Board of Directors Public Meeting - 7.6.18

Schedule	Thursday 07 June 2018, 09:00 AM — 11:30 AM BST
Venue	Large Training Room, Learning & Development Centre, Calderdale Royal Hospital
Organiser	Kathy Bray

Agenda

9:00 AM	1.	Welcome and introductions: Sian Grbin, Staff Elected Governor Brian Moore, Publicly Elected Governor/Lead Governor Presented by Philip Lewer
9:01 AM	2.	Apologies for absence: Presented by Philip Lewer
9:02 AM	3.	Declaration of interests Presented by Philip Lewer
9:03 AM	4.	Minutes of the previous meeting held on 3 May 2018 To Approve - Presented by Philip Lewer APP A1 - PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 3.5.18.pdf 1 APP A2 - PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 3.5.18 - Appendix - APP A DRAFT - PUBLIC BOD MINS - 3.5.18 v1.pdf 3
9:08 AM	5.	Action log and matters arising: To Approve - Presented by Philip Lewer APP B1 - ACTION LOG PUBLIC BOARD OF DIRECTORS.pdf 13 APP B2 - ACTION LOG PUBLIC BOARD OF DIRECTORS - Appendix - APP B DRAFT ACTION LOG - BOD - PUBLIC - As at 31 May 2018.pdf 15
9:13 AM	6.	Chair’s Report To Note - Presented by Philip Lewer

9:18 AM	7. Chief Executive's Report: a.Appointment of Interim Chief Nurse b.Independent Reconfiguration Panel report c.Lord Carter's review into unwarranted variations in mental health and community health services To Note - Presented by Owen Williams	
	APP C1 - CHIEF EXECUTIVES REPORT - JUNE 2017.pdf	20
	APP C2 - CHIEF EXECUTIVES REPORT - JUNE 2017 - Appendix - APP C - Chief Executive's report - Lord Carter summary report.pdf	22
9:28 AM	8. Patient/Staff Story & Quality Report "Treat Me Well Campaign" Presented by Amanda McKie, Matron for Learning Disabilities To Note - Presented by Jackie Murphy	
9:48 AM	9. High Level Risk Register To Approve - Presented by Jackie Murphy	
	APP D1 - High Level Risk Register.pdf	32
	APP D2 - HLRR APPENDIX.pdf	35
9:53 AM	10. Governance Report a.Board Work plan To Approve - Presented by Victoria Pickles	
	APP E1 - GOVERNANCE REPORT - JUNE 2018 - BOARD WORKPLAN.pdf	52
	APP E2 - GOVERNANCE REPORT - JUNE 2018 - BOARD WORKPLAN - Appendix - Annual Workplan 2018-2019 - WORKING DOC.pdf	54
9:58 AM	11. Strategy on a Page 2018-19 To Approve - Presented by Victoria Pickles	
	APP F1 - STRATEGY ON A PAGE 2018-2019.pdf	59
	APP F2 - STRATEGY ON A PAGE 2018-2019 - Appendix - 5 Year and 1 Year Plan 2018.19 updated following workshop.pdf	61
10:03 AM	12. Compliance with General Data Protection Regulation To Approve - Presented by Mandy Griffin	
	APP G - GDPR Update.pdf	65

10:13 AM	13.	Health and Safety Annual Report To Approve - Presented by Lesley Hill	
		APP H1 - Annual Health & Safety Report.pdf	69
		APP H2 - Annual Health & Safety Report - Appendix - CHFT Annual Health & Safety Report 2017-2018.pdf	72
10:23 AM	14.	Integrated Performance Report To Approve - Presented by Helen Barker	
		APP I1 - Integrated Performance Report.pdf	83
		APP I2 - Integrated Performance Report - Appendix - Integrated Performance Report - April 2018.pdf	85
10:33 AM	15.	Digital Health Next Steps and EPR Stabilisation To Approve - Presented by Mandy Griffin	
		APP J1 - Digital Health – Future Partnership Working.pdf	96
		APP J2 - Digital Health - Future Partnership Working - APPENDIX.pdf	99
10:43 AM	16.	Deloitte report on digital maturity To Approve - Presented by Mandy Griffin	
		APP K1 - Deloitte report on Digital Maturity.pdf	127
		APP K2 - Deloitte report on Digital Maturity - Appendix - NHS England - Digital Maturity QA - Site Visit Report - CHFT (1).pdf	130
10:53 AM	17.	Outpatient Transformation Report To Approve - Presented by Lesley Hill	
		APP L1 - Outpatient Transformation Report.pdf	151
		APP L2 - Outpatient Transformation Report - Appendix - BOD OPT Report June (1).pdf	153
11:03 AM	18.	Update from sub-committees and receipt of minutes & papers - Quality Committee draft minutes of the meeting 30.4.18 & verbal update from meeting 4.6.18 - Finance and Performance Committee minutes from the meeting 27.4.18 & verbal update from meeting 5.6.18 - Workforce Well Led Committee minutes from the meeting 11.5.18 - Council of Governors minutes from the meeting 4.4.18	

- Audit and Risk Committee minutes from the meeting 18.4.18
- Charitable Funds Committee minutes from the meeting 22.5.18

To Note - Presented by Philip Lewer

19. Date and time of next meeting(s):
Thursday 5 July 2018 commencing at 9.00 am
Venue: Large Training Room, Learning Centre, CRH
and
Thursday 19 July 2018
Joint Board of Directors/Council of Governors Annual General Meeting commencing at 6.00 pm
Venue: Large Training Room, Learning Centre, CRH

To Note - Presented by Philip Lewer

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th June 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 3.5.18 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 May 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 May 2018

Main Body

Purpose:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 May 2018

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 May 2018

Appendix

Attachment:

APP A DRAFT - PUBLIC BOD MINS - 3.5.18 v1.pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 3 May 2018 at 9am in the Boardroom, Calderdale Royal Hospital

PRESENT

Philip Lewer	Chairman
Owen Williams	Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Medical Director
Gary Boothby	Executive Director of Finance and Procurement
Brendan Brown	Executive Director of Nursing
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Richard Hopkin	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Kate Bell	Patient
Mandy Griffin	Managing Director Digital Health
Victoria Pickles	Company Secretary
Lindsay Rudge	Deputy Director of Nursing (for item xx)

OBSERVERS

Annette Bell	Public Elected Governor
Brian Moore	Lead Governor

67/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

68/18 APOLOGIES FOR ABSENCE

There were no apologies for absence.

69/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

70/18 MINUTES OF THE MEETING HELD 5 APRIL 2018

The minutes of the previous meeting were approved as a correct record subject to the following amendments:

- Correction to Richard Hopkin's name
- 57/18 to be updated to reflect that there had been a request for an item on EPR at a future Board meeting.

OUTCOME: The minutes of the meeting were **APPROVED** as a correct record.

71/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

There were no matters arising which had not been included on the agenda.

The Managing Director of Digital Health confirmed that an item on compliance with the General Data Protection Regulations would be brought to the Board in June.

