commitment to the Trust, our patients and their colleagues. Rebecca never lets anything in the way of doing her best to achieve her goals and objectives and is extremely resourceful. Rachel was a shining example and role model for 'growing our own' as she talked of her journey from healthcare assistant to Matron. Stevie supports and enables the Trust volunteers (215 of them) and has a strong 'can do' approach thinking of ways to support the Trust objectives through volunteering. I am hoping the Board can hear from Stevie during Volunteers' Week in June. Emma was so enthusiastic about her job, how much she cares for people and how going to extra mile is 'just common sense'. The Urgent Community Response Team epitomised a great team ethic and had real breadth in working across boundaries, not just between secondary and community but with social care. The roles of Advanced Care Practitioners blurring boundaries of professions – AHPs and nursing for example, is leading edge and recognised nationally for being so.

I also visited the Pharmacy Department who also won a CHuFT award for the Safari Discharge Team. As well as hearing about this great initiative, our Chief Pharmacist Lis Street took me behind the scenes of Pharmacy where the stock is managed, the procurement and the logistics they have to work through, as well as dispensing. It was great to hear about the success of their recent Apprentices.

I was delighted to be invited to a visit by the President and Vice President of the Royal College of Surgeons – Professor Neil Mortensen and Mr Tim Mitchell. It was a great opportunity for our surgical division to showcase their work and innovation. They were clearly impressed by the work that Arin Saha, Consultant in Upper GI, Bariatric and General Surgery presented to them and it was great to see so many different people involved in the visit including workforce and OD colleagues, physicians associates, nursing colleagues and consultants.

Helen Barker, who has been leading on developing the new target operating models for when we reconfigure services took myself, Gina Choy and Stephen Baines, two of our Governors, on a tour of Calderdale Royal Hospital to share the future plans. This really brought the reconfiguration to life and demonstrated the scale of what we aim to achieve for our local communities.

I joined a Wednesday operational leadership briefing where the Art of Brilliance were supporting colleagues with their Goal Setting. It was great to hear about the work that was being done on waiting times in MSK – over 90% improvement on appointment slot issues and patient satisfaction rates of 99% reporting good or very good.

The Board held a development day focussed on CQC Well led, our strengths and areas for improvement. The Council of Governors and the NEDs also discussed the development plan for the Council of Governors as well as the induction programme for new Governors.

In this reporting period I also chaired the Council of Governors meeting in public, the Charitable Funds Committee (Highlight Report attached) and the Organ Donation Committee.

Health and Care System

I attended the monthly partnership meeting for trust chairs, local authority leaders, health and wellbeing board chairs, ICB place committee chairs and ICB non-executive members; WYAAT Committee in Common; a planning meeting for the development of WY Partnership Board; and one to ones with other Trust Chairs and the ICB Chair.

National/other

I attended two round table events one an NHS Providers Event about working with local government and the other about Provider Collaboratives

I am enrolled on a national chair's development programme and module 3 fell in this period where we covered system and partnership working.

Helen Hirst
Chair
17 February 2023

8. Chief Executive's Report

To Note

Presented by Brendan Brown

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 despite the operational pressures
- Reconfiguration plans are progressing and there are significant developments planned for the next 6 months
- The health and wellbeing of people remains paramount, and we continue to focus on recruiting and retaining colleagues across all disciplines
- Our draft Five Year Strategy and One Year Plan are here on the agenda for this meeting for approval, setting out our aims over those time periods. Alongside this, we are in the process of finalising our plans for 2023/24 as part of the wider West Yorkshire Plan.
- While we are on track to deliver this year's financial plan, 2023/24 will be a significant challenge.

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
23 February 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 changing national agenda, against each of our strategic objectives.

1.2. I write this report in the context of significant international, national, and local events which impact on our colleagues, our patients and the wider public in many different ways. The recent earthquakes in Turkey and Syria have had a devastating impact. The ongoing war in Ukraine is concerning and distressing. Both are felt by both our colleagues and local communities, some of whom will have friends and relatives affected and who wish to do everything they can to support the people in those countries.

1.3. People continue to feel the impact of the cost-of-living increases and the general significant rises we have seen in food, fuel, and other essential expenditure. The impact of this is being seen in the strike action happening in Trusts and services around us. While the strikes for next week in nursing have been called off, there remains dates for industrial action by the Junior Doctors later in March and ongoing disputes in services that affect our colleagues.

1.4. These are challenging times both inside and outside of the Trust and I would ask the Board to consider the report in this context.

2. Keeping the base safe

2.1. Colleagues on the Board will be very aware of the significant operational pressures our teams have experienced throughout the Christmas and New Year periods, which continue to the current time. We have seen an unprecedented number of attendances at both of our emergency departments, with extremely high levels of demand leading to OPEL 4 escalations throughout January. There have been well over 100 patients on the transfer of care list, and as a result we have had additional beds open across both of our hospital sites.

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

2.3. I fully recognise the impact that recent NHS pressures have been having on our patients and people and I would like to publicly place on record my sincere thanks to everyone for their commitment and contribution to upholding our one culture of compassionate care. Grateful recognition was also received from the leaders across our local places and from the West Yorkshire ICB leadership team.

2.4. Our colleagues have continued to focus on doing the right thing for our patients, including ensuring ambulance handover waits are kept to a minimum; maximising patient flow across the Trust; keeping patients safe in the community; focusing on achieving cancer targets; and reducing the elective backlog ahead of the national target. We also continue to focus on other key measures we know are important to patients. For example, our complaints response performance has improved significantly to 94%, a 16% improvement on December's performance, and feedback through the Friends and Family Test responses remains extremely positive.

2.5. During the pandemic, restrictions on visiting and being able to accompany family members to appointments, meant that in some cases people felt isolated and those with caring responsibilities found it difficult to access the Trust. We recently launched John's Campaign within the Trust, championed by Assistant Director of Nursing for the Medical Division, David Britton. Part of our Keep Carers Caring work, John's Campaign recognises the valuable role carers have in the reassurance and dignity of people living with dementia. We want carers to feel seen, heard and supported across our hospitals and within the community services we provide.

2.6. Our broader work with carers forms part of our annual Public Sector Equality Duty (PSED) Report included for discussion at this meeting. This report gives examples of activities and outputs of our work in relation to workforce, patients, and member/Governor groups.

2.7. As well as our work to address inequalities relating to protected characteristics, a key aspect of our recovery from the pandemic has been the work we have delivered on addressing health inequalities. At our meeting in November, the Board approved the Health Inequalities Strategy, and today's meeting includes the first update of progress against this Strategy.

2.8. Our health inequalities work includes innovations such as the BLOSM service. Launched in January, the service is aimed at engaging with vulnerable service users attending the emergency department, addressing health inequalities, and supporting people who have experienced trauma and adversity.

2.9. Our focus also remains on maintaining strong performance against regulatory standards. Earlier this month the Care Quality Commission (CQC) published the results of its maternity survey. This survey looked at the experiences of women and other pregnant people who had a live birth in early 2022. The report covers all aspects of care from ante-natal, post-natal and through to discharge and beyond. Improvements have been noted since the previous survey a year ago thanks to a huge amount of dedicated work. The team scored especially well in how they answered questions ahead of their labour and birth, providing the best advice in advance where a woman's induction was required and making sure discharges went to plan and on time. The report also singled out the individual care provided with our teams who make sure all personal circumstances of every family are considered.

2.10. As I write this report, we are also due to welcome CQC colleagues to our surgical and critical care services on 1 March 2023. This is the latest in a series of engagement visits where our team share the work they are doing to ensure compliance with the CQC

fundamental standards and follows previous visits to look at end of life care and our emergency departments.

2.11. This month we were reaccredited as Veteran Aware by the Veterans Covenant Healthcare Alliance (VCHA). VCHA is a group of NHS healthcare providers in England committed to providing the best standards of care for the armed forces community, based on the principles of the Armed Forces Covenant. The reaccreditation underlines our ongoing commitment as a Trust to support our patients, colleagues and their families who are currently serving, or have served in the Armed Forces with access to care and opportunities for employment.

3. **Transforming services and improving patient care**

3.1. Our reconfiguration plans continue at pace. This week I marked one year since the initial excavations started for our new Emergency Department at Huddersfield Royal Infirmary (HRI). Since then, work has continued apace, and I saw for myself how much progress has been made. The external work is almost complete and work to install cupboards and facility pendants has begun in the interior. The work is on track to be completed in the summer with time for handover of the building and orientation prior to opening.

3.2. The hoardings have also gone up on the Calderdale Royal Hospital (CRH) site ahead of work starting on our new state-of-the-art Learning Development Centre The new, two-storey facility will be home to the library, training and seminar rooms and a wellbeing outdoor area. Demolition has started and will take around five weeks, ahead of the build itself.

3.3. The move of the Learning and Development Centre is part of the preparatory work for the major build project at CRH. Another element of this preparatory work is the move of the Child Development Centre to new premises at Elland which opened earlier this month. The new

healthcare centre has state-of-the-art technology and purposely designed facilities for our young patients aged 0-5 years with developmental conditions. The hub will host around 12,000 appointments for both clinics and play sessions every year. Our Charity provided the latest in distraction technology including moving skylight pictures in every room and a new soft play area. There is also a Changing Places facility which is a first for our Trust. Specialist Children's Nursing teams including community, epilepsy and diabetes are also be based there so families can receive care under one roof without multiple visits and appointments.

3.4. Last week, we also welcomed Professor Tim Briggs to the Trust. Professor Briggs created the Getting It Right First Time (GIRFT) programme, setting the highest standards for surgery across the UK. The visit by Professor Briggs and the GIRFT team was part of the assessment process for us to achieve Centre of Excellence status and become a designated Surgical Hub based on all the work we have been undertaking to reduce the waiting list backlog created by the pandemic, at the same time as addressing health inequalities. If we acheive the accreditation, we will be one of just eight centres in the country. To gain accreditation we must demonstrate successful outcomes in the following categories: Patient Pathway, Staff and Training, Clinical Governance and Outcomes, Utilisation and Productivity, Facilities and Ringfencing. We will know the outcome in the next few weeks.

3.5. We have been awarded almost £20 million to work in partnership with the University of Huddersfield in the development of a new Community Diagnostic Hub. The one-stop service offer a range of diagnostic checks, scans and tests following a GP referral to enable quicker diagnosis. This is in addition to the investment we have already made in MRI and scanning facilities at CRH.

3.6. CHFT has a strong research and development department and during the pandemic we were extremely successful in our research recruitment and participation for a Trust of our size. We continue to build on our expertise and this month we launched a new research study looking at preventing pneumonia after stroke which recruited its first patient within five days of opening, hailed as a record by the central research team.

4. **A workforce fit for the future**

4.1. As referenced in my introduction to this report, there has been a series of dates of industrial action across the NHS over the last couple of months. While we have not directly had colleagues participating in the strikes, we been mindful of the impact on neighbouring organisations and partners, and the impact on our people. Strike action planned for this week has been called off as talks with nursing unions take place, however, strikes by the Junior Doctors are planned for mid-March. We will work with colleagues and partners to ensure our junior doctor colleagues are able to exercise their right to strike while maintaining the safety of our services.

4.2. Next week (9 March) will see the publication of the 2022 National Staff Survey. While results are currently under embargo our Workforce Committee received a presentation on our local results, without any benchmarking information, which show a positive picture for the Trust overall. The full results will be shared with the Board. It is important that we celebrate the positive progress we have made, as well as ensure we work with teams across the organisation to address any areas of concern.

4.3. Recruitment and retention of colleagues remains a real priority for us. On Saturday 25 February, we held a recruitment event, focusing on paediatric nursing for both our children's inpatient services and our emergency departments. Colleagues in our Family and Specialist Services Division have worked with the communications and workforce teams to develop a recruitment video focussed on paediatric nursing – you can watch it here. This is part of a wider recruitment video, highlighting roles across our organisation, which will be available at the end of the month.

4.4. Developing our leaders is key to retention of colleagues and we will be holding a Leadership Conference in April. Bringing together leaders at different levels across the Trust, the event will focus on One Culture of Care, the behaviours we expect from our leaders, what good leadership looks like, and how we work in partnership as leaders in the Trust.

4.5. On 22 February 2023, NHS England published the annual Workforce Race Equality Standard (WRES) data report. The 2022 report continues to make use of more granular data than pre2020 versions, reporting by ethnicity, sex, region and occupation - a welcome inclusion

that will aid the development of targeted initiatives to tackle race inequality through an intersectional lens. You can read the report here or a summary by NHS Providers here

4.6. Our Apprenticeship and Widening Participation Team has played a vital role in helping CHFT achieve a Purpose Coalition Award, specifically for 'the right advice and experiences.' The Purpose Coalition measures organisations against what they are doing for their customers, patients, colleagues, and communities through Purpose Goals. CHFT's award is for Levelling Up Goal 4: Right advice and experiences, ensuring that opportunity is spread as widely and as possible. Examples include work experience placements, employability workshops, embedding kickstart recruits into their roles, supporting internal colleagues with applications and interviews, partnership with REALISE to support maths and English in the workplace, Project Search, the clinical and non-clinical Prince's Trust Pathway, and the targeted volunteering project.

4.7. Jo Hardcastle, our Assistant Director of Finance for Surgery and Anaesthetics Division and The Health Informatics Service was a finalist in the One NHS Finance Value Makers conference. Jo was nominated in the Drives Value for Taxpayers category.

4.8. Three colleagues in our Community division have just been awarded the Queens Nurse accreditation, taking the number of accreditations within the Division to six serving as leaders and role models within Community nursing.

4.9. As described in the PSED Report on today's agenda, we have strong networks across the Trust through our colleague-led equality groups. 8th March is International Women's Day, and we are holding an event under the theme 'Inspire to Grow'. Speakers include our Chair, our Chief Nurse, and Rob Birkett, our Chief Digital and Information Officer. They will talk about their personal journeys and share tips on how to take the first steps for personal growth. I would encourage Board colleagues to attend if they can from 12.00pm – 1.00pm in the Learning Centre at HRI.

5. **Sustainability**

5.1. In December, NHS England published its Planning Guidance for 2023/2024 which sets out three main areas of focus; the ongoing need to recover core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

5.2. There is a recognition that 2023/2024 will be challenging and the national approach reflects both new ways of working, as recently articulated in the NHS Operating Framework, and an acknowledgement of the continuing complexity and pressures being faced. Alongside this, the national guidance sets out the most critical, evidence-based actions that will support delivery, based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

5.3. Over the last two months we have been working with divisional teams to develop the plans for 2023/24. Within the Trust, Divisional and Departmental teams are working through their plans. Our Finance and Performance Committee discussed the draft plan, and we will be considering this in the private part of today's meeting. This will form part of the overall West Yorkshire Integrated Care System Plan, ahead of it coming to public Board for approval in April.

5.4. While you will see we are on track to deliver this year's financial plan, the position for 2023/24 is likely to be a significant challenge, and it is important that our plans are detailed and realistic. We have been working with colleagues across all areas of the Trust to identify efficiencies and quality improvements to ensure that we provide services in the most cost-effective way possible.

5.5. West Yorkshire ICB has been consulting on its Joint Forward Plan. The consultation ended on the 20 February and key themes emerging include money and how its spent; access to services, particularly primary care; getting the basics right; workforce; and co-ordination of services. Full report findings are due in a couple of weeks.

5.6. Our draft Five Year Strategy and associated One Year Plan are at this meeting for approval. The Five-Year Strategy has been mapped against the WY ICS and Place based strategies and has been shared with partners for comment. This is a key document setting out our ambition and how we will achieve it, set in the current context I have described in this report. We will review our progress against the One Year Plan each quarter at the Board and assess the implications for the Five-Year Strategy each year.

5.7. Within this, we talk about our role as an anchor partner in the system. NHS Providers have recently published a report about being an anchor institution and the impact on population health which is worth considering.

5.8. Board colleagues will be aware that I am the current Chair of the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT is a key part of the WY ICS infrastructure and in my role as Chair, I sit as the acute sector representative on the ICS Board. WYAAT has key programmes of work that it is progressing, which will come to the Board for decisions over the coming year, including the new asceptics service; pathology; and non-surgical oncology. Working together with our acute sector partners is vital for securing sustainably and efficient services for the future for our communities.

5.9. The Trust is committed to environmental sustainability, and we have been making progress against our Green Plan, published last year. Our wholly owned subsidiary, CHS Ltd, have been running a travel and transport survey to find out how colleagues travel to work which will help shape the future of travel and transport across the Trust. The survey covers a range of topics from parking to public transport, cycling and electric vehicles. Following previous surveys, we have installed more cycle racks and lockers have been provided. We have also upgraded the shower facilities and changing rooms at HRI. The results of the survey will be available ahead of the next Board meeting.

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.

9. Health Inequalities Update

To Note

Presented by Rob Aitchison

Date of Meeting:	2 March 2023
Meeting:	Board of Directors
Title:	Progress update against the Trust's Health and Inequalities Strategy – March 2023
Author:	Rachel Crossley, Public Health Specialty Registrar
Sponsoring Director:	Rob Aitchison, Deputy Chief Executive
Previous Forums:	Trust Health Inequalities Group, 22 February 2023

Purpose of the Report

To update the Board on progress against the actions set out in the Trust's Health and Inequalities Strategy (2022-24)

Key Points to Note

The Trust's updated Health and Inequalities Strategy was approved at the November 2022 Board of Directors meeting. Alongside this, the Trust's Health Inequalities Group was relaunched and met for the first time in February.

This update will be provided to the Trust Board three times per year, with a backward look (What we have done) as well as a forward one (What we have planned). This update also includes a revised Plan on a Page summarising the key elements of the Trust's Health Inequalities Strategy.

Key elements to highlight within this update include:

- The development of a Trust vulnerabilities matrix continues and will be trialled during the coming months
- The Greenwood Primary Care Network asthma inequalities project will soon be coming to a close. There are a number of successes from this project that should be celebrated
- Planning is underway for a joint workshop with Calderdale and Kirklees Local Authorities to discuss and align our strategic partnership approach to inequalities

EQIA – Equality Impact Assessment

The Trust's approach to Health Inequalities plays an important role in reducing the impact that inequalities have on access to care. Specific initiatives within this work will continue to be reviewed to ensure they do not disadvantage individuals or groups negatively.

Recommendation

The Board is asked to **RECEIVE** the attached Health Inequalities update

Progress update against the Trust's Health & Inequalities Strategy

2nd March 2023

NHS
Calderdale and Huddersfield
NHS Foundation Trust

CHFT Population Health and Inequalities Strategy

Connecting with our communities and partners

Harnessing our role as an anchor institution and key partner in the local health and care system, we will work to address inequalities in the wider determinants of health in our local communities, deliver social value, and work with system partners to identify and deliver shared priorities to improve population health.

- Develop a joint strategic **approach to inequalities with partners** across Calderdale and Kirklees
- Continue delivery of the **BLOSM service in ED** for vulnerable patients, including rollout of trauma informed practice and Trauma Navigators
- Evaluate success of the **reducing inequalities in asthma pilot** with Greenwood PCN and look to expand learning and new approaches
- Use the output from **Social Value Assessment** to inform implementation plans for estate developments

Equitable access and prioritisation

We will reduce inequalities in access to care by removing barriers, improving access for the most vulnerable groups, and moving towards a more holistic approach to prioritisation where a broader range of risk factors are considered.

- Develop and pilot a **"Health Inequalities Vulnerability Matrix"** to support a more holistic approach to prioritisation
- Monitor and proactively respond to **key inequalities indicators:** waiting times, Did Not Attends, unplanned admissions
- Development and implementation of the **Digital Inclusion Strategy**
- Carry out **Reasonable Adjustments audit**, and review of **patient contact preferences** and requirements

Lived experience and outcomes

We will address disparities in experience of care to improve patient outcomes. We will focus on improving the lived experience of patients, particularly those known to be most at-risk of experience inequalities and poor outcomes. We will take a holistic and compassionate approach, recognising the importance of behavioural and wider determinants of health.

- **Smoking** Rollout Long-Term Plan smoking cessation pathway for all inpatients
- **Maternity** Health pregnancy classes, ESOL antenatal classes, discovery interviews, cultural competence
- **Learning Disability** Deep dive into care pathway for LD patients, business case for LD care navigators, 90% staff completion of LD e-learning
- **Mental Health** Pilot of goal setting support sessions to aid patient transition to self-management, promotion of inpatient and screening and referral for depression

Diverse & Inclusive Workforce

We are committed to ensuring our workforce reflects the diverse populations we serve and that we take action to promote equality of opportunity. We will promote colleague health and wellbeing and create a compassionate and inclusive environment in which all our workforce feels valued in line with our One Culture of Care approach.

- **One Culture of Care values and behaviours** implemented into recruitment
- **EDI Awareness and Education Programme**, EDI module in leadership development for managers
- Growing inclusive recruitment through the **Widening Participation** channels, growing the **apprenticeship programme**
- Promote, support and engage with the **Equality Networks**
- 12-month **Inclusion event programme**

Ways of working: data and intelligence, collaborative working, leadership

What we've already done

- The BLOSM service, engaging with vulnerable service users attending ED, goes from strength to strength. During January, our care navigators came into post.
- Embedded Equality Impact Assessments as part of any service changes.
- The Trust has worked with the Social Value Portal (SVP) to support the measurement and reporting of the delivery of social value from our estate investments.
- In January, we met jointly with local authority leads from Calderdale and Kirklees to discuss how we coordinate and shape our strategic approach to inequalities in partnership.
- Community Matron, Sarah Wilson (pictured), attended the WY Community Collaborative in January to highlight the important work she has done in North Halifax supporting vulnerable service users in a pop-up clinic.

What we have planned

- Assess potential to expand the new ways of work established through the Greenwood PCN asthma inequalities pilot across the CHFT footprint.
- Continue with the roll out of trauma informed practice training to all ED staff within CHFT.
- Continue delivery of the new BLOSM service (including the Trauma Navigator pilot) in ED and collect data and evidence to evaluate impact of the service.
- Use the output from the Social Value Assessment to inform implementation plans for the estate developments.
- Multi-agency partnership workshop with Kirklees and Calderdale to coordinate joint strategic approach to inequalities.

What we've already done

- Analysed waiting list data through an inequalities lens and reduced gaps in waiting times seen between White and BAME patients, and patients from the most and least deprived communities
- Continued the development of a "Health inequalities vulnerability index" to identify those patients at increased risk of experiencing inequalities.
- People with learning disabilities prioritised under the reset and recovery programme, with all known people with a learning disability on existing waiting lists having their surgery.
- 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.
- Met with partners from the local health system to review urgent care demand patterns, with a specific focus on inequalities

What we have planned

- Development of the "Health inequalities vulnerabilities matrix" as a predictive risk identification tool to support a more holistic approach to prioritisation and care.
- To pilot use of the "Health inequalities vulnerability matrix" within a small number of specialities prior to wider implementation
- Continue to monitor and proactively respond to inequalities in access to services and waiting times.
- Analyse data on unplanned admissions, emergency attendances, and "Did Not Attends" through an inequalities lens
- Monitor data quality of inequalities indicators, including completeness of ethnicity data.

What we've already done

- A wide programme of work has taken place to improve the experience of patients with a learning disability, including ensuring that patients with a learning disability are prioritised on the waiting list and their care access and experience improved.
- A range of work has been undertaken across Maternity services to enhance the experience of those receiving maternity care, including through improvements to accessibility, piloting English as a Second Language antenatal classes, cultural ompetence training for staff, and smoking in pregnancy research.

What we have planned

- Implementation of Long-Term Plan smoking cessation pathway for all inpatients.
- Increase engagement with maternity discovery interviews.
- Evaluate pilot of the ESOL for pregnancy antenatal classes and provide further classes.
- Repeat the cultural competence staff survey following rollout of cultural competency training. Identify any further training and development needs.
- Further developing our approach to LD including prioritisation of patients waiting for care on an outpatient pathway

What we've already done

- Established several Colleague Voice equality groups.
- Guidance developed to include engagement with all internal network groups and links to engagement team as part of Equality Impact Assessments for service design.
- Embedded process for previewing all cases of racial discrimination in disciplinaries & complaints prior to progress through formal stages.
- New recruitment strategy developed and launched, including bold and ambitious statements for equality of opportunity.
- Inclusive talent toolkit and framework developed and embedded in People Strategy.

What we have planned

- One Culture of Care values and behaviours implemented into recruitment.
- ED&I Awareness and Education Programme (face to face for managers and e learning for colleagues)
- Leadership development for managers. ED&I Module dedicated to increase cognisance of difference and how managers can be an inclusion ally
- Reverse Mentoring / Coaching Opportunities
- Shadow Board
- Root out Racism programme
- Diversity in Health and Care Partners Programme
- Utilising widening participation channels as a tool to support inclusive recruitment / talent development.
- Growing the apprentice programme, including level 5 & 7 apprenticeships.
- Continue to promote, support, and engage with the Equality networks.
- Inclusion programme

10. Annual Strategic Plan – Progress Update for 2021/2023 - Strategic Objectives

To Note

Presented by Anna Basford

Date of Meeting:	**2 March 2023**
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**Annual Strategic Plan – 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 December 2022.

Key Points to Note

In November 2021 the Trust Board approved an 'annual' strategic plan describing the key objectives to be progressed during the period November 2021 to March 2023 that will support delivery of the Trust's 10-year strategy. Each of the objectives has a named Director lead accountable and responsible for delivery. The report details the progress against delivery of the objective and also includes the risk score included on the Board Assurance Framework that relates to the objective.

This report highlights that of the 19 objectives:

0 are rated red
0 are rated amber
18 are rated green
1 has been completed

EQIA – Equality Impact Assessment

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

Recommendation

The Board is 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 December 2022

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)	

Appendix 2

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	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 for the new Accident Emergency Department at Huddersfield Royal Infirmary has been approved by NHSE. Construction has commenced and is scheduled to complete in Summer 2023. The Reconfiguration Outline Business Case has been approved by NHSE and DHSC and submitted for Treasury approval. Delay in Treasury decision on the business cases could impact on programme timescale and affordability.	**NHSE and Treasury Approval of Reconfiguration Business Cases** **Lead: AB** Transformation Programme Board , Trust Board ICS, NHSE, DHSC	20 BAF Risk 1/19 Reconfiguration
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	**Clear plans agreed with partners to implement improved, resilient and**	

		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 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 Placed	**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

		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 resilient network connections from both hospital sites. • A focus on how data is used at both Trust and Regional level, specifically around further progress on health inequalities but also a predictive approach to vulnerability and learning disabilities as two examples. • Scan for Safety is coming to an end as a programme however, work continues with the technology in supporting wider trust strategies such as Reconfiguration. • Capital funding for 23/24 is limited however includes a continued refresh of End User Devices and network infrastructure refresh. • Continued support of Trust Reconfiguration activities including 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). Collaboration with BTHFT to continue and include contract extension, possible future	**Continued progress towards strategic objectives to include key milestones for data integration, ERP Optimisation and delivery of key capital 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.	12 BAF risk 02/20 Digital Strategy

		partnerships with Cerner, regional organisations inc Education, place based entities and other acute Trusts (inc Airedale) • Digital Governance at Divisional Level is now established but time is needed to fully embed Technical/project management support assigned to each divisional board to provide specialism. • Multiple Digital Central Funding bids have continued to be submitted enabling the trust to further invest in digital technology in line with Digital Strategy.		
Use population health data to inform actions to address health inequalities in the communities we serve.	**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	**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

		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 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)		
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	**Staff accessing HWB assessments receive timely and effective outcomes**. **Lead: LR** Weekly Executive Board Trust Board	16 BAF risk 05/20 Recovery

		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 recovery plans to ensure it meets the national performance targets in place for 2022/23	Workforce committee	
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	**Maintain the Good rating, achieve some outstanding ratings.** **Lead: LR** Quality Committee Weekly Executive Board	12 BAF risk 04/20 CQC rating

		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 transition to the new CQC single inspection framework.		
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".	**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.	**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

• achieving patient safety metrics		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 and families. Feedback has been positive in regard to the changes made.		
Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery.	**GREEN** on track	The Trust is making good progress on its elective recovery plans with performance on 104-week, 74-week and 52-week waits amongst the best in the country. 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 timely handover of patients from the ambulance service.	**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.	**Implement actions in the Health and Safety Plan** **Lead: SD** Quality Committee Trust Board	

		A continued focus around COVID compliance assurance measures by improvements to risk assessments and monitoring oversight has taken place and continues. A lens has also been placed upon improving compliance across THIS, HPS to ensure they have the right local measures in place. Direct working has taken place with the Community Healthcare Division to understand their needs and expectations around lone working and violence and aggression prevention with a focus group, expanded to include all other community run services. First aid training in the non-clinical areas has been reviewed, with an uplift of 45 extra trained colleagues Home working display screen equipment assessment tool has been revised and planned for sharing to all relevant colleagues.		6 BAF risk 16/19 Health and Safety
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. To deliver the strategy we continue to focus on:- • the national target of 0 vacancies through the Healthcare Support Worker Programme. Further work is underway to review progress against the 'New to Care' element of the programme. • Continued progress on reducing registered nurse vacancies. • Enhanced international nurse recruitment including further cohorts in 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

<table>
<tr><td></td><td></td><td>Extension of international recruitment to a limited number of AHP roles is underway for 2023.
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.</td><td></td><td></td></tr>
<tr><td>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.</td><td>GREEN
on track</td><td>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.</td><td>Improved National Staff Survey, WRES and WDES scores

Lead: SD
Workforce Committee</td><td>12
BAF risk 11/19
Recruitment and Retention</td></tr>
</table>

		• Empower and Stepping into Leadership Programmes provide colleagues with the 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	Recent developments comprise:- • A Trust values and behaviours refresh positioning One Culture of Care at its centre ensuring 'we put people first'. • Creation of One Culture of Care charters for every team/service area • Compassionate Leadership sessions for our leaders/managers have been delivered with an ongoing programme to ensure we capture a critical mass that facilitates embedding essential leadership behaviours in support of One Culture of Care	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention

		• 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 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. A values based applicant screening tool is scheduled to trial in a number of services in March 2023. 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. 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	**Improved National Staff Survey scores** **Lead: SD** Workforce Committee	12 BAF risk 1/22 Health and Well Being

		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 has been submitted and agreed with ICS. At Month 9 the Trust has an adverse variance to plan in the year to date but the reported forecast continues to be delivery of the deficit plan as submitted to regulators. Delivery of this plan is reliant on agreed support from system partners and the underlying position remains a challenge. The 2022/23 efficiency challenge of £20m remains on track to be delivered. A range of risks and opportunities continue to be managed to deliver this position.	**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). Performance against the agency expenditure ceiling brings a pressure to the use of resources score and means that the	**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

		Trust must deliver the planned deficit in order to maintain a score of 3.		
Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust's carbon footprint.	**GREEN** on track	The Green Plan was first approved by Transformation Planning Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the 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: • A new travel survey is out for consultation until the end of February 2023. • 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. • The CHFT Sustainability Website is now live • 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 • CHS is rolling out Carbon Literacy training for colleagues • a Travel Plan has been adopted by the Trust to support more active travel	**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

		• 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 • 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. 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:	**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	16 BAF risk 8/19 Performance Targets

		• 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 The Trust is working closely with partners to provide ‘mutual aid’ and enable service recovery and resilience.	System Leadership Meetings with NHSE and WY ICS	

11. Strategy

- 2023-2028 5 Year Strategy
- 2023-2024 1 Year Strategy

To Approve

Presented by Anna Basford

Date of Meeting:	Thursday 2 March 2023
Meeting:	Public Meeting of the Board of Directors
Title:	**CHFT Five Year and One Year Strategic Plans**
Author:	Anna Basford, Deputy Chief Executive & Director of Transformation and Partnerships
Sponsoring Director:	Brendan Brown, Chief Executive
Previous Forums:	Development of the Trust's strategic plans has been informed by discussions: • at Trust Board workshops held on 7th April, 9th June, 6th October 2022. • at workshop and meetings of the Council of Governors held on 15th November 2022 and 16th February 2023.

Actions Requested:
The Trust Board is requested to approve CHFT's Five Year and One Year Strategic Plans.

Purpose of the Report

The purpose of this report is to describe CHFT's Five Year strategic ambitions for 2023 - 28 and the actions we will take in year one ((2023-24) to make progress to deliver this.
The Trust Board is requested to approve the plans.

Key Points to Note

The review of the Trust's strategic plans builds on and refreshes our previous strategy – this has been informed by significant engagement with colleagues and partner organisations and is aligned to the West Yorkshire Integrated Care System and Calderdale and Kirklees Place Strategies.

The refreshed five year and one year strategic plans set out our ambitions across the 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

EQIA – Equality Impact Assessment

The Trust's Strategic Plans aim to address the needs of the whole population, including those who currently experience disadvantage, the plans are intended to help improve access, experience, and outcomes for all. Our Five Year and One Year Strategic Plans describe the actions we will take to address health inequalities.

Recommendation

The Board is requested to approve CHFT's Five Year Plan for 2023 - 28 and One Year (2023-24) Strategic Plans.

Five Year Strategic Plan

April 2023 – March 2028

Contents

03	Introduction
06	About the Trust
08	Performance
09	Our vision
10	Our Five Year Strategic Plan goals
16	Summary plan on a page
17	Conclusion

Introduction

Calderdale and Huddersfield NHS Foundation Trust (CHFT) delivers compassionate care from our two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary, as well as in community sites, health centres and in patients' homes.

We provide healthcare and specialist services for people living in Calderdale, Huddersfield and beyond.

We work closely with our health, social care, voluntary sector, and academic partners in the Integrated Care System (ICS) across West Yorkshire, and in our local places as a member of the Calderdale Cares Partnership and Kirklees Health and Care Partnership.

We are committed to integrated working to progress our shared ambitions, to:

- Improve health outcomes for people
- Reduce health inequalities
- Support social and economic development
- Enhance productivity and value for money

In March 2020, the Trust Board agreed a longer-term strategic plan. Over the past two years, we have seen fantastic achievements across the Trust, but we have also been met with challenges.

The COVID-19 pandemic has impacted every part of our society and necessitated many changes across our health and social care system. While the pandemic inevitably presented multiple challenges, we also learned a lot about how we transform and provide care and how we work in partnership at local and regional level to ensure the very best services and outcomes for the populations we serve. We want to ensure that this learning informs our future plans.

Our strategic context has changed, but our vision remains the same:

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

This draft Five Year Strategic Plan builds on and refreshes our previous strategy. This has been informed by significant engagement with colleagues and partner organisations.

185 CHFT colleagues, nine health and care partner organisations, and more than 1300 patients and members of the public have shared their thoughts with us about key learning from their experiences during the pandemic. Alongside this, meetings have taken place with every clinical specialty and workshops have been held with Trust Board members and our Council of Governors.

This refreshed strategic plan updates and sets out our ambitions across 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

Our focus continues to be on delivering high quality, compassionate care, where and when our patients need it. We will support our partners in the promotion of health and wellbeing and, as an anchor partner organisation, support training and career opportunities for local people. This will be essential if we are to provide long-term solutions to the health inequalities that currently affect our communities.

Colleagues across the health and care system work incredibly hard in the face of extraordinary challenges to deliver compassionate and safe healthcare and we will support their development, value their diversity, and ensure they are listened to and have a sense of belonging in our local places.

Our draft Five Year Strategic Plan is aligned to the West Yorkshire ICS and Calderdale and Kirklees Place Strategies. It will:

Deliver outstanding quality and safety of care

Enable people to have control over their lives (personalised care)

Improve health outcomes for people

Tackle and reduce health inequalities

Enhance productivity and value for money

Generate social value through employment, career and development opportunities to support economic recovery

About the Trust

CALDERDALE COMMUNITY SERVICES

CALDERDALE ROYAL HOSPITAL

HUDDERSFIELD ROYAL INFIRMARY

6,581
COLLEAGUES

142
VOLUNTEERS

200
CONSULTANTS

212
APPRENTICES

1,827
NURSES

1,080
ADMIN AND ESTATES

650
BEDS

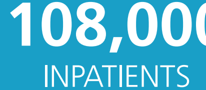
1
CULTURE OF CARE

DIGITAL ASPIRANT TRUST

44
WARDS

172,000
A&E PATIENTS

108,000
INPATIENTS



439,000
OUTPATIENTS

4,700
TOTAL BIRTHS

322,000
ADULT COMMUNITY CONTACTS

212,000
THERAPY COMMUNITY CONTACTS

Performance

- The Trust has a CQC rating of **'good'** and aspires to achieve delivery of 'outstanding' care.

- Our colleagues and partners have worked hard to recover from the impact of the pandemic and to address the delays and backlogs of care that this has generated. We are currently on track to achieve 2022–23 year-end recovery targets:

  - 104% of 2019/20 patient activity by end March 2023
  - Zero 78-week-waits by end March 2023
  - Reduction in 52-week-waits by March 2023 and zero 52-week-waits by March 2025
  - 95% of diagnostic patients seen within six weeks by end March 2023 (ahead of the national target for 2025).

- CHFT is proud to be one of three trusts nationally achieving cancer waiting time standards.

top 10%
A&E waiting times

- The Trust continues to be in the top 10% performance nationally on A&E waits being less than 4 hours – but we know there is more work needed to reduce waiting times and improve patient experience in A&E.

- The Trust is in financial turnaround and on track to deliver £25m (5%) efficiency savings in 2022–23. CHFT's year-end financial forecast continues to be in line with our planned deficit of £17.4m.

£25m efficiencies

- The Trust, and Calderdale and Kirklees systems, have significant financial challenges that continue into future years related to: delayed transfers of care, social care capacity and funding, Covid and flu increasing demand, staff availability, industrial action, inflationary costs.

- Longer term financial viability of the Trust is reliant on major service reconfiguration plans to reduce structural costs associated with dual site working and to ensure value for money from the Trust's PFI and non-PFI estate. These plans are in progress.

- CHFT is working closely with Kirklees and Calderdale Place leaders to deliver system-wide joint financial recovery plans.

Our vision

Together with partners, we will deliver outstanding compassionate care to the communities we serve.

This is underpinned by four 'pillars' of behaviour that guide how we work, to ensure that:

- We put patients and people first
- We 'go see' (learning from others)
- We work together to get results
- We do the 'must dos' (to ensure regulatory and statutory compliance)
- We care for ourselves and each other in the same way we care for our patients through **One Culture of Care**

Our Five Year Strategic Plan goals

Transform services and population outcomes

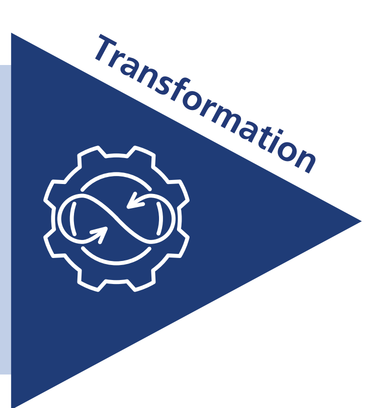
Deliver the best quality and safety of care – "Keeping the base safe"

Ensure an inclusive workforce that supports local employment and development opportunities

Deliver financial, economic and environmental sustainability

Digital technology is a key enabler for CHFT's Five Year Strategic Plan:

- Interoperability – enabling integrated care and system working at place and across West Yorkshire
- Digital appointments and remote monitoring
- Health inequalities data to inform actions and plans
- Real-time access to patient records, enabling patients to tell their story once



- Safety alerts
- Mandated entry of essential information
- Safer services e.g. blood tracking, ECG carts
- Interoperability – enabling real-time information for colleagues
- Remote working – enabling timely senior clinical advice/MDTs from any site

- Ease of access to all the information needed
- Prompts and safety alerts
- Quicker – voice recognition
- Safer – bar codes, access to senior advice
- Home and remote working options
- State of the art technology that supports recruitment and retention

- Productivity and efficiency
- More robust planning
- Green solutions – remote working
- Smart buildings and asset tracking

There is an opportunity to transform services enabled by estate development and optimising digital opportunities

We will transform services and improve population outcomes.

We will build new, modern, state-of-the-art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.

Patients and colleagues will be digitally enabled to provide and receive care – in any location this is needed – to improve patient experience and outcomes. The Trust:

- has a track record of digital progression for more than 20 years, with the ambition to continue into the future
- has been independently verified as one of the most digitally-effective trusts in the UK
- has a culture that is bold and open to digital change across all aspects of the organisation
- provides digital services at regional level, across multiple care settings, through a shared service, and;
- is enabling transformation of care and efficiency by linking different digital systems together.

Working with our partners, we will use population health data to prevent ill health and reduce health inequalities.

- We will make sure that people from Black, Asian and Minority Ethnic communities, people living in the most deprived areas, and people that have a learning disability do not experience longer waiting times.
- We will generate social value through targeted investment and development opportunities to create local jobs, apprenticeships and training opportunities.
- We will work with our colleagues in primary care to target support where there is inequality in deprived communities.

Working with academic, health and social care partners, we will participate in research and innovation to prevent ill-health, improve patient care, and achieve better outcomes and faster recovery for patients.

Plans are progressing for development of a Community Diagnostic Hub, to help improve access to out-of-hospital diagnostic tests and provide these closer to home.

We will deliver the best quality and safety of care – "Keeping the base safe"

We will deliver and enable outstanding quality, safety and experience of care for people needing hospital and community services.

We will consistently achieve key performance targets that matter most to patients.

We will be well-led and governed, and compliant with our organisational, partnership and statutory duties.

Patients will be able to shape decisions about service developments and their personal care based on what matters to them, and their individual strengths and needs.

We will ensure an inclusive workforce that supports local employment and development opportunities.

We will be widely known as one of the best places to work through an embedded One Culture of Care, supporting the health and wellbeing of all colleagues.

We will foster an open learning culture that listens to colleagues, demonstrates lessons learned, and actively seeks and celebrates best practice.

We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.

We will be ambitious in our work with partners to create local employment, career, voluntary, and development opportunities for people.

We will deliver financial, economic and environmental sustainability.

We will consistently deliver our annual financial plans and demonstrate value for money and productivity.

We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.

Our investments and use of resources will generate social value to support economic recovery in Calderdale and Kirklees Places.

- The Trust is working with contractors and the supply chain to generate social value by targeting the creation of local jobs, training and apprenticeships to support the most deprived groups and communities in Calderdale and Kirklees. This will support recovery from the impact of COVID-19, contribute to tackling economic inequality, address health inequalities and support action on climate change.

Summary plan on a page

The table below summarises the CHFT Five Year Strategic Plan.

Our vision:

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

Our values and behaviours:

- 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'

Our goals and results:

Transforming services and population outcomes	Keeping the base safe – best quality and safety of care	Inclusive workforce and local employment	Financial, economic and environmental sustainability
We will have built new modern 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.	We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.	We will be widely known as one of the best places to work through an embedded one culture of care – supporting the health and wellbeing of all colleagues.	We will be consistently delivering our annual financial plans and demonstrating value for money.
Patients and colleagues will be digitally enabled to provide and receive care – in any location this is needed – to improve patient experience and outcomes.	We will be consistently achieving key performance targets that matter most to patients.	We will foster an open learning culture that listens to colleagues, demonstrates lessons learnt and actively seeks and celebrates best practice.	We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.
Working with partners we will use population data to prevent ill health and reduce health inequalities.	We will be well-led and governed and compliant with our organisational and partnership statutory duties.	We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.	Our investments and use of resources will generate social value to support economic recovery in Calderdale and Kirklees places.
Working with academic, health and social care partners we will participate in research and innovation to prevent ill health, improve patient care and achieve better outcomes and faster recovery for patients.	Patients will be able to shape decisions about personal developments and their personal care based on 'what matters' to them and their individual strengths and needs.	We will be ambitious in our work with partners to create local employment, career, voluntary and development opportunities for people.	

Conclusion

The Trust's Five Year Strategic Plan has been developed by colleagues, people, patients, the public and partners from across Calderdale and Kirklees and will enable the delivery of outstanding compassionate care to the communities we serve.

2023-24 strategic plan on a page

The content below summarises the CHFT One Year Strategic Objectives that will support delivery of the Five Year Strategic Plan

Our vision:

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

Our values and behaviours:

- 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'

Our goals and results:

Transforming services and population outcomes

We will have opened the new A&E at HRI and commenced construction of the new Learning and Development Centre and Multi-storey Car Park at CRH.

We will deliver our 12-month digital programme to improve integration within the Trust and across the system, this will provide digital developments and products (e.g. Patient Portal, SDEC module), and ensure the infrastructure and end user devices are secure, current and designed for the role.

We will make progress against the Year 1 milestones in the Trust's Health Inequalities Strategy within the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion and provide updates on these to the Board.

We will continue with the established successful clinical research portfolio, engaging with Partners; participate in the ICB Place Based Research Collaborative; work to address Health Inequalities; broaden the research portfolio to a wider group of patients, and further encourage participation in R&D.

Keeping the base safe – best quality and safety of care

We will deliver the quality, safety and experience strategies; implement PSIRF; meet the KPIs of the Trust Quality priorities; undertake a programme of work to maintain HSMR/SHMI within expected range; support and respond to a CQC inspection of Maternity Services.

Working within the resources available we will meet national standards in relation to elective recovery. We will meet priority KPIs for cancer services. We will maintain our position within the top quartile of diagnostic performance. We will maintain our position within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.

We will complete the governance review; deliver the key elements of the System Oversight Framework (SOF); ensure compliance with the new CQC framework.

We will implement the RESPECT programme; deliver the Carers strategy including Johns Campaign; work with partners to review Birth Centre provision across CKW footprint; continue to reduce Health Inequalities working with partners to support meeting people's individual needs e.g. Learning Disabilities.

Inclusive workforce and local employment

We will increase emphasis on appreciation and continue to focus on providing a healthy workplace, providing access to physical, mental and financial wellbeing advice.

We will ensure personal and professional development is accessible and open to all through health academies, apprenticeships, equality, diversity and inclusion education and awareness.

We will deploy workforce planning tools to design roles and approaches to deliver our reconfigured hospital and community services and implement an inclusive recruitment approach aligned to our values and behaviours.

We will increase routes into employment, working with Calderdale and Kirklees Councils and further education partners to develop a Health Academy for Calderdale and Kirklees.

Financial, economic and environmental sustainability

Deliver the ICB and NHSE approved financial plan. Demonstrate improved performance against Use of Resources key metrics and NHSE productivity metrics.

We will develop a calendar of sustainability engagement events for 2023/24; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028.

We will demonstrate the additional social value generated by investment in the new A&E at HRI to create local jobs, training opportunities and to support local businesses.

12. Quality Committee Chair’s Highlight Report

- Director of Infection Prevention Control (DIPC) Q3 Report (Review Room)

To Approve

Presented by Denise Sterling

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	16th January 203
Date of Board meeting this report is to be presented:	2nd March 2023

ACKNOWLEDGE

- Research and Innovation continues to be a success with CHFT maintaining a reputation nationally and regionally of excellence in research activity, performance and a wide range of studies for patients. It is encouraging that commercial research is now increasing post pandemic and achievements include CHFT being selected to be the lead NHS site for an international commercial Haematology study and to be 1 of 4 sites to be accepted for a commercial paediatric study opening in June 2023. A new research strategy is due to be launched and implementation used to increase awareness of the work.

- The Committee noted the review undertaken with clinical colleagues across the divisions to inform the development of the quality and safety 2023. It was recognised that the approach used for colleague involvement was effective and moving forward the benefit will be increased ownership and commitment to the strategy. Examples of the quality ambitions and how these will be achieved were discussed and committee supported the proposed timeline for strategy approval for implementation in April 2023.

ASSURE

- Report received of the review of the follow up pathway this was undertaken in response to concerns from a SI panel that pts are at risk of being lost to follow up because of EPR. The review found that this was not the case and the majority of the incidents related to data input error. The review identified ongoing risks linked to data entry and clinical validation as well as ongoing capacity and demand concerns. Recommendations to address these issues are being taken forward and to be completed within 6 months reporting into WEB and quarterly update to quality committee.

- The Maternity Oversight Report provided assurance that the robust monitoring of maternity transformation plan ensures progress is maintained. The HSIB cases and maternity incidents were discussed and it was agreed that the maternity dashboard will be included in future reports to enable the comparison of CHFT performance with peers. All the newly qualified midwives are now in post and the service should be commended for the consistent performance in terms of the safe staffing indicators the November position of 1:1 care in labour was 98.3% and the labour ward coordinator was 100% supernumerary for all shifts worked.

- Highlighted from the quality report was the quality priority for timely treatment of sepsis which remains challenged. Audits are underway to identify reasons for the

delays and the further actions required. The three CQUINS not achieving targets have action plans in place. The response to complaints continues to improve with 78% complaints closed within target time frame in December.

- The update provided regarding the HSMR at October 2022 shows positive progress with some improvement linked to the increased numbers of palliative care discharges coded which helps the HSMR position. However, committee was cautioned that figures could rise again. The December crude mortality data shows an increase in hospital mortality and a decrease in out of hospital mortality which appears to be in line with the national trend and this is to be looked into further.

- Integrated Performance Report – acknowledged impact of ongoing increased attendances at ED and longer trolley waits. A review of patient incidents related to the emergency department when in OPEL 4 to be reported to committee.

AWARE

- A review has been undertaken of the CQC 2018 must do and should do action plan. A revised plan has been agreed to include the actions no longer in an embedded position with deadlines for further assurance to be presented to the CQC group.

13. Quality Report

To Note

Presented by David Birkenhead

Date of Meeting:	Thursday, 3 March 2023
Meeting:	Board of Directors
Title:	Quality Report (Reporting period January 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:	Quality Committee – Monday, 20 February 2023

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 Quality Committee and 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 Quality Committee and 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 Quality Committee and 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 January 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

1. Introduction
2. Care Quality Commission (CQC)
3. Patient Experience, Participation and Equalities
4. Patient Advice and Complaints Service (PACS)
5. Legal Services
6. Incidents
7. Medicines Safety

Quality Account Priorities:

8. Recognition and timely treatment of Sepsis
9. Reduce the number of hospital-acquired infections including COVID-19
10. Reduce waiting times for individuals attending the Emergency Department

Focussed Quality Priorities

11. Reducing the number of falls resulting in harm
12. Increase the quality of clinical documentation across CHFT
13. Clinical prioritisation (deferred care pathways)
14. Reduction in number of CHFT-acquired pressure ulcers
15. Nutrition and hydration for inpatient adults and paediatric patients
16. Making Complaints Count
17. End of Life Care

Appendix 1 - BRAG rating assurance

2. Care Quality Commission (CQC)

A full review of all 'Must Do' & 'Should Do' actions which were issued post the 2018 CQC Inspection has been undertaken. This is to ensure progress has been maintained of any embedded actions and to identify any potential gaps. All Core Services were tasked to self-assess their current position against actions set out in 2018, Core Services leads presented the position at the November 2022 CQC & Compliance Group. The action position updates were then ratified and agreed at the January 2023 CQC & Compliance Group.

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 agreed overall position of the 2018 CQC actions as of January 2023 is:

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

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

Engagement Meetings:

- Planned engagement meeting on 20th December was cancelled due to apologies and operational pressures. However, a meeting was requested with ED colleagues to discuss how Strep A and the current pressures in ED are being managed.

Planned Onsite Visits:

- CQC have requested a planned onsite visit focusing on Surgery & ICU this was due to take place on 1st February 2022 but was rescheduled to 1st March 2022.
- The senior leadership will present an overview of services to CQC followed by a walk around of Surgical SDEC, Ward 10, Theatres, and ICU.
- Twice weekly huddles have been established with the senior team to plan the visit and presentation.
- Mini J2O's were carried out on all area's w/c 16/01.

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

CQC are bringing together specialist sector teams (adult social care, hospitals, primary medical services) into one Operations group. This will break down barriers that previously separated the different sectors. These teams will work across four geographic areas or 'networks. They will be responsible for carrying out assessments of quality. The four networks are:

- London and East of England
- Midlands
- North
- South

The new senior leadership team leads the Operations group. This team comprises Director roles that replace previous Deputy Chief Inspector roles. As part of this wider Operations group, CQC are also establishing a National Operations directorate. This will include registration and national operations teams, for example oral health and children's services.

Within the networks, CQC will divide into local teams. These teams will include colleagues with a mix of expertise and experience of different types of health and social care services. This will make sure specialist skills and knowledge are shared about all sectors.
Depending on the services in a particular area, teams will contain a mix of these roles:

- **Assessors:** will have an ongoing view of quality, safety, and risk for services in their area. Supported by the inspector and regulatory co-ordinator, they will make judgements about the quality of care. To do this they will consider evidence collected from all sources – both on and off site.
- **Inspectors:** will lead enforcement activity. While assessors will collect evidence off-site, inspectors will gather evidence on site visits.
- **Regulatory co-ordinators:** help carry out engagement with providers and local groups of people. They will support with triaging information and collecting evidence.
- **Regulatory officers:** support administrative duties. For example, inspection planning and gathering the experiences of people using services.

For Providers this means:

- Providers will still be assessed by CQC colleagues who are experts in your service type. But the teams can have better conversations about how things are working between services and the other services they interact with in the local area.

- Teams will be more tailored and efficient to support in relationship meetings with services. Providers can speak with members of local teams for different types of advice and rely less on one person to provide support.
- They'll be an up-to-date view of quality and better understanding of what is driving poor or outstanding care. This means CQC can support improvement specifically where it's needed and promote good care.

For the public this means:

- People will have a better understanding of what the quality of care is like in the services where they live. CQC will be able to look at all types of care across an area, in a way that's much more in line with how people access care.
- People will be able to make more informed decisions about their care because CQC will provide a more up-to-date view of quality.
- People will be more involved because of better quality and more consistent engagement. This includes with local Healthwatch and other local advocacy and community groups that represent the public. These groups include or act for people most at risk of having a poorer experience of care and those who face inequalities.

What is happening now?

- The national programme of inspections in maternity services has commenced. To-date, CQC have carried out 28 location inspections with a further 52 planned by 31 March 2023.
- 'People First' resource. This aims to help all parts of the urgent and emergency care (UEC) pathway. CQC are continuing coordinated inspection activity over the coming months. They'll look at 4 UEC pathways across the country to see how well providers are being supported and encouraged across key areas.
- Continue to complete monthly reviews of services. These are based on information CQC know about them, which in some cases will indicate they may need to take further regulatory action. In 2022, CQC carried out almost 7,000 direct monitoring calls with services as a result. They'll continue doing this until they introduce their new assessment approach.

What will happen next?

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

January has been dominated by the hard launch of John's Campaign across the Trust. From a quality perspective the focus has been on establishing the profile of the Carers we have reached, understanding their experiences of being seen, heard, and involved in decision making whilst also connecting carers to appropriate support organisations and identifying opportunities to learn from our feedback, not only from carers, but staff too.

Staff across the Trust have really embraced the Campaign which welcomes all unpaid carers and provides a series of practical support tools and resources which have been selected with the input of local carers and volunteers of Healthwatch Kirklees.

During January 2023 over 100 carers were identified and supported and it is encouraging to report that carers across multiple caring roles were identified. The highest number of carers lanyards were distributed to carers supporting patients with a physical disability, dementia, and long-term conditions. Every carer has received a follow-up call, where they have been asked to complete a survey.

It is challenging to identify carers, as often they do not identify themselves as carers. Carers between the ages of 16-80+ have benefited from the campaign with staff also able to reach young carers, who are typically the hardest to identify as frequently they are hidden; this can be for a multitude of reasons for example due to culture, embarrassment for those whom they are providing care, or fear and mistrust of health professionals so this is a great achievement.

Key findings from the carers survey:

- 46% of carers had not tried to access information or advice on caring within the last 12 months. For those who had, 28% found it difficult to find
- 40% of carers had utilised the free car parking provided to carers. However, 60% said this was something they wouldn't use. They alternatively use public transport, had blue badges, were dropped off and picked up for appointments and visiting or were happy to continue to pay for parking.
- 70% said they were involved in discussions about the patient, which helped them feel more assured about the care and treatment being provided.
- 25% of carers had a disability of their own
- 86% of carers identified as women
- 74% of were within working age
- 47% were happy to be referred to a local carer's organisation for information, advice, and support

Ageing Well Service Update:

During January a review of the patient feedback of the Ageing Well Service within Calderdale was undertaken. The service was established to help patients age well within their own home. The service is available across all Primary Care Networks in Calderdale.

With a holistic approach, the Ageing Well Practitioners complete home visits, explore the patient's ability to manage their activities of daily living, medication management, nutritional intake and risk of malnutrition, ability to manage their health condition, clinical observations, and social support needs. The Practitioners identify what matters the most to their patients and look at what barriers are preventing them meeting their goals.

Additional support the Practitioners provide includes:

- Lifestyle advice
- Wound Care
- Completing a basic medication review
- Advanced Care Planning
- Discussions about DNACPR forms
- Assessing and ordering equipment
- Carer Support
- Signposting and referrals to other services such as Social Care, Falls Team, District Nurses, and the voluntary sector.

By supporting patients and their carers within their own home it is anticipated that there will be an improvement in patient care without patients having to attend their GP practice for appointments. It is also possible that patients will be less likely to need to be admitted to hospital and when they are, their discharge and recovery will feel more supported.

Practitioners have gathered feedback from 46 patients which they have supported, using an old version of the Friends & Family Test.

When asked the question: **How likely are you to recommend our service to friends and family members if they needed to use a similar service or treatment?**

95% said extremely likely, and 5% said likely.

What patients value about the service:

- Friendly and encouraging approach
- Patients feel listened to
- Patients are now able to access resources they did not know were available
- Patients are empowered by the team
- Information is shared in a way that is easy to understand
- Questions are answered

Quotes from patients:

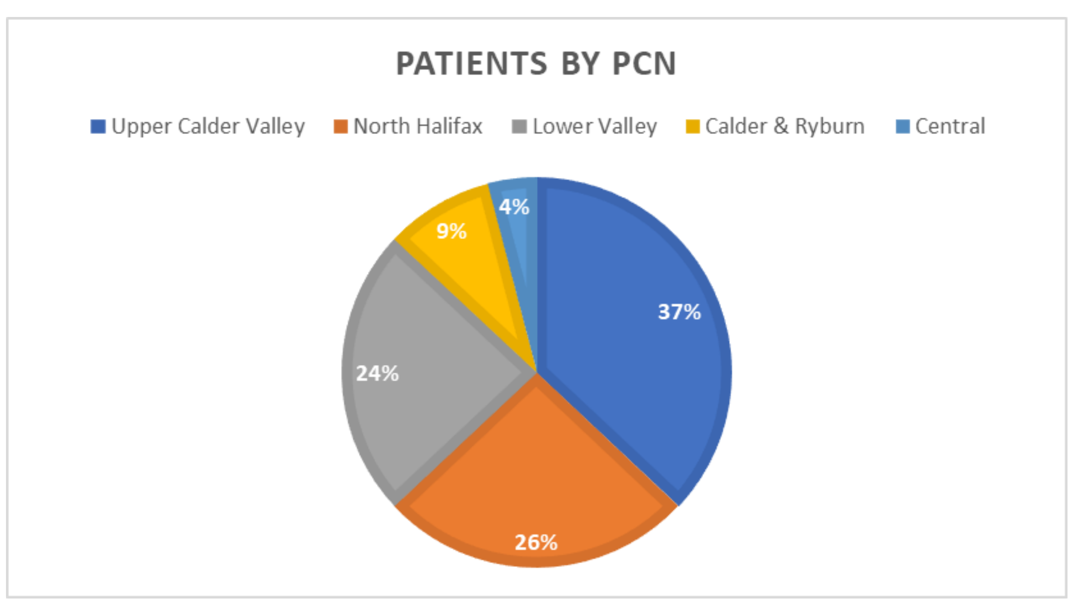
"I had been reluctant initially, but my friend said at least try. Michelle was so pleasant - once at ease I was able to explain things"

"After feeling sad and fearful I have spent some time with Faye, and I'm already feeling much better, and I've been very much understood"

"It is a great service, offering advice and help that we did not know we could get Jackie is lovely"

"A big thank you for your wonderful service and support to my mum. You have given us great hope in moving forward and I would recommend family and friends to this service, we could not have had this without from you"

"The good thing is that someone has the time to talk. listen and then explain in detail why and how things happen, subsequently followed by recommendations to eliminate one's concerns. I personally was very impressed with Mike and the service provided"



Recommendations:

- As the Trust is looking to update the way in which Friends & Family Tests (FFT) are collected, it is suggested that the Ageing Well service should be a pilot area for our new improved way of working.

  Using Microsoft Forms, feedback will be able to be captured from the patient and carers in real time, questions can be altered so they are specific to the service, also adding PCN focused questions if desired. There will be no need to leave cards to be completed, however if the patient prefers this method, they will be available.

- When using the cards for collecting FFT feedback, the most up to date version should be used. The latest version asks patients to share with us what went well, and what can be improved. In addition to this is the equality monitoring information, which is important in helping the Trust continue to be an equitable and fair service.

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 drafted and is awaiting comments. Once agreed, this will be shared with all Divisions for comments to ensure we are all working within same process. Weekly meetings are on-going with Divisions and are helpful in identifying any issues and flagging concerns. The Trust's overall performance has improved and is currently at 94% which indicates weekly scrutiny is having a positive impact and communication has improved with our complainants.
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.

<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

	Jan 2023
Complaints received	28
Complaints closed	34
Complaints closed outside of target timeframe	2
% of complaints closed within target timeframe	**94%**
Complaints reopened	5
PALS contacts received	180
Compliments logged	71
PHSO complaints received	1
PHSO complaints closed	0
*Complaints under investigation with PHSO (total)	12

5. Legal Services

There continues to be growing demand around claims and inquests, with an increase in portfolio size of around 12% for claims and 21% for inquests since July 2022. The portfolio size has increased from 170 to 195 (Claims) and 79 to 100 (Inquests). The Trust currently have 5 x high, 16 x moderate, 43 x low and 37 x minimal risk inquests, with approximately 12 incident investigations linked to an open inquest.

There has been increased sickness and annual leave for the month of January 2023 with administrative support reduced to 1 x 0.6 WTE for majority of the month. An offer has been made to fill the Band 3 vacancy (0.6 WTE) and it is hoped the team will be fully staffed by March 2023. Annual leave is expected to continue until the new financial year and cross cover has been arranged within the team.

A business case is being finalised to provide a review of current resources, operational need, and long-term sustainability in view of the increased activity and oversight of the legal services team.

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.

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
Overall, the audit found 'significant' assurance, albeit a 'management response' to each of the recommendations is required relating to compliance with the Legal SOP, rather than an issue with the process. An action plan has been put in place to ensure compliance with the SOP and effective management of the inquests service, this will be managed by the Head of Legal Services.

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

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. A draft SOP is to be trialled across the Trust in early January 2023 and any issues/feedback provided to the group. This has been delayed due to demand in within the team, and it is hoped the SOP will be trialled in February 2023.

Statement disclosure
All Safeguarding and Police requests for information continue to come via Legal Services. This has enabled to Trust to review requests for information, challenging these where appropriate and supporting staff to prepare their statements. A SOP is currently being worked on and will be shared with the Divisions for awareness.

There has been increased activity within this workstream particularly around children related proceedings. Each request requires a review of the draft statements, discussions with staff

and attendance at court (where required). For the month of January 2023 there have been 4 requests.

Recent Data
This report covers the period **1 January – 31 January 2023**

Clinical Negligence

- **168** (from 157) active clinical negligence claims
- **3** new clinical negligence claims were received (1 Medicine, 2 FSS)
- **7** clinical negligence claims have been concluded (3 Medicine, 2 SAS, 2 FSS)

Employers' and Public Liability (EL/PL) Claims

- **26** active EL/PL claims- **10 open PL/ 17 EL open active**

Employers Liability Claims- 4 Acute Medicine, 3 Elderly Care, 1 Paediatrics, 1 Radiology, 2 Stroke, 1 Pharmacy, 5 Trust wide
Public Liability Claims- 2 Emergency Department, 2 Paediatrics, 1 Gastroenterology, 1 Medical Engineering, 1 Equipment Loan, 1 Estates, 2 TBC

- **0 new** EL/ claims were received / 0 new PL
- **0** PL claims was concluded

Inquests

- **100 (from 87) active inquests**

Medicine - 75 in total consisting of High-Risk x 3, Moderate Risk x 11, Low Risk x 33, Minimal Risk x 28
SAS - 22 in total consisting of High-Risk x 2, Moderate Risk x 4, Low Risk x 9, Minimal Risk x 7
FSS - 4 in total consisting of High-Risk x 0, Moderate Risk x 1, Low Risk x 1, Minimal Risk x 2
Community - N/A

- **11** inquests were opened (2 x related to reports in lieu of post-mortem and 2 x record requests)
- **3** 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. Due to increased activity within Legal and leave, review of the cases has been put on hold until next month.

The Legal Services Team have already made changes to the internal governance processes to drive education and learning from claims and inquests. Legal have been trialling engagement at speciality audit and clinical governance forums to introduce the legal services team and their legal portfolios which has been met with interest and positive feedback from General Surgery, O&G and Anaesthetics/Critical Care. Further invites have been received from Ophthalmology, Radiology and Paediatrics. 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

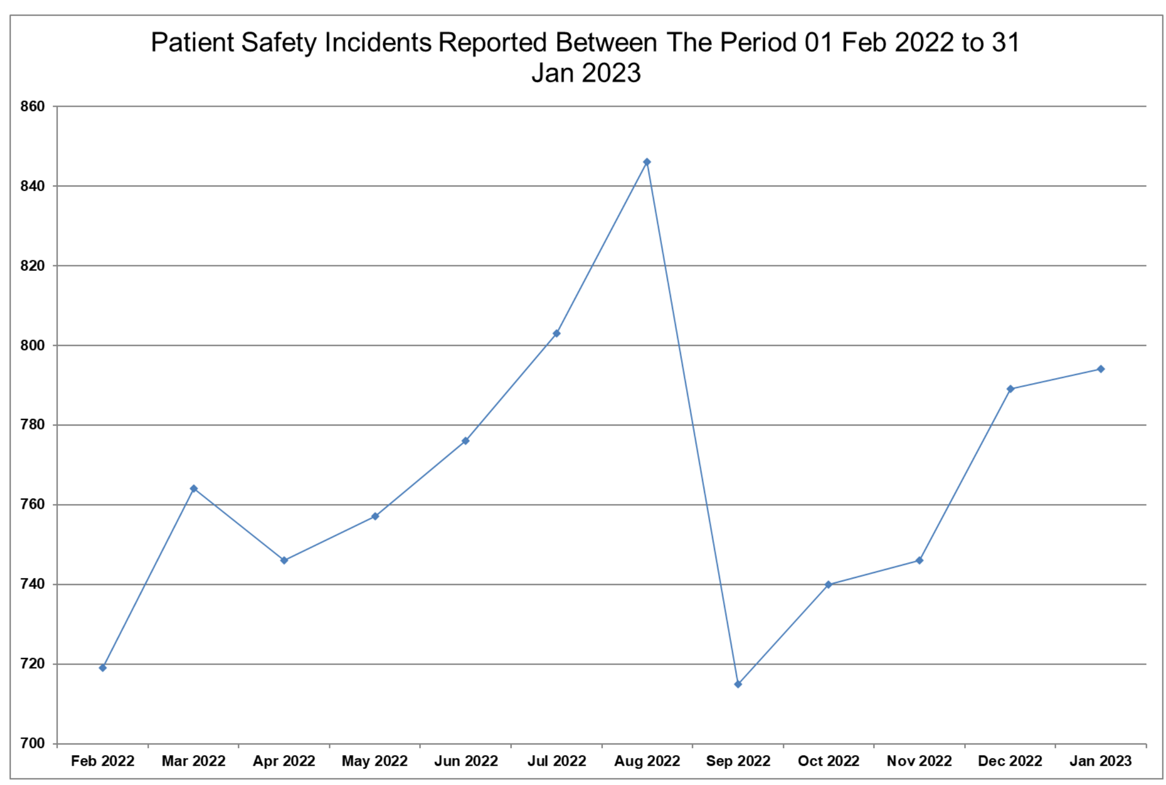
Below is a summary of patient safety incidents and incidents with severe harm or death, for the rolling year 01 January 2022 to 31 December 2022, and number of serious incidents (SIs) reported by month.

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
Feb 2022	719	9	3
Mar 2022	764	12	5
Apr 2022	746	4	2
May 2022	757	10	4
Jun 2022	776	5	1
Jul 2022	803	11	5
Aug 2022	846	11	5
Sep 2022	715	7	2
Oct 2022	740	8	4
Nov 2022	746	12	4
Dec 2022	789	19	9
Jan 2023	794	10	4
Total Over rolling 12 Months	**9196**	**118**	**48**

The number of patient safety incidents reported in January 2023 is slightly above average. The Average for the rolling 12 months is 766 patient safety incidents per month.

When analysing the data for December 2022 and January 2023, there were no trends, patterns, or concerns to indicate over/under reporting for both December 2022 and January 2023.



Over the last 12 months there has been a total of 118 incidents where the level of harm has been recorded as severe or catastrophic harm. Upon analysing this data, Assessment treatment and diagnosis, was the most frequently reported type of incident that result in either severe/catastrophic harm or death 72 Incidents over the last 12 months.

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

The table below shows the top 10 incidents by category (reported between 01 February 2022 to 31 January 2023), with level of harm either severe or catastrophic/death harm only.

Top Ten Incidents by Category with Level of Harm either Severe/Catastrophic/Death	**Severe harm**	**Catastrophic or Death**	**Total**
Assessment/Treatment/Diagnosis	24	48	72
Appointment/Admission/Transfer/Discharge	4	7	11
Infection Control	2	9	11
Slips, trips, and falls	2	6	8
Maternity Incidents	2	2	4
Investigations (Scans/Tests/Results)	2	1	3
Medical Device	2	0	2
Medication	2	0	2
Abuse/Self-Harm	1	0	1
Confidentiality/Communication/Consent/IG	0	1	1
Total	**41**	**74**	**115**

Over the 12-month rolling period of 01 February 2022 to 31 January 2023, the most frequently and common type of incident reported **(regardless of the level of harm),** is Slips, Trips and Falls, with 1910 incidents reported in the 12-month rolling period. This is closely followed by Pressure Ulcers / Moisture Associated Skin Damage (MASD) with 1681 and Appointment / Admission / Transfer / Discharge with 1239 reported incidents.

On analysis of all the incidents reported during 01 February 2022 and 31 January 2023, show there are no trends or patterns that can be identified with the numbers reported during that period. 95% of incidents reported during 01 February 2022 to 31 January 2023 resulted in either no harm or minimal harm to patient.

November and December 2022 Data:

During the month of December 2022 and January 2023, a total of 1583 patient safety incidents were reported on Datix.

For the last period (October 2022 and November 2022), there was a total of 1486 patient safety incidents reported for that period.

December 2022 and January 2023 has seen a slight increase in the number of incidents reported when compared to the last report. There was a total of 97 more incidents recorded during this period when compared to the previous period.

The average number for patient safety incidents reported each month is 776 incidents per month, 93.1% of all patient safety incidents reported in both December 2022 and January 2023 resulted in either no harm or minor harm to the patient.

The top 10 most common type of incidents reported between 01 December 2022 and 31 January 2023 are shown below:

TOP 10 Incidents Reported During December 2022 and January 2023	**Dec 2022**	**Jan 2023**	**Total**
Slips, trips, and falls	181	167	348
Pressure Ulcers/Moisture Associated Skin Damage (MASD)	142	172	314
Appointment/Admission/Transfer/Discharge	90	100	190
Assessment/Treatment/Diagnosis	87	85	172
Medication	69	79	148
Maternity Incidents	68	58	126
Confidentiality/Communication /Consent/IG	27	34	61
Infection Control	27	27	54
Investigations (Scans/Tests/Results)	20	21	41
Infrastructure/Resources/Staffing	23	10	33
Total	**734**	**753**	**1487**

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

All Slips, Trips and falls incidents reported during the period of December 2022 and January 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 February 2022 and 31 January 2023, the Trust has reported 6 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 within 60 working days.
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.
208731	11/03/2022	Surgical & Anaesthetics Services Division	Wrong site surgery (Never event)	Doctor injected Botox into neck and the product should have been injected into the mouth.	Report signed of at SI Panel and submitted to Integrated Care Board for review and approval.
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.	Report signed of at SI Panel and submitted to Integrated Care Board for review and approval.

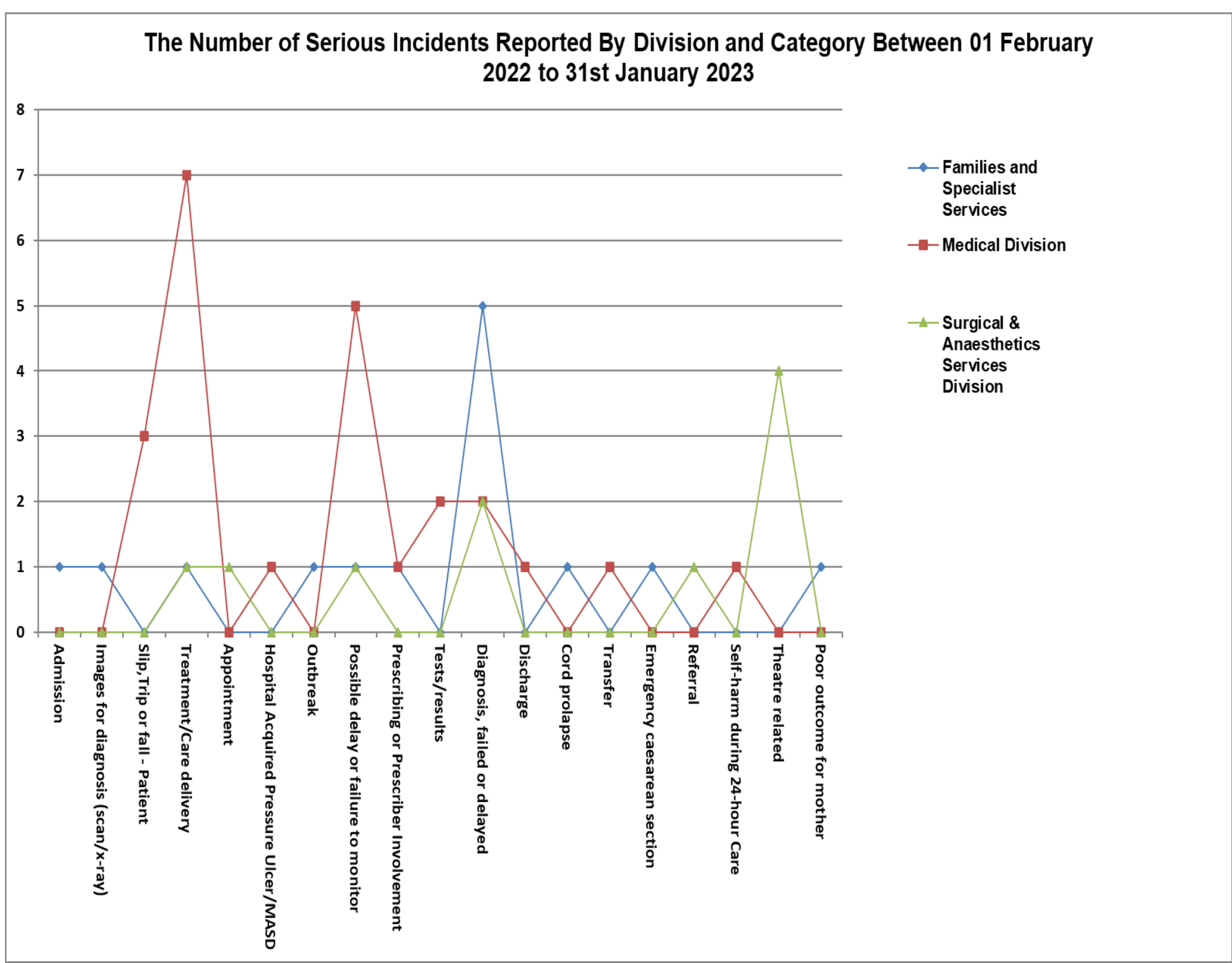
There was 1 new Never Events reported during the month of January 2023., This was in relation to a wrongly placed NG Tube. Previously the last Never Event reported by the Trust was in December 2022 which was in relation to wrong side block – Both These Never events are included in the Table above

*** 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 February 2022 to 31st January 2023)

For the rolling month total (between 01 February 2022 to 31 January 2023, there has been 48 Serious Incidents declared on Strategic Executive Information System (StEIS) that are either under investigation or the investigation has been completed and closed. The 48 SI's have been recorded across 3 divisions: Families and Specialist Services **(14),** Medical Division **(24)** and Surgical & Anaesthetics Services Division (**10)**

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



The top two must frequently (and common) reported category for a serious Incidents over the last 12 rolling months (from 01st February 2022 to 31 January 2022) are Diagnosis/failed or delayed (9) and Treatment and care delivery (9)

When analysing serious incidents recorded under the category of diagnosis/failed, there were a total of 7 serious incidents that were in relation to missed cancer/delayed diagnosis.

Under serious incidents recorded under the category treatment and Care delivery, there was a total of 5 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 31st January 2023, the Trust has 36 serious incident investigation that are **currently** on going and under investigation. The 36 ongoing serious incident investigation are across 3 division: families and specialist services (12), Medical division (18) and surgical and anaesthetic division (6)

The below table shows the 36 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
Abuse/Self-Harm	0	1	0	1
Appointment/Admission /Transfer/Discharge	1	2	1	4
Assessment/Treatment/ Diagnosis	3	9	5	17
Investigations (Scans/Tests/Results)	1	2	0	3
Maternity Incidents	6	0	0	6
Medication	1	0	0	1
Pressure Ulcers/Moisture Associated Skin Damage (MASD)	0	1	0	1
Slips, trips, and falls	0	3	0	3
Total	**12**	**18**	**6**	**36**

Summary of Progress with Serious Incident Actions

The risk team continue to have oversight of all serious incidents 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.

Serious incidents reported between December 2022 and January 2023

A total of 13 incidents have been reported to StEIS during the period 01 November 2022 and 31 December 2022. 4 serious incidents were declared in November 2022 and 9 in December 2022. Below is a table showing serious incidents reported during the period November and December 2022:

SI Category by Month declared	Dec 2022	Jan 2023	Total
Treatment/Care delivery	4	1	5
Possible delay or failure to monitor	2	1	3
Diagnosis, failed or delayed	1	1	2
Self-harm during 24-hour Care	1	0	1
Theatre related	1	0	1
Poor outcome for mother	0	1	1
Total	**9**	**4**	**13**

Serious Incidents Closed by Integrated Care Board (ICB) in December 2022 and January 2023.

There was a total of 7 serious incident investigation reports that were approved and closed by the ICB during the month of December 2022 and January 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
210000	Surgical & Anaesthetics Services Division	Referral	Failure in referral process	The root cause of not seeing the patient is the failure to correctly expedite the referral through reprioritisation on the ERS and contacting the ENT service directly.	Dec 2022
202745	Medical Division	Hospital Acquired Pressure Ulcer/MASD	Hospital Acquired Pressure Ulcer Category 4	the inconsistent approach to following tissue viability advice and the inconsistent repositioning could have contributed to the lack of escalation and subsequent actions regarding the patient's overall risk assessments in line with the CHFT Pressure Ulcer Prevention and Management policy	Dec 2022
211712	Surgical & Anaesthetics Services Division	Treatment/Care delivery	Treatment/Care delivery Unintended injury during an operation or clinical task	Patient underwent elective gastric band removal 2017. Five years later, claim has been received for retained section. Technical issues meant it was not possible to 'unbuckle' the band in the normal way Band was instead divided into several pieces One piece was retained	Dec 2022
201914	Medical Division	Test results/reports failure/delay to report test results	Pt went for MRI spine due to leg weakness Report Verbally handed over to on call doctor, not HOOPED as no function on HOOP to chase MRIs. MRI report not reviewed until a day later MRI showed cord compression, delay in discussion with neurosurgical team.	If the scan had been ordered earlier and/or performed earlier and/or reported earlier and if the report had been read, appreciated, and acted upon earlier then it is possible that more treatment options would have been available to the patient.	January 2023

207589	Families and Specialist Services	Cancer - Dx failed or delayed	CT scan performed on 15 November 2019 - missed a right ovarian mass which was subsequently identified on 20 January 2022	The abnormal size of the patient's ovaries identifiable on the CT scan images of November 2019 were not picked up and reported on. Human Error	January 2023
211698	Medical Division	Failure to act on adverse symptoms	HOOP request was sent out saying patient felt short of breath and vomited green vomit x 1. Dr Attended several hours later as the information given suggested patient was low priority for clinical review but vomiting fresh red vomit (blood) many times and was in serious condition.	The root cause was a combination of poor communication between nursing and medical team, failure to monitor, failure to escalate and failure to recognise clinical deterioration. This is due to Human Factors	January 2023
212929	Surgical & Anaesthetics Services Division	Cancer - Dx failed or delayed	Patient lost in follow up. Initially seen in 2018. Patient admitted in May 2022, scans showed that patient has inoperable disease in liver.	The reason this patient was delayed for surveillance was due human error within the reporting and referral systems and the delays within Endoscopy services impacted by the covid pandemic.	January 2023

Learning from Serious Incidents

Three completed serious incident investigation reports have been submitted to the Integrated Care Board (ICB) in December 2022 and January 2023 for closure. These are as follows:

Incident Summary	Learning Need and Organisational Learning
213644: Patient had biopsy of 3 lesions of which one was a melanoma in situ. Pt presented 3 years later to GP as area on cheek was getting larger and changing in colour. Histology reports reviewed and sites and concern that the wrong area was excised.	The root cause of this was human error, likely due to a combination of a failure of the referrer to specify the exact site in the referral letter and a failure of the doctor to stop and clearly check the site in the maxillofacial clinic.
207965: Patient developed acute subdural haemorrhage which led to death several days	• Update the junior doctors involved to reiterate the INR should have been checked and chased. • Feed back to the lab regarding the sample not

later, and which medical documentation described as being related to anticoagulation.	being flagged up as an issue. • To follow the investigation tests to ensure these are done. If not done, to flag up with the investigation team that these are still required.
211242: Outbreak of MRSA of SBCU with 4 positive HCAI MRSA babies identified	Overall, the outbreak was well managed with no further spread of MRSA on the unit once the outbreak was declared. Actions taken were appropriate, timely and as per advice of UKHSA specialists. While sadly one of the babies died due to other reasons other than MRSA, the other three babies were discharged with no ill effects from MRSA.
215528: Brought to E/d at CRH by ambulance as pre-alert for stroke complaining of jaw/temporal pain radiating to chest, confusion, slurred speech. Clinical assessment and CT by stroke team excluded Stroke to handed back to E/D. Further clinical assessment. Bloods normal and discharged with oramorph. Died at home 8 hours later. Haemoperitoneum from Aortic dissection identified at PM.	• Improved communication and understanding of roles are required between the stroke team and emergency department when a patient is considered not to have a stroke and their care is transferred to the emergency department team. • The degree of pain the Deceased reported may have been considered a “red flag”. This may have warranted a review by the emergency department senior clinician.

7. Medicines Safety

The Medication Safety and Compliance Group (MSCG) continues to raise awareness of the importance of the safe handling, storage, prescribing and administration of medication. Attendance at the January meeting was good with all divisions represented. This is a significant improvement.

Medication Incident reporting has increased in January compared to previous months.

	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
No Harm	95	86	86	75	88	101
Minor Harm	5	3	8	7	3	8
Moderate harm	0	2	3	1	4	3
Severe harm	0	1	0	1	0	1
Catastrophic or Death	0	0	0	0	1	0
Death - not caused/related to incident	0	0	0	1	0	0
Total	100	92	97	85	96	113

Four of the January incidents were classed as moderate to severe harm. The severe harm involved a patient on the incorrect flow rate of oxygen (3 lpm oxygen via 35% venturi but to function correctly a 35% venturi requires 8lpm oxygen).

The three moderate harm incidents included wrong dose of insulin, an extravasation reaction to an iron infusion and the administration of iv lorazepam to an aggressive patient. These are currently being investigated and learning will be shared with the teams.

Oxygen alert: NatPSA/2023/001/NHSPS

A patient safety oxygen alert was received on 10th January; Use of Oxygen Cylinders Where Patients Do Not Have Access to Medical Gas Pipeline Systems. The alert required a response / action completed by 20th January.

An extraordinary Medical Gas Committee was held 13/01/2023 with medical gas committee members (including clinical, nursing, pharmacy, Estates and Facilities, authorised persons, medical physics, health and safety, fire officer). The committee reviewed the NHS England 'Safe use of oxygen cylinders' best practice guidance and assessed the use of oxygen in patients being acutely cared for at CHFT without routine access to medical gas pipeline systems. This especially pertains to the Emergency Departments.

The Medical Gas Committee were assured that there are relevant up to date adult and paediatric clinical guidelines that cover prescribing, target saturations, oxygen saturation monitoring in accordance with British Thoracic Society (BTS) Guidance in place that are widely disseminated and embedded in clinical practice. There is also advice and guidance and a policy that cover the safe use of both piped and medical gases supplied via cylinders, including detailed FAQs for staff. This is currently being updated.

The annual trust wide oxygen audit undertaken in June 2022 demonstrated 75% of adult patients on oxygen had it prescribed. (100% had target saturations monitored and 78% patients had monitored saturations with the target range-). This has been presented at trust governance meeting.

Specific Health and Safety risk assessments are in place in ED for non-designated patient areas confirming patients requiring oxygen therapy will not be placed in these areas. Use of oxygen cylinders is managed to a minimum with 1 hourly assurance checks to be carried out in Emergency Departments overseen by senior nursing staff and reported as part of the daily

operational management. The checks cover checking oxygen tubing and supply is intact, the level of oxygen in the cylinder and that flow rates are correct and oxygen saturation monitoring is in place.

Supply of venturi masks and pulse oximeters has been confirmed as robust.

There is a transfer policy in place for clinical and non- clinical staff (portering) to ensure the safe use and supply of oxygen on transfer including checking the contents of cylinders and monitoring supply and where possible transferring patients onto piped supply e.g., radiology. This is routine practice and staff are trained.

The fire safety officer and Health and Safety lead with support from the ED team carried out assessments of all ED clinical areas on 16TH and 17th Jan where patients on oxygen are managed. The Medical Gas Committee were assured that there is good moving and handling and storage of cylinders using appropriate storage devices and transport trolleys in place as evidenced by visits to the areas. A concern was highlighted regarding the use of cylinder transport trolleys being used as storage units and the condition of some of the existing trolleys and their storage

<u>Action</u> Further work to be done by Medical Gas committee/medical physics lead around procurement of trolleys that can be used in Surge/super surge condition with clear labelling of which size oxygen cylinders can be safely stored on a trolley. Also, ongoing work around use of wall storage and transfer brackets and impact of new ED build.

The next Medical Gas Committee is Feb 14th where progress on the above action will be reviewed.

Electronic Controlled Drugs Register (eCDR) Development

To improve our compliance with controlled drug documentation (as highlighted at previous CQC inspections) we have developed an electronic CD register. This will both ensure that we no longer have issues with crossings out in the paper CD register in additional to overall improvement in governance standards and CD oversight. This is first of type for an Acute Trust and allows both CD recording / documentation, electronic ordering of CDs in addition to CD audit functionality.

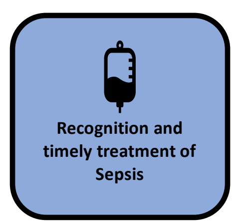
Ward 19 and the inpatient pharmacy are piloting the new system w/c 30th January. If the pilot is successful, the system will then be rolled out to all ward areas by summer 23.

Controlled Drugs Assurance

There has been slippage in the CD assurance checks undertaken by the pharmacy team due to vacancies and sickness within the pharmacy staffing. These audits of ward CD storage should take place as a minimum, once every 6 months. These are additional CD assurance checks to the monthly CD audits that the ward managers complete.

Progress has been made and now there are only 8 CD audits outstanding (43 in total) at HRI. Focus for February will be to complete the outstanding audits at CRH, 22 are overdue (45 in total)

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** **October 2022 = 50.0%** **November 2022 = 48.3%** **December 2022= 33.3%** **January 2023= 38.9%** **All patients coded with sepsis ED** **October 2022 = 48.0 %** **November 2022 = 67.3 %** **December 2022= 44.1 %** **January 2023= 65.7%** **External reporting compliance (within hour of clinical assessment) = 86%** **Current position** ▪ Compliance of antibiotics administered within 60 mins of earliest alert for red flag deteriorated in the month of December with an increase of 5.6% compliance in January. We know clinician and nurse staffing gaps have impacted review and treatment times. There has also been higher usage of agency staff who are less familiar with the ED processes. 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. ▪ Yorkshire Trial of pre-made intravenous Piperacillin Tazobactam introduced and well received	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	in Dept. We now know that the premade bags will not be available in near future as the Trial was to support a decision regarding manufacturing additives unit. Sepsis nurse has liaised with CHFT additives manager and the Macoset devices have now being reintroduced to both EDs with top ups. This device speeds up the mixing of IV Pip Tazocin and is more cost effective versus the use of needle and syringe. ▪ 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 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. ▪ Mobile phone and Dect-phone introduced at both sites so middle grade doctor can be contacted quickly by nursing staff for quicker reviews. Some issues have occurred with usage at CRH however use of Nerve centre device for making calls will be actioned, please see below. ▪ Nerve centre went live in October, call option on Zebra devices will be set up by Nerve centre team in due course which will provide additional functionality to request urgent reviews. 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 no longer available due to changes in the ED work force models at both sites. ▪ 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.	

What do we aim to achieve?	Update	Progress rating
	▪ NICE are expected to publish new guidance for sepsis recognition, treatment, and management of patients in March 2023. Once available the sepsis collaborative will discuss and action an agreed assessment/screening process involving key clinicians and group members. **Risks and mitigations** ▪ Use of sepsis phone variable, Nerve centre have confirmed that call facility is possible on the Zebra devices and will be set up as soon as possible. ▪ 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. ▪ Staffing shortages have been negatively impacting patient reviews and treatment times. There has been a noted increase in agency nursing staff which may be affecting administration response as they are not used to processes in the Depts. The ED Depts have successfully recruited several substantive registered nurses who are currently undergoing induction. The sepsis nurse is speaking at one of the induction training days about sepsis, targets, and treatment. 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. ▪ 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 date to set up call facility in nerve centre devices. -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	

What do we aim to achieve?	Update	Progress rating
	equal to CHFT at 86% -Work underway to improve EPR sepsis screening methods in line with national guidance (being updated in March 2023). - Patient group directive (PGD) being considered for use of IV Pip tazocin in the EDs. Trust sepsis nurse has liaised with Yorkshire sepsis network team so a 'Go see' exercise can be undertaken with another Trust. So far, no Trust is using a PGD for pip taz in ED so sepsis nurse will contact the national sepsis network members for information. **<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. ▪ Sepsis boards highlighting data, information in both EDs ▪ 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.	

What do we aim to achieve?	Update				Progress rating
Aim 2 BUFALO Bundle Total Compliance (%)	**October 2022** (Total BUFALO target = 60% and > 90% target for each element)	**November 2022**	**December 2022**	**January 2023**	
Blood Cultures	80.9%.	84.4 %	77.8%	84.7%	**Reasonable**
Urine output	64.5%	63.9%	73.0%	54.1%	**Reasonable**
Fluids	100.0%	99.2%	100.0%	98.2%	**Substantial**
Antibiotics	99.1%	99.2%	98.4%	100.0%	**Substantial**
Lactate (waiting adding to EPR)	54.5%	81.1%	88.9%	84.7%	**Substantial**
Oxygen	91.8%	87.7%	96.8%	91.9%	**Substantial**
TOTAL	**52.7%**	**45.9%**	**55.6%**	**39.6%**	
Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**Current position** ▪ Blood culture compliance improved in January by 6.5% ▪ Urine output remains variable with drop of 18.9% in January 2023. ▪ Fluids, antibiotics, and oxygen remain good at > 90% ▪ Lactate compliance data now available. ▪ Total % compliance has declined from 55.6% to 39.6% Dec/Jan 23. 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. ▪ 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.				

What do we aim to achieve?	Update	Progress rating

- IV fluids and antibiotics are consistently over 95%
- Oxygen compliance has remained above 90% for the last 2 months.

	Blood	Urine	Fluids	Antibiotics	Lactate	Oxygen
Numerator	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.
Denominator	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

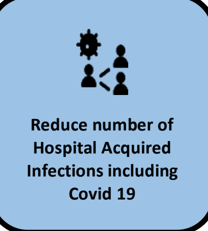
Risks and mitigation's

- 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 on the 11/10/22. Agreed that further discussions were required to ascertain who will be responsible to deliver blood culture training, further meeting taking place however sepsis nurse has not had a response to emails requesting a further date, so support requested at the January CAIP meeting.
- 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

What do we aim to achieve?	Update	Progress rating
	reminded they can submit another entry if this is the case. **<u>Next steps</u>** ▪ Push on Blood culture compliance via medical and surgical clinician meetings. Sepsis nurse visiting ward/Dept handovers. Poster drops and use of Sepsis Press to relay messages ▪ Discussion regarding urine output data to take place in February 2023 so improved measures are established.	
Aim 3 Sepsis ESR Training Compliance (75%)	Business intelligence have now provided the training numbers. **Compliance January 2023= RNs 77.59% Doctors 52% AHP 33.3%** **Total 70%** **<u>Current Position</u>** ▪ 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. **<u>Risks and mitigations</u>** ▪ 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	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	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

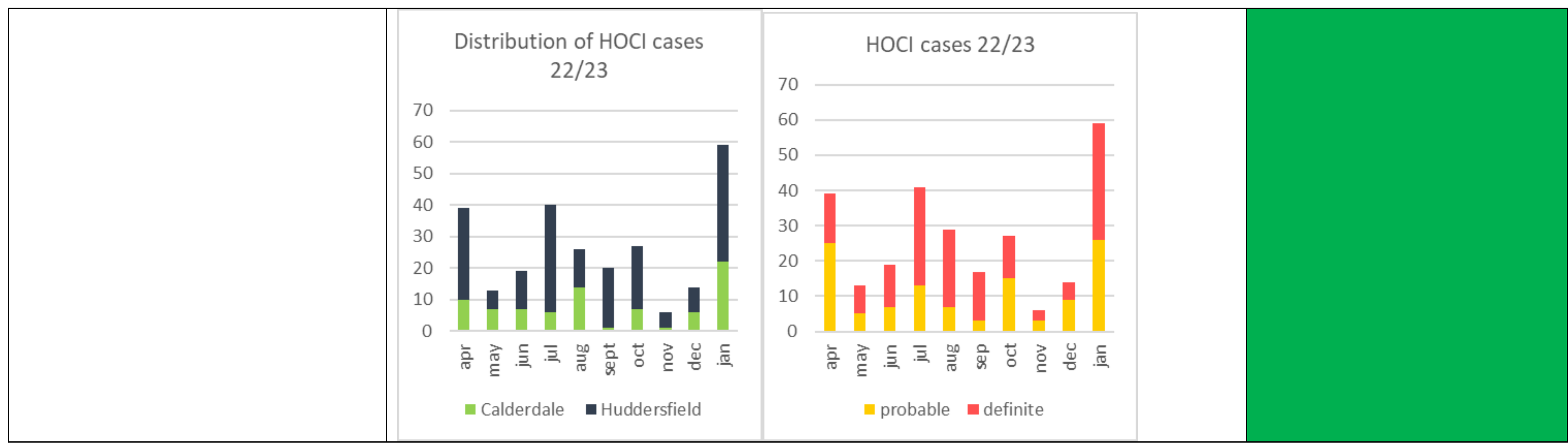
Reporting

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

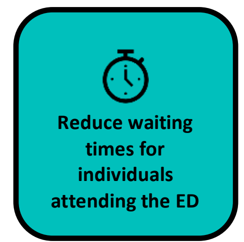
What do we aim to achieve?	Update	Progress rating
Aim 1 COVID 19 in patient testing compliance (%)	The schedule of in-patient testing had been suspended after the last report. As of 10/10/22, all admissions are tested on arrival, but no further testing is carried out unless symptoms occur. **Compliance from 10th October to 31/12 is 37% of admissions tested. The data in KP+ needs exploring to ascertain if patients not required to be screened are included (previous positive /SDEC patients/ ED etc).**	**Limited Assurance**
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. The increase in C.difficile 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). **Currently, there are 52 cases reported including 20 Community onset, healthcare associated cases. This is over the trajectory for the year.**	**Reasonable Assurance**

	CDifficile objective vs cumulative cases 22/23 60 50 40 30 20 10 0 apr may jun jul aug sep oct nov dec jan feb mar 19/20 20/21 21/22 22/23 objective	
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. **The following charts include the data to date 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**

NHS
Calderdale and Huddersfield
NHS Foundation Trust


Distribution of HOCI cases 22/23
70
60
50
40
30
20
10
0
apr
may
jun
jul
aug
sept
oct
nov
dec
jan
Calderdale
Huddersfield
HOCI cases 22/23
70
60
50
40
30
20
10
0
apr
may
jun
jul
aug
sep
oct
nov
dec
jan
probable
definite

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	See SPC charts below for YTD LOS Dec 22, 2433, LOS >8 Hours Jan 23, 1197, LOS >8 Hours	The reduction in attendances for Jan 23 had a positive impact on the LOS in ED with a reduction in admitted, non-admitted and overall numbers. We started to see an increase in LOS at the back end of the month as attendances started to go up.
Aim 2 Monitor 10 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards	Dec 22, 1399, LOS > 10 Hours Jan 23 569 LOS > 10 Hours	Additional HCA for the waiting room to monitor patients with a LOS >4 hours Senior medic (ST6+) added supernumerary in aid of decision making and front door turnaround
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	Dec 22 887 LOS >12 Hours Jan 23 324 LOS >12 Hours	Still monitoring and capturing and reporting DTAS's, increase in month of MH attendances (189 Trust) closer working with MH teams as acknowledged MH attendances breach all ECS milestones.

LOS at CRH ED

700.0
600.0
500.0
400.0
300.0
200.0
100.0
0.0

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

Admitted LOS — Non-Admitted LOS — Total — 4 Hour Target

LOS at HRI ED

800.0
700.0
600.0
500.0
400.0
300.0
200.0
100.0
0.0

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

Admitted Non-Admitted Total 4 Hour Target

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

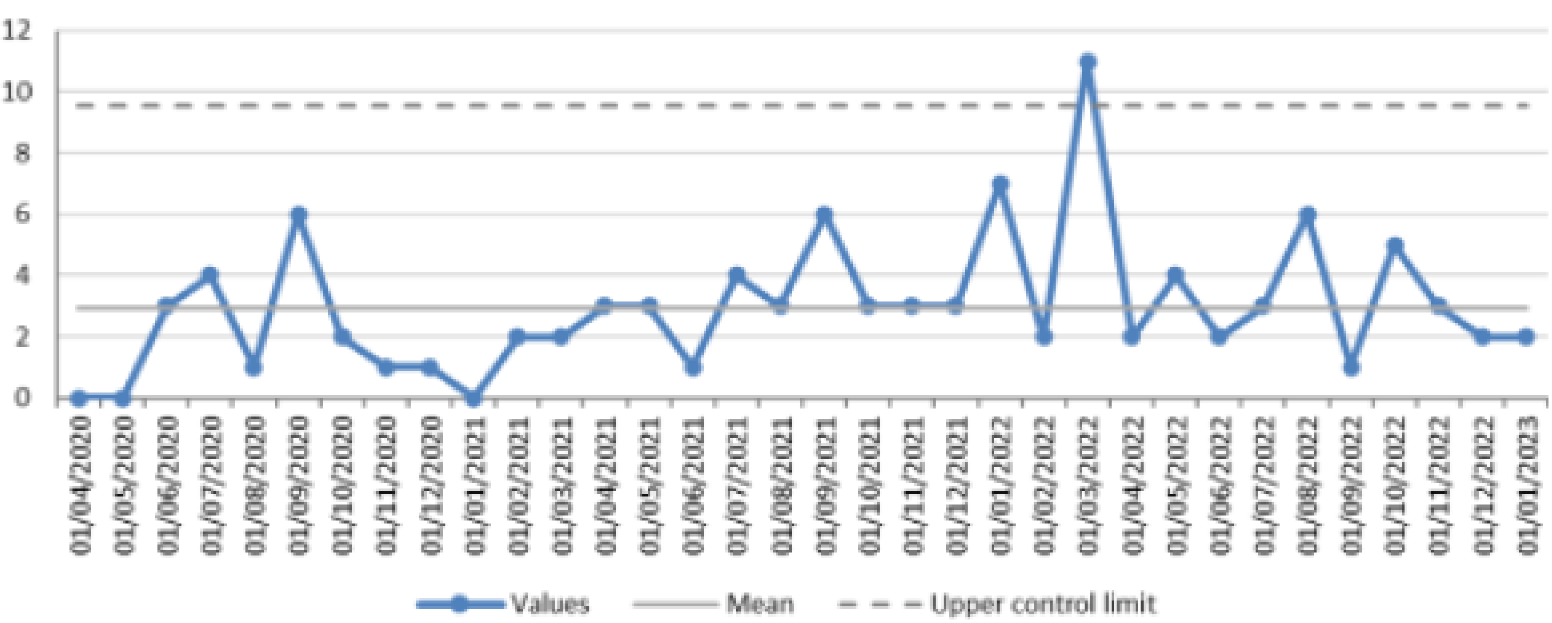
Reporting

- 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. 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. Ward mapping completed and staff are stationed in specific areas to monitor patients safely, WFM reviewed to reflect this. Falls KPIs are being reviewed by Falls Collaborative to ensure correct and appropriate data is being collected. Task and finish group to be created to review FISH Tool. AF have their own SOP for new and visiting staff in relation to falls prevention. Ward mapping and SOP will be rolled out across all wards if successful. Once SOP approved by Falls Collaborative in Feb 2022 and will roll out across all wards. Chart to be created identifying what interventions have been successful over last 18 months – will be presented at Feb 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. 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. Ward mapping completed and staff are stationed in specific areas to monitor patients safely, WFM reviewed to reflect this. Falls KPIs are being reviewed by Falls Collaborative to ensure correct and appropriate data is being collected. Task and finish group to be created to review FISH Tool. AF have their own SOP for new and visiting staff in relation to falls prevention. Ward mapping and SOP will be rolled out across all wards if successful. Once SOP approved by Falls Collaborative in Feb 2022 and will roll out across all wards. Chart to be created identifying what interventions have been successful over last 18 months – will be presented at Feb 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.	**Reasonable Assurance**

NHS
Calderdale and Huddersfield
NHS Foundation Trust


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
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01/07/2022
01/08/2022
01/09/2022
01/10/2022
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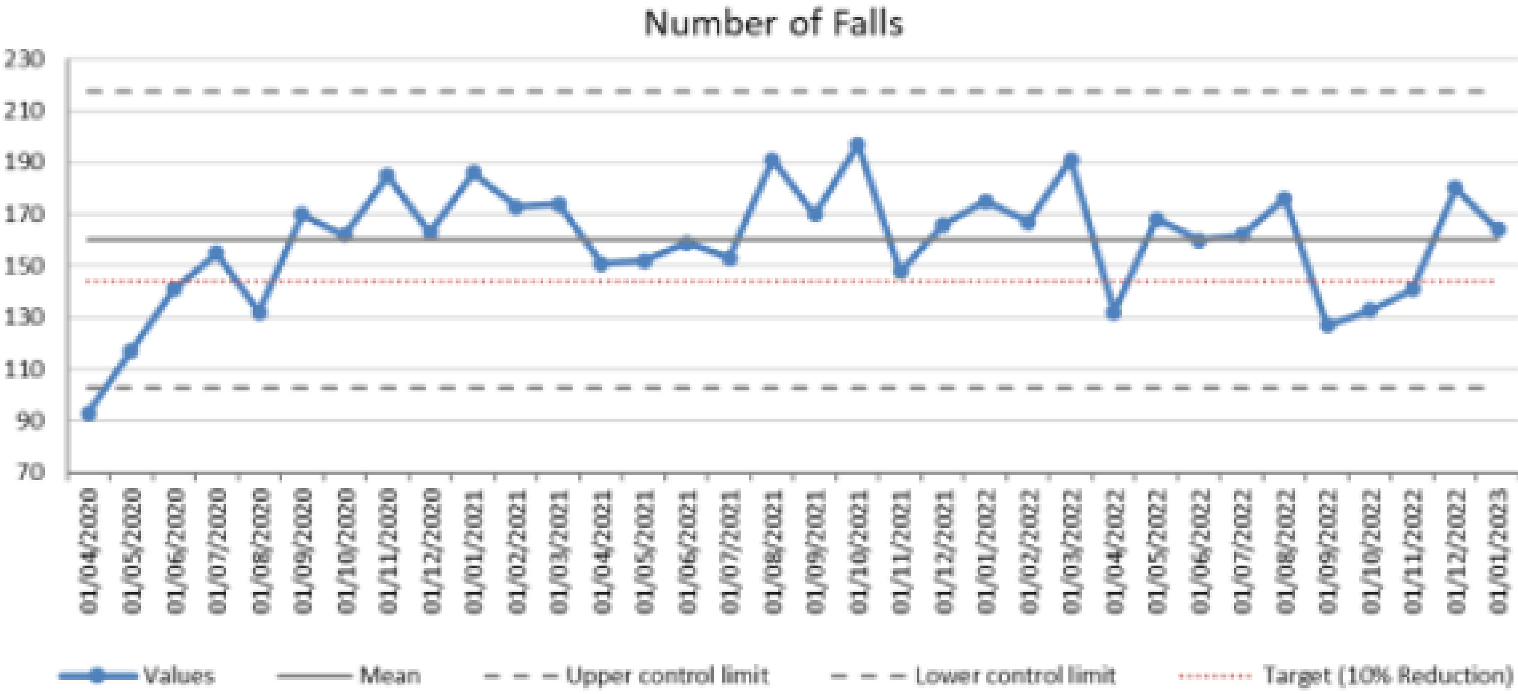
01/01/2023
Values
Mean
Upper control limit

NHS
Calderdale and Huddersfield
NHS Foundation Trust


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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01/04/2022
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 (January 2023)	Progress rating
Aim 1	Optimise the Clinical Record by improving the workflows and making it easier to achieve the Must do's	Work has commenced on updating the nursing admission and care plans within EPR. Contractors have also been employed to update the pharmacy drug catalogue and other outstanding change requests.	**Reasonable 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	Screens have been received into the trust and a project manager has been assigned to the project. This project has been delayed due to operational pressures but will recommence in February with some traction. Change facilitator interviews 9/02/2023.	**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)

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 (August to September 2022)	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.	**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.	**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 remain above target for October, November, and December 2022. 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. Significant staffing challenges.	**Limited Assurance**

What do we aim to achieve?	Update	Progress rating

Pressure Ulcers per 1000 Bed Days

Hospital acquired, exc Community

Rate per 1000 bed days

3.0 2.8 2.6 2.4 2.2 2.0 1.8 1.6 1.4 1.2 1.0 0.8 0.6 0.4 0.2 0.0

(2.94)

(2.03)

(1.12)

target:(0.8746064271078)

01-Apr-2022 01-May-2022 01-Jun-2022 01-Jul-2022 01-Aug-2022 01-Sep-2022 01-Oct-2022 01-Nov-2022 01-Dec-2022

Month

Latest
2.0
Variance Type
Common cause variation
Target
0.8746064271078
Target Achievement
The system is expected to consistently fail the target

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, 54% for december occuring in division of community services which is a decrease for this division.

Divisional Breakdown | **Injury Breakdown** | **Dying Patients**

Division	YTD	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022
Trust Total	**885**	**103**	**100**	**92**	**99**	**104**	**99**	**90**	**98**	**100**
Community	**519**	49	68	60	59	58	56	52	63	54
FSS	**3**	-	-	-	-	-	1	-	-	2
Medicine	**247**	43	20	20	26	34	29	25	24	26
Other	**1**	-	-	-	-	-	-	-	-	1
Surgical	**115**	11	12	12	14	12	13	13	11	17

What do we aim to achieve?	Update	Progress rating

Categories of CHFT Acquired Pressure ulcer

A reduction to 2 Cat 4 for December 2022 from 6 in November. All category 4 CHFT acquired pressure ulcers identified in December 2022 were existing pressure ulcers which have naturally debrided from an Unstageable (2). 1 category 4 was due to infection with underlying vascular issues.

Values	Month								
	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022
Total number of CHFT acquired pressure ulcers	103	100	92	99	104	99	90	98	100
Category 2	39	48	39	47	50	52	32	39	43
Category 3	0	0	3	0	0	0	0	2	1
Category 4	1	2	0	0	1	3	1	6	2
DTI's	46	32	39	33	43	32	34	41	41
Unstageables	17	18	11	19	10	12	23	10	13
Number of patients with a Pressure Ulcer	76	78	79	85	84	82	80	81	78

Medical Device Related Pressure ulcers

Devices causing skin damage (10 pressure ulcers) in December 2022 included, NIV, ET ties, urinary catheter and plaster cast & other. Other has been questioned as a duplication on KP+ as also listed uner NIV. 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.

Values	Month									
	Totals	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022
Total number of CHFT acquired pressure ulcers	**115**	9	11	11	18	14	16	10	16	10
Category 2	**68**	6	8	6	10	8	10	4	10	6
Category 3	**1**	0	0	1	0	0	0	0	0	0
Category 4	**1**	0	0	0	0	0	0	0	0	1
DTI's and Unstageables	**45**	3	3	4	8	6	6	6	6	3

What do we aim to achieve?	Update	Progress rating
	Pressure Ulcers caused by Medical Device by Device Type Foley catheters/c... 22 Other 19 Orthopaedic casts 17 Endotracheal tubes 8 Oxygen nasal can... 8 NIV masks 6 Oxygen Mask 6 Orthopaedic cervi... 5 Splints 5 Bandages 4 Nasogastric Tubes 3 Orthopaedic braces 3 Faecal manageme... 2 Hearing aids 2 Compression hosi... 1 Feeding tubes 1 Hoist slings 1 Prosthetic limb 1 Reading glasses 1 - 0 **Improvement Work** Presence of Tissue Viability Nurses on wards at weekends 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. CQUIN **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 Systmone. New moisture associated skin damage care plan written for Sysmone. 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	

What do we aim to achieve?	Update	Progress rating
	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. Collaborative work with Trust Decontamination team to explore increasing availability of air mattresses out of hours. Business case submitted for 60 additional Pure air 8 mattress in the acute.	
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 already exists on Systmone. Implementation is due in the coming months. Pressure ulcer risk assessments completed within 12 hours: August 2022 – 57% September 2022 – 55% October 2022 – 54% Pressure ulcer risk assessments completed within 6 hours: November 2022 – 32.2% December 2022 – 31.2% (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. % of pts that received a pressure ulcer risk assessment within 6 hrs of admission/transfer Adult inpatients 47.9% 41.2% 34.4% 27.7% 20.9% Apr-2022 May-2022 Jun-2022 Jul-2022 Aug-2022 Sep-2022 Oct-2022 Nov-2022 Dec-2022	**Limited Assurance**
Aim 3 95% of relevant staff will have completed Pressure Ulcer Prevention training	86.58% of staff have completed React to Red Training as of January 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 are community and SAS showing 91% compliance with pressure ulcer training. Medicine 81% and FSS 86%. 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.	**Reasonable Assurance**

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** (January 2023)	Progress rating
Aim 1 % of Complaints Closed within agreed timescale	The Trust's performance relating to complaints closed within an agreed timescale is still seeing an improvement. The Trust's current performance is 94% which is a 16% improvement on December's performance which was 78%. 32 out of the 34 formal complaints closed in January 2023, were closed within agreed timescales. Divisional engagement and communication with complainants are also improving. 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 facing. 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. 5 complaints were re-opened in January 2023, which is like the previous data shared, at 15% of closed complaints are being re-opened. This will continue to be monitored and any actions required will be identified as to why we are not getting this right first time, 15% of the time.	**Limited Assurance** The rise in complaint numbers continues to be our priority. 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	As mentioned in the previous report, we have agreed with Divisions that any concerns raised relating to a current, on-going admission are being telephoned through to Matrons (instead of emailed) to request direct contact with the patient/their family, to avoid these issues escalating further – this is working well, and Matrons are being responsive. This continues to be regularly monitored. Work continues to take place with all the Divisions to reiterate the importance of responding to concerns as quickly and effectively as possible to avoid them escalating to complaints.	**Reasonable Assurance** In this reporting period, zero concerns have escalated to a formal complaint.

Focused Quality Priority (2022-2023)

End of Life Care

End of Life Care

Executive Lead

Lindsay Rudge

Operational Leads

Mary Kiely
Gillian Sykes
Christopher Button

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	**October / November 2022** 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). In the early stages of the 7 days service, we found that having 2 CNSs on at the weekend was depleting the midweek team and therefore missing patients. There appears to a correlation between a reduction in staff	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	presence on a weekend and numbers of missed referrals. We have started 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.	
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	**October/November 2022** 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 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	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
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	**January 2023** • The Quality Improvement manager for patient experience has presented the data obtained at the EOLC steering group and a 6-month plan developed. • The Team now phone all relatives of deceased patients and send out a box to each family. On 16th January our new KP+ database commenced to keep record of activities /outcomes. • The team are trialling the Marigold sign to be 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 starts on Monday 13th February and will go Trust wide on 20th March. This was raised by CQC on their visit last year. • Increase in in reach/training /support for staff in recognising dying/communications skills which was highlighted in the NACEL audit/complaints – 58 staff have been involved in the in reach over the past couple of months. We are now going to go to Ward 22 and 5ABCD to provide in reach.	**Substantial Assurance**

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

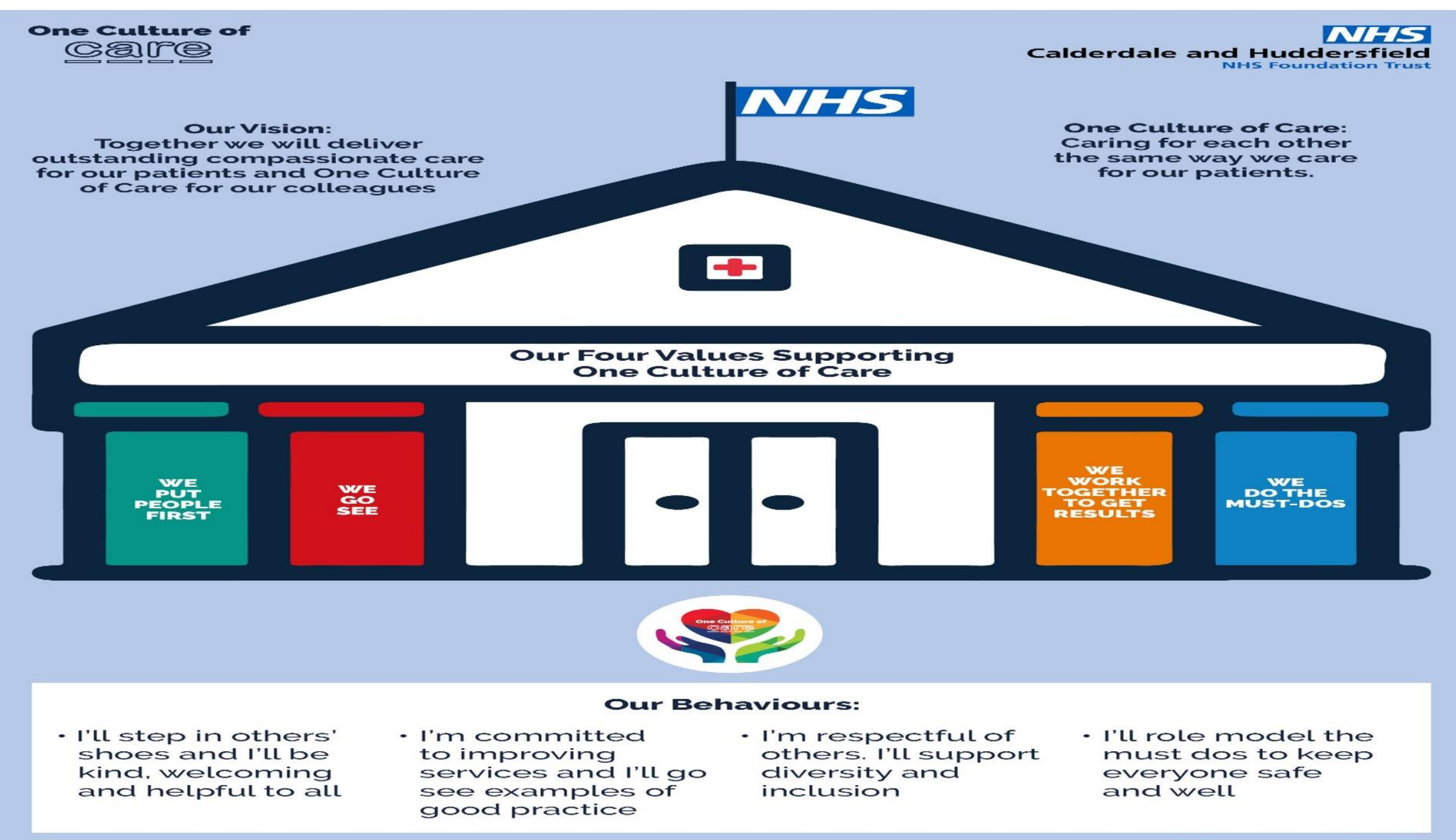
Quality Report

Executive Summary - Reporting Period January 2023

Quality & Safety Team

Calderdale and Huddersfield NHS Foundation Trust

Quality Report - Executive Summary - Reporting Period January 2023



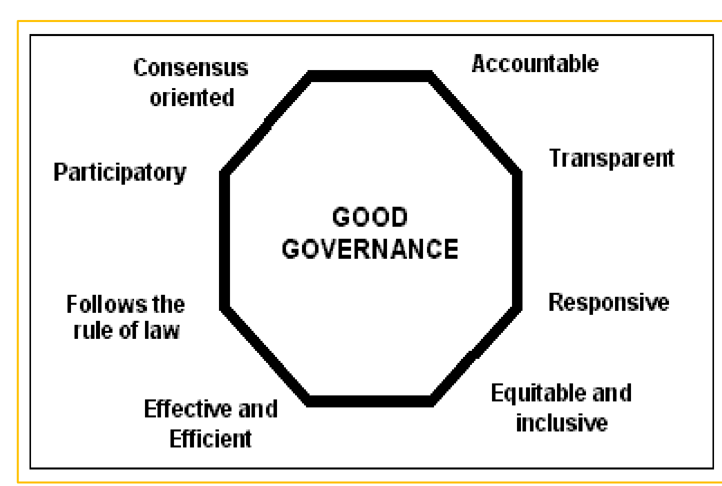
Purpose

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 January 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.

- **Antibiotics** - Compliance of antibiotics administered within 60 mins of earliest alert for red flag deteriorated in the month of December with an increase of 5.6% compliance in January. ED consultant sepsis write back audit paused due to work absence from within the department. Sepsis nurse seeking appropriate person to complete this task.

- **Blood cultures** – compliance improved in January 2023 by 6.5%. 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

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. The data in KP+ needs exploring to ascertain if patients not required to be screened are included (previous positive /SDEC patients/ ED etc).
- Hospital Onset Covid-19 infection (HOCI) increases and decreases in line with that seen in the wider population. 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.
- Outbreaks of HOCI continue to be experienced predominantly in the elderly medicine wards at HRI. The open nature of some of the ward environments makes outbreak control more of a challenge.
- The number of C-Difficile infections is monitored nationally, reported via the UKSHA HCAI data capture system. Currently, there are 52 cases reported including 20 Community onset, healthcare associated cases. This is over the trajectory for the year.

Quality Priorities

Reduce waiting times for individuals attending the Emergency Department:

Aim 1 (Monitor 8 Hour Breaches):

- December 2022 (2,433 LOS >8 hours); January 2023 (1,197 LOS>8 hours)
- The reduction in attendances for January 23 had a positive impact on the LOS in ED with a reduction in admitted, non-admitted and overall numbers.

Aim 2 (Monitor 10 Hour Breaches):

- December 2022 (1,399 LOS >10 hours); January 2023 (569 LOS >10 hours)
- Additional HCA for the waiting room to monitor patients with a LOS >4 hours Senior medic (ST6+) added supernumerary in aid of decision making and front door turnaround

Aim 3 (Monitor 12 Hour Breaches):

- December 2022 (887 LOS >12 hours); January 2023 (324 LOS >12 hours)
- Still monitoring, capturing and reporting DTAS's, increase in month of MH attendances (189 Trust) closer working with MH teams as acknowledged MH attendances breach all ECS milestones.

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 of advance care plans is not yet available across the CHFT footprint, however data available for Kirklees is demonstrating an increase in the number of Advance Care Plans recorded on EPaCCS. Increase in in-reach/training/supporting staff in recognising dying was highlighted in the NACEL audit, further training continues in this area.

Increase the quality of clinical documentation across CHFT - Work has commenced on updating the nursing admission and care plans within EPR. Contractors have also been employed to update the pharmacy drug catalogue and other outstanding change requests. 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 continues to improve. The Trust's current performance is 94% which demonstrates a 16% improvement on December's performance. 32 out of the 34 formal complaints closed in January 2023, were closed within agreed timescales. Meetings with the divisions continue to work well, are well attended and are pivotal for escalating issues in a timely fashion.

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 – Time of day now added to falls dashboard to identify any themes. Falls KPIs currently being reviewed by the Falls Collaborative Group to ensure that correct and appropriate data is being collated. An audit of harms falls is currently underway and results will be feedback in February.

Reduction in the number of CHFT-acquired pressure ulcers – Hospital acquired pressure ulcers remain above target for November and December 2022. High numbers of complex patients, long trolley waits, high numbers of patients being admitted following a long lie. Significant staffing challenges. Face to face training has recommenced with a 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.

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

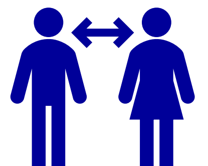
Admin Validation - Cancelled appointment with Requests (CAWR), Incomplete Orders (IO's)and the Holding (82k patients, pre COVID 62k) list all require admin validation when 12 weeks overdue. This removes approximately 50%of IO's and 20%of the CAWR and Holding list. Over 212k admin validations have been 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.

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.

Harm Reviews - The harm review process will be integrated into clinical prioritisation, subject to further development, any harm identified during clinical prioritisation or at the point of appointment/treatment will be reported through DATIX and managed in accordance with the Trust SI process.

Care Quality Commission



Review of 2018 CQC MD & SD Actions:

- A full review of all 'Must Do' & 'Should Do' actions which were issued post the 2018 CQC Inspection has been undertaken. This is to ensure progress has been maintained of any embedded actions and to identify any potential gaps. All Core Services were tasked to self-assess their current position against actions set out in 2018, Core Services leads presented the position at the November 2022 CQC & Compliance Group. The action position updates were then ratified and agreed at the January 2023 CQC & Compliance Group.

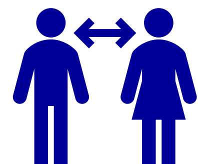
Planned Onsite Visits:

- CQC have requested a planned onsite visit focusing on Surgery & ICU this was due to take place on 1st February 2022, but was rescheduled to 1st March 2022.
- The senior leadership will present a overview of services to CQC followed by a walk around of Surgical SDEC, Ward 10, Theatres and ICU.

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

Care Quality Commission



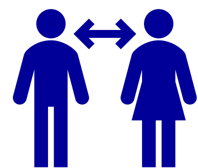
CQC are changing:

CQC are splitting the roles and responsibilities involved in carrying out assessments.

Within the networks, CQC will divide into local teams. These teams will include colleagues with a mix of expertise and experience of different types of health and social care services. This will make sure specialist skills and knowledge are shared about all sectors.

Depending on the services in a particular area, teams will contain a mix of these roles:

- **Assessors:** will have an ongoing view of quality, safety and risk for services in their area. Supported by the inspector and regulatory co-ordinator, they will make judgements about the quality of care. To do this they will consider evidence collected from all sources – both on and off site.
- **Inspectors:** will lead enforcement activity. While assessors will collect evidence off-site, inspectors will gather evidence on site visits.
- **Regulatory co-ordinators:** help carry out engagement with providers and local groups of people. They will support with triaging information and collecting evidence.
- **Regulatory officers:** support administrative duties. For example, inspection planning and gathering the experiences of people using services.



How CQC are changing

For Providers this means:

- Providers will still be assessed by CQC colleagues who are experts in your service type. But the teams can have better conversations about how things are working between services and the other services they interact with in the local area.
- Teams will be more tailored and efficient to support in relationship meetings with services. Providers can speak with members of local teams for different types of advice and rely less on one person to provide support.
- They'll be an up-to-date view of quality and better understanding of what is driving poor or outstanding care. This means CQC can support improvement specifically where it's needed and promote good care.

Patient Experience, Participation, Equalities

Friends and Family Test

Since November 2022 we have seen a decline in the recorded Friends & Family Test results across all divisions. This has been at a time that has seen staff dealing with winter pressures and delivering care at Opel 4. We are currently developing Microsoft Forms to make the process easier to capture. This also allows the FFT questions to be adapted to tailor feedback for the respective wards and clinics.

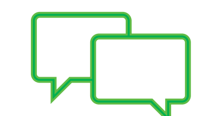
Commitment to Carers

During January 2023 over 100 carers were identified and supported and every carer has received a follow-up call. A full insight report will be provided once a quarter. This will include ethnicity monitoring and triangulated learning.

Ageing Well Service

A review of the patient feedback of the Ageing Well Service within CHT has been undertaken. Practitioners have gathered feedback from 46 patients which they have supported, using an old version of the Friends & Family Test. By supporting patients and their carers within their own home it is anticipated that there will be an improvement in patient care without patients having to attend their GP practice for appointments. It is also possible that patients will be less likely to need to be admitted to hospital and when they are, their discharge and recovery will feel more supported.

Patient Advice and Complaints Service (PACS)



	Dec 2022	Jan 2023
Complaints received	21	28
Complaints closed	41	34
Complaints closed outside of target timeframe	9	2
% of complaints closed within target timeframe	**78%**	**94%**
Complaints reopened	6	5
PALS contacts received	122	180
Compliments logged	24	71
PHSO complaints received	1	1
PHSO complaints closed	0	0
*Complaints under investigation with PHSO (total)	11	12

Medicines Safety

Medication incident reporting has increased in January compared to previous months. Four of the January incidents were classed as moderate to severe harm. The severe harm involved a patient on the incorrect flow rate of oxygen(3lpm oxygen via 35% venturi but to function correctly a 35% venturi requires 8lpm oxygen). The three moderate harm incidents included wrong dose of insulin, an extravasation reaction to an iron infusion and the administration of iv lorazepam to an aggressive patient. These are currently being investigated and learning will be shared with the teams.

A patient safety oxygen alert was received on 10th January; Use Of Oxygen Cylinders Where Patients Do Not Have Access To Medical Gas Pipeline Systems. An extraordinary Medical Gas Committee was held 13/01/2023 with medical gas committee members (including clinical, nursing, pharmacy, Estates and Facilities, authorised persons, medical physics, health and safety, fire officer). The committee reviewed the NHS England 'Safe use of oxygen cylinders' best practice guidance and assessed the use of oxygen in patients being acutely cared for at CHFT without routine access to medical gas pipeline systems. The Medical Gas Committee were assured that there are relevant up to date adult and paediatric clinical guidelines that cover prescribing, target saturations, oxygen saturation monitoring in accordance with British Thoracic Society (BTS) Guidance in place that are widely disseminated and embedded in clinical practice.

Ward 19 and the inpatient pharmacy are piloting the new electronic controlled drugs register system w/c 30th January. If the pilot is successful, the system will then be rolled out to all ward areas by summer 23.

Risk Management (Incidents)

Never Events:

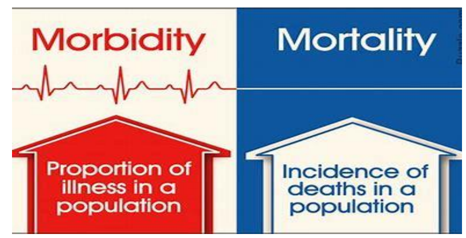
Between 01 February 2022 and 31 January 2023, the Trust has reported six Never Events.

Serious Incidents:

In total, for the rolling month of 1 February 2022 to 31 January 2023, there have been 48 Serious Incidents declared on Strategic Executive Information System (StEIS) that are either under investigation or the investigation has been completed and closed. The 48 SI's have been recorded across three divisions; Families and Specialist Services (14), Medical Division (24) and Surgical & Anaesthetics Services Division (10)

As of 31st January 2023, the Trust has 36 serious incident investigation that are **currently** ongoing and under investigation. The 36 ongoing serious incident investigation are across three divisions: families and specialist services (12), Medical division (18) and surgical and anaesthetic division (6)

Mortality and Morbidity



Monthly Mortality Update: December 2022

The HSMR figure showed an improving position to 102.26 to the end of October 2022, from 103.96 in September 2022.

Trust benchmarking for Crude mortality has remained stable at 48th position nationally (out of 123 Trusts), this is the same position in the previous release, this remains in the 2nd quartile for national performance.

Latest SHMI release shows an improving position to 105.86 to the end of September 2022 from 106.65 up to the end of August 2022.

Legal Services

There continues to be growing demand around claims and inquests, with an increase in portfolio size of around 12% for claims and 21% for inquests since July 2022. The portfolio size has increased from 170 to 195 (Claims) and 79 to 100 (Inquests). The Trust currently have 5 x high, 16 x moderate, 43 x low and 37 x minimal risk inquests, with approximately 12 incident investigations linked to an open inquest.

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 until next month.

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.

An internal audit of the Trust's Inquest Portfolio found found 'significant' assurance, albeit a 'management response' to each of the recommendations is required relating to compliance with the Legal SOP, rather than an issue with the process. An action plan has been put in place to ensure compliance with the SOP and effective management of the inquests service, this will be managed by the Head of Legal Services.

14. Finance and Performance Chair Highlight Report

For Assurance

Presented by Andy Nelson

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:	7 and 28 February 2023
Date of Board meeting this report is to be presented:	2 March 2023

ACKNOWLEDGE

- Continued strong performance in Cancer although 3 performance measures missed in January
- Recovery performance still on track with strong achievement on 78- and 104-week waiters and 52-week waiters compared with the external plan. Will be close to our internal target of zero 52-week waiters at year end. CHFT clearly best performer in West Yorkshire ICB – a real credit to all involved. Diagnostics performance dipped over Xmas but still over 94%
- Complaints performance has improved further with 94% of complaints closed within the agreed timeframe – our best performance in almost 2 years. Now need to tease out the key themes from these complaints to ensure we take on board the learning from them

ASSURE

- The committee did deep-dive follow-ups on stroke and neck of femur looking at the latest performance and the effectiveness of the actions that were proposed in the previous deep dives reviews into each specialty. Key points to note:
    - Both specialties facing significant growth in numbers of admissions vs 2019
    - Stroke performance has improved underpinned by a number of the proposed actions which are now complete. Overall SSNAP score improved from C to B
    - Hitting the 4-hour target for admission to the acute stroke unit remains a major challenge that requires a number of changes to show the required improvement
    - Neck of femur mortality rate has improved but very modest progress in improving the 36-hour admission to surgery performance. Further actions proposed including 'go see visits' to other trusts where performance is better
- The committee did a deep dive into elective recovery plans and were assured by the work being done on validation, the Harm Review Process and plans for Elective Recovery Transformation. Against the overall 104% target now forecasting 103.1% for year-end for inpatient activity and 105.3% for outpatient first
- We remain on track to meet the CIP target of £20m in 2022/23
- Integrated Performance Report (IPR) and framework being refreshed to update for NHS performance and local performance metrics. To be used at May Board for the first time

AWARE

- HSMR performance improved but mortality rates being looked into
- Transfer of Care (TOC) numbers remain a concern being consistently over 100 and continue to be the subject of intense work with system partners
- Backlog volume of ASIs and Follow-Up appointments still a concern – will it lead to greater pressure on 52-week waits
- At the end of month 10 the trust is reporting a deficit position of £20.4m which is £3.48m adverse to plan (vs £1.78m at month 8). This is driven by Covid/ED numbers and greater patient acuity leading to high bed capacity and agency spend alongside non-pay inflation.
- These financial pressures are offset by non-recurrent savings, various elements of additional funding and vacancies such that the trust is forecasting to meet its deficit plan of £17.35m. At the end of month 10 there remains a gap of £1.53m to deliver our plan but further monies and some caution in our divisional forecasts gives us confidence the plan will be delivered. This assumes the current operational pressures continue but CIP is achieved and pay awards and elective recovery are fully funded
- The committee were assured that all risks to the financial plan are getting the necessary executive attention including working with partners at place and ICB level.
- Cash position strong primarily due to capital underspend. Forecast is now to underspend our capital plan by £11.34m primarily due to a reduction on PDC supported expenditure on Reconfiguration
- F&P received a presentation on the draft 23/24 financial plan at the 7 Feb meeting and an update to this at the 28 Feb meeting. The committee noted the challenging nature of the plan, the aim to deliver a £25m CIP and the remaining uncertainties about ICB funding

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

	0<18				18>26				26>40				40>52			
Provider	Dec-21	Jan-23	^v	%	Dec-21	Jan-23	^v	%	Dec-21	Jan-23	^v	%	Dec-21	Jan-23	^v	%
Leeds	54,434	54,566	↑	0%	9,770	12,155	↑	24%	6,526	13,117	↑	101%	2,079	5,783	↑	178%
Mid Yorks	26,143	29,597	↑	13%	4,453	6,653	↑	49%	3,320	7,135	↑	115%	998	2,431	↑	144%
Bradford	21,722	25,045	↑	15%	6,364	4,052	↓	-36%	6,072	4,238	↓	-30%	763	1,403	↑	84%
Calderdale	19,089	20,898	↑	9%	5,039	4,595	↓	-9%	6,328	4,168	↓	-34%	2,029	1,780	↓	-12%
Harrogate	15,551	15,487	↓	0%	2,904	3,656	↑	26%	2,328	3,295	↑	42%	911	1,279	↑	40%
Airedale	7,913	9,313	↑	18%	995	1,684	↑	69%	656	1,865	↑	184%	219	740	↑	238%
Total	**144,852**	**154,906**	↑	7%	**29,525**	**32,795**	↑	11%	**25,230**	**33,818**	↑	34%	**6,999**	**13,416**	↑	92%

	52>78				78>104				>104				Total			
Provider	Dec-21	Jan-23	^v	%	Dec-21	Jan-23	^v	%	Dec-21	Jan-23	^v	%	Dec-21	Jan-23	^v	%
Leeds	2,079	3,190	↑	53%	831	430	↓	-48%	480	9	↓	-98%	76,199	89,250	↑	17%
Mid Yorks	639	1,074	↑	68%	118	39	↓	-67%	-	-	-	-	35,671	46,929	↑	32%
Bradford	611	557	↓	-9%	336	31	↓	-91%	154	-	↓	-100%	36,022	35,325	↓	-2%
Calderdale	2,444	832	↓	-66%	636	122	↓	-81%	106	-	↓	-100%	35,671	32,395	↓	-9%
Harrogate	877	1,156	↑	32%	203	108	↓	-47%	45	-	↓	-100%	22,819	24,981	↑	9%
Airedale	306	435	↑	42%	107	86	↓	-20%	12		↓	-100%	10,208	14,123	↑	38%
Total	**6,956**	**7,244**	↑	4%	**2,231**	**816**	↓	-63%	**797**	**9**	↓	-99%	**216,590**	**243,004**	↑	12%

15. Month 10 Financial Summary

For Assurance

Presented by Gary Boothby and Kirsty Archer

COVER SHEET

Date of Meeting:	Thursday 2nd March 2023
Meeting:	Board of Directors
Title:	Month 10 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 10 (January 2023)

Key Points to Note

Year to Date Summary

Year to date the Trust is reporting a £20.40m 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.

- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, based on delivery of 104% of 19/20 elective activity. ERF of £9.81m has been assumed in the year to date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year (H1). National guidance suggests that ERF is not likely to be clawed back in the second half of the year, but this has not yet been formally confirmed.
- The Trust has been allocated block funding of £6.0m for the year to support Covid-19 costs by the Integrated Care System (ICS) and subject to approval continues to have access to 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.
- Year to date the Trust has incurred costs relating to Covid-19 of £13.62m, (excluding costs outside of System Envelope), £6.10m higher than planned. Covid-19 activity remains higher than planned and is one of a number of factors driving additional staffing

costs and consumables, with extra capacity opened over and above the planned level and ongoing Emergency Department segregation.
- Year to date the Trust has delivered efficiency savings of £15.97m, £0.14m higher than planned.
- Agency expenditure year to date is £11.73m, £6.12m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has already exceeded that ceiling.
- Total planned inpatient activity, for the purpose of Elective Recovery, was 99.3% of the activity planned year to date, (103.9% of 19/20 activity levels).

Key Variances

- Income is £12.92m above the planned year to date due to: changes to Tariff based funding (£5.26m YTD) 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, £0.44m of Covid-19 funded has been reallocated in month 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 of £3.15m includes £1.94m for hosted GP trainees.
- Pay costs are £7.82m above the planned level year to date, including £6.00m relating to the higher than planned Pay Award. Additional funding has been allocated to offset this pressure, although this is not currently sufficient to entirely offset the cost. Excluding pay award, the underlying year to date variance is £1.82m above the planned level, with an adverse variance in Month 10 of £0.60m. In the year to date position the cost of additional capacity and higher than planned Agency and Bank premium rates have been offset to some extent by a combination of vacancies in FSS and Community Divisions and lower than planned Elective Recovery costs.
- Non-pay operating expenditure is £9.22m 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.

Forecast

Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support. A mitigation gap of c.£1.0m remains to be identified. The forecast assumes full delivery of a challenging £20m efficiency target and that the Trust will deliver its elective activity plan, delivering 104% of 19/20 activity levels within the planned funding envelope.

Attachment: Month 10 Finance Report

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to receive the Finance Report and note the financial position for the Trust as at 31st January 2022.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jan 2023 - Month 10

KEY METRICS

	M10			YTD (JAN 2023)			Forecast 22/23		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m	Plan £m	Forecast £m	Var £m
I&E: Surplus / (Deficit)	(£1.64)	(£2.33)	(£0.69)	(£16.92)	(£20.40)	(£3.48)	(£17.35)	(£17.35)	£0.00
Agency Expenditure (vs Ceiling)	(£0.65)	(£1.39)	(£0.74)	(£5.61)	(£11.73)	(£6.12)	(£6.90)	(£13.90)	(£7.00)
Capital	£5.08	£4.42	£0.66	£33.40	£13.81	£19.59	£41.99	£30.65	£11.34
Cash	£37.01	£40.82	£3.81	£37.01	£40.82	£3.81	£19.26	£21.91	£2.65
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	93.1%	-2%	95.0%	91.4%	-4%			
CIP	£2.06	£1.79	(£0.26)	£15.82	£15.97	£0.14	£20.00	£20.00	(£0.00)
Use of Resource Metric	3	4		3	4		3	3	

Year to Date Summary

Year to date the Trust is reporting an £20.40m 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.

• Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, based on delivery of 104% of 19/20 elective activity. ERF of £9.81m has been assumed in the year to date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year (H1). National guidance suggests that ERF is not likely to be clawed back in the second half of the year, but this has not yet been formally confirmed.
• The Trust has been allocated block funding of £6.0m for the year to support Covid-19 costs by the Integrated Care System (ICS) and subject to approval continues to have access to 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.
• Year to date the Trust has incurred costs relating to Covid-19 of £13.62m, (excluding costs outside of System Envelope), £6.10m higher than planned. Covid-19 activity remains higher than planned and is one of a number of factors driving additional staffing costs and consumables, with extra capacity opened over and above the planned level and ongoing Emergency Department segregation.
• Year to date the Trust has delivered efficiency savings of £15.97m, £0.14m higher than planned.
• Agency expenditure year to date is £11.73m, £6.12m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has already exceeded that ceiling.
• Total planned inpatient activity, for the purpose of Elective Recovery, was 99.3% of the activity planned year to date, (103.9% of 19/20 activity levels).

Key Variances

• Income is £12.92m above the planned year to date due to: changes to Tariff based funding (£5.26m YTD) 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, £0.44m of Covid-19 funded has been reallocated in month 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 of £3.15m includes £1.94m for hosted GP trainees.
• Pay costs are £7.82m above the planned level year to date, including £6.00m relating to the higher than planned Pay Award. Additional funding has been allocated to offset this pressure, although this is not currently sufficient to entirely offset the cost. Excluding pay award, the underlying year to date variance is £1.82m above the planned level, with an adverse variance in Month 10 of £0.60m. In the year to date position the cost of additional capacity and higher than planned Agency and Bank premium rates have been offset to some extent by a combination of vacancies in FSS and Community Divisions and lower than planned Elective Recovery costs.
• Non-pay operating expenditure is £9.22m 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.

Forecast

Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support. A mitigation gap of c.£1.0m remains to be identified. The forecast assumes full delivery of a challenging £20m efficiency target and that the Trust will deliver its elective activity plan, delivering 104% of 19/20 activity levels within the planned funding envelope.

Total Group Financial Overview as at 31st Jan 2023 - Month 10

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	4,766	3,775	(991)
Non-Elective	48,730	45,168	(3,562)
Daycase	41,483	42,153	669
Outpatient	362,512	377,203	14,690
A&E	146,005	146,586	581
Other NHS Non-Tariff	1,543,744	1,639,829	96,085
Total	**2,147,241**	**2,254,713**	**107,472**

TOTAL GROUP: INCOME AND EXPENDITURE

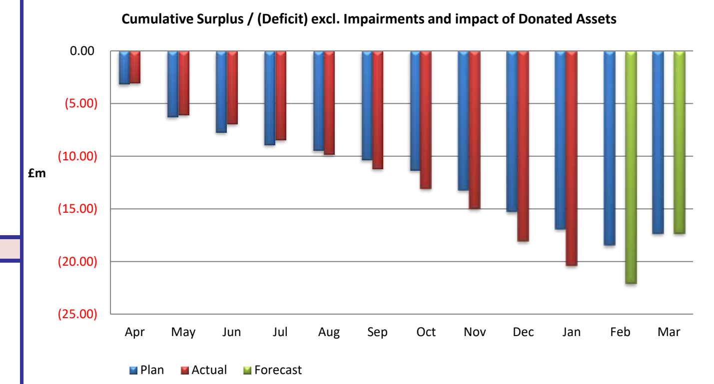
	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£19.07	£14.86	(£4.22)
Non Elective	£109.25	£108.11	(£1.14)
Daycase	£29.11	£29.57	£0.46
Outpatients	£33.05	£36.75	£3.70
A & E	£24.50	£25.94	£1.44
Other-NHS Clinical	£144.39	£154.36	£9.97
CQUIN	£0.00	£0.00	£0.00
Other Income	£44.75	£47.46	£2.71
Total Income	**£404.13**	**£417.04**	**£12.92**
Pay	(£267.40)	(£275.22)	(£7.82)
Drug Costs	(£38.17)	(£37.42)	£0.75
Clinical Support	(£32.14)	(£32.49)	(£0.35)
Other Costs	(£44.56)	(£53.92)	(£9.37)
PFI Costs	(£11.92)	(£12.17)	(£0.25)
Total Expenditure	**(£394.18)**	**(£411.22)**	**(£17.04)**
EBITDA	**£9.95**	**£5.83**	**(£4.12)**
Non Operating Expenditure	(£26.87)	(£26.23)	£0.65
Surplus / (Deficit) Adjusted*	**(£16.92)**	**(£20.40)**	**(£3.48)**

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

DIVISIONS: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£85.12)	(£83.95)	£1.17
Medical	(£102.85)	(£109.12)	(£6.27)
Families & Specialist Services	(£74.57)	(£72.91)	£1.65
Community	(£23.23)	(£22.58)	£0.66
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£44.64)	(£45.88)	(£1.24)
THIS	£1.03	£1.12	£0.09
PMU	£1.99	£0.90	(£1.09)
CHS LTD	£0.41	£0.23	(£0.18)
Central Inc/Technical Accounts	£309.12	£312.28	£3.16
Reserves	£0.94	(£0.50)	(£1.44)
Surplus / (Deficit)	**(£16.92)**	**(£20.40)**	**(£3.48)**

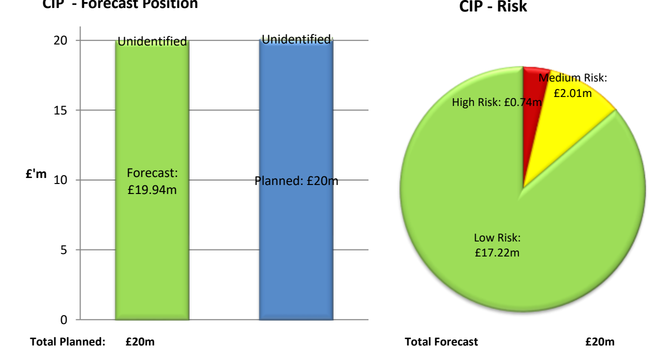
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date: M10 Plan	Year To Date: M10 Actual	Year To Date: Var	Year End: Forecast: Plan	Year End: Forecast: Forecast	Year End: Forecast: Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£16.92)	(£20.40)	(£3.48)	(£17.35)	(£17.35)	£0.00
Capital	£33.40	£13.81	£19.59	£41.99	£30.65	£11.34
Cash	£37.01	£40.82	£3.81	£19.26	£21.91	£2.65
Invoices Paid within 30 days (BPPC)	95%	91%	-4%			
CIP	£15.82	£15.97	£0.14	£20.00	£20.00	(£0.00)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	4		3	3	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £20m

Total Forecast £20m

YEAR END 22/23

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,774	4,666	(1,108)
Non-Elective	58,360	54,457	(3,903)
Daycase	50,173	50,567	394
Outpatient	436,084	452,825	16,741
A&E	170,928	172,640	1,711
Other NHS Non- Tariff	1,867,647	1,986,945	119,298
Total	**2,588,966**	**2,722,099**	**133,133**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£23.08	£18.02	(£5.06)
Non Elective	£123.29	£122.99	(£0.30)
Daycase	£35.10	£35.89	£0.79
Outpatients	£40.60	£45.21	£4.61
A & E	£28.76	£30.39	£1.63
Other-NHS Clinical	£180.77	£192.12	£11.36
CQUIN	£0.00	£0.00	£0.00
Other Income	£53.66	£57.81	£4.15
Total Income	**£485.26**	**£502.45**	**£17.18**
Pay	(£318.79)	(£328.17)	(£9.39)
Drug Costs	(£45.79)	(£44.86)	£0.92
Clinical Support	(£38.80)	(£39.19)	(£0.39)
Other Costs	(£52.67)	(£63.97)	(£11.30)
PFI Costs	(£14.31)	(£14.60)	(£0.30)
Total Expenditure	**(£470.36)**	**(£490.80)**	**(£20.44)**
EBITDA	**£14.90**	**£11.64**	**(£3.26)**
Non Operating Expenditure	(£32.25)	(£28.99)	£3.26
Surplus / (Deficit) Adjusted*	**(£17.35)**	**(£17.35)**	**£0.00**

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

DIVISIONS: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.29)	(£101.49)	£0.79
Medical	(£124.34)	(£131.36)	(£7.02)
Families & Specialist Services	(£89.56)	(£87.60)	£1.96
Community	(£27.88)	(£27.22)	£0.66
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£53.56)	(£55.09)	(£1.53)
THIS	£1.23	£1.12	(£0.11)
PMU	£2.39	£0.98	(£1.41)
CHS LTD	£0.54	£0.25	(£0.29)
Central Inc/Technical Accounts	£374.02	£380.54	£6.52
Reserves	£2.09	£2.52	£0.42
Surplus / (Deficit)	**(£17.35)**	**(£17.35)**	**£0.00**

Total Group Financial Overview as at 31st Jan 2023 - Month 10

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables (excl. Current Loans)	(£109.68)	(£107.53)	(£2.15)	
Receivables	£26.70	£27.15	(£0.45)	

Payables

BETTER PAYMENT PRACTICE CODE

% Number of Invoices Paid within 30 days

CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£37.01	£40.82	£3.81	
Loans (Cumulative)	£15.46	£15.46	£0.00	

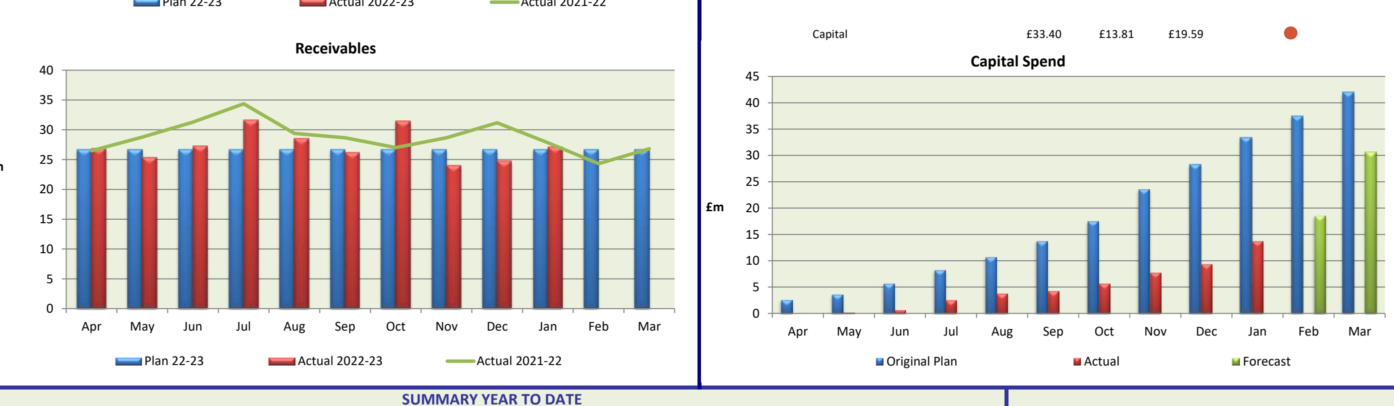
Cash

CAPITAL

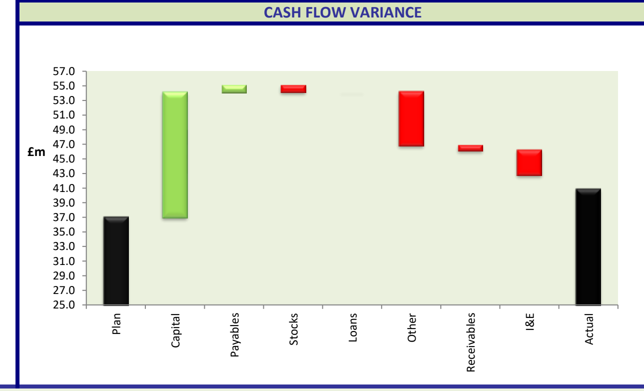
	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital	£33.40	£13.81	£19.59	

Receivables

Capital Spend



CASH FLOW VARIANCE

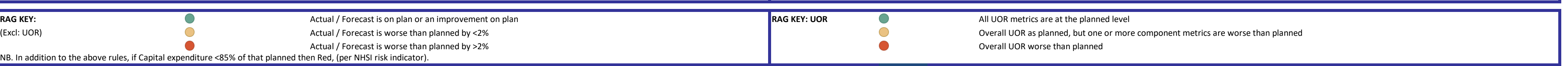


SUMMARY YEAR TO DATE

- Year to date the Trust is reporting an £20.40m deficit, a £3.48m adverse variance from plan.
- The adverse variance is driven by inflationary pressures, the cost of opening additional capacity and the associated premium rate staffing costs.
- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, based on delivery of 104% of 19/20 elective activity.
- £9.81m of ERF has been assumed in the year to date position as planned. National guidance suggests that ERF is not likely to be clawed back this year, although this has not yet been formally confirmed.
- Total planned inpatient activity for the purposes of Elective recovery was 99.3% of the activity planned year to date, (103.9% of 19/20 activity levels).
- Year to date the Trust has incurred costs relating to Covid-19 of £13.62m, (excluding testing and vaccination costs funded outside of System envelope), £6.10m higher than planned.
- Capital expenditure is lower than planned at £13.81m against a planned £33.40m. Capital plans now also include any new leases.
- Year to date the Trust has delivered efficiency savings of £15.97m, £0.14m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 4, worse than planned, with 2 metrics currently away from plan.

NOTES

- Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support. A mitigation gap of c.£1.0m remains to be identified.
- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of January 23, £19.94m of efficiency has been identified and is forecast to deliver.
- The forecast assumes that the Trust will deliver it's elective activity plan and secure £11.72m of Elective Recovery Funding.
- The total loan balance is £15.46m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £30.65m on Capital programmes in this financial year including £0.16m on leases. The £11.34m forecast underspend 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 Trust has a cash balance of £40.82m, £3.81m higher than planned.



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

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

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

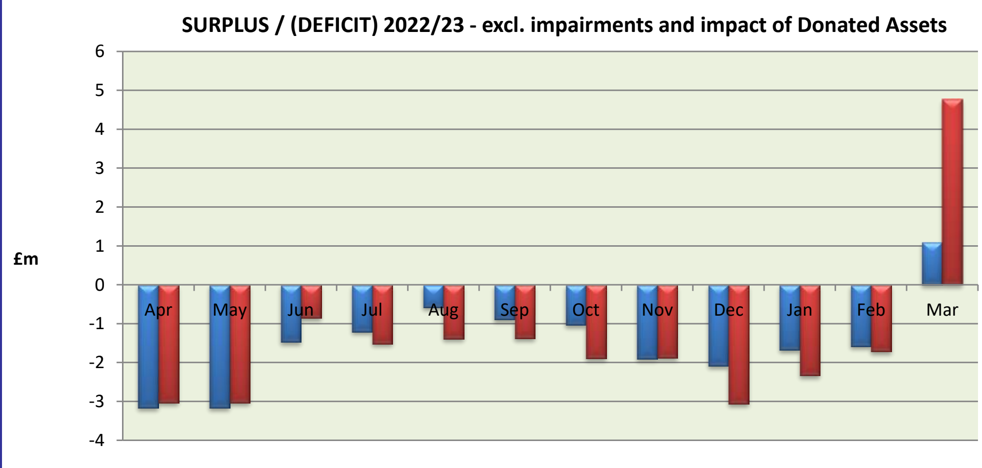
FORECAST POSITION 22/23

22/23 Forecast (31 Mar 23)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m
Income	£485.35	£502.74	£17.39
Pay expenditure	(£318.79)	(£328.17)	(£9.39)
Non Pay Expenditure	(£151.58)	(£162.63)	(£11.05)
Non Operating Costs	(£32.68)	(£29.52)	£3.15
Total Trust Surplus / (Deficit)	**(£17.69)**	**(£17.59)**	**£0.11**
Deduct impact of:			
Impairments (AME)[1]	£0.00	(£0.00)	(£0.00)
Donated Asset depreciation	£0.43	£0.53	£0.11
Donated Asset income (including Covid equipment)	(£0.08)	(£0.30)	(£0.21)
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00
Gain on Disposal	£0.00	£0.00	£0.00
Adjusted Financial Performance	**(£17.35)**	**(£17.35)**	**£0.00**

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

MONTHLY SURPLUS / (DEFICIT)



- The Trust is forecasting to deliver the revised plan of a £17.35m deficit.
- Whilst forecasting to deliver this planned deficit, the year to date deficit shows how challenging this will be and significant mitigation will be required to offset the ongoing operational pressures. Capacity requirements remained high in January and continue to be above the planned level due to higher than planned Emergency attendances, Covid-19 & Flu activity, Delayed Transfers of Care and other operational pressures. This continues to drive additional costs, particularly in relation to bank and agency expenditure.
- The additional funding for inflation was required to flow in full to improve the Trust overall financial position and assumed that plans included sufficient funding to cover any pressures. The increase in RPI since March 22 is driving additional inflationary pressures over and above the planned level, particular in relation to Energy costs and the PFI contract. It is also impacting on the ability to achieve planned procurement savings.
- The forecast assumes full delivery of a challenging £20m efficiency target. Additional schemes have been identified to offset slippage on the original plan, leaving just a small gap yet to be identified. The expectation is that closing the remaining gap is feasible and full delivery of the target is expected.
- The Pharmacy Manufacturing Unit has not delivered the planned surplus in the year to date and is forecasting an adverse forecast variance of £1.41m by year end.
- Vacancies have driven underspends in Community and FSS Divisions in the year to date, mitigating the operational pressures described above to some extent.
- Indications are that the forecast £11.73m of Elective Recovery Funding is secure, although formal confirmation from NHS England that funds will not be reallocated has not yet been received.
- The forecast assumes that the more targeted Bank rate enhancement scheme introduced from the 6th of November is a cheaper option than the previous 50% Bank enhancement scheme and costs no more than £417k per month as modelled.
- Further mitigation has been identified to offset Divisional forecast pressures, but a gap of c. £1.0m remains. However, given the scale of the challenge, the current 'likely case' forecast as reported to the Integrated Care Board is delivery of the planned financial position.