72/18 CHAIR'S REPORT

The Chair gave feedback on various meetings held as part of his induction process including those with the chairs of acute trusts and clinical commissioning groups across West Yorkshire. He highlighted that the meeting of the West Yorkshire Association of Acute Trusts Committee in Common had been interrupted due to a fire alarm and that the meeting would be reconvened at a future date.

OUTCOME: The Board **NOTED** the Chair's report.

73/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive informed the Board that he had met with the Secretary of State for Health and Social Care as part of a group of Chief Executives to develop a 10 year view for the NHS. There had been particular discussion on medical and nursing training and how this will remain a challenge over the next four to five years. It is likely that increasingly Integrated Care Systems will be the way in which money is allocated and how systems hold themselves to account.

Linda Patterson asked whether social care was discussed given the role of the Secretary of State. The Chief Executive responded that there had been some discussion on social care and recognition of the need to include local government in these sessions in the future.

Karen Heaton asked whether the discussion had included the difficulties of recruiting. The Chief Executive explained that the difficulties of recruiting non-EU staff had been raised along with concerns about the impact of Brexit both on recruitment and retention of staff. It was recognised that there needs to be a clear national statement about the future for these staff.

OUTCOME: The Board **NOTED** the Chief Executive's report

74/18 PATIENT/STAFF STORY – EXPERIENCE OF LGBT PATIENTS USING OUR SERVICES

The Chair welcomed Kate Bell to the meeting. The Chief Executive explained that there had been significant work relating to staff and patients from a black and minority ethnic background and a report on this would come to a future board. There was now an increasing focus on the experience of lesbian, gay, bi-sexual and transgender (LGBT) patients and staff and Kate was invited to give a presentation on her experience in two of the Trust's services.

Kate explained that on the whole there was very little research on the experience of LGBT patients in health services but there had been two recent national studies looking at the experience of LGBT patients against those of the wider population. These had shown that LGBT patients:

- Report poorer experiences when accessing health and social care
- More likely to delay access to healthcare based on previous negative experiences and low expectations
- More likely to report poor health

Kate then gave two contrasting personal experiences of accessing services within the Trust. In one service Kate had experienced:

- Assumptions about sexual identity and marital status
- Inappropriate questions
- Pressure to disclose sexual orientation
- Feeling unsafe and vulnerable
- Lack of staff understanding
- Lack of LGBT visibility

In the second service Kate had experienced:

- Staff demonstrating understanding of the needs of a lesbian couple

- Being listened to and involved ein decision-making
- Inclusive language, e.g. gender neutral terms used
- Forms designed for same sex couples
- No assumptions
- Welcoming environment
- Feeling safe

Kate gave her top tips of learning for the Trust as:

- Avoiding making assumptions
- Use of inclusive language and how questions are framed
- Update standard forms
- Raise staff awareness of LGBT issues
- Increase visibility of LGBT people
- Display non-discrimination statement

The Executive Director of Workforce commented that this is about respecting people's difference generally. The Company Secretary informed the Board that a number of staff had recently attended an event with transgender patients to look at their experience of services and what could be improved. Karen Heaton highlighted the importance of a network and the need to review policies and procedures to ensure they are gender neutral.

OUTCOME: The Board **RECEIVED** the presentation and thanked Kate for her open and constructive feedback.

75/18 HIGH LEVEL RISK REGISTER

The Executive Director of Nursing reported the risks scoring 15 or above within the organisation. These had been discussed in detail at the Executive Board, Finance and Performance Committee, Quality Committee and Risk and Compliance Group. It was noted that there had been significant movement on the risk register over the last month.

The following risks are scored at 25 or 20 on the high level risk register:
7169 (25): Non delivery of 2018/19 financial plan
6903 (20): ICU/Estates joint risk
7062 (20): 2018**/**19 Capital Programme
7078 (20): Medical staffing risk
6658 (20): Patient flow
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk

There were no risks with an increased score.

Risks with a reduced score were:

- 7194 Family and Specialist Services: Laboratory systems and re-use of numbers which could lead to results being reported back on the wrong patient, scored at 15. During April this risk has reduced to a score of 12 as it is expected that a solution will be in place in May 2018.

- 6829 Insufficient capacity for the Pharmacy Dispensing Service – this risk has reduced from 15 to 12 as progress has been made with the interim solution.

- 6598 – Essential skills training risk has been reduced from a score of 16 to 9 during April 2018 due to a significant increase in the compliance rates across all essential skills by 2017/18 year end. Plans are now being made to ensure that the upward trend continues and that training is undertaken throughout the year and not end-loaded in Q4 in the future.

The new risks agreed following the Risk and Compliance Group were :

- 7169 (25): Trust Financial Control 2018/19 (update of 2017/18 risk)
- 7248 (16): Mandatory training – refreshed risk following closure of 6977

The EPR Risk Panel met on 6 April 2018 and was assured that processes were in place within divisions and specific EPR risks are being identified through divisional governance processes, reflecting the progress made by the Trust in the implementation and stabilisation of EPR

The following risks had been reviewed and agreement given to close them:
7049 Trust wide EPR financial risk for 2017/18
7046 Trust wide EPR clinical risk for 2017/18
7148 Medical division clinical EPR risk
7047 Trust wide EPR performance risk

The following risks were also agreed for closure:
6441 Surgical and Anaesthetics division income risk 2017/18
7147 Medical division income risk 2017/18

The risk relating to sepsis (risk 6990) has been closed and replaced by sepsis risk 7134 as there were two sepsis risks, one Trust wide and one in the division. It was agreed to circulate the wording on this outside the meeting.

ACTION: Executive Director of Nursing

The 2017/18 risk, 6977, regarding mandatory training has been closed as the risk had reached its target date. It was confirmed that target audiences are now clearly identified, subject matter experts are in place and compliance is improving

Richard Hopkin asked if consideration was being given to reducing the risk relating to the financial plan as it had been agreed. The Executive Director of Finance explained that this would be considered at Finance and Performance Committee following discussion with the regulators in relation to their approach given that the Trust had not accepted the control total.

ACTION: Executive Director of Finance / Finance and Performance Committee

Discussion took place around the risk relating to the capital programme and ability to update the resuscitation area. The Executive Director of PEF explained that there are a number of issues including ventilation, size, pendants that supply medical gases and the battery backup, but that some of these issues had been around for a number of years and there was a need to balance undertaking the upgrade with the impact on patient flow. The Chief Operating Officer responded that there are business continuity arrangements in place if it were to fail or need to be closed down and that the clinical team were satisfied with the work carried out the previous year to improve patient safety and dignity. It was noted that a response to the letter from the authorising engineer would be considered at Quality Committee.

David Anderson asked about the impact of Advanced Care Practitioners on the risks relating to medical staffing. The Executive Director of Nursing responded that there were 12 in training coming into A&E and they would make a difference but would not be on the rota during their two year training period. He highlighted that in addition the Trust had agreed to fund an additional 10 middle grades with the Deanery and that this had been accepted as a result of the Trust's positive General Medical Council feedback.