Risks and Potential Benefits

- The forecast assumes full delivery of the £20m efficiency target, although there are a few schemes that remain high risk.
- The combined impact of the funded pay award and the changes to National Insurance rates is a £0.60m shortfall in funding.
- The forecast assumes that surge capacity remains open for the remainder of the winter period. A retraction of the bed base would lead to a reduction in costs and contribute to closing the forecast gap to plan.
- There is a risk that the revised scheme for Bank enhancements proves more expensive than expected or an expansion of the scheme is required due to operational pressures.
- Opportunities to reduce Agency costs are being explored including a scheme to retract from Tier 3 Nursing Agency rates.
- It is now expected that the requirements for the Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)), will be met, securing the £0.86m rebate.

COVID-19 & Recovery

Covid-19 Expenditure YTD JAN 2023	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	819	0	819
Remote management of patients	170	0	170
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	73	73
Segregation of patient pathways	10,875	443	11,319
Existing workforce additional shifts	229	0	229
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	332	332
COVID-19 virus testing - rt-PCR virus testing	182	84	266
COVID-19 virus testing - Rapid / point of care testing - all other locally procured devices	38	0	38
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	15	3	18
Total Reported to NHSI	**12,424**	**941**	**13,366**
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)	525	0	525
Support for stay at home models	0	24	24
Internal and external communication costs	0	-1	-1
Grand Total	**13,087**	**949**	**14,036**

Recovery Costs YTD JAN 2023	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	10	5,706	5,715
Additional Staffing - Medical	1,887	0	1,887
Additional Staffing - Nursing	387	0	387
Additional Staffing - Other	965	0	965
Non Pay	0	1,740	1,740
Enhanced Payment Model - Medical	0	0	0
Enhanced Payment Model - Nursing	720	0	720
Total	**3,968**	**7,446**	**11,414**

Covid-19 Costs

Year to date the Trust has incurred £14.04m 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 £13.62m versus a plan of £7.52m, an adverse variance of £6.10m. 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 £0.42m year to date.

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

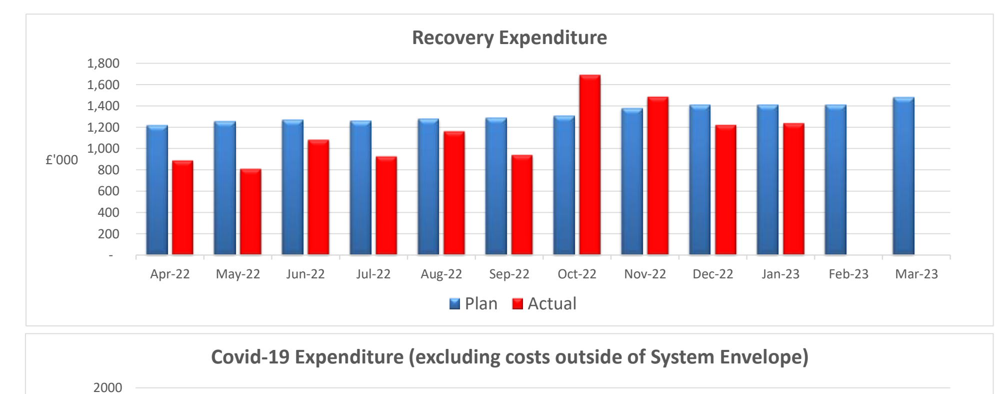
Covid-19 Funding

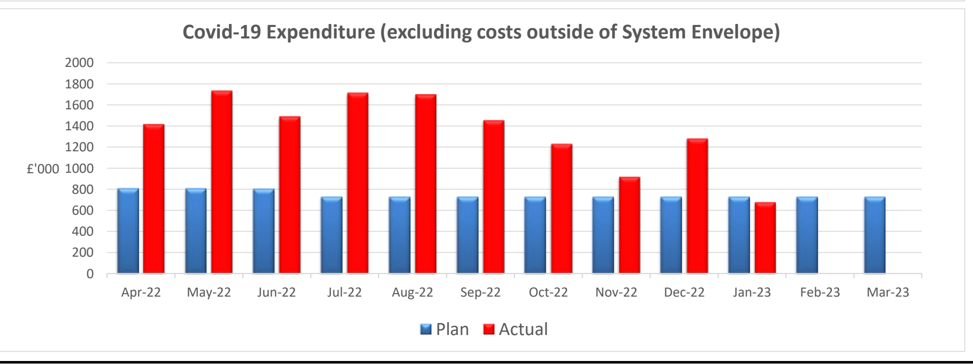
The Trust was allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £6.00m for the year (£5.00m year to date). A further £1.3m of additional funding has been allocated in Quarter 4 (£0.44m YTD), to support operational pressures.

Recovery

- Year to date Recovery costs are £11.41m, £1.67m lower than planned.
- Total planned Recovery costs for the year are £15.97m to deliver the required 104% of 19/20 activity.
- Funding of £11.72m of Elective Recovery Funding (ERF) is forecast, receipt of which should be reliant on the Trust achieving it's activity targets as planned. £9.81m of ERF has been assumed in the year to date position as planned, (profiled in line with activity plans). Funding has been secured for H1 and National guidance suggests that ERF is not likely to be clawed back in the second half of the year, although there is a local agreement to return £0.40m of the planned ERF to the Integrated Care Board (ICB) to support Independent Sector overspends in Kirklees Place.

Note: Both Covid-19 and recovery plans assumed that associated CIP schemes would be delivered in full.





16. Workforce Committee Chair Highlight Report

For Assurance

Presented by Karen Heaton

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and OD Committee
Committee Chair:	Karen Heaton.
Date(s) of meeting:	14 February 2023
Date of Board meeting this report is to be presented:	2 March 2023

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee meeting on 14 February 2023.

- Failure to meet target for EST on Fire Safety remains a concern. Issues with ESR were highlighted with an action agreed to remedy this. System issues preventing updating the module contributed and action is underway to remedy this. There needs to be a balance between face to face and 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. An update to be presented to the next meeting of the Committee in April.
- IPR- concern remains over the level of short-term sickness absence and the number of return-to-work interviews remains below target with further work planned to improve this. Completion of appraisals was improving , turnover remains high in Estates and amongst AHP colleagues, starters overall exceeded leavers , however nursing vacancies remains high. Agency and bank costs remain high and the Trust has now ceased to work with the most expensive agency.
- The Committee undertook a deep dive into vacancies and continued action is in place to reduce the number of vacancies , some of which are national shortage areas. It was noted that there is a significant difference between actual and planned vacancies, this is partly due to the increase in expanding the number of beds. The Committee raised the need for a more concerted effort from the Centre on a national recruitment campaign.

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ASSURE

- The Committee received a detailed update report on progress against the actions flowing the sickness absence audit with progress being made on a significant number of the actions.
- The disability and BAME network Groups presented and the Committee was encouraged by their plans, ideas and level of enthusiasm.
- The Trust has much stronger, well designed and more cohesive development plans and programmes in place ;this showed real commitment , energy and drive to develop and grow the potential of our colleagues.
- Overall the staff survey results were positive and the Board will receive a more detailed presentation in due course.
- The Board Assurance Framework covering Medical Staffing was discussed and whilst it was recognised the score hadn't changed and the environment

remained challenging the actions to mitigate the risk gave the Committee assurance this was being well managed.

- The internal audit report covering medical revalidation prompted no recommendations and an absolute credit to the Medical Director and his team.

AWARE

- Staffing levels continue to remain a challenge alongside turnover. Although recruitment has been going well and in particular international recruitment.
- The Committee is revising its approach to include presentations from Divisions on a themed approach which will provide a better overview of the actions and progress taking place against the People Strategy themes.
- 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.

17. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Integrated Performance Report

December 2022

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	YTD	Performance Range		
SAFE																Green	Amber	Red
Never Events	2	0	0	0	1	0	1	1	1	0	0	0	0	**1**	**4**	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%**	**49.89%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.62%	98.23%	98.23%	98.39%	98.05%	98.16%	**in arrears**	**97.89%**	>=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%	92.03%	90.41%	91.78%	91.86%	92.44%	**in arrears**	**91.65%**	>=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%	80.34%	**in arrears**	**81.06%**	>=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%	93.26%	94.24%	93.38%	**in arrears**	**94.74%**	>=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%	95.31%	92.81%	96.79%	98.03%	**in arrears**	**94.19%**	>=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**	**2**	0		>=0
Preventable number of Clostridium Difficile Cases	5	1	1	0	0	2	1	1	0	0	0	0	0	**0**	**7**	<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				**105.86**	<=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			**102.26**	<=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%**	**70.77%**	>=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%**	**26.15%**	>=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%	98.23%	**95.84%**	**97.44%**	>=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%	**98.17%**	**98.40%**	>=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%	99.45%	97.85%	98.90%	99.02%	99.11%	**98.76%**	**98.73%**	>=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%	97.44%	97.30%	93.94%	**100.00%**	**98.08%**	>=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%	**98.55%**	**99.57%**	>=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%	48.00%	**83.33%**	**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%	85.96%	90.69%	92.22%	**90.16%**	**88.87%**	>=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%	70.37%	78.57%	**90.00%**	**82.22%**	>=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%	75.92%	73.66%	77.37%	78.14%	77.15%	**77.19%**	**76.41%**	>=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%**	-	<=4.75%	<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%**	-	<=3.0%	<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%**	-	<=1.75%	<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%**	-	>=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%**	-	>=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%**	-	>=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**	**-2.79**			

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 (104 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.
- Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs.
- 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.
- 3 Colleagues in Community division have just been awarded the Queens Nurse accreditation, taking the number of accreditations within Division to 6 serving as leaders and role models within Community nursing.
- 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.
- Theatre lists still not up to pre-covid numbers but pipeline staffing showing a positive position over the next few weeks and months.
- Some specialties i.e. large complex cases are not recovering at the same pace as others.
- 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.
- Trust Estate and dual site configuration reduces flexibility.

Opportunities

- The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period.
- The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy -in.
- Medicine is enacting plans to effectively use allocated face to face clinic capacity to ensure this is used effectively across all specialties to ensure patients with the highest priority are seen.
- 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.
- Patient appliance trustwide budget is to be consolidated into the community division, this will come with a cost pressure but streamlines operational pressures and improves patient pathways.
- 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.
- 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 boked 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.
- Significant delay in Theatre refurbishment (theatres 7 & 8), unable to commence as plan, in conversation re: delaying until next year due to threat to recovery.
- 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 within the division due to Private Ambulance costs over and above CCG YAS commissioned service. This service has moved to the corporate division from May 2022.
- Risk of further vacancies in community nursing due to local organisations rebanding DN roles to Band 7. It has now been agreed to uplift Community DN's to band 7 backdated to January 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 December and Forecast

Point of Delivery	YTD Performance Against 2019/20 and 104% Target				Performance Against 2022/23 Plan				Forecast Performance Against 2019/20 and 104% Target			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	2022/23 Plan YTD - activity	2022/23 Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Daycase	35,750	37,699	1,949	105.5%					48,300	50,495	2,195	104.5%
Elective	3,939	3,393	- 546	86.1%					5,285	4,711	- 574	89.1%
Sub-total Planned Inpatient	**39,689**	**41,092**	**1,403**	**103.5%**	**41,421**	**104.4%**	**- 329**	**-0.8%**	**53,585**	**55,206**	**1,621**	**103.0%**
Outpatient First Attendances*	**108,239**	**113,941**	**5,702**	**105.3%**	**114,013**	**105.3%**	**- 72**	**-0.1%**	**143,668**	**151,878**	**8,210**	**105.7%**
Outpatient Follow-ups	195,323	224,174	28,851	114.8%	212,872	109.0%	11,302	5.8%	270,804	298,869	28,065	110.4%

* actual outpatient first activity includes an estimate of 110 attendances for OMNES (ENT) and 1251 attendances for Pioneer (ENT, Ophthalmology & Neurology) not yet input into EPR for Nov & Dec

- **Planned inpatient spells**
  - Currently delivering **103.5% of 2019/20 levels**
  - Forecasting to deliver **103.0% of 2019/20 levels** and therefore 1% (522 spells) below 104% target.

- **Outpatient first attendances**
  - Currently delivering **105.3% of 2019/20 levels**.
  - Forecasting to deliver **105.7% of 2019/20 levels** and therefore 1.7% (2,463 attendances) above 104% target

Position Against Revised Elective Recovery Trajectory

	MONTH 8 FORECAST				MONTH 9 FORECAST				MOVEMENT	
	Forecast Performance Against 2019/20 and 104% Target				Forecast Performance Against 2019/20 and 104% Target				Forecast Movement	
Point of Delivery	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast	Activity	%
Daycase	48,300	50,593	2,293	104.7%	48,300	50,495	2,195	104.5%	- 98	-0.2%
Elective	5,285	4,766	- 519	90.2%	5,285	4,711	- 574	89.1%	- 55	-1.0%
Sub-total Planned Inpatient	**53,585**	**55,359**	**1,774**	**103.3%**	**53,585**	**55,206**	**1,621**	**103.0%**	**- 153**	**-0.3%**
Outpatient First Attendances*	**143,668**	**151,697**	**8,029**	**105.6%**	**143,668**	**151,878**	**8,210**	**105.7%**	**181**	**0.1%**

- The month 8 revised elective recovery trajectory was to deliver **103.3% on DC/EL** and **105.6% on outpatient firsts**.
- The month 9 forecast maintains this position within outpatient firsts, but reflects **a small deterioration within DC/EL of 153 spells, 0.3%.** This is mainly due to the month 9 'in-month' position which was 102 spells worse than forecast (across a range of specialties).
- The revised forecast was based upon a number of agreed elective recovery actions approved at ERG as follows:
  - Day case: improved run-rate in last quarter within Endoscopy, Oral Surgery and Pain – still forecast to happen
  - Outpatient firsts: use of GUTCARE across a range of Medical specialties
    - Clinics have been agreed across medicine and funding will be fully utilised
    - Clinics set up have been a mixture of CAS clinics and face to face to maximise activity
    - Clinics where possible have utilised internal resource to maximise value for money and insourcing as a second resort, again to maximise activity
  - Spend of £200k (re-allocation from Surgery into Medicine) – still forecast in line with this

Outpatient Follow-ups – Position to December and Forecast

Point of Delivery	YTD Performance Against 2019/20 and 104% Target				Performance Against 2022/23 Plan				Forecast Performance Against 2019/20 and 104% Target			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	2022/23 Plan YTD - activity	2022/23 Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Outpatient Follow-ups	195,323	224,174	28,851	114.8%	212,872	109.0%	11,302	5.8%	270,804	298,869	28,065	110.4%

- Currently delivering at **114.8%** of 2019/20 levels and forecasting to be at **110.4%.**

Point of Delivery	MONTH 8 FORECAST: Forecast Performance Against 2019/20 and 104% Target				MONTH 9 FORECAST: Forecast Performance Against 2019/20 and 104% Target				MOVEMENT: Forecast Movement	
	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast	Activity	%
Outpatient Follow-ups	270,804	297,321	26,517	109.8%	270,804	298,869	28,065	110.4%	1,547	0.6%

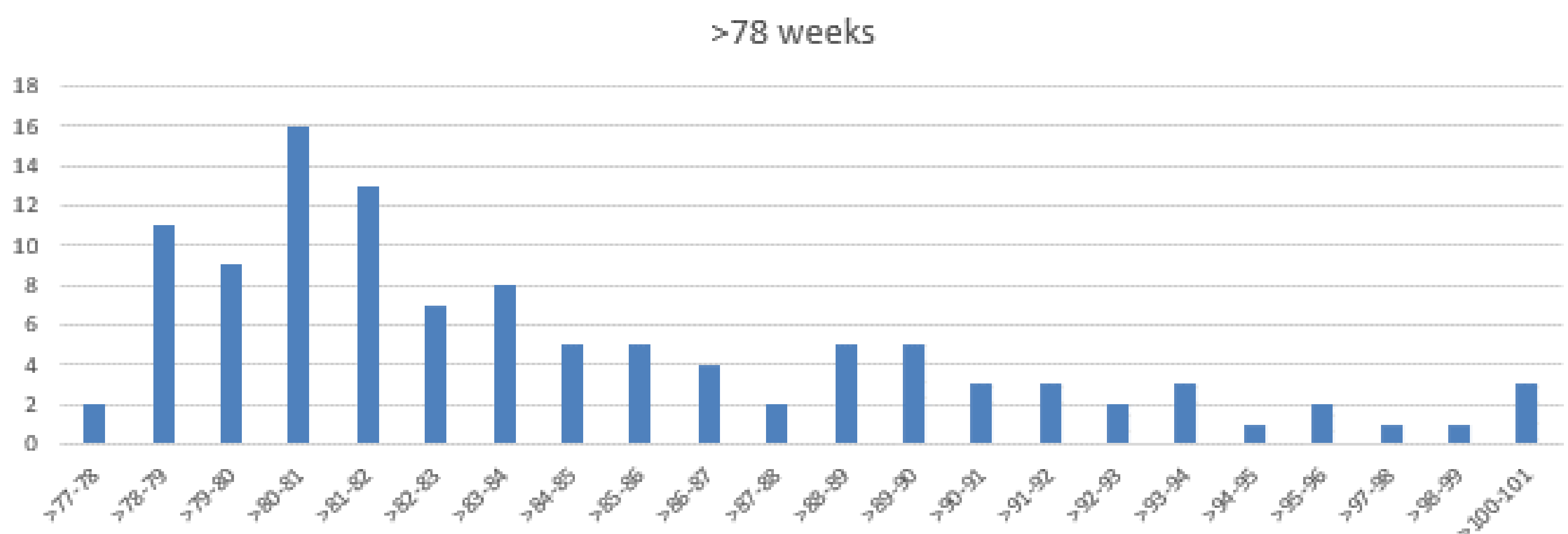
- The month 8 forecast was to deliver **109.8%** and this has increased to **110.4%** - the increase is mainly within Urology non face to face which is being reviewed to understand the movement.

Summary

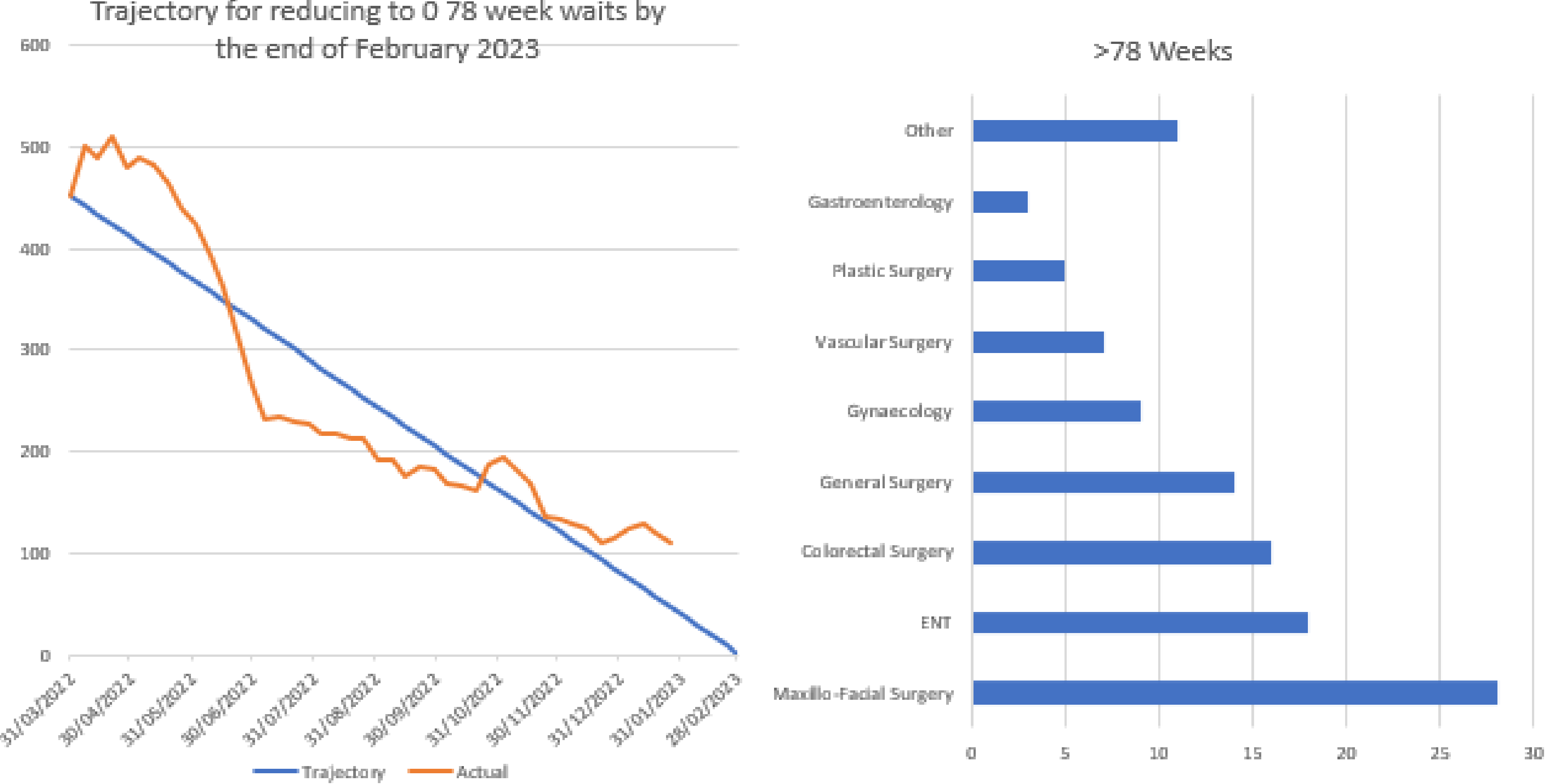
		As of 13/01/2023	Current Trajectory as	Variance to trajectory	Variance against trajectory				Main areas above Trajectory
					Medical	Surgical	FSS	Community	
Elective Backlogs	104 Weeks RTT	0	0	0	0	0	0	-	-
	78 Weeks RTT	128	66	62	11	43	9	-	Max Fax, General Surgery
	52 Weeks RTT	1044	2133	-1089	-143	-853	-93	-	Max Fax, ENT, Gastroenterology, Colorectal Surgery & General Surgery
	Total ASI's	11467	5764	5703	1789	2999	1037	12	Neurology, Max Fax & Gynaecology
	ASIs over 22 weeks	518	116	402	217	122	54	3	Neurology and Max Fax much smaller numbers in Gynaecology
	Holding List overdue	24520	5414	19106	10140	7152	1461	-	Urology, Cardiology, Dermatology, Gastro, Neurology, Respiratory Med, T&O, Ophthalmology & Gynaecology

Current 104 week wait Position

- As of the 25th January 2023 , We currently have 0 patients waiting over 104 weeks.
- Next longest waiting patient is currently at 101 weeks (has a Minor Ops appt in Early February).

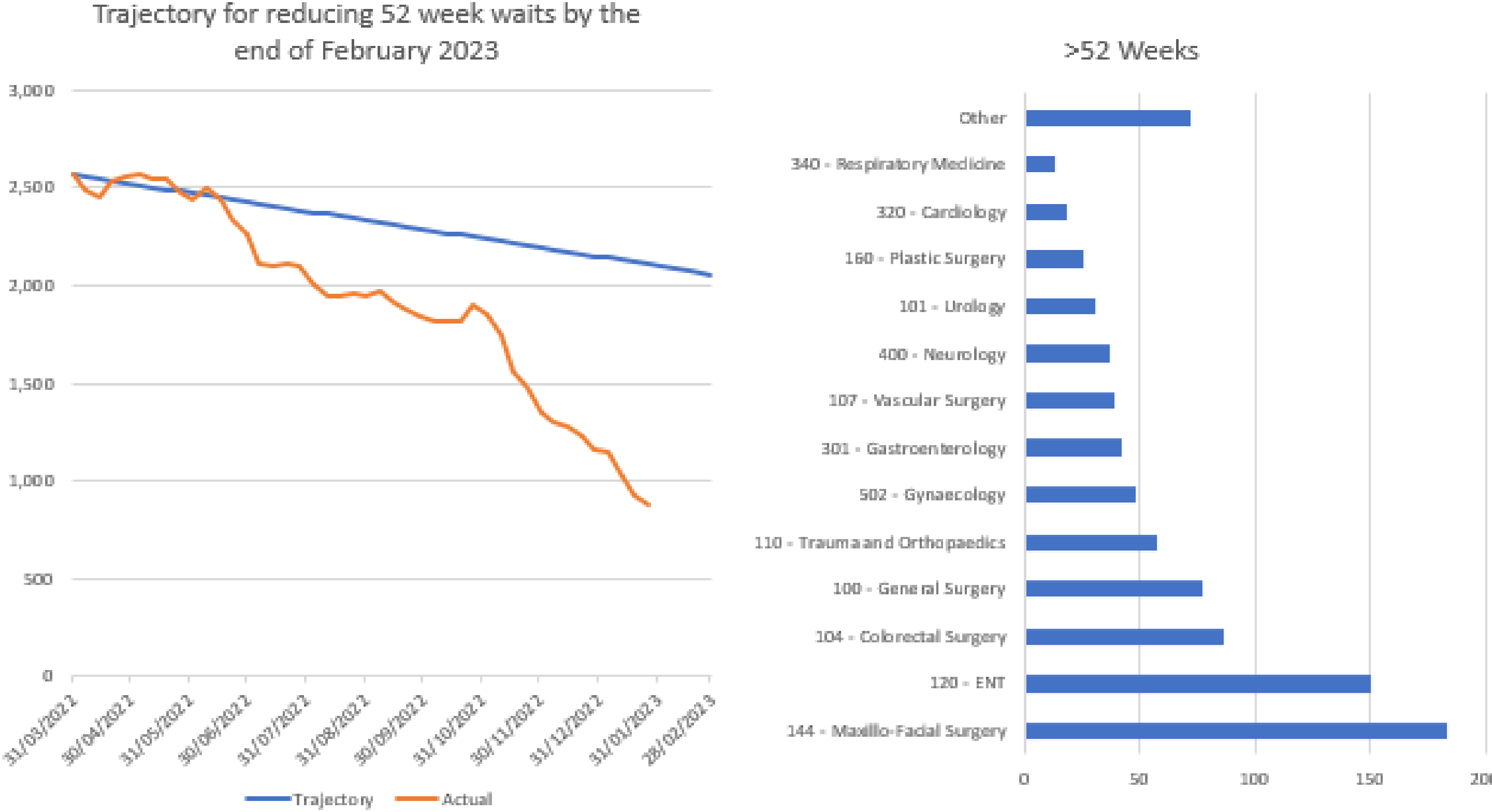


RTT – 78 Weeks



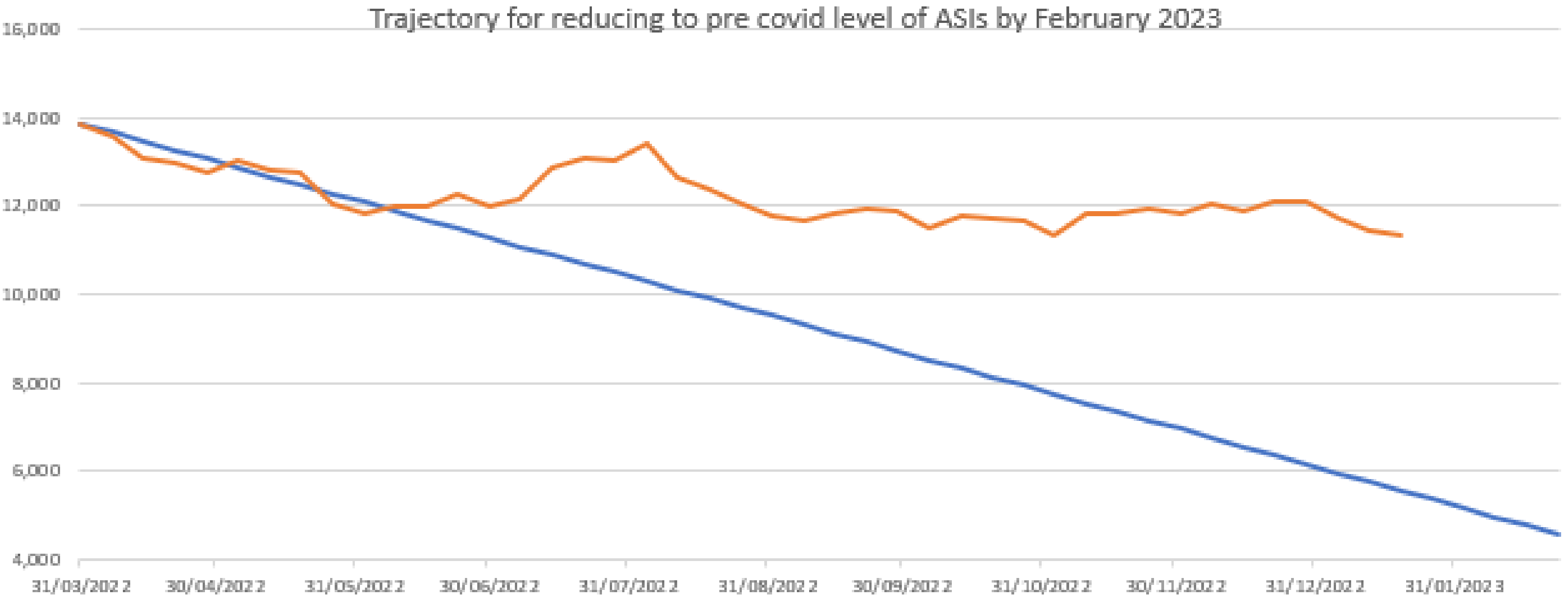
National expectation to be at zero by end of March 2023, on track to deliver.

RTT – 52 Weeks



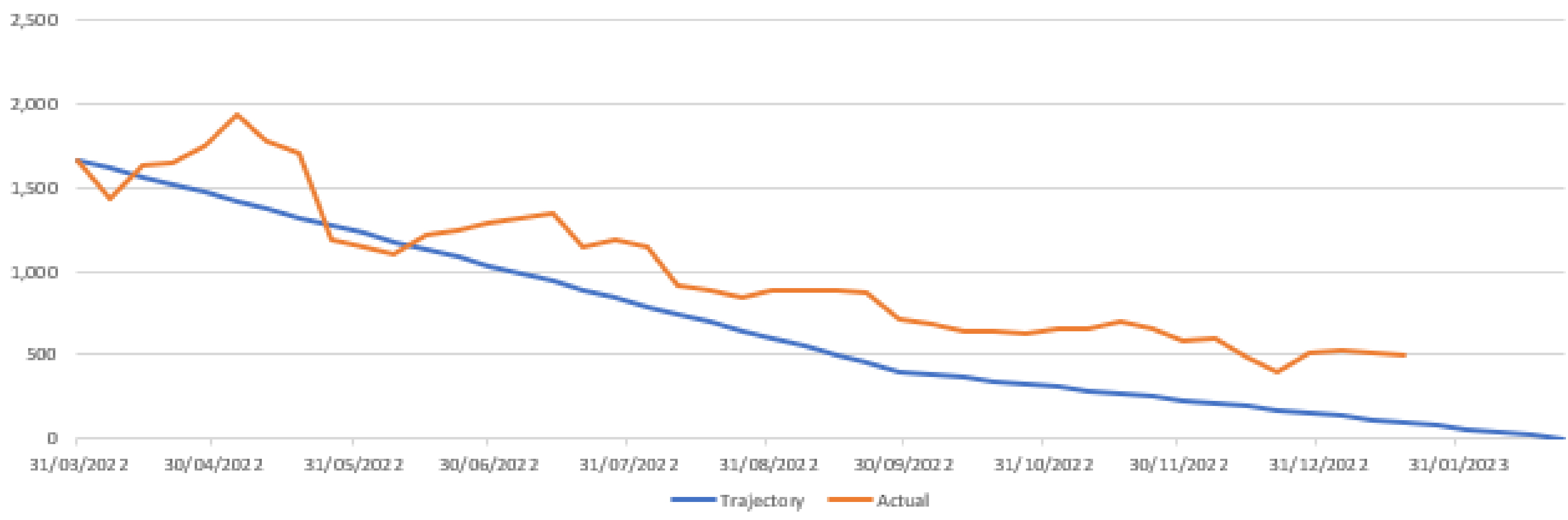
National expectation to be at zero by end of March 2025, on track to deliver NHSE ask.

Outpatients – New (total ASIs)



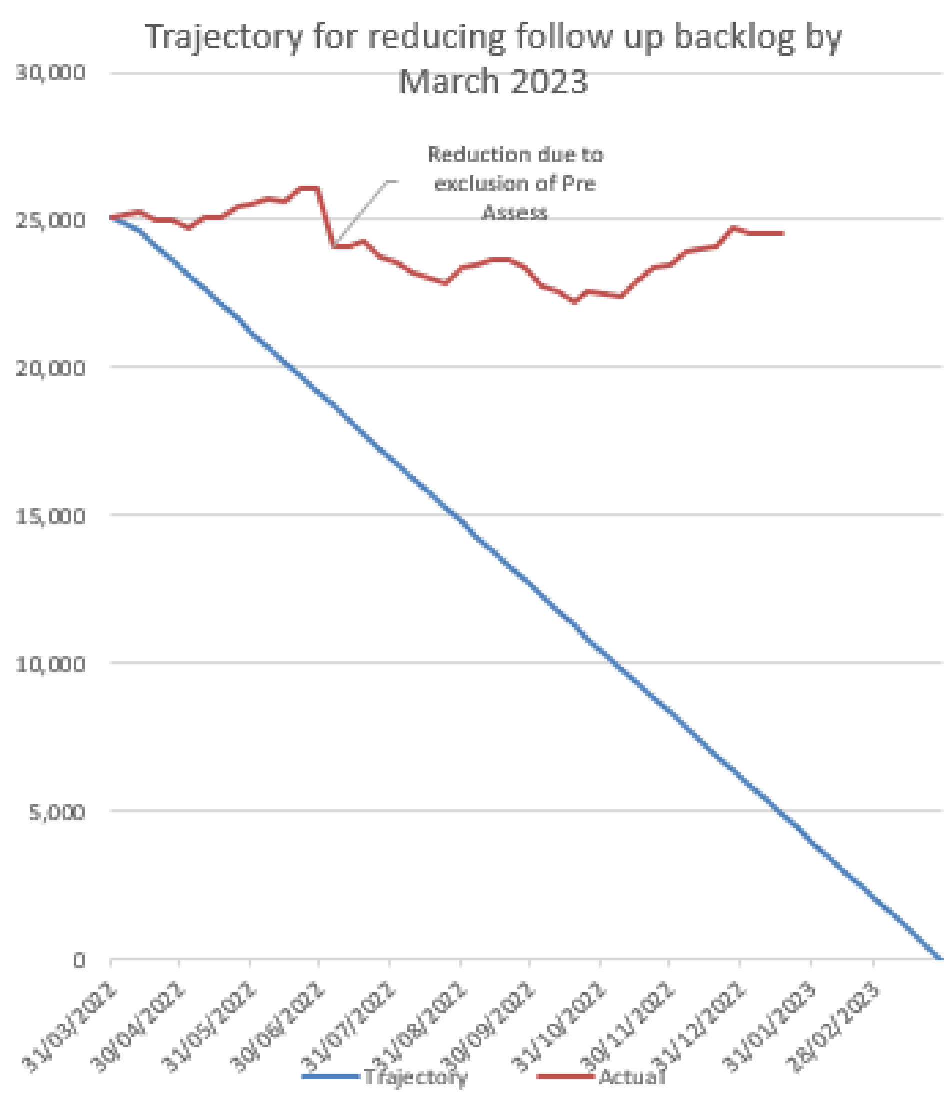
- No external target and no requirement to report centrally. Internal target to get back to pre-covid levels.
- Current ASIs = reduced by 13.6% (1,800) from 13,141 in April to 11,353 middle of January 2023
- Risk of not addressing is on overall length of RTT pathways

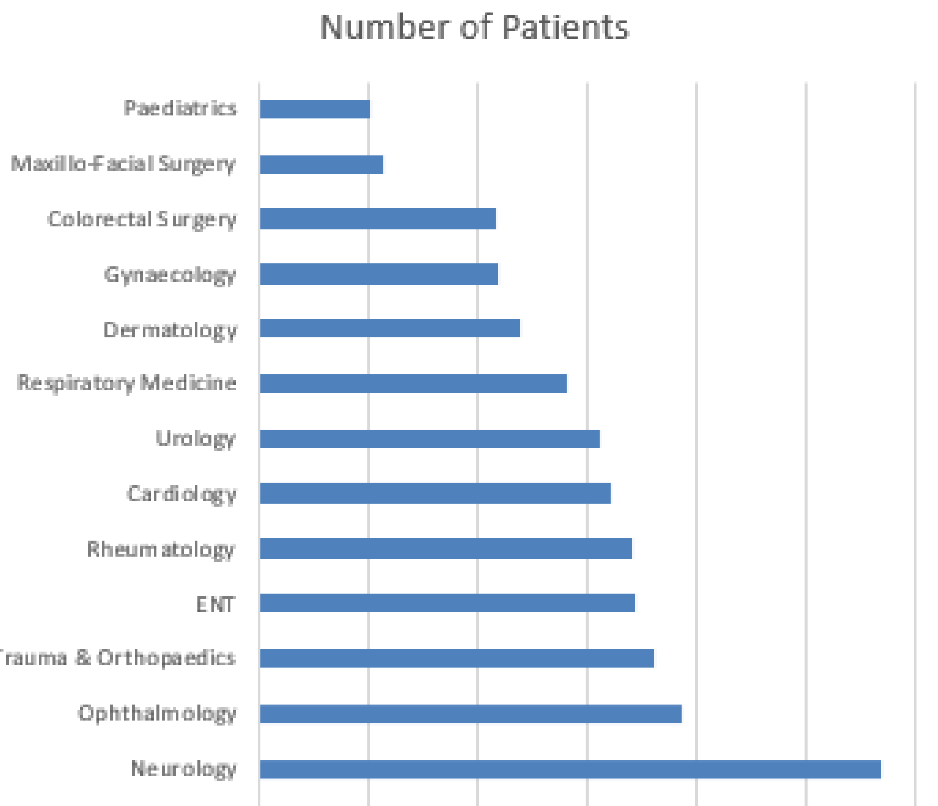
Outpatients – New (ASI > 22 weeks)



- Trajectory is a locally set target that will help achieve a reduction in 52/78 week RTT Waits. ENT ahead of plan. Other specialties behind plan, leading to the gap.
- Remaining ASIs over 22 weeks:
  - 111 in Neurology
  - 172 in Max Fax
  - 67 in Trauma & Orthopaedics

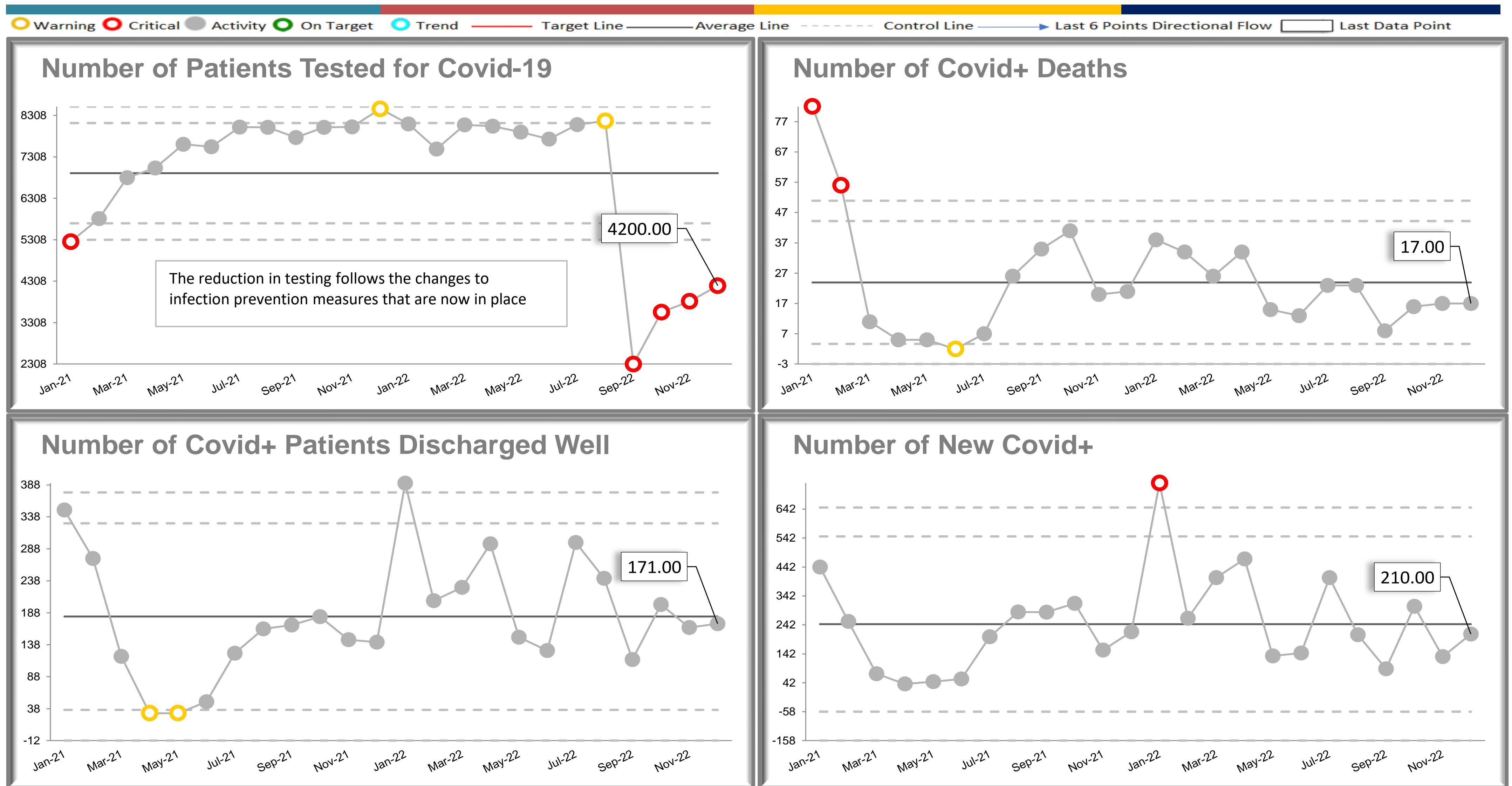
Outpatients – Follow Up



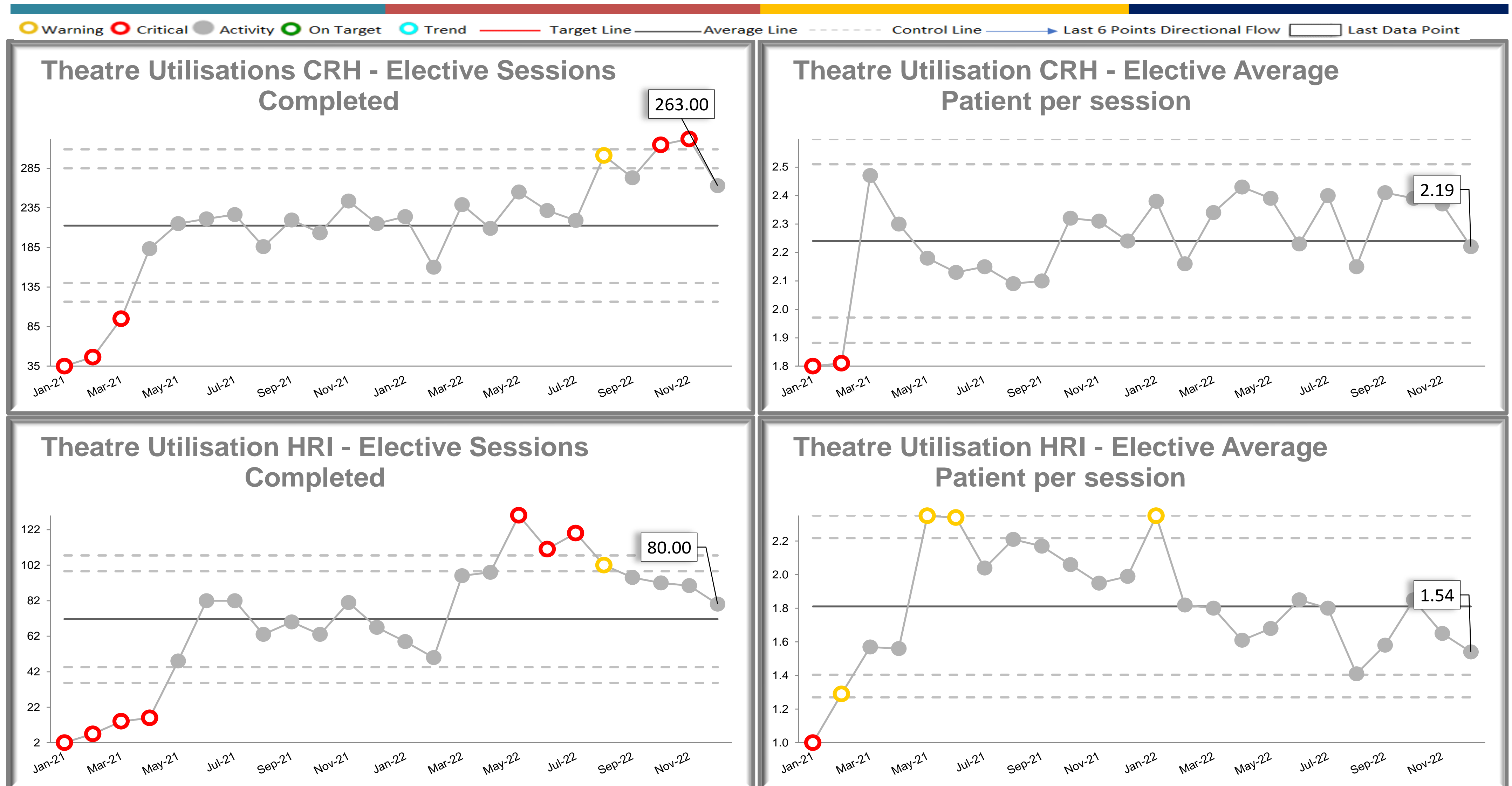


- No external target or requirement to report externally
- Internal target to reduce to 0

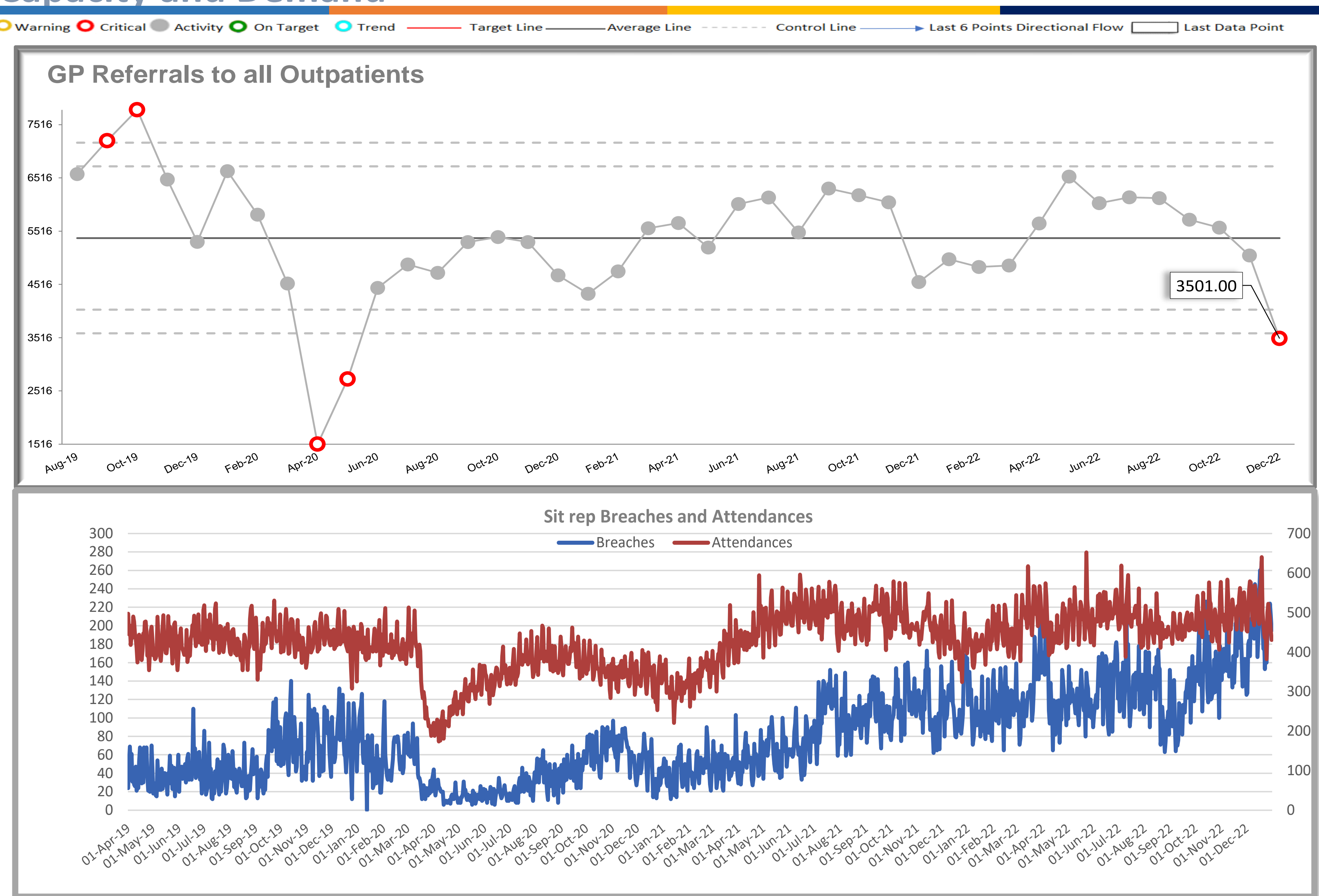
Covid-19 - Charts



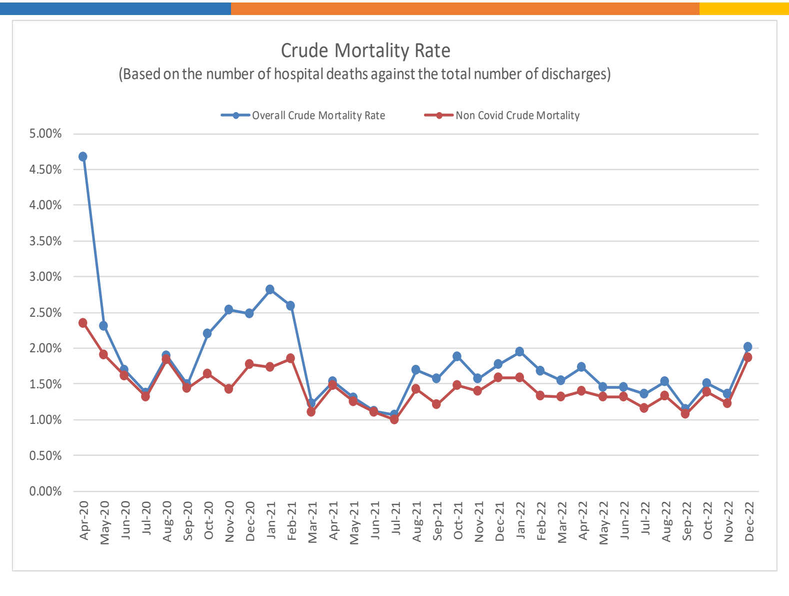
Theatres - Charts

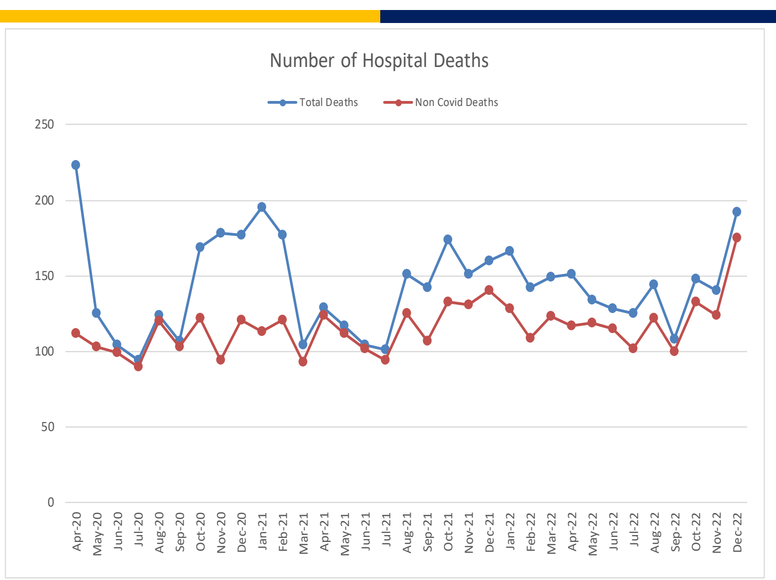


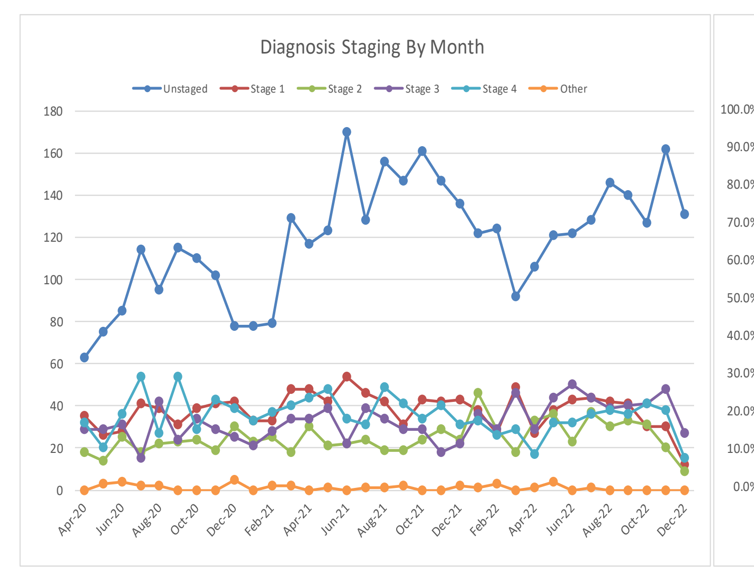
Capacity and Demand

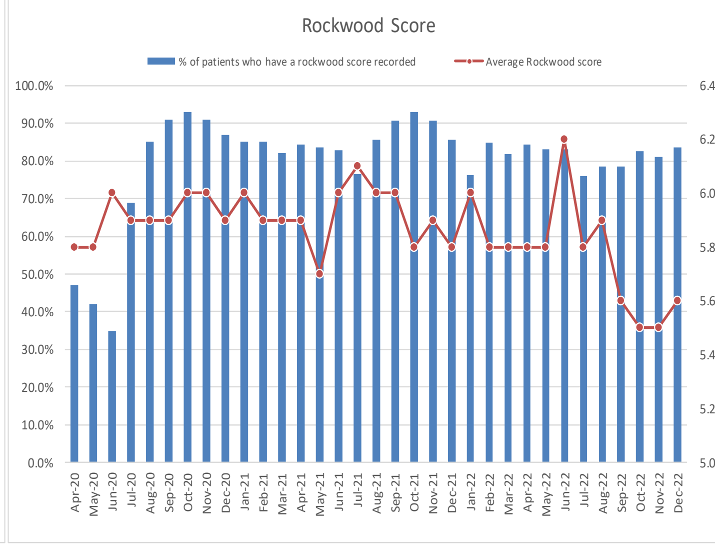


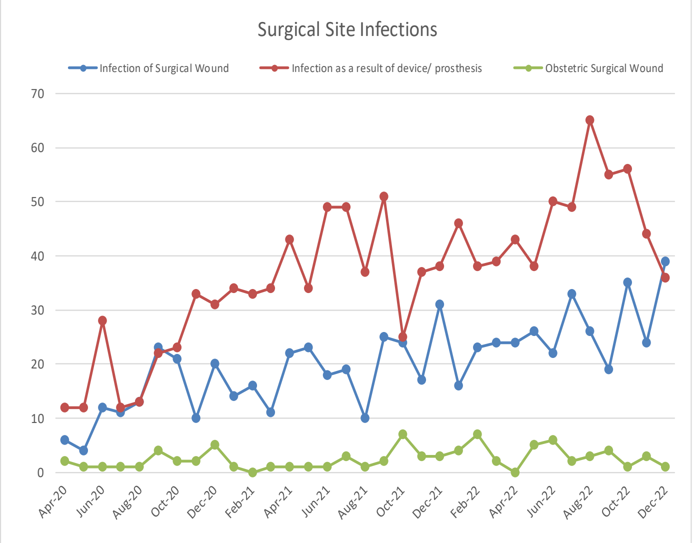
Outcome Measures











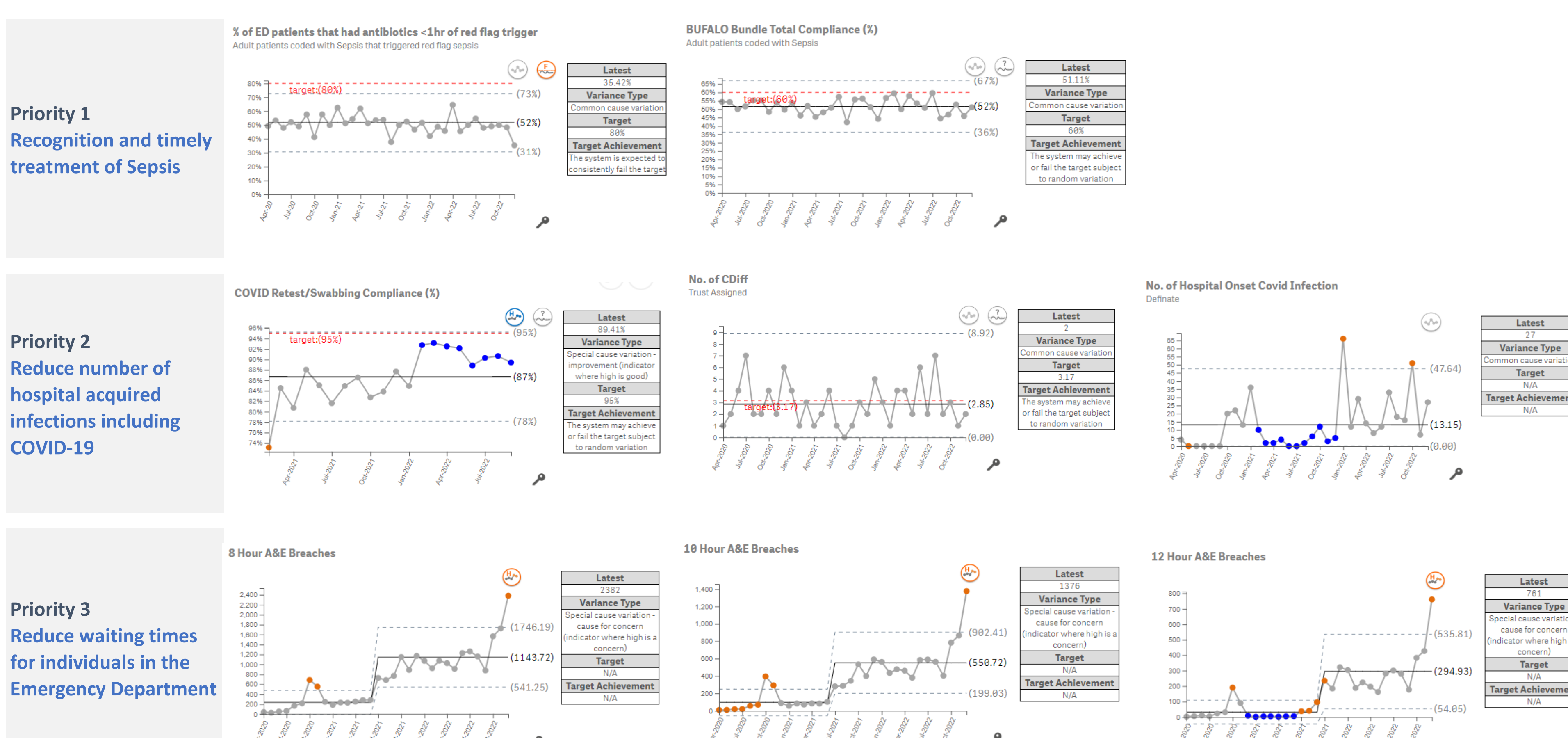
Graphs produced by the Quality Performance Team

Quality Priorities - Quality Account Priorities

Priority 1
Recognition and timely treatment of Sepsis

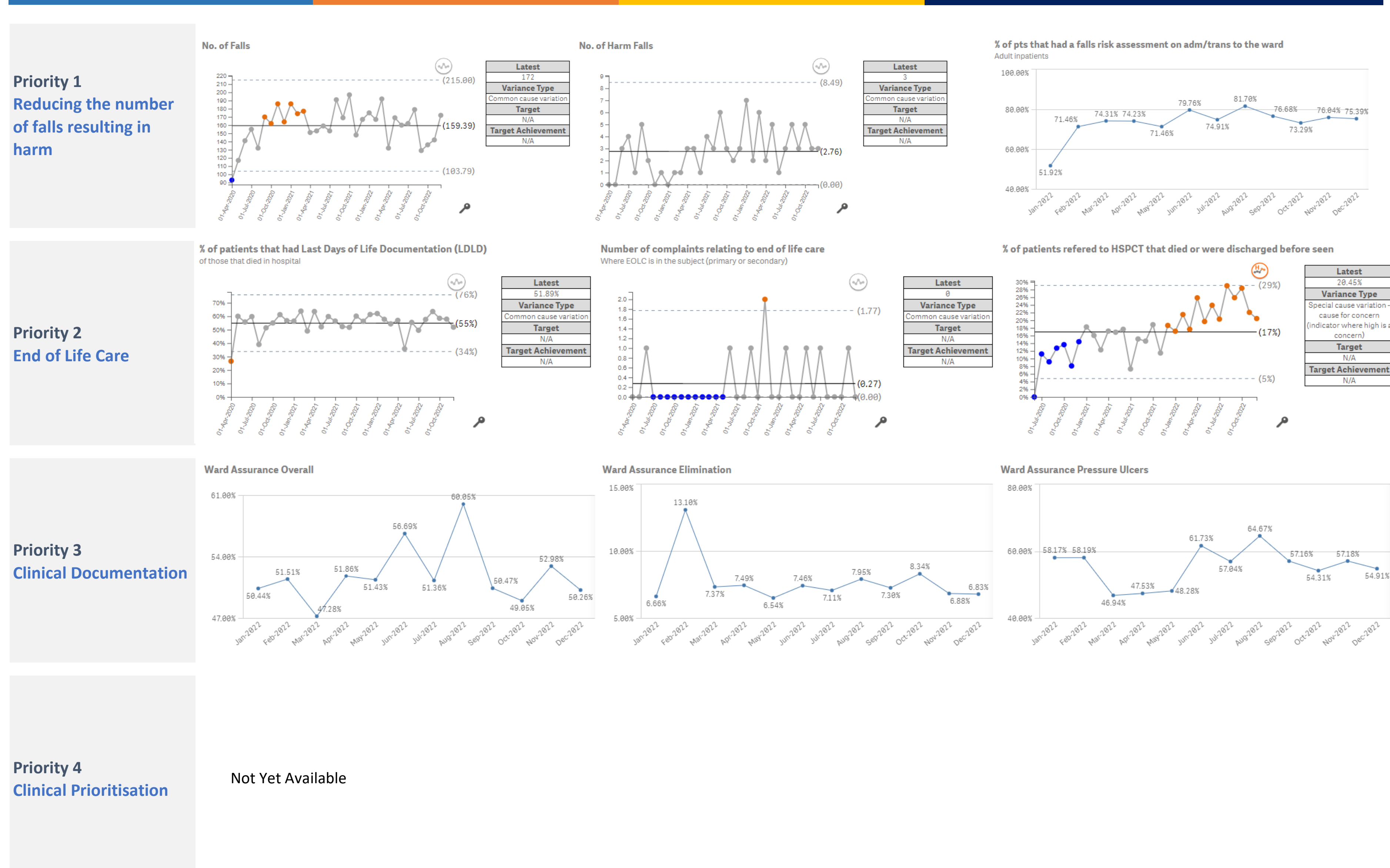
Priority 2
Reduce number of hospital acquired infections including COVID-19

Priority 3
Reduce waiting times for individuals in the Emergency Department



Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities

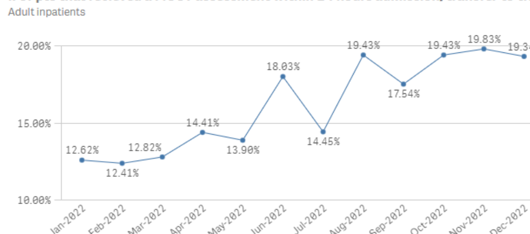


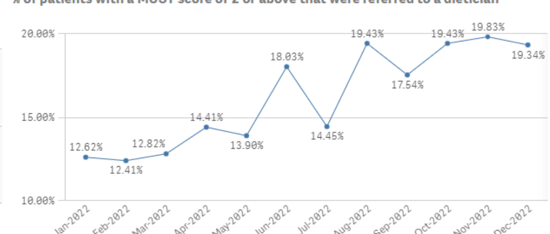
Not Yet Available

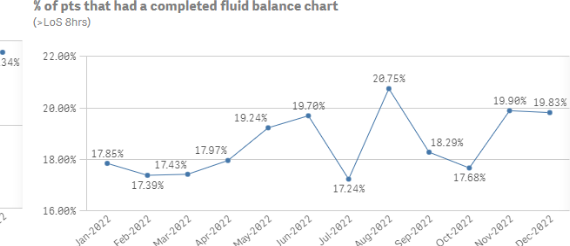
Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities

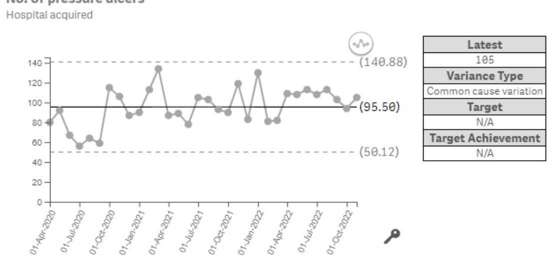
Priority 5
Nutrition and Hydration

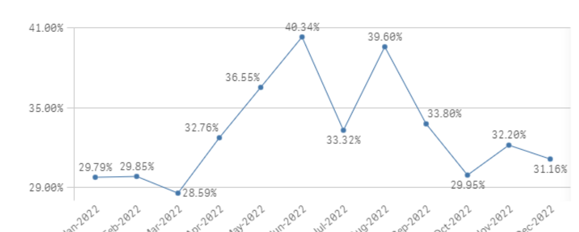






Priority 6
Reduction in the number of CHFT acquired pressure ulcers



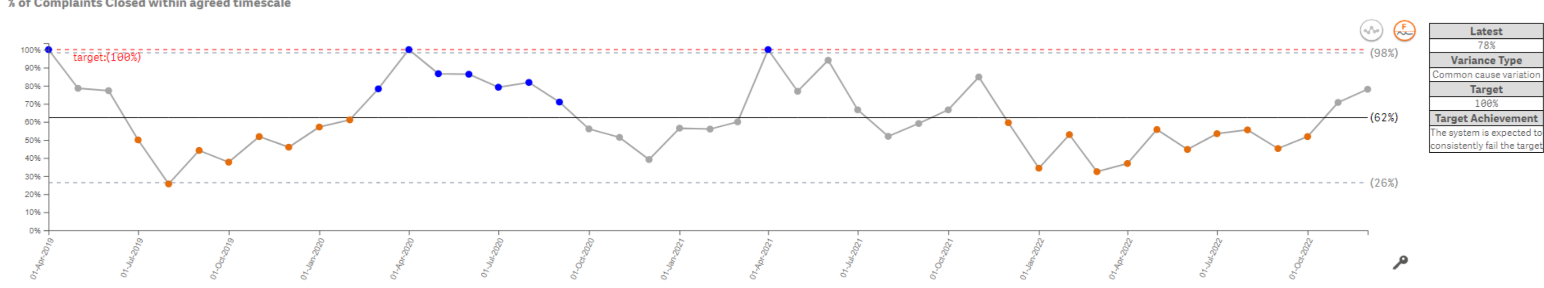


95% of relevant staff* will have completed Pressure Ulcer training in last 2 years.
*(RNs, Nursing Associates and HCAs)

Trust Compliance

85.24%

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											
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%								
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%								
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%								
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%								
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%								
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%								
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%								
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%								
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%								

CQUIN - Key Measures

Indicator Name	Reality	Response	Result
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achievement of the 5 elements of the UTI Diagnosis/ Management CQUIN requires overall compliance of >60% to receive full payment. After 1st quarter we are achieving 57% overall compliance. The element requiring greatest degree of intervention is the sampling element. Q2 data is still being verified.	A campaign is being prepared to improve urine sampling for launch early in Q3.	Aiming for overall >60% compliance for the 5elements of the CQUIN.
CCG4: Compliance with timed diagnostic pathways for cancer services	In Q2 we achieved 8% compliance, which is a small improvement from Q1 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 second 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 Q2 is 4.33% which is below the 35% target.	Response not yet available	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 first quarter we are achieving 28.4% compliance, the reason for low compliance this quarter is due to the data collection framework not being in place. Q2 data is still being validated.	Data collection framework is now in place with a meeting set to take 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

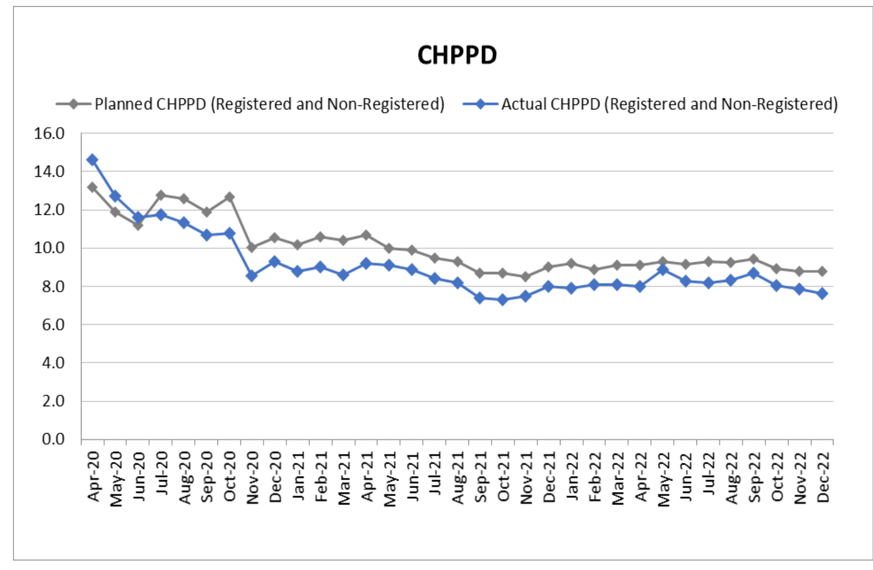
TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

	Oct-22	Nov-22	Dec-22
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	88.6%	88.6%	88.6%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	92.7%	92.7%	92.7%
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.9	8.8	8.8
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.0	7.9	7.6

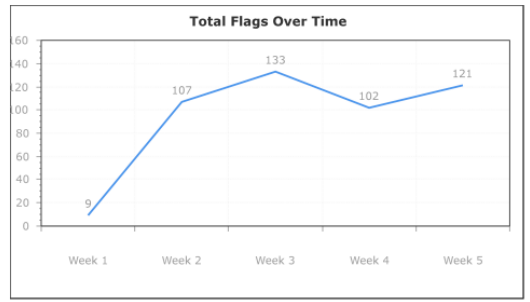
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

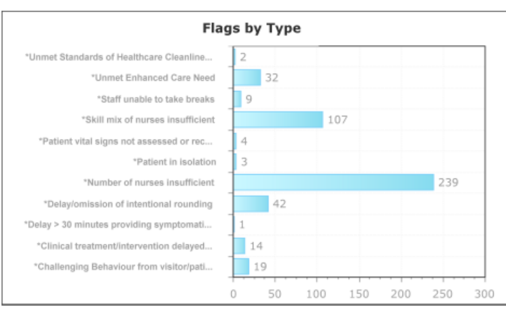
A review of December data indicates that the combined RN and Non-registered clinical staff metrics resulted in 24 of the 28 clinical areas delivering fewer CHPPD than planned, with a total deficit of 1.2 CHPPD across the Trust.
The CHPPD planned vs actual gap is most prominent in the Surgical division (2.1 CHPPD deficit). This is largely attributable to matching staffing in the elective surgical wards to patient requirement when there were reduced numbers of patients on the wards. This allowed the movement of staff to other areas where there were nursing shortfalls, including extra capacity areas to maintain safety across the Trust. The 'Actual' levels on ICU represent the staffing required to care for the patients each shift according to GPICS ratios. This on-day movement was risk assessed at the daily staffing meetings.
The deficit of 1.8 CHPPD in the FSS division is reflective of the vacancy position in both maternity and childrens' services. Daily assessments are made in areas and clinical services moved as per escalation plan (e.g. Birth Centre relocated to Labour Ward) and staff deployed into the numbers to ensure safety (e.g. Trainee Paediatric Advanced Clinical Practioners allocated to nursing shifts).

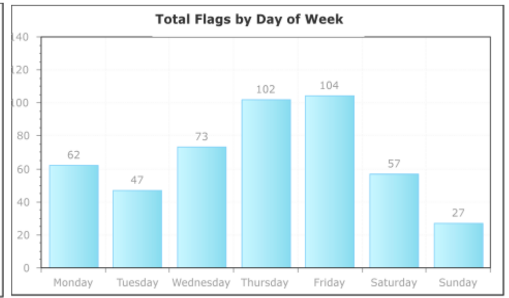
The apparent over-staffing of non-registered staff in some clinical areas represents the shift fill for patients requiring 1:1 care which are not featured in the planned workforce model.
A review of the nurse sensitive indicators demonstrates incidence of falls and pressure ulcers to be within normal variation.

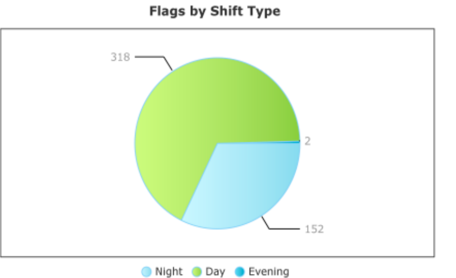


STAFFING RED FLAG INCIDENTS





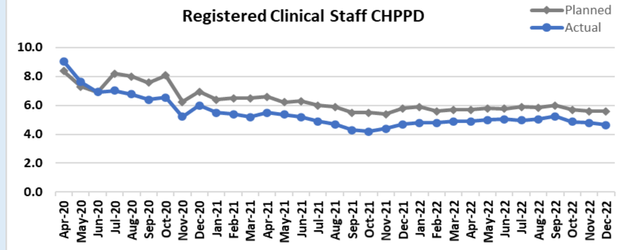
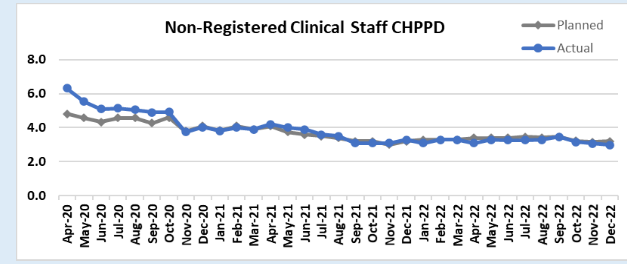




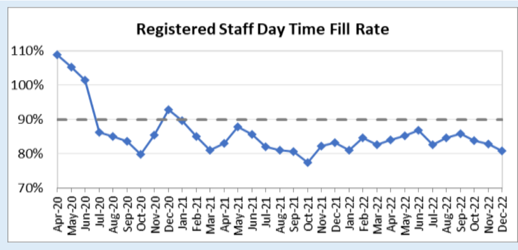
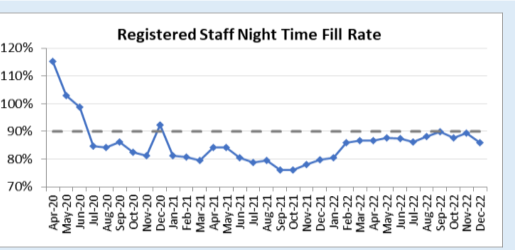
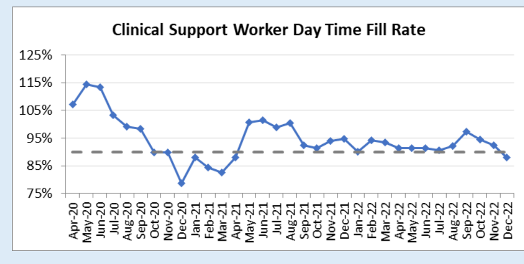
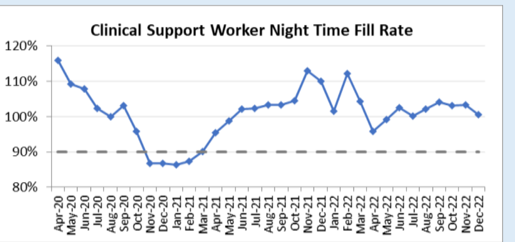
A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and monthly through the Nursing workforce strategy group.

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)

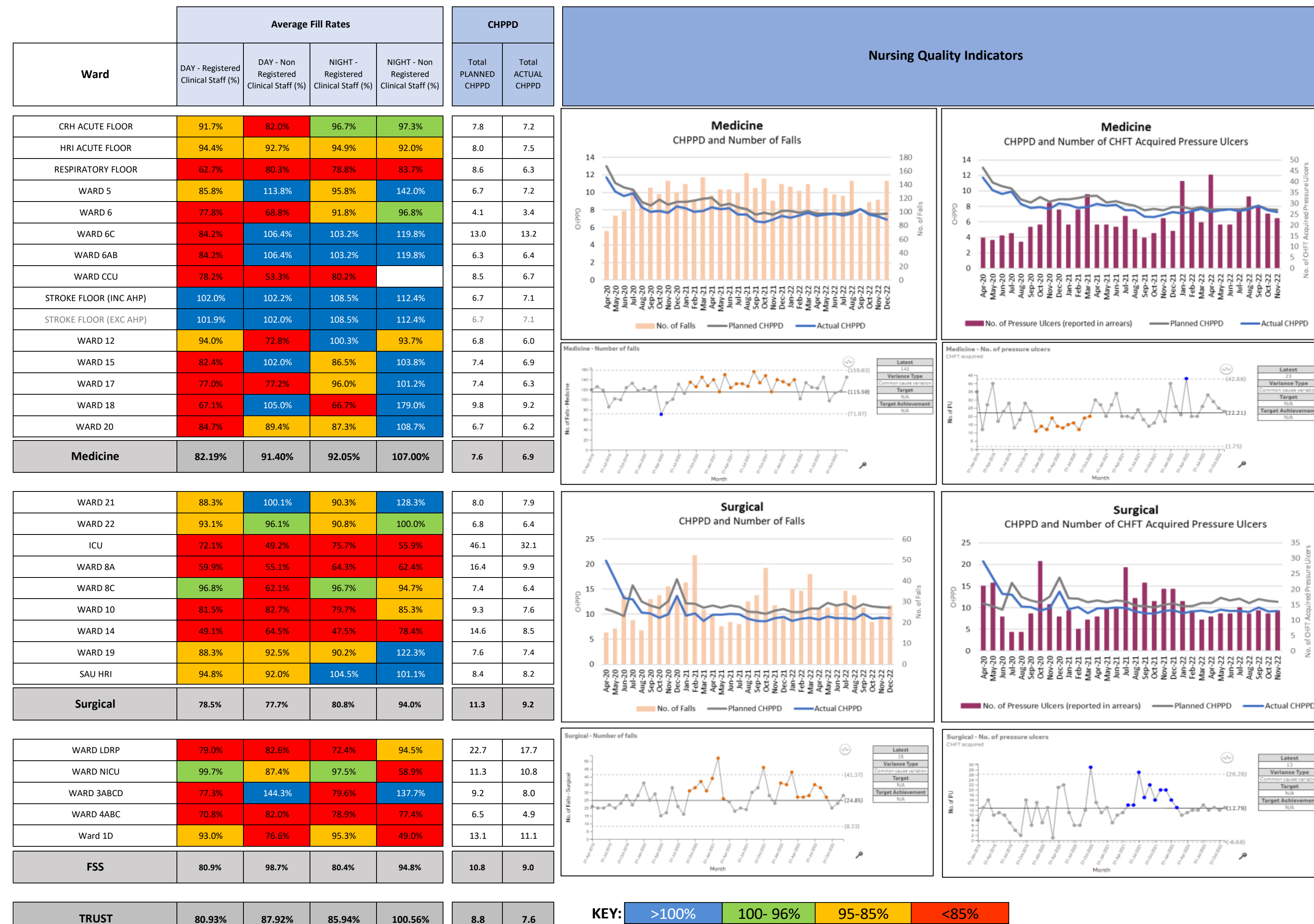
	Aggregate Position	Trend	Result
CHPPD BY STAFF TYPE			
Registered Clinical Staff Monthly hours (day and night combined) divided by average patient count at midnight	CHPPD was 5.6 for planned and 4.6 For actual for Registered Clinical Staff		Overall there is a shortfall of 1.0 CHPPD against an overall requirement of 5.6 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. Both 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 3.2 for planned and 3.0 for actual for Non-Registered Clinical Staff		There was a shortfall of 0.2CHPPD against the planned CHPPD provided by non-registered clinical staff. Nightshift fill is prioritised over day shift due the increased vulnerability of patients requiring 1:1 and having fewer health professionals on the wards and the need to mitigate against reduced RN availability.

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.	80.93% 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.	87.92% 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.	92.47% 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.	100.56% of expected Non Registered Clinical Staff hours were achieved for night shifts.	

Hard Truths: Safe Staffing Levels (3)

NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION



Ward	Average Fill Rates: DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	CHPPD: Total PLANNED CHPPD	Total ACTUAL CHPPD
CRH ACUTE FLOOR	91.7%	82.0%	96.7%	97.3%	7.8	7.2
HRI ACUTE FLOOR	94.4%	92.7%	94.9%	92.0%	8.0	7.5
RESPIRATORY FLOOR	62.7%	80.3%	78.8%	83.7%	8.6	6.3
WARD 5	85.8%	113.8%	95.8%	142.0%	6.7	7.2
WARD 6	77.8%	68.8%	91.8%	96.8%	4.1	3.4
WARD 6C	84.2%	106.4%	103.2%	119.8%	13.0	13.2
WARD 6AB	84.2%	106.4%	103.2%	119.8%	6.3	6.4
WARD CCU	78.2%	53.3%	80.2%		8.5	6.7
STROKE FLOOR (INC AHP)	102.0%	102.2%	108.5%	112.4%	6.7	7.1
STROKE FLOOR (EXC AHP)	101.9%	102.0%	108.5%	112.4%	6.7	7.1
WARD 12	94.0%	72.8%	100.3%	93.7%	6.8	6.0
WARD 15	82.4%	102.0%	86.5%	103.8%	7.4	6.9
WARD 17	77.0%	77.2%	96.0%	101.2%	7.4	6.3
WARD 18	67.1%	105.0%	66.7%	179.0%	9.8	9.2
WARD 20	84.7%	89.4%	87.3%	108.7%	6.7	6.2
Medicine	82.19%	91.40%	92.05%	107.00%	7.6	6.9
WARD 21	88.3%	100.1%	90.3%	128.3%	8.0	7.9
WARD 22	93.1%	96.1%	90.8%	100.0%	6.8	6.4
ICU	72.1%	49.2%	75.7%	55.9%	46.1	32.1
WARD 8A	59.9%	55.1%	64.3%	62.4%	16.4	9.9
WARD 8C	96.8%	62.1%	96.7%	94.7%	7.4	6.4
WARD 10	81.5%	82.7%	79.7%	85.3%	9.3	7.6
WARD 14	49.1%	64.5%	47.5%	78.4%	14.6	8.5
WARD 19	88.3%	92.5%	90.2%	122.3%	7.6	7.4
SAU HRI	94.8%	92.0%	104.5%	101.1%	8.4	8.2
Surgical	78.5%	77.7%	80.8%	94.0%	11.3	9.2
WARD LDRP	79.0%	82.6%	72.4%	94.5%	22.7	17.7
WARD NICU	99.7%	87.4%	97.5%	58.9%	11.3	10.8
WARD 3ABCD	77.3%	144.3%	79.6%	137.7%	9.2	8.0
WARD 4ABC	70.8%	82.0%	78.9%	77.4%	6.5	4.9
Ward 1D	93.0%	76.6%	95.3%	49.0%	13.1	11.1
FSS	80.9%	98.7%	80.4%	94.8%	10.8	9.0
TRUST	80.93%	87.92%	85.94%	100.56%	8.8	7.6

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

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

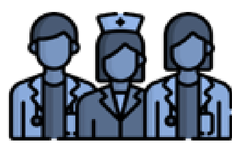
Conclusions

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

Ongoing 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.
2. The Nursing and Midwifery Workforce Steering Group is progressing work to understand the detail of the vacancy position and potential leavers and aligning this to the recruitment/training strategy in partnership with the local HEI, as well as high impact retention strategies.
3. A section on Knowledge Portal Plus has been developed to support triangulation of the workforce position to the agreed suite of nurse sensitive indicators and has been supported with a staff engagement and training exercise.
4. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment and retention strategies. The Safer Nursing Care Tool (Acuity/Dependency Scoring) is currently being used on in-patient wards and the emergency departments to collect data to inform the next bi-annual review.
5. The International recruitment project continues to progress. There are currently 52 nurses in the OSCE preparation process who are anticipated to go into shiftfill numbers by April 2023. The latest funding support offer from NHSE is being considered to inform our planned intake from March to November 2023.
7. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to assist the RN workforce recruitment strategy.
8. There is a commitment to retract from Agency spending, commencing with the high cost agencies.
9. A recent external audit has provided highly significant assurance of the CHFT nurse staffing governance processes.

Workforce Metrics
January 2022

The Cupboard
One Culture of
care



Target:
Vacancies (NHSi submitted position) – 230.08 FTE

Workforce

Headcount	↑	6191
Actual FTE	↑	5496.32
Establishment FTE	↑	5964.64
Vacancies FTE	↑	468.32

Most Vacancies:
Nursing and Midwifery **(188.58 FTE)**
Admin & Clerical **(81.23 FTE)**
Additional Clinical Services **(77.98 FTE)**

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

Non Covid- Sickness Absence

Rolling 12 month	↑	4.80%
In-month	↑	6.08%
FTE days lost per FTE (Rolling)	↑	22.04

Main Reason (in-month):
Anxiety, stress, and depression **(25.97%)**

Highest Staff Groups (in-month):
Estates & Ancillary **(10.93%)**
Additional Clinical Services **(7.44%)**

Target:
Rolling – 11.5%

Turnover

Rolling 12 month	↑	8.56%
In-month	↑	0.40%
Leavers FTE	↑	28.04

Highest Staff Groups:
Estates & Ancillary **(13.57%)**
Allied Health Professionals **(11.37%)**
Administrative & Clerical **(10.68%)**

Target:
EST - 90%
Appraisal – 95%

Essential Safety Training & Appraisal

Overall EST Compliance	↑	92.74%
Appraisal Compliance*	↑	74.47%

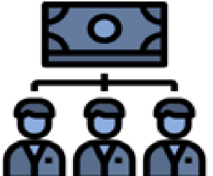
*69.06% at the end of appraisal season 2021/2022.
** Appraisal season for 2022/23 moved & extended to July to December 2022

Lowest EST Core Suite Elements:
Fire Safety **(88.12%)**
Data Security **(89.19%)**

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

Recruitment

Vacancy approval to advert placement 1	↑	7.8
Interview to conditional offer 2	↓	2.8
Unconditional offer to acceptance 3	↓	1.0



Forecast Budget (YTD):
Substantive - £222.6M
Agency - £4.5M
Bank - £13.0M

Spend (YTD)

Substantive	£211.8M
Agency	£10.3M
Bank	£24.7M

Highest Agency Spend:
Medical and Dental **(£1.8M)**
Nursing and Midwifery **(£7.9M)**

All data correct as at 31 December 2022

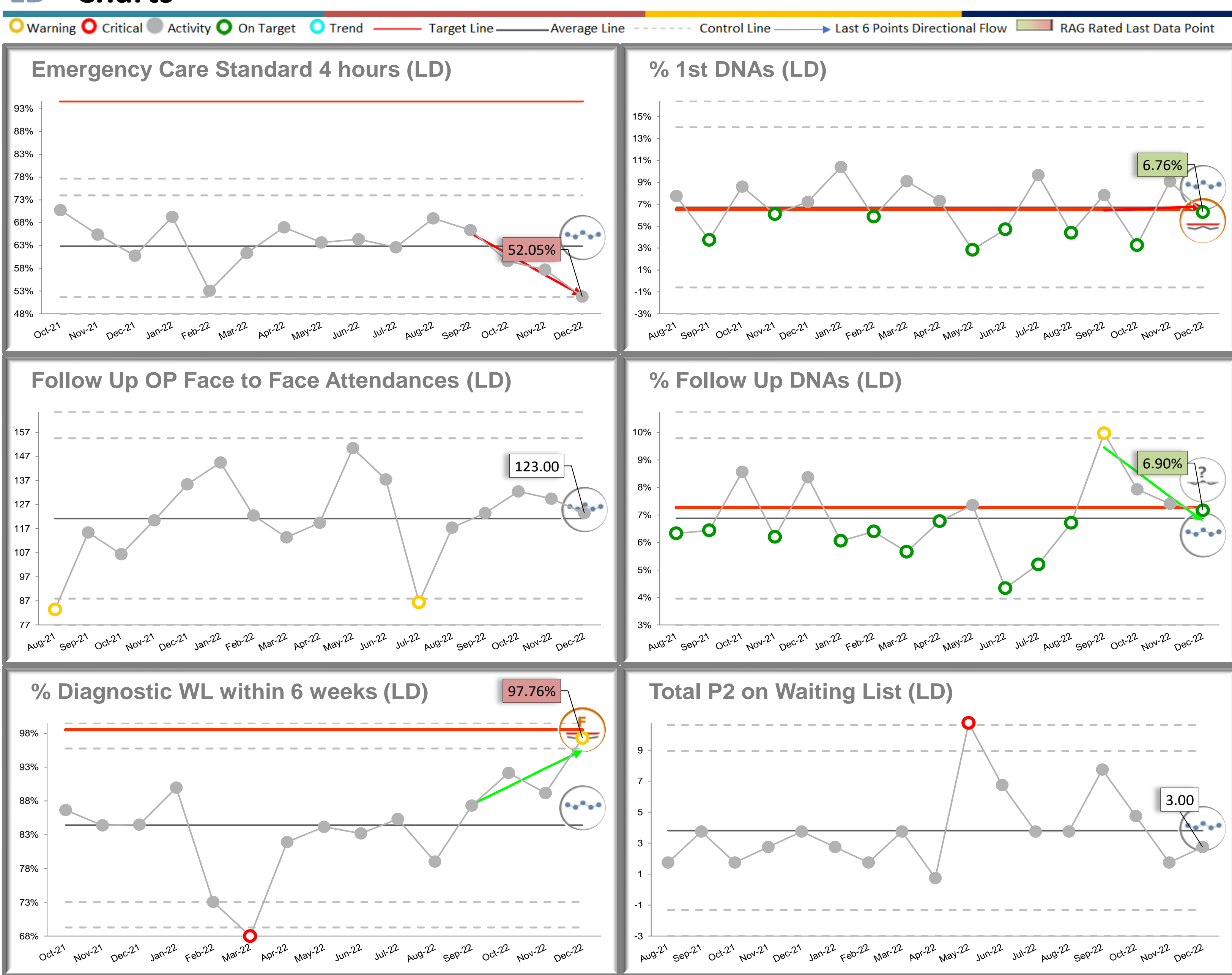
Directorate Health Heatmap

Directorate	Division	NHS SS Response Rate 2022 (Early Data)	Engagement Score 2021	EST (Dec 2022)	AfC Appraisal 2022-23 (YTD)	Sickness (Non-Covid) (12m)	Annual Leave Usage Apr-Dec 2022	Turnover (12m)	Vacancy Rate (Dec 2022)	Health Score
Community Management	Community	58.8%	7.4	98.3%	93.5%	2.12%	76.05%	4.3%	-3.9%	94.4%
Workforce and Organisational Development	Corporate	81.0%	7.6	98.1%	98.9%	2.68%	80.86%	12.0%	-1.7%	94.4%
Finance	Corporate	82.2%	8.0	99.5%	95.0%	0.82%	77.67%	4.8%	-2.7%	88.9%
Information	Health Informatics	85.5%	7.8	98.4%	89.6%	2.24%	81.35%	5.8%	0.5%	88.9%
FSS Management	Families & Specialist Services	56.7%	7.2	95.6%	96.3%	3.36%	77.24%	9.7%	5.4%	88.9%
Medical Divisional Management	Medical	54.5%	7.4	93.9%	73.3%	5.10%	45.57%	3.2%	-1.9%	72.2%
Surgical Divisional Support	Surgery & Anaesthetics	68.9%	7.8	92.7%	64.5%	4.40%	47.63%	7.6%	6.4%	72.2%
Critical Care	Surgery & Anaesthetics	51.2%	6.5	97.7%	53.5%	7.37%	71.87%	7.6%	-10.3%	66.7%
Outpatients & Records Services	Families & Specialist Services	57.8%	6.5	99.1%	98.1%	5.02%	87.47%	13.5%	16.0%	66.7%
General Surgery	Surgery & Anaesthetics	34.5%	6.9	95.1%	86.9%	3.20%	72.58%	5.8%	2.3%	66.7%
Head & Neck	Surgery & Anaesthetics	37.8%	6.7	98.0%	88.9%	4.89%	73.30%	10.9%	5.2%	66.7%
Surgical Medical Secretaries	Surgery & Anaesthetics	58.1%	6.9	98.1%	57.1%	5.03%	79.62%	10.0%	8.3%	61.1%
Community Therapies	Community	51.0%	7.0	95.4%	90.3%	4.05%	75.00%	12.7%	6.9%	61.1%
Quality	Corporate	59.0%	7.3	93.4%	53.3%	5.19%	69.68%	8.5%	-7.4%	61.1%
Pharmacy	Families & Specialist Services	46.9%	6.7	97.7%	92.4%	3.80%	77.69%	15.3%	10.1%	61.1%
Corporate Services	Corporate	70.4%	8.1	94.1%	63.5%	2.02%	61.23%	14.4%	-1.2%	55.6%
Corporate & Operations	Health Informatics	64.0%	7.1	97.2%	90.6%	1.82%	68.51%	13.3%	7.0%	55.6%
Radiology	Families & Specialist Services	43.0%	6.3	96.0%	89.4%	2.90%	58.00%	10.7%	9.8%	55.6%
Pathology	Families & Specialist Services	39.1%	6.4	98.9%	94.5%	5.51%	73.43%	10.8%	10.1%	50.0%
Childrens	Families & Specialist Services	40.8%	6.9	95.6%	71.9%	4.19%	65.73%	6.5%	9.3%	50.0%
Pharmacy Manufacturing Unit	Pharmacy Manufacturing Unit	62.3%	6.1	94.2%	98.1%	6.06%	78.94%	23.6%	13.7%	50.0%
Community Nursing	Community	33.8%	7.1	92.7%	80.8%	6.39%	73.22%	5.6%	6.7%	44.4%
Womens	Families & Specialist Services	44.1%	6.3	93.5%	72.9%	5.22%	66.86%	7.0%	17.5%	44.4%
Operating Services	Surgery & Anaesthetics	31.6%	6.2	91.1%	68.1%	5.60%	73.43%	6.3%	1.2%	44.4%
Medical Specialties	Medical	32.1%	6.3	93.6%	45.3%	4.71%	57.33%	6.3%	13.8%	38.9%
Integrated Medical Specialties	Medical	30.3%	6.8	94.1%	66.2%	5.12%	66.27%	9.0%	7.6%	38.9%
Corporate Central Operations	Corporate	28.8%	-	91.9%	27.0%	8.82%	70.19%	7.5%	11.3%	37.5%
Acute Medical	Medical	27.1%	6.4	94.0%	63.1%	6.70%	62.14%	6.4%	12.9%	33.3%
Emergency Care	Medical	28.4%	6.3	90.8%	77.2%	5.17%	63.26%	4.2%	7.6%	33.3%
Orthopaedics	Surgery & Anaesthetics	25.7%	6.0	95.5%	63.7%	4.88%	67.75%	11.2%	9.3%	27.8%
Service Delivery	Health Informatics	-	-	78.0%	83.3%	12.12%	69.09%	54.5%	20.0%	0.0%

LD - Key measures

	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	YTD	Performance Range		
Recovery																Green	Amber	Red
Total P2 on Waiting List (LD)	32	4	3	2	4	1	11	7	4	4	8	5	2	**3**	**3**	No target		
Total P3 on Waiting List (LD)	119	7	8	11	11	15	17	13	10	11	11	12	7	**8**	**8**	No target		
Total P4 on Waiting List (LD)	58	3	2	1	1	2	3	4	4	2	2	3	4	**3**	**3**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	61.02%	69.57%	53.33%	61.62%	67.26%	63.93%	64.66%	62.89%	69.23%	66.67%	59.84%	57.97%	**52.05%**	**62.23%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	69	61	63	54	50	48	55	41	35	37	35	33	**35**	**35**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	45	41	47	38	10	8	8	5	4	6	5	3	**4**	**4**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.8497	0.9043	73.54%	68.48%	82.40%	84.64%	83.68%	85.80%	79.51%	87.80%	92.61%	89.63%	**97.76%**	**86.32%**	>=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%	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	100.00%	100.00%	100.00%	**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	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	100.00%	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	not applicable	not applicable	not applicable	100.00%	not applicable	**not applicable**	**100.00%**	>=90%		<89%
Activity - Number of Attendances																		
New Outpatient Attendances - Face to Face (LD)	366	38	38	24	31	37	40	41	40	48	59	38	50	**31**	**354**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	25	18	16	18	11	20	15	9	13	16	18	13	**17**	**114**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	135	144	122	113	119	150	137	86	117	123	132	129	**123**	**1116**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	47	45	56	67	57	62	61	42	48	50	55	74	**44**	**493**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	7.69%	10.87%	6.35%	9.59%	7.79%	3.33%	5.19%	10.14%	4.88%	8.33%	3.75%	9.57%	**6.76%**	**6.66%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	8.10%	5.79%	6.13%	5.39%	6.50%	7.09%	4.07%	4.93%	6.44%	9.70%	7.66%	7.14%	**6.90%**	**6.80%**	<=7.0%	7.1% - 7.9%	>=8.0%

LD - Charts



Date of Meeting:	Thursday 2nd March 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 Gemma Berriman, Director of Operations, Corporate Division
Sponsoring Director:	Jonny Hammond, Acting 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 January 2023.	
Key Points to Note	
January saw an improvement in emergency pressures with less attendances at both EDs resulting in better 4-hour performance, shorter ambulance handovers, less patients spending over 12 hours in ED and smaller numbers of 12-hour trolley waits. We continue to perform well on our Recovery Programme where our 104-week, 78-week and 52-week waits are amongst the best in the country. Unfortunately we missed 3 key cancer targets – 31-Day Subsequent Surgery Treatment, 62-Day Referral from Screening to Treatment and 28-day Faster Diagnosis Standard. This is the first time since January last year that 3 such targets have not been achieved which shows we are dealing with fine margins. We have also had another never event in January. There are still a number of areas where we have action plans in place and are yet to see some traction in performance improvement including stroke, #neck of femur and dementia screening. HSMR 1 year rolling position to November is now below 100 for the first time in over 12 months. Significant work has gone into improving our Complaints system and we have seen the best performance in a number of years in terms of responding to complaints within timeline at 94%.	
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 January 2023.

Performance
January 2023

Recovery Benchmarking
We continue to perform well in terms of our Recovery position around 104 weeks, 78 weeks and 52 weeks.

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 continued to increase, peaking in late December and early January. The second week in January saw ED attendances tail off slightly following national media interest. Covid attendances dropped throughout November, December and January however Covid inpatient numbers began rising following a spate of HOCIs peaking at 75 in early January. We have seen an expected increase in respiratory illnesses with Flu numbers growing with the dominant strain being Flu A, these peaked at the end of December and continue to fall to below 10 to date. 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. Between the end of December and the first week in January 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 115, ED attendances were high and nurse staffing was in a challenging position. This is the first time we have entered OPEL 4 and this gave us the opportunity to test our responses and actions and has led to introducing new actions and discontinuing actions that were not effective. We stayed in OPEL 4 for 1 week 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.

Although we have seen an increase in ED attendances when compared to 2019 these have not necessarily translated into emergency admissions which are actually 10% below the same period in 2019 (April to December). One area that is showing a significant increase in non-elective admissions is Respiratory Medicine where activity has increased by 30% and further work is being done to understand this increase.

Overall **acuity** at Trust level for all non-elective admissions has increased by 20%, **length of stay** by 14% (Adult Medicine 26%) which is impacting on bed pressures etc.

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.

We have not seen any significant impact from the industrial action being held by the RCN as we did not meet the threshold for striking, however we have provided support to other local organisations in terms of repatriating patients back into our bed base within 24 hours and planning this prior to the strikes.

Responding to complaints In January 2023, 34 formal complaints were closed – 32 of those were closed within agreed timeframes, which equates to 94% performance. In comparison to the previous month (78%) a 16 percentage point improvement is noted.

Since the last report was shared the number of open formal complaints has increased from 97 to

102, with 90% of these on schedule to be closed within timeframe.

An increased level of oversight and scrutiny continues at both divisional level and corporate level, with weekly oversight meetings to ensure that we continue on this trajectory.

CHFT's **HSMR** figure showed an improving position to 99.98 to the end of November 2022, from 102.26 in October 2022.

The latest **SHMI** release shows an improving position to 104.66 to the end of October 2022 from 105.86 up to the end of September 2022.

Trust benchmarking for Crude mortality has remained stable at 44th position nationally which is the same position in the previous release and remains in the 2nd quartile for national performance. Looking at the rolling 12 months figure (February 2022 – January 2023) crude mortality is 1.57% (1,760 deaths). This is largely the same performance as was seen in the previous rolling 12-month period (January 2022 – December 2022), 1.57% (1,747 deaths).

No new alerts were flagged in the recent data release.
The Trust has no alerts in HSMR between December 2021 and November 2022.

There are 3 alerts carried over in other systems as follows:
SHMI - November 2021 - October 2022 Pathological fracture - red alert.
CUSUM alert - September 2022 - COPD and bronchiectasis - amber alert.
SHMI (VLAD) HES alert - August 2022 - other liver disease - red alert.

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.

Community Services can now perform ISRs online using a tool adapted from the Trust's generic template to best suit their needs. Work is progressing to bring ED ISRs online.

A vacancy for a Structured Judgement Reviewer has been successfully filled which will assist the team, however two reviewers are currently off work meaning there remains pressure on others to perform more reviews than they would normally perform. Despite this, the majority are completed with 14 days of assignment.

From a financial point of view, in the 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, including bank and agency expenditure.

Agency expenditure year to date is £11.73m, £6.7m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has already exceeded that ceiling. The full year forecast agency expenditure is £13.9m.

ERF of £9.8m has been assumed in the year-to-date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year. National guidance suggests that ERF is not likely to be clawed back in the second half of the year.

Whilst the reported year-end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non-recurrent funding, technical flexibilities, and system support. A mitigation gap of c.£1.0m remains to be identified. The forecast assumes full delivery of a challenging £20m efficiency target and that the Trust will deliver its elective activity plan and secure £11.63m of Elective Recovery Funding.

Our rolling 12-month non-Covid **absence rate** is at 4.73% (short-term 3.08%, long-term 1.65%), a

small reduction from 4.8% in December. The January in-month rate is 5.19% (short-term 1.91%, long-term 3.28%), a significant reduction from 6.08% in December mainly due to the return to work of colleagues experiencing short-term ill health. However, staffing remains a significant challenge with the overall (including Covid related absence) in-month rate at 5.69% (6.73% in December). There is a continued need for bank and agency workers.

Essential Safety Training (EST) core programme compliance is strong albeit there is a general downward trend which is subject to close monitoring. Data Security Awareness, Fire Safety and Infection Prevention and Control EST remain below our 90% target with plans in development to remedy the position.

The 12-month turnover rate is at 8.86% and is somewhat volatile albeit this represents a second month reduction from a year-high of 9.32% in September 2022.

Overall there is a shortfall of 0.9 **CHPPD** against an overall requirement of 5.7 CHPPD for registered staff through January. 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 has also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations. Both falls and pressure ulcer prevalence remain within normal variation in month. It is noted that pressure ulcers in the Medical division have been above average for 5 consecutive months however, they have not reached the upper level of normal variance. This is being monitored closely.

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.

The Safer Nursing Care Tool (Acuity/Dependency Scoring) has been used on inpatient wards and the emergency departments to collect data through January to inform the next bi-annual review in March 2023.

The International recruitment project continues to progress. There are currently 27 nurses in the OSCE preparation process who are anticipated to go into shift fill numbers by April 2023, and a further 11 are awaiting results from the test earlier this month. CHFT have placed a bid for funding from NHSE to support recruitment of a further 30 International Nurses to arrive before the end of November 2023. We are experiencing pressures with fill rates for non-registered staff due to an increasing number of HCSW vacancies – currently at 140wte. The current pipeline is not meeting demand and there are plans to work towards the introduction of new to care roles to attract new candidates to this role.

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 meeting 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.

Integrated Performance Report

January 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	YTD	Performance Range		
SAFE																	Green	Amber	Red
Never Events	2	0	0	0	1	0	1	1	1	0	0	0	0	1	**1**	**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%**	**53.51%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.62%	98.23%	98.23%	98.40%	98.08%	97.98%	97.60%	**in arrears**	**97.86%**	>=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%	91.94%	92.44%	93.80%	**in arrears**	**91.86%**	>=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%	76.69%	**in arrears**	**80.61%**	>=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%	93.20%	97.53%	**in arrears**	**94.88%**	>=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%	95.31%	92.81%	96.79%	98.18%	86.82%	**in arrears**	**93.76%**	>=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**	**2**	0		>=0
Preventable number of Clostridium Difficile Cases	5	1	1	0	0	2	1	1	1	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				**104.66**	<=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			**99.98**	<=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%**	**70.78%**	>=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%**	**26.65%**	>=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%	98.29%	95.78%	**98.51%**	**97.54%**	>=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%**	**98.56%**	>=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%	98.87%	**98.34%**	**98.71%**	>=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%	**87.18%**	**96.89%**	>=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%	**100.00%**	**99.62%**	>=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%	85.71%	**23.53%**	**46.33%**	>=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%	**90.18%**	**88.99%**	>=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%	**52.00%**	**80.15%**	>=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%	77.37%	78.13%	77.20%	76.85%	**73.61%**	**76.12%**	>=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%**	-	<=4.75%	<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%**	-	<=3.0%	<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%**	-	<=1.75%	<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%**	-	>=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%**	-	>=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%**	-	>=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**	**-3.48**			

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 (104 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. • Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs. • 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. • Theatre lists still not up to pre-covid numbers but pipeline staffing showing a positive position over the next few weeks and months. • 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 SAFER programme continues to pull together existing workstreams and those stopped during the Covid period. • The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in. • 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. • Patient appliance trustwide budget is to be consolidated into the community division, this will come with a cost pressure but streamlines operational pressures and improves patient pathways. • 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. • 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

104% Elective Recovery – Position to January and Forecast

Point of Delivery	YTD Performance Against 2019/20 and 104% Target				Performance Against 2022/23 Plan				Forecast Performance Against 2019/20 and 104% Target			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	2022/23 Plan YTD - activity	2022/23 Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Daycase	39,858	42,153	2,295	105.8%					48,300	50,567	2,267	104.7%
Elective	4,331	3,775	- 556	87.2%					5,285	4,666	- 619	88.3%
Sub-total Planned Inpatient	**44,189**	**45,928**	**1,739**	**103.9%**	**46,143**	**104.4%**	**- 216**	**-0.5%**	**53,585**	**55,233**	**1,648**	**103.1%**
Outpatient First Attendances*	**119,996**	**126,383**	**6,387**	**105.3%**	**126,680**	**105.6%**	**- 298**	**-0.2%**	**143,668**	**151,294**	**7,626**	**105.3%**
Outpatient Follow-ups	224,159	250,820	26,661	111.9%	235,832	105.2%	14,988	6.7%	270,804	301,531	30,727	111.3%

* actual outpatient first activity includes an estimate of 9 attendances for OMNES (ENT) and 940 attendances for Pioneer (ENT, Ophthalmology & Neurology) not yet input into EPR for December & January

- **Planned inpatient spells**
  - Currently delivering **103.9% of 2019/20 levels**
  - Forecasting to deliver **103.1% of 2019/20 levels** and therefore 0.9pp (495 spells) below 104% target.
  - The revised elective recovery trajectory agreed at Month 8 was 103.3% and so the Trust is on track to achieve this.

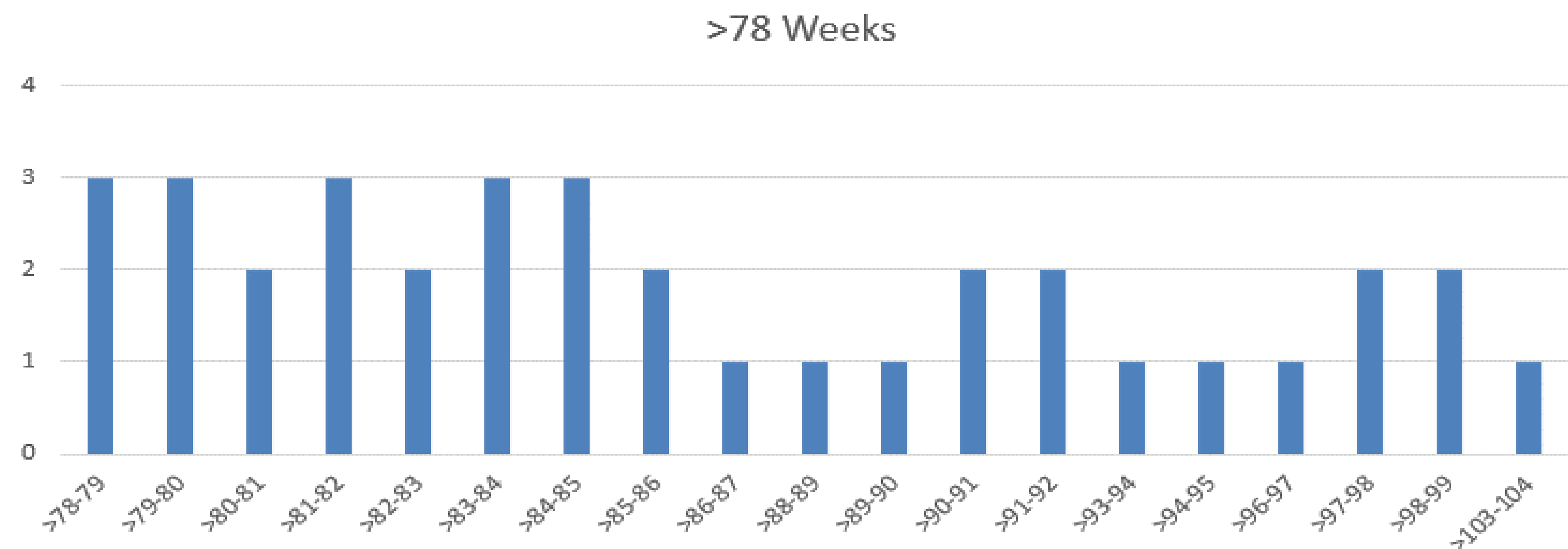
- **Outpatient first attendances**
  - Currently delivering **105.3% of 2019/20 levels**.
  - Forecasting to deliver **105.3% of 2019/20 levels** and therefore 1.3pp (1,879 attendances) above 104% target
  - The revised elective recovery trajectory agreed at Month 8 was 105.6% and so the Trust is on track to achieve this.

Summary

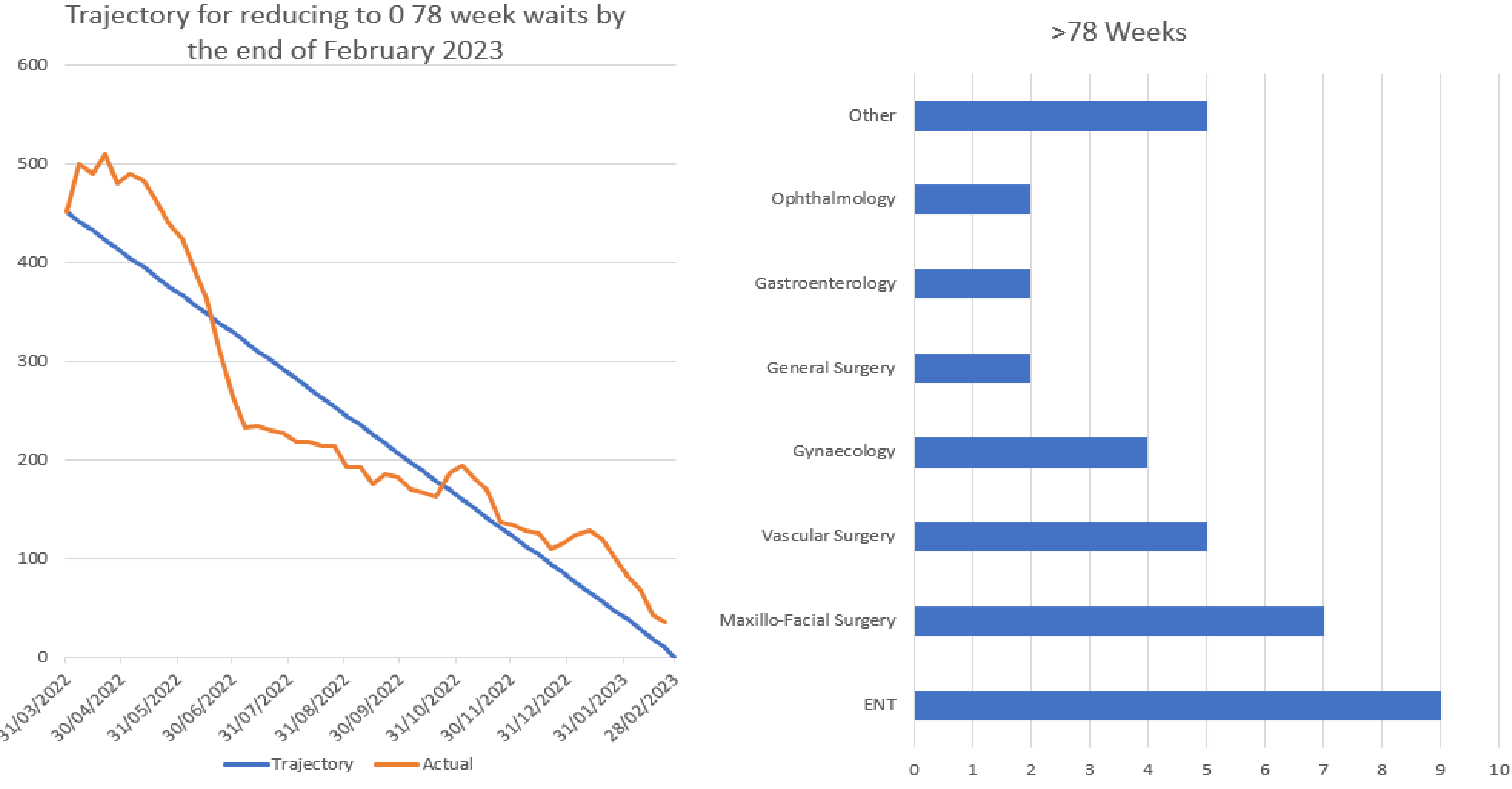
		As of 14/02/2023	Current Trajectory as	Variance to trajectory	Variance against trajectory				Main areas above Trajectory
					Medical	Surgical	FSS	Community	
Elective Backlogs	104 Weeks RTT	0	0	0	0	0	0	-	-
	78 Weeks RTT	55	19	36	5	23	8	-	Max Fax, General Surgery
	52 Weeks RTT	628	2,089	-1,461	-278	-1,049	-134	-	Max Fax, ENT, Gastroenterology, Colorectal Surgery and General Surgery
	Total ASI's	11,276	4,974	6,302	1,553	3,475	1,164	110	Neurology, Max Fax and Gynaecology
	ASIs > 22 weeks	394	38	356	203	128	15	3	Neurology and Max Fax much smaller numbers in Gynaecology
	Holding List overdue	24,708	3,445	21,263	11,545	8,162	1,435	121	Urology, Cardiology, Dermatology, Gastro, Neurology, Respiratory Med, T&O, Ophthalmology and Gynaecology

Current 104 week wait Position

- As of the 21st February 2023 , We currently have 0 patients waiting over 104 weeks.
- Next longest waiting patient is currently at 103 weeks (has a TCI Date)

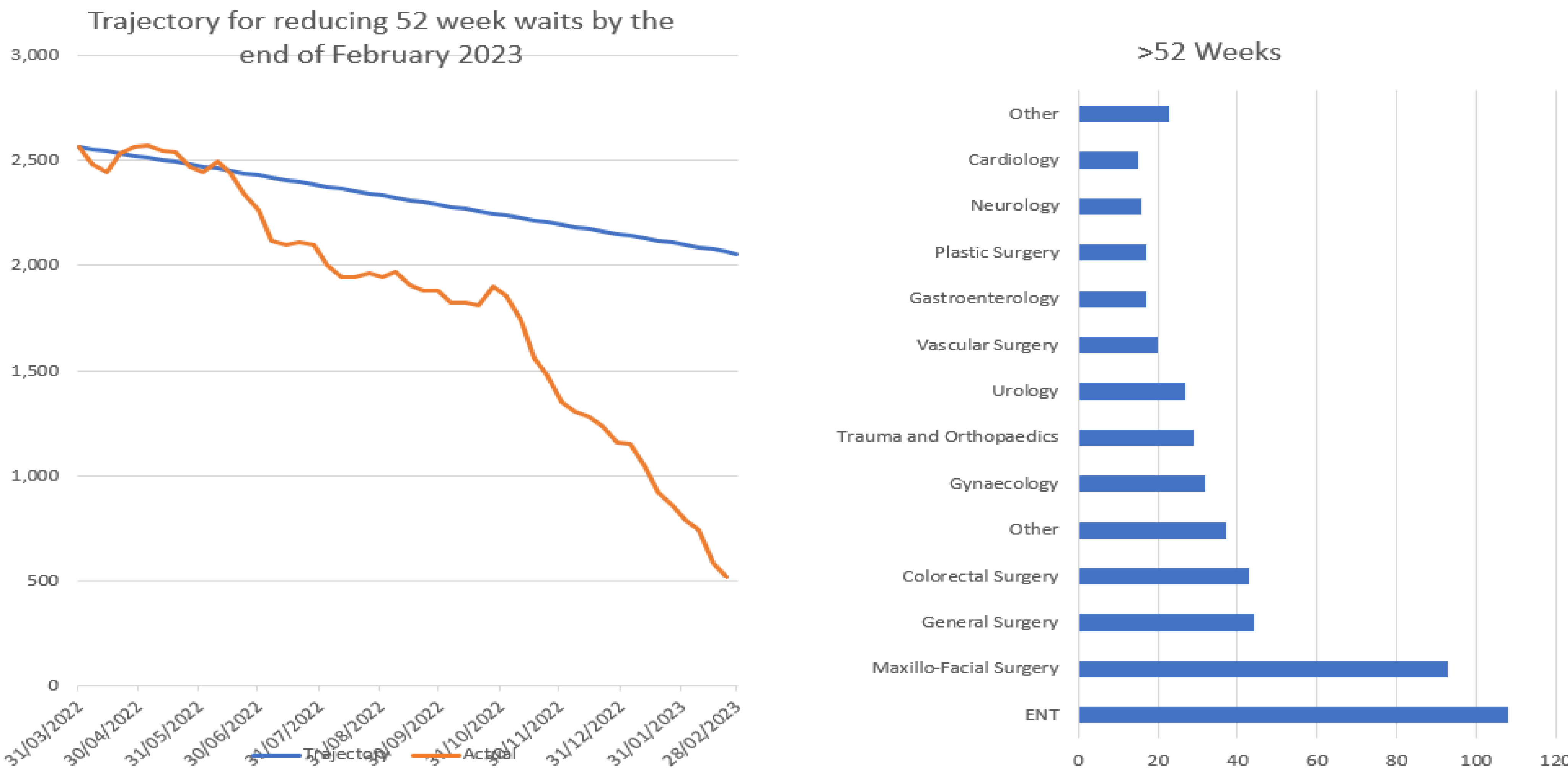


RTT – 78 Weeks



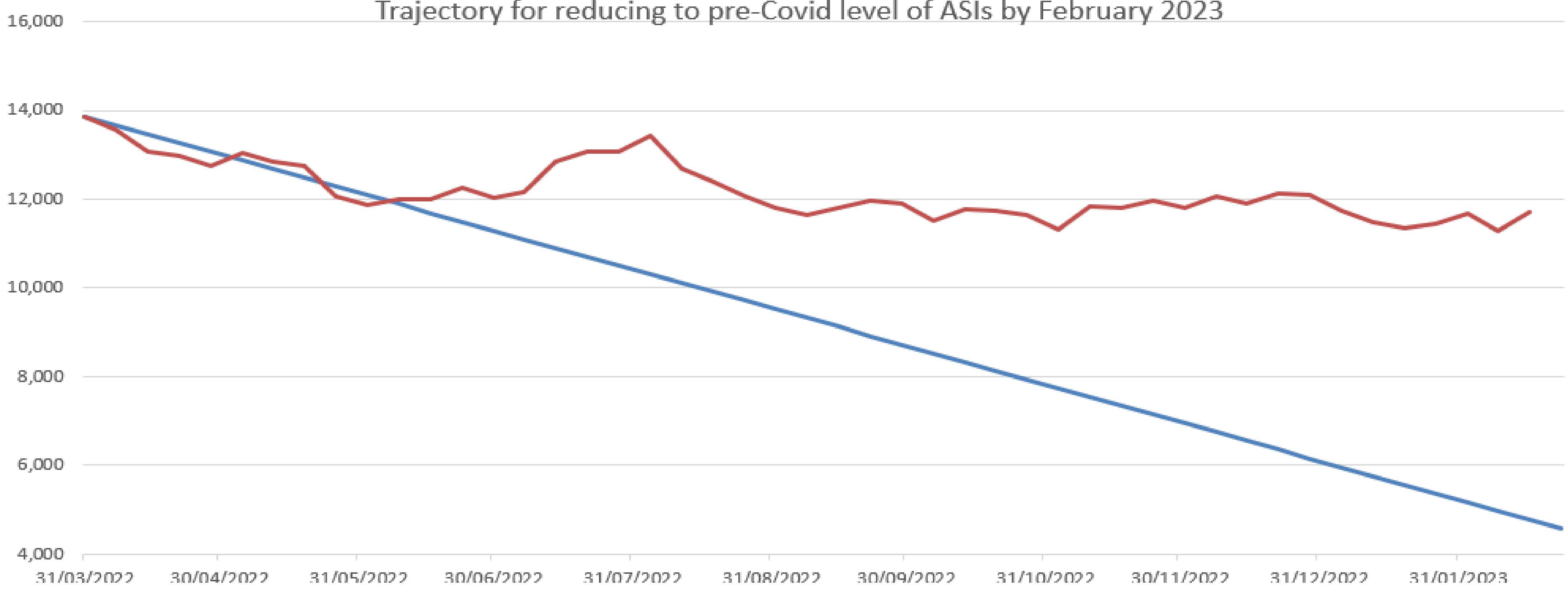
National expectation to be at zero by end of March 2023, on track to deliver by end of March 2023

RTT – 52 Weeks



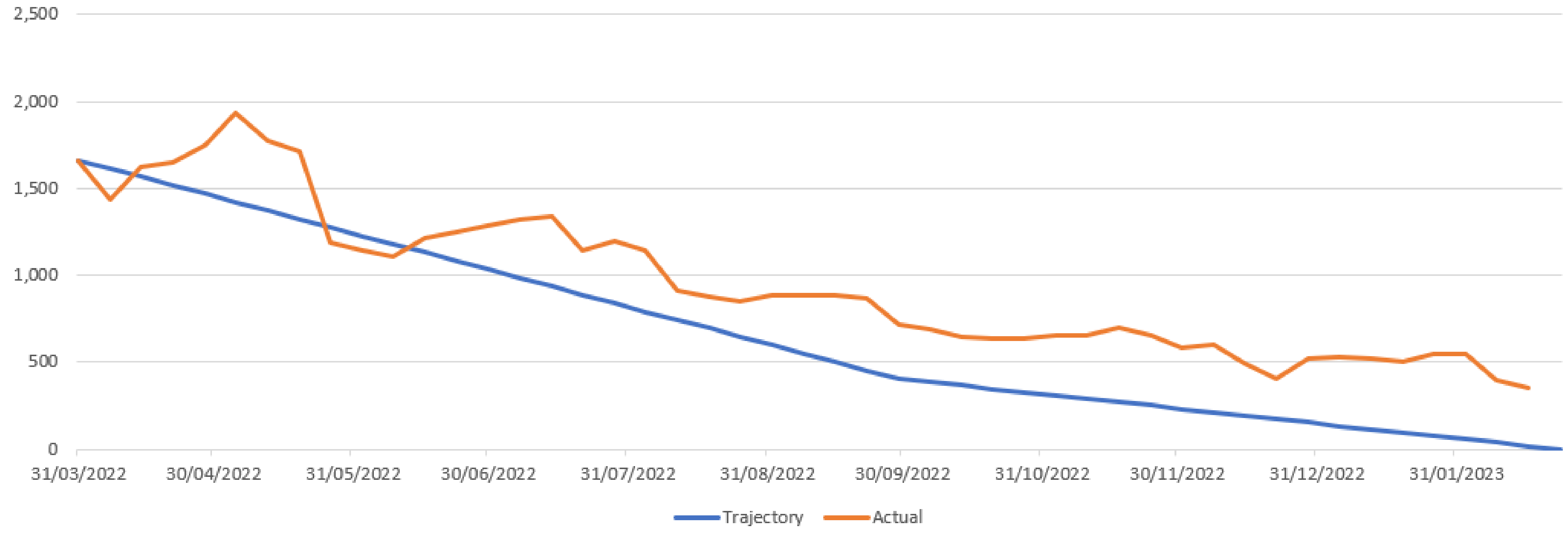
National expectation to be at zero by end of March 2025, on track to deliver NHS E/I trajectory.

Outpatients – New (total ASIs)



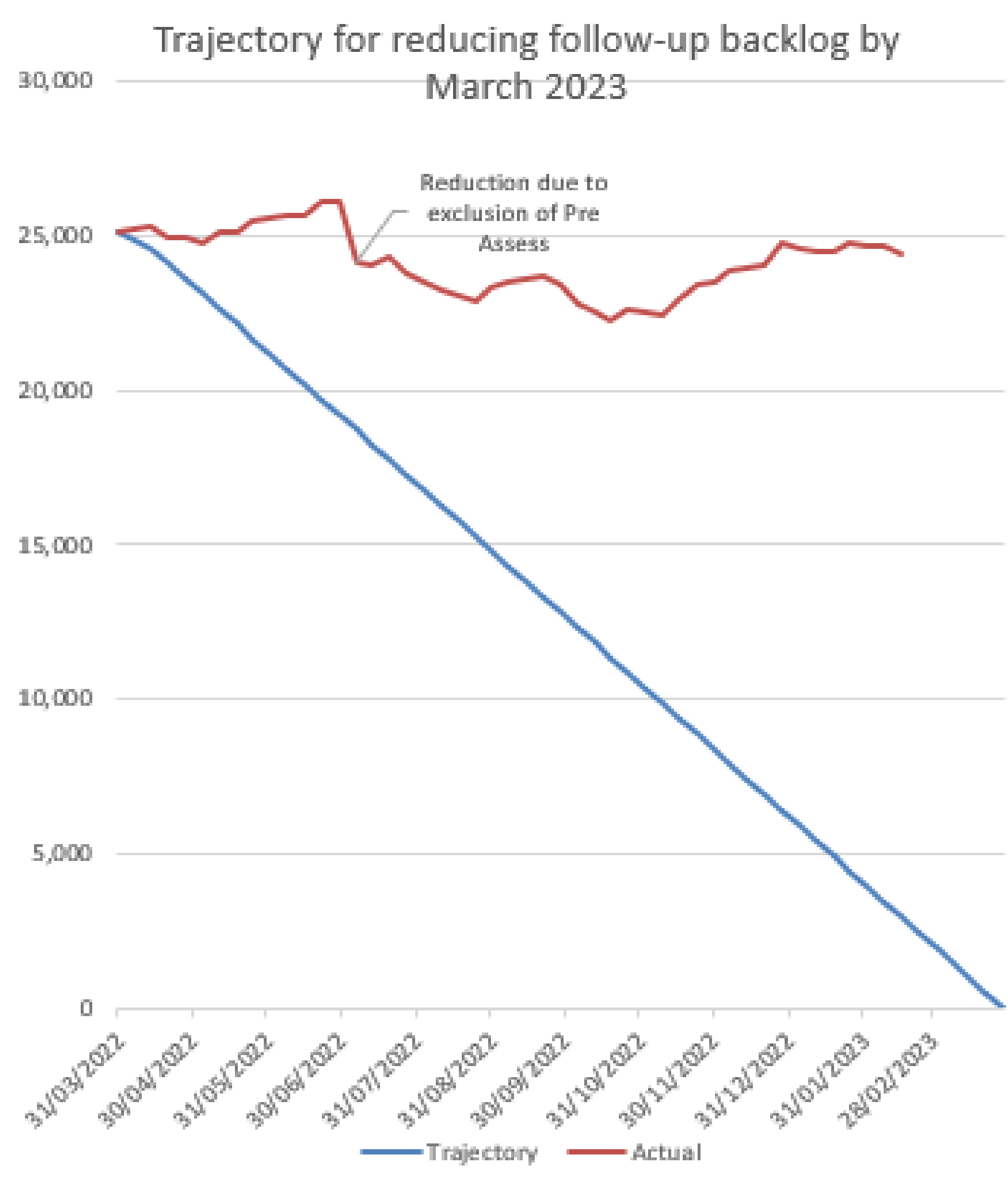
- No external target and no requirement to report centrally. Internal target to get back to pre-covid levels.
- Current ASIs = reduced by 1,300 from 13,141 in April to 11,874 middle of February 2023
- Risk of not addressing is on overall length of RTT pathways

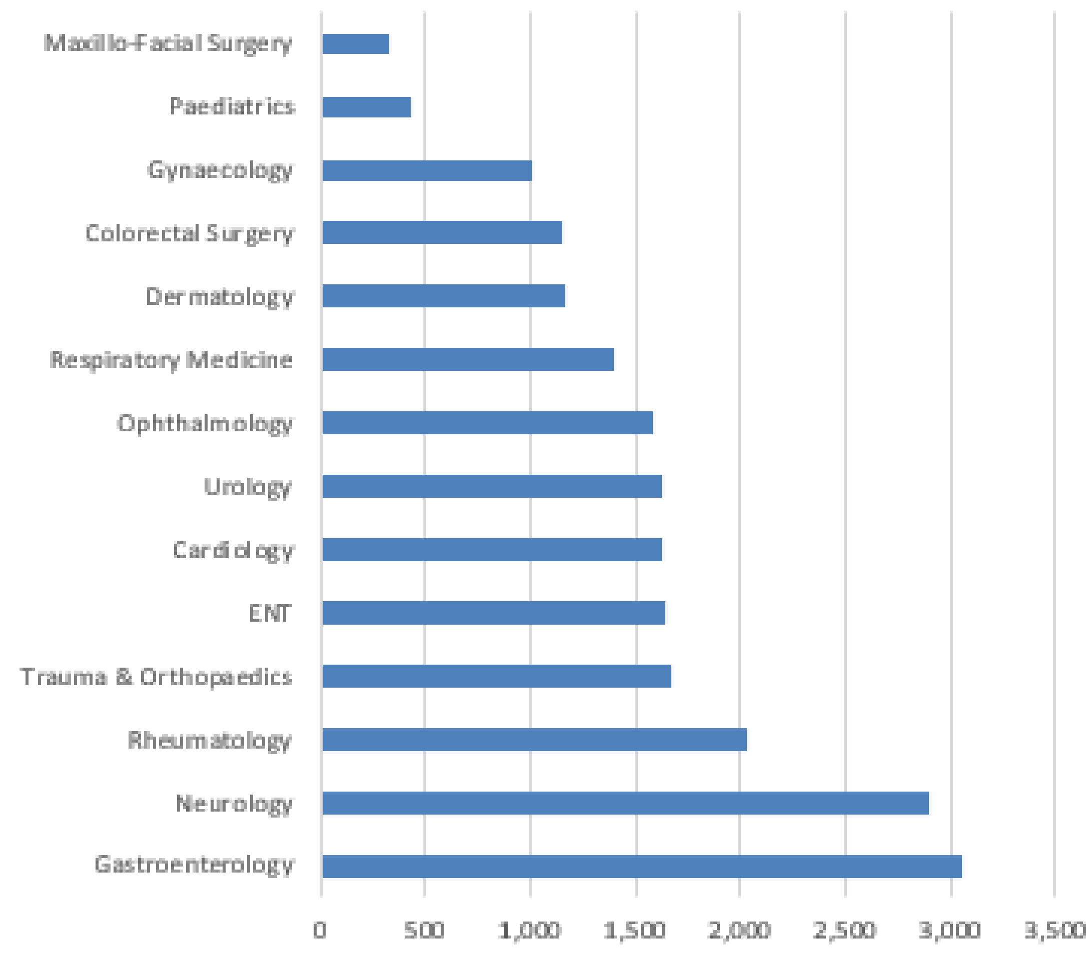
Outpatients – New (ASI > 22 weeks)



- Trajectory is a locally set target that will help achieve a reduction in 52/78 week RTT Waits. ENT ahead of plan. Other specialties behind plan, leading to the gap.
- Of the 333 Remaining ASIs over 22 weeks:
  - 100 in Neurology
  - 76 in Max Fax
  - 70 in Trauma & Orthopaedics

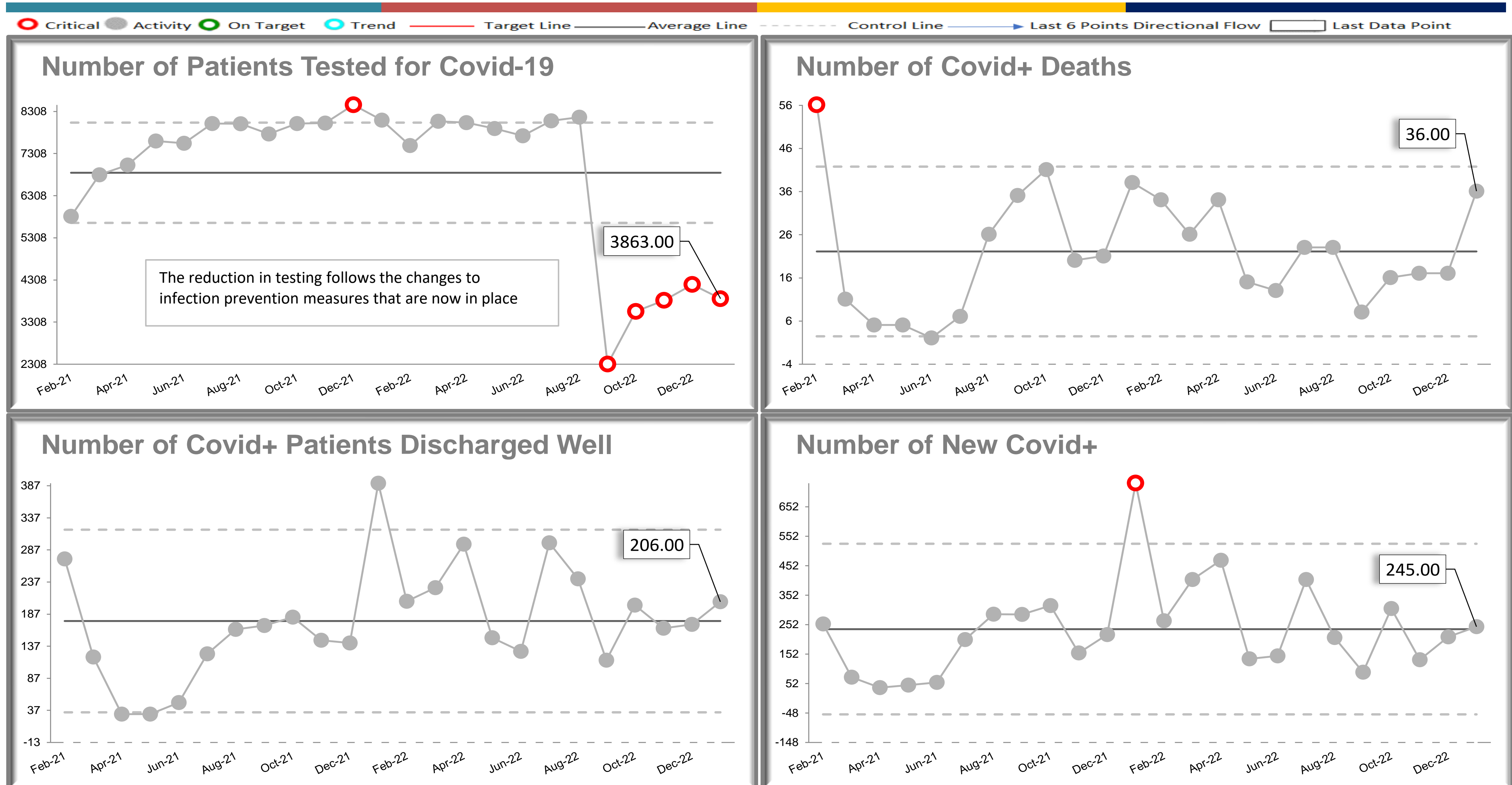
Outpatients – Follow Up



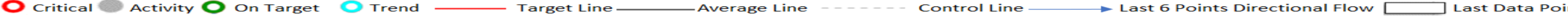


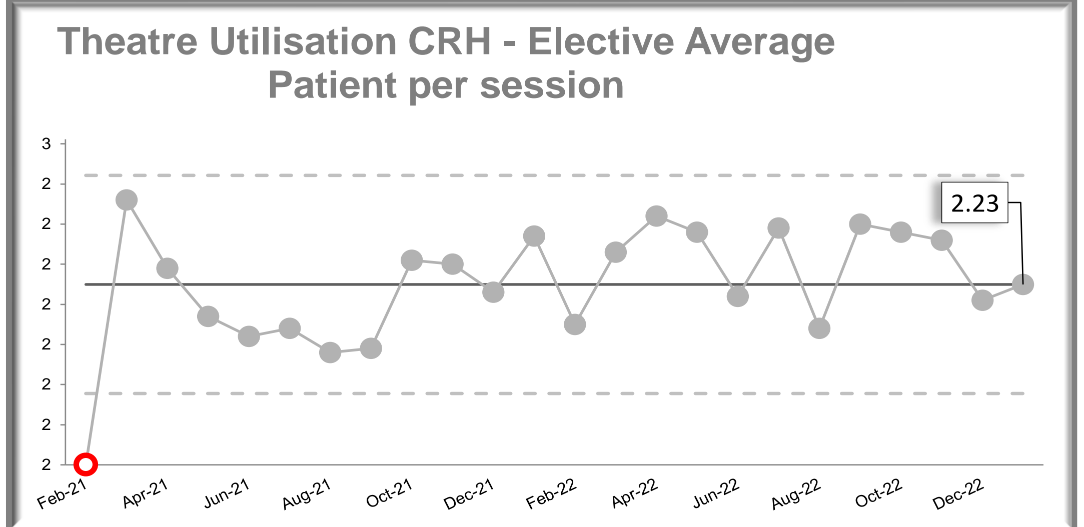
- No external target or requirement to report externally
- Internal target to reduce to 0

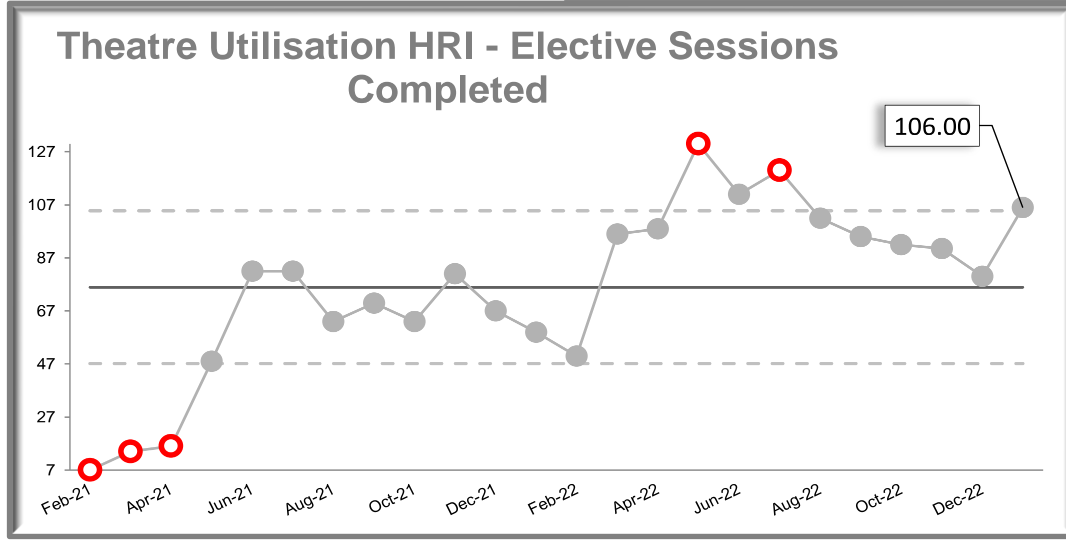
Covid-19 - Charts

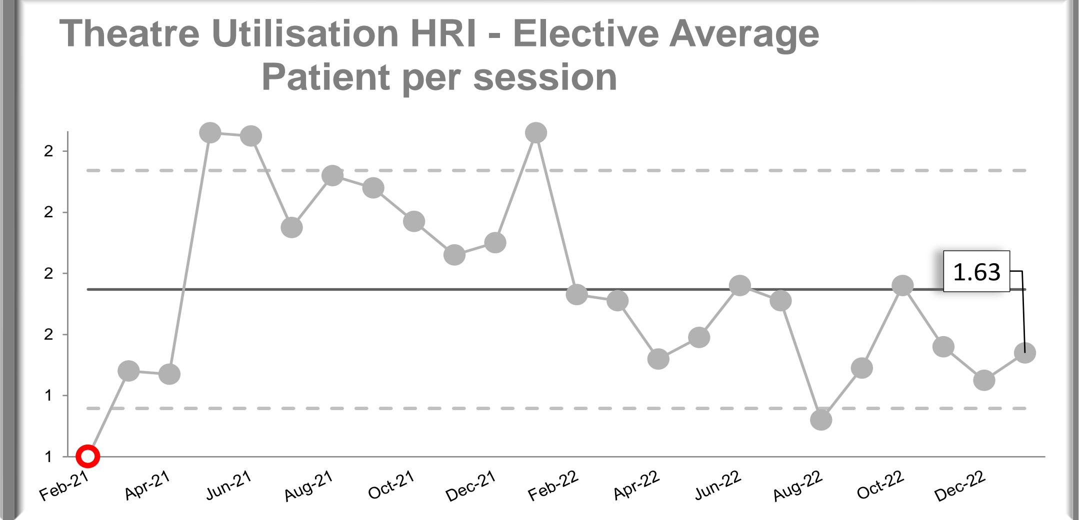


Theatres - Charts

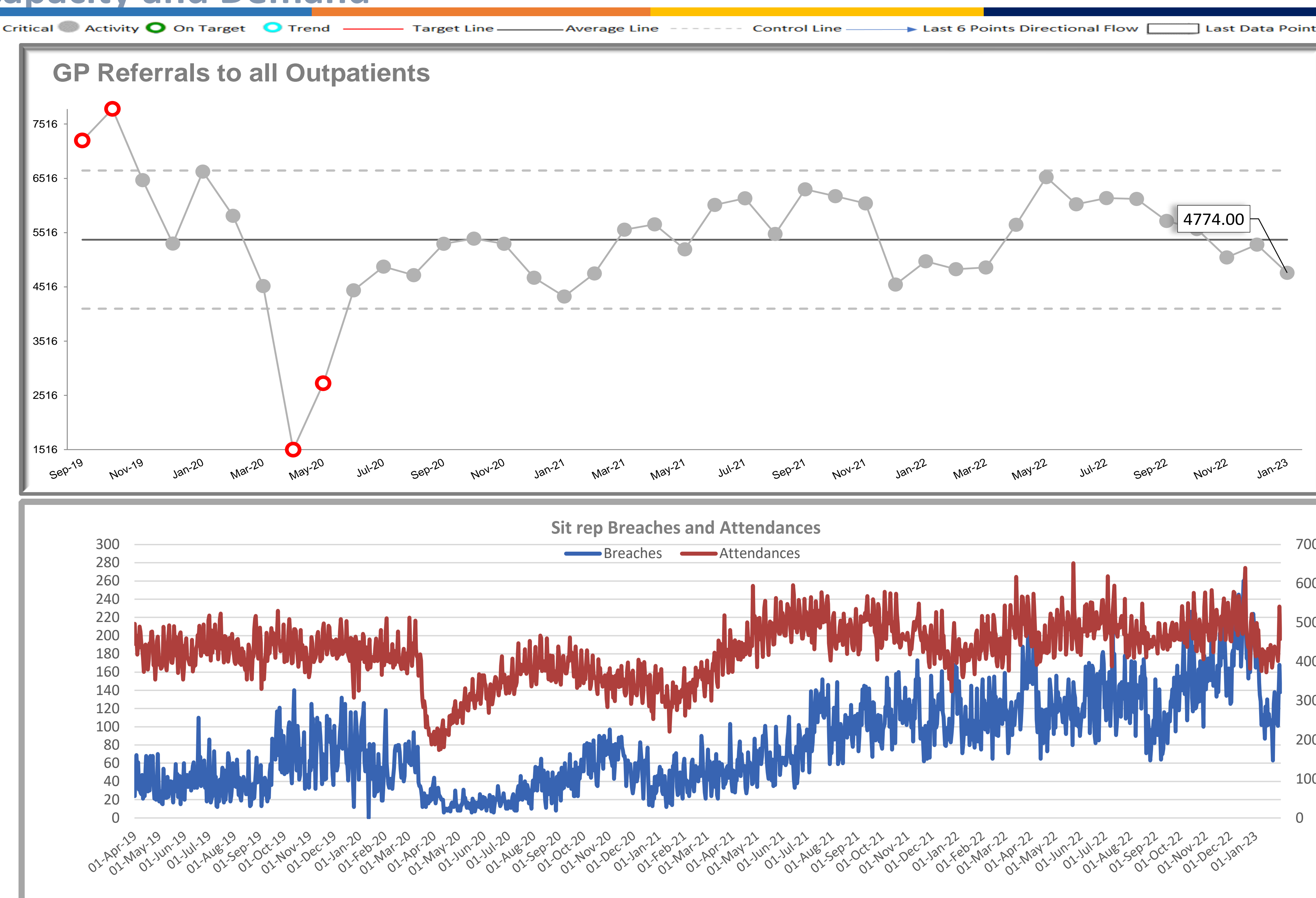




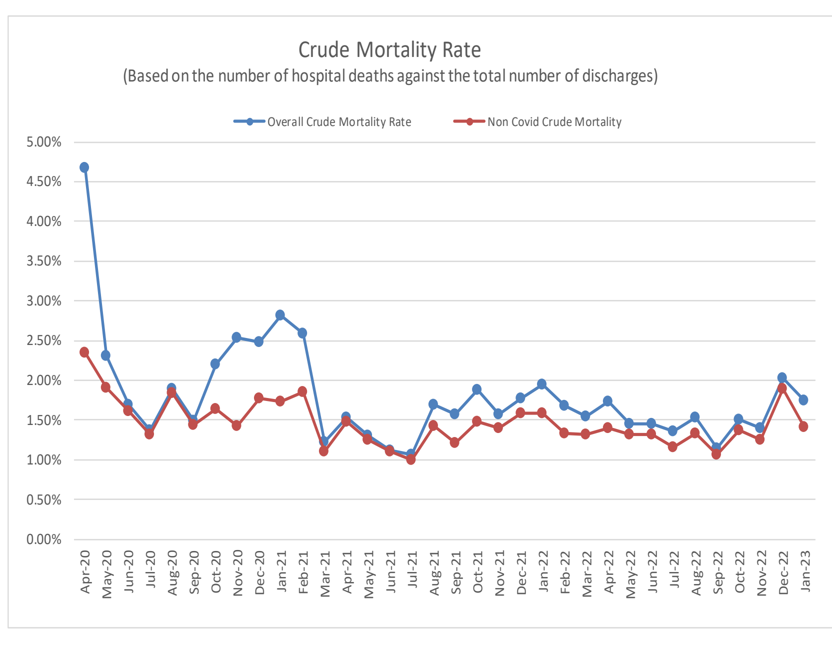


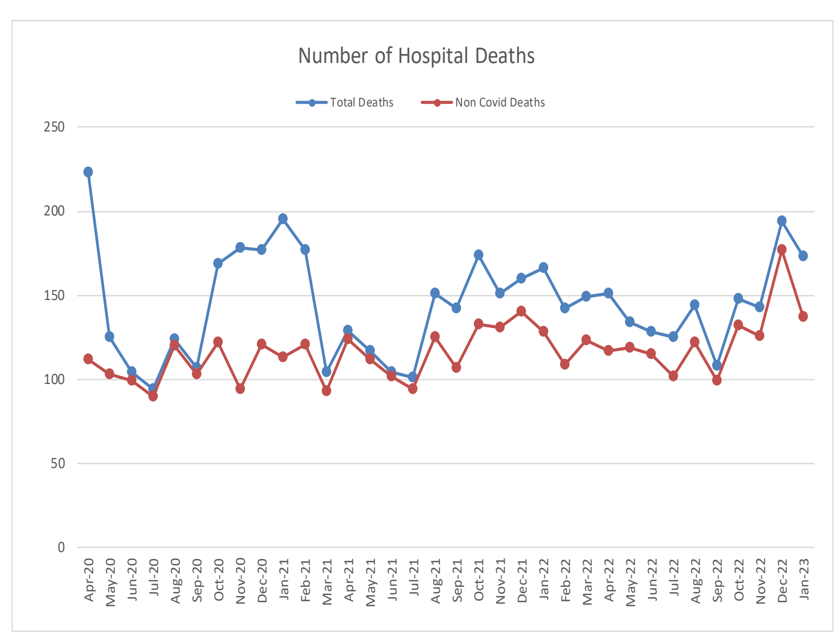


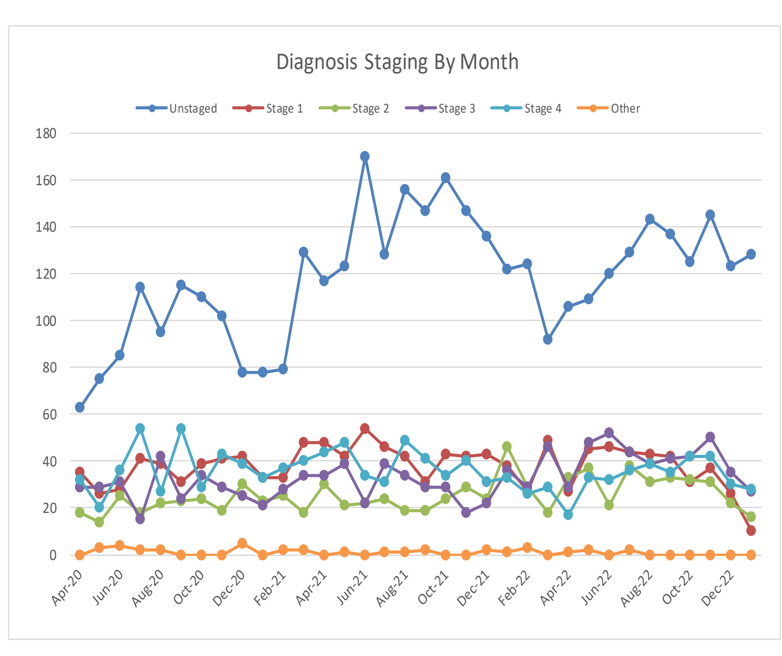
Capacity and Demand

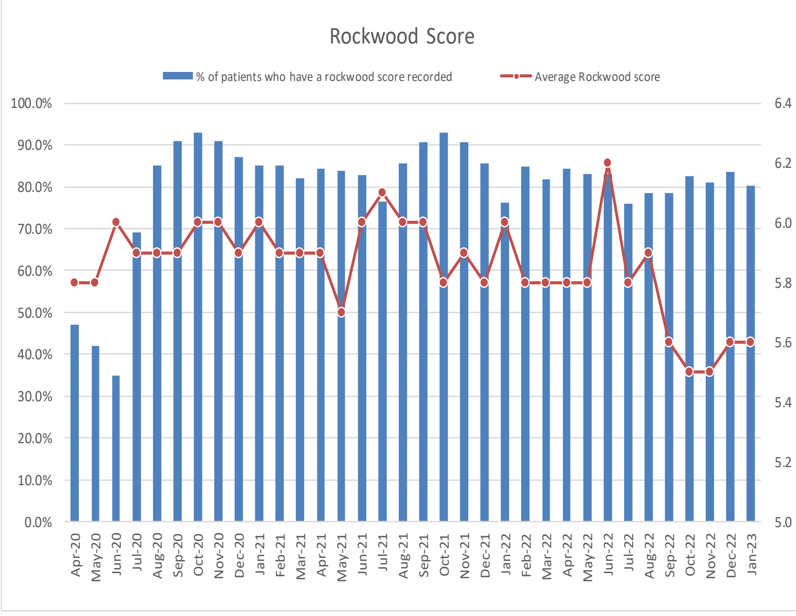


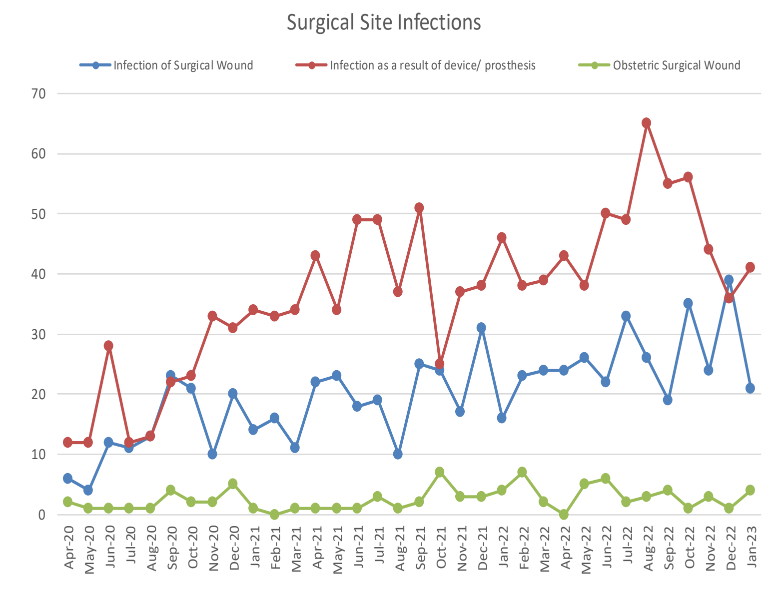
Outcome Measures





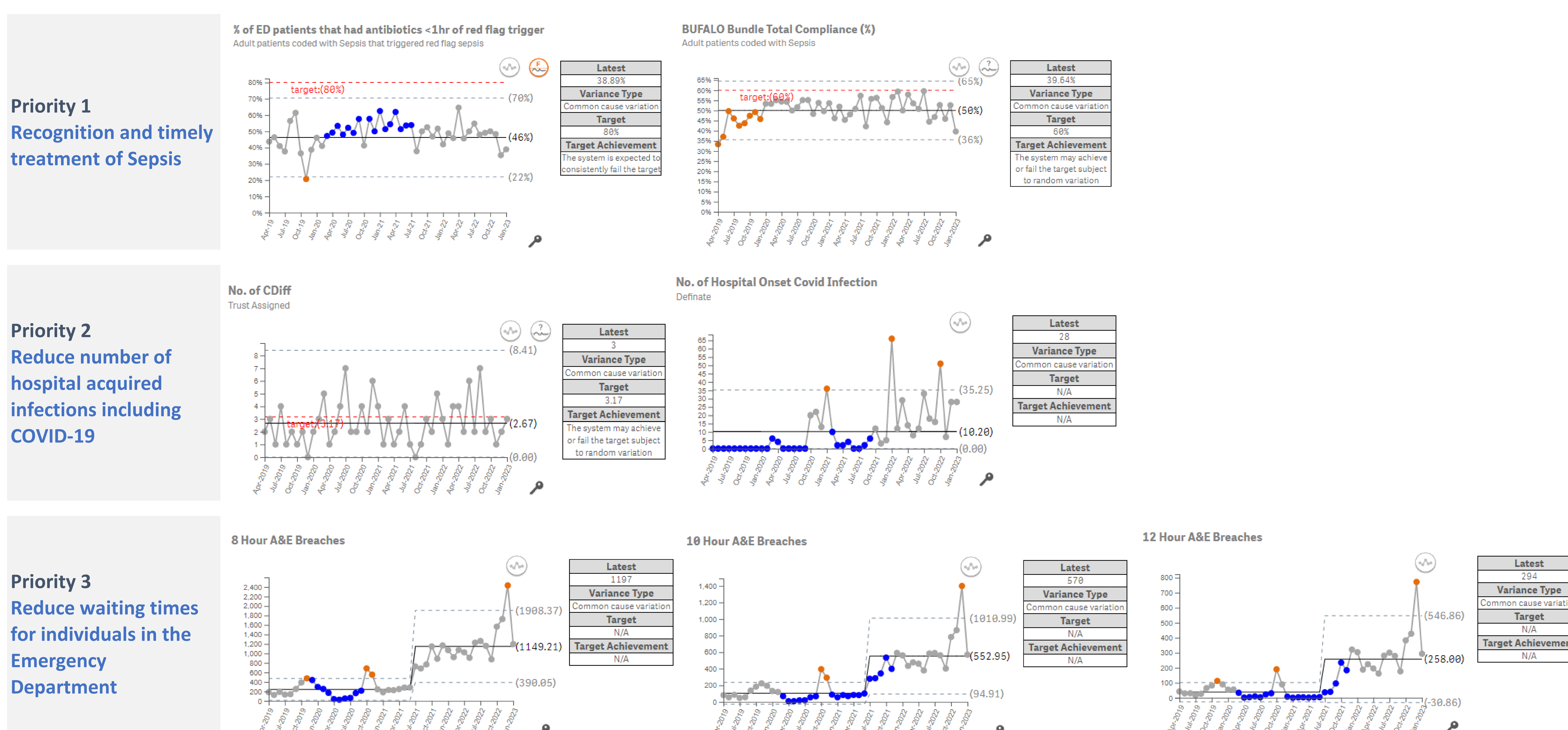






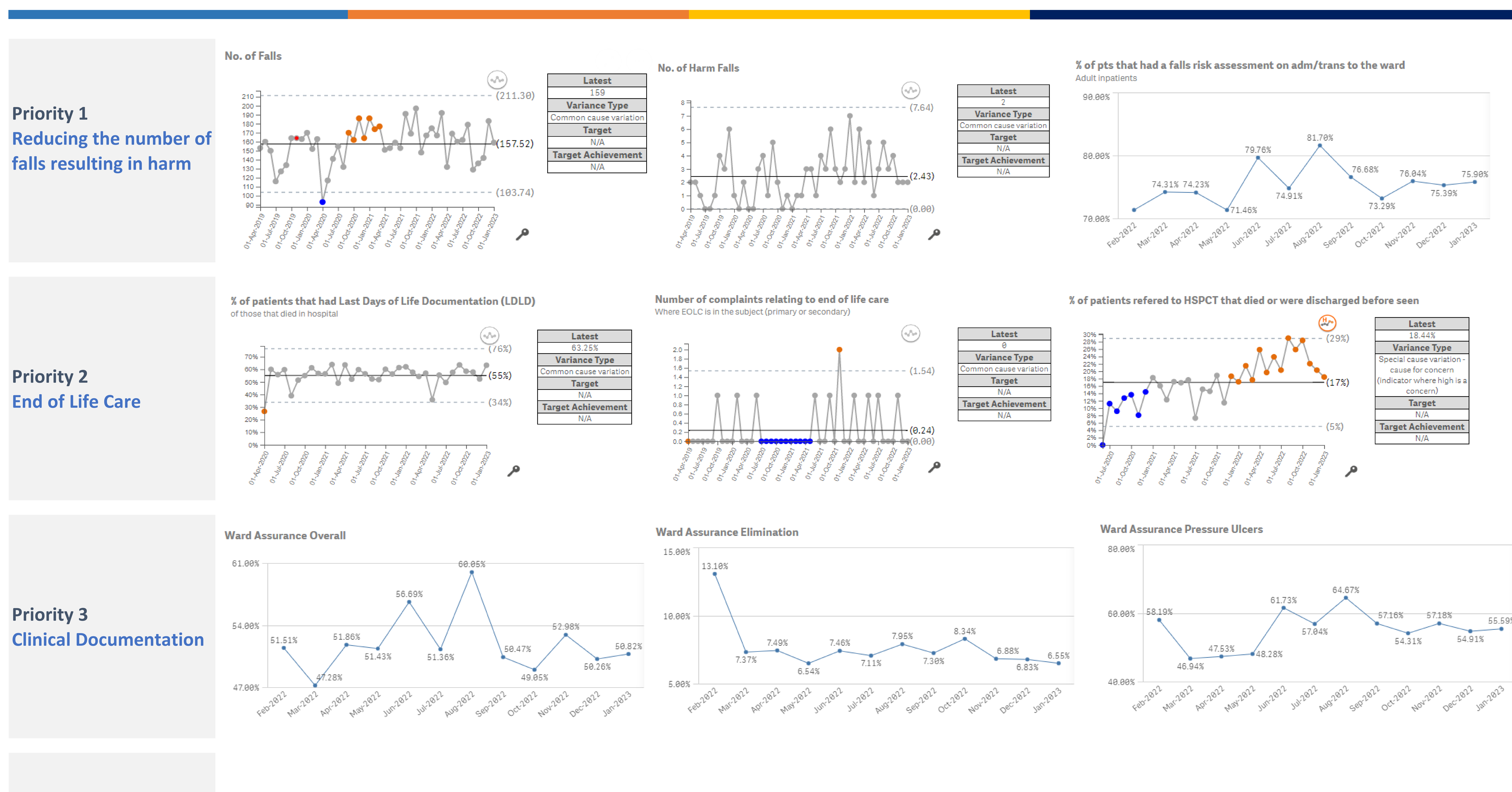
Graphs produced by the Quality Performance Team