Richard Hopkin highlighted that there had been a significant discussion at the Audit and Risk Committee in relation to the level of risks relating to EPR that remain. Andy Nelson suggested that they remain on the risk register alongside a narrative as to why they are recommended for closure prior to being removed. The Board suggested that the high level EPR risks be reviewed again and the wording updated to reflect the current position. The Chief Operating Officer reflected that the EPR risk relating to clinic activity is more about the capacity of the workforce than EPR itself and that an achievable activity plan had been set. It was agreed to review the wording and include the evidence that the risks are being managed and mitigated.

Action: Executive Director of Nursing

The Chief Operating Officer reported that there would be a recommendation to close risk 6658 - patient flow as the plan for 2018/19 included an increase in the funded bed base alongside the appropriate workforce to enable the Trust to manage. A new risk relating to demand would be considered.

Discussion took place regarding the achievement of the mandatory training performance and the corresponding closure of the risk. The Board noted that this would need to be maintained. The Chief Executive reflected that there had been a discussion at the Executive Committee where there had been commitment to maintaining and achieving the 95% target and that this was now included in the weekly performance meetings.

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

76/18 STRATEGY ON A PAGE – END OF YEAR PROGRESS REPORT

The Company Secretary introduced the report setting out the progress made in year against each of the strategic objectives.

It was noted that of the 20 objectives:

- None are rated red (off track with no plan in place)
- Three are rated amber (off track with a plan)
- Eight are rated green (on track)
- Nine have been fully completed

The Executive Director of Finance explained that the financial position had improved slightly following submission of the report hence the difference in the numbers reported later on the agenda.

Clarity was sought on the progress with the health informatics business plan across the West Yorkshire Association of Acute Trusts. The Managing Director for Digital Health responded that there was not the appetite to progress a single service across West Yorkshire therefore this work had not progressed.

Discussion took place on the development of the plan for 2018/19. The Company Secretary explained that key deliverables had been drafted and would be part of the discussion with the Council of Governors at the workshop to be held on 25 May 2018. The Chief Executive highlighted that these needed to be smart objectives and that it would be useful to remind colleagues about how the five year and one year plans had been developed as part of that workshop. He added that work would also be required on updating the five year strategy to reflect potentially the next ten years.

OUTCOME: The Board **RECEIVED and NOTED** the end of year progress report.

77/18 HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT

The Executive Director of Finance presented the report. He highlighted that all licences have been maintained and some new ones agreed. Staffing levels had also been maintained and the business demonstrated strong performance across all the workforce metrics. The report showed that there had been an increased contribution from HPS and the Trust had seen significant growth in the business. Richard Hopkin explained that he is a member of the HPS board and that it had shown really strong performance which had been reflected in the confidence around the HPS Strategy recently presented to the Board.

OUTCOME: The Board **RECEIVED** the HPS Annual Report asked that the Chair write to the staff of the HPS on behalf of the Board to express thanks and recognition of their hard work.

ACTION: Chair

78/18 DIRECTOR OF INFECTION PREVENTION AND CONTROL QUARTERLY REPORT

The Medical Director presented the quarterly report on the position of healthcare associated infections, which included the year end position for 2017/18.

It was noted that there have been five MRSA cases attributed to the organisation; 3 post case and 2 pre cases which is the 2nd highest position across West Yorkshire. The Trust was also one of few trusts reporting an increase in E-coli bacteraemia cases and had seen an increase in influenza which had been challenging to manage due to the number of side rooms available with en-suite facilities. There was some evidence of transmission of C diff.

The Medical Director explained that a detailed action plan had been put in place following a 'go-see' to Wolverhampton which has consistently good performance. This would be supported by refreshed and strengthened governance arrangements and progress would be reported to the Quality Committee. The Executive Director of Nursing added that a 'must-do's' programme was due to start to ensure that people are following best practice and understand their accountabilities and responsibilities.

OUTCOME: The Board **RECEIVED** the report.

79/18 SAFEGUARDING ANNUAL REPORT

The Chair welcomed the Deputy Director of Nursing who attend the meeting to give a presentation on the Safeguarding Annual Report. She explained that the report set out the Trust's statutory responsibilities in relation to safeguarding and provided detail of the progress against the priorities.

Linda Patterson explained that she is the non-executive lead for safeguarding. She added that there had been significant progress over the year. Richard Hopkin thanked the Deputy Director of Nursing for an excellent report and asked what role the voluntary sector has in safeguarding. The Deputy Director of Nursing responded that the voluntary sector is represented on the local safeguarding boards. She highlighted to the work undertaken by the Trust with Age UK on the Trust's discharge lounge and with Royal Mencap on the first phase of the 'Treat Me Well' Campaign.

Andy Nelson asked about progress on reporting safeguarding incidents. The Deputy Director of Nursing responded that as a result of more reliable reporting there is a specific sub group under the Safeguarding Committee which will look at themes and trends and what will make a difference. She added that there is a range of audits and a robust audit cycle, the results of which would be included in the next report. The challenge would be to implement the learning from child sexual exploitation, domestic violence and increasing isolation.

OUTCOME: The Board **APPROVED** the Safeguarding Annual Report.

80/18 NURSING AND MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENTS

The Executive Director of Nursing introduced the report and explained that staffing levels will continue to be challenging over the next five years. He commented that the national report focuses on nursing but it should be broader to include more professions. He pointed out that the Trust's band 5 nursing vacancy rate is lower when compared to other trusts across West Yorkshire which reflects the Trust's recruitment approaches. The Executive Director of Nursing highlighted the need to consider how more experienced staff are rewarded to retain their skills and expertise.

Other key points from the report included:

- 94 Filipino nurses still going through recruitment processes;
- Positive work undertaken with nursing associates which will have an impact going forward;
- The need to consider recruitment and retention in community and the opportunities presented by being an integrated trust;
- An upgrade made to the e-rostering system.

The Executive Director of Nursing explained that a report on the results of the nursing review had been presented to Finance and Performance Committee and key performance indicators were being drafted for ongoing monitoring. He added that other trusts were using the Trust's terms of reference for the review to undertake their own. Karen Heaton asked if the review had identified any surprises. The Executive Director of Nursing responded that it had been good to hear external views of the challenges experienced by the Trust and provided a different view point on potential responses. The use of high cost agency nurses to fill posts had been stopped Monday to Thursday. This had been a challenge however the wards had responded well.

David Anderson asked about the incidents in relation to ward 20. The Executive Director of Nursing explained that ward 20 is the elderly care ward and was part of the recent medical services reconfiguration. The ward had been challenging to recruit to but was now part of a wider rotation programme and that work had been done to encourage incident reporting by staff. The Executive Director of Nursing reported that relationships were being fostered further with the University of Huddersfield to encourage staff to gain academic qualifications alongside practical experience. The Trust is encouraging more placements and a broader experience including theatres and community. He added that there would be a professor of midwifery post within the Trust alongside the professor of nursing.

Linda Patterson suggested that work be undertaken to look at the areas which experience staffing pressures and how this maps to length of stay. The Executive Director of Workforce and OD commented that this should be considered alongside a wider report across all staff groups. The Chief Operating Officer added that a vacancy deep dive would be considered by the Executive Committee at the end of May to identify areas of pressure.