Quality Priorities - Quality Account Priorities



Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities



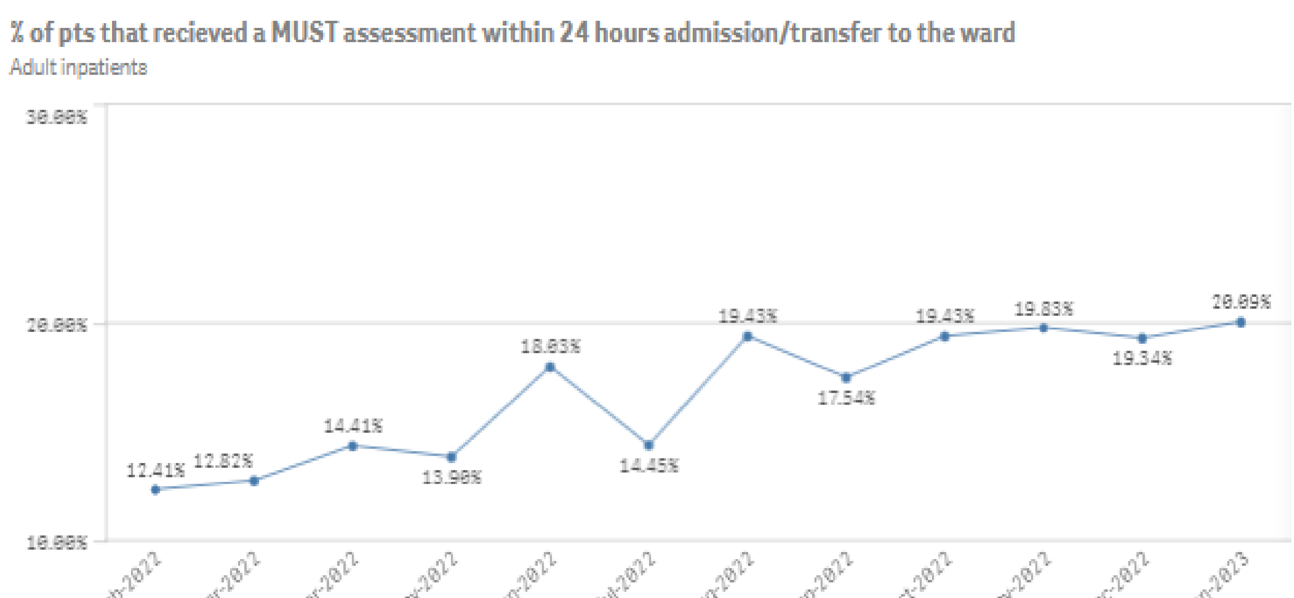
Priority 4
Clinical Prioritisation

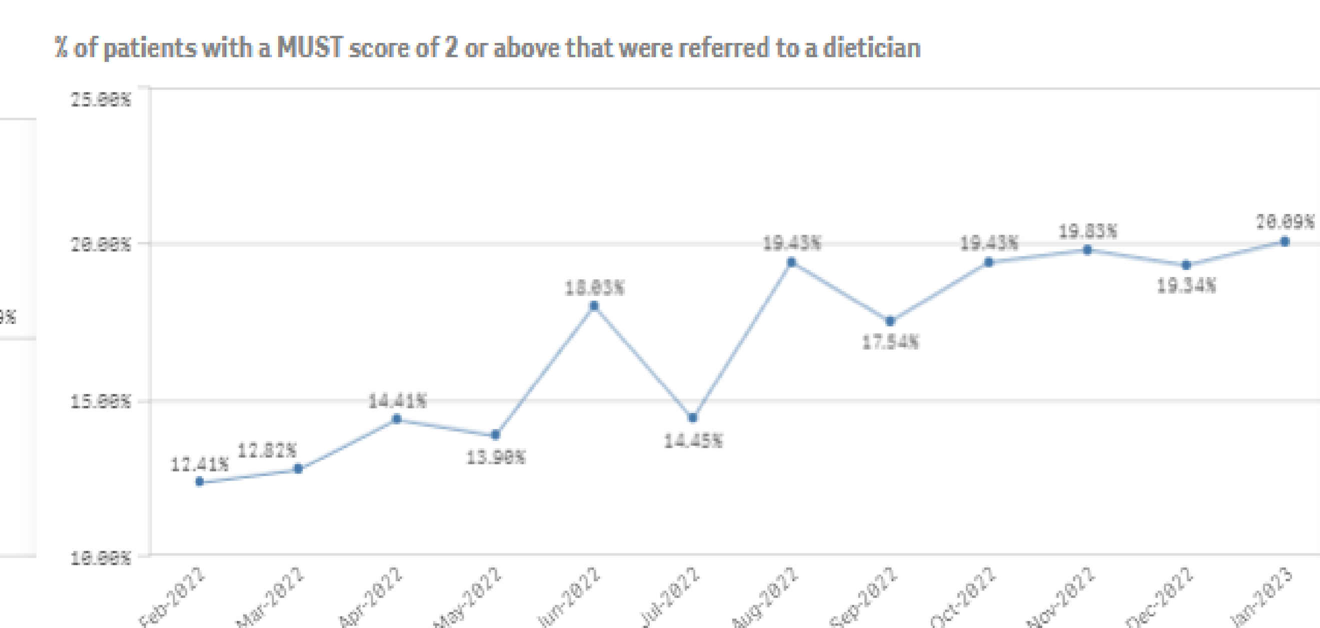
Not Available

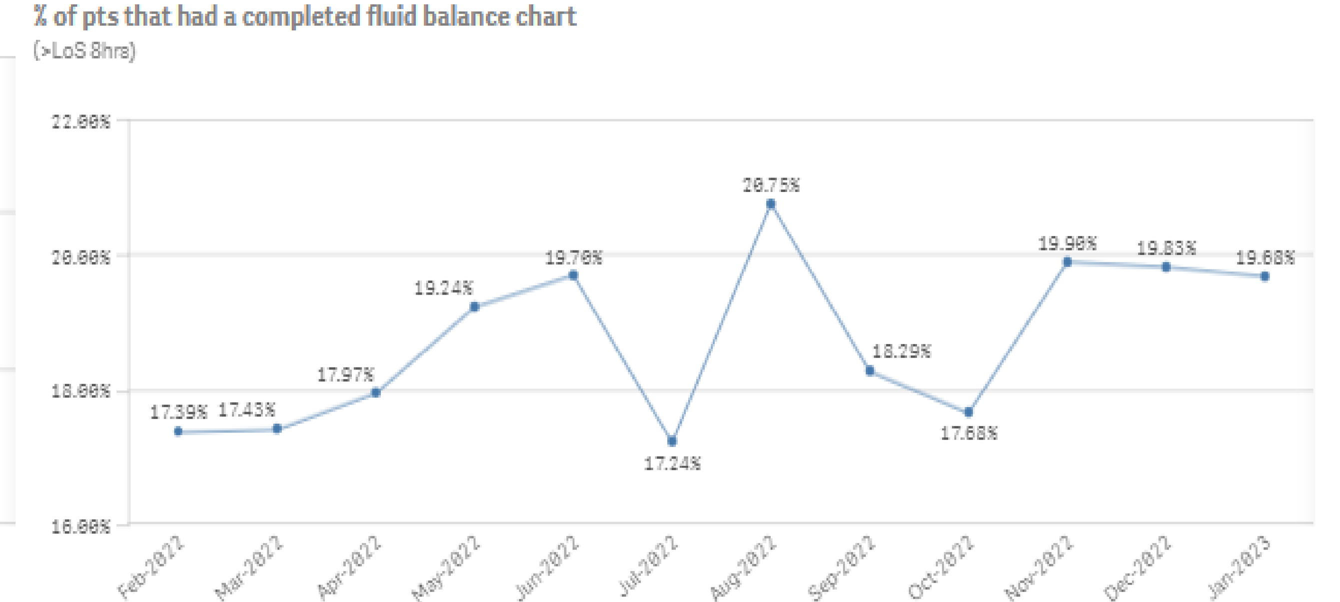
Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities

Priority 5

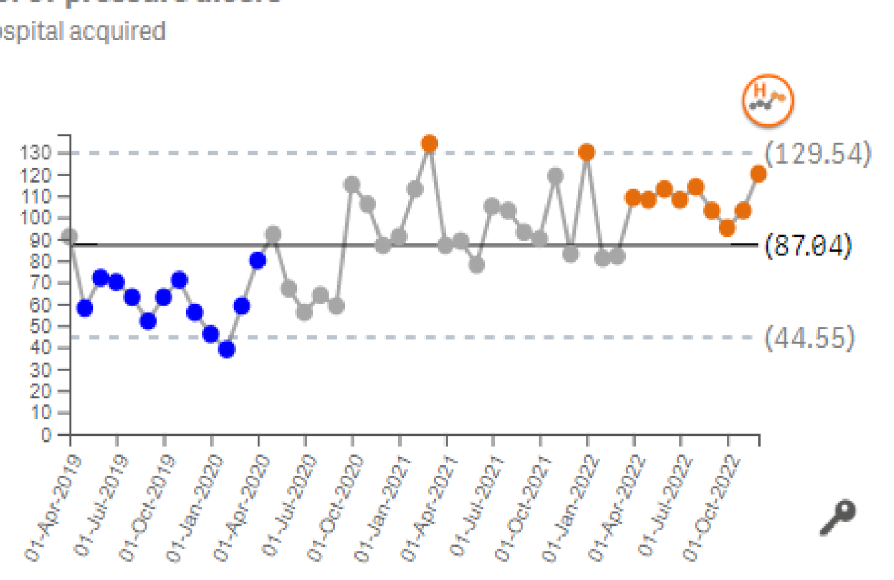




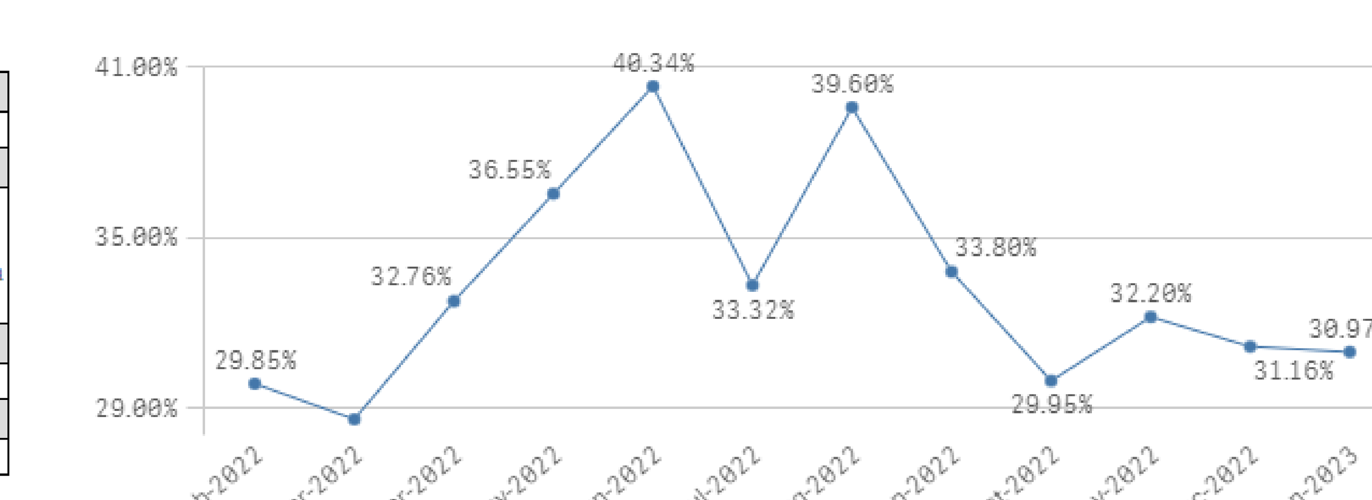


Priority 6
Reduction in the number of CHFT acquired pressure ulcers

No. of pressure ulcers
Hospital acquired



Latest
120
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A



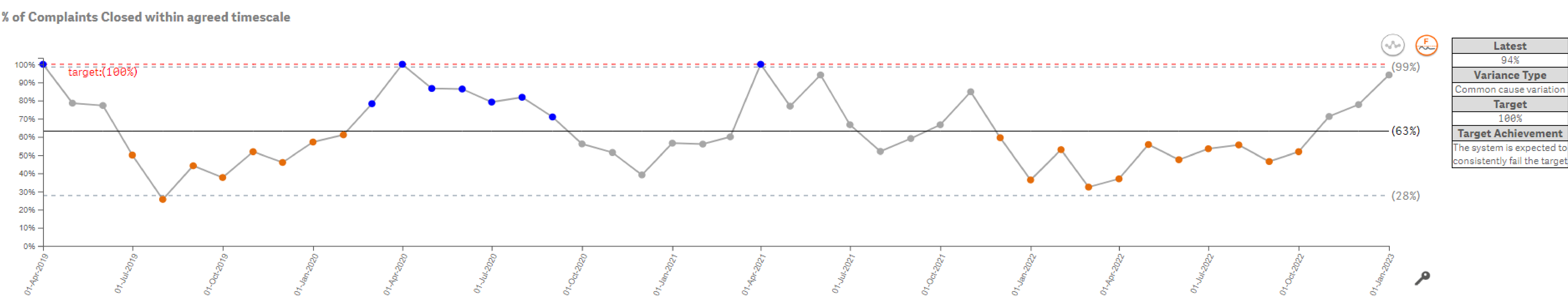
95% of relevant staff* will have completed Pressure Ulcer training in last 2 years.
*(RNs, Nursing Associates and HCAs)

Trust Compliance

86.58%

Priority 7
Making complaints count

% of Complaints Closed within agreed timescale



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%								
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%								
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%								
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%								
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%								
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%								
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%								

CQUIN - Key Measures

Indicator Name	Reality	Response	Result
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achievement of the 5 elements of the UTI Diagnosis/ Management CQUIN requires overall compliance of >60% to receive full payment. After 1st quarter we are achieving 57% overall compliance. The element requiring greatest degree of intervention is the sampling element. Q2 data is still being verified.	A campaign is being prepared to improve urine sampling for launch early in Q3.	Aiming for overall >60% compliance for the 5elements of the CQUIN.
CCG4: Compliance with timed diagnostic pathways for cancer services	In Q2 we achieved 8% compliance, which is a small improvement from Q1 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 second 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 Q2 is 4.33% which is below the 35% target.	Response not yet available	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 first quarter we are achieving 28.4% compliance, the reason for low compliance this quarter is due to the data collection framework not being in place. Q2 data is still being validated.	Data collection framework is now in place with a meeting set to take 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)

	Nov-22	Dec-22	Jan-23
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	88.6%	88.6%	84.0%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	92.7%	92.7%	93.8%
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.8	8.8	9.0
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	7.9	7.6	7.9

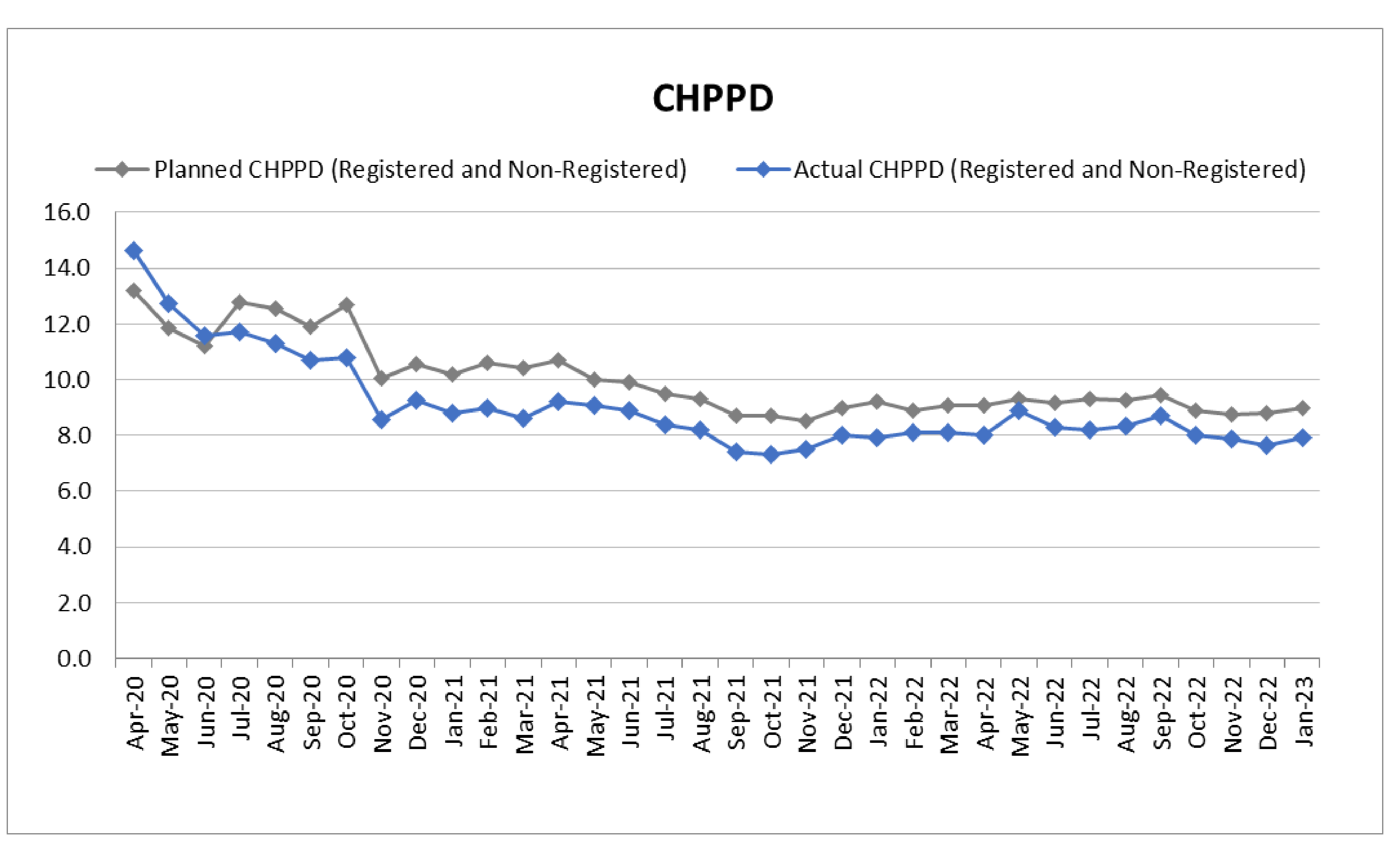
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. It is calculated by averaging the number of occupied in-patient beds at midnight each day, then dividing by the number of clinical hours provided by staff on the roster. CHPPD is not a stand alone measure and should be reviewed alongside clinical quality and safety outcome measures.

A review of the January data indicates that the combined RN and non-registered clinical staff metrics resulted in 25 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 0.9 CHPPD across the Trust.
The CHPPD planned vs actual gap is most prominent in the Surgical division (1.9 CHPPD deficit). This is largely attributable to the staffing in ICU which continues to report the planned shifts whereas the 'actual' levels represent the staffing required to care for the patients each shift according to GPICS ratios. The low numbers of patients at midnight on the elective surgical wards, where day surgery occurs, contribute to an elevated 'planned CHPPD' position. The 'actual' represents the safe staffing required to care for the patients according to professional judgement in the daily staffing meeting.

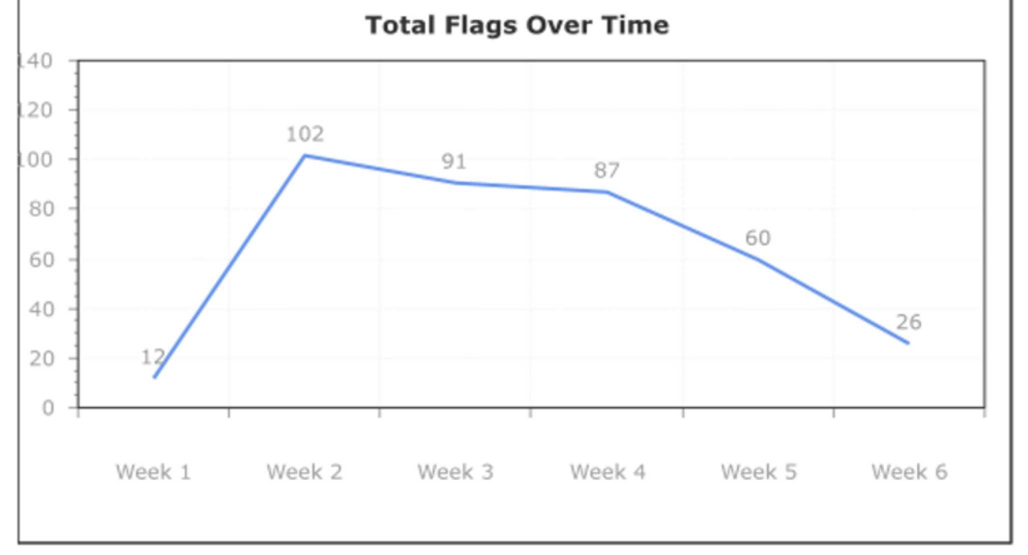
The apparent shiftfill beyond 100% for some of the wards' non-registered shifts represents requirement for additional staff to provide 1:1 care for patients.

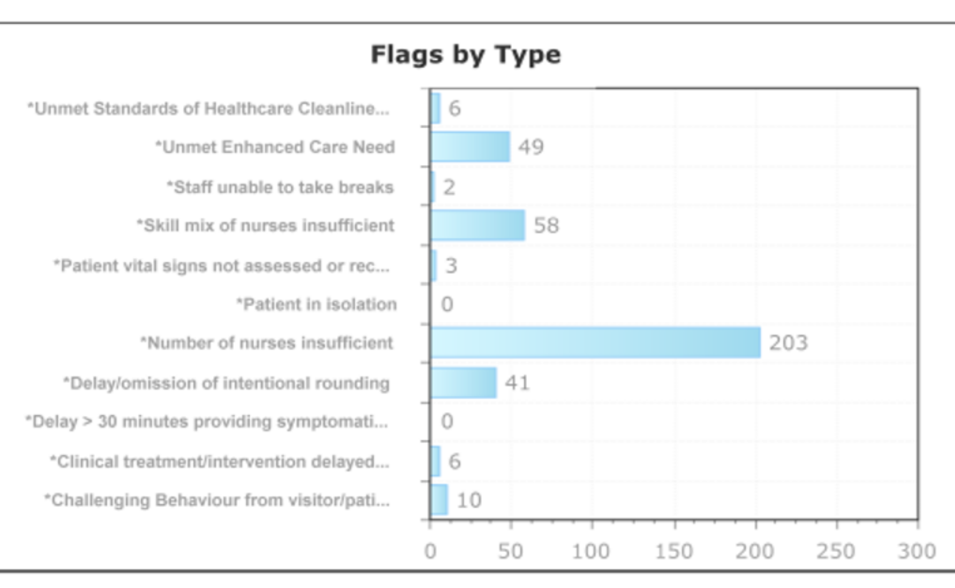
Challenges of the requirement to staff additional capacity areas continue to impact on the ability to staff all areas according to workforce model.

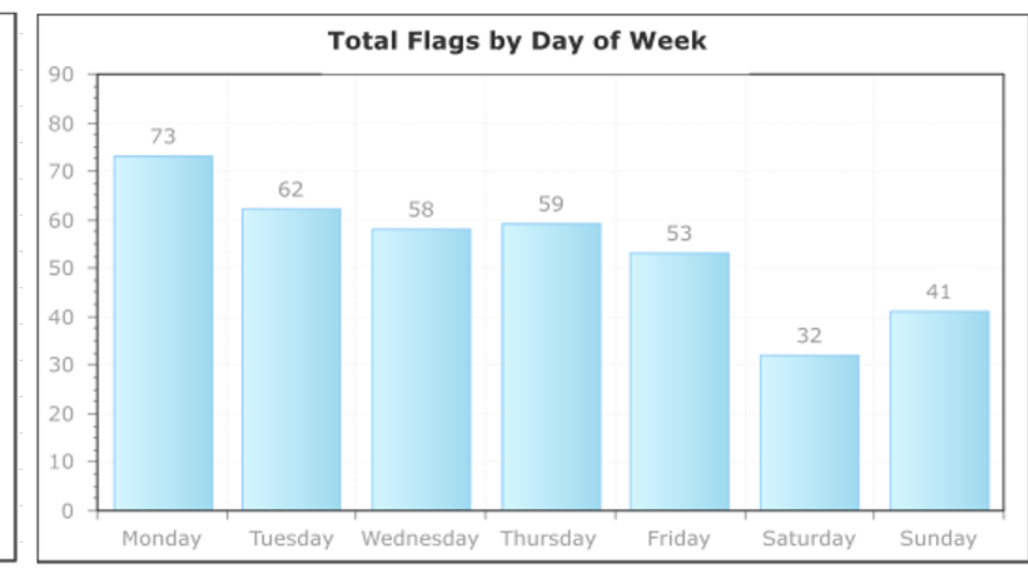
A review of the nurse sensitive indicators demonstrates incidence of falls and pressure ulcers to be within normal variation.

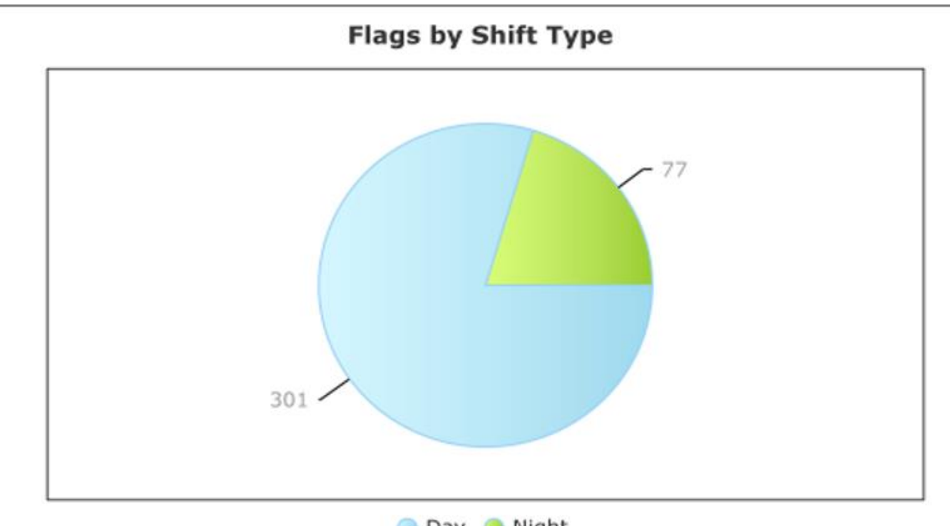


STAFFING RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and monthly through the Nursing workforce strategy group.

The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required. The closure of redflags remains inconsistent and a focussed piece of work is being conducted to address this issue.

Hard Truths: Safe Staffing Levels (2)

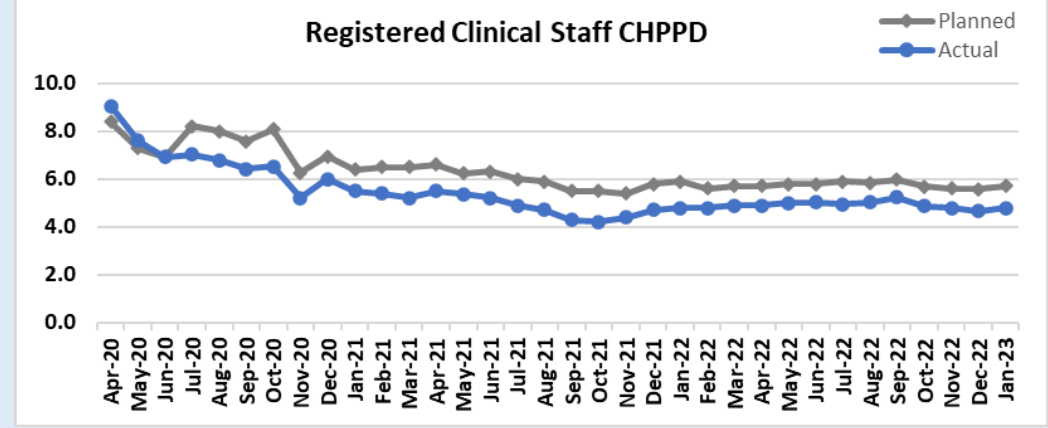
	Aggregate Position	Trend	Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

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

CHPPD was 5.7 for planned and 4.8 For actual for Registered Clinical Staff

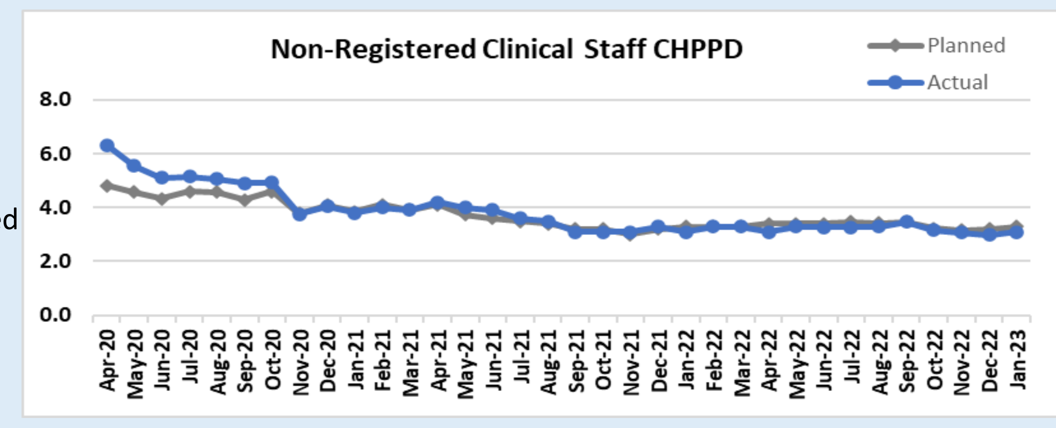


Overall there is a shortfall of 0.9 CHPPD against an overall requirement of 5.7 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse 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. Both falls and pressure ulcer prevalence remain within normal variation in month. It is noted that pressure ulcers in the Medical division have been above average for 5 consecutive months however, they have not reached the upper level of normal variance. This will be monitored closely.

Non-Registered Clinical Staff

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

CHPPD was 3.3 for planned and 3.1 for actual for Non-Registered Clinical Staff



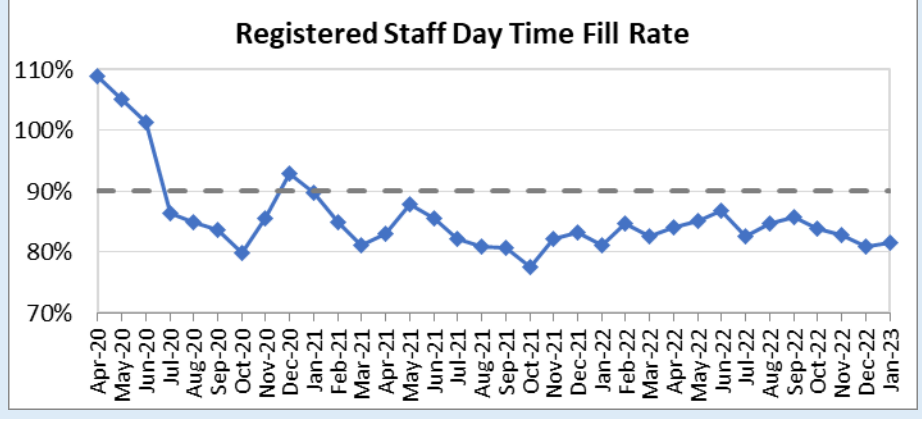
There was a shortfall of 0.2 in the planned CHPPD provided by non-registered clinical staff.
Nightshift fill is prioritised over day shift due the increased vulnerability of patients and having fewer health professionals on the wards and the need to mitigate against reduced RN availability.

FILL RATES BY STAFF AND SHIFT TYPE

Registered Clinical Staff Day

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

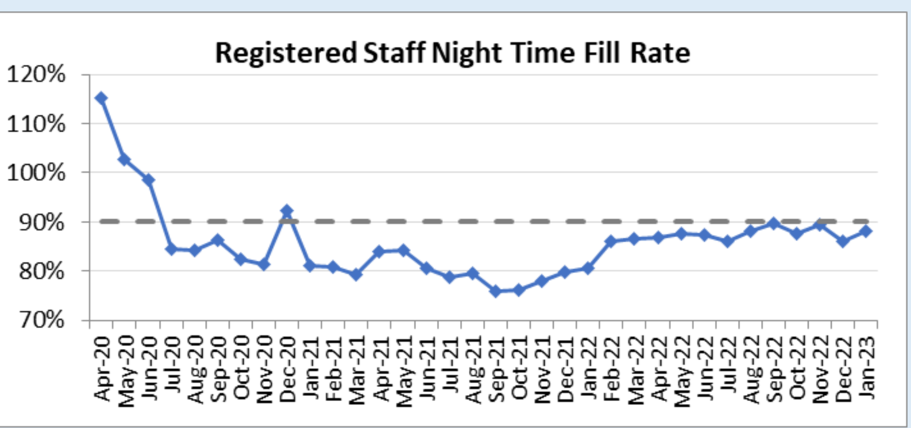
81.65% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

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

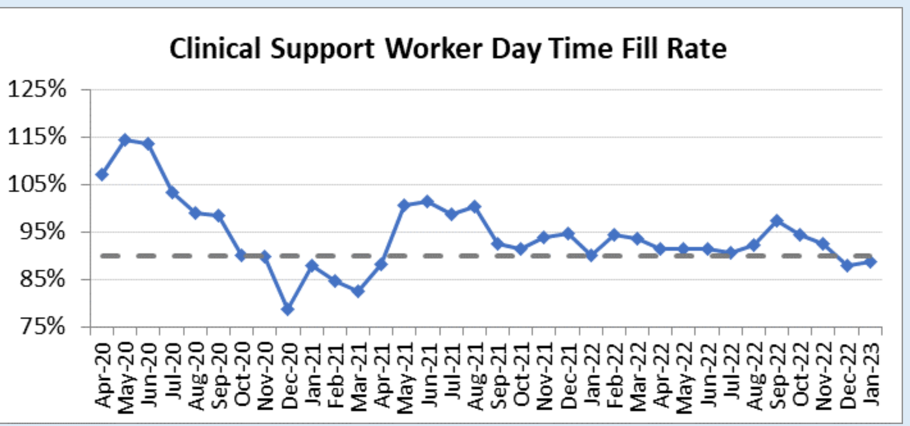
88.10% of expected Registered Clinical Staff hours were achieved for night shifts.



Non-Registered Clinical Staff Day

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

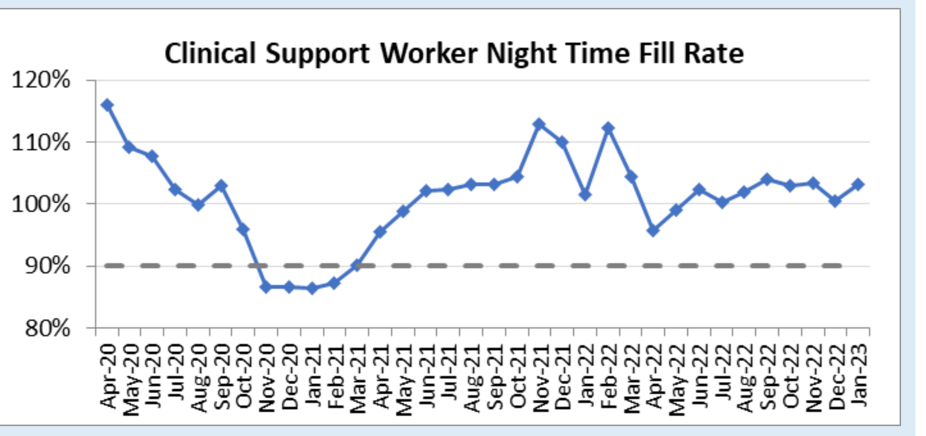
88.59% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non-Registered Clinical Staff Night

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

103.24% 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	88.9%	79.7%	98.8%	95.1%	8.3	7.5
HRI ACUTE FLOOR	95.5%	91.3%	100.1%	100.6%	8.2	8.0
RESPIRATORY FLOOR	59.8%	83.6%	82.3%	92.5%	9.0	6.8
WARD 5	87.3%	103.4%	101.1%	132.3%	6.7	6.9
WARD 6	77.1%	69.6%	97.5%	100.3%	4.1	3.4
WARD 6C	84.6%	85.4%	102.6%	113.7%	12.7	12.1
WARD 6AB	84.6%	85.4%	102.6%	113.7%	6.3	6.0
WARD CCU	75.9%	58.5%	94.1%		9.1	7.4
STROKE FLOOR (INC AHP)	89.3%	80.4%	101.9%	106.6%	7.8	7.3
STROKE FLOOR (EXC AHP)	89.5%	79.5%	101.9%	106.6%	7.8	7.3
WARD 12	96.8%	85.3%	100.0%	106.5%	6.3	6.0
WARD 15	86.1%	125.0%	94.4%	123.8%	7.2	7.7
WARD 17	82.6%	92.0%	96.1%	121.0%	7.1	6.7
WARD 18	90.3%	112.0%	65.7%	213.6%	8.6	9.6
WARD 20	86.2%	89.3%	96.3%	95.1%	7.2	6.6
Medicine	82.20%	89.10%	94.94%	109.76%	7.8	7.1
WARD 21	83.8%	97.0%	97.6%	126.9%	8.1	8.0
WARD 22	92.0%	92.9%	93.6%	101.5%	6.7	6.3
ICU	77.8%	45.9%	74.5%	48.3%	47.7	33.7
WARD 8A	73.8%	58.8%	88.1%	86.5%	12.0	9.0
WARD 8C	97.4%	68.0%	93.5%	100.4%	7.3	6.4
WARD 10	83.4%	94.6%	88.4%	95.1%	9.4	8.4
WARD 14	46.7%	55.2%	51.7%	61.8%	13.9	7.4
WARD 19	87.9%	96.8%	98.9%	112.7%	7.8	7.7
SAU HRI	97.0%	92.1%	101.1%	99.1%	7.8	7.6
Surgical	81.1%	77.6%	83.6%	91.6%	11.0	9.1
WARD LDRP	86.6%	84.3%	77.2%	97.7%	21.2	17.7
WARD NICU	87.7%	46.3%	93.7%	52.9%	13.4	11.3
WARD 3ABCD	73.5%	169.9%	73.5%	144.9%	12.5	10.9
WARD 4ABC	78.0%	94.5%	90.8%	79.5%	5.6	4.7
Ward 1D	93.8%	83.8%	100.3%	90.3%	12.1	11.3
FSS	81.5%	104.8%	81.4%	98.4%	11.5	9.8
TRUST	81.65%	88.10%	88.59%	103.24%	9.0	7.9

Nursing Quality Indicators

Medicine – CHPPD and Number of Falls

Medicine – CHPPD and Number of CHFT Acquired Pressure Ulcers

Medicine - Number of falls

Medicine - No. of pressure ulcers

Surgical – CHPPD and Number of Falls

Surgical – CHPPD and Number of CHFT Acquired Pressure Ulcers

Surgical - Number of falls

Surgical - No. of pressure ulcers

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

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

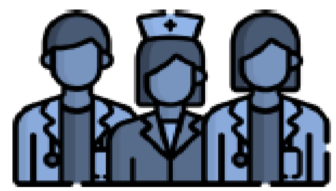
The Trust remains committed to achieving its nurse and midwifery staffing establishments to provide safe and compassionate care to patients.

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.
2. 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.
3. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment and retention strategies. The Safer Nursing Care Tool (Acuity/Dependency Scoring) has been used on in-patient wards and the emergency departments to collect data to inform the next bi-annual review in March 2023.
4. The International recruitment project continues to progress. There are currently 27 nurses in the OSCE preparation process who are anticipated to go into shiftfill numbers by April 2023, and a further 11 are awaiting results from the test earlier this month. CHFT have placed a bid for funding from NHSE to support recruitment of a further 30 International Nurses to arrive before the end of November 2023.
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 plan to retract from Agency spending, commencing with the high cost agencies.

Workforce Metrics

February 2023

The Cupboard
One Culture of
care



Target:
Vacancies (NHSi submitted position) – 230.08 FTE

Workforce

Headcount	↑	6209
Actual FTE	↑	5507.52
Establishment FTE	↑	5969.73
Vacancies FTE	↑	462.21

Most Vacancies:
Nursing and Midwifery **(183.53 FTE)**
Admin & Clerical **(87.64 FTE)**
Additional Clinical Services **(79.51 FTE)**

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

Non Covid- Sickness Absence

Rolling 12 month	↓	4.73%
In-month	↓	5.19%
FTE days lost per FTE (Rolling)	↓	21.10

Main Reason (in-month):
Anxiety, stress, and depression **(29.63%)**

Highest Staff Groups (in-month):
Estates & Ancillary **(9.62%)**
Additional Clinical Services **(8.22%)**

Target:
Rolling – 11.5%

Turnover

Rolling 12 month	↑	8.86%
In-month	↑	0. 53%
Leavers FTE	↑	28.04

Highest Staff Groups:
Allied Health Professionals **(12.06%)**
Estates & Ancillary **(11.90%)**
Administrative & Clerical **(11.29%)**

Target:
EST - 90%
Appraisal – 95%

Essential Safety Training & Appraisal

Overall EST Compliance	↑	92.76%
Appraisal Compliance*	↑	75.86%

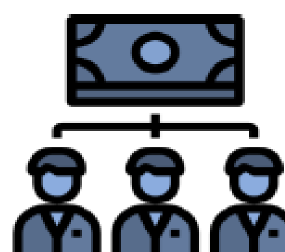
*69.06% at the end of appraisal season 2021/2022.
** Appraisal season for 2022/23 moved & extended to July to December 2022

Lowest EST Core Suite Elements:
Fire Safety **(87.26%)**
Data Security **(88.43%)**

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

Recruitment

Vacancy approval to advert placement 1	↑	9.3
Interview to conditional offer 2	↓	2.5
Unconditional offer to acceptance 3	↓	0.0



Forecast Budget (YTD):
Substantive - £247.49M
Agency - £5.03M
Bank - £14.88M

Spend (YTD)

Substantive	£235.41M
Agency	£17.73M
Bank	£28.08M

Highest Agency Spend:
Medical and Dental **(£2.0M)**
Nursing and Midwifery **(£8.9M)**

All data correct as at 31 January 2023

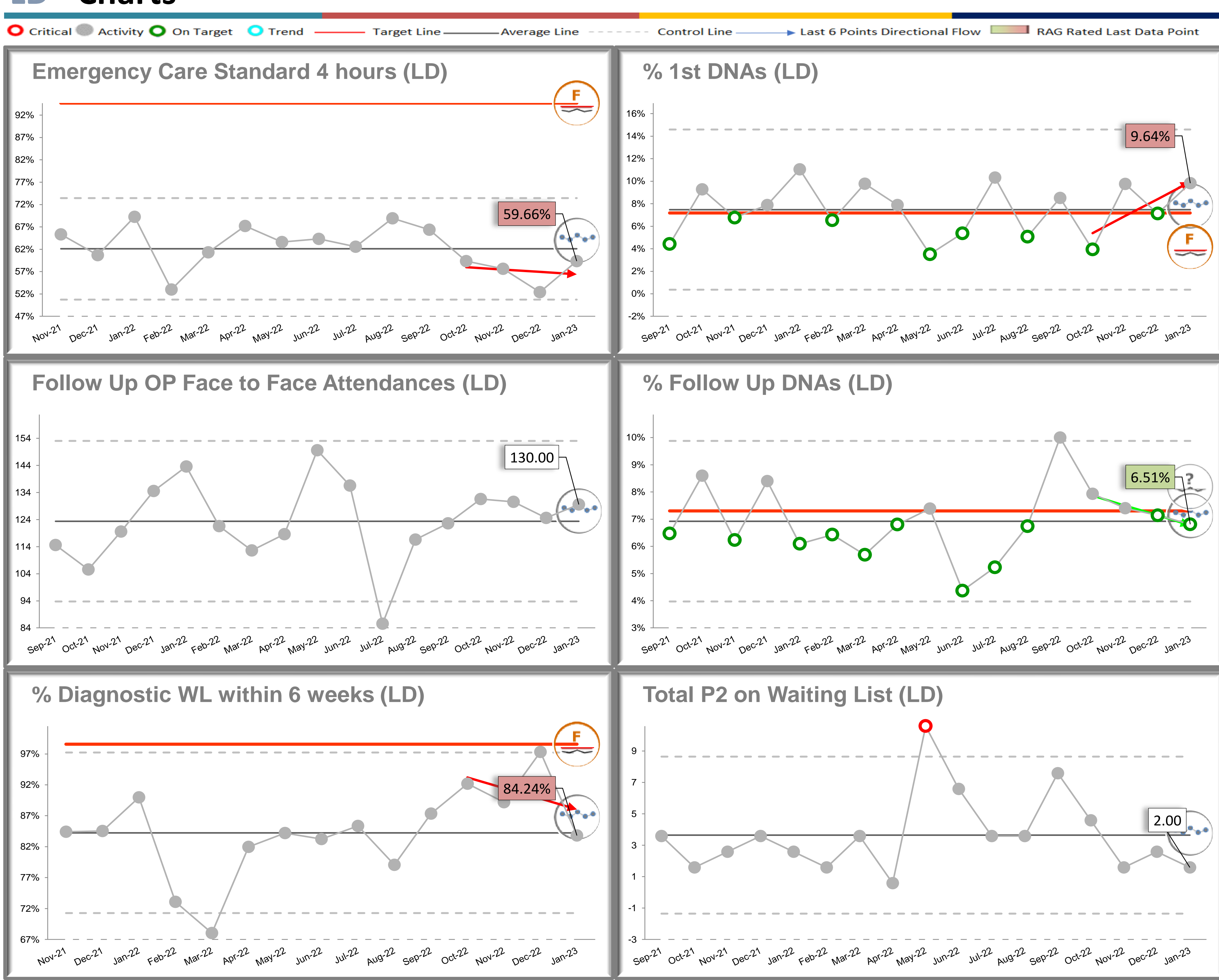
Directorate Health Heatmap

Directorate	Division	NHS SS Response Rate 2022	Engagement Score 2021	EST (Jan 2023)	AfC Appraisal 2022-23 (YTD)	Sickness (Non-Covid) (12m) (Dec 2022)	Annual Leave Usage (Apr 2022 - Dec 2022)	Turnover (12m) (Jan 2023)	Vacancy Rate (Jan 2023)	Health Score
Community Management	Community	66.7%	7.4	96.1%	91.5%	2.12%	72.30%	4.3%	-5.2%	88.9%
Workforce and Organisational Development	Corporate	87.1%	7.6	96.8%	97.9%	2.68%	69.85%	11.8%	-4.1%	83.3%
Finance	Corporate	86.7%	8.0	98.5%	95.0%	0.82%	67.35%	4.6%	-5.3%	77.8%
Information	Health Informatics	86.8%	7.8	98.5%	89.6%	2.24%	66.52%	5.8%	0.5%	77.8%
FSS Management	Families & Specialist Services	56.7%	7.2	95.6%	96.6%	3.36%	65.83%	9.4%	1.9%	77.8%
Medical Divisional Management	Medical	57.6%	7.4	92.9%	73.1%	5.10%	36.83%	5.6%	1.8%	72.2%
Community Therapies	Community	54.4%	7.0	94.5%	90.1%	4.05%	74.95%	11.7%	5.6%	72.2%
Surgical Divisional Support	Surgery & Anaesthetics	73.3%	7.8	90.0%	62.1%	4.40%	39.76%	7.5%	9.3%	66.7%
Critical Care	Surgery & Anaesthetics	56.9%	6.5	98.2%	55.0%	7.37%	71.87%	7.7%	-8.4%	66.7%
Outpatients & Records Services	Families & Specialist Services	62.6%	6.5	99.2%	96.8%	5.02%	77.23%	15.2%	16.3%	66.7%
General Surgery	Surgery & Anaesthetics	37.1%	6.9	91.6%	86.5%	3.20%	72.04%	5.8%	3.6%	66.7%
Quality	Corporate	62.2%	7.3	92.7%	53.8%	5.19%	65.04%	8.4%	-2.8%	61.1%
Corporate & Operations	Health Informatics	68.2%	7.1	95.4%	89.9%	1.82%	60.02%	12.4%	6.3%	61.1%
Corporate Services	Corporate	71.6%	8.1	92.5%	59.5%	2.02%	51.88%	14.3%	-3.5%	55.6%
Surgical Medical Secretaries	Surgery & Anaesthetics	62.2%	6.9	96.8%	58.0%	5.03%	70.57%	9.9%	8.5%	55.6%
Pharmacy	Families & Specialist Services	51.8%	6.7	97.2%	94.9%	3.80%	73.02%	13.8%	10.4%	55.6%
Radiology	Families & Specialist Services	44.8%	6.3	97.1%	88.1%	2.90%	44.82%	10.8%	9.1%	50.0%
Childrens	Families & Specialist Services	43.2%	6.9	92.0%	74.1%	4.19%	63.65%	6.3%	7.7%	50.0%
Head & Neck	Surgery & Anaesthetics	42.4%	6.7	95.2%	88.5%	4.89%	72.14%	12.8%	6.0%	50.0%
Community Nursing	Community	34.7%	7.1	91.3%	82.9%	6.39%	73.17%	5.7%	4.8%	50.0%
Pathology	Families & Specialist Services	40.8%	6.4	96.6%	93.4%	5.51%	66.43%	11.1%	8.3%	44.4%
Womens	Families & Specialist Services	48.4%	6.3	93.0%	73.0%	5.22%	66.68%	7.0%	13.9%	44.4%
Medical Specialties	Medical	34.1%	6.3	90.2%	44.5%	4.71%	54.65%	6.4%	13.3%	44.4%
Operating Services	Surgery & Anaesthetics	33.8%	6.2	89.8%	65.8%	5.60%	73.41%	6.8%	0.8%	44.4%
Integrated Medical Specialties	Medical	31.0%	6.8	89.8%	68.0%	5.12%	63.68%	9.8%	6.7%	38.9%
Pharmacy Manufacturing Unit	Pharmacy Manufacturing Unit	69.5%	6.1	96.2%	94.4%	6.06%	64.86%	23.0%	12.3%	33.3%
Corporate Central Operations	Corporate	30.8%	-	91.8%	36.1%	8.82%	68.96%	10.6%	13.4%	31.3%
Acute Medical	Medical	29.6%	6.4	89.7%	68.5%	6.70%	62.14%	6.5%	16.6%	27.8%
Emergency Care	Medical	29.3%	6.3	89.9%	75.7%	5.17%	62.79%	4.4%	7.7%	27.8%
Orthopaedics	Surgery & Anaesthetics	26.5%	6.0	88.8%	63.8%	4.88%	67.37%	9.8%	7.5%	22.2%
Service Delivery	Health Informatics	-	-	95.0%	83.3%	12.12%	60.77%	36.4%	20.0%	16.7%

LD - Key measures

	21/22	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	YTD	Performance Range		
Recovery																Green	Amber	Red
Total P2 on Waiting List (LD)	32	3	2	4	1	11	7	4	4	8	5	2	3	**2**	**2**	No target		
Total P3 on Waiting List (LD)	119	8	11	11	15	17	13	10	11	11	12	7	8	**15**	**15**	No target		
Total P4 on Waiting List (LD)	58	2	1	1	2	3	4	4	2	2	3	4	3	**2**	**2**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	69.57%	53.33%	61.62%	67.52%	63.93%	64.66%	62.89%	69.23%	66.67%	59.68%	57.97%	52.74%	**59.66%**	**62.08%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	61	63	54	50	48	55	41	35	37	35	33	35	**21**	**21**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	41	47	38	10	8	8	5	4	6	5	3	4	**1**	**1**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.9043	0.7354	68.48%	82.40%	84.64%	83.68%	85.80%	79.51%	87.80%	92.61%	89.63%	97.76%	**84.24%**	**84.24%**	>=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	not applicable	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	100.00%	100.00%	100.00%	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	not applicable	not applicable	100.00%	not applicable	not applicable	100.00%	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	not applicable	not applicable	100.00%	not applicable	not applicable	**not applicable**	**100.00%**	>=90%		<89%
Activity - Number of Attendances																		
New Outpatient Attendances - Face to Face (LD)	366	38	24	31	38	40	41	40	48	59	38	50	30	**47**	**431**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	18	16	18	11	20	15	9	13	16	18	13	17	**15**	**147**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	144	122	113	119	150	137	86	117	123	132	131	125	**130**	**1250**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	45	56	67	57	62	61	42	48	50	55	74	44	**51**	**544**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	10.87%	6.35%	9.59%	7.69%	3.33%	5.19%	10.14%	4.88%	8.33%	3.75%	9.57%	6.94%	**9.64%**	**6.96%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	5.79%	6.13%	5.39%	6.50%	7.09%	4.07%	4.93%	6.44%	9.70%	7.63%	7.10%	6.84%	**6.51%**	**6.76%**	<=7.0%	7.1% - 7.9%	>=8.0%

LD - Charts



18. Safeguarding Update - Adults and Children - Executive Summary

For Assurance

Presented by Lindsay Rudge

Date of Meeting:	2nd March 2023
Meeting:	Board of Directors
Title:	Safeguarding Adults and Children Bi - Annual Report
Author:	Andrea Dauris (Associate Director of Nursing – Corporate Services) Alison Edwards (Head of Safeguarding – CHFT)
Sponsoring Director:	Lindsay Rudge (Chief Nurse)
Previous Forums:	Safeguarding Committee Meeting 01st February 2023 Quality Committee 20th February 2023

Actions Requested:

TO NOTE: The key activity of the Safeguarding Team for the reporting period April 2022 - September 2022

Purpose of the Report

This report provides an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust for the reporting period April 2022 - September 2022.

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

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

- Prevent
- Safeguarding Boards/Partnerships
- Hidden Harms
- Mental Capacity Act and Deprivation of Liberty Safeguards/Liberty Protection Safeguards
- Training
- Safeguarding Supervision
- Adult Safeguarding
- Children's Safeguarding
- Mental Health
- Children Looked After Calderdale
- Maternity Safeguarding

Key Points to Note
- We have achieved above 90% compliance in levels of safeguarding Adults/Children/ Prevent/ MCA/DoLS training   - Training compliance is below 90% for Female Genital Mutilation (FGM- 87%) and Receipt and Scrutiny Training (57%)   - Safeguarding supervision is reported at 66% which demonstrates a 11% increase in compliance; however, work continues in partnership with the Divisions to look at how we can support to increase compliance.   - We continue to maintain a business-as-usual functionality continuing with day-to-day operations and attendance at multi-agency virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Calderdale and Kirklees and their sub-groups.   - We continue to fulfil our statutory responsibility in responding to partnership requests for information in relation to serious practice reviews; domestic homicide reviews and serious adult reviews   - We are reporting on our progress of the Safeguarding Strategy (2022-2024) through the Safeguarding Committee.   - We have completed the Safeguarding Standards and Mental Capacity assurance documents requested by the ICB formerly CCG.   - CHFT staff have continued to make Deprivation of Liberty applications throughout this period ensuring the rights of our patients are safeguarded. These have continued to increase in in the first 6 months of 2022 showing a maintained awareness amongst staff to ensure the Human Rights of patients are protected.   - We have collated and submitted our response to the consultation on the Mental Capacity Act Code of Practice.   - We have successfully recruited to the Deputy Head of Safeguarding/Named Professional Adult Safeguarding post.   - Initial and Review Health Assessments carried out by the Children Looked After Team in Calderdale have continued. A contingency plan has been implemented to address the backlog of review health assessments for children out of area placed in Calderdale.   - Kirklees and Calderdale Safeguarding Adults Board have recognised the work of the BLOSM project and the pilot relating to the Trauma Navigators in our Emergency Departments
EQIA – Equality Impact Assessment https://intranet.cht.nhs.uk/non-clinical-information/equality-and-diversity/equality-impact-assessment-process/ (consider the accessibility / readability of this report from a standpoint of our protected characteristic groups. Confirm that an EQIA has been completed in relation to potential impact arising from the report finding and recommendations – summarise if any significant issues have arisen from this assessment)
Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that those in the most vulnerable groups are protected from harm.
Recommendation
The Board of Directors are asked to note the key highlights of the report.

Signed off by: ……………………….

Date signed off: ……………………..

1. INTRODUCTION

This report is the Bi Annual Safeguarding Adults and Children Report for the Trust Board, for the reporting period April 2022 – September 2022.
The report provides an overview of activity and outlines key achievements and developments on priorities and our safeguarding strategy for 2022-2024.

2. PREVENT

The Counterterrorism and Security Act (2015) places a duty on CHFT to have; *'due regard to the need to prevent people from being drawn into terrorism.'*
CHFT Safeguarding Team undertakes regular patient information requests regarding potentially high-risk individuals and shares these with PREVENT partner agencies. We also attend Channel panel meetings to discuss individual cases to understand their vulnerability to being drawn into terrorism activities, as well as engaging with the person and partner agencies (e.g., Child and Adolescent Mental Health Service (CAMHS), Housing, Social Care) to support these vulnerable individuals to consider how they can make positive changes to their lives.
PREVENT training is now available by Government PREVENT wrap training. We have worked closely with the PREVENT lead in the local authority and the BAME network to address some issues that have been highlighted in relation to this training. In response to the concerns raised; there has been contact with the Department of Health and Social Care who have been keen to receive feedback in relation to the concerns raised about the content of this training. Our Named Nurse Safeguarding Children has updated the BAME network in relation to any progress with this work.
CHFT has met its statutory responsibilities with the key achievements set out below: -

Key Achievements

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

Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)

- Ensure representation of adults and children's representatives at Calderdale Channel panel.

3. SAFEGUARDING BOARDS/ PARTNERSHIPS

The Safeguarding Team have maintained the safeguarding service, ensuring our key statutory roles were maintained. There has been further recruitment of a 0.8 wte Specialist Nurse in the Looked After Children/Care Leavers Team. The Named Professional Adult Safeguarding post has become vacant and there were initially difficulties in recruiting to this post, resulting in a

review of the job description. This has led to development of a new post as Deputy Head of Safeguarding/Named Professional Adult Safeguarding. Recruitment to this post has been successful and the post will be filled later in the year.

Given the gap in cover arrangements the team have prioritised essential safeguarding work and informed key partners of the staffing position.

The Safeguarding Boards and Partnerships have been kept fully briefed and updated throughout this period. The Safeguarding Team have fulfilled all partnership requests for information and have contributed towards several safeguarding and domestic homicide reviews during this period. We have developed a process with the Risk Management Team to ensure the Serious Incident Panel have oversight of the safeguarding review process. Significantly, many of the reviews have identified that trauma informed practice approaches, should improve the health outcomes of patients with complex needs and may address some local health inequalities. Kirklees and Calderdale Safeguarding Adults Board have recognised the work of the BLOSM project (Bridging the gap; Leading a culture in change; Overcoming adversity; Supporting vulnerable people; Motivating independence and confidence) and the pilot relating to the Trauma Navigators in our Emergency Departments. The BLOSM project supports a trauma informed approach to emergency care and through the development of social pathways, the trauma navigators and ED staff can support vulnerable service users who attend our ED departments and be able to respond to their specific needs on a 24-hour basis.

Self-neglect continues to be a significant theme in Serious Adult Reviews (SARS) and the self-neglect pathways and risk escalation conferences continue to be promoted and are in regular use. Other SAR reports have identified the use of the Mental Capacity Act (MCA) with patients who may have difficulties with their executive functioning (such as those with substance misuse problems, head injuries and phobias etc). We have updated the MCA policy to reflect this area and have input into various groups (such as the High Intensity User Group) to ensure that recent case law is drawn to the attention of staff working with people with complex needs. Self-Neglect/MCA/DoLS was a focus topic during Safeguarding Week in June 2022.

We continue to work closely with SWYFT to support staff with the management of complex mental health patients (adults and children) within the Divisions over the past six months.

The learning from this review and the National Panel Thematic Review on Non-Accidental Injury to Under One Year Olds identifies hidden males/significant others as a key area of learning and this will help inform in safeguarding practice going forward. Safeguarding children training has been updated to reflect this. Hidden males/significant others were a focus topic during Safeguarding Week in June 2022.

Key Achievements

- We have carried out business as usual within the team and continued to maintain our operational service throughout.
- We have sent our Kirklees and Calderdale partners assurances regarding our business continuity arrangements.
- We have continued to attend virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Kirklees, and their safeguarding subgroups.
- Collaboratively our partner SWYFT has worked with CHFT to support the management of complex mental health patients.
- Contributed to Safeguarding Week 2022, promoting MCA/DoLS/Self-Neglect/Hidden males and significant others.
- Supported the BLOSM project.

Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan

- Continue to learn about the impact of the Covid 19 pandemic in relation to safeguarding children/ adults at risk and pregnant women how this is influencing safeguarding practice.
- Continue to support the learning from safeguarding and domestic homicide reviews influences our safeguarding practice.
- Publicise the safeguarding strategy and monitor our progress in relation to this.
- Continue to support the work of the BLOSM project.

3.1 Hidden Harms

Crimes such as child abuse, child sexual exploitation, domestic abuse (including "honour" based abuse), sexual violence and modern-day slavery, typically take place behind closed doors, hidden away from view. The pandemic has provided and opportunity for hidden harms to children and adults to escalate, and this has increased the complexity of the needs of families requiring effective early intervention and help. Our response to this is described below:

3.2 Health based Independent Domestic Violence Advisor (IDVA):

CHFT recruited to the role and our IDVA who commenced in post 24.01.2022. Funding for the IDVA post has been extended until 2025. With the funding for 2021-2022 we were able to secure places for the IDVA to complete the Women's Aid IDVA training and the Domestic Abuse Specialist Advisor to complete the Saving Lives IDVA training. Both have successfully completed the course.

The role of the health IDVA is first line contact for patients who are victims, offering refuge, emergency accommodation, support, liaison with police and establishing links for individuals and their families to longer term community-based support. This now occurs often whilst the victim is in hospital or in the Emergency Department (ED).

The role includes accessing and screening the referrals made by the ED and then referring into either the DRAMM (Calderdale) or DRAMM (Kirklees) daily risk assessment multi-agency meetings. Proactively the health IDVA service aims to improve the training and education of front-line staff to develop understanding and confidence in responding to domestic abuse.

The IDVA has a visible presence in ED supporting staff and seeing patients presenting with domestic abuse or when a patient discloses domestic abuse.

As part of the funding CHFT provide midyear reports and end of year reports for the Ministry of Justice (MOJ). The midyear report includes data from April to September. The IDVA has supported 94 victims. The age range of victims supported is between 13 and 75+ years.
Initial feedback from the victims supported by IDVA submitted to the MOJ is:

"It feels nice to know that there is someone in the hospital who rang to ask how I was and discuss what support is available".
"It is really reassuring to talk to someone about what support is available and how I can access support".
"No professionals have rung back to ask me, how I was doing once discharged from their service. I was surprised you did call back to check on me. I was overwhelmed and happy".
"You have helped me so much with your advice and always encouraging me, I just wanted to

say thank you and let you know I have received my visa and benefits”. “Your support and guidance have really helped me through my hard times, even though I asked for your advice which was not always related to domestic abuse, you listen to me, and I did not feel rushed or ignored”.
“I was very happy that I was able to explain to you in my language and you listened and understood my needs”.

The IDVA continues to provide bespoke training for domestic abuse monthly. There are plans to strengthen the targeted enquiry training and routine enquiry training for domestic abuse from September 2022.

3.3 Calderdale Domestic Abuse Services –

Safe Lives have been commissioned to undertake a whole system review by operationalising a Public Health approach. Using systems thinking methodology and through the lens of the whole family this will identify opportunities for improving the risk led response, early intervention, and prevention of domestic abuse. This includes a systems-wide assessment of the current local landscape, identifying data and ongoing monitoring opportunities, consulting with service users and providers to understand risk and protective factors.

The new Domestic Abuse DRAMM (Daily Risk Assessment Management Meeting) was successfully implemented in Calderdale. Following this report, the domestic abuse hub moved to a DRAMM meeting. The Domestic Abuse Specialist Practitioner attends the daily meeting and shares health information from CHFT, LOCALA and SWYPFT.

The first MARAC (Multi-Agency Risk Assessment Conference) meeting was held in July 2022. CHFT is represented at MARAC by the Named Midwife Safeguarding & Domestic Abuse Lead providing CHFT’s health updates into the risk assessment and discussion of high-risk domestic abuse cases.

There is a planned audit in October 2022 to conduct a review of all health providers responses to domestic abuse through an audit of cases (including child of all ages and unborn) to identify any areas for improvement in process and procedures from the Domestic Abuse Hub.

3.4 Kirklees Joint Targeted Area Inspection (JTAI) Child Sexual Exploitation/ Criminal Exploitation

Notification of the inspection was received from the CCG now the ICB 13/06/2022 and this was completed 01/07/2022. The agencies involved were the Police; Children’s Social Care; Education and relevant Health Services.

These Inspections are carried out by inspectors from:
OfSTED
Care Quality Commission (CQC)
Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)

Focus of the inspection – to better understand and evaluate the multi-agency response in relation to criminal exploitation, and to look at whether agencies have a distinct and effective focus on identifying children at risk of or experiencing sexual exploitation. The scope of the inspection was to evaluate practice over the previous 6 months.

Overall summary from Inspectors.
The feedback from the JTAI Inspection team was summarised with an overarching positive narrative. They particularly thanked colleagues for their enthusiasm and engagement, patience and co-ordination and how readily learning opportunities have been taken on board.

It was noted that Team Kirklees have: Strong professional relationships; Meetings are well attended by partners; 'Health' voices are heard and valued; Strong evidence of working together; Young people are cared for by well supported and knowledgeable practitioners; Practitioners are well supported by skilled, knowledgeable and approachable safeguarding teams; Our partnership is well led; Together we are tenacious, creative and persistent at engaging with our young people; Together we support risks being reduced to young people

Our young people said to the inspectors:

"They listened a lot"

"I'm feeling positive about the future"

Feedback specific to CHFT

- training data good (in expected target area).
- supervision mandatory and the rostered small groups supports good discussion and reflection which will enhance knowledge and skills.
- vulnerable children are identified early using CP-IS and internal flagging systems, with work underway with local authority to enhance flagging systems.
- navigator posts in autumn to support trauma presentations demonstrate the Trust's commitment to supporting 11-25 years old cohorts with trauma presentations.
- inconsistencies in professional curiosity, records didn't consistently demonstrate curiosity and sometimes 'medical model' focused.
- work to be done around recognising the 'golden' opportunities when a young person presents and exploring the route cause rather than just the medical presentation.
- some barriers to consistently using the screening questions and would benefit from some specific 'exploitation' focused questions to support clinical colleagues to be further curious about the root causes behind a presentation but they noted the plans to review the tools used.
- noted the delay in the trauma pathways in ED being embedded, with recent further delay noted in referral to CSC.
- liaison out, remembering to link in with GP colleagues.

An action plan has now been developed to support the learning and strengthen our response to child sexual exploitation/criminal exploitation. This is now being monitored via the Safeguarding Committee and Kirklees Health Assurance Improvement Group.

Key Achievements

- We continue to support local partnership meetings for children and young people at risk of exploitation.
- We have agreed a system with the local authority to flag hospital records of children/young people at risk of exploitation.
- Worked alongside ED and Paediatric colleagues to support the Kirklees JTAI.
- The under 18 and adults at risk CHFT bespoke proforma has now been built into EPR.
- We have monitored our safeguarding data closely throughout the year and provide assurance to the Safeguarding Boards/Partnership relating to our activity.
- Continue Review the impact of the Health Based IDVA.
- Increased access to Domestic Abuse training.
- Attendance at Calderdale MARAC.

Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)

- Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this.
- Develop awareness and training regarding the under 18's and adults at risk safeguarding proforma.
- Raising awareness of the Trauma Informed approach to working with patients and their families.
- Support staff to identify and provide support for those who have multi-complex needs; are homeless or display signs of self-neglect.
- Support the JTAI action plan.

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

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

All CHFT DoLS applications continue to be quality assured by the Adult Safeguarding Team providing evidence that the restrictions on the patient, that amount to a deprivation of liberty, are the least restrictive and in the patient's best interests, in addition to meeting the statutory requirement for an urgent DoLS authorisation and an application for a Standard Authorisation. Once the Standard Authorisation has been granted, the team ensure that any conditions on CHFT are complied with and that the Relevant Persons Representative (RPR) or paid RPR is identified in the patient's records. We continue to work closely with the Independent Mental Capacity Advocate (IMCA) Service.

4.1 DoLS Data

	Number of Urgent DoLS Authorisations	Number of Standard Authorisations	Average p/month
2018/19	219	27	18
2019-20	186	20	15
2020-21	191	0	16
2021-22	350	3	29
April 22-Sept 22	191	3	31

The number of Urgent Authorisations has risen in the reporting period and reflects CHFT staffs ongoing commitment to protecting the Human Rights of their patients.

4.2 The Mental Capacity (Amendment) Bill

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

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

Hospitals will become the responsible body and will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager). To ensure CHFT meets it statutory and legal responsibilities and to guarantee the deprivation is lawful, referral pathways and the authorisation process will need to be considered and agreed within the organisation.

For the responsible body to authorise any deprivation of liberty, it needs to be clear that:

- The person lacks capacity to consent to the care arrangements
- The person is of unsound mind
- The arrangements are necessary and proportionate

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

LPS will apply to children aged 16 and 17.

The MCA code of practice/regulations was released for consultation in March 2022. The Safeguarding Team has collated the consultation response from CHFT, and this has been submitted. The consultation period has closed on the 14/07/2022 and the Government will need to consider its response and it is anticipated that this will take place over the winter of 2022-2023. Following this period of consideration, with possible further amendments to the code of practice/regulations and its transition to law, it is expected that LPS will not come into force until October 2023 and possibly April 2024. The code of practice resulted in lack of clarity around what constitutes a deprivation of liberty, and this makes it difficult to plan for the resource required to support LPS.

An audit of MCA/DoLS has been completed and the results show there is variable knowledge and skills amongst our workforce relating to MCA and DoLS. An action plan is being developed to support staff in their understanding of this to help support the correct application of the MCA and subsequently our transition to LPS. The training offer relating to MCA/DoLS has been reviewed and the e-learning packages have now been identified on the electronic staff record. The e-learning will be supplemented by bespoke face to face sessions.

CHFT continue to attend the Local Implementation Network (LIN) and there are regular meetings with the ICB formerly CCG lead.

As part of the commissioning process, ICB's (formerly CCG's) will reasonably expect to see evidence of the LPS working effectively and the MCA LPS is likely to be included in the NHS standard contract.

Key Achievements

- DoLS referrals during this period have continued which demonstrates an awareness amongst our staff to ensure the Human Rights of our patients are maintained.
- We continue to quality assure all referrals made by CHFT staff.

- Training offer has been reviewed and identified on the electronic staff record.
- Developed and delivered bespoke training sessions in response to identified gaps in knowledge and skills.
- Audit completed relating to the use MCA/ DoLS.
- The MCA/ DOLS policy has been updated.

Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)

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

5 TRAINING

The Safeguarding Children's training packages for level 2 and level 3 have now been reviewed and include a hybrid approach of e-learning and face to face sessions. This ensures compliance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and the Looked After Children: Roles and Competencies for Healthcare Staff (2020).

The Safeguarding Adults training package is currently the package agreed during the Covid-19 pandemic and is an e-learning package requiring self-certification upon completion. This will be reviewed once the Named Professional Safeguarding Adults is in post to ensure compliance with the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2018). We continue to supplement this training through regular updates and briefings though divisional Patient Safety and Quality Board meetings, safeguarding newsletter, supervision sessions and bespoke training.

ED bespoke training reviewed, and a new format established with a proposed start date of Dec 22

Figure 1 indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee. As of September 2022, overall compliance was at 92.21%.

	31.03.22					30.09.22					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6176	24091	22378	1713	92.89%	6179	24022	22151	1871	92.21%	-0.68%
Competence Name											
NHS|MAND|Mental Capacity Act - 3 Years|	202	202	184	18	91.09%	247	247	220	27	89.07%	-2.02%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3329	3329	3144	185	94.44%	3316	3316	3031	285	91.41%	-3.04%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	776	776	727	49	93.69%	804	804	768	36	95.52%	1.84%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1750	1750	1654	96	94.51%	1723	1723	1665	58	96.63%	2.12%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3807	3807	3608	199	94.77%	3788	3788	3495	293	92.27%	-2.51%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	537	537	519	18	96.65%	559	559	547	12	97.85%	1.21%
372|LOCAL|Female Genital Mutilation|	606	606	529	77	87.29%	562	562	493	69	87.72%	0.43%
NHS|MAND|Prevent WRAP - No Renewal|	6176	6176	5784	392	93.65%	6179	6179	5729	450	92.72%	-0.94%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1747	1747	1647	100	94.28%	1718	1718	1661	57	96.68%	2.41%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3755	3755	3561	194	94.83%	3801	3801	3521	280	92.63%	-2.20%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	590	590	562	28	95.25%	548	548	512	36	93.43%	-1.82%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	82	82	56	26	68.29%	87	87	50	37	57.47%	-10.82%
372|LOCAL|Safeguarding Supervision|	727	727	397	330	54.61%	690	690	459	231	66.52%	11.91%
Grand Total	**6176**	**24091**	**22378**	**1713**	**92.89%**	**6179**	**24022**	**22151**	**1871**	**92.21%**	-0.68%

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

(Figure 1)

5.1 Exception reporting: Receipt and Scrutiny Training and Safeguarding Children Supervision.

During the reporting period no receipt and scrutiny training has taken place due to the retirement of the post holder. SWYFT have been reviewing this training and are now able to recommence this training from October 2022. We continue to work with SWYFT and our Nurse Consultant in Mental Health to ensure our staff are supported in receipt and scrutiny of Mental Health Act papers.

The levels of Receipt and Scrutiny (of statutory Mental Health Act documentation) training is 57% for this period however this should start to increase once the training recommences.

Safeguarding Supervision is delivered virtually though Microsoft Teams and compliance is 66.5%. Compliance continues to be monitored via the Safeguarding Operational Group and Safeguarding Committee and the plan to increase compliance is to adopt a targeted approach by working more directly with line managers to identify challenges in relation to attendance and recording compliance.

Work is underway to refresh and embed the safeguarding champions role across the CHFT footprint, including improving measures for safeguarding supervision facilitation. Recent feedback from clinical staff identified that they were not always aware of who their champion was. In response to this, champions are now identified by a badge. Going forward we are looking at increasing the champions network to include MCA and Prevent champions.

Key Achievements

- We continue to engage and share training compliance with Divisions bi-monthly.
- The delivery of Safeguarding Children Training is compliant with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and the Looked After Children: Roles and Competencies for Healthcare Staff (2020).
- Receipt and Scrutiny training will recommence from October 2022.

- Updated the Safeguarding Supervision Policy.

Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)

- Review of the Adult Safeguarding training to ensure compliance with the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2018).
- Continue to develop a more targeted approach to increase safeguarding supervision compliance.
- Continue to work with SWYFT to support attendance at the Receipt & Scrutiny training.
- Review and support the development of the Safeguarding champions role.
- Introduction of MCA/ Prevent champions.

6. ADULT SAFEGUARDING

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

Ineffective or unsafe discharges remain an issue for safeguarding; this position continues to be shared at Safeguarding Committee meetings which has representation from the four divisions. The Safeguarding Team continue to work with local authority partners to ensure oversight and investigation of all these cases. Kirklees Local Authority have previously agreed that poorly managed discharges can be managed by a different approach to Calderdale and that some of these can be managed as quality-of-care concerns. In Calderdale all ineffective discharges are managed as S42 investigations under the Care Act 2014. To date this process remains unchanged.

The strategic transformation programme has been addressing continual improvement and the Trust now has in place the Safari programme at HRI whereby pharmacists are working directly with discharges to ensure that the patient fully understands their medication use, potential side effects and that they have the correct medication for their discharge. The initial safeguarding data appears to confirm that the medication issues on discharge have decreased, and we anticipate this improvement will be sustained. Additionally, the Standard Operating Procedure (SOP) introduced in ED has made some improvements with the quality of discharges from ED.

Data relating to discharges is now received onto the Enhanced Dashboard Metric and early data highlights a reduction in discharge related incidents. This measure continues to be monitored on a weekly basis going forward. The Clinical Governance Support Mangers submit separate reports to Divisional PSQB's identifying trends in incidents related to discharges. The Director of Operations has confirmed that information relating to discharges is now monitored through the Urgent & Emergency Care Delivery Group (U&ECDG).

The clinical site matrons do look at discharge as part of their everyday role, however the ward matrons and ward teams have more of a key role in this and it should fall under their remit to monitor through their directorate and divisional PSQBs. This information is then reported through the U&ECDG as exceptions to ensure we capture any learning at ward level.

The Deputy Head of Safeguarding/Named Professional Adult Safeguarding will attend U&ECDG once in post and will continue to work with the Local Authorities to provide assurance relating to discharges with a safeguarding element.

Where CHFT are required to provide feedback regarding adult safeguarding initial investigations to the Local Authority, we are not meeting the multi-agency agreed timeframes which are defined in the multi-agency safeguarding adult's policy. We are continuing to work with the Local Authority to improve this process, however due to the impact of staffing within the Local Authority and the vacant Named Professional Adult Safeguarding post this work is progressing slowly.

In response to this, there has been ongoing work with the Risk Management Team to align Trust and safeguarding processes and increase understanding between the two teams of how this can be addressed. The Risk Management Team are meeting regularly to review incidents and the Safeguarding Team feed into these huddles. A dashboard has been developed to identify open cases and meetings are planned with the Local Authority to manage open cases. We have continued to work with the Local Authority to close some of their long-term cases during this reporting period. This risk remains at 9 on the risk register.

The Named Professional Adult Safeguarding will meet with the Local Authority to discuss our approach to further reducing this risk when in post.

Key Achievements

- Management of Patients Not Brought for Appointments Policy has been reviewed.
- Worked alongside the Local Authority to close some of the chronic cases.
- Adult Safeguarding continue to work closely with Kirklees Local Authority to agree that the increased number of ineffective discharges could be managed internally by CHFT as opposed to formal individual Care Act (2014) Section 42 investigations.

- **Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**
- Streamline safeguarding processes and investigations.
- Working with the new Lead Nurse Children to progress the embedding of the Transition Policy.
- To contribute to support Divisions and the ongoing work to drive quality improvements in relation to hospital discharges.
- To work alongside and support Divisions with regard to providing timely feedback to the local authority.

7. CHILDREN SAFEGUARDING

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

Key Achievements

- Effective partnership working demonstrated as part of the Kirklees JTAI (Joint Targeted Area Inspection) undertaken June – July 2022. Positive feedback received. Action plan developed and recommendations successfully being progressed.
- Safeguarding Children Policy reviewed.
- Recruitment within FSS of two Specialist Nurses. One Bereavement Nurse and the other a Mental Health Liaison Nurse, both working closely with the Safeguarding Team to improve processes and outcomes for children, young people, and their families.

- Process established for identifying where 16- to 17-year-olds are admitted, joint working relationships with departments developed and safeguarding team continuing to support.
- Developed a pathway with the Calderdale Integrated Care Board (ICB) formerly CCG and Calderdale Children's Social Care for non-mobile babies referred under the BBS protocol via GP services.
- Development of a Barriers to Discharge Flowchart / Escalation flowchart to support with complex prolonged admissions relating to children and young people.
- Development of a new ad-hoc electronic ED Paediatric Liaison Notification form with a proposed go-live date of January 2023.
- Paediatric Sit Rep embedded into core safeguarding work, children and young people reviewed and supported by the team. Sit reps are now produced over the weekend where previously they were produced Monday to Friday.
- Re-established Paediatric Emergency Department Forum with a standing agenda item for a Safeguarding Team update.
- Robust oversight of paediatric patients who have mental health concerns and closer working with the paediatric department with the support of the newly appointed Mental Health Liaison Nurse. Safeguarding representation at MDT meetings established.
- Links established with the Trauma Navigator Leads (BLOSM) and work completed to support with the development of the pathways. Target age range 11 – 25 years. Launch planned for January 2023.

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Paediatric Liaison Sister and Safeguarding Children / Maternity Advisor to maintain links with the Trauma Navigators - BLOSM.
- Continued work ongoing to support inclusion of the child's voice/lived experience of the child in safeguarding practice. Development of a 7-minute briefing on professional curiosity completed.
- Audit introduction of the ad-hoc electronic paediatric liaison notification form.
- Progress the ongoing work relating to the improvement of the quality of the paediatric discharge summaries.

8. MENTAL HEALTH

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

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

Around one in four women experience mental health problems in pregnancy and during 12 months after giving birth. If left untreated, mental health issues can have a significant negative and long-lasting effects on the woman, the child and the wider family. CHFT Maternity Services continue to work with SWYFT, Locala and the voluntary sector to provide services for pregnant and post-natal women who have mental health concerns, including those who may have experienced baby loss/removal at birth/birth trauma.

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

Key Achievements

- The Department of Health and Social Care (DHSC) and NHS England (NHSE) have provided guidance to professionals on the use of the Mental Health Act during the pandemic. The Court and Tribunals Department instructed the MHA office to carry out their functions remotely during the Coronavirus period. The Mental Health Act Tribunals and Hospital Managers hearings which are co-ordinated by the MHA Office have continued remotely, ensuring our patients' rights to appeal have been discharged throughout this period.
- The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.
- There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

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

9. CHILDREN LOOKED AFTER AND CARE LEAVERS (CALDERDALE)

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

Looked after children may live in foster homes, residential placements or with family members (connected carer's).

Quarter 1

Our entire Initial (IHA) and Review Health Assessments (RHA) have been undertaken face to face. This includes children placed in Calderdale from an external local authority.

Initial Health Assessments
A total of 18 IHA's have been completed. 100% in timescales:

Review Health Assessments
A total of 96 RHAs were due. 87 RHAs were completed in timescales. 91% in timescales:
-1x young person appointment delayed due to carer cancelling. RHA completed the following month
-1x young person initially difficult to engage with. RHA completed the following month.
- 1x young person health assessment delayed to placement move. RHA completed the following month
-2x young people refused their health assessments. Children Looked After (CLA) nurse continues with attempts to engage.

1x young person appointment cancelled by Carer, young person then went away on holiday. RHA completed the following month.
1x child delayed due to local area undertaking on behalf of Calderdale

Quarter 2
Our entire Initial (IHA) and Review Health Assessments (RHA) continue to be undertaken face to face. This includes children placed in Calderdale from an external local authority.

Initial Health Assessments
A total of 36 IHA's (18 in Q1) have been completed
- 14 under 5 years
- 22 children were over the age of 5 years, including 8 UASC

67% in timescales
Key reasons for delay:
3 UASC (unaccompanied asylum-seeking children) had a delay in notification to the health team (15, 19 and 19 days). All 3 then had a placement move. Unable to comment on why there was a delay in notification. No reply received from social worker.
5 siblings placed in Stockport. Initial arrangements were made for their IHA to be completed by the local CLA health team. The children were then moved to Sheffield before this could be completed. We saw them within 10 days of the placement move.
2 siblings were placed in Scarborough for 2 weeks for a temporary placement prior to a move back to Calderdale. We were asked to delay the IHA until back in the local area.
3 siblings placed in Harrogate. Initial arrangements were made for their IHA to be completed by the local CLA health team. The children were then moved back to Calderdale before this could be completed.
1 placed in mother and baby placement in Barnsley. The child's social worker decided that it was more appropriate to complete the IHA by the Barnsley CLA health team even though they could not complete within timescales.
1 appointment was cancelled by the foster carer and had to be rearranged.

Review Health Assessments
A total of 89 RHAs were due. 75 RHAs were completed in timescales. 85 % in timescales:

4 remain uncompleted (1 placed in Scotland but now moved to Calderdale liaising with Scotland to see if she had her RHA before being moved, 1 failed visit and waiting for further contact with YP to rearrange, 1 unable to contact new carers (parents), and 1 team error but has since been organised).
10 have since been completed but out of timescales.
- 1 initially OOA (over 50 miles) but then moved within 50 miles and has now been completed by Calderdale CLA health team.
- 2 delayed due to carers holidays
- 2 siblings delayed due to placement move
- 1 placed over 50 miles and completed by local CLA health team
- 1 working full time and limited availability to complete the RHA
- 2 siblings initial date clashed with contact visit and requested a change of date
- 1 placed with connected carer and delayed due to unable to find acceptable time for the carer to attend.

During this period the CLA team have been fully staffed, however due to staff movement there will be two vacancies from December 2022/ January 2023. Recruitment processes are currently in progress and the team are developing a plan to mitigate risk relating to completion of health assessments.

Key Achievements

- Further development of electronic records to support with data collection & analysis.
- Audit to review children placed in Calderdale from out of area and the impact this has on their unmet health needs, Calderdale Health Service provision and to highlight any gaps.
- CLA health team group supervision to look at team development/new ways of working.
- CLA implementation of processes to support externally placed children/young people.

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Continue to support links for care leavers over 18.
- Explore use of continued virtual assessments (to prevent breeches or when attempting to engage with a YP).
- Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).
- To continue to develop Standard Operation Procedures to ensure a consistent approach is used team members so that children and young people receive an equitable service.
- To conduct monthly quality assurance audit of a sample of Initial Health Assessments/Review Health Assessments.

10. Maternity Safeguarding

Within maternity services, safeguarding from early intervention to child protection is a key factor. Babies can be particularly vulnerable to abuse, and early assessment, intervention and support provided during the antenatal period can help minimise any potential risk of harm. Issues that can impact on parenting ability are parental substance misuse, perinatal mental illness, domestic abuse, where a member of a household poses risk or potential risk to children, parents known to services because of historical concerns i.e. neglect, child protection planning or removal of children and parents who are or was looked after children and parents under the age of 18 though this list is not exhaustive (West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures).

Where it has been identified that the woman or her family have safeguarding concerns and more detail is required, practitioners document this information within the confidential element of the electronic maternity patient record (Athena). This ensures that all maternity staff have a clear overview of the concerns within the pregnancy as well as the plan for the unborn if the case is open to children's social care.

CHFT maternity service have a specialist midwifery panel that meets once a week. The purpose of this panel is to ensure that there is a robust review process in place for referrals to the Specialist Midwives with a clear rationale for outcome of the referral based on criteria and a follow up process if cases need review.

The panel reviews all referrals to ascertain whether the pregnant woman would benefit from additional support or case loading by the Substance Misuse Specialist Midwife or additional support and caseload supervision by the Perinatal Mental Health Lead (Midwifery Services). The panel provides a safeguarding management plan for Midwives to follow.

10. 1 Swans (supporting women in antenatal services)

Within Kirklees key agencies such as children's social care, MARAC (Multi-agency risk assessment conference – domestic abuse), West Yorkshire Police, CHFT Midwifery services, Mid Yorkshire Midwifery services, SWYPFT Perinatal Mental Health, Pennine Domestic Abuse Service (PDAP), Integrated Sexual Health Service and Drug and Alcohol Service work

together to provide holistic health care and safety planning to ensure the safety of adults, children and the unborn.

This meeting is organised and managed by LOCALA, but the meeting is chaired by the Named Midwife Safeguarding from CHFT and MYHT and is held monthly to have a coordinated approach to safeguarding and assessing the health and social needs of 'vulnerable' pregnant women and the unborn who are affected by substance misuse, domestic abuse, poor physical, sexual and mental health, homelessness, poverty, involvement in sex work, criminal justice system, multiple removal of previous children and possible concealed pregnancy.

From April 2022 to September 2022 there were 19 new referrals made for woman being cared for by CHFT maternity services, and 42 review cases discussed.

10.2 MAPLAG (Multi agency pregnancy liaison advisory group)

The MAPLAG was established within Calderdale following a Serious Case Review in 2007. This meeting is organised and led by CHFT Named Midwife Safeguarding where assessment of risk to the unborn is discussed. The meetings are attended by Children's Social Care and Family Intervention Team, CHFT Maternity services, CHFT perinatal mental health lead, SWYFPT perinatal mental health, LOCALA perinatal health visitor, domestic abuse health practitioner, Calderdale Drug and Alcohol Service.

From April 2022 to September 2022 there were 18 new referrals made for women being cared for by CHFT maternity services, and 50 review cases discussed.

An audit is planned to be completed for 2021-2022 for all cases heard at MAPLAG to assess the outcome for women and babies heard in the MAPLAG meeting. The audit will be presented to Maternity Forum, Safeguarding Operational Group prior to being presented at the Calderdale Safeguarding Children Health Assurance & Improvement Group (CHAIG) in December 2022.

Key Achievements

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

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

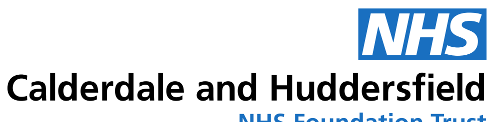
- To work with both local authorities in developing a robust pathway for referring female children/new-born babies into children's social care.
- To update CHFT FGM policy.
- To ensure a think family approach is embedded in Maternity to include robust risk assessments into partners/fathers and significant others.
- To develop a robust mechanism for recording safeguarding referrals to the Local Authority.

Executive Summary

Safeguarding Adults and Children

Bi Annual Report April 2022- September 2022

SAFEGUARDING



Prevent

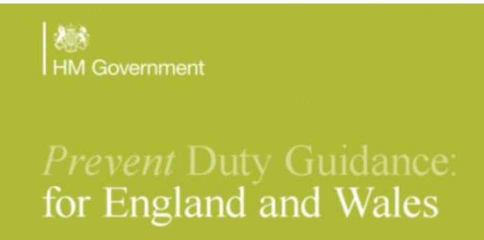
Prevent is about safeguarding people and communities from the threat of terrorism

Key Achievements

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

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Ensure representation of adults and children's representatives at Calderdale Channel panel



NHS
Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding Boards/ Partnerships

Key Achievements

- Continued to attend and support Adult Boards/ Children's Partnership meetings and information requests
- Contributed to Safeguarding week promoting MCA/ DoLS/ Self Neglect/ Hidden males and significant others
- Supported the BLOSM project which has supported our response to the findings from SARS

Priorities 2022-2023 (including actions from 2022-24 Safeguarding Strategy workplan)

- Continue to learn from the effects of the pandemic on families, influencing safeguarding practice with what we have learned.
- Continue to support the learning from safeguarding and domestic homicide reviews
- Continue to support the work of the BLOSM project

Hidden Harms

Hidden Harms take place behind closed doors or away from view eg domestic abuse, sexual abuse, child sexual abuse and modern slavery. Our response to these harms is:

Key Achievements

- Supported the Kirklees JTAI CSE/ CE
- Developed a system with partner agencies for flagging records
- Represent CHFT at the Calderdale MARAC meeting

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy work plan)

- Continue to raise awareness of the complex issues relating to contextual safeguarding and share intelligence around this
- Review the impact of the Health Based IDVA
- Raise awareness of the trauma informed approach to working with patients and their families who have complex needs

MCA and DoLS/ Liberty Protection Safeguards

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

Key Achievements

- E-learning MCA/ DoLS training offer reviewed and identified on ESR
- MCA/ DoLS audit completed
- CHFT response to Gov. consultation MCA Code of Practice submitted

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Task and Finish group to support staff with understanding and application MCA/ DoLS
- Develop bespoke MCA/ DoLS training
- Ongoing development of strategic plan to implement LPS

Training Compliance

	31.03.22					30.09.22					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6176	24091	22378	1713	92.89%	6179	24022	22151	1871	92.21%	-0.68%
Competence Name											
NHS|MAND|Mental Capacity Act - 3 Years|	202	202	184	18	91.09%	247	247	220	27	89.07%	-2.02%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3329	3329	3144	185	94.44%	3316	3316	3031	285	91.41%	-3.04%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	776	776	727	49	93.69%	804	804	768	36	95.52%	1.84%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1750	1750	1654	96	94.51%	1723	1723	1665	58	96.63%	2.12%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3807	3807	3608	199	94.77%	3788	3788	3495	293	92.27%	-2.51%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	537	537	519	18	96.65%	559	559	547	12	97.85%	1.21%
372|LOCAL|Female Genital Mutilation|	606	606	529	77	87.29%	562	562	493	69	87.72%	0.43%
NHS|MAND|Prevent WRAP - No Renewal|	6176	6176	5784	392	93.65%	6179	6179	5729	450	92.72%	-0.94%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1747	1747	1647	100	94.28%	1718	1718	1661	57	96.68%	2.41%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3755	3755	3561	194	94.83%	3801	3801	3521	280	92.63%	-2.20%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	590	590	562	28	95.25%	548	548	512	36	93.43%	-1.82%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	82	82	56	26	68.29%	87	87	50	37	57.47%	-10.82%
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Key

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

The chart above indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee.

Adult Safeguarding

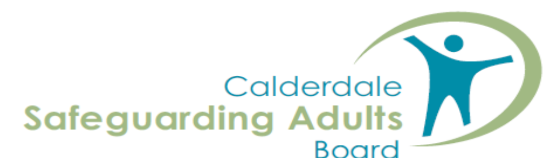
Is protecting a person's rights to live in safety, free from abuse and neglect

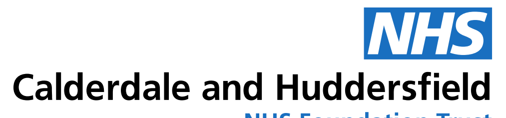
Key Achievements

- Successful recruitment to Deputy Head of Safeguarding/ Named Professional Adult safeguarding post
- Worked closely with the local authority to close some of the chronic safeguarding cases
- Adult safeguarding continue to work closely with the local authority to agree that ineffective discharges are managed internally

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- To contribute to support Divisions and the work to drive quality improvements in relation to hospital discharges
- To work alongside and support Divisions with regard to providing timely feedback to the local authority
- Work with the lead nurse children to embed the transition policy





Safeguarding Children

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

Key Achievements

- Safeguarding Children policy reviewed
- Ongoing work with bereavement nurse and mental health liaison nurse to improve processes and outcomes for children, young people and their families
- Process developed to support 16-17 year olds admitted to adult wards

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Support complex discharges
- Continued work to support the inclusion of the child's voice/ lived experience
- Audit the electronic liaison notification forms (live Jan 23)

Mental Health Act

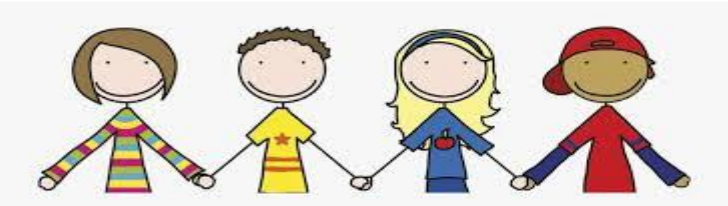
The Mental Health Act covers the assessment, treatment and rights of people with a mental health disorder.

Key Achievements

- The safeguarding team have continued to support the MHA Office with their scrutiny and reporting mechanisms

Priorities 2022-23 (including actions from 2022-224 Safeguarding Strategy) work plan

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



Children Looked After (CLA)

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

Key Achievements

- Audit to review out of area children placed in Calderdale – impact on health needs; gaps in Calderdale service provision
- Implementation of processes to support externally placed children/ young people
- Further development of electronic patient records to support with data collection and analysis

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Continue to support links for care leavers over 18.
- Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).
- Quality assurance audit of IHA's and RHA's

Maternity Safeguarding

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

Key Achievements

- Audit transfer antenatal/ postnatal information
- Audit FGM
- Audit effectiveness MAPLAG

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Collaborative working with the local authorities in developing a robust pathway for referring female children/ new born babies into children's social care
- To develop a robust mechanism for recording safeguarding referral to the local authority
- Review the FGM policy

Safeguarding is Everyone's Responsibility

19. Public Sector Equality Duty (PSED) Annual Report

To Approve

Presented by Suzanne Dunkley

Date of Meeting:	Thursday 2 March 2023
Meeting:	Board of Directors
Title:	Public Sector Equality Duty Annual Report – January to December 2022
Author:	Andrea McCourt, Company Secretary (Members and Governors) Nikki Hosty, Assistant Director Workforce and Organisational Development (Workforce) Nicola Greaves, Quality Improvement Manager (Patient)
Sponsoring Director:	Vicky Pickles, Director of Corporate Affairs Suzanne Dunkley, Executive Director of Workforce & OD Lindsay Rudge, Chief Nurse
Previous Forums:	Previous Annual Report - Board of Directors, 4 March 2021

Actions Requested:
To approve

Purpose of the Report

To present the annual report as required by the Public Sector Equality Duty. The annual report highlights the activities CHFT have been working on to address the needs of patients and colleagues who fall under the nine protected characteristics as outlined in the Equality Act 2010.

Key Points to Note

The Public Sector Equality Duty Report aims to eliminate discrimination, advance equality of opportunity and foster good relations between people. The duty applies to the public sector, including the NHS and also to others carrying out public functions.

The annual report gives examples of activities and outputs of our work in relation to workforce, patients and member/Governor groups.

EQIA – Equality Impact Assessment

All equality groups have been consulted on the Equality, Diversity and Inclusion approach we are taking in the Trust. Many colleagues have been involved in the activities delivered for patients and colleagues. We are raising awareness of difference, integrating difference and identifying barriers and removing them for patients and colleagues.

Recommendation

The Board is asked to approve the Public Sector Equality Duty Annual Report for 2022.

PUBLIC SECTOR EQUALITY DUTY

ANNUAL REPORT

JANUARY TO DECEMBER 2022

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SECTION	
1	**Introduction**
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2.1	Equality Act 2010
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3.1	Embedding equality, diversity and inclusion in our workforce
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5	**Conclusions/Looking ahead to 2023**
6	**Contacts and Enquiries**

Appendices

1. People Strategy (Nikki Hosty)
2. Equality, Diversity and Inclusion in our workforce reports (Nikki Hosty)
3. Health Inequalities in our workforce reports (Nikki Hosty)
4. Health Inequalities Strategy (Rachel Crossley)
5. Membership and Engagement Strategy (Andrea McCourt)

1 Introduction

2022 saw a continued impact of the COVID 19 pandemic across the entire Health and Social Care sector. At CHFT, a growing demand for urgent and non-elective services as well as work to clear elective backlog has led to immeasurable operational challenges.

However, opportunities to review and limit the disproportionate impact on protected characteristics has further improved our understanding of, and ambition to address, health inequalities, not just for our patients, but for our colleagues too.

This equality report for the period January to December 2022 provides assurance to the Board that Calderdale and Huddersfield NHS Foundation Trust (CHFT) continues to meet its responsibilities under the Equality Act 2010 and that it meets the requirements of the Public Sector Equality Duty.

The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the general equality duty. The report also contains the People Strategy at Appendix 1.

Our purpose is to provide outstanding Compassionate Care to the communities that we serve. We will do that by creating One culture of Care in our Workforce, ensuring that our values and behaviours (our four pillars) are embedded in everything we do.

Equality, diversity and inclusion activities and principles are fundamental to the Trust's work to improve the experience and health outcomes for everyone in its care.

This report highlights our approach and work to address any additional needs of those patients or colleagues who identify with a range of protected characteristics. Examples of what we have been doing at CHFT to address these needs are included in the report. The examples are, however, only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

NHS Employers defines Equality, Diversity, and Inclusion in the following way:
"Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included."

By adopting this definition, we can be clear with both patients and colleagues about what we mean by equality, diversity and inclusion and therefore develop a shared understanding of what we are trying to achieve.

2 The Legal and Compliance Framework

2.1 Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single, legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like CHFT to publish relevant information to demonstrate their compliance with the duty.

The Act applies to service users and Trust employees who identify with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment, and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the general equality duty published on our website by 30 March each year;
- Equality Objectives (which are specific and measurable) published for the first time by 5 April 2012, reviewed annually and re-published at least every four years.

2.2 Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Equality and diversity considerations are specifically addressed as part of its key line of enquiry around a Trust's responsiveness to patient needs. The CQC asks "Are services planned and delivered to meet the needs of people?" and "Do services take account of needs of different people, including those in vulnerable circumstances?"

The Trust was rated as 'Good' at the last inspection in April 2018 and now prepares itself for reinspection by focusing on those activities that will help to respond to regulatory questions positively.

3 Our progress in 2022

Equality, Diversity, and Inclusion is managed across three departments: Workforce equality is led through our Workforce and Organisational Development team; patient experience through our Quality team and Membership by our Company Secretary. Each team is equally responsible for the progress required as part of the PSED.

Teams work closely together to progress our work on equality, diversity, and inclusion as well as health inequalities and the Trust has made good progress on its Health Inequalities strategy.

3.1 Workforce Equality, Diversity, and Inclusion

We refreshed our People Strategy in 2022 with input from our colleagues. There are six chapters:

Chapter	Commitment
Equality, Diversity & Inclusion	We celebrate difference and are inclusive
Health & Wellbeing	We prioritise colleague health and wellbeing
Engagement	We seek views and act upon them
Improvement	We continuously improve services for people
Talent Management	We grow our own

Workforce Design	We design services informed by patient and colleague experience

We also refreshed our values and behaviours in order that 'we put people first' and they are at the centre of everything we deliver.

Equality, Diversity, and Inclusion (ED&I), Wellbeing, Engagement and Talent are fundamental chapters in the People Strategy and there has been lots of activities to connect with colleagues in 2022 in order that they can have their say on the way we do business around here.

- Equality, Diversity, and Inclusion

Equality, diversity, and inclusion is really important to us. We have developed a 5-year plan to embed equality, diversity and inclusion into everything we do in our Trust. We aim to build environments where there are happy, productive, motivated people in our organisation that respects and embraces difference in each other and in our patients. Having a diverse group of people working at CHFT means we have channels to share a whole range of ideas and solutions that, delivers inclusive and compassionate care. A place where everyone is treated equitably, respecting the diversity of all who work here and enable all colleagues to achieve their full potential, to contribute fully, and to gain maximum benefit from the opportunities available.

We are all, at any point in our lives, several protected characteristics at once. 80% of colleagues are patients and members of our community. Our approach is to celebrate difference, engage colleagues to learn about difference and tackle inequalities.

All activity is informed by: -

- Staff Survey
- Workforce data i.e., workforce profile, recruitment, disciplinaries, leavers
- Engagement with colleagues i.e., walkarounds, events
- Equality group discussions

We have Trust sponsored, colleague-led, equality network groups.

Whenever we are planning a new service or considering a change to an existing service, we complete an Equality Impact Assessment (EQIA) to ensure that we consider the impact on a diverse range of people and review if we are being fair in how we do what we do.
We have hosted a number of ED&I events in 2022 including Windrush Celebration Event, Black History Month Interactive Education session, International Women's Day, Pride Events, and International Day of Disability Event.

- Wellbeing

Colleague wellbeing is a people priority here at CHFT. We have supported 1000s of colleagues through a range of interventions and it is pleasing that the wellbeing staff survey score is healthy. Colleagues perform better when they are well, energised, fit and valued. It is more important than ever that NHS workplaces become environments that encourage and enable staff to lead healthy lives and make choices that support positive wellbeing. Everyone should feel able to thrive at work. Our One Culture of Care approach is our enabler to ensure colleagues take care of one another the same way we care for our patients.
Our two core interventions are our Friendly Ear service which colleagues can access 9 to 5 every weekday and Employee Assistance Programme hosted by Care First, who provide free wellbeing support 24/7, 365 a week.

We have a dedicated colleague support page on our Intranet which provides information on all the support available to colleagues, including our Health and Wellbeing Risk Assessment.

Colleague wellbeing is one of the most talked about subjects on walk rounds. Our feedback helps us to focus on reducing mental pressures; how important our work/life balance is; our shifts and hours and the importance of having breaks; and things like having proper equipment.

We have designed a comprehensive wellbeing offer (including the benefit of a weekly wellbeing hour) that provides our colleagues the opportunity to sustain their workplace health and wellbeing. The offer focuses on four themes social, physical, financial and mental. Activities include:

- Engaging, clear communications –supporting "it's okay not to be okay" and reducing the stigma of mental health
- Induction – Connectivity with the wellbeing advisor team from the outset
- Refreshed appraisal approach including wellbeing check-in, including improved conversations regarding colleague development
- Compassionate Leadership programme – role modelling, harness curiosity, create time and space to talk
- Connect and Learn Session – Health & Wellbeing Conversations
- Men's Health Week Roadshow
- 5 a side football tournament
- Top up shops – discreet food banks for colleagues

- Cost of Living – Focus on financial education, access to low-cost loans through salary finance, 24/7 support through Employee Assistance Programme, promotional material regarding what help is available on the local patch.
- SS Dance and Fitness - weekly sessions held on site
- White Rose school of Beauty spa session for Respiratory
- Halsa online wellness webinars including reflexology
- Workforce Phycologist commenced employment to support a trauma informed workforce
- Wellbeing and Engagement calendar of events
- Seasonal Health and Wellbeing strategies
- Health & Wellbeing Festival**s –** engaged colleagues from across the CHFT footprint to discuss all things wellbeing.
- Change Society – CHFT menopause support community.
- Suicide prevention in the workplace – partnership project with WYHP Hub and regional suicide prevention service. Aim of the project is to raise awareness and understanding of suicide risk and prevention in the workplace.
- Mindfulness community – 183 colleagues from across the Trust have signed up to this service. Mindfulness for apprentices is included in the apprenticeship induction programme
- Focused bespoke ward support for high intensity areas – ED, ICU, respiratory have regular on-site support
- Post incident support for groups and teams –provide group sessions that offer trauma support to colleagues affected by workplace incidents

- Engagement

Engagement goes from strength to strength with the Trust embracing One Culture of Care. Activity delivered 'with' rather than 'done to.'

One Culture of Care is embedded in all people activities including a refreshed people strategy to respond to what colleagues were telling us.

- Call to arms – we are 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
- OCOC embedded throughout the colleague journey

Great colleague engagement is when everyone has a voice, feels valued and the environment has a 'feel good' factor. This means we make the best decisions and work in a place that feels open and honest; where we aren't shy about saying how we feel, where we can suggest good ideas; and where we know we'll be supported if we pick up on other people's behaviour that isn't OK. We want to make the best contribution to compassionate care that we can, and this means that we will be contributing to making our Trust a successful organisation too. It is equally important that we take care of one another, and our One Culture of Care enables that to happen.

Creating the right environment for colleagues to give their best each day where colleagues are valued, healthy, motivated, and supported to deliver compassionate care for our patients and One Culture of Care for our colleagues.

Our annual staff survey results and quarterly People Pulse survey results will inform our approach to what we do, and tell us whether our People Strategy is relevant, focusing on and dealing with what matters most to our colleagues.

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for all colleagues. You can raise a concern about risk, malpractice or wrongdoing that you think is harming the service we deliver.

We all know our colleagues do brilliant things every day, whether that's something transformational or a tiny act of kindness that has a big impact. That's why we focus on appreciation. We have developed local appreciation toolkits including thank you cards, nomination forms for monthly star awards and information regarding our annual CHuFT awards.

The annual CHUFT awards offered colleagues to nominate someone who had delivered excellence in 6 categories, who role modelled CHFT values and behaviours across 6 categories including "One Culture of Care", "Putting People First", "working together to get results", "Go See", "Must Do's" and the "Rising Apprentice". 250 colleagues were invited to the event including golden ticket winners and colleagues who nominated others Please check out the link below for further details:
https://f.io/RXCPiT8A

We hosted two appreciation events across the CHFT footprint (including events for homeworkers). Giving colleagues an opportunity to shout about a colleague and discuss the current appreciation programme asking for their views to shape the strategy in the future.

- Talent Management

Talent management enables CHFT to attract and retain talented colleagues, develop skills, nurture abilities whilst motivating and engaging them to deliver compassionate care.

- Talent Management Framework

Everyone has talent, but talent for what? Our Talent Management Framework enables us to understand one another, express hopes and ambitions, and connects our people to a wealth of support providing every colleague with the opportunity to be their best self. Our Talent Management Framework shows how all of our people activities align to attract, retain and develop colleagues at CHFT.

The seven main components of our Talent Management Framework are:

We have refreshed the Trust appraisal paperwork in order that the process works for everybody, whilst making sure everyone has a conversation that focuses on their health, potential, aspirations and readiness, not just their performance. We will develop career pathways for colleagues at all levels and within all professions and put in place a plan to address any gaps or risks. All initiatives and programmes will be accessible to each of our colleagues.

- Widening Participation at CHFT

Over the last 12 months, the Apprenticeship & Widening Participation Team have continued to evolve and create a new range of entry pathways for local people to access work readiness and employment opportunities here at the Trust. This includes progression into entry clinical and nonclinical apprenticeships, volunteering, work experience and a variety of pre-employment routes including cadets, the Prince’s Trust and aspirational raising activities and employability development.

One of the main objectives of this work is to help "grow our own", with particular focus on supporting underrepresented groups from across our local communities. The development of a range of external partnerships has been pivotal in the success so far as we strive to:

- Harness and leverage the power and commitment of local people whilst retaining the absolute best local talent in our local communities.
- To be the local apprenticeship “employer of choice” in Huddersfield and Calderdale.
- To ensure the staff base is representative of the people we serve and reaching out even further.

- To ensure promotion of the hugely important role of "pre-employment pathways" and progression into paid bank, substantive entry roles and apprenticeships.
- To encourage and support CHFT colleagues to follow a career path that suits them and their life making full use of resources such as the apprenticeship levy and the continued offer of "in work support" including careers advice and guidance.
- To use our Health & Social care employer status as a key driver for economic and social recovery, particularly impacting those who face additional barriers and from underrepresented groups.

- What have we achieved?

Since the team's inception, we have helped to change lives for the communities we serve through a range of employability and outreach activities that helps raise aspiration and support work readiness including:

Targeting high schools, further education institutions and local community, statutory and charitable organisations with a range of workshops that promote applications for opportunities at the Trust, apprenticeship masterclasses, 'Sector spotlight' Q&As, aspirational visits to the Trust and bespoke trust careers events in local institutions. This has so far reached over 4000 young adults across Kirklees and Calderdale delivering a range of in person and Microsoft Teams careers and aspirational based activities.
The Widening Participation Team has also developed a range of external partnerships that promote extracurricular activities for local disadvantaged young people including NHS Cadets - a youth volunteering programme delivered by St John Ambulance. This is a personal development and volunteering led program for over seventy young people aged 14-18 - across 3 cohorts - and prioritises underrepresented groups across Kirklees and Calderdale who have been disproportionately affected by the pandemic. Outside of London, West Yorkshire has the second highest take up of NHS Cadets in the UK, with 81 cadets registered to date. Crucially, 13 are Young Carers, 11 receive free school meals, 6 cadets have at least one or more NEET (not in education, employment or training) indicators, 5 were previously excluded from school and 67% of the 81 cadets are from Black, Asian and minority ethnic communities.

The Trust has successfully embedded a SWAP (Sector work-based academy) model collaborating with its partners at JCP+ and Kirklees LA supporting the recruitment of domestic, portering and catering staff. So far this has supported 12 people into sustained employment including long term unemployed residents, residents with right to remain and older candidates who have struggled to secure employment previously.

The Trust is also delivering 'Project Search' for people with a Learning Disability – this offers a year-long supported internship combining classroom-based learning delivered by Calderdale College and work experience in the Trust. The aim is to boost opportunities to learn new skills to help secure fulltime, paid employment. Project Search is made up of ten young people, all which have Education and Healthcare Plan (EHCP) plans and 40% are

from Black, Asian or minority ethnic communities. So far 50% have progressed into full-time employment.

In November 2021, CHFT became a gateway provider for local disadvantaged young people aged 18-24 in receipt of Universal Credit. Through its Kickstart programme individuals can access a placement or a fixed 6-month term role in a clinical or nonclinical setting. The Trust has recruited 20 trainees, with over £115,000 in salary subsidy and 13,000 additional workforce hours. 75% of trainees have secured an apprenticeship or substantive post with CHFT because of this pathway. The Kickstart cohort is made up of unemployed young adults, of which 52% are Male, 47% Female, 58% White, 37% Black, Asian or minority ethnic and 47% of the cohort aged under 20, with 53% aged 20-24

Young people aged 16-18 benefit from a 5-day block work placement supporting the Trust as 'ward helpers' and in non-clinical settings. From April 2022 till December 2022, the Trust has welcomed back over 200+ local students back into work placements after a 2-year absence due to Covid-19.

The team have also developed an offer to support colleagues with job applications and interview practice so to help reduce anxieties when applying for progression opportunities. We have delivered targeted sessions to support our WRES and WRAD colleagues. A partnership was also launched in July 2022 with 'REALISE Training' who now deliver functional skills in math's, English and digital skills to colleagues seeking upskilling. 95 colleagues have so far registered their interest.

A clinical Prince's Trust pathway was launched in February 2022 and run's quarterly for cohorts of up to 10 young, disadvantaged adults aged 18-30. Participants gain 4-6 weeks work experience as ward helpers with the potential to progress into apprenticeship pathways where appropriate. Prince's Trust cohorts has so far welcomed over 50 young people into CHFT with 15 candidates progressing into entry apprenticeships.

CHFT's targeted volunteering project has so far recruited over 100+ young adults into CHFT. Of those, 52% are aged 19-24, 52% White British, 45% Black, Asian or minority ethnic. This is targeting young adults - 16-30 - from underrepresented groups, interested in working for the NHS with referrals received from a range of educational, statutory, and charitable partners. 5 volunteers have also progressed into apprenticeships.
Targeted in person and online Employability workshops have reached over 200 young adults across the Calderdale and Huddersfield communities. 55% are aged between 16-18. 54% with a recognised disadvantage marker. 27% participants from Black, Asian and minority ethnic communities.

The Widening Participation team have had great success over the past 12 months, and we have some additional exciting projects coming up. We have also had national recognition recently and was awarded the "Purple Coalition award" for widening access for opportunities for local people who previously would not have accessed CHFT.

- Apprenticeships at CHFT

We are also a “employer apprenticeship provider” that delivers our own Health Care Support Worker apprenticeship. Non-clinical entry level apprenticeships are delivered in partnership across a range of local providers. Both pathways are promoted and prioritised to existing pre-employment participants from a range of projects CHFT has recently embedded into the Trust including Kickstart, Princes Trust ‘Get Into’, Inclusive Volunteering project, NHS Cadets, Project Search and SWAP (sector-based academies) and other participants referred in via external partnerships.

These are projects that specifically target school and college leavers and NEET young adults with additional barriers to entry or those from underrepresented groups from across Calderdale and Huddersfield’s local communities. Since January 2022, over 50 x local young unemployed adults have accessed apprenticeships and employment at CHFT as a direct result of new entry pathways.

The Trust offers clear internal pathways upon completion of an entry apprenticeship into a substantive band 2 positions or higher-level apprenticeships. Graduates from CHFT’s entry level apprenticeships are also prioritised to apply for one of eighty Clinical TNA Foundation degree pathways to encourage continued training participation - 40 candidates (50%) were successful last year. Throughout 2022, CHFT added 157 new apprenticeship starts, 75 new entrants and 82 from existing Trust colleagues. Apprenticeship learners at CHFT achieved a 4% attrition rate and 97% achieved a Merit / Distinction grade.

3.2 Patient Equality Diversity and Inclusion

Significant work has been undertaken to progress patient equality diversity and inclusion. The following are examples achieved in 2022:

- Keep Carers Caring – John’s Campaign

In March 2022, the Trust agreed its Carers Strategy. 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 of 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.

The pilot was successful with carers and staff. 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.

> "*My mum was referred by her GP to A&E at Huddersfield Royal Infirmary. I accompanied her wearing the carer lanyard and was immediately and proactively advised that it would be ok for me to stay with my mum, on account of my carer status. I noticed a carer lanyard poster on display in A&E.*
>
> *"My mum was subsequently admitted to a ward, and I went with her when she was transferred to the ward from A&E. Once again, the carer lanyard was immediately "recognised" by the ward team and I was advised that, as her mum's carer, I could visit "any time".*
>
> *"We appreciated the proactivity displayed by hospital staff who were clearly already aware of the significance of the lanyard. We had, on previous occasions, had the negative experience of being advised that I could not stay with my mum in A&E with comments being made along the lines of: "Your mum will be fine on her own - won't you, mum? We will look after her." However, mum has a range of hidden disabilities that can often cause her significant anxiety and distress, when she is required to remain/wait alone within a healthcare setting - so it was a great relief when we had a very positive experience this time."*
>
> Independent Feedback shared with Healthwatch - Kirklees

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. John's Campaign recognises the valuable role carers have in the reassurance and dignity of people living with dementia.
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.

Within our hospitals we welcome carers outside of usual visiting times and have made it possible for carers to stay, in a bed, should they wish to do so throughout the night.

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

Within the first four weeks of the launch of John's Campaign over 100 carers were identified by staff across the Trust. Not only are our carers now seen, and heard more, they are also able to be connected to local carers support organisations. Every carer who is identified within our Trust is provided with a support call. Not only does this allow us the opportunity to build a profile of the carers we are reaching, but the carer is also asked if they were involved in discussions about the patients care and treatment, and if they would benefit from additional advice and support from carer specific organisations.

Key findings:

- 46% of carers have not tried to find information of advice on caring, for those who had, 28% found it difficult to find
- 85% of carers recorded their ethnicity as White British, with 15% from BAME heritage
- 86% of carers identified themselves as female
- 4% of carers are 'Young carers", with 74% of working age
- 25% of carers told us they had a disability of their own
- 70% felt they had been involved in discussions about the patient, which made them feel reassured about the care they received

To date, 47% of carers have been referred to either Carers Count, Carers Wellbeing Service or Calderdale Young Carers Service.
Throughout 2023/2024 the monitoring of John's Campaign will be undertaken through the Patient Experience Group (PEG), and divisionally through Patient Safety Quality Board meetings on a quarterly basis.

Carers want: to be seen, heard and involved in decisions relating to the person they provide care for

The Trust responded by:

- Introducing Carers lanyards across our hospital sites: ED, In patent and outpatient areas
- Re-launching John's Campaign and appointing two John's Campaign Ambassadors
- Open visiting for carers
- Providing free meals and warm drinks when carers are onsite for a prolonged period of time

- Providing free car parking to carers who have one of our lanyards
- Carers are encouraged to work with staff to complete the *'See who I am document*'
- Introduced signposting to local carer organisations
- Designed and distributed a 'Keep Carers Caring' information leaflet including an audio version which is available on the Trust website
- Increased signage on each ward/clinic welcoming carers
- Each ward/clinic has completed and displayed their own pledge as to how they will support carers

- Improving the experience of People with Visual Impairment

The Improving the experience of People with Visual Impairment Group has continued to work across the trust, with some significant developments within 2022/2023. The working group, which meets on a quarterly basis, includes representatives from Halifax Society for the Blind, Disability Partnership Calderdale and Kirklees Visual Impairment Network, Trust staff are represented from Ophthalmic and Orthoptic, Estates, and Quality.

The 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.

Whilst addressing any issues highlighted the group is also committed to heightening awareness to clinical teams about how small changes can make a big difference to patient experience.

This could not be achieved without the on-going commitment of the estates teams who help provide solutions to environmental and estates issues that may hamper safety and independence in our services.

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
- External issues with the crossing between Huddersfield Royal Infirmary and Acre Mills have been completed by the council (following the request made by the group)
- Training has been completed by the Ophthalmology Department using the 'Simulation Specs' to put staff in the shoes of our patients
- Recruited Visual Impairment Champions

> "*I am really impressed with the work you are doing. This is going to make a massive difference to hundreds of patients"*
> Pete Hoey, Halifax Blind Society

- Amputee Rehabilitation

The Amputee Rehabilitation Team at Calderdale & Huddersfield NHS Foundation Trust provide a service for medically stable patients who need support to enable them to return to a level of mobility they had before they came into hospital. The team provide suitable

patients with access to physiotherapists and occupational therapists with patients working with staff to meet mutually agreed rehabilitation goals.

During Covid-19 the team adapted the way in which they delivered rehabilitation. Patients moved away from group sessions and have 1-2-1 appointments within the hospital. In November 2022 the Trust engaged with our patients to identify how they would like to continue to receive care in the future.

Patients were asked about:

- Having an initial hospital assessment within their home, prior to commencing treatment at Calderdale Royal Infirmary
- The length of time of the physiotherapy sessions
- The frequency of their physiotherapy sessions
- If they would have valued the opportunity to have group sessions with other amputee patients
- If having a single Physiotherapist throughout their treatment was important

Feedback received:
It is pleasing to report that 100% of patients who completed the survey said that they would recommend the service to a family member or friend, should they need it. 100% also graded the overall service as being excellent. Patient's used examples to describe what they meant by this.

> '*I have felt encouraged about my rehabilitation from day one*'. '*The team have worked with me to set goals*', '*I enjoy my sessions, the staff are very knowledgeable, I feel like we have become friends*'.

100% of patients who recalled having their assessment at home, said that it provided them with the information they needed prior to commencing their treatment within hospital. During the survey some patients explained that it helped remove anxiety that they had about their treatment and increased their confidence in attending.

92% of patients felt that the twice weekly sessions were just right for their treatment. With 8% saying they were too long. However, 100% of patients said that the one-hour long sessions were appropriate for their rehabilitation.

We asked patients if, given the opportunity, did they feel they would have benefited from a group session for their treatment. 100% said they felt that the1-2-1 sessions were their preferred way of receiving treatment. One patient, who had used group sessions when having treatment for a previous amputation said that '*although it was nice to meet other patients who were dealing with the same things as you, it wasn't always easy to ask questions in a group*'. The patient said that with their most recent treatment the 1-2-1 sessions were far more personalised.

When asked about how important it was to have the same Physiotherapist treat them every time 75% of patients said yes it was important. With most patients citing that not having to explain their situation and progress every time being the reason for this. 25% of patients said they were not bothered if the quality of care and treatment was of a high standard.
During the survey patients referred to a key team of 3 staff who they regarded as the 'same people' treating them

- 58% of the patients who completed the survey were male, with 42% female,
- 100% categorised their sexual orientation as heterosexual.
- 100% of patients stated they were white, British.
- 100% of patients were over 50 years of age. The majority (41%) of patients were 60-69 years old.
- 100% of the patients classified themselves as having a disability
- 75% have a carer that supported them. All of those with a carer explained how family members provided this support.

Patients want:
To have appointments delivered in a 1-2-1 setting, so they can ask personal questions on what matters to them.
Not to have to explain their condition to different health professionals every time they attend appointments.

The Trust responded by:

- Agreeing to deliver care and treatment by 1-2-1 sessions
- Helping support patients who may want peer support in the future to access this
- Providing carer support information for patients to take home to their carers

- Quality Measures - Observe & Act

Observe and Act is the patient experience element of our "Journey 2 Outstanding" framework.

A comprehensive toolkit has been developed with the aim to provide a 360-degree evaluation of the ward environment, workforce, patient safety and patient experience. The aim is to give Ward Managers and their teams the opportunity to showcase safe and compassionate care which is delivered across the Trust every day. The framework is also designed to identify where extra support may be needed to support services.
It is based upon the Care Quality Commission's 5 Key lines of Enquiry:

- Safe
- Effective
- Caring
- Responsive
- Well-led

It is not an inspection, it is a way to identify supportive issues around a service that may seem small but can make a big difference to the experience of patients.

Within Observe and Act there are a series of questions that are asked to identify if the wards are being caring and inclusive.

Here is a selection of the fields monitored within the process:

- The person looks safe, relaxed and comfortable within the care setting?
- Staff call bells positioned within easy reach of the person, and do they know how to use them?
- Staff established the patients preferred name and this is how the person is addressed in conversation?
- Behind the bed boards are appropriate identifiable magnets in place which assists in delivering individual patient care (with the patients consent) and is there a process to update these: i.e., Visually impaired, hard of hearing, Butterfly logo (diagnosed with dementia)?
- Staff are aware of the CHFT Carers Strategy/ John's Campaign
- John's Campaign Posters are displayed on the ward
- Is there evidence of carers involvement as appropriate for individual patients needs in the ward
- Staff are aware of the VIP passport to support people with learning disabilities and aware how to access the plan in EPR
- Staff facilitate communication between patient and family members if patient is unable to do so themselves utilising virtual visiting/ letter to loved one
- Staff are aware of how to access the Enhanced Care Team to support patients with a cognitive impairment

Observe and Act contributes to service improvement by providing information about what patients and carers view as important, providing real-time feedback to staff on good practice and identifying areas where improvements can be made.

3.3 Membership and the Council of Governors

- Our membership profile

We strive to ensure that we have a diverse membership that is representative of the people we serve and our community. In line with our Membership and Engagement Strategy, we monitor how representative our membership is on a regular basis, using age, gender and ethnicity demographics.

The census data from 2021 became available during 2022 so we were able to compare our membership with up-to-date data about our local populations. As at 31 December 2022 the groups most under-represented within our membership were younger people, those from Asian/Asian British backgrounds and males:

Age band	Under/over
16 - 19	under - 7.1%
20 - 29	under - 6.9%
30 - 49	under - 9.5%
50 - 69	over - 2.8%
70 +	over - 20.7%

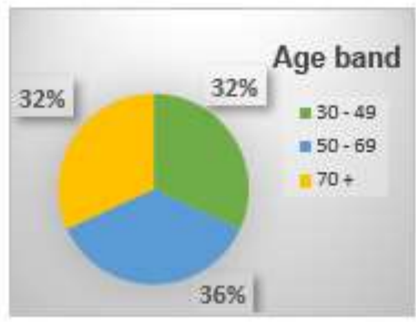
Ethnicity	Under/over
White	over - 7.6%
Mixed	under - 0.6%
Asian/Asian British	under - 7.3%
Black/Black British	over - 1.1%

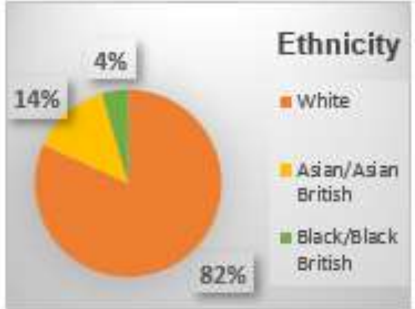
Gender	Under/over
Male	under - 30%
Female	over - 30%

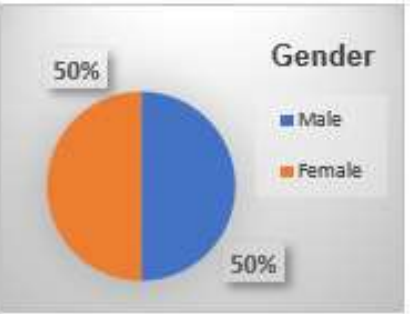
Our recruitment activities in the next year will focus on these groups, and the younger people group will have a specific objective within our revised Membership and Engagement Strategy for 2023-26.

- Our Council of Governors profile

The following charts show the current profile of our Governors:







The data shows that people from non-white groups are under-represented on our Council of Governors (CoG). We are holding Governor elections in early 2023 and we will use these as an opportunity to broaden the diversity of our CoG by encouraging nominations from across all groups in our local areas.

- Engagement Activities

The newly established Membership and Engagement Working Group (MEWG) met three times in 2022. Working in conjunction with the Membership Team, the group has made good progress against the priorities in our Membership and Engagement strategy in terms of engagement activities between governors and our members/members of the public.

During 2022, with the lifting of many restrictions imposed due to the COVID-19 pandemic, our governors were able to attend external engagement events again.

Governors have started to attend the Ward Partnerships meetings of Kirklees Council, and this has given them the opportunity to engage with a wide range of service users and stakeholders.

The MEWG has also focused on developing strategies for encouraging membership from under-represented sectors of our communities. This work will be given priority when our Membership and Engagement Strategy is refreshed in 2023.

4 EDS (Equality Delivery System)

EDS is a framework that helps the Trust, in discussion with local partners including local people, review and improve performance for people with protected characteristics.

Our partnership work during 2022/23 in relation to patient equality, diversity and inclusion includes:

The Carers lanyard Pilot, which was launched during Carers Week (6-12th June 2022) was developed in partnership with local carers and local healthcare and third sector organisations. These included:

- Locala
- Carers Count
- Kirklees Council
- Carers - Wakefield & District
- The Mid Yorkshire Hospitals NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Healthwatch (Kirklees, Calderdale & Wakefield)

From the design, distribution, promotion and monitoring this has been a partnership approach throughout. Due to covid restrictions at the time, all of our meeting were held by Teams, however, this do not prove to be a barrier to achieving a positive outcome.

The carers lanyards were not only provided to the Trust, but also distributed across Kirklees, within GP practices, pharmacies, and community carer settings. We received positive feedback from various sources including carers, John's Campaign, Cancer Alliance, Kirklees Integrated Care Board and Kirklees Primary Care Network.

Locala and Kirklees Council funded 2000 lanyards for the initial Pilot. Due to its success, CHFT adopted the lanyards which continue to be delivered through the 'Keep Carers Caring' initiative. An additional 2,000 lanyards have been funded, specifically for carers supporting the patients we are providing care and treatment for.

In December 2022, we shared an evaluation of the launch with the Calderdale Carers Strategy Group. The Trust is currently supporting them in adopting this model within their locality.

Improved experience for those with a Visual Impairment

Listening, learning, and responding to the needs of our patients and visitors with a visual impairment continues to be important. Working in partnership with Disability Partnership Calderdale and Halifax Society for the Blind we have captured a great deal of rich intelligence from those accesses our hospitals, about their lived experiences.

Several volunteers offered to share their views, opinions, and experiences of the Trust. These were captured by filming patient stories, which has allowed the visual impairment working group to understand what their reality is genuinely like.

As a direct outcome of the feedback, we have made simple, inexpensive, yet much needed improvements to our hospitals during 2022. These include:

- Improved signage on the toilets
- Improved signage at the main entrance to Calderdale Royal Hospital
- Increased signage around the cash machines

We will continue to apply the learning with the design and build stages of future developments, including the reconfiguration programme.

5 Conclusions / Looking ahead to 2023

We will continue to build colleagues confidence and competence in addressing equality issues and will continue to engage our colleagues and patients in the issues giving rise to disproportionate impacts on members of our community.

In 2023 the Trust will also continue to focus on the Health Inequalities experienced by our patients and colleagues as a powerful next step in our Inclusion journey. We are currently developing our EDI priorities for 2023/24 with our partners

We are proud of the work that we have achieved in 2022 and will further improve our approach in 2023, particularly in issues relating to the equality, diversity and inclusion of our Members and Governors

6 Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats, e.g., large print, braille, languages other than English, please contact the following colleagues:

For workforce equality matters, please contact Nicola.hosty@cht.nhs.uk
For patient equality matters, please contact Nicola.greaves@cht.nhs.uk
For membership equality matters, please contact Andrea.mccourt@cht.nhs.uk

20. Audit and Risk Committee Chair Highlight Report

To Note

Presented by Nigel Broadbent

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:	31 January 2023
Date of Board meeting this report is to be presented:	2 March 2023
ACKNOWLEDGE	
• ARC approved the Treasury Management Policy, the Health & Safety Policy, an updated Health & Safety Strategy covering the period 2023-2028 and the Conflict of Interests Policy. • ARC also approved updated terms of reference for the sub-committees reporting to it (Health & Safety Committee, Compliance Group, Information Governance & Records Strategy Group and Risk Group).	
ASSURE	
• The third update of the Board Assurance Framework (BAF) was recommended to the Board with a reduced risk score on Health & Safety and updates to the key risks on the BAF. • ARC approved and recommended to the Board, revisions to the Trust's Standing Orders, Standing Financial Instructions (SFIs) and Scheme of Delegation and noted that a further updated of the SFIs would be brought to the July meeting incorporating changes to the authorisation limits.	
AWARE	
• There are a number of outstanding recommendations from internal audit reports which are overdue and some which do not have revised target dates for completion. ARC agreed that a list of recommendations from audit reports which are due to be completed before the end of March 2023 would be provided to the Executive Board to encourage completion and recording of these to inform the audit opinion on the Trust. • Internal Audit reports on quality governance and sickness absence, which have limited assurance, were presented at the meeting. Responses have been made to all of the recommendations and it was agreed that the Quality Committee and Workforce Committee would be asked to monitor progress with implementation of these actions as appropriate. • The latest update on counter fraud was received by ARC and the need to continue to be vigilant for potential fraud and to undertake awareness training was emphasised. It was agreed that CHFT colleagues would be encouraged to provide	

feedback to Audit Yorkshire on the previous fraud awareness training and attend future training provided.
- ARC received a sector update from KPMG and their audit plan for 2022-23. The Committee agreed that the audit fee increase for 2022-23 would be delegated to the Director of Finance along with an additional fee to cover the work required under the new accounting standard ISA 315.
- The Audit Committee self-assessment questionnaire was approved for circulation to members of the Committee.
- The timetable for the annual report and financial statements was agreed with the aim of reviewing these documents at the June committee meeting.

ONE CULTURE OF CARE

- One Culture of Care was considered as part of the Health & Safety Strategy and Policy.
- One Culture of Care also considered within the Board Assurance Framework in relation to the health and well-being of colleagues.

21. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 2 March 2023
Meeting:	Board of Directors
Title:	Board Assurance Framework – Update 3 2022/23
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee 31 January 2023 (full BAF) Finance and Performance Committee 7 February 2023 Finance and Performance Risks

Purpose of the Report

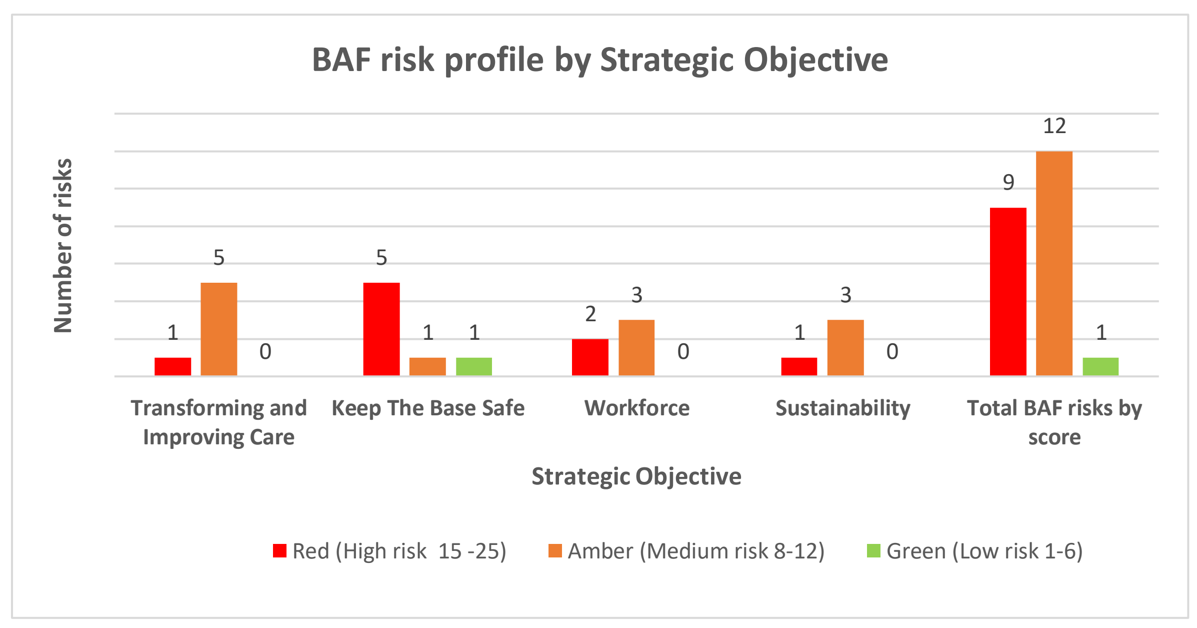
The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year.

This report presents the third and final update of the Board Assurance Framework (BAF) for 2022/23 for approval, having been reviewed by the Audit and Risk Committee on 31 January 2023, with a recommendation to the Board for approval.

Key Points to Note

Risk Profile

The Trust has the following risk profile for risks to its strategic objectives as at 17 February 2023 with a total of 22 risks. The Keeping the Base Safe strategic objective has the greatest number of high (red) risks, at 5 of the 22 risks on the BAF.



All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF.

Top Risks

The BAF, via the heat map, shows the top two risks for the Board, both with a risk score of 20, which are:

1. Workforce - nurse staffing
2. Transforming and Improving Care - approval of hospital reconfiguration strategic outline case, outline case and full business case.

To note risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16. In terms of the 2022/23 financial plan the Trust corporate risk register has a risk ref 8057 with a risk score of 20, reflecting the risk of not achieving the 2022/23 financial plan.

There are no new risks on the Board Assurance Framework (BAF) or risks proposed for a removal.

To note that the lead Director has changed for the risk relating to Health Inequalities, risk 07/20, due to the commencement of the Deputy Chief Executive reflecting changes in portfolios. A comprehensive review of this risk has taken place.

At the Finance and Performance and Committee it was confirmed that BAF risk 7/19, scored at 16, is on the BAF to support our strategic ambitions and originated from regulatory non- compliance with NHS England in relation to the financial position (rather than performance). A full review of risk 7/19, including the risk score, will take place by the Director of Finance in 2023/24 alongside the BAF long term financial sustainability risk (BAF risk 18/19) and reflect the position in relation to performance targets and finance within the approved annual plan for 2023/24.

Risk 7/19, including the risk score, will be fully reviewed in 2023/24 alongside the BAF long term financial sustainability risk (BAF risk 18/19) and the position in relation to performance targets and finance within the annual plan for 2023/24 will be reflected in the revised risks.

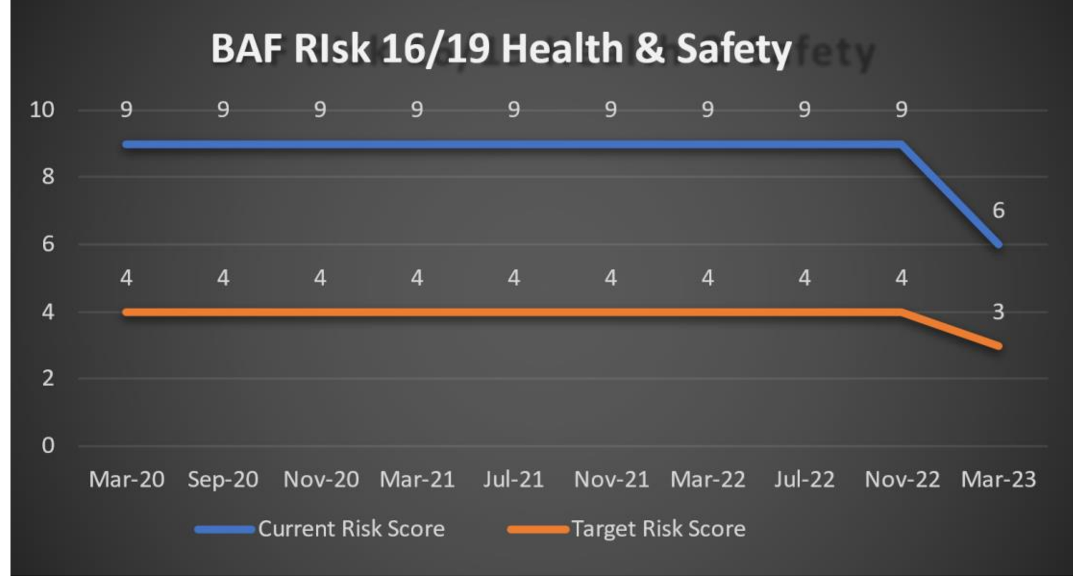
Risk Score Movement

There is one risk with downward movement in risk score noted below. The rationale for the movement in risk score given together with the risk score history is given for each of these risks.

Risk score movement	BAF Risk reference and score	Risk score
⇩	16/19 Compliance with Health and Safety	6 (reduced from 9)

- ***16/19 Health and Safety Compliance*** - risk reduced from a risk score of 9 to 6 with a reduction in the risk likelihood score from 3 to 2 due to good progress made towards achieving the NHS workplace health and safety standards requirements. The target score has been reduced from 4 to 3 to reflect increased ambition by the team.

The Audit and Risk Committee, which oversees risk 16/19, supported the proposed reduction following discussion of the risk with the Head of Health and Safety at its meeting on 31 January 2023.



Risk Exposure
Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 17 February 2023 there are seven areas of risk exposure summarised below.

Strategic Goal: Transforming and Improving Care	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
7/20 Health Inequalities	12 =	Harm and safety	Low
Strategic Goal: Keeping the Base Safe	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
7/19 NHS Improvement Compliance	16 =	Regulation	Moderate
8/19 Performance targets	16 =	Regulation	Moderate
5/20 Recovery of elective activity	16 =	Harm and safety	Low
Strategic Goal: Workforce			
12/19 Colleague engagement	12=	Workforce	Low
1/22 Colleague health and well-being	12 =	Workforce	Low
Strategic Goal: Sustainability			
18/19 Long term financial sustainability	16 =	Financial/Assets	Moderate

2023/24

The Trust is approving a revised five year strategy for 2023-28 and strategic objectives for one year for the financial year 2023-24. Work will take place in the new financial year to ensure the Board Assurance Framework risks align with these strategies.

It is anticipated that the two risks relating to performance, 8/19 regarding performance targets and risk 5/20 regarding elective recovery will be reviewed, with a view to developing one risk going

forwards, removing areas of cross over and reflecting 2023/24 priorities and operational planning guidance on recovery of core services and productivity.

EQIA – Equality Impact Assessment

The BAF has a specific risk, risk 07/20, which relates to the Trust not reducing health inequalities for our most vulnerable patients.

The Trust Board receives a report four times a year on progress with health inequalities actions at Board meetings.

In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.