OUTCOME: The Board **RECEIVED** the Nursing and Midwifery Staffing Hard Truths report.

81/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance. It was noted that this report had been discussed in detail at the Executive Board, Quality Committee and Finance and Performance Committee.

The key highlights from the report were:

- Improved performance in PPH and had no category 4 pressure ulcers
- The Friends and Family Test (FFT) results worsened in A&E particularly at Huddersfield which reflected the performance against the Emergency Care Standard. The results in community also deteriorated despite changing method of capturing the information. Results improved in maternity.
- The complaints response time is not in an acceptable position and have an escalation performance process in three of four divisions
- Performance against the #NOF standard has improved and is being monitored weekly to ensure this is sustained.
- There have been issues with some of the stroke indicators in relation to availability of stroke beds for assessment in A&E. This must be resolved by the end of May.
- Performance against the emergency care standard was 92% for the year.
- There was a slight deterioration on cancelled operations in March
- All cancer targets were delivered in March. This has continued in April apart from screening due to low numbers and one patient declined which had an impact on performance figures.
- Performance against the workforce indicators has improved.
- Achieving the agency trajectory has been challenging.

Discussion took place on the number of 'stranded' patients with a length of stay over 7 days. It was noted that this was due to the number of additional beds open over the Easter period, staffing challenges and increased agency usage.

The Chief Operating Officer explained that the Executive Board has a robust process for deep dives on areas of underperformance. Divisional performance review meetings had focussed on agency trajectories and the activity profile.

The Chief Operating Officer explained that the IPR has been reviewed to look at thresholds, increase efficiency and tidy up over all. A report on any changes will be brought to the Board although it will make it more difficult to do a year on year comparison

OUTCOME: The Board **RECEIVED** and **APPROVED** the Integrated Performance Report

82/18 MONTH 12 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance explained that the report is the one submitted to regulators. He highlighted the following key points:

- The Trust delivered the position committed to the regulator in year
- The year-end deficit was £47.68m (including impairments) - a variance from control total of £7.97m.
- This is a small improvement on the £8m variance agreed in month 9.
- Delivery of CIP of £17.91m against the planned level of £20.00m.
- Capital expenditure of £15.62m, this is above the planned level of £14.39m.
- Cash balance of £2.00m against a plan of £1.91m.
- Use of Resources score of level 3, in line with the plan.

Alastair Graham highlighted that setting up the wholly owned subsidiary had delivered an in-year financial benefit. Phil Oldfield commented that as Chair of Finance and Performance Committee he wanted to congratulate the team for delivering against a challenging financial plan.

The Chief Executive explained that the Trust has not accepted its control total moving forward and that this would be discussed with regulators at the performance review meeting.

OUTCOME: The Board **RECEIVED** and **APPROVED** the financial narrative.

83/18 ANNUAL BUSINESS PLAN AND 2018/19 BUDGETS

The Executive Director of Finance presented the budget book for 2018/19. The Trust's allocated control total has reduced from a £26.04m deficit (excluding Sustainability and Transformation Funding (STF)) in 2017/18 to a £22.56m deficit in 2018/19. Provider Sustainability Funding (previously STF) has increased from £10.10m to £14.20m, but this is only available if the Trust accepts the control total. The Trust has not been able to accept the control total for 2018/19. The final plan submission to NHS Improvement submitted on the 30th of April 2018 describes a financial deficit position of £43.1m which is a £20.5m adverse variance to the control total. The plan assumes delivery of £18.0m new CIP in 2018/19 which when combined with the full year effect of 2017/18 CIP represents 5.6% of operating costs. This challenging target is set in recognition of the scale of recovery that is required and in acknowledgement of specific strategic and technical opportunities that exist and would be expected to stretch the achievable value.

A paper had been presented to Finance and Performance Committee on the risks relating to capital and what is being done to bring more capital in. Capital bids are to the NHS Improvement emergency capital pot as well as the West Yorkshire Sustainability and Transformation Partnership capital process where bids will be considered after September. The Trust is being asked to consider what flexibilities there are around these and the associated clinical risk. It was noted that the Chief Executive and Executive Director of Finance would both sit on the allocation panel.

Phil Oldfield. Chair of the Finance and Performance Committee explained that the budgets and plan had been considered at the Committee and were recommended to the Board for approval.

The Executive Director of Finance informed the Board that the Trust has agreed an aligned incentive contract with commissioners which assumes a level of growth while protecting income. This will enable the Trust to think differently about pathways of care and how digital technology can be used to support this. Bed days will be used to measure activity which better measures acuity.

Richard Hopkin asked about the agency spend increases forecast for the final four months. The Executive Director of Finance explained that actions would be in place to minimise the use of agency however the assumptions enable the Trust to better plan for spikes in activity. He added that the plan also assumes significant cash borrowing to pay suppliers that these will be approved by the regulator.

OUTCOME: The Board **APPROVED** the Annual Business Plan and 2018/19 budgets.

84/18 UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES

The Board received an update from each of the sub-committees who had met prior to the Board meeting.

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee gave a verbal report following the meeting held on 30 April 2018. The Committee had received a report on the progress of the work on sepsis and the improvements made. The Committee had also received an initial report on the impact of the medical services reconfiguration which had demonstrated improvement across some key performance indicators. A final report will be presented to the Committee in July. The Committee had also received an update on the actions since the Care Quality Commission inspection in early April.

OUTCOME: The Board **RECEIVED** the update from the meeting held on 30 April 2018.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee gave feedback from the meeting on 30 April 2018. The Committee had received a report on the results of the nursing review which had showed staffing levels based on guidance with little evidence of a richer skill mix. The report highlighted that pay is slightly under national average. The key challenges were the use of agency and bank staff; length of stay; and rostering efficiency. The Committee had asked for work to be done on the risks resulting from the capital plan and had received a presentation on the application of the sustainability and transformation fund. Discussion had also taken place on the budget and aligned incentive contract.

OUTCOME: The Board **RECEIVED** the minutes from the meetings held on 3 April 2018 and **NOTED** the update from 27 April 2018 meeting**.**

c. Audit and Risk Committee

Richard Hopkin, Chair of the Audit and Risk Committee provided an update from the meeting held on 18 April 2018. He highlighted the main areas to bring to the attention of the Board:

- Work is to be done to develop the arrangements for how the Committee considers assurance mechanisms, to include a meeting of the sub-committee chairs;
- The membership of the Committee is to be reviewed;
- The Board Assurance Framework will be developed to be aligned to the 18/19 plan;
- Five internal audit reports had been received with limited assurance including Sepsis, patient flow and payroll;
- The 18/19 internal audit programme had been considered and some amendments suggested to come back to the Committee in July;
- The Committee had asked for a future report on clinical audit processes.

OUTCOME: The Board **NOTED** the update from the meeting held on 18 April 2018.

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 7 June 2018 commencing at 9.00 am in the Large Training Room, Calderdale Royal Hospital.

The Chair thanked Brendan Brown and Kathy Bray for their hard work and contribution to the Board as it was their final meeting.

The Chair closed the public meeting at 11:00 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th June 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG PUBLIC BOARD OF DIRECTORS - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 31 May 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 31 May 2018

Main Body

Purpose:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 31 May 2018

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 31 May 2018

Appendix

Attachment:

APP B DRAFT ACTION LOG - BOD - PUBLIC - As at 31 May 2018.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.12.17 183/17	**PATIENT STORY** It was agreed to discuss how EPR can support the serious incident investigation and information capture.	OW / JC	**1.2.18** **Agreed that EPR/Serious Incident Investigation would be presented at a future meeting.** **WINTER PRESSURES** **The COO advised that at the end of the quarter she would bring a paper to Board updating on winter planning arrangements and conversations with partners**	TBC		
7.12.17 187/17	**CHIEF EXECUTIVE'S REPORT** The Quality Committee will undertake a review of the impact of the recent interim medical services reconfiguration and report back to the Board	Chair of Quality Committee / HB		July 2018 ~~May 2018~~		
7.12.17 188/17	**QUARTERLY QUALITY REPORT** The Quality Committee will undertake a deep dive on sepsis and will report back to the Board	Chair of Quality Committee / DB		July 2018		
7.12.17 197/17	**UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES** The Chief Executive advised that a piece of work was underway looking at staff experience of appraisals would be brought to a future BOD meeting	SD		TBC		
4.1.18 9/18	**PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)** Presentation received. It was agreed that	MG		June 2018 ~~May 2018~~		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	progress against plan would be monitored by the Executive Board and Audit and Risk Committee. It was agreed that clear governance arrangements would be provided through this route and an update brought to the Board in May 2018.					
1.1.18 13/18 and 5.4.18 65/18	**GUARDIAN OF SAFE WORKING** Update received. Concern was expressed regarding the lack of administrative support for the Guardian. It was agreed that the Executive Medical Director would speak to colleagues in the Trust to ascertain whether there was any dedicated support which could be provided from within the organisation to assist the Guardian of Safe Working.	DB	**1.2.18** **Requirements were clarified with Guardian, the Trust are in support and will hopefully be resolved very shortly. It was agreed that this would remain on the Action Log until the matter had been fully resolved.**	June 2018		
4.1.18 11/17	**IPR – ACTION CARDS** Discussion took place regarding Action Cards and it was agreed that the COO would be asked to circulate a briefing to the NEDs to explain the process around the use of these cards.	HB	1.2.18 The COO agreed to circulate a briefing to the NEDs to explain the process around the use of these cards. **1.3.18** **It was confirmed that this had not yet been actioned. The Chief Operating Officer was asked to circulate a briefing to the Non-Executive Directors to explain the process around the use of these cards.**	April 2018		
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT**	DA		TBC		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed that he would investigate this further.					
1.2.18 28/18	**EQUALITY AND INCLUSION ANNUAL REPORT** Karen Heaton recommended that the Trust set itself targets in relation to diversity of the workforce. The Chief Executive recommended that this could be discussed as part of a Board workshop. Action A: It was agreed that the Company Secretary would include on the agenda for a future Board workshop. Action B: Suzanne Dunkley / Karen Heaton to explore the workforce element timeline.	SD/KH	**Agreed to consider at a Workforce Well Led Committee 'hot spot' workshop** **Added to the Board workplan post workshop**	June 2018		
1.3.18 37/18	**INTEGRATED PERFORMANCE REPORT – WEIGHTINGS REVIEW** Andy Nelson asked that an action be recorded for the item "weighting of mandatory training set against other targets should be reviewed". The Board agreed that this should be actioned by the Chief Operating Officer as this could affect the scorecard going forward.	HB		TBC		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
1.3.18 43/18	**CARE OF THE ACUTE ILL PATIENT REPORT** The Chief Executive commended the Medical Director and Associate Medical Directors for their leadership and ability to identify where improvements are required and communicate this to staff, recognising the good achievements and how this is translated to the workforce. The Chief Executive agreed that he, along with the newly appointed Chair would ensure that lines of communication with staff continued and wider communications put in place.	OW/PL		TBC		
1.3.18 44/19	**BOARD SKILLS AND COMPETENCIES** Arrangements were being made to prepare a Board Development Programme and utilise some of the intelligence from this exercise, along with strategic issues in its development and would be brought back to the Board in the near future.	OW/PL/SD/ VP		July 2018		
5.4.18 57/18	**HIGH LEVEL RISK REGISTER** It was agreed Audit and Risk Committee would monitor the risk to business continuity should a power outage or cyber attack occur.	MG / RH		July 2018		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 31 May 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
5.4.18 62/18	**DATA QUALITY ASSURANCE** Receive the outcome of the NHSI Data Quality Assessment and associated recommendations	HB		July 2018		
3.5.18 75/18 (1) 75/18 (2) 75/18 (3)	**HIGH LEVEL RISK REGISTER** Circulate the wording on the Sepsis risks Discussion at Finance and Performance Committee on control totals EPR risks to be reconsidered and proposed wording shared	 JM GB / PO JM		June 2018		
3.5.18 77/18	**HPS ANNUAL REPORT** Chair to write to the staff of HPS with thanks from the Board	PL		June 2018		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th June 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CHIEF EXECUTIVES REPORT - JUNE 2017 - The Chief Executive will provide updates on a number of matters at the meeting including the attached Lord Carter review.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Chief Executive will provide an update on a number of items at the Board meeting including:
- The appointment of the Interim Chief Nurse
- The publication of the Independent Reconfiguration Report into the proposed reconfiguration of hospital services which can be found at https://www.gov.uk/government/publications/irp-calderdale-and-huddersfield-advice.
- The recent Lord Carter Review into unwarranted variations in mental health and community services - a copy of which is attached to this paper.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to review the attached Lord Carter report.

Appendix

Attachment:

APP C - Chief Executive's report - Lord Carter summary report.pdf

NHS operational productivity: unwarranted variations

Mental health services and community health services

Summary document

Foreword by Lord Carter of Coles

Like all parts of the NHS, mental health and community services face a number of challenges that can be partly addressed through operational and structural improvements. NHS mental health and community health services account for about £17 billion of NHS expenditure in England, complementing the £52 billion spent on acute services, and providing critical support for over 2 million patients every day.

The role and importance of mental health services are clear, but that of community health services, with a wide range of local specifications and provisions, is not. If the aspirations expressed in the Five Year Forward View are to be met, we will need to shorten the average length of stay in English acute hospitals from its current 7 days to something approaching Denmark at 5.5 days or the United States at 6.1 days[1], although some estimates put these even lower. To achieve this, the provision and efficiency of community health services will have to be significantly strengthened. The key challenge for mental health services, by contrast, is in meeting the significant levels of unmet demand. Even taking into account the significant expansion in children's mental health services, workforce constraints mean that by 2020/21 we only plan on meeting the needs of a third of children with diagnosable mental health conditions. Improving the productivity of services is an important part of the answer to how we go further in both sectors.

Operational improvement – £1 billion savings opportunity to support patients

Since January 2017 we have engaged with many mental health trusts and providers of community services, and talked to the healthcare teams and patients who use their services. As a result of that engagement, this review has identified critical and unwarranted variations in all key resource areas. It is clear from the performance of some providers that parts of the sectors know what to do well – the challenge we face is how we raise the average standard of performance closer to the level of the best. Our work has identified four important areas where operational improvement must be made.

1. **Staff:** we spend £10.4 billion per year on staff; giving detailed attention to how they use their time, particularly at this moment of critical labour shortages in all grades, is of the utmost importance. Effective rostering, job planning, managing sickness absence, maximising the clinical time of community staff, appropriate skills mixing, and effective training all lend themselves to detailed management attention. This is, however,

[1] OECD, 'Health at a Glance 2017'; https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en

something that we have found to be missing in too many providers. Culturally, the high levels of bullying and harassment staff report is inconsistent with the continued mantra that our staff are our most valuable asset.

2. **Contract specification:** the approach to contract specification and management is inconsistent and overly bureaucratic. Clinical commissioning groups commission core services against hugely detailed and often very different specifications. These variations are often unwarranted and the approach has resulted in the imposition of too many reporting requirements – in one case 6,000 in a single trust. This creates confusion and unacceptable frictional cost.

3. **Technology:** the use of technology is not optimal and lags behind even other public sector services, let alone the best in class. Over a quarter of trusts still operate paper-based systems for community nursing services and, where they do exist, many of the case management systems in community and mental health services are cumbersome and time-consuming for staff to use. The inability to provide a single view of the patient across organisations to date is lamentable. This lack of investment in adequate systems is indefensible in 2018, and means valuable staff time is wasted and patients do not receive the best care. While many trusts have, or are implementing mobile working, e-rostering systems and dynamic scheduling, much more needs to be done to ensure these are being used effectively and driving the productivity and efficiency gains that are possible. There must also be questions about electronic procurement, stock management and the use of electronic prescriptions which are not at a sufficiently advanced stage.

4. **Delivery:** ensuring that these issues are dealt with is the responsibility of NHS Improvement in the case of operational matters, and NHS England in the case of commissioning. NHS Improvement needs to have a clear idea of ‘what good looks like’ in these areas by broadening the focus of the clinically led Getting It Right First Time (GIRFT) programme and providing effective benchmarking information to providers through an adapted Model Hospital. The proposed new regional structure across both organisations will need to be implemented at pace to help providers up their game.

In summary, we could find no reason why the system should not move more quickly to adopt best practice, save for the constraints of capability and capacity.

Structural issues – supporting the Five Year Forward View

There are a number of structural issues in the provision of services delivered in the community that are well recognised but have not been adequately dealt with and which community health services could play a more significant role in resolving.

1. **Delayed transfers of care:** these remain one of the biggest problems in the NHS. They account for about 5,000 beds at any one time. The main NHS reason given for these delays is the number of patients ‘awaiting further non-acute NHS care’. We saw examples where effective use of community health services and social care has reduced average length of stay in acute beds by four days.

2. **Wound care:** research has shown that the NHS spends about £5 billion a year managing wounds, undertaking over 40 million patient visits. But most trusts do not capture clinical information or operate within nationally defined pathways. The GIRFT programme must extend its approach to community health services to support more efficient pathways in the community.

3. **Community hospitals:** in many areas it is unclear how community health services should be provided to best support patients: some areas have inpatient community hospitals while others have none. We were unable to find any evidence that the often expensive provision of inpatient community hospitals improved outcomes. Patients need to access appropriate local services and there is scope for a wide range of community services to be located in 'hubs'. In doing so we need to achieve a reasonable balance of size and accessibility if such hubs are to secure the confidence of their local communities and funders. A much clearer idea of 'what good looks like' is needed but one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure. Effective national leadership working with local sustainability and transformation partnerships (STPs) across community health, mental health, primary care, general practice and social care services needs to take this forward.

4. **Lifetime healthcare costs:** at current funding levels the lifetime healthcare costs of an individual in England are approximately £185,000, and if social care costs are added this could rise to over £220,000[2]. As Lord Darzi's recent review of health and care[3] draws out, nearly half of this expenditure occurs after the age of 65. The average length of stay for non-elective patients, for example, is 13 days for those aged over 85. It is critical that the management of these groups of patients is undertaken on a much more focused basis to ensure that acute care interventions are minimised and a much more effective system of dealing with the co-morbidities of old age is found.

5. **Integrated care:** The expansion of the role of the Secretary of State for Health and Social Care to include responsibility for social care should make the dream of integrated care more realistic. The dilemma of social care being means-tested and acute care being free at the point of delivery causes inevitable tensions. There must be some way of incentivising acute hospitals to discharge medically fit patients to step-down and intermediate care facilities, for if nothing else it will enable these hospitals to undertake their economically rewarding elective care work and reduce waiting lists for patients. Other healthcare economies have regarded post-acute care, for a limited period, as an essential part of the acute hospital financing package, aiming as they must to keep the optimal flow of patients through the highest risk and most expensive part of the healthcare continuum. Resolving these issues, as part of the move to place the funding of the NHS on a long-term sustainable basis is critical.

I am grateful for the opportunity to extend my work and undertake this review and I would like to thank the cohort of 23 trusts that has dedicated considerable personal time and effort to

[2] NHS Improvement analysis
[3] The Lord Darzi Review of Health and Care: Interim report: https://www.ippr.org/publications/darzi-review-interim-report

supporting the work. This review is as much theirs as mine. I would also like to thank my team and all those who advised and supported me over the last 18 months.

I am confident that if the recommendations in this report are implemented, up to £1 billion of efficiency and productivity savings per year can be achieved by 2021. The structural issues will be more difficult to resolve in the short term, and we have not at this stage quantified the benefits although I believe them to be significant. At the simplest level this will mean paying much closer attention to how the wider system supports reductions in avoidable admissions and limits the average length of stay, particularly for older patients. If we are to be successful in delivering the Five Year Forward View, these simple tests must be met.

Lord Carter of Coles
May 2018

Executive Summary

This review has looked at the productivity and efficiency of mental health and community health services. It has done so in the context of the Five Year Forward View and its delivery plan which are clear that these services provide critical support to patients in the most appropriate setting, and assist the better management of mental and physical health conditions.

The review makes 16 recommendations across eight chapters. They are designed to improve productivity and enable the benefits to be reinvested in improving quality and access to care. We developed them by working closely with trusts delivering these services across England, in particular a cohort of 23 trusts. In doing so we identified many examples of 'what good looks like' in all aspects of service delivery and patient care, and significant good practice. We also found a significant amount of unwarranted variation. The findings are summarised below:

- There is significant good practice but there needs to be stronger mechanisms for sharing this between trusts.
- Workforce productivity is mixed, particularly in services delivered in the community, and NHS Improvement must step up its support for trusts to drive improvements in the engagement, retention and wellbeing of their staff.
- The Getting It Right First Time (GIRFT) programme should extend its approach to community health and mental health services, and specify more efficient and high quality pathways of care for patients.
- The use of mobile working and technology to drive efficiency and productivity is inconsistent and poor in many areas.
- There is scope for trusts to take action across all areas of spend including corporate services, procurement and estates.

Chapter 1: Mental health and community health services

The NHS in England spends about £17 billion providing community and mental health services. There are currently 53 specialist providers of mental health services and 18 community trusts, but many more trusts deliver some services in these areas. We have found significant diversity in what trusts provide. The Five Year Forward View for Mental Health described a number of challenges facing mental health services, with the critical areas of concern being historical underfunding of mental health services, the extent of unmet need in mental healthcare, which is higher than other sectors, and the lack of parity of esteem with physical health. NHS England is making good progress in tackling these through investment and reform under clear national leadership and with support from partners across the system. Community health services provide an equally important role in supporting patients and the wider health system. This has been described in national strategies including the Five Year Forward View. However, there is a disparity in the extent of clear national leadership between mental health and community health services. We

recommend that NHS Improvement and NHS England do more to recognise the role of community health services in a way that builds on the new models of care.

Chapter 2: Quality and efficiency across the pathway

Examining the whole patient pathway is a crucial means of understanding where productivity and efficiency improvements can be made. This includes where patients could be better cared for in terms of quality of care, patient experience, efficiency and value for money. Analysis of an individual's lifetime care costs shows how spend is skewed towards acute hospital care, when in fact providing care to patients in their homes or the community can be better in terms of quality and efficiency. The Getting It Right First Time (GIRFT) programme is well established in 35 clinical work streams, and is supporting improvements in quality and efficiency across these. It must now extend its approach to mental health and community health services. For mental health inpatient services, this approach will support national efforts to reduce the estimated £500 million spent each year on inappropriate out of area placements. Alongside this, there is scope to strengthen and simplify existing commissioning and contract arrangements to drive standardisation in the community health services 'offer'. Trusts currently have to work with a number of commissioners delivering the same service against often different specifications, and the approach to contract management can create an unnecessary administrative burden for trusts. There are also specific areas of care provision that warrant a closer focus and support, specifically healthcare for veterans and restricted patients.

Chapter 3: Engaging the workforce

We recognise that staff are our biggest asset but more can be done to support them in delivering effective and efficient care to patients. All staff in mental health and community health services are committed to delivering high quality services to patients, but we were told that they are coming under increasing strain. Staff engagement, sickness absence, bullying and harassment and retention levels are concerning and show significant variation between different organisations. Effective action must be taken to support trusts in addressing these issues. This includes an emphasis on leadership at all levels in the organisation and the importance of the role of trust boards in driving this. NHS Improvement must work with all trusts to help improve the engagement, retention and wellbeing of their staff.

Chapter 4: Optimising clinical resources in the community

Services delivered in the community account for about 70% of mental health and community trusts' clinical work. To better understand the productivity and efficiency challenges and solutions in these services, the review team collected data from cohort trusts and worked closely with them to analyse this. This showed that there is a large amount of unwarranted variation in metrics such as direct care time per clinical day, and the number and duration of contacts. Similar variation was observed in other services delivered in the community. The review also saw large differences in how services are managed between trusts including the way referrals are managed, approaches to case management and the effective use of administrative resources. We found that a key enabler for improving workforce productivity in these services was the use and uptake of digital technology and mobile working. Often this was inconsistent and poor, with estimates

showing that a quarter of community nursing services are still paper-based, and many clinical record systems in mental health trusts being time-consuming and difficult for staff to use. NHS Improvement needs to support trusts to change this by developing guidance on good operating practices for services delivered in the community, and providing benchmarking metrics for mental health and community health service lines on the Model Hospital by April 2019.

Chapter 5: Optimising inpatient services and other clinical resources

Unwarranted variation was also seen for other clinical services. We examined the inpatient workforce, medical staff, and medicines and pharmacy. For inpatient services, the nursing cost per bed varies significantly between trusts, and for smaller-sized units can be over £100,000 for an occupied bed per year in both mental health and community health wards. The review collected data for care hours per patient day (CHPPD) and reviewed rostering practices. In many cases there was scope for significant improvements to better manage unused hours, approve rosters at least six weeks in advance, and reduce spend on bank and agency staff. NHS Improvement will refine the CHPPD collection methodology, including developing tools to show levels of acuity and dependency, and will develop good practice guidance for all trusts around inpatient workforce deployment and e-rostering. Medical staff job planning is mixed, and early data collected suggests that this is an area that requires further examination. The review also focused on medicines and pharmacy optimisation. This was recognised as a critical clinical service that had a profound impact on costs and care quality across the patient pathway. There were specific challenges facing trusts around the infrastructure that ensures the supply of medicines and how pharmacists were deployed across services delivered in the community and inpatient services. Trusts should assess where they can make changes to allow pharmacists and other pharmacy staff to spend more time on patient-facing medicines optimisation, especially in community settings.

Chapter 6: Optimising non-clinical resources

Non-clinical resources account for about 30% of mental health and community trust spend, and are a critical enabler of frontline patient care. Expenditure on corporate services tends to be higher on average for mental health and community trusts compared to other provider organisations, owing to their smaller scale. There was also variation in the costs of core corporate services functions, such as the cost per payslip and human resources cost per employee. There are opportunities for trusts in the sectors to collaborate and share their corporate services provision across neighbouring organisations, including sustainability and transformation partnerships (STPs). For estates and facilities management, in the £1.3 billion spend per year by mental health and community trusts there was significant variation in the running costs per square metre, from about £30 to over £230, and in the use of space. There is scope for trusts to rationalise their estate, building on good practice demonstrated by a number of trusts across the sectors, and in line with ongoing work in STPs. One trust found it could dispose of 14% of its properties. NHS Improvement will provide a more comprehensive set of benchmarks for the sectors, and trusts should review their estate to identify opportunities for consolidation and rationalisation. To support this, NHS Improvement will also review the current arrangements for estates leased from property companies. The review also examined trusts' procurement practices and

functions. This found significant unwarranted variation in prices paid for the same product, including one type of dressing where the price paid varied from £1.62 to £20.29 per unit. Our engagement showed that trusts are not leveraging their buying power or collaborating at scale to secure the best price. Trusts should use the Purchase Price Index and Benchmarking tool to evaluate prices paid for products, and NHS Improvement's National Procurement Programme will focus on a set of common goods used by trusts in the sectors to support better cross-sector buying power.

Chapter 7: Expanding the Model Hospital

A key recommendation from the acute hospital sector operational productivity review was the establishment of the Model Hospital to provide benchmarking data to trusts to identify efficiency and productivity opportunities. Expanding and extending benchmarking data on the Model Hospital to include mental health and community health services will be a central element of implementing the recommendations in this review, in particular to show the metrics for services delivered in the community as set out in chapter 4. This will take time to develop fully but rapid progress must be made. As part of this, NHS Improvement will review the branding of the Model Hospital as it expands to incorporate different types of providers.

Chapter 8: Securing effective implementation

The implementation of the recommendations in this report will be supported by a team in NHS Improvement's Operational Productivity Directorate that will engage with trusts across community health and mental health services. However, it will need leadership and action far beyond that from a range of partners and stakeholders, and the challenge to NHS Improvement, NHS England and individual trusts from this review is how to lead, operationalise and sustain significant action against the review's recommendations. Although some trusts have already started to tackle some of the issues hindering their productivity, achieving long-term efficiencies and improvements to quality will also require targeted support from national bodies working more closely together.

The findings in this report are underpinned by our identification of significant unwarranted variation across clinical and non-clinical resources. We consider that removing this unwarranted variation would result in an efficiency opportunity worth up to £1 billion a year by 2020/21 from a more productive and efficient use of existing resources. Removing this variation will support providers in delivering their required annual efficiencies and existing cost improvement plans. In some cases, delivering the identified efficiencies may require investment in infrastructure to release longer-term benefits for the NHS, patients and the taxpayer. It is critical that all savings identified in this report are reinvested alongside new investment to ensure that more people are able to gain timely access to evidence-based mental health and community health services. The Five Year Forward View for Mental Health is clear that mental health services have been underfunded for decades and our recommendations will help ensure that the investment made to move towards parity of esteem both maximises the support to patients and delivers value for money.

Summary of Recommendations

1. **Learning from new models of care:** NHS England should codify and share the learnings from new models of care and the successful 'Vanguards' to support community health services to play their full role in supporting the wider system.
2. **Quality of care and Getting It Right First Time (GIRFT):** The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress in undertaking work in mental health. For mental health, this should include supporting the elimination of inappropriate out of area placements for adult mental healthcare by 2021.
3. **Driving standardisation in the community health services 'offer':** NHS England should help strengthen commissioning and contracting mechanisms for mental health and community health services. This should include supporting providers and commissioners to work together within sustainability and transformation partnerships to develop model frameworks for specifications of services.
4. **Restricted patients:** The Department of Health and Social Care, Ministry of Justice and their arm's length bodies should work more closely to improve the administrative management of restricted patients.
5. **Optimising workforce well-being and engagement:** Improving cultures are critical to better staff engagement, driving positive change across organisations and improving both productivity and care quality. NHS Improvement should work with all mental health and community trust boards to help improve the engagement, retention and wellbeing of their staff.
6. **Strengthening the oversight of workforce productivity for services delivered in the community:** With support from NHS Improvement and NHS Digital, and using the Model Hospital as a national benchmarking dashboard, providers should improve their understanding and management of productivity at organisational, service and individual level.
7. **Improving the productivity of the clinical workforce for services delivered in the community:** Providers of services delivered in the community should increase the productivity of their clinical workforce by improving and modernising their delivery models, in particular through better use of digital solutions and mobile working.

8. **Cost of inpatient care and care hours per patient day:** NHS Improvement should develop and implement measures for analysing workforce deployment, and trusts should use these to report on the cost and efficiency of their inpatient services to their boards during 2018/19.
9. **Inpatient rostering and e-rostering:** All community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practice that require improvement. NHS Improvement should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.
10. **Medical job planning:** NHS Improvement should work with trusts to ensure that the right doctor is available for patients at all times using effective and comprehensive job planning and rostering, and identify improvements in clinical efficiency and productivity.
11. **Medicines and pharmacy optimisation:** Trusts should develop plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.
12. **Corporate services:** Trusts should reduce the variation in the cost of their corporate service functions. As part of this, they should examine the opportunities to collaborate and share corporate service functions.
13. **Estates and facilities management:** NHS Improvement should develop a comprehensive and tailored set of benchmarks for the sector by 2019/20, and all mental health and community trusts should review their existing estates and facilities and provide a report to their boards by April 2019.
14. **Procurement:** Trusts should reduce unwarranted price variation in the procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking.
15. **Model Hospital:** NHS Improvement should develop the current Model Hospital and the underlying metrics to ensure there is one repository of data, benchmarks and good practice so all trusts can identify what good looks like for services they deliver.
16. **Implementation**: Trusts, NHS Improvement, NHS England and other national bodies must take the action required to implement these recommendations. NHS Improvement must ensure that the best practice observed throughout this review is shared, key benchmarks are specified, and more intensive support is provided.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 7th June 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: High Level Risk Register - To present the high level risks on the Trust Risk Register as at 29 May 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The draft high level risk register has been reviewed by members of the Risk and Compliance Group at it's meeting on 21 May 2018.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The high level risk register is presented on a monthly basis to ensure that the Board of Directors are aware of key risks facing the organisation and is a fundamental part of the Trust's risk management system.

Main Body

Purpose:

To assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks identified on the high level risk register.

Background/Overview:

The high level risk register is presented on a monthly basis to ensure that the Board of Directors are aware of all current risks facing the organisation and is a key part of the Trust's risk management system.

The Risk and Compliance Group consider and review all risks that may be deemed a high level risk with a risk score of 15 or more on a monthly basis, prior to these being presented to the Board of Directors.

Divisional risk registers are also discussed within divisional patient safety quality boards, with divisions identifying risks for consideration for escalation to the high level risk register for review at the Risk and Compliance Group.

The Issue:

The attached paper includes:

i. Identification of the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks. This paper refers to a summary of the Trust risk profile as at 29 May 2018.

ii. The high level risk register which identifies risks and the associated controls and actions to manage these.

iii. One new risk, risk 6895 regarding procurement, which has been added to the high level risk register during May 2018.

iv. One risk has a reduced score, risk 6924 mis-placed naso -gastric tube, reducing from 15 to 10 due to a reduction in the likelihood of this risk occurring following actions to mitigate the risk. The risk is now being managed within the medical division risk register

v. One risk, 6658 relating to patient flow has been closed, having reached its target score

Next Steps:

Meetings are taking place during June with risk owners for high level risks where risks scores have remained unchanged to review the risk - this is part of work to strengthen the risk register following discussion with Non Executive Directors.

Discussion is also taking place about EPR related risks and any confirmed new EPR risks following this will be reported to the Board next month.

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the high level risk register are being

appropriately managed.
ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required.

Appendix

Attachment:

There is no PDF document attached to the paper.

High Level Risk Register Board Summary – May 2018

Risks as of 29th May 2018

High Level	Number of Risks
Very high (Risk Score of 20 , 25)	8
High (Risk Score of 15, 16)	13
Total	21

TOP RISKS

The following risks scored at 25 or 20 on the high level risk register are:

7169 (25): Trust Financial Control 2018/19
7062 (20): Capital programme
7078 (20): Medical staffing risk
6903 (20): Estates/ ICU risk, HRI
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7049 (20): EPR financial risk

The Trust risk appetite is included below.

RISKS WITH REDUCED SCORE

6924 Misplaced NG Tube Previous Risk Score 15 Current Risk Score 10
Risk of mis-placed nasogastric tube for feeding due to lack of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm
Reason for Reduction

- Training programme agreed for nursing staff and junior doctors