Recommendation

The Board is asked to:

i. **NOTE** the reduced risk scores for risk 16/19 health and safety
ii. **APPROVE** the updates to the risks on the Board Assurance Framework
iii. **CONSIDER** if there are any further risks to the achievement of strategic objectives

Update 3 -For 2 March 2023 Board
2022/23

BOARD ASSURANCE FRAMEWORK
2022/23 Update 3

Contents:

1 Summary sheet
2 Risk Appetite
3 Full List
4 Heat map
5 Transforming and improving patient care
6 Keeping the base safe
7 A workforce fit for the future
8 Sustainability
9 Key

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	TOP THREE RISKS	Initial Score	Current score	Target Score	Lead	Link to High Level Risk	Risk Category	Risk Appetite
Transforming and Improving Patient Care								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	2827, 7413	Strategic/ Organisational	Significant
A workforce fit for the future								
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	9	LR	6345	Quality/Innovation & Improvement	Significant
Sustainability								
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate

Area of risk exposure

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming and Improving Patient Care								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	7413	Strategic/ Organisational	Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	**9=**	4	DB	None	Regulation	Moderate
04/19	Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a a meaningful way to patient and service user feedback resulting in services not designing services using patient recommendations.	12	**12=**	4	VP	None	Regulation	Moderate
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**12 =**	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	RB	None	Innovation/ Technology	High
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 =**	8	RA	None	Harm and safety	Low
Keeping the base safe								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15 =**	10	LR	See sheet	Regulation	Moderate
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement resulting in enforcement action.	25	**16 =**	10	GB	None	Regulation	Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**16 =**	12	JH	7615, 6453, 7454	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	7413, 7474, 7955, 8415, 8386	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**6** ↓	3	SD	7414 , 7474	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation.	12	**12 =**	6	LR	None	Regulation	Moderate
05/20	Risk that the Trust is not able to achieve its recovery targets, due to operational pressures resulting in patient harm, potential adverse impact on health inequality and impact on PLACE and Integrated Care System and partners	20	**16 =**	8	JH	7689, 7683, 7809, 7634, 8283, 8324,8132, 8034	Harm and safety	Low
A workforce fit for the future								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	DB	8077, 7637, 6100, 8277, 7671, 7328, 7678	Quality/Innovation & Improvement	Significant

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	9	LR	6345, 7539, 8454, 8473, 8483, 8088, 8290, 8079, 7776	Quality/Innovation & Improvement	Significant
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms.	12	**12=**	4	SD	None	Workforce	Low
1/22	Risk of colleague health and well-being deteriorating due to well-being proprities not being intergated throughout the organisation, embedded in our culture, leadership and people management	12	**12 =**	4	SD	None	Workforce	Low
Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12 =**	12	GB	None	Financial/Assets	Moderate
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution.	**9 =**	**9 =**	6	GB	None	Commercial	High
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate
06/20	Risk of climate action failure resulting in adverse impacts on public health, patients, natural environment and reputation denotes risk with risk exposure.	16	**8 =**	8	SS	None	Strategic/ Organisational	Significant

Area of risk exposure

CHFT RISK APPETITE STATEMENT - Revised September 2022

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, and local impact, 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 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**

HEAT MAP

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
High Likely (5)			6/19 Compliance with quality standards =		
Likely (4)		15/19 Commercial growth =	02/20 Digital Strategy = 12/19 Staff engagement =	18/19 Long term financial sustainability = 8/19 National and local performance targets = 10a /19 Medical Staffing levels = 05/20 Recovery = 7/19 Compliance with NHS Improvement =	10b/19 Nurse Staffing levels = 1/19 Approval of hospital reconfiguration strategic outline case, outline business case and full business case =
Possible (3)			3/19 Seven day services =	1/22 Health and Well-Being = 4/19 Patient & Public involvement = 04/20 CQC rating = 14/19 Capital = 11/19 Recruitment and retention = 01/20 Clinical Strategy = 07/20 Health Inequalities =	9/19 HRI Estate fit for purpose =
Unlikely (2)			16/19 Health & Safety ↓	6/20 Climate change =	
Rare (1)					

= no change to risk score

Assessment is Likelihood x Consequence

BOARD ASSSURANCE FRAMEWORK
MARCH 2023
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023** **Risk category: Strategic** **Risk appetite: Significant**		
								Initial	**Current**	**Target**
1/19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/ DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Travel Plan approved by the TPB and the Green Plan by the Trust Board. Planning Permission for the new A&E at HRI was approved in September 2021. Planning Permission for the build of a Multi-storey car park and the new clincal buildings at CRH was approved by Calderdale Council in March 2022 Third line ICS and NHSE/NHSI review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE Joint Investment Sub-Committee (JISC) in December 2021. Construction of the new A&E is in progress and remains on schedule for completion in Summer 2023. The Reconfiguration OBC was approved by NHSE Joint Investment Committee (JIC) on 25th February 2022. Reconfiguration OBC submitted for approval by Treasury with expectation that this would be in July 2022. National political uncertainty has delayed this decision generating risk to the timely progression of the programme and the estate developments at CRH.	• See below for further detail. 1. Her Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Work has been undertaken and presented to Transformation Programme Board (TPB) to define the skills and capacity needed for next stage of the programme to develop the Reconfiguration Full Business Case. Approval has been given to secure the necessary additional capacity / expertise. Project structures for the next phase of work have been implemented and progress is reported into the TPB each month.	5x5 = 25	5x4 = 20	2x5 = 10

Gaps in Control	Timescales	Lead
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been developed and is progressing to completion -this will require Treasury approval. 4. Build of a Multi-storey car park at CRH by 2024.	AB for all actions

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in A&E - workforce standards, A&E and critical care
7413 - fire compartmentation risk HRI

BOARD ASSSURANCE FRAMEWORK
MARCH 2023
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION (What is the risk?)	KEY CONTROLS (How are we managing the risk?)	POSITIVE ASSURANCE & SOURCES (How do we know it is working?)	GAPS IN CONTROL (Where are we failing to put controls / systems in place?)	GAPS IN ASSURANCE (Where are we failing to gain evidence about our system/ controls?)	RATING MARCH 2023 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
3/19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days due to staffing pressures resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges - poor patient outcomes and experience	• Governance systems and performance indicators in place, Learning from Deaths group and Care of the Acutely Ill Programme re-established, reports to Clinical Outcomes Group and Quality Committee. Mortality Surveillance Group in place providing detailed review of mortality information,. Quality Comittee and Executive Board oversight of SHMI / HSMR. • Specialty rosters are reviewed regularly as part of the tactical / operationl site meetings, with any staffing gaps discussed at this point and escalated whre needed to ensure every opportunity of filling the gap. • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) •Changes have been implemented within Medicine Division to enable greater 7 day cover including a 7 day dedicated Respiratory rota, an additional Specialty Trainee in Medicine at CRH (subject to additional shift being filled), and an improved structured approach in terms of regular review of medical outliers.' • 'In ED there is an additional consultant rostered between 14.00 and 22.00 (subject to additional shift being filled) and with additional mitigation that where that shift can not be filled a Paediatric Consultant may work in ED seeing Paediatric patients. • Use of independent service provision for endoscopy, echo, cardiac and neuro-physiology	First line HSMR: improving position of 102.26 at the end of October, from 103.96 at the end of September 2022, within the 'as expected' range. SHMI: improving position of 105.86 at the end of September 2022, from 106.65 at the end of August 2022, meaning CHFT lies within the expected range. Second Line Integrated Board report with SHMI/HSMR reporting. Annual Learning from Deaths (LfD) report to Board July 2021, 7 July 2022 . Quarterly Learning from Deaths report to Board (3 March 2022 (Q3), 7 July 2022 (2021/22 annual report), 1 September 2022 (Q1 2022/23) Clinical Outcomes Group re-established reviews reports on LFD group and monitors quality improvement programme. Annual seven day services Assurance report to Quality Committee 20 June 2022, with audit of 4 key Keogh standards demonstrating compliance.Re-audit planned for March 2023. Third line None	Improved staffing in Accident and Emergency, however remains insufficient to deliver extended Consultant presence in accordance with National Guidance. Challenging to meet this standard until reconfigured service in place. Action: Revised workforce models and recruitment campaign in A&E- see BAF risk 10a/19 medical staffing Lead:Clinical Director A&E Timescale: Ongoing Radiology - insufficient staff to provide MRI diagnostic capacity (national challenge) Pressures on diagnostic capacity post-Covid recovery Action: SOP for next day follow up of urgent patients requiring out of hours MRI . Development of Community Diagnostic Hubs which should reduce some elective work, subject to national funding following submission of business case Timescale: 2024/25 for Huddersfield hub Lead: Associate Director of Strategy Cardiac(stress tests , angiography delays from Covid) / neurophysiology are challenging Action: plan for additional internal activity as part of Recovery response: Planned recovery for Neurophysiology - March 2023 Planned recovery for echo - **December 2022** lead Interim Chief Operating Officer	Scope for futher implementation limited without service reconfiguration or additional investment	5x3 = 15	3x3= 9 =	2x2 = 4

Action	Timescale	Lead
Radiology - SOP for next day follow up of urgent patients requiring out of hours MRI. Development of Community Diagnostic Hubs (CDH). Ongoing review of staffing pressures A&E Plan additional diagnostic capacity as part of Recovery response	March 2023 (CDH) Ongoing Ongoing	Interim Chief Operating Officer Interim Chief Operating Officer Clinical Director A&E

Links to risk register:
No high level risks with score >15

BOARD ASSSURANCE FRAMEWORK
MARCH 2023
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING MARCH 2023 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
4/19	Quality Committee	Chief Nurse	**Risk** Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - poor patient experience Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) mandates the workplan and oversees progress and audit activity for public involvement and patient experience, governor and Healthwatch are members •Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs •Patient and Service User Engagement Strategy approved by Quality Committee. Observe and Act patient observation tool as part of Journey to Outstanding reviews •Carer's Strategy approved March 2022, developed with service users and local voluntary sector organisations that: raises the profile of carers, improves education and training, supports person centred care, and reviews CHFT as an employer. Recruited and trained over 120 ward volunteers to help combat feelings of loneliness and isolation for patients (and training opportunities for local residents). • Patient engagement in Outpatient Transformation Programme •Patient Story Process Map 2022 in place with a robust process for capturing, sharing, and learning through patient stories, which are now a standard agenda item within our Patient Experience & Caring Group, also presented at each divisional PSQB • Patient-led Visual Impairment Group • Health Inequalities group and workplan with a focus on the experience of BAME services users and people living with learning disabilities, Governor attends Health Inequalities Group as lay member. BAME Community Engagement Advisor Engagement with Race Equality network group create engagement opportunities with local BAME communities . • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD groupings - Active member of Calderdale involving People Network and Calderdale Comms, Engagement, Experience and Involvement Group	First line Patient Experience Group. Regular review by Quality Committee as part of bi monthly quality report Examples of good practice with patient feedback, service users include co design and development of children's community hub, a 'sleep well at night' training video, continuity of carer maternity teams supporting greater engagement in decisions about personal care (BAME / areas of deprivation), engagement on relocation of Rainbow Child Development Service, project to improve access to healthcare for disadvantaged groups focused in ED, high intensity users group in place developed with partners, new Clinical Nurse Specialist post for transition of young people with neruo-disability, improved pathway for cancer patients accessing treatment as EOL care workstream,patient line for cardiology and haematology 24/7 accessed by 80 per month, dedicated oncology patient helpline Second line Patient Story to Board meetings and to PEG Governor attends PEG and is chaired by Associate Non-Executive Director. PEG reporting to Quality Committee quarterly, Commissioner member at Quality Committee. Board quality report includes a section in relation to service users involvement. Third line Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data - lead AD Quality and Safety / Quality Governance Lead for Patient Experience Develop Patient Experience engagement plan and mechanism for systematic involvement of members of BAME communities. Action: Refresh of Patient and Service User Engagement Strategy , Assistant Director Patient Experience Timescale: March 2023 Lead: Monitored through our Patient Experience & Caring Group. Regular updates provided within the patient experience section of our divisional PSQB's. Current operational pressures are impacting on the pace of progression of some workstreams due to focus on recovery plan Lack of clear lead for ensuring implementation of Accessible Information Standard. Action: Identify lead and undertake asessment Timescale: March 2023 Lead: DIrector of Corporate Affairs		3x4 = 12	4x3 = 12 =	1x4 = 4

Action	Timescales	Lead
Refresh of Patient and Service User Engagement Strategy Identify lead for ensuring implementation of Accessible Information Standard	March 2023 March 2023	Quality Directorate / L Rudge Director of Corporate Affairs

Links to risk register:
No risks on the high level risk register

BOARD ASSSURANCE FRAMEWORK
MARCH 2023
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE							
Ref & Date added	**OWNER** Board committee Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk category: Strategic Risk appetite: Significant**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB) David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk	Refreshed Clinical Strategy - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - clinical strategy informing decisions made to reconfigure services and ensure that the redesigned hospital model is fit for purpose (see BAF risk 1/19 reconfiguration) ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Transformation Programme Board ensures estate is aligned with the clinical strategy. Recently established Planned Care Alliance to co-ordinate and plan phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity Report into Oncology Services for WY by Mike Richards complete and supports CHFT as a hub. Independent reivew report (Dec 2021) recommends two site service model for NSO. CHFT Medical Director Chairs South sector implementation Board for NSO. Project Manager support. Target Operating Models in process of agreement. CHFT/ MYHT Partnership Board established which discusses fragile services and fosters closer working relationships CHFT partner at Calderdale and Kirklees PLACE level clinical and professional forums,Quality Forum and PLACE Boards (sub group of ICB) to agree local health priorities and strategy. CHFT Medical Director appointed as SRO for South Pathology Network	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private), refreshed Clinical Strategy July 2021 Board approved Board Business Better Than Usual report to 2 July 2020 Board describing learning from Covid-19 will help to inform any necessary adaptation of the Clinical Strategy ICS clinical forum 7 July 2020 discussed Planned Preventative Care post Covid-19 Response to COVID-19 has by necessity driven enabling work for the strategy, including remote working, developments in community care, and virtual outpatients. New Pathology Partnership Update to January 2023 Board (CHFT Medical Director is SRO) LIMS implemetation progressing, CHFT planned for 2024. Managed service contract for laboratory equipment to be concluded January 2023. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Diagnostics Board and Imaging Collaborative established across West Yorkshire	Non-Surgical Oncology (NSO) - acute system pressures across WY require additional support from CHFT. Working with LTHT, MYHT to ensure short term service support in place, whilst sustainable WY solution in place. Action: Service model will be subject to ICS support and ongoing dialgoue with Oversight & Scrutiny Committee re public engagement West Yorkshire and Harrogate WYAAT Clinical Strategy under development. Action: Following pause during Covid, WYAAT clinical lead restarting clinical strategy work,including refresh of workforce data, linking with fragile services work. ICS to develop clinical strategy - ICS Medical Director to confirm timeframe, WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid recovery programme may reduce ability to deliver new services	Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone. Lead: David Birkenhead Timescale: 31.7.23.	**Initial:** 3x5=15 **Current:** 3x4=12 **Target:** 2x5=10

Action	**Timescales**	**Lead**
WYAAT - Refresh of West Yorkshire Clinical Strategy, incorporating work on fragile services ICS Clinical Strategy to be developed - Medical Director to confirm plans Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone	WYAAT to confirm ICS Medical Director to confirm 31 July 2023 - lead David Birkenhead	David Birkenhead, Medical Director WYAAT clinical lead / WYAAT Chief Executives, David Birkenhead

Links to risk register: None
See 1/19 reconfiguration BAF risk

BOARD ASSSURANCE FRAMEWORK
MARCH 2023
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk Category; Innovation/Technology Risk Appetite: High**		
								Initial	**Current**	**Target**
02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund and deliver the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 3 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the next 5 year digital strategy Continued central funding available and committed capital funding from the Trust which will enable progression along the national Digital Aspirant Programme. Joint Director of Digital Operations and Delivery role co-ordinating digital programmes and providing leadership whilst maintaining alignment toTrusts operational needs. Year 3 of the Digital Strategy (23/24 digital/EPR plan) will focus on improving on the digital basics and optimised use of existing systmes where funding may not be available. Governance via Digital Health Forum and Digital Operations Board.Digital Operations Board chaired by Chief Digital and Information Officer (CDIO), with reviewed terms of reference Monthly meetings with Chief Digital and Information Officer (CDIO) and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards enusre appropriate spend of investment and report into the Digital Operations Board which has oversight of investment in line with strategy. Digitial governance investment reviewed by Business Cases Approval Group (BCAG).	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 10 November 2022 Digital Strategy Progress and Update to Board with plan to 2025. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** Digital Aspirant Trust Scan for Safety Programme in progress. WYAAT Chief Information Officer meetings ensures alignment of stategy on regional digital deployment.	Business case for review of digital health team capacity and capability now aligned to BTHFT and possible addition of third Trust on current EPR tenant. Action: Business Case Approvals Group to consider business case which redefines scope of digital health programme in line with EPR optimisation, reconfiguration and cross - organisational partnerships Lead: Chief Digital and Information Officer Timescale: March 2023 Alignment of work priority to Trust requirements whilst continuing business as usual activity. Action: Embed clinical resources in prioritisation process and monitor capability and capacity requirements. Lead: Chief Digital and Information Officer Timescale: March 2023	Prioritisation process not clinically led to be reviewed again. Action New Chief Clinical Information Officer and Chief Nursing Information Officer in post. with focus on alignemnt of work priorities to Trust alignment. Timeframe: Review by 28.2.23.	4x3 = 12	4x3 = 12	3x3=9

Action	**Timescales**	**Lead**
Review clinicial prioritisation process for efficacy and revise workforce model as needed	28 February 2023	Rob Birkett, CDIO
Review of digital health team capacity and capability and redefine scope of digital health programme	March 2023	Rob Birkett, CDIO
Monitoring via Finance and Performance Committeee	Ongoing	Gary Boothby

Links to risk register see linked 1/19 reconfiguration risk

BOARD ASSSURANCE FRAMEWORK
MARCH 2023
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Deputy Chief Executive	Risk of failing to respond to the health inequalities that exist within our populations due to lack of quality priorites to advance health equity, incomplete population health and patient ethnicity data, helthcare service delivery not matching patient needs in the most deprived areas or lack of resource allocation and programmes for health prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Deputy Chief Executive is the named Board Executive providing accountable leadership for tackling health inequalities. 2022-2024 Population Health and Inequalities Strategy at November 2022 Board. Strategy focussed around four key areas of priority: Connecting with our communities and partners Access and prioritisation Lived experience and outcomes Diverse and inclusive workforce Health Inequalities Group, chaired by Deputy CEO, ensures oversight of all Trust workstreams in relation to health inequalities. Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a quarterly basis. Equality impact assessment (EQIA) process for service and policy changes.	**First Line** - Trust-wide health inequalities group meets monthly and oversees the organisations action plan and response to health inequalities. Health inequalities consideration and understanding included as a core element of all services supported by the development of data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. **Second Line** - Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a quarterly basis. Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive roles in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** The Trust is working in collaboration as part of the West Yorkshire (WY) Integrated Care Board, WY Association of Acute Trusts and WY Community Collaborative, as well as continuing to showcase work nationally.	Plan to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust is working to deliver NHS wide high impact actions in respective of equality and diversity. Lead: Director of Workforce and Development Timescale: March 2023 Continue to develop a structured approach to how patient-level demographic information can be used to prioritise clinical care. Intention to initially trial an approach within a small number of specialities during Q1 of 2023/24. Lead: Deputy Chief Executive Timescale: 31.3.23.	Population Health and Inequalities Strategy (2022-24) now in place. Progress against action plan underway. Action: To review assurance following first update to Board in March 2023. Lead: Deputy Chief Executive	4x4=16	4x3=12=	2x4=8

Action	Timescales	Lead
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	March 2023	Suzanne Dunkley
Review of assurance process following first update against Population Health and Inequalities Strategy at March 2023	March 2023	Rob Aitchison

Links to risk register: 2827

BOARD ASSURANCE FRAMEWORK
MARCH 2023
KEEPING THE BASE SAFE

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION (What is the risk?)	KEY CONTROLS (How are we managing the risk?)	POSITIVE ASSURANCE & SOURCES (How do we know it is working?)	GAPS IN CONTROL (Where are we failing to put controls / systems in place?)	GAPS IN ASSURANCE (Where are we failing to gain evidence about our system/ controls?)	RATING MARCH 2023 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
06/19	Quality Committee	Chief Nurse/ Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety Bi month reports to Quality Committee for assurance , Monthly reports to Trust PSQB for oversight and scrutiny Quality and Safety Strategy - each clinical division reports into performance review meetings on delivery of the ambitions of the strategy . Review under way (completion April 2023) • Serious incident (SI) investigation process identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning • Clinical Effectiveness and Audit Group reviews assurance on guidance and national audits • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee • Strengthened risk management arrangements at divisional level, including compliance registers Strengthened quality section within performance review meetings more in depth analysis of quality and safety priorities , further scrutiny at Quality Committee revised quality priorities with specific KPIs in place • Patient Safety Incident Response Framework (PSIRF) and draft investigation model that aligns with PSIRF framework implementation plan now in place, with revised investigation policy in place to support this •Process in place for refresh of compliance register with increased level of scrutiny at dedicated Compliance Group meeting • Focused Journey to Outstanding (J2O) programme and review of maternity services on implementation of Ockenden recommendations • Programme of ward assurance visits in place - clinical area quality dashboard in place reviewed at at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry • Consistent mandatory and essential training compliance Care of the Acutely Ill Patient programme in place to improve mortality outcomes • Risk management strategy revised and refreshed • Learning and Improving: Quality and Safety Strategy agreed and rolled out Refresh and relaunch of Nursing and Midwifery Strategy (8 October 2021) which reinforces importance of real time monitoring of quality of care. • Children and Young Peoples Improvement Plan	First line Assessment of compliance with NICE guidance with increased oversight at CEAG Performance against safety must dos reviewed at ward / matron level. HSMR & SHMI. Mandatory training compliance Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed with increased oversight at CEAG Bi-monthly Quality Report to Quality Committee and Board - increased scrutiny. Maternity report to Quality Committee. Regular report to Board on maternity - response to Ockenden review KPIs in Integrated Performance Report, PSQB reports to Quality Committee. Infection Prevention and Control report to Board IPC Board Assurance Framework approved at Board 2 July 2020, progress with IPC BAF recommendations regularly report to Board via Quality report and reviewed through governance structures Further update December 2021 Serious incident report to Quality Committee which includes lessons learnt section and "backlog" investigations addressed with positive feedback from CCG . Safer Staffing Hard Truths report to Board 4.11.21., 3.3.22. Refreshed Nursing and Midwifery Strategy (2021) approved by Quality Committee and Board. Maternity Services report to Board (March, May, July 2022) Majority of CQUIN on target to deliver . Complaints performance improved allowing time to focus on learning from complaints, with themes and trends identified and linked to Quality Priorities 2023/24. Third line CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.)CQC In patient Children's and Young Peoples survey 2021. Quality Account reviewed by stakeholder bodies for 2021/22 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatory bodies. CQC TMA visits have taken place in ED, Maternity and Vaccination centre.Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	1.Existing Incident policy being aligned with PSIRF framework March 2023 Lead: Assistant Director Quality & Safety Timeframe: March 2023 2• Gaps in control within the quality governance structure resulting in not providing an effective quality review function. Action: Implement recommendations from Internal Audit report on quality structure. Timescale: Completion by February 2023 Lead: Associate Director Quality & Safety	• CQC assessed the Trust as requires improvement for safe domain Internal audit further review of quality governance structure during 2023/24	3x5 = 15	3x5= 15 =	2x5 = 10

Action	Timescales	Lead
Alignment of existing Incident Reporting Policy with PSIRF framework Implementation of recommendations re: quality governance structure and internal audit follow up review	March 2023 2023/24 to be confirmed in Internal Audit Plan	Assistant Director Quality & Safety Internal Audit

Links to risk register:
7809 theatre and clinical capacity, 7683 isolation facilities, 7474 Medical devices, 6453 delay of surgical repair of #NOF, 7615 emergency care delays not meeting the 4 hour emergency care standard, 6715 inconsistent completion EPR documentation, 6035 C difficile infections, 8429 Cardiology PCI / angiogram wait, 8002 & 8088 therapies, 8009, 6079, 8121 out patient capacity, 7946 safeguarding discharge arrangements
See also risks 10a/19 and 10b/19 relating to staffing

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING MARCH 2023 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
7/19	Finance & Performance Committee	Director of Finance	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England (NHS Etable) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Board approved 10 Year Strategic Plan • Board member participation in Place based system meetings with NHS E/I(1 Kirklees, 1 Calderdale) with ICS feedback letter • ICS system financial regime • Standing Financial Instructions and budget management • Business Case Approval Group ensures sound decision-making on investments and monitors delivery of benefits. • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Transformation project support in place • Use of Resources (UoR) work steered by Finance and Performance Committee • Executive leads assigned for 5 Use of resources areas with working groups reporting to Executive leads • Post project evaluation reported at Capital Management Group for capital schemes and Commercial Investment Strategy group for revenue investment Turanround Executive (meets weekly), chaired by Deputy Chief Executive, which holds Executive sponsors to account for tor the design, imlementaiton and of the Trust's efficiency programmes to support financial plans Joint Financial Recovery Group with Calderdale and Kirklees partners (with independent Chair and ICB, WYAAT represntation) , meets monthly, to design, implement and monitor delivery of transormational efficiencies across the system (DoF, COO, Director of Transforamtion and Partnerships attend) Finance brief produced to ensure Board awareness of both current and historic financial challenge	<u>First line</u> Transformation project support Monthly monitoring of performance, Covid and recovery spend Minutes from Capital Management Group and Business Case Approval Group, reporting into Finance and Performance Committee. <u>Second line</u> Integrated Board report monitoring of key regulatory standards to every Board public meeting and Finance and Performance Committee, most recent F&P discussion UoR update provided to F&P on 1.6.21 that detailed actions taken from last inspection and provided evidence of where discussions take place and where further improvement remains in focus. On a control total basis the Trust delivered it's 2021/22 financial plans with positive external audit VFM assessment. Internal audit review on Business Cases Pre and Post Implementation given significant assurance, August 2022. <u>Third line</u> NHS England (NHS E) / HFMA Financial Sustainability Checklist self assessment completed and evidence reviewed and confirmed by internal audit and submitted to NHS E. Reporting of financial position and forescast monthly to WY Integrated Care Board and NHS E.	Not yet identified the full target cips for 2023/24 and beyond Action: Turanround Executive to identify full programme of efficiences for delivery over a multi year period as apporpirate to the programme.. Lead: Director of Finance Timescale: 31.3.23. Agree timescale for Finance Strategy (or other forward financial plan) to be adopted. Lead: Director of Finance by 31.3.23.	• Performance against key targets - recurrent balanced budget Reconfiguration outline business case yet to receive Treasury approval Timescale tbc by Treasury	5x5 = 25	4x4 =16	2x5 = 10

Action	Timescales	Lead
Effective Resources Group to identify 5 year recurrent efficiency oppprtunties	31.3.23.	Director of Finance
Consider development and promotion of Finance Strategy	31.3.23	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
MARCH 2023
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING MARCH 2023 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
8/19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets, including Recovery Plan targets **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience -Elective recovery Funding - Reputational damage with stakeholders - clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need. Increased number of outcome metrics within performance reporting monitored through performance framework . WYAAT system approach to capacity management. Urgent Care System Board and ICS Discharge Forum with social care providers to plan / consider options, supplemented with Reason To Reside Work Performance Management and Accountability Framework to support delivery of national standards and Trust quality,financial and operational objectives. Current Covid-19 management and governance arrangements in place to oversee the delivery of needs-based care. Daily escalation of performance issues from divisional hubs into Bronze, Silver and Gold levels as appropriate. Operational dahsboards for recovery reviewed by divisional senior leadership teams highlight any issues on a daily and weekly basis and via groups below. Access Delivery Group, Cancer Group, Urgent Care Delivery Group meet monthly (since April 2022) to monitor recovery programmes, standards and waiting lists. Modelling of waiting list projections in place and monitored through Access delivery Group. Health Inequalities linked to elective recovery monitored at a divisional level. Clinical prioritisation/holistics needs assessment matrix. Continue to utilise external capacity for backlogs, internal enhancement scheme being reviewed and new scheme in place to try and secure further additionality. Elective Care Improvement Group led by primary care discusses exceptions and agrees next steps.	First line Daily Bronze meeting and silver when required with process to enact GOLD if needed. Trust feeds into weekly silver meeting with partners. Risk registers reviewed at Divisional PSQBs & PRMs. Integrated Performance report focus of one WEB each month for detailed scrutiny of recovery performance and activity. Regular monitoring of waiting time past due date for clinically prioritised Second line Board sub committee detailed appraisals of position and actions. Integrated Performance Report discussed at each Board sub committee and Board of Directors. Clinical Prioritisation agreed as a key Quality Indicator, led by Medical Director reporting via PRMs and into Quality Committee. Review of revised IPR indicators with Board members 6.10.22. Detailed review of backlog position across planned care through Finance & Performance Committee. Monitoring of Covid position. Review of Cancer performance received at F and P 10/01/23 Third line Routine reporting to NHS E/I.	Insufficent theatre capacity for elective work and across the system . Action: Recruitment pipeline in place, enhancement scheme, in sourcing companies utilise theatres at week-end - to March 2023. Overreliant on outsourcing capacity to manage elective demand and backlogs. Action: Elective care transformation programme relaunch planned Feb 2023 and to include GIRFT recomendations to enable sustainable programme of elective recovery Non-elective impact on community - workforce - significant deficit of care hours in community resulting in delayed transfers of care (DTOC) and increased presure on urgent care• Action: weekly ICS Discharge Forum and focus on internal management of TOC patients - Ongoing 2. Improvement Programmes reporting to Finance & Performance Committee for theatre transformation to improve	Development of further outcome metrics for IPR. Lead: Interim Chief Operating Officer Timescale: Revised IPR report to start May 2023, reporting on April 2023	4x5 = 20	4x4 = 16 =	4 x 3 = 12

Access Delivery Group, Cancer Delivery Group and Urgent Care	Timescales	Lead
Performance reporting - development of further outcome metrics Improvement Programmes - Theatres and Emergency Department Further mobile scanning capacity to manage backlog and demand	April 2023 April 2022 - March 2023 December 2022	Chief Operating Officer all actions

Links to risk register: 7615 - 4 hour Emergency Care standard, 6453 delay of surgical repair of fractured neck of femur, 7454 Radiology performance targets

BOARD ASSURANCE FRAMEWORK
MARCH 2023
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Funding secured for ED HRI and MSCP CRH and in 2022/23 capital plan • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Plans in place to demolish DATs building to reduce backlog maintenance. Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable supported by the Transformation Programme Board 19 December 2022 Capital has been secured for 20202/23 to meet the 2022/23 plan and requirements as agreed in the annual internal capital planning round.	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners Second line Estates strategy (revised) approved at Board 2.9.21. H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports. Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage systems.	• MSCP is reliant on agreement with Albany at CRH for access to site and succesful variation in parallel with or in advance of Project ECHO. HMT Treasury visit on 26th May to progress ECHO. The Trust awaits the outcome of the business case review process with HM Treasury before further progress can be made.	PLACE assessment (Patient-Led Assessments of the Care Environment) re-start October 2022 by Quality Performance and Service Manager Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate. Action: Review of compliance, February 2023.	4x4 = 16	5x3= 15	2x4 = 8

Action	**Timescales**	**Lead**
Review of HTM compliance	Complete by 28.2.23.	Head of Estates

Links to risk register:
Risk 7413 - Fire compartmentation risk, HRI , Risk 7474 - Medical Devices , 7955 Radiology (plain film service), 8336 Hed & Neck naso-endoscopes, 8415 angiography (flouorscopy equipment)

BOARD ASSURANCE FRAMEWORK
MARCH 2023
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING MARCH 2023 Risk category: Regulation Risk appetite: Moderate – Initial	Current	Target
16/19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage Internal audit review of H&S action plan underway	•Board approved 5 year H&S strategy, NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities. The Strategy has been revised in September 2022 with now 8 priorities and will be presented to the Board in 2023. •General Health and Safety Policy (Updated September 2022) clearly highlights the overarching roles and responsibilities from Director level right to front-line colleagues. The roles and responsibilities clearly set-out expectations so that CHFT can be confident of meeting its legal obligations • Individual health and safety policies under continous review across 2022/23 and shared with CHFT health and safety commitee - each policy with individual subject matter expert ownerships • SLA in place for CHS to provde Health and Safety Induction Training f- on-site contractors and visitors • Director and Non-Executive Director Health and Safety Champion identified as well as Director responsible for Fire Safety Operational responsibility for H&S across sites sits with CHS for HRI and our PFI partners at CRH -. • Proactive Health & Safety Committee firmly established. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Annual report on Health and Safety to Board, • Health and Safety with updates to Board, Audit and Risk Committee oversight and future attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years).	<u>First line</u> Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . <u>Second line</u> Board joint responsibility for risk understood. WEB reports on mandatory training, health and safety training compliance H&S Committee reporting to Audit and Risk Commitee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months. Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2021/22 Annual Health and Safety report and action plan to Board - 12 January 2023 • Health and Safety Strategy revised September 2022, review of 2023 - 2028 Strategy by Audit and Risk Committee 31.1.23. Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022, <u>Third line</u> External health and safety review (Quadriga) 2019.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved, expected full by early 2023 Lead: Head of H&S Timescale: February 2023 Monitoring/Auditing of Compliance of the NHS Workplace Health and Safety Standards Lead: Head of H&S Timescale: Early 2023 COSHH sub group meetings with divisional leads / key users to commence, 3 monthly frequency, to review COSHH incidents / near misses and review current policy. Action: COSHH sub groups established. Lead: Richard Hill Timescale: February 2023.	When the NHS Workplace health and safety standards are embeded into the Trust it is possible to audit and produce dashboard assurance reports, but this will take place early 2023, when the standards are all embedded across the organisation.	3x3 = 9	→ 3x2 =6	3x1 = 3

Action	Lead: F	Lead
Stage 1 -Development and implementation of NHS Workplace Health and Safety Standards Stage 2: Monitoring/Auditing of Compliance of the NHS Workplace Health and Safety Standards	February 2023 Early 2023	Head of H&S Head of H&S

Links to risk register:
7413 fire compartmentation, 7474 medical devices

BOARD ASSURANCE FRAMEWORK
MARCH 2023
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
04/20 July 2020	Quality Committee	Chief Nurse	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of quality of servies to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC Group with refreshed terms of reference meets monthly, oversee compliance with regulatory standards/ -and reports to Quality Committee Review of must do and should do actions from 2018 CQC report, compliance with medical staffing in ED dependent on reconfigutaion and GPICS standards on critical care. Regular engagement meetings with CQC and on site focus visits taking place Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reviewed and updated, piloted and being rolled out. Journey to Outstanding (J20) implemented with increased breadth and depth of assurance - working towards business as usual model Focused Journey to Outstanding programme review of maternity services	**First Line:** Reports to CQC & Compliance Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC & Compliance Group . Also have focused J20 process Divisional review of must do and should do actions from 2018 CQC report, September 2022 **Second Line:** Quality Committee reports from CQC Group and as part of Bi monthly quality report Quality update report to each Board bi monthly CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. Maternity Services Update to Board 5.5.22. Caring Domain CQC Board Development Session 9.6.22. **Third Line:** Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance Board well-led interviews undertaken by external reviewer as part of Board Development Programme	Framework not yet developed at PLACE level for system / PLACE based CQC reviews under new regulatory framework. Action: progress through PLACE based Quality architecture. Lead: Medical Director / Chief Nurse Timescale: December 2023	2023 move to Single Assessment Framework for future CQC inspections and rating regime. Towards the end of 2023 CQC will gradually start to carry out assessments in the new way. This means a new approach to inspection and new assessment framework. In summer a new online provider portal will be lunched. This will be done in stages and provide support and guidance. In the first stage: Providers will be able to submit statutory notifications CHFT now have access to this portal and will submit notifications via this methodology for greater level of assurance	4x3=12	4x3=12	3x2=6

Action	Timescales	Lead
Continue to progress CQC roadmap and refresh for 2023/24	March 2023	Chief Nurse
Journey to Outstanding implementation underway via rolling programme including focused visits	12 month rolling programme incl	Chief Nurse
Well -led governance assessment for senior leadership team	July 2023	Director of Corporate Affairs
Development of PLACE level framework for system reviews with partners	December 2023	Chief Nurse

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
MARCH 2023
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk appetite: Low (Ham and Safety)**		
								Initial	Current	Target
05/20 July 2020	Finance and Performance Committee	Chief Operating Officer	Risk that the Trust is not able to achieve its recovery targets, due to operational pressures resulting in patient harm, potential adverse impact on health inequality and impact on PLACE and Integrated Care System and partners. See also BAF 08/19 re performance targets and BAF 7/20 health inequalities	Access Delivery Group holds divisions to account for delivery of recovery plans as required for any performance issues, reports into F&P Committee. Recovery plans set to achieve national standards. These link to transformation plans. Winter Plan includes super surge planning for various scenarios including at what point elective work would stop. Implementing national initiatives to improve patient flow and discharge. Surge plan in place across Divisions to support recovery whilst maintaining capacity and triggers for future surges. Bed plans and flow arrangements reflect the risk of increased non elective demand.Review of surge plan. Bi-Monthly Divsional performance review with Executive team, exception reporting and review to progress issues IPC pathways amended to reflect national guidance which will increase elective capacity , cross checked with Board of Directors principles on patient and staff safety. Maintaining separation of elective and non elective bed capacity. Continuing to utilise the Independent sector. Retained additonal diagnostic capacity for CT (MRI mobile scanner returned) to supplement reduced internal capcaity and provide additional capacity for backlog clearance and non elective demand increases. All inpatient waiting lists clinically reviewed and priority status identified. Criteria for outpatients agreed and clinical review ongoing. Full review of elective trajectories undertaken in October 2022 with actions implemented to ensure achievement of 2022/23 elective targets within funding available. Monitoring arrangements in place through access delivery group.. Reviewing waiting lists and cross referencing with deprivation index, overssen by Health Inequalities Group. Regular reporting at IMD level now available showing progress in closing the 'waits gap' since March 2021. This is also available for BAME/Non-BAME patients.Working with system partners on referral pathways.Health & Well-Being risk assessment of staff. Scenarios modelled for various configurations of Covid activity.	**First Line:** Daily review of Covid-19 activity flu and acute demand and weekly review of all other waiting list data. Each division has weekly review of activity, recovery and performance against plan feeding into the Access Delivery Group and divsional performance reviews. Submission of national data sets. Daily tactical meetings chaired by senior Operational manager monitoring demand and bed capacity All admitted waiting lists clnically prioritised with consistency checking process in place and monitoring of waiting time against priority score The outcome of this is evidenced by the continued reduction of the longest waiting patients on the RTT list and that the Trust is on trajectory with the waiting time national objectives for 2022/23 (104 weeks and 78 weeks) **Second Line** Finance & Performance Committee oversight of activity and backlogs with new IPR that includes a Recovery section Performance reports to relevant Board Sub-Committees (Finance and Performance, Quality Committee, Workforce Committee) Recovery Update reports to public Board meetings (13 January, 3 March, 5 May, 7 July, 1 September 2022) 6.10.22.Discussion with Board on key elective recovery metrics. 10 November 2022 Board presentation of Winter Plan 2022/23, including super surge and patient flow initiatives. **Third Line** Weekly reporting to NHSE/I regarding position against waiting times, reports received shows CHFT in a favourable position compared to regional and national.peers, i.e on trajectotry with having no over 78 week waiting patients by April 2023, also continued progress with over 52 week waiters. Presented at Executive Board 26th Jan 2023.	1. Reset plans have interdependency risks on workforce availability that will limit capacity. Action: Daily monitoring of workforce availability 2. Finance - pressures on pay impacting workforce availability Action: Discussions on pay in senior forums (WEB, Board, Finance and Performance Committee (5.10.22.) Lead: COO/ Director of Workforce and OD	Agree key IPR metrics for monthly reporting to Board and Committees Action: Timescale: Revised IPR report to start My 2023, reporting on April 2023 Lead: COO	4 x 5 - 20	4 x4= 16 →	2x4=8

Action:	Timescales	Lead
Monitoring of workforce availability	Daily	Chief Operating Officer
Impact of pay pressures on workforce availability being reviewed	Autumn 2023	COO / Director of WOD
Monitoring position re elective recovery funding arrangements	April/May 2023	COO/ Director of Finance

Links to risk register:
7689 out patient waits, 7683, isolation capacity, 7809 theatre and clinical capacity, 7634 theatre list cancellation due to vacancies, 8283 Radiology, 8324 clincial out patient validation and prioritisation, 8132 Gynaecology elective surgery, 8034 acute in patient bed base

BOARD ASSURANCE FRAMEWORK
MARCH 2023
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant**		
								Initial	**Current**	**Target**
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to gaps in the clinical workforce (local and national challenges) **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver range of key performance indicators as defined by multiple organisations - Increased risk of litigation and negative publicity. - Poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	•Consultant Succession planning • "Grow our own" approach - through different methodologies • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. Global fellows in Radiology, •Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity (planning for April 2023/24 underway) • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out) • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced practitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Non-Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology • ED business continuity plan in place; ED Clinical Fellows with 30% education time to improve recruitment to this tier . 2 ED Consultants and 1 Specialist now commenced in post (1 specialist later in the year) • Ongoing medical staffing recruitment. • Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Re-launch of Medical Workforce Steering Group meetings with wider group of stakeholders - provides an overview of the programme to ensure full visibility, shared view and tracking of all medical workforce based projects. Meeting monthly with highlight reports from workstream leads. • Recruitment through external agencies for posts difficult to recruit to •New national contract launched for specialty doctors and specialist doctors enabling appointments at specialist level with more independence. Adopted SAS (Staff and Associate Specialists)doctor charter. •Refreshed engagement approach - eg Medical Director's Office created well-being talks, SAS Forum, Junior Doctor Forum •SAS asdvocate appointed and new SAS tutor appointed - these support more effective engagement with SAS cohort • Enhanced reporting data (eg sickness absence, staff in post by grade/specialty, trunover, vacacncy, retention) enabling a more robust view of medical workforce status. • Revised extra contractual pay rates	First line Staffing levels, training & education compliance reported and review through departmental and divsional governance structures. Escalation of any short term gaps to Bronze tactical meeting/ internal command arrangements. Weekly meeting between Divisional Directors and Medical Director's Office (with COO attending) to enable sharing of information. Roll out of new appraoch to sharing training data across Trusts for junior doctors IPR with key KPIs including sickness levels, and agency spend, with monitoring of spend. Weekly divisional medical staffing meetings to optimise fill rates. Medical workforce steering group meetings re-launched Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 27 medical and dental posts from December 2021 to December 2022. Medical Appraisal and revalidation report to Board, September 2022 Guardian of Safe Working Hours annual and quartely report to Board. Refresh of Recruitment Strategy Medical Workforce Programme Update to Workforce Committee Third Line Plans discussed with NHS E Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Report on Junior Doctor Experience GMC Employer Liaison Meeting with Responsible Officer / Medical Director Local Negotiating Committee (with BMA in attendance) regular engagement to raise any concerns regarding medical workforce.	Medical E-rostering partially implemented for doctors - ongoing project Pensions rules affect willingness of medical staff to deliver additional work Action: Review Trust approach to options on reycling pension Lead: Suzanne Dunkley. Dependence on HEE allocation of trainees. Impact of Covid on existing medical staff who may take early retirement, reduce job plans, not undertake any recovery/additional activity **Action** Active engagement and monitoring of recovery and job plan via operational routes. Lead: Divisional Directors and Directors of Operations Potemtial for Strike action March 2023 Action: Monitor ballot results (WOD) and plan as needed by operational teams. Trainee Induction being reviewed to ensure engaging and relevant. Director of Medical Education, August 2023	Unpredictability of staff absences and impact on services at short notice in context of staff fatigue impact on staff health and well being. Short term sickness absence may be under-reported by medical staff. Action: Divisional directors to monitor and manage. Working Together to Get Results sessions to build on success of embedded Physician Associate scheme by providing development opportunities and additional support to junior doctor rotas and aid retention. Lead: Deputy Medical Director Timescale: Meetings to be held by December 2022, plan to be developed 2023 Develop business case for lead Physician Associate: Deputy Medical Director 31.3.23.	4 x 4= 16	4 x4=16 =	3 x 3 = 9

Action	**Timescales**	**Lead**
E-rostering being rolled out to medics- Pensions Recycling Working together to get results sessions across 3 divisions completed and development plan agreed Business Case for lead Physician Associate Monitor outcome of junior doctor ballot Trainee Induction Refresh	Ongoing project 31 March 2023 31 July 2023 31 July 2023 March 2023 August 2023	Lisa Cooper, Medical Workforce with Jackie Robinson, Divisional clinical management teams / Deputy Medical Director Director of Medical Education

Links to risk register:
8077 Paediatric / Neonatal medical rota, 7637 paediatric medical staffing, 6100 paediatric staffing compliance with Royal College Standards, 8277 neurology, 7671 stroke, 7332 ENT, 7678 medical staffing levels ,

BOARD ASSURANCE FRAMEWORK
MARCH 2023
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant**		
								Initial	**Current**	**Target**
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse leadership rota provides ongoing visibility and dialogue across clinical areas, supports staffing escalation. • Senior nurse staffing meetings twice a week. •Daily and weekly nurse staffing escalation reports • Staffing Command links to availability, OPEL level escalator, senior medical and nursing leadership oversight and directly links to bronze command. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, revised Safer Staffing OPEL action cards • Nursing and Midwifery Strategy- implementation of "Time to Care" - reviewed 2022/23. • Ongoing recruitment programme in place aligned to national programme, including international recruitment • Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022.. •Apprenticeship Strategy in place to support career pathways into nursing, midwifery,AHPS • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for registered workforce to encourage uptake of shifts. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes, People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Quality Committee, • Nursing and Midwifery Workforce Steering Group, meet monthly monthly meeeting reviews operational issues, strategy and seeks assurance • Nursing and Midwifery Safer Staffing Groups meets twice weekly to review the Enhanced Dashboard Metrics	First line Twice daily staffing meetings chaired by Associate Directors of Nursing. Weekly review of the Enhanced Dashboard Metric Divisional business meetings and PSQBs consider staffing levels as part of standard agenda Bi-annual reviews of Nursing and Midwifery staffing levels Trust recruting to fill all HCSW vacancies 2022/2023 International nurse recruitment programme Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues. Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Workforce Committe and then Board of Directors (last reported 3rd March 2022, 10 November 2022) KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Quality Committee deep dive of risk - papers 7.12.22. Third Line Performance reported into NHSE. Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Insufficent workforce availability to meet demand above core bed base and in community services. Action: Ongoing use of bank and agency staff and derogated staffing models in place as per OPEL action staffing cards. Pace of embedding all elements of the Nursing and Midwifery Strategy has been impacted by recovery programme Action: To refocus nursing workforce on key deliverables of Time to Care Lead: Andrea Dauris Timescale: March 2023	Ability to be clear about national and local supply of workforce through pre-registration training porgrammes to meet vacancies and demand. Action: Continue to work with national recruitmnt and retention programmes and Health Education Institutes Lead: Lindsay Rudge	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
To refocus nursing workforce on key deliverables of Time to Care	01/03/2023	Andrea Dauris
Use of bank and agency staff to meet demand	Ongoing	Chief Nurse

Links to risk register:
Risk 6345 - nurse staffing risk, 7539 Paediatric Nurse staffing, 8454 midwifery staffing, 7776 Paediatric staffing (APNP), 8473 senior leadership childrens nursing, 8483 senior leadership neontal, 8088 community therapy staffing, 8290 Speech & Language Therapist In Patient capacity, 8079, community nursing (District Nurses)

BOARD ASSURANCE FRAMEWORK
MARCH 2023
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION (What is the risk?)	KEY CONTROLS (How are we managing the risk?)	POSITIVE ASSURANCE & SOURCES (How do we know it is working?)	GAPS IN CONTROL (Where are we failing to put controls / systems in place?)	GAPS IN ASSURANCE (Where are we failing to gain evidence about our system/ controls?)	RATING MARCH 2023 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant Initial	Current	Target
11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Recruitment strategy for 2022-25 launched and launch meetings taken place with nursing and medical workforce leaders • Progressed into implementation phase for values based recruitment • OD Plan developed • Deployed a screening tool for values and behaviours as part of the onboarding process. • Board to agree Succession Planning approach which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach • Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • New recruitment microsite now in place • Focused recruitment and retention work through medical, nursing and AHP workstreams provides an opportunity to review traditional methods of recruitment which includes looking at alternative roles • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Refreshed our values and behaviours • Clinical Director review complete with induction programme developed and now in place • Workforce design methodology developed to support with workforce remodelling. • Widenining access programme rolled out July 2021 development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Development of 24/7 helpline for colleagues to receive support with their mental health including specialist psychological help if required • Well being hour and appointment of 50 well being Ambassadors • Health and Well Being assistance in place for staff via bespoke psychological and mental health support	First line • Clinicians leading of transformation programmes • Recruitment to key roles across the Trust - see BAF risk 10a • Workforce Committee reviews key workforce indicators at its meetings • CHuFT Awards Recognition programme, 130+ nominations from a range of grades, Divisions and specialisms colleague to colleague nomination • Presented Inclusive Recruitment approach to Race Equality Network steering groupon (Ask RP). REN happy with progress. • Values Based Recruitment Second line Integrated Performance Report and Workforce Committee reports show Turnover of 8.28% Results of Medical turnover review discussed at Executive Board. Reduction in vacancies to 115.26 Revalidation report to Board. Talent Management framework to Board in July 2022. Third line GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT Trusts.	• Lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. **ACTION**: Complete Medical roll-out by March 2023. • Review of inclusive recruitment approaches **ACTION**: Complete review and further actions required to increase diversity. Including alignment with national inclusive recruitment toolkit by March 2023.		4x4 = 16	3x4 =12 =	3x3 = 9

Actions	Action, Lead, Timescales	Lead
Review inclusive recruitment approaches	31/03/2023	Suzanne Dunkley
Complete roll-out of e-rostering for Medical and AHPs	31/03/2023	David Birkenhead/Lindsay Rudge

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
MARCH 2023
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE								
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023** Risk Category: Workforce Risk appetite: Low
12/19	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / Quarterly Pulse Survey	• Refreshed People Strategy and values and behaviours • 4 Hot Houses per year • Spring and Autumn leadership conferences • 9 point plan for moving to a engagement score of 7 which is monitored by Workforce Committee. • HR Business Partners present monthly Divisional updates on Staff Survey actions to WOD. WOD Senior leaders challenge progress. • External validation of our staff survey action plans and reflecting on results. • Workforce and OD Engagement Team in place with a defined role and iterative activity programme. • Clear responsibility for colleague engagement in Assistant Director of HR portfolio. • Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult few years. • Trust appointed 50 HWB ambassadors to engage with colleagues across all services areas. All have been trained in trauma support. • Engagement events carried out by divisions focused on services and coping with enormous challenges related to elective recovery and increasing volume and activity across the Trust. • Leadership visibility / walkarounds carried out by senior colleagues • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) resource - appointed clinical FTSU guardian so that colleagues who want to raise safety concerns feel more able to do so • FTSU Ambassador network is established. • Medical CHFT's Got Talent Awards • CHuFT awards • Monthly Star Award • Wellbeing festival and 2 appreciation events • Homeworker appreciation event • One Culture of Care checklist to aid visibility visit and provide consistency • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to REN network, Colleague Disability Action Group, Pride. Network chairs meet regularly to share best practice. • Community engagement post established in engagement team works with patients and communities and links to REN network, balancing colleague and patient experience • Equality, Diversity and Inclusion events • Festive activities including Exec walkarounds and Christmas cracker • Refreshed appraisal paperwork	First line Monthly workforce monitoring meeting reviews all workforce data sets • Apprenticeship services assessed as GOOD with one area of Outstanding in July 2021 • 658 appreciation messages received during Appreciation Week • 2022/23 data shows an increase in uptake of appraisals. Second line Workforce Committee reviews progress with colleague engagte,ent with health and well being activities / programmes. PRMs monitoring roll out of staff survey actions. Deep dive of risk 12/19 at Workforce Committee on 11 Oct 2022. Third line Quarterly People Pulse survey/ national staff survey Investors in People accreditation - Silver award to 2021. CQC rating of Good for well-led domain	Colleagues in Operational areas have 1 hour a year to focus on development conversation. **ACTION**: Host appraisal workshops. Lead Engagment Team by March 2023.	Lack of assurance of the progress being made with hotspot areas from Staff Survey results. **ACTION**: Targeted plan for hotspot areas. Lead: HR Business Partners by April 2023 Lack of assurance of the One Culture of Care checklist outcomes. **ACTION**: Audit of the process Lead: Workforce and OD Business Manager by March 2023.	**Initial** 3x4 = 12 **Current** 3x4 =12 = **Target** 1x4 = 4
Action to address gap in control					**Action and timescale**			**Lead**
Audit of the One Culture of Care checklist process Host appraisal workshop Targeted plan for hotspot areas.					March 2023 March 2023 April 2023			WOD Business Manager Engagement Team HR Business Partners
Links to risk register: No high level risk register related risks scoring over 15.								

BOARD ASSURANCE FRAMEWORK
MARCH 2023
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2023** Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
1/22 June 2022	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of colleague wellbeing deteriorating due to wellbeing priorities not being integrated throughout the organisation; embedded in our culture, leadership and people management. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Workforce and OD Wellbeing Team in place with a defined role and iterative activity programme so that promoting and supporting employee wellbeing is at the heart of our purpose. Healthy workplaces help people to flourish and reach their potential. • Clear responsibility for wellbeing in Assistant Director of HR portfolio. • Employee Assistance Programme through CareFirst • Friendly Ear Service • 50 Health and Wellbeing ambassadors to engage with colleagues across all services areas as investing in employee wellbeing can lead to increased resilience, better employee engagement, reduced sickness absence and higher performance and productivity • Health and Wellbeing Risk Assessment available to all colleagues. • Appointment of a Workforce Psychologist in November 2022 which gives us the ability to alleviate and reduce the psychological pressure placed on colleagues. The implications of such a service will aim to reduce abnormal psychological symptoms of healthcare professionals and introduce tools to support a trauma informed workforce. • Wellbeing festival held bi-annually. • Mens Health 5-a-side event • Financial wellbeing resources currently in development • Refreshed guidelines on wellbeing hour • Weekly Wellbeing advisor walkarounds • Domestic abuse support session • Suicide prevention resource pack • Connect and Learn session successfully trialled in WOD and will be rolled out to each Division, improving visibility of the Wellbeing Team. • Revised appraisal documentation with greater emphasis on health and well-being	First line Monthly workforce monitoring meeting reviews all workforce data sets RTW compliance now being monitored through Performance Review Meetings in Divisions. Second line Sickness absence metrics reported to every Board meeting via the Integrated Performance Report. Quarterly metrics provided by CareFirst. Workforce Committee reviews progress on health and well being activities / programmes. Third line None	Return to work (RTW)compliance has been removed from the IPR, in line with other Trusts. **ACTION**: Review sickness absence data to assess the impact of the removal of RTW data from IPR. Lead: HR Business Partners by April 2023.		3x4 = 12	3x4 =12 =	1x4 = 4
Action to address gap in control					**Action and timescale**			**Lead**		
Review sickness absence data to assess the impact of the removal of RTW data from IPR.					Apr-23			HR Business Partners		
Links to risk register: No high level risk register related risks scoring over 15.										

BOARD ASSURANCE FRAMEWORK
MARCH 2023
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme. September 2022 process for prioritising capital spend October 2022 - March 2023 completed. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum.	First line Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes Second line Strategic outline case for reconfiguratoin and final business case for HRI A&E reconfiguration approved by NHS E/I . Third Line Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance Action: Representation to key bodies re: securing appropriate funding.	5 year capital plans submitted to ICS but allocation process is still to be agreed by ICS partners. Lead: Director of Finance Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible, Approval of Full Business Case Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case Action: Close monitoring of Treasury plans via NHS E on behalf of Trust	4x5 = 20	4x3 = 12	3x4=12
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through Finance &Performance Committee and Board					Ongoing			Director of Finance all		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
MARCH 2023
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk Category: Commercial Risk appetite: Moderate**		
								Initial	**Current**	**Target**
15/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Huddersfield Pharmacy Specials (HPS), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place: THIS Commercial Strategy approved by Board September 2021 HPS Commercial Strategy approved annually at HPS Board Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings Director of Finance monitors monthly budget performance and Deputy Chief Executive Director is lead for overall HPS performance.. Joint Liaison Committee for CHS - reviews overall CHS financial performance and reporting on commercial ventures, review of CHS commercial strategy. CHS Head of Commercial Projects appointed.	**First line** Individual boards (THIS, HPS, CHS) and report on performance against targets into Finance and Performance Committee **Second Line** Successful bid for digital aspirant funds to support both digital development and ongoing capital requirements. Board review of HPS funding options 2021	HPS contribution from wholesaling reduced due to reduced product offer following review. Additional challenged from Contract Pricing Unit re:HPS access to NHS negotaited prirces. Action: CPU to respond to report from DoF demonstrating implications if remove access to NHS prices and impact on contribution for all PMUs. HPS requires further capital investment to continue to grow. Action: National announcement of capital expected, bid for this prepared. Impact for HPS to be considered given agreed national direction for PMUs. Action: Details to be confirmed by national group before Trust can progress. Lead: Director of Finance	Report from CPU confirming position re HPS access to NHS prices. National capital not yet announced for Pharmacy Manufacturing Units Lead: Director of Finance External bodies to confirm timescale.	3x3 = 9	3x3 = 9 =	3x2= 6
Action					**Timescale**			**Lead**		
Ongoing monitoring of financial position through F&P and Board					Ongoing			Director of Finance		
Links to high level risk register: None										

BOARD ASSURANCE FRAMEWORK
MARCH 2023
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING MARCH 2023 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit –and reliance on cash suppport. Whilst the Trust is developing a business case that will bring it back to unsupported financial balance in the medium term. this plan is subject to approval and the release of capital funds **Impact** - financial sustainability - loss of financial recovery funding (FRF) - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities - Joint Financial Recovery Group set up following review of PLACE based arrangements with partners meets monthly Budgetary control process with increased profile and ownership Turanround Executive (meets weekly, with Deputy Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. Accurate activity, income and expenditure forecasting Development of: - 25 year financial plans in support of Business Case - 5 year Long Term Financial Plan forms part of ICS financial plan Standing Financial Instructions set authorisation limits Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	First line Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly Capital Management Group meeting receives capital plan update reports Second line Scrutiny at Finance and Performance Committee and Board Reports on progress with strategic capital to Transformation Programme Board (monthly) Board Finance reporting ICS working towards balanced financial forecast for 2022/23 (June 2022) Internal audit report on efficiencies provided significant assurance April 2022 WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. Third line Monthly return to NHS E/ I CRH Outline Business Case submitted November 2021	Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Action: Continued liaison with regulator and HM Treasury Lead: Chief Executive Limited additional revenue costs have been included for the development of the Reconfiguration Business Case.	Joint Financial Recovery Group at early stage of dvelopment Action: Development of plans to dirve efficiences across the Kirlees and Calderdale PLACE Lead: Partnership reps, CHFT Director of Finance, Director of Transformation and Partnerships, Chief Operating Officer Timescale:April 2023	**5x5 = 25**	**4x4 = 16**	**3x4=12**
Action					**Timescales**			**Lead**		
System financial recovery plans to be developed led by external resource					Nov-22			Director of Finance		
Links to high level risk register risks: Risk 8057 relating to 2022/23 financial position scored at 20 See BAF risks 10a and 10b re workforce shortages										

BOARD ASSURANCE FRAMEWORK
MARCH 2023
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	RATING MARCH 2023 Risk Category: Strategic Risk appetite: Significant		
								Initial	Current	Target
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	**Risk** Risk of climate action failure including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	CHS is rolling out Carbon Literacy Training for its senior management team and this will be cascaded to all colleague by the Environment Manager. Energy - 100% energy bought from green sources and installation of LED lighting to reduce energy consumption Signed up to NHS pledge to reduce plastic usage in hospital Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Green Planning Committee (meets monthly) chaired by a NED within CHFT has been established to oversee delivery of sustainability action plan which will report to Transformation Programme Board on quarterly basis. The Committee is attended by a range of internal and external partners and we continue to expand the membership. Travel Plan in place to support more active travel, less car use and more car sharing Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. Green Plan approved and in place The Green Planning Committee (with approved terms of reference) meets monthly, monitor progress against sustainability action plan, focusing on idea generation and initiatives to reduce carbon emissions, eg re-usable items.Dashboard monitors the impact of the Green Plan. Quarterly update to Transformation Programme Board. Funding successfully awarded through Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. External controls - Environment Manager and MD of CHS connected into a range of West Yorkshire sustainability groups involving the WYCA, WYAAT, Kirklees & Calderdale Councils.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan, via newly developed Green dashboard of key indicators to Transformation Programme Board. Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Submitted Green Plan to ICS. 2. Annual Board paper on sustainability/climate change, May 2022 Climate change sustainability brief for the reconfiguration agreed and taken to Board 5 November 2020 Third line Share energy data records with NHS E/I on new NHS energy data platform	QIA procedure to be reviewed along with business case applications to ensure that a standing section for sustainability is featured and addressed in Board paper submissions. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: June 2023	.	4x4 = 16	4x2 = 8	4x2=8

Action	Date	Lead
Review QIA procedure and business case applications re sustainability	Jun-23	Stuart Sugarman via Environmental Co-ordinator

No related risks on high level risk register

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CHS	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HPS	Huddersfield Pharamcy Specials
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
	Outline Business Care
	Overview and Scrutiny Committee
	Private Finance Initiative
PMU	Pharmacy manufacturing unit
TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
WYSTP	West Yorkshire Sustainability and Transformation Plan
ICS	Integrated Care System
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JH	Jonny Hammond, Chief Operating Officer
RB	Rob Birkett, Managing Director of Digital Health
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
RA	Rob Aitchison, Deputy Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Director of Finance
ALL	All Board members

22. High Level Risk Report

To Approve

Presented by Victoria Pickles

Date of Meeting:	Thursday 12 March 2023
Meeting:	Public Board of Directors
Title:	High-Level Risk Report
Author:	Sharon Cundy, Head of Quality & Patient Safety John Milne, Datix Manager
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
We are continuing to work with divisions to review and refine the risk identification, management and mitigation process and clarification on how these are reported across the organisation.

As this work progresses, this report provides a summary of the highest scoring risks, so that the Board continues to have oversight of those areas which present the biggest risk to delivery of our services, as well as an update on the progress of the work to improve our risk reporting and management arrangements.

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 and is considered in detail by the appropriate department and governance structure. All 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 it. All risks are reviewed monthly at the Risk Group.

Currently there are 58 risks rated as high and 17 very high risks. There have been no new risks added to the high level risk register. There have therefore been no changes to the risks since the last meeting.

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 current capacity of the Glaucoma consultant service to meet the demands of referrals received
  - 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.

- Keeping the base safe
  - The vacancy position across several services including emergency department, maternity services, paediatrics, radiology, dietetics and speech and language therapy.
  - Not meeting the emergency care standards
  - Equipment in the Fluoroscopy service
  - Capacity available to validate outpatient appointments

- Sustainability
  - Financial plan; funding related to increasing activity to clear the backlog from covid as per the national target.

Themes of risks scoring high (15-16) are:

- Transforming care
  - Digital systems – use and business continuity
  - The provision of play therapy to support the whole organisation
  - The capacity of the pharmacy department in relation to the British Oncology Pharmacy Association standards
  - The workforce capacity within the ultrasound department to meet the Royal College of Obstetricians and Gynaecologists guidance.

- 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

- Workforce
  - Maintaining the wellbeing of our workforce; and the use of agency staff to support patient demand

- Sustainability
  - Developing funding streams using the new ICS framework to ensure stability

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.

The full risk report is available in the reading room for those who wish to review the detail as we continue to work through these with divisional colleagues.

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.

23. Charitable Funds Committee Chair Highlight Report

To Note

Presented by Helen Hirst

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Charitable Funds Committee
Committee Chair:	Helen Hirst
Date(s) of meeting:	15 February 2023
Date of Board meeting this report is to be presented:	2 March 2023

ACKNOWLEDGE
The Committee congratulated the Charity Team on their achievements described in the Manager's report. A set of bids presented were approved, some requiring sign off with colleagues in Estates as a condition of approval. More information was required for one bid (hospital radio).
ASSURE
The Committee received assurance that the team were prioritising the development of business partnerships to support the work of the Charity. The Committee approved the revised Reserves Policy (an annual requirement). The finance report was reviewed.
AWARE
The Committee requested an appraisal of the customer relationship management options which was part of the development grant award. The Charity is undertaking a survey to better understand the impact of the Charity's brand. A Big Hospital Walk is planned to coincide with the NHS 75th Birthday. A small group will consider the scope and opportunity of this event

24. Governance Report

a) Standing Orders

b) Standing Financial Instructions

c) Scheme of Delegation

d) Board of Directors Terms of Reference

e) Delegation of 2022/23 Annual Report and Accounts Report approval

f) Delegation of 2022/23 Quality Accounts

g) Use of Trust Seal

h) Board of Directors Declarations of Interest Register

i) Fit and Proper Persons Self-Declarations Register

j) Board of Directors Workplan for 2023-2024

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 2 March 2023
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Vicky Pickles, Director of Corporate Affairs
Previous Forums:	None

Purpose of the Report

This report brings together governance items to the Board for noting and approval. This includes key documents which from the Trust's governance framework and declarations relating to members of the Board of Directors which are part of the Trust's commitment to openness and transparency in its work and decision-making.

Key Points to Note

a) **Standing Orders (SOs)**

NHS Trusts are required by legislation to make Standing Orders (SOs) which regulate the way in which the proceedings and business of the Trust will be conducted. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly. The SOs form a central part of the Trust's governance framework, together with the linked documents Standing Financial Instructions and Scheme of Delegation.

A comprehensive review of the Standing Orders of the Board of Directors has been undertaken as scheduled. The revisions include updates for legislation, national guidance and definitions, additions re Director roles, clarification re casting vote of Chair, mandatory and non-mandatory Committees and Standards of Public Life.

The Standing Orders are enclosed as Appendix N1.

The proposed revisions were reviewed by the Audit and Risk Committee on 31 January 2023 and are recommended to the Board for approval.

The Standing Orders of the Board of Directors are included as Annexe 8 to the Trust Constitution. Once approved the amended version will replace the existing Standing Orders of the Board of Directors within the Constitution.

RECOMMENDATION: The Board is asked to **APPROVE** the Standing Orders.

b) **Standing Financial Instructions (SFIs)**

Standing Financial Instructions detail financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that our financial transactions are carried out in accordance with the law.

Key changes proposed relate to: reporting requirements in the event that these SFIs have not been complied with; the need for all budget holders to sign up to allocated budgets; additional instructions relating to bank accounts; and an amendment relating to agency pay expenditure rules. Section 7, Procurement and Contracting, has been re-written to ensure compliance with the Public Contract Regulations following a review by the Head of Procurement. Further work on the presentation of authorisation limits which are an appendix to the SFIs will be undertaken and brought to the Board for ratification on 7 September 2023 following review by the Audit and Risk Committee on 25 July 2023.

The Standing Financial Instructions are enclosed as Appendix N2.

The Audit and Risk Committee has reviewed the proposed revisions to the SFIs and recommends these to the Board of Directors for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the Standing Financial Instructions.

c) **Scheme of Delegation (SoD)**

The scheme of delegation sets out the formally delegated responsibilities of the Trust's functions, duties and powers to Directors and officers of the Trust. These have been reviewed by the Audit and Risk Committee on 31 January 2023 as part of a scheduled review and in conjunction with the revised Standing Financial Instructions and are recommended to the Board for approval.

The Scheme of Delegation includes the following:

- Reservation of Powers to the Board
- Appendix A Matters delegated by the Board of Directors from Standing Orders
- Appendix B Matters delegated by the Board of Directors delegated from Standing Financial Instructions
- Detailed Scheme of delegation with financial limits
- Scheme of delegation relating to Mental Health Act activities

The Scheme of Delegation is enclosed as Appendix N3.

RECOMMENDATION: The Board is asked to **APPROVE** the Scheme of Delegation

d) **Board of Directors Terms of Reference**

The annual review of the terms of reference of the Board of Directors which describes the role and work of the Board of Directors is presented for approval and is enclosed as Appendix N4. Changes include reference to the triple aim of the NHS and alignment with revisions to Standing Orders, e.g. re quoracy.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors terms of reference.

e) **Request for delegation of 2022/23 Annual Report and Accounts approval**

For the past three financial years the Board has agreed delegation to the Audit and Risk Committee for the end of year sign off processes for the approval of the annual report and accounts.

The Audit and Risk Committee noted the 2022/23 year end reporting timetable at its meeting on 31 January 2023. The 2022/23 annual report and accounts deadline is 30 June 2023 and does not align with the schedule of Board meeting dates. It is therefore requested that the Trust Board delegate to the Audit and Risk Committee the sign off of:

- 2022/23 audited annual accounts
- 2022/23 annual report.

The current date planned for the Audit and Risk Committee approval of the audited annual Accounts and annual report is 27 June 2023, subject to Board approval for this delegation.

RECOMMENDATION: The Board is asked to **APPROVE** the delegation of authority to the Audit and Risk Committee to approve on behalf of the Board, at its meeting of 27 June 2023, the 2022/23 audited annual accounts and annual report.

f) **Request for delegation of 2022/23 Quality Accounts**

The Quality Account is no longer part of the Trust's Annual Report, with a requirement for Trusts to publish a separate Quality Account. The 2022/23 Quality Accounts require sign off by 30 June 2023, which does not align with the schedule of Board meetings.

As in previous years, it is recommended that the Trust Board agree delegation of authority to the Quality Committee for the approval of the 2022/23 Quality Accounts, with consideration of the Quality Account to take place at the Quality Committee meeting on 21 June 2023.

RECOMMENDATION: The Board is asked to **APPROVE** the delegation of authority to the Quality Committee to approve on behalf of the Board, at its meeting of 21 June 2023, the 2022/23 Quality Account.

g) **Use of Trust Seal**

There are no documents requiring use of the Trust Seal since the last report on the Trust seal to the Board on 10 November 2022.

RECOMMENDATION: The Board is asked to **NOTE** that there has been no requirement to use the Trust seal during the last quarter.

h) **Board of Directors Declarations of Interest Register**

The Trust is committed to openness and transparency in its work and decision making. As part of that commitment the Trust maintains and publishes this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors.

Schedule 7 of the National Health Service Act 2006 and Section 32 of the Trust's Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors of which they are a member. A register of these interests must be kept by the Trust.

The Trust has in place a Conflicts of Interest and Standards of Business Conduct Policy which notes the duty to ensure that dealings are conducted to the highest standards of integrity and helps staff and Non-Executive Directors manage conflicts of interest effectively. On an annual basis the interests of members of decision-makers in the Trust, including the Board members are required to be updated.

In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests.

The Board of Directors Declarations of Interests Register as at 23 February 2023 is attached at Appendix T5. The Board declarations of interest register is available to the public on the Trust website at the following address: https://www.cht.nhs.uk/publications/

Any changes in interests must be made using the online declarations system as soon as is practicable and notified to the Company Secretary.

The Trust, in line with NHS England's guidance on good governance and collaboration (October 2022), works collaboratively as part of system and place-based partnerships and within a provider collaborative. This includes attendance at a range of partnership meetings by members of the Board. With system and place based partnerships now on a statutory footing since the NHS Health and Care Act 2022 and the introduction of the duty to cooperate between NHS bodies and NHS bodies and local authorities in the Act (section 75), declarations pertaining to these partnerships are included for decision-making bodies only.

This item is presented to the Board to note in line with the Trust Constitution, Standing Orders (section 5.2 Register of Interests) and the Code of Governance.

RECOMMENDATION: The Board is asked to **NOTE** the Board of Directors Declarations of Interest Register.

i) **Fit and Proper Persons Self-Declarations Register**

The Fit and Proper Persons Regulation (FPRR) requirements came into effect for all NHS Trusts and Foundation Trusts in November 2014 to ensure greater regulation of NHS Board level Directors. Regulation 5 of the Health and Social Care Act 2008 provides for the CQC to monitor and assess how well Trusts discharge their responsibility to comply with the fit and proper persons requirements for Directors.

The regulation requires NHS Trusts to seek the necessary assurance that all Executive and Non-Executive Directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. The CQC holds Trusts to account in relation to FPPR through their well-led domain assessments and inspections.

The Board of Directors Fit and Proper Person Self-Declaration Register as at 23 February 2022 is attached at Appendix T6. The following groups of staff are required to complete a Fit and Proper Persons declaration annually:

- Executive Directors (including the Chief Executive)
- Directors
- Non-Executive Directors (including the Chair)
- Deputy Directors (Finance, Medical, Nursing, Operations and Workforce and Organisational Development)

This item is presented to the Board to note in line with the Trust Constitution, Standing Orders (section 5.3 Fit and Proper Persons Regulations) and the Code of Governance.

RECOMMENDATION: The Board is asked to **NOTE** the Fit and Proper Persons Declaration and that all current Directors satisfy the Fit and Proper Persons requirements.

j) **Board of Directors workplan 2023/24**

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 T7 is presented for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors workplan for 2023/24.

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:

- 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 2022/23

The Board is asked to **NOTE** the following:

- Use of the Trust Seal
- Board of Directors Declarations of Interest
- Fit and Proper Persons Self-Declarations Register

UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
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:	7 July 2022
Date issued:	7 July 2022
Date of latest review:	January 2023
Next review date:	March 2025 - or earlier if required by regulation or statutory changes

TRUST STANDING ORDERS

UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
Review Lead: Company Secretary

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UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
Review Lead: Company Secretary

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:

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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.

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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 the Board	Document setting out those powers which only the Board can exercise
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

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UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
Review Lead: Company Secretary

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.

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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.

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UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
Review Lead: Company Secretary

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

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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.

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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 Chair. In the event of a resignation, the Board may appoint another Executive Member.

2.9 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.

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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.

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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.

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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.

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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

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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).

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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.

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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.

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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.

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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

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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.

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Any Committee or joint committee appointed under this SO may, subject to such directions as may be given by NHS Improvement 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.

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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.

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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.

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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.

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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

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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

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(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.

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• **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.

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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.

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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.

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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.

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UNIQUE IDENTIFIER NUMBER: G-2-2015
Review Date: January 2023
Review Lead: Director of Finance

APPENDIX N2

GROUP STANDING FINANCIAL INSTRUCTIONS

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ΦReviewed January 2023 Φ

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.

UNIQUE IDENTIFIER NUMBER: G-2-2015
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1. INTRODUCTION

1.1 GENERAL

This document 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.

1.1.1 The Code of Governance for NHS Boards requires that each NHS Foundation Trust shall give and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities, which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust SOs.

1.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can, in certain circumstances, be regarded as a disciplinary matter that could result in dismissal.

1.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts or in the Terms of Authorisation or Constitution, shall have the same meaning in these instructions; and in addition:

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a) "Trust" means the Calderdale and Huddersfield NHS Foundation Trust Group and incorporates the subsidiary company, Calderdale and Huddersfield Solutions;

b) "Accounting Officer" shall be the Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

c) "Authorisation" means the authorisation of the Trust by the Regulator, NHS England (NHSE), formerly NHS Improvement, the organisation responsible for overseeing foundation trusts and NHS trusts.

d) "Board of Directors" means the Board of Directors as constituted in accordance with the Constitution.

e) "Council of Governors" shall mean the Council of Governors as constituted in accordance with the Trust's constitution.

f) "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

g) "Budget Holder" means the director or employee with delegated authority to manage finances (Income, Expenditure and Capital) for a specific area of the organisation.

h) "Chair" means the person appointed to be Chairperson of the Trust under the terms of the constitution.

i) "Chief Executive" means the chief executive (and accounting officer) of the Trust.

j) "Commissioning" means the process for determining the need for obtaining the supply of healthcare and related services by the Trust within available resources.

k) "Committee" means a committee appointed by the Trust.

l) "Constitution" means the constitution of the Trust as approved by the Regulator (1.2.1 c).

m) "Director of Finance" means the chief financial officer of the Trust.

n) "Executive Director" means a director who is an officer appointed in accordance with the constitution.

o) "Funds held on Trust" (Charitable Funds) shall mean 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.

p) "Legal Adviser" means the properly qualified person appointed by the Trust to

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provide legal advice.

q) "Nominated Officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

r) "Non-Executive Director" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Trust.

s) "Officer" means an employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or non-executive Director of the Trust.

g) "Regulator" refers to the organisation responsible for overseeing foundation trusts and NHS trusts, currently NHS England, but some relevant guidance will have been issued by NHS Improvement and prior to that Monitor.

t)

u) "SFIs" means the Standing Financial Instructions.

v) "SOs" means the Standing Orders.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Any reference to any statute or Statutory Instrument shall include any statutory modification or re-enactment thereof.

1.2.5 "NHS England" is the current regulator replacing NHS Improvement, which became part of NHS England in July 2022 and itself replaced "Monitor". When describing various items of guidance, all three terms are relevant depending on the date the guidance was issued and the term 'the Regulator' will be used.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within approved allocations;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d) defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Scheme of Delegation document; and

e) receiving regular reports on financial performance

1.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the 'Reservation of Powers to the Board of Directors' document.

1.3.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust system of internal control.

1.3.5 The Board of Directors should maintain a sound system of internal control to safeguard public and private investment, the NHS Foundation Trust's assets, patient assets and service quality. The Regulator's publication, NHS Foundation Trust Annual Reporting Manual and the latest NHS Foundation Trust Accounting Officer Memorandum provide further guidance.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board of Directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7 <u>The Director of Finance is responsible for:</u>

a) implementing the Trust financial policies and for coordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, the duties of the Director of Finance include:

   a. the provision of financial advice to the Trust and its Board of Directors and employees;

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b. the design, implementation and supervision of systems of internal financial control; and

c. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation;

(e) maintaining effective risk management arrangements.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 AUDIT AND RISK COMMITTEE

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit and Risk Committee of non-executives, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;

b) reviewing financial systems;

c) monitoring compliance with Standing Orders and Standing Financial Instructions;

d) reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

e) reviewing the establishment and maintenance of an effective system of internal control and risk management, and advising the Board of Directors accordingly;

f) receiving the annual report of the Local Counter Fraud Specialist.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit and Risk Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to the Regulator (to the Director of Finance in the first instance).

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit and Risk Committee shall be involved in the selection process when an internal audit service provider is changed.

2.1.4 The Audit and Risk Committee will make recommendations to the Council of Governors regarding the appointment of the External Auditor. The Regulator recommends market testing at least once every five years.

2.2 FRAUD AND CORRUPTION

2.2.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with Directions on fraud and corruption and The Bribery Act 2010.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS fraud and corruption manual and guidance and The Bribery Act 2010.

2.2.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and work with The NHS Counter Fraud Authority in accordance with the NHS Fraud and Corruption Manual.

2.3 DIRECTOR OF FINANCE

2.3.1 The Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

d) ensuring that an annual internal audit report is prepared for the consideration of the

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Audit and Risk Committee and the Board of Directors. The report must cover:

- a clear opinion on the effectiveness of internal control, in accordance with current controls assurance guidance
- major internal [financial] control weaknesses discovered
- progress on the implementation of internal audit recommendations
- progress against plan over the previous year
- strategic audit plan covering the coming three years
- a detailed plan for the coming year
- reliance placed on the audit work of other recognised audit bodies

2.3.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises, members of the Board of Directors or employee of the Trust;

c) the production of any cash, stores or other property of the Trust under an employee's control; and

d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls including the degree to which risk management, control and governance support the achievement of the Trust’s objectives;

c) the suitability of financial and other related management data;

d) the extent to which the Trust assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- fraud and other offences,
- waste, extravagance, inefficient administration,
- poor value for money or other causes.

e) the adequacy and appropriateness of remedial action taken by managers following the issue of an adverse audit report or audit comment.

f) The Head of Internal Audit will produce an annual audit opinion on the effectiveness

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of the system of internal controls.

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.4.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairman and Chief Executive of the Trust.

2.4.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.4.5 A summary of reports and an annual report will be presented to the Audit and Risk Committee.

2.5 EXTERNAL AUDIT

2.5.1 The Council of Governors appoints the external auditor.

2.5.2 The Council of Governors may reappoint the external auditor for the following year without going through a formal selection process on the recommendation of the Audit and Risk Committee.

2.5.3 The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria of the Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General, at the date of appointment and on an on-going basis throughout the term of their appointment.

2.5.4 External audit must comply with the responsibilities and functions set out in the Code of Audit Practice issued by the NAO on behalf of the Comptroller and Auditor General.

2.5.5 The Trust will provide the external auditor with rights of access to documents and information (including third parties), which appears to them necessary for the purposes of their functions.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

a) a statement of the significant assumptions on which the plan is based;

b) details of major changes in activity, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board of Directors. Such budgets will:

a) be in accordance with the aims and objectives set out in the annual financial plan as submitted to the Integrated Care Board and the Regulator;

b) accord with activity and workforce plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds; and

e) identify potential risks.

3.1.3 The Director of Finance shall monitor financial performance against budget and business plan, routinely review and report to the Board of Directors.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.1.7 The Director of Finance shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) the amount of the budget;
b) the purpose(s) of each budget heading;
c) individual and group responsibilities;
d) authority to exercise virement;

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e) achievement of planned levels of service; and
f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement contained within the approved budget by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board of Directors in a form approved by the Board of Directors containing:

- income and expenditure to date showing trends and forecast year-end position;
- movements in working capital, cash and borrowing;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, activity and workforce plans;

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

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c) no permanent employees can be appointed without giving due consideration of the ongoing financial resources required to fund the post within the approved budget.

3.3.3 The Chief Executive is responsible for ensuring the Trust is financially viable, meets its financial duties, and takes such action as is necessary.

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvements, cost reductions and efficiencies and income generation initiatives in accordance with the requirements of the Annual Business Plan.

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12).

3.5 MONITORING RETURNS

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation(s). .

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Regulator, the Trust accounting policies, and the required accounting standards;

(b) prepare and submit annual accounts to the Regulator in accordance with current guidelines; and

(c) submit financial returns in accordance with the requirements of the Integrated Care Board (ICB) and the Regulator.

4.2 The Trust's Annual Accounts must be audited by the external auditor appointed by the Council of Governors. The Trust's audited annual accounts must be approved by the Board of Directors, presented to a public meeting of the Council of Governors and made available to the public.

4.3 The Trust publishes an annual report, in accordance with guidelines on local accountability, and presents it at a public meeting. The document will comply with the NHS Foundation Trust Annual Reporting Manual and any other guidelines as required by the Regulator

4.4 Ensure that a copy of the annual accounts, the annual report and any report of the external auditor on them, are laid before Parliament and copies of these documents are sent to NHS England.

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5. BANK ACCOUNTS

5.1 GENERAL

5.1.1 The Director of Finance is responsible for managing the Trust banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance / Directions issued from time to time by the Regulator.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 BANK AND GBS ACCOUNTS

5.2.1 The Director of Finance is responsible for:

a) bank accounts and Government Banking Service (GBS) accounts;

b) establishing separate bank accounts for the Trust non-exchequer funds;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

d) reporting to the Board of Directors all arrangements made with the Trust bankers for accounts to be overdrawn (including arranging a working capital facility).

5.3 BANKING PROCEDURES

5.3.1 The Director of Finance will ensure detailed instructions are in place for the operation of bank and GBS accounts which must include:

a) the conditions under which each bank and GBS account is to be operated;

b) the limit to be applied to any overdraft (or working capital facility);

c) maintaining up to date bank mandates identifying those officers authorised to approve transactions, and

arrangements to control and regulate all on-line banking activity including documented details of all those with access to on-line bank, their levels of access, transaction approval and dual approval thresholds.

5.3.2 The Director of Finance must advise the Trust bankers in writing of the conditions under which each account will be operated.

5.4 TENDERING AND REVIEW

5.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES,

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ELECTRONIC TRANSFERS AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance is responsible for identifying, designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection, banking and coding of all monies due.

6.1.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received whether physical or electronic.

6.1.3 The Director of Finance will issue instructions that the Trust will not accept cash payments of amounts greater than £10,000.

6.2 FEES AND CHARGES

6.2.1 The Trust shall follow the guidance as set out in the NHS Standard Contract for patient services.

6.2.2 The Director of Finance in conjunction with the directors are responsible for designing, maintaining and ensuring compliance with the system for approving and regularly reviewing the level of all fees and charges other than those determined by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Trust's Standards of Business Conduct and any relevant NHS guidance shall be followed.

6.2.3 All employees must inform the Finance department promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance is responsible for ensuring that appropriate recovery action on all outstanding debts is taken.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such stationery or electronic equivalents;

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c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.1 PROCUREMENT AND CONTRACTING PROCEDURE

7.1.1 These Procurement and Contract Procedures set out the procedures to be followed in relation to spend and contracts, whatever the method of payment, such as for the purchase and sale of goods, works and services, entered into by or on behalf of the Trust and CHS. They aim to ensure a system of openness, fairness, and transparency and facilitate the Trust and CHS achieving value for money.

7.1.2 These Procedures should be read and acted upon in conjunction with the Standing Financial Instructions along with advice and guidance provided by the CHS Procurement Team.

7.1.3 All procurements and contracts must comply with UK legislation, directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions.

7.1.4 The Trust shall comply as far as is practicable with the requirements of the Regulator's guidance, the Government Financial Reporting Manual and "Estatecode" in respect of capital investment and estate and property transactions.

7.1.5 Where the Trust or CHS is utilising grant funding, the terms and conditions of grant must be examined closely and complied with. It should be noted that agreements with other public bodies and with NHS-owned companies may also be subject to these regulations, and advice should be sought from the Procurement Team.

7.1.6 These procedures do not apply to:

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a) contracts of employment which makes an individual a direct employee. (These procedures do apply to contracts for recruitment agency services and the employment of consultants or agency staff).

b) agreements regarding the acquisition, disposal or transfer of land for which provision is made within the Local Government Act 1972 and in relation to which Financial Regulations apply, (unless the use of land is for development purposes).

7.1.7 All values stated in these procedures are exclusive of VAT and are aggregated values of the total value of a specific good, service or works procured. Total values shall not be disaggregated specifically to avoid competition or a specific type of competition.

7.1.8 The Chief Executive and Directors of Finance are responsible for ensuring officers within their directorate comply with these procedures.

7.1.9 Any failure to comply with these procedures may result in disciplinary action against the officer(s) concerned. Officers must exercise the highest standards of conduct, integrity and impartiality when involved in the procurement, evaluation, award and management of contracts. The Trusts Anti-Fraud, Corruption Policy and Code of Conduct must be complied with.

7.1.10 Any difference of opinion regarding the meaning of these Procedures shall be resolved by the Chief Executive (Trust) and Managing Director (CHS).

7.1.11 Proper and accurate records must be kept of all aspects of the procurement process, including: steps taken, selection and evaluation of bidders, decisions made and approvals obtained etc. All documentation must be retained in accordance with the Trusts record retention policy. Records wherever practicable should be in electronic form and in PDF format and uploaded to the project or contract in Atamis.

7.1.12 These Procedures shall be reviewed annually by the Chief Executive, Head of Procurement Team and other key officers.

7.2 EXISTING ARRANGEMENTS

7.2.1 Before commencing any procurement process the following must be considered.

(a) In-house Providers

Before commencing any proposed procurement process the relevant Delegated Officer must consider the need to consult any other Delegated Officer who may be able to provide the works, services, or goods required.

(i) to determine whether the works, services or goods can be provided in-house.

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If so, the relevant Delegated Officer may decide, subject to value for money considerations, not to seek competition but to arrange for the works, services or goods to be provided in-house. The relevant Delegated Officer(s) will record their decision; or

(ii) where (i) above does not apply, to determine whether the director of Finance or Divisional Director would like to submit an in-house bid and if so, then they shall be included in the list of contractors invited to quote/tender under these Procedures.

(iii) For estates, facilities and medical engineering related services provided by Calderdale and Huddersfield Solutions Ltd (CHS) included in the respective Service Agreements, the Trust should offer the work to CHS, unless this is inappropriate considering the provisions of those Service Agreements. The Procurement Team should be contacted with any queries officers may have in relation to this.

(iv) Where (a)(iii) does not apply, for the purposes of (a)(i) and (ii), the Managing Director of CHS shall be regarded as a Delegated Officer of the Trust who may be able to provide works and services for another Delegated Officer of the Trust and may submit an in-house bid.

(v) If the Delegated Officer referred to in (a) decides to proceed in accordance with (c) or is otherwise invited to tender, the Delegated Officer of the in-house service may obtain quotations/tenders in respect of supplies of goods, equipment, services or elements of the works that it is proposed are ordered or sub-contracted from a supplier/sub-contractor to enable a quotation/tender to be prepared. The procedures to be adopted for selection of a supplier/sub-contractor shall be those set out in these Procedures.

(vi) Every such invitation to a supplier/sub-contractor shall include a statement to the effect that:

> The quotation/tender is to be used only for the purpose of compiling a tender or quotation for goods, services or works which the Delegated Officer intends to submit.
>
> There is no obligation on the part of the Trust or CHS to order any supplies, services or work from the supplier/sub-contractor or any other supplier/sub-contractor.

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(vii) All such bids will be treated as confidential and will not be used other than for the purposes for which they are sought.

(b) Corporate Contracts

Where a corporate or framework contract is in place with a supplier, this should be utilised rather than sourcing alternative providers.

(c) Collaborative Procurement Arrangements

(i) Consideration should be given to whether any existing collaborative arrangements would be appropriate. Collaborative procurement arrangements include procurement arrangements with another Trusts, ICS, government department, or frameworks available through a public service purchasing consortium.

(ii) Due diligence needs to be carried out to ensure the legal requirements have been met and it is appropriate and suitable for the Trust or CHS to make use of any such arrangement. The Procurement Team should be contacted for advice in connection with this process.

7.1.2 The procedures below set out what should be considered before undertaking any procurement activity. Prior to undertaking procurement activity officers must ensure that:

(a) they take all necessary legal, financial (including insurance) and other professional advice (for example procurement, health and safety and risk management). Officers should have regard to current policies, procedures and standard documentation available from the Procurement Team.

(b) contract value is calculated (irrespective of the method of payment) in accordance with Public Contract Regulations 2015 (irrespective of whether they apply). This will include, amongst other things, the whole life costs for the full duration of the contract and any optional period of extension and any maintenance or continuing costs. Contracts should not be artificially divided into two or more separate contracts in an attempt to avoid these Procedures or the Public Contract Regulations 2015.

(c) Officers must ensure that they have obtained the necessary approval(s) to authorise the expenditure, procurement, or sale of goods, works or services. In addition, a business case must be prepared and approved by the relevant officer(s) for all procurement activity in line with the business case approval process.

(d) the Trust or CHS requirements are clearly documented. In the form of a specification or an explanation of the detailed outcomes that need to be met to achieve the requirements, as the circumstances dictate. This is an important exercise since this document will form

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the basis of any contract.

(e) every effort is made to make the best of buying power by aggregating purchases whenever possible. Although consideration should be given in all cases to whether it is appropriate to divide the requirements into smaller lots where there is an economic or social value resulting from the lotting.

(f) they are satisfied that key stakeholders have been identified and consulted.

(g) any risks associated with the procurement/contract are identified, assessed, and recorded together with the actions required to manage and maintain them at an acceptable level as part of the procurement.

(h) the course of action taken will represent Value for Money.

(i) Social value should be explicitly evaluated in all central government procurement, where the requirements are related and proportionate to the subject-matter of the contract, rather than just 'considered' as currently required under the Public Services (Social Value) Act 2012.

(j) taking all necessary advice, the procurement is properly categorised for the purpose of the Regulations, including whether as works, supplies or services, and that any Light Touch Services are correctly identified.

(k) Before quotations/tenders are invited, the award criteria must be recorded in writing, including the basis for assessing price or cost, any quality criteria and all weightings. The criteria, sub-criteria and weightings should be made available to bidders as early as practicable in the procurement process and not later than the invitation to tender/quotation stage. Sub-criteria and weightings cannot be used which have not previously been brought to a bidder's attention. More information is available from the Procurement Team.

(i) The Price / Quality split
(ii) The reasons for the Price / Quality split

7.3 IT AND MEDICAL DEVICE PROCUREMENTS

7.3.1 Before quotations/tenders are invited, regardless of value, Delegated Officers must have full engagement of The Health Informatics Services or CHS Medical Engineering when requiring new, changes to or retirement of any IT systems, medical devices, software, services or hardware. **(See overlap with SFI No. 15)**

7.4 PERFORMANCE OF CONTRACTS

7.4.1 Delegated Officers must consider any steps necessary to protect the Trust or CHS interests in the event of contractor default, having regard to advice from the

Procurement Team.

7.4.2 This consideration should be based on risk, taking account of the circumstances, including:

(a) the value of the Contract
(b) the type of Goods, Services or Works being procured
(c) the payment profile of the Contract
(d) the financial strength of the suppliers in the market
(e) affordability and proportionality.

and should assess whether additional security is required in the form of a bond, guarantee, retention, or (where performance is required by a particular date, and where delay would have financial consequences) provision for liquidated damages.

7.5 PROCUREMENT PROCESS

General Applicability Relating to Procurement

7.5.1 Expert advice and guidance should be sought from the Procurement Team in all circumstances

7.5.2 For all procurement activity resulting in the spend or awarding of a contract, the Trust and CHS e-commercial portal, Atamis, must be used.

7.5.3 All contracts £25,000 and above must be published to the public Contract Register and Contracts Finder via Atamis. For openness and transparency, it is best practice to publish all contracts to Contracts Finder regardless of value.

7.5.4 The Trust and CHS Contract Register is available on the Trust and CHS website.

7.5.5 Consideration should be given in all cases as to whether wider, additional advertisement is necessary to identify appropriate potential suppliers, for example, specialist/trade journals.

7.5.6 Where an additional advertisement is placed or where there is an open invitation on Atamis, an advertisement must also be placed on Contracts Finder for any contract over £25,000.

7.5.7 Where the Regulations apply, a contract notice must be published on Find a Tender Service (FTS) before any other notice/advertisement is published and no other notice/advertisement should contain any more information than that published in the FTS.

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7.5.8 Every tender for goods, materials, services, or disposals shall embody such terms of the NHS Standard Contract Conditions as are applicable. Supplier terms and conditions should not be agreed unless incorporated within the NHS Terms and Conditions with the NHS Terms and Conditions taking precedent. Advice must be sought from the Procurement Team.

7.5.9 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors.

7.5.10 The NHS Terms and Conditions shall be modified and/or amplified to accord with DHSC guidance and, in minor respects, to cover special features of individual projects. Any other significant amendments must be notified to the Risk and Assurance Group.

7.5.11 Prior to the submission of their bids, bidders have an opportunity, if they consider necessary, to request in writing clarification regarding the requirements via Atamis. Any response to bidders should also be in writing via Atamis. There are rules that must be followed to ensure fairness and transparency during these clarification phases, advice should be sought from the Procurement Team.

7.5.12 The main procurement routes for competition are detailed below:

7.5.13 **Spend and Contracts up to and including £10,000**

For spend and contracts valued up to and including £10,000 the Procurement Buying Team shall proceed in a manner which ensures value for money and the efficient management of the service. Where possible this process shall prioritise the placing of orders with local businesses.

7.5.14 **Contracts between £10,001 and up to and including £50,000**

(i) For contracts above £10,000 and up to and including £50,000 the Procurement Team must seek to achieve competition and for that purpose invite at least three quotations via Atamis. Where appropriate at least two of the companies invited to quote should

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be local businesses. In instances where only a single bid is received, then guidance should be sought from the Head of Procurement.

(ii) When inviting suppliers to quote, the officer responsible should ensure they rotate between suppliers where the market permits and allows to ensure a fair, open and transparent process is applied.

(iii) Where a framework agreement is being utilised, the procurement must comply with the call-off procedure as set out in the framework usage terms and conditions.

7.5.15 **Contracts between £50,001 and up to the Government Find a Tender thresholds for goods and services**

i) All procurements above £50,000 in total contract value must be undertaken by the Procurement Team.

ii) For procurements above £50,000 to the Threshold for goods and services, an open tender procedure or utilisation of a relevant framework agreement must be followed.

iii) Specification of Requirement and all relevant documentation including the terms of which the contract are to be awarded must be published to the suppliers at the time of the procurement procedure.

iv) Using an open procedure the contract is advertised and suppliers invited to submit a tender by a certain date in proportion to the value, risk and market availability (being not less than 14 calendar days from the date of the notice).

7.5.16 **Contracts above Public Contract Regulations 2015 Threshold**

i) Where the spend or a total contract value, including available extensions, is estimated to be equal to or exceeds the relevant threshold the Regulations shall apply:

The Regulation thresholds at 1 January 2023 are:

	Excluding Vat	**Including Vat**
• Goods and Services	£115,633.33	£138,760.00
• Works Contracts	£4,447,447.50	£5,336,937.00
• Light Touch Regime	£552,950.00	£663,540.00
• Utilities	£355,795.83	£426,955.00
• Utilities – Works	£4,447,447.50	£5,336,937.00

ii) Publication of all FTS notices will be performed by a member of the Procurement Team via the Atamis portal. A contract notice in the prescribed form shall be published in the FTS in order to invite tenders or expressions of interest.

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7.5.17 For above Regulation thresholds the following procedures can be used and must be carried out by the Procurement Team;

- Open Procedure
- Restricted Procedure
- Light Touch Services
- Competitive Procedure with Negotiation
- Competitive Dialogue/ Innovation Partnership.

7.5.18 **Frameworks/Dynamic Purchasing System**

7.5.19 Where it is considered that the utilisation of an existing Framework Agreement of another public body is the most appropriate means to meet the requirements, this must be discussed with the Procurement Team. The Procurement Team may need to complete an access agreement prior to utilisation of the framework. Where such relevant Framework Agreements contain a number of different contractors able to provide goods/services a mini competition between all contractors or a direct call off (where permissible) should be undertaken.

7.5.20 Framework Agreements / Dynamic Purchasing Systems shall be procured in accordance with these Rules and the Regulations and where the relevant Regulation thresholds apply. Procedures described by the Regulations shall apply to all aspects of the procurement and operation of the Framework Agreement / Dynamic Purchasing System including: -

- the procurement methodology.
- any orders placed under the Framework Agreement;/Dynamic purchasing system.
- re-opening of competition or call off competition between all contractors/suppliers on the Framework/Dynamic Purchasing System.
- the duration of a Framework / Agreement (which shall not normally exceed 4 years) / or the Dynamic Purchasing System (As the period stated in the tender documents).

7.5.21 All call offs / mini competitions from framework agreements must be performed on Atamis.

7.5.22 **Exceptions to Requirements of Competition (where the Regulations do not apply)**

7.5.23 Where the Regulations apply, they must be complied with. Further advice and guidance can be sought from the Procurement Team

7.5.24 For contracts above £10,000 and up to and including £115,633.33 in exceptional circumstances and considering all the information available a Delegated Officer may

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decide that it is justified to invite less than three quotations in a particular instance or type of transaction.

The relevant Delegated Officer shall ensure the goods/services and/or works to be procured subject to the waiver to competition have a fully detailed specification and the NHS terms and conditions agreed with the supplier.

The relevant Delegated Officer must explain their reasons for this by completing the Single Source request ensuring the form is completed, signed and submitted to the Procurement Team for review and approval. If Procurement agree with the reasons of the waiver, the waiver will be given a Atamis contract reference number and signed by the Head of Procurement prior to the Budget Holder and Divisional Director.

7.5.25 Approval and/or comments shall be provided in the format set out in the Waiver to Competition Form. The Procurement Team must ensure an electronic version of the report and approval is saved (PDF format) and uploaded into the project file on Atamis.

7.5.26 The reasons why a waiver to the Rules regarding the requirements for competition is justified, may include the circumstances below, provided that such an approach is consistent with the Trusts or CHS' duty to obtain value for money and its commercial strategy and policies.

(a) No Available Competition

The relevant Delegated Officer must state the reason for the waiver is due to no available competition.

This can occur in a limited number of circumstances as in the following:-

1. The purchase of proprietary or patented goods or materials only from one firm, and where no equivalent or no reasonably satisfactory alternative is available;

2. The execution of works or supply of services of a specialised nature which can only be carried out by only one firm and where no equivalent or no reasonably satisfactory alternative is available;

3. The purchase of a named product required to be compatible with an existing installation for which no equivalent or no reasonably satisfactory alternative is available;

4. The appointment of a developer to exercise functions under Section 278 of the Highways Act 1980;

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(b) Variation

The relevant Delegated Officer can order additional works under a waiver in the following circumstance:

Additional works, services or supplies are required to the original contracts that are within the original scope, provided the overall value is not greater than 25% of the original contract.

(c) Emergency Circumstances

Where purchases for works and services are required by the appropriate Delegated Officer urgently, due to circumstances not foreseeable and not attributable to the Trust or CHS, as not to permit compliance with the requirements of competition.

(d) Strategic/Tactical Procurement

Where the Head of Procurement and the relevant Delegated Officer consider a waiver to competition for the following reasons:-

Aggregating different contracts together but an extension is required to align contract start dates.

Due to shortage of resources to enable procurement event to be properly project managed which could not have been forseen or managed.

7.5.27 The Procurement Team shall maintain a register of all such exceptions.

7.5.28 In compliance with the Local Government Transparency Code, all contracts created by a waiver to competition shall be promoted to the Trust and CHS Contracts Register. In addition, all contracts awarded above £25,000 must have a contract award notice publicised on Contracts Finder.

7.5.29 **Submission and Opening of Quotations and Tenders**: Atamis must be used for the return / submission of quotations and tenders in accordance with the system's requirements.

7.5.30 The opening and release of submitted bids (after the specified deadline) must be performed on Atamis by the Procurement Team in line with the tender governance process:

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7.5.31 Late Quotations/Tenders: Late bids may only be accepted with the approval of the Head of Procurement where the bidder has gained no advantage as a result of the late submission for reasons where, for example, there is evidence that technological reasons have prevented the submission on time, through no fault of the bidder.

7.5.32 **Evaluation of Quotations and Tenders**

7.5.33 Evaluation of quotations/tenders must be completed in accordance with criteria and the scoring methodology set out in the quotation/ tender documents provided to suppliers to ensure the process is performed in open, fair and transparent manner.

7.5.34 Each member of the evaluation team for procurement above £115,633.33 must complete and sign a Declaration Form to state whether they have a vested interest in or links to, any potential supplier who has submitted a bid. It is the responsibility of the Procurement Team to manage this process by ensuring the forms are completed by all members of the evaluation team at the start of the process and recorded for audit purposes. Where there is a conflict of interest (COI) involved, the Procurement Team must consider the declared COI and manage this appropriately. If a COI is declared by a member of the evaluation panel, then this person/persons must be excluded from the evaluation panel to avoid exposing the Trust or CHS to any commercial risk i.e. supplier challenge.

7.5.35 Records should be kept of the evaluation process, for example, criteria, sub-criteria, weightings, individual and consensus scoring including completed moderation forms (signed by the individuals involved in the evaluation) clarifications and reasons for decisions. Records should be saved electronically (PDF format) and stored on Atamis and in accordance with the Records Retention Policy.

7.5.36 Following the receipt of bids the Procurement Team has the opportunity, if necessary, to request in writing via Atamis, clarification of any aspect of a bid and any response from bidders should also be in writing via Atamis. This should only be performed where an obvious error has been made and does not allow a bidder to add or improve their bid.

7.5.37 Where the total value of a contract is higher than the budgeted value, additional approval from the budget holder must be obtained prior to proceeding with a contract award.

7.5.39. Errors in Quotations/Tenders

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7.5.38 Certain contract documentation will prescribe the rules to be adopted in relation to errors in quotations/tenders. In other cases, the Procurement Team will advise bidders of the approach that will be taken.

Errors in quotations/tenders shall be dealt with in one of the following ways:

(a) The bidder shall be given details of the error(s) found during the examination of the quotation/tender and shall be required at the sole option of the Procurement Team to confirm without amendment or withdraw the quotation/tender; or

(b) Amending the quotation/tender to correct genuine error(s) provided that, in this case, apart from these genuine errors no other adjustment, revision or qualification is permitted.

All amendments shall be fully recorded with justification for the action taken within the Atamis record.

7.5.39 **Abnormally Low Tenders**

7.5.40 Where a tender appears abnormally low it may not be rejected without:

- giving the tenderer an opportunity to explain the tendered price (such explanation to be given in writing),
- considering the evidence provided, and
- obtaining the written approval from the Head of Procurement and the Director of Finance.

7.5.41 **Post Tender Negotiations (Negotiations after receipt of formal bids and before award of contract)**

7.5.42 Where the Regulations apply, they must be followed. Post tender negotiations are not allowed in Regulations procurement processes unless the competitive process with negotiation with tender procedure is used.

7.5.43 Where the Regulations do not apply, and the relevant Delegated Officer considers that post tender negotiations are in the Trust or CHS interests and may achieve added value then post tender negotiations may exceptionally be appropriate. Post tender negotiations must only take place where they do not distort competition or disadvantage any bidder. The process should be transparent and non-discriminatory and ensure bidders are treated equally.

7.5.44 Post tender negotiations with any tenderers must be in accordance with the following conditions:

(a) Approved by the relevant Delegated Officer in consultation with the Division Director and Director of Finance and are carried out in accordance with the law;

(b) Conducted by a team of suitably experienced officers approved by the Director of Finance and trained in post tender negotiations;

(c) Written records of the negotiations are kept and a clear written record of the added value obtained by the post tender negotiations is incorporated into the contract with the successful tenderer. All evidence must be kept in the Atamis record.

The above requirements apply equally to procurements below £115,633.33.

7.5.45 **Acceptance of Quotations/Tenders and Award**

7.5.46 The Trust or CHS is not bound to accept any quotation or tender and this must be made clear to bidders in writing at the beginning of the process and as appropriate throughout.

7.5.47 Quotations and tenders may be accepted on behalf of the Trust or CHS by the relevant Division Director provided they have been sought, evaluated and are to be awarded fully in compliance with these Regulations and the necessary approval has been obtained.

7.5.48 In relation to all contracts, once a decision to award a contract is made, all bidders must be notified at the same time, as soon as possible, in writing via Atamis, of the intention to award the contract to the successful bidder, giving reasons for the decision providing the characteristics of the successful bidder against the unsuccessful bidder. This is the responsibility of the Procurement Team.

7.5.49 For all contracts tendered in accordance with the Regulations, a mandatory 10-day standstill period must be observed between the decision to award being notified to all bidders and entering into a contractually binding agreement with the successful bidder.

7.5.50 If an unsuccessful bidder challenges the decision to award the contract, if the contract has not already been awarded it shall not be awarded until the advice of the Head of Procurement and in some circumstances an external legal representative have been sought.

7.5.51 Unsuccessful bidders may request a debrief which should be provided to them in writing. Further information should be sought from the Procurement Team.

7.5.52 **Contracts Register and Contract Award Notices**

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7.5.53 All contracts must be promoted to the contract register on Atamis regardless of value.

7.5.54 Where a contract has been tendered pursuant to the Regulations, the Procurement Team shall publish a contract award notice in FTS no later than 30 days after the date of award of the contract and BEFORE any other award notice is publicised.

7.5.55 Where a contract has been awarded valued £25,000 or greater, regardless of the procedure used (including call-off from Framework Agreements), details of the award must be published on Contracts Finder, within 30 days of the award of the contract.

7.6 CONTRACT FORMALITIES

7.6.1 **Contracts.**

7.6.2 Contracts include the Trust and CHS electronic purchase orders in addition to contracts prepared and/or approved by the Procurement Team. The Procurement lead and relevant Delegated Officer must ensure that officers give proper consideration to the form of contract required in each case and obtain advice from the Head of Procurement where necessary.

7.6.3 Every contract must have a Atamis contract record and an assigned contract reference number generated by the Procurement Team.

7.6.4 Every contract should be in electronic format unless in exceptional circumstances where not possible.

(a) must be signed by Head of Procurement where the contract value is up to and including £250,000

(b) must be signed by Director of Finance or Managing Director where the contract value exceeds £250,000.01

7.6.5 The relevant Delegated Officer must ensure that every contract must set out:

(a) the works, goods, services, materials, matters or things to be carried out or supplied;

(b) the price to be paid and/or the amounts and frequency or the method of calculation of contract payments with a statement of discounts or other deductions;

(c) the time(s) within which the contract is to be performed; and

(d) such other matters as the Head of Procurement considers necessary.

7.6.6 Any standard terms and conditions of contract submitted by a supplier shall not be accepted without advice or review from the Head of Procurement.

7.6.7 Every contract must be concluded (executed by all parties) prior to the commencement of any works, services or any supply. Exceptionally, and only for certain categories of procurement such as construction, a letter of intent may be utilised to enable forward planning and mobilisation activities but must be value capped and time limited. Proceeding under a letter of intent can give rise to risks and advice should always be sought from the Head of Procurement before utilising a letter of intent.

7.6.8 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust Constitution and Standing Financial Instructions

(b) Public Contract Regulations 2015 and other statutory provisions

(c) Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants

(d) Such of the NHS Standard Contract Conditions as are applicable

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance

(f) Contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. If a departure becomes necessary the reasons for the departure must be recorded in a permanent record and in the Atamis project file;

(g) In all contracts made by the Trust, the Board shall endeavor to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

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7.7 AGENCY OR TEMPORARY STAFF CONTRACTS (see also SFI No.9).

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.8 HEALTHCARE SERVICE AGREEMENTS (see overlap with SFI No. 8)

Service agreements with NHS providers for the supply of clinical and non-clinical support services shall be drawn up in accordance with guidance issued by the independent regulator, or subsequent responsible NHS body.

7.9 DISPOSALS (see overlap with SFI No. 14)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) Items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;

(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) Land or buildings concerning which Secretary of State guidance has been issued but subject to compliance with such guidance.

7.10 APPLICABILITY OF SFIS ON TENDERING AND CONTRACTING TO CHARITABLE FUNDS

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's charitable funds and private resources.

8 HEALTHCARE SERVICE ARRANGEMENTS

8.1 The Chief Executive as the Accounting Officer is responsible for ensuring the Trust enters into suitable contracts with the service commissioners for the provision of NHS Services. All contracts should aim to implement the agreed priorities contained within the NHS Plan and wherever possible be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive shall take into account.

a) the license from the Regulator
b) the standards of service quality expected (core standards as a minimum)
c) the relevant national service framework (if any)
d) the provision of reliable information on the price and volume of services
e) national planning priorities
f) NHS performance ratings
g) integration where appropriate with existing investment plans with other partners (e.g., Social Services)
h) integrated care pathways
i) Assessment of risk

8.2 A good contract will result from a dialogue of clinicians, uses, carers, public health, professionals and managers. It will reflect knowledge of local needs and inequalities. This

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will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from contracts.

9 PAY EXPENDITURE AND TERMS OF SERVICE

9.1 REMUNERATION AND TERMS OF SERVICE FOR EXECUTIVE DIRECTORS AND OTHER SENIOR EMPLOYEES

9.1.1 In accordance with Standing Orders the Board of Directors shall establish a formal Committee overseeing the remuneration and terms of service comprising Non-Executive Directors with clearly defined terms of reference. These shall specify which posts fall within its area of responsibility, its composition and the arrangements for reporting. The Committee is formally known as the Nominations and Remuneration Committee.

9.1.2 Taking account of professional advice and using available benchmarking data, the Committee will

(a) advise the Board of Directors about appropriate remuneration and terms of service for all executive directors and other senior employees, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) informs the Board of Directors of its decisions on the remuneration and terms of service of executive directors and other senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust circumstances and performance and to the provisions of any national arrangements for such staff where appropriate

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

9.1.3 Committee decisions will be formally reported in the minutes of meetings received by the Board of Directors at its meeting immediately after the decision has been made.

9.2 REMUNERATION AND TERMS OF SERVICE FOR NON EXECUTIVE DIRECTORS

9.2.1 The Council of Governors Nominations and Remuneration Committee will determine the remuneration and terms of service for the Chairman and Non-Executive Directors. The Committee will determine remuneration and terms of service taking account of professional advice, benchmarking data and national guidance as appropriate.

9.3 REMUNERATION AND TERMS OF SERVICE FOR EMPLOYEES

9.3.1 Remuneration and terms of service will be consistent with locally and nationally determined frameworks.

9.3.2 Nationally determined pay awards will be applied consistently with nationally determined remuneration and terms of service and local contracts of employment.

9.4 STAFF APPOINTMENTS

9.4.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless it is consistent with service activity and financial plans.

9.5 PROCESSING OF PAYROLL

9.5.1 The Director of Workforce and Organisational Development is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) making payment on agreed dates; and

(c) agreeing method of payment.

9.5.2 The Trust's payroll provider on behalf of and in agreement with the Director of Workforce and Organisational Development will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) procedures for payment by cheque, bank credit, or cash to employees;

(h) procedures for the recall of cheques and bank credits

(i) pay advances and their recovery;

(j) maintenance of regular and independent reconciliation of pay control accounts;

(k) separation of duties of preparing records and handling cash; and

(l) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.5.3 Appropriately nominated managers have delegated responsibility, under established procedures, for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the instructions of the Trust's payroll provider acting on behalf of and in agreement with the Director of Workforce and Organisational Development; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement.

9.5.4 Payroll arrangements and activity shall be maintained through robust internal controls and be subject to independent audit review on a regular basis.

9.6 CONTRACTS OF EMPLOYMENT

9.6.1 The Board of Directors shall delegate responsibility to the Director of Workforce and Organisational Development for:

(a) ensuring that all employees are issued with a Contract of Employment in a form which complies with employment legislation and good practice; and

(b) dealing with variations to, or termination of, contracts of employment.

9.7 PENSIONS

9.7.1 The Trust will comply with its legal and statutory obligations in the provision of pension arrangements for its employees. The Trust will provide access to the NHS Pension Scheme and the National Employment Savings Trust (NEST) for its employees. The Trust will comply with the regulations for these schemes.

9.8 TEMPORARY, AGENCY AND BANK WORKING

9.8.1 The Trust will secure the 'best' available supply of temporary workers at the lowest cost

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with due consideration of the Regulator's agency rules in relation to price and contract frameworks.

9.8.2 The Trust will establish and maintain an internal bank for the supply of temporary workforce and will wherever possible operate a 'bank first' approach.

9.8.3 The Trust will review its agency rates and bank worker supply and pay rates on a systematic basis taking into account service activity and value for money.

9.8.4 The Trust will comply with HMRC IR35 rules by maintaining processes that are consistent with establishing the employment status of an individual.

9.8.5 Commitment to employ temporary staffing must only be made through the Trust's agreed processes and procedures.

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9.9 WORKFORCE PLANS

9.9.1 Workforce plans will be developed and agreed internally and submitted to the ICB and the Regulator in accordance with national planning guidance.

9.9.2 Workforce plans should be detailed and appropriately modelled and align with financial and service activity plans to ensure that the proposed workforce levels are affordable, efficient and sufficient to deliver safe care to patients.

9.9.3 The workforce establishment should be consistent with the approved service activity and financial budget.

10 NON-PAY EXPENDITURE

10.1 DELEGATION OF AUTHORITY

10.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Director of Finance will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Director of Finance shall ensure adequate procedures are set out for the seeking of professional advice regarding the supply of goods and services.

10.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

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(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(ii) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director must provide, in writing, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable

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to meet his commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

(a) be in a form approved by the Director of Finance, generally this being the Trust's electronic ordering system;

(b) state the Trust terms and conditions of trade; and

(c) only be issued to, and used by, those duly authorised by the Chief Executive.

(d) Verbal orders may be made by authorised corporate credit card holders. Such orders will be checked to subsequent statements. Credit cards issued must have appropriate credit limits and be appropriately restricted.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with rules on public procurement;(as per Section 7).

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars must be less than £20.

(ii) conventional hospitality, such as lunches in the course of working visits;

(see Trust Standards of Business Conduct policy for further guidance)

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

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(f) all goods, services, or works are ordered on an official order; except those requested using the approved purchasing card facility, or works and services executed in accordance with a contract, and purchases from petty cash up to a maximum value of £40 per item. Charitable funds limit for petty cash purchases is a maximum value of £75.

(g) verbal orders must only be issued very exceptionally except in the case of corporate credit cards. These must be confirmed by an official order and clearly marked "Confirmation Order".

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds and/or regulations, (as per Section 7).

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash and a purchasing card are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(l) petty cash and purchasing card records are maintained in a form as determined by the Director of Finance.

(m) drugs shall only be ordered via the Pharmacy Department or the Huddersfield Pharmacy Specials Unit;

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.2.8 All staff have a responsibility for the maintenance of confidentiality of all information. No member of staff shall reveal information that could:

a) Prejudice fair competition;

b) Result in the Trust failing to achieve the most advantageous price in respect of purchases or income in respect of sales.

Any breach of confidentiality, whether or not for personal gain, may render an individual open to disciplinary action in accordance with the Trust's disciplinary procedures and which may ultimately result in dismissal.

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11 EXTERNAL BORROWING AND INVESTMENTS

11.1 EXTERNAL BORROWING

11.1.1 The Director of Finance will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed new borrowing, within the limits set by the Regulator. The Director of Finance is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans and overdrafts.

11.1.2 Any application for a loan, overdraft or PDC revenue support will only be made by the Director of Finance or by an employee so delegated, and within the limits set and governance processes prescribed by the Regulator.

11.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.4 All borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any borrowing requirement in excess of one month must be authorised by the Director of Finance.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

11.1.6 The Director of Finance will prepare a Treasury Management Policy which will include procedural instructions on the operation of borrowing, reporting requirements and the records to be maintained.

11.2 INVESTMENTS

11.2.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within the terms of guidance as may be issued by NHS Improvement.

11.2.2 The Director of Finance is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

11.2.3 The Director of Finance will prepare a Treasury Management Policy which will include procedural instructions on the operation of investment accounts delegation limits, reporting requirements and the records to be maintained.

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12 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 CAPITAL INVESTMENT

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all consequences.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure that due consideration is given to:

(a) a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements;

(iii) robust capital costs and revenue consequences;

(iv) the involvement of appropriate Trust personnel and agencies;

(v) the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall be responsible for identifying, designing, maintaining and ensuring compliance with systems giving:

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(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust Standing Orders.

12.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 PRIVATE FINANCE (including leasing)

12.2.1 When the Trust proposes to use finance which is to be provided other than through its borrowing limit set by the Regulator or Public Dividend Capital, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the funder.

(b) The proposal must be specifically agreed in a business case approved in accordance with delegated authority.

(c) Any finance or operating lease must be agreed by the Director of Finance.

12.3 ASSET REGISTERS

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling three year programme.

12.3.2 The Trust shall maintain an asset register recording fixed assets.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

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12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be established to current values in accordance with methods specified in the Trust's Accounting Policies.

12.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Trust's Accounting Policies.

12.3.8 The Trust shall maintain a publicly available property register recording protected property, in accordance with the guidance issued by the Regulator.

12.3.9 The Trust may not dispose of any protected property without the approval of the Regulator. This included the disposal of part of the property or granting an interest in it.

12.4 SECURITY OF ASSETS

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 The Director of Finance is responsible for identifying, designing, maintaining and ensuring compliance with systems for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of the Board of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS Foundation Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions. Budget holders are responsible for the

security of assets held in their section of the asset register and that these assets are used efficiently and effectively.

12.4.5 Any damage to the Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

12.4.7 Employees, unless specifically authorised by their director, shall not use the Trust's assets for personal use.

13 STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant

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overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

13.9 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 DISPOSALS AND CONDEMNATIONS

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is proposed to dispose of a Trust asset, authorisation from the appropriate party must be sought prior to disposal. Delegated limits are set out in Appendix 2.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

14.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

14.1.5 Any disposal of IT equipment must also comply with the IT Security Policy.

14.2 LOSSES AND SPECIAL PAYMENTS

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance must also prepare a ‘fraud response plan’ that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately

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inform their head of department, who must immediately inform the Director of Finance or inform an officer with responsibility for security, theft or damage, or to the Trust's Counter Fraud Specialist if fraud is suspected. The Director of Finance must immediately inform the police if theft or arson is involved if this has not already happened.

In cases of fraud or corruption or of anomalies that may indicate fraud or corruption, the Director of Finance must inform the relevant Counter Fraud regional team before any action is taken and reach agreement upon how the case is to be handled.

14.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board of Directors, and

(b) the External Auditor.

14.2.4 The Board of Directors has delegated limits for the writing-off of losses, debts etc. These are contained in Appendix 2.

14.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Board of Directors.

14.2.9 In accordance with HM Treasury Managing Public Money guidance, there is a category of expenditure for which the Treasury cannot delegate responsibility and the Trust must seek consent from the Regulator before proceeding. These are transactions which set precedents, are novel, contentious or could cause repercussions elsewhere in the public sector, e.g. special severance payments, unusual financial transactions, payments to compensate for official errors, unusual schemes or policies.

15 INFORMATION TECHNOLOGY

15.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust data, programs and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

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(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

15.2 The Director of Finance shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Authorities/Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.4 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.6 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Appropriate finance staff have access to such data; and

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(c) such computer audit reviews as are considered necessary are being carried out.

16 PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17 CHARITABLE FUNDS

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17.1 INTRODUCTION

17.1.1 Standing Orders (SOs) identify the Trust responsibilities as a corporate trustee for the management of funds it holds on trust "Charitable Funds" and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 The Reserved Powers of the Board of Directors and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.1.3 As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

17.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.5 The Director of Finance has primary responsibility to the Board of Directors for ensuring that the SFIs are complied with in this section.

17.2 EXISTING FUNDS

17.2.1 The Director of Finance shall arrange for the administration of all existing funds. He shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines shall identify the restricted nature of certain funds,

17.2.2 The Director of Finance shall periodically review the funds in existence and if appropriate shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

17.3 NEW FUNDS

17.3.1 The Director of Finance shall arrange for the creation of a new fund where cash and / or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing fund.

17.3.2 The Director of Finance shall present the rationale for the establishment of a new fund to the Charitable Funds Committee for adoption as required. Such a document shall clearly identify, inter alia, the objects of the new trust, the capacity of this Body to delegate powers to manage and the power to assign the residue of the fund to another fund contingent upon certain conditions, e.g. discharge of original objects.

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17.4 SOURCES OF NEW FUNDS

17.4.1 In respect of donations, the Director of Finance shall:

(a) provide guidelines to officers of this Body as to how to proceed when offered funds. These to include:

(i) the identification of the donor's intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice;
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted.

17.4.2 In respect of Legacies and Bequests, the Director of Finance shall:

(a) provide guidelines to officers of this Body covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where this Body is the beneficiary;

(c) be empowered, on behalf of this Body, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

17.4.3 In respect of fund-raising, the Director of Finance shall:

(a) deal with all arrangements for fund-raising by and / or on behalf of the Trust and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge. The Director of Finance shall be the only officer empowered to give or delegate approval for such fundraising subject to the overriding direction of Directors;

(c) be responsible for alerting the Charitable Funds Committee to any irregularities regarding the use of the Trust's name or its registration numbers; and

(d) be responsible, after due consultation with the Legal Adviser, for the appropriate treatment of all funds received from this source.

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17.4.4 In respect of Trading Income, the Director of Finance shall:

(a) be primarily responsible, along with other designated officers, for any trading undertaken by the Trust as corporate trustee; and

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

17.4.5 In respect of Investment Income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 INVESTMENT MANAGEMENT

17.5.1 The Director of Finance shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he/she shall be required to provide advice to the Charitable Funds Committee shall include:

(a) the formulation of investment policy within the powers of this Body under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers, and;

(i) the Director of Finance shall agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which written agreements shall be signed by the Director of Finance (subject to approval by the Charitable Funds Committee);

(c) pooling of investment resources;

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

17.6 DISPOSITION MANAGEMENT

17.6.1 The exercise of this Body's dispositive discretion shall be managed by the Director of Finance in conjunction with the Charitable Funds Committee. In so doing he shall be

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aware of the following:

(a) the objects of various funds and the designated objectives;

(b) the availability of liquid assets within each fund;

(c) the powers of delegation available to commit resources:

(d) the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Trust shall be discharged by charitable funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust in accordance with Charity Commission guidance; and

(f) the definitions of "charitable purposes" as agreed by the Charity Commission.

17.7 BANKING SERVICES

17.7.1 The Director of Finance shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each fund where this is deemed necessary by the Charity Commission.

17.8 ASSET MANAGEMENT

17.8.1 Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure that:-

(a) appropriate records of all assets owned by the Trust as corporate trustee are maintained and that all assets , at agreed valuations, are brought to account;

(b) appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) donated assets received on trust rather than into the ownership of the Trust shall be accounted for appropriately;

(d) all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Trust.

17.9 REPORTING

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17.91 The Director of Finance shall ensure that regular reports are made to the Charitable Funds Committee to cover as a minimum the receipt of funds, investments, and the disposition of resources.

17.9.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Charitable Funds Committee for approval within agreed timescales.

17.9.3 The Director of Finance shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.

17.10 ACCOUNTING AND AUDIT

17.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit and provide them with all necessary information.

17.10.3 The Charitable Funds Committee shall be advised by the Director of Finance on the outcome of the annual external audit. The Director of Finance shall submit the Management Letter to the Charitable Funds Committee.

17.11 ADMINISTRATION COSTS

17.11.1 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Charitable Funds Committee, shall charge such costs to the appropriate funds.

17.12 TAXATION AND EXCISE DUTY

17.12.1 The Director of Finance shall ensure that this Body's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

18 RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for identifying, designing, maintaining and ensuring compliance with systems for archiving all documents required to be retained under the direction contained in current Department of Health guidance.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

19 RISK MANAGEMENT & INSURANCE

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19.1 The Chief Executive shall ensure that the Trust has a programme of risk management in accordance with the terms of the license issued by the Regulator. This programme will be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by Guidance issued by the Regulator.

19.3 The Chief Executive shall ensure that insurance arrangements exist in accordance with the risk management programme.

19.4 The Board of Directors shall decide if the Trust will insure through the risk pooling scheme administered by NHS Resolution or self-insure for some or all of the risks covered by the schemes. If the Executive Board decides not to use the risk pooling schemes (clinical, property and non-clinical third party liability) this decision shall be reviewed annually.

19.5 All risk pooling schemes require members to make some contribution to the settlement of claims (the “deductible”). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

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APPENDIX 1

AUTHORISATION LIMITS

Personnel	Revenue Expenditure Note 1	Capital Expenditure Note 2	Asset Disposals	Charitable Expenditure Note 3
BOARD (As group)	>£2,500,000	>£2,500,000	>£1,000,000	>£100,000
CHIEF EXECUTIVE / DIRECTOR OF FINANCE (See notes below)	<£2,500,000	<£2,500,000	<£500,000	<£100,000 Note 5
EXECUTIVE BOARD (See notes below)	<£2,000,000 Note 4	<£2,000,000 Note 4	<£1,000,000 Note 4	<£100,000 Note 5
EXECUTIVE DIRECTORS / DIVISIONAL DIRECTORS	<£500,000	<£50,000	Nil	<£50,000
DIRECTOR OF OPERATIONS / DEPUTY DIRECTOR	<£250,000	Nil	Nil	<£25,000
ASSISTANT DIRECTOR NURSING / FINANCE	<£100,000	Nil	Nil	<£10,000
THEATRE MANAGER	<£50,000	Nil	Nil	Nil
GENERAL MANAGER	<£25,000	Nil	Nil	<£5,000
HEAD OF DEPARTMENT/ DEPARTMENT MANAGER / MATRON	<£25,000	Nil	Nil	Nil
TEAM LEADER / WARD SISTER	<£5,000	Nil	Nil	Nil

Notes

All approval limits refer to the total project and/or full lifecycle cost.

1 Any single transaction.
2 Capital expenditure approvals to be in line with approved Trust capital programme as managed by the Capital Management Group.
3 In addition to the limits identified, all Charitable Funds expenditure must have fund holder approval in the first instance.
4 Any two directors to include Chief Executive or Director of Finance.
5 To include one Charitable Funds Committee Member and Chief Executive or Director of Finance.

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APPENDIX 2

AUTHORISATION LIMITS RELATING TO DISPOSALS, LOSSES, WRITE-OFFS AND OTHER COMPENSATION ITEMS

Condemning & Disposal	**Issue**
DIRECTOR OF HEALTH INFORMATICS	All IT equipment with new price <£5,000
EXECUTIVE DIRECTORS / DIVISIONAL DIRECTORS	All medical and non-medical equipment with new price <£5,000
DIRECTOR OF PLANNING, ESTATES AND FACILITIES	All mechanical and engineering plant <£5,000
CHIEF EXECUTIVE / DIRECTOR OF FINANCE	All equipment with new price >£5,000

Losses, Write-off & Compensation	**Issue**
CHIEF EXECUTIVE / DIRECTOR OF FINANCE	Losses and Cash due to theft, fraud, overpayment & others <£50,000
CHIEF EXECUTIVE / DIRECTOR OF FINANCE	Fruitless Payments (including abandoned Capital Schemes) <£250,000
DIRECTOR OF FINANCE	Bad Debts <£1,000
AUDIT COMMITTEE	Bad Debts >£1,000
CHIEF EXECUTIVE / DIRECTOR OF FINANCE	Damage to buildings, fittings and equipment due to culpable causes <£50,000
HEAD OF GOVERNANCE AND RISK	Ex-gratia payments for loss of personal effects <£2,500
CHIEF EXECUTIVE / DIRECTOR OF FINANCE	Ex-gratia payments for loss of personal effects <£100,000
ASSISTANT DIRECTOR FOR QUALITY AND SAFETY	Payments or admissions of liability for personal injury claims involving negligence where legal advice has been obtained and guidance applied <£10,000 for employers liability and <£3,000 for public liability (to reflect the excess payment)
CHIEF EXECUTIVE / DIRECTOR OF FINANCE	Other, except cases of maladministration where there was no financial loss by claimant <£50,000

Note

The following safeguards must have been made before payment can be made:

a. For clinical negligence claims, the claim has been agreed with 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.

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UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2025
Review Lead: Finance Director

APP N3

SCHEME OF DELEGATION
AND
RESERVATION OF POWERS TO THE BOARD

FOR

Calderdale and Huddersfield NHS Foundation Trust

(Reviewed January 2023)

Version 5

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

Document Summary Table		
Unique Identifier Number	G-3-2010	
Status	Ratified	
Version	5	
Implementation Date	April 2010	
Current/Last Review Dates	January 2023 Board extension to 2 March 2023	
Next Formal Review	By March 2025 for Board approval	
Sponsor	Director of Finance	
Author	Company Secretary	
Where available	Intranet	
Target audience	All staff	
Ratifying Committee		
Board of Directors		2 March 2023
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

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APPENDICES

SCHEME OF DELEGATION IMPLIED BY

- **Standing Orders of the Board of Directors** **APPENDIX A**

  AND

- **Standing Financial Instructions** **APPENDIX B**

  AND

- **Detailed Scheme of Delegation** **APPENDIX C**

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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 high quality 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

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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 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 establish 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.

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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 the 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/minute 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.

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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

Appendix D: A detailed 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 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	Approve and sign all documents which will be necessary in legal proceedings .
6.4	CE/DOF/DEPUTIES OR HEAD OF PROCUREMENT	Approve and sign any contract, agreement or document not required to be executed as a deed.

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APPENDIX B

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDESFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTUCTIONS

STANDING FINANCIAL INSTRUCTIONS

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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.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDESFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTUCTIONS

STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
3.1.2 3.1.3 3.2	DoF DoF CE	Submit budgets. Monitor performance against budget, submit to Board financial estimates and forecasts. 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
7.5.31	Head of Procurement	Decide whether any late tenders should be considered.
7.3.8		Remove as approved supplier lists not permitted

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SCHEME OF DELEGATION FOR CALDERDALE AND HUDDESFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTUCTIONS

STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
7.1.1	CE	Best value for money is demonstrated for all services provided under contract or in-house.
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.

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SCHEME OF DELEGATION FOR CALDERDALE AND HUDDESFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTUCTIONS

STANDING FINANCIAL INSTRUCTIONS

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SFI REF	DELEGATED TO	DUTIES DELEGATED
11	DoF	Advise Board on borrowing and investment needs and prepare procedural instructions.
12.1	CE	Capital investment programme
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.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDESFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTUCTIONS

STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
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.
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

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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	

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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	
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 Procurement form. Quotes – refer to paragraph 7.5.24 of the Standing Financial Instructions subject to the completion of the relevant Procurement form.	Director of Finance and Head of Procurement) (reported to the Audit and Risk Committee) Head of Procurement	Head of Procurement will review the over threshold Waiver requests and only submit to DoF if no other option is available. DoF will need to authorise due to breach of procurement regs.

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			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.	**Engagement of Management/Specialist Consultancy (non-medical)**		
a) i. ii iii	Booking of Bank or Agency Staff • Nursing Off framework Above 50% wage Bank and Tier 1 Agency cap • Medical	Appropriate Director Executive Director Executive Director Deputy Director of Nursing (via Nursing Daily staffing meeting)	

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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		
	iv) all general equipment with new price <£5,000	Chief Executive or Director of Finance	
	v) all equipment with new price >£5,000		

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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**	Chief Executive and Director of Finance	

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	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.**		
12. a) b)	Reporting of Incidents to the Police Where a criminal offence is suspected i) criminal offence of a violent nature ii) other than fraud Where a fraud in involved	 Duty Manager Appropriate Director Director of Finance	 SFIs Section 2 & 14 Fraud Policy & Response Plan
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.	**Personnel, Pay and Expenses**		
a)	Authority to fill funded post on the establishment with permanent staff.	Director/ Divisional Director of Operations	
b)	Authority to appoint staff to post not on the formal establishment.	Director/Divisional Director of Operations	
d)	Regrading All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure.	Director of Workforce and Organisational Development/ Divisional Director Operations	
e)	Establishments 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	

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g)	<u>Leave</u>		
	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	
	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)	<u>Sick Leave</u> i. Extension of sick pay	Director of Workforce and Organisational Development/ Divisional Director Operations	
i)	<u>Study Leave</u> i. Study leave outside the UK	Divisional Director	
	ii. Medical staff study leave (UK)	Clinical Director/General Manager/Line Manager	
		Line Manager	

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	iii. All other study leave (UK)		
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. Requests for new posts to be authorised as mobile telephone users.	 Line Manager 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

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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 • Outside Hours b) Emergency • Within Hours • • Outside Hours	Head of Communications 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	General Manager General Manager	

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	• Theatres • Other b) All proposed changes in bed allocation and use • Temporary Change • Permanent Change	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	

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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

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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

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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.

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BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTITUTION

In accordance with its Constitution, the Trust has a Board of Directors, which comprises both Executive Directors, one of whom is the Chief Executive and Non-Executive Directors, one of whom is the Chair.

As set out in Annex 8 of the Constitution, the Trust has Standing Orders for the Board of Directors which describe the practice and procedures for the business of the Trust. Those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, information for the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

2. PURPOSE

The principal purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust 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.

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, which is a unitary Board, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

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Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, the Integrated Care System, PLACE level partner organisations including local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients, service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision, strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets, maintains and oversees the implementation of the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when

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required;
- Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:
- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:
- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS England from time to time such as the Code of Governance for NHS Provider Trusts) and appropriate codes of conduct, accountability and openness applicable to Foundation Trusts and NHS Providers;
- Ensures that the Trust operates in accordance with its Constitution;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures the Trust protects the health and safety of Trust employees and all others to whom it has a duty of care;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- Review and approve the Trust's Annual Report and Accounts - the Board may agree delegation of this to the Audit and Risk Committee if required to meet national timescales
- Review and approve the annual Quality Account or equivalent - the Board may agree delegation of this to the Quality Committee if required to meet national timescales
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account the lived experience of patients and carers;
- Ensures that all required returns and disclosures are made to the regulators

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and complies with all relevant regulatory, legal and code of conduct requirements, including Care Quality Commission fundamental standards for all regulated activities;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business;
- Agrees the schedule of matters reserved for decision by the Board of Directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:
- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services;
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining Committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:
- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community;
- Meets its engagement obligations in respect of the Council of Governors and members and ensures that governors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website;
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:
- Ensures that the Trust operates effectively, efficiently, economically;
- Agrees the Trust's financial objectives and approve the financial plan;
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources;

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- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and Council of Governors and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors.

The Deputy Chair, a Non-Executive Director, will chair the Board in the absence of the Chair.

The composition of the Board is set out in the Constitution of the Trust (section 24) and the Standing Orders of the Board of Directors (Annex 8). Associate Non-Executive Directors may also attend meetings of the Board of Directors.

The Board may invite non-members to attend its meetings on an ad-hoc basis, as it considers necessary and appropriate, and this will be at the discretion of the Chair.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

7. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS'

The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting.

After each Board meeting held in public, the Board of Directors will send a copy of the minutes to the Council of Governors.

The Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. To execute this accountability effectively, the Non-Executive Directors and Associate Non-Executive Director will need the support of their Executive Director colleagues. A well-functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial

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performance; to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship. The Non-Executives also should ensure that the Board as a whole allows Council of Governors' time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS AND PROCEDURES

The Board of Directors will meet at least six times a calendar year in public on dates agreed with the Chair. Dates of forthcoming meetings held in public shall be posted on the Trust's website. Board meetings may be conducted virtually and, where this is the case, a recording of the Board meeting will be made available on the Trust website as soon as is practically possible after the meeting.

Agendas and papers for forthcoming meetings of the Board to be held in public, and minutes of previous meetings held in public, shall be posted on the Trust's website.

Urgent meetings shall be convened in accordance with section 3.4 of the Standing Orders of the Board of Directors in Annex 8 of the Trust's Constitution.

Additional meetings of the Board may be held in private for consideration of confidential business.

Further details on the practice and procedure of the Board of Directors, including voting, can be found in Annex 8 of the Constitution, Standing Orders of the Board of Directors.

9. QUORUM

Six directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

If an Executive Director is unable to attend a meeting of the Board, an alternative may be appointed to attend that meeting or part of it, if so requested by the Chair. Any such alternative shall not be counted as part of the required quorum unless they have been formally been appointed by the Board as an Acting Director.

Non-quorate meetings may go forward unless the Chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Company Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward

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- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the Council of Governors and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all Directors and others as agreed with the Chair and Chief Executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

The Board will review its effectiveness in the following ways:

~~Annual assessment of Board effectiveness~~
Review of attendance records
Annual reports from Board Committees
Board of Director Development Programme
Outputs from any Well-Led Governance Reviews

Date drafted: 13 February 2023

Date approved: 2 March 2023 (tbc)

Review Date: February 2024

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DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT 23 FEBRUARY 2023

Date of Declaration	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies	Ownership/Part Ownership of private companies and businesses	Shareholdings and other ownership interests	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Outside Employment (paid or non-paid) with a third party
EXECUTIVE DIRECTORS							
18.01.23	Brendan Brown	Chief Executive	Nil	Nil	Nil	Partner member (West Yorkshire Association of Acute Trusts) of West Yorkshire Integrated Care Board Calderdale Cares Partnership Board member Kirklees Integrated Care Board partner member Member of West Yorkshire People Board Honorary Professor University of Bradford	Nil
16.02.23	Robert Aitchison	Deputy Chief Executive	Nil	Nil	Nil	Nil	Nil
16.02.23	Dr David Birkenhead	Executive Medical Director	Benson Medical Services – Infection Control advice to the BMI Hospital, Huddersfield	Nil	Nil	Nil	

16.02.23	Lindsay Rudge	Chief Nurse	Nil	Nil	Shareholdings of Chris Rudge Transport Services Limited	Children & Young People Mental Health Shared Decision Making Council North East and Yorkshire Region	01.04.21
16.02.23	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships	Nil	Nil	PLACE Director of Finance for Kirklees and member of Kirklees Integrated Care Board WY Finance Representative for Supply Chain Northern Customer Board *	Nil
23.01.23	Kirsty Archer	Acting Director of Finance	Nil	Nil	Nil	NEP Consortium Board Member Also * above as required	Nil
27.02.23	Suzanne Dunkley	Executive Director of Workforce & OD	Nil	Nil	Nil	Nil	Nil

CHAIR AND NON-EXECUTIVE DIRECTORS							
15.02.23	Helen Hirst	Chair	Nil	Director of Helen Hirst Ltd.	Nil	Calderdale Cares Partnership Board member Trustee of Wakefield Hospice Trustee of Staying Put Bradford (domestic abuse charity)	Nil
16.02.23	Karen Heaton	Non-Executive Director	Nil	Nil	Nil	Nil	Nil
15.02.23	Andy Nelson	Non-Executive Director	Nil	Nil	Nil	Nil	Nil
22.02.23	Peter Wilkinson	Non-Executive Director	Non-Executive Director Decipher Consulting UK Ltd. Consultancy business based in Manchester/Macclesfield Director of Pennine Property Partnership	PW Advisory Ltd – own consultancy company based in Holmfirth	Nil	Nil	Nil
15.02.23	Denise Sterling	Non-Executive Director	Nil	Nil	Nil	Nil	Nil
08.02.23	Tim Busby	Non-Executive Director	Director and Chair of Calderdale and Huddersfield Solutions Limited Director of Rosemont Pharmaceuticals and each of Primrose Group of Companies (Owners of Rosemont) Director of Busby Consulting Ltd.	Nil	Shareholder of Rosemont Pharmaceuticals	Leeds Grand Theatre and Opera House Ltd – independent member of the Board and Trustee. A company limited by guarantee and a registered charity.	Chief Financial Officer for Rosemont Pharmaceuticals
07.02.23	Nigel Broadbent	Non-Executive Director	Nil	Nil	Nil	Vice Chair of the Audit Yorkshire Board	Nil

ATTENDEES AT BOARD OF DIRECTORS							
20.02.23	Anna Basford	Director of Transformation & Partnerships	Nil	Nil	Nil	Nil	Nil
23.01.23	Robert Birkett	Chief Digital and Information Officer	Nil	Nil	Nil	~~Nil~~	Nil
10.10.22	Jonathan Hammond	Chief Operating Officer	Nil	Nil	Nil	Nil	Nil
16.02.23	Andrea McCourt	Company Secretary	Nil	Nil	Nil	Appointed Governor of South West Yorkshire Partnership Foundation Trust	Nil
14.02.23	Victoria Pickles	Director of Corporate Affairs	Nil	Nil	Nil	Vice Chair of Overgate Hospice and Overgate Hospice Support Ltd Trustee of Mountain Rescue England and Wales	Nil

FIT AND PROPER PERSON SELF-DECLARATION REGISTER FEBRUARY 2023

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK / RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN CED IN CHFT	INSOLVENCY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
EXECUTIVE DIRECTORS										
07.02.23	**AITCHISON**	Rob	Deputy Chief Executive	N/a	October 2023	September 2022	Airedale CEO, Foluke Ajayi	15.11.22	Clean 15.2.23.	Clean 15.2.23
21.02.23	**ARCHER**	Kirsty	Deputy Director of Finance	Chartered Management Accountant, ACMA (CIMA)	17 October 2021	17.06/2022	Gary Boothby	01.08.08	Clean 15.02.23	Clean 15.2.23
24.01.23	**BIRKENHEAD (Dr)**	David	Executive Medical Director	GMC 3280122	October 2018	19.12.2022		01.12.99	Clean 15.02.23	Clean 15.2.23
23.01.23	**BOOTHBY**	Gary	Executive Director of Finance	Assoc CMA 8659790 CIPFA 41612-CIP	December 2021	18.08.2021	Owen Williams	07.03.16	Clean 15.02.23	Clean 15.2.23
02.02.23	**BROWN**	Brendan	Chief Executive	RGN PIN 88IO16E	December 2021	n/a	n/a	04.01.22	Clean 15.02.23	Clean 15.2.23
16.02.22	**DUNKLEY**	Suzanne	Executive Director of Workforce & OD	FCIP 31049644	December 2021	12.10.21	Owen Williams	01.02.18	Clean 17.02.22	Clean 15.2.23
13.02.23	**RUDGE**	Lindsay	Chief Nurse	NMC 90E0076E	23 October 2021 - 23.10.23	31.10.2022	Brendan Brown	12.07.93	Clean 15.02.23	Clean 15.2.23
DIRECTORS & COMPANY SECRETARY										
21.01.23	**BASFORD**	Anna	Director of Transformation & Partnerships	-	28.06.2016	14.11.2022	Brendan Brown	15.7.13	Clean 15.02.23	Clean 15.2.23

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
23.01.23	**BIRKETT**	Robert	Chief Digital Information Officer	N/a	25 October 2022	Nov 2022	Brendan Brown	May 2002	Clean 15.2.23.	Clean 15.2.23
22.02.23	**HAMMOND**	Jonathan	Acting Chief Operating Officer	BSc (Hons) Physiotherapy MSc Leadership, Management and Change in Health and Social Care	October 2022	08.07.2022	Ashwin Verma and Jo Fawcus	05.10.20	Clean 15.2.23.	Clean 15.2.23
14.02.23	**MCCOURT**	Andrea	Company Secretary	-	9 January 2023	22.12.2022	Brendan Brown and Victoria Pickles	18.05.15	Clean 15.02.23	Clean 15.2.23
15.02.23	**PICKLES**	Victoria	Director of Corporate Affairs	CIPR / ICSA	1 April 2022	23.11.2022	-	20.06.22	Clean 15.02.23	Clean 15.2.23
NON-EXECUTIVE DIRECTORS										
10.02.23	**HIRST**	Helen	Chair	MCIPD 10034462	12 March 2023	17.01.2023	Karen Heaton	01.07.22	Clean 15.02.23?	Clean 15.2.23
07.02.23	**HEATON**	Karen	Non- Executive Director	-	12 May 2016	June 2022	Philip Lewer	01.03.16	Clean 17.02.22	Clean 15.2.23
07.02.23	**NELSON**	Andy	Non- Executive Director	-	9 October 2017	June 2022	Philip Lewer	01.10.17	Clean 15.02.23	Clean 15.2.23
07.02.23	**STERLING**	Denise	Non- Executive Director	Health and Care Professionals Council OT10114	October 2019	June 2022	Philip Lewer	01.10.19	Clean 15.02.23	Clean 15.2.23
07.02.23	**WILKINSON**	Russell Peter	Non- Executive Director	Member of the Royal Institution of Chartered Surveyors (MRICS) Ref No 0085230	September 2019	June 2022	Philip Lewer	01.01.20	Clean 15.02.23	Clean 15.2.23

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
17.02.22 No update due to long term absence	**SEANOR**	Nicola	Associate Non-Executive Director	-	12 November 2021	n/a	Denise Sterling	15.12.21	Clean 15.02.23	Clean 15.2.23
31.01.23	**BROADBENT**	Nigel	Non- Executive Director	Member of the CIPFA 00011153	31 March 2022	04.01.2023	Helen Hirst	01.06.22	Clean 15.02.23	Clean 15.2.23
21.02.23	**BUSBY**	Tim	Non- Executive Director CHFT and Chair CHS Limited	ACMA CGMA (Chartered Institute of Management Accountants)	12.4.22	07.02.2023	Helen Hirst	05.04.22	Clean 15.02.23	Clean 15.2.23
DEPUTY DIRECTORS										
10.02.23	**EDDLESTON**	Jason	Deputy Director of Workforce and OD	MCIPD 10327459 Post requires CIPD qualification, not CIPD registration	Post does not fall within the legal provisions that govern the processing of a DBS standard or enhanced check	18.08.2022	Suzanne Dunkley	08.02.1999	Clean 15.02.23	Clean 15.2.23
22.02.23	**BHASIN**	Neeraj	Deputy Medical Director	General Medical Council – Full Registration – 4630694 Royal College of Surgeons of England – Fellowship – 931505 Institute of Leadership and Management – Membership – 20312089	Recheck underway	01.11.2022	D Birkenhead	01.11.22	Clean 15.02.23	Clean 15.2.23
31.01.23	**RUSSELL**	Philippa	Deputy Director of Finance	Associate Chartered Management Accountant (ACMA), Chartered Global Management Accountant (CGMA) (ID: 1-	04/04/2018 Standard 04/04/2018 Renewed 04/04/2022	06.07.2022	Kirsty Archer	01/04/2012	Clean 15.02.23	Clean 15.2.23

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
				77FMBB)						
21.01.23	**MIDDLETON**	Joanne	Deputy Chief Nurse	Registered general Nurse 89H0351E	November 2022	23.2.2023	Lindsay Rudge	21.11.22	Clean 15.02.23	Clean 15.2.23

Draft BOARD PLAN 2023/2024 – as at 21.2.23 v7

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				✓		
Workforce OD Strategy	✓					

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Risk Management Strategy	✓					✓
Annual Plan	✓ for 2023/24					✓
Capital Plan					✓	
Winter Plan				✓		
Green Plan (Climate Change)	✓					
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	✓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	

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Public Sector Equality Duty (PSED) Annual Report						✓
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	✓ QC ✓ F&P ✓ TPB	✓ Workforce	✓ARC			✓QC ✓ NRC BOC
Constitutional changes (+as required)	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Fire Strategy 2021-2026	✓ (B/f from March 2023 BOD)					✓
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

a) Finance and Performance Committee

b) Quality Committee

To Approve

Presented by Helen Hirst

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Version:	1.1 - first draft circulated for review to Chair / CE / DoF / DDof 1.2 - comments received OW / CB / AH 1.3 - Amendments from the Board of Directors 2.1 – Reviewed and updated for membership and to reflect planning cycle 3.1 – Reviewed and updated to include a Performance Delivery and Assurance Section 4.1 – Reviewed and updated – March 2019 5.1 – Reviewed and updated – June 2020 6.1 – Reviewed and section 5.3 added to allow for quoracy. November 2021 7.1 – Reviewed and section 5.1 attendees updates. June 2022 8.1 - Review of quoracy December 2022 9.1 Scheduled review January 2024
Approved by:	Board of Directors
Date approved:	
Date issued:	
Review date:	

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

1. **Constitution**
   The Trust Board hereby resolves to establish a Committee to be known as the Finance and Performance Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. **Purpose**
   The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements and providing assurance to the Board on these. This includes monitoring the delivery of the ~~5 Year Plan and supporting~~ Annual Plan and oversight of decisions on investments and business cases.

   The Committee will ensure that Board members have a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

3. **Authority**
   The Finance and Performance Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

4. **Role and duties of the Committee**
   The Finance and Performance Committee will provide the Board with assurance that finance and performance is being monitored and managed across the organisation and that progress is being made in the implementation of the Annual Plan.

   The duties of the Committee can be categorised as follows:

   4.1. **Finance and Financial Performance**
   - Provide assurance that the finance position and financial performance reporting systems of the organisation are robust through detailed review of the Monthly Financial Report.
   - Seek assurance that any appropriate management action has been taken to return the Trust's financial performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
   - Provide assurance to the Board that cost improvement plans to support organisational changes are being delivered.
   - Review the Trust's Long Term Financial Model and any national or regional submissions to test assumptions and provide assurance that the returns represent a true and fair view of the financial performance for the period under review.
   - Review all significant financial risks on the high level risk register and the Board Assurance Framework.
   - Review the finance elements of the NHS Oversight Framework and Use of Resources metric.
   - Examine any matter referred to the Committee by the Trust Board or one of the other assurance Committees.

4.2 **Performance Delivery and Assurance**

- Provide assurance that the performance reporting systems of the organisation are robust through detailed review of the Integrated Performance Report (IPR) on a monthly basis.
- Keep the content of the Trust's IPR under review, ensuring that it includes appropriate performance metrics and detail of exceptions to provide assurance to the Board on all aspects of organisational performance against its strategic objectives.
- Seek assurance that any appropriate management action has been taken to return the Trust performance to plan and that any such actions or recovery plans that are in place are adequately resourced, implemented and monitored and that appropriate EQIA has been completed.
- Provide assurance to the Board that the performance of Clinical Divisions and corporate teams are in line with agreed annual plans and receive escalation where recovery plans do not resolve any adverse variance, with deep dives into specialties / issues as required
- Review all performance related risks on the Board Assurance Framework

4.3 Business and commercial development

- Ensure compliance with the Treasury Management guidance.
- Review the Trust's Annual Plan, , Capital Plans and Financial Model and recommend to the Board for approval.
-
- Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.
- Agree investment / dis-investment in services (with full understanding of financial and service implications of these decisions e.g. overheads)

4.4 Treasury Management

- Maintain an oversight of the Trust's Treasury Management activities, ensuring compliance with Trust's policies.
- Review borrowing arrangements and liabilities
- Review and monitor the Trust's Treasury Management Policy *(approval is through the Audit & Risk Committee)*.
- Review the activities undertaken at Cash Committee

4.5 **Procurement**

- Review the activities undertaken by Procurement and the contributions made along with performance against key national metrics.

5. Membership and Attendees

5.1. The Committee shall consist of the following members:
- Three Non – Executive Directors, one of whom will be Chair
- Executive Director of Finance
- Chief Operating Officer
- Director of Transformation and Partnerships.

- Director of Corporate Affairs

5.2. The Deputy Director of Finance and the Company Secretary will regularly attend. All Board members are invited to attend any assurance Committee.
5.3. Directors and other senior management staff may be required to attend discussions when the Committee is discussing areas of performance or operation that are their responsibility.
5.4. Two Governors will be invited to attend each meeting as observers.
5.5. If a Non-Executive Director or Executive Director is unable to attend a meeting, they should nominate a deputy, subject to the agreement with the Trust Chair and Chief Executive, and that deputy will be counted for the purpose of quoracy.

6. Attendance

6.1. Attendance is required by members at 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

6.2. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardies the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. Administration

7.1. The Committee shall be supported by the Secretary to the Executive Director of Finance, whose duties in this respect will include:
- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee;
- Taking the minutes and keeping a record of matters arising and issue to be carried forward;
- Advising the group on scheduled agenda items;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

8. Meetings

8.1. Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar;
8.2 Meetings could be held either in person or using virtually using digital technology
8.3 Items for the agenda must be sent to the Committee Secretary a minimum of 8 days prior to the meeting: urgent items may be raised under any other business;
8.4 An action schedule will be circulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers; and
8.5 The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

9 Reporting

9.4 The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board when approved, together with a highlight report of the meeting(s) from the Committee Chair.

9.5 The Chair of the Finance and Performance Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.

9.6 The Turnaround Executive, Capital Management Group, Business Case Approvals Group, the, Cash Committee, Huddersfield Pharmacy Specials, Joint Liaison Committee, PFI Quarterly Contract meeting, THIS Executive Board and , Access Delivery Group, Urgent and Emergency Care Delivery Group, Pennine Property Partnership Board will provide minutes of its meetings to the Committee along with reports as agreed.

10 Quorum

To be quorate at least three of the members of the Committee must be present, including at least one Non-Executive Director.

If a quorum is not reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

11 Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

12 Monitoring Effectiveness

In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 7 days prior to the meetings;
- The action schedule was circulated within 3 working days of the meeting, on 80% of occasions

QUALITY COMMITTEE
TERMS OF REFERENCE – v7

1. Constitution

1.1. The Board of Directors hereby resolves to establish a Committee to be known as the Quality Committee. The Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority

2.1. The Quality Committee is constituted as a Standing Committee of the Board of Directors. Its constitution and terms of reference are subject to amendment by the Board of Directors.

2.2. The Committee derives its power from the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

2.3. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1. The purpose of the Quality Committee is:

- To provide assurance to the Board of Directors that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care

- To ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

3.2. The Quality Committee is responsible for:

- Reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.

- Seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

- The ongoing monitoring of compliance with national quality standards and local requirements.

4. Duties

The duties of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

Quality improvement

4.1. To review proposed quality improvement priorities and monitor progress and compliance against defined quality priorities.

4.2. To maintain a focus on patient experience through a number of data sources including stories; friends and family test; national surveys and seek assurance that the Trust is learning from experience.

4.3. To oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication and review progress against these.

4.4. To review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding progress with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

4.5. To receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

4.6. To establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

Governance and risk

4.7. Ensure all quality risks are appropriately managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the high-level risk register and Board Assurance Framework

4.8. In response to the publication to redefine the Non-Executive Director (NED) Champion roles (NHS England's Enhancing board oversight: a new approach to non-executive director champion roles), the Committee will consider and review on behalf of the Board the following:

- Hip fracture, falls and dementia
- Learning from Deaths (assuring published information on the Trust's approach, achievements and challenges via a report to the public Board)
- Palliative Care and End of Life Care
- Safeguarding (annual report to Board)
- Resuscitation (requiring Resuscitation Policy sign off on behalf of the Board)
- Children and Young People (Core Service Inspection Framework for Children and Young People refers to an interview with the NED in the Board with responsibility for Children and Young People, noting oversight – NED on Quality Committee
- Health and Safety (aspects include patient safety, employee safety and system leadership)
- Safety and Risk

4.9. Promote a just and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

4.10. Seek assurance on the process for reviewing and reporting incidents and serious incidents and sharing the learning from these.

4.11. Seek assurance against compliance with NICE guidelines / guidance and any rationale for non or partial compliance

4.12. Seek assurance that there are effective systems of governance, performance and internal control in relation to clinical services, research and development through an annual governance review.

4.13. Review performance against the quality and safety aspects of the Integrated Performance Report

4.14. Undertake an annual review of the quality impact assessment process to gain assurance that the risks to any impact on quality arising from proposed cost improvements have been managed and mitigated.

4.15. Ensure any procedural, policy or strategy documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural Documents (Policy for Policies) and any key national standards and best practice

4.16. Receive a quarterly report from each of the sub-groups to the Committee.

4.17. Establish an annual work plan which the Committee will review quarterly

4.18. Produce an annual report against delivery of the terms of reference of the Quality Committee.

Quality and safety reporting

4.19. In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

Audit and assurance

4.20. To approve and oversee delivery of the clinical audit plan and a review of its findings.

4.21. To receive all reports regarding the Trust produced by the Care Quality Commission and other external bodies, e.g. Royal Colleges, and seek assurance on the delivery of actions to address recommendations

4.22. Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions

4.23. To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken to address these.

4.24. Gain assurance from divisions that they implement the activity required to achieve compliance with service quality and governance standards.

4.25. To receive internal audit reports (with a quality element) and seek assurance on recommendations

5. Membership and attendance

5.1. The Committee shall consist of the following members:

- Three Non-Executive Directors, one of which will Chair the meeting
- Associate Non-Executive Director
- Medical Director
- Chief Nurse
- Director of Corporate Affairs

5.2. The following will be expected to attend each meeting:

- Deputy Chief Nurse
- Deputy Medical Director
- Chief Operating Officer
- Deputy Director of Workforce and Organisational Development
- Assistant Director of Patient Safety
- Clinical Director of Pharmacy / Trust Controlled Drug Accountable Officer
- Head of Quality and Safety **OR** Head of Risk and Compliance
- Governance administrator (minutes) **(MA)**

5.3. The Chair of the Board of Directors will appoint a representative of the Council of Governors to attend each meeting as an observer. The appointment will be reviewed each year

5.4 The following shall be required to attend the meetings to present their sub-group report, as required:

- Representative from Medicines Management Committee **(Annually)**
- Representative from Safeguarding Committee **(6-monthly)**
- Representative from Clinical Ethics Group **(6-monthly)**
- Representative from Clinical Effectiveness and Audit Group **(Quarterly)**
- Representative from Medical Gases Group **(Quarterly)**

5.5 Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.6 A quorum will be four members of the Committee and must include at least two Non-Executive Directors and one Director.

5.7 Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Administrator of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1. The Committee shall be supported by the Administrator, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation
- Maintaining a record of attendance.

7. Frequency of meetings

7.1. The Committee will meet every month and at least nine times per year.

8. Reporting

8.1. The Committee Administrator will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2. An action schedule will be articulated to members following each meeting and must be duly completed and returned to the Administrator for circulation with the agenda and associated papers.

8.3. The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4. Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next Board of Directors' meeting.

8.5. A summary report will be presented to the next Board of Directors' meeting.

9. Review

9.1. As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2. The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

10. Monitoring effectiveness

10.1. In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers distributed 3 working days prior to the meetings;
- The action points from each meeting are circulated within two working days, on 80% of occasions

Sub-Groups

BOARD OF DIRECTORS

QUALITY COMMITTEE

Chair: Denise Sterling
Meeting Frequency: Monthly

Research & Innovation Group
Chair: Deputy Medical Director
Reporting: Annually

Clinical Ethics Group
Chair: Associate Medical Director
Reporting: Quarterly

Infection Prevention and Control Board
Chair: Medical Director
Reporting: Quarterly

Safeguarding Committee
Chair: Deputy Chief Nurse
Reporting: 6-monthly

Trust Patient Safety and Quality Board
Chair: Associate Director for Patient Safety
Reporting: Quarterly

Cancer Delivery Group
Chair: Chief Operating Officer
Reporting: Quarterly

Clinical Effectiveness and Audit Group
Chair: Associate Medical Director
Reporting: Quarterly

Clinical Outcomes Group
Chair: Medical Director
Reporting: Quarterly

Medicines Management Committee
Chair: Consultant Oncologist
Reporting: 6-monthly

Medical Gases Group / Non-Invasive Ventilation (NIV) Group
Chair: Acute Consultant
Reporting: 6-monthly

CQC Group
Chair: Chief Nurse
Reporting: Bi-monthly

Reports aligned to CQC domains

CQC domain	Reporting to Quality Committee via
Safe	▪ Infection Prevention and Control Board (Quarterly) ▪ Trust Patient Safety and Quality Board (Quarterly) ▪ Medical Gases Group (6 monthly) ▪ Medicines Management Committee (6-monthly) ▪ Safeguarding Committee (6 monthly & annual report) ▪ Clinical Ethics Panel Report (6-monthly) As required: ▪ High Level risk report (Bi-monthly)
Caring	▪ Patient Experience and Caring Group (Quarterly) ▪ Annual Patient Experience Report ▪ Annual Complaints Report
Responsive	▪ Cancer Delivery Group Report (Quarterly) ▪ Quality Report (bi-monthly) ▪ Quality Account Priorities (bi-monthly) ▪ Quality Accounts (Annual) ▪ Quality Committee Annual report ▪ Integrated Performance Report
Effective	▪ Clinical Outcomes Group (Quarterly) ▪ Clinical Effectiveness and Audit Group (Quarterly) As required: ▪ Medical Examiner Update ▪ Learning from Death
Well-Led	▪ CQC and Compliance Group (Bi-monthly) ▪ Research and Innovation (Annual) ▪ Board Assurance Framework As required Getting It Right First Time report (GIRFT)

Version Control	
1.1	first draft circulated for review to Chair / Director of Nursing
1.2	Amendments prior to Board of Directors
1.3	Amendments after submission to Quality Committee
1.4	Further amendments
1.5	Further amendments
2	Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3
3	Amendments made: ▪ Chief Operating Officer removed from membership ▪ Executive Director of Planning, Estates and Facilities removed from membership ▪ Two non-executive directors instead of three ▪ Purpose added in relation to internal audits
3.1	Amendments made (with Chair) (June 2019) ▪ Organ Donation Committee and Cancer Board added to sub-groups at appendix 2 ▪ Frequency of sub-group meetings amended at appendix 2 ▪ Frequency of meetings amended at appendix 3
4	Amendments made (Jan 2020) ▪ Organ Donation Committee removed from sub-groups at appendix 2 ▪ Addition of named NED at appendix 2 ▪ Frequency of Medication Safety & Compliance Group changed from quarterly to monthly - appx 2 & 3
4.1	Amendments made (June 2020) ▪ Clinical Director of Pharmacy added to membership ▪ Executive Director of Workforce and Organisational Development amended to Deputy Director of Workforce and Organisational Development
5	Amendment made (January 2021) ▪ Assistant Director of Patient Experience added to membership
5.1	Amendment made (April 2021) ▪ Medicines Management Committee added as a sub-group ▪ CQC and Compliance Group; Clinical Effectiveness and Audit Group; Clinical Ethics Group and Medical Gases Group added as sub-groups ▪ Serious Incident Review Group; Medication Safety and Compliance Group and Cancer Board removed as sub-groups
5.2	Amendment made (July 2021) ▪ Cancer Board reinstated as a sub-group, to receive minutes only ▪ Amendment Oct 2021 – CM no longer public elected governor
5.3	Amendment made (November 2021) ▪ Chief Operating Officer added to core membership
5.4	Amendment made (February 2022) ▪ Removal of Assistant Director for Patient Experience from core membership ▪ Addition of Legal Services reporting into Quality Committee ▪ Addition of Associate NED onto core membership
6	Amendment made 3 March 2022 ▪ Additional areas of responsibility in light of B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)
6.1	Amendment made in June 2022 ▪ Addition of Director of Corporate Affairs into core membership
6.2	Amendment made in October 2022 ▪ Addition of Head of Quality and Safety into core membership
6.3	Amendment made in December 2022 ▪ Addition of Deputy Chief Executive into core membership
7	**Amendment made in February 2023** ▪ **Addition of Deputy Medical Director onto membership** ▪ **Removal of Legal Services Report and Cancer Board Minutes** ▪ **Quoracy amended**

Issued by Quality Committee and Date of Review	February 2023 and February 2024
Approved by Board of Directors	TBC

26. Items for Review Room

1. Minutes of Board Committees

- Finance and Performance Committee November 2022
- Quality Committee 14 November 2022
- Workforce Committee 7 December 2023
- Charitable Funds Committee 23 November. 15 February 2023

Partnership papers: Kirklees Health and Care Partnership Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)
and Calderdale Cares Partnership Meeting papers - Calderdale Cares Partnership

To Note

27. Date and time of next meeting

Date: Thursday 4 May 2023

Time: 10 am

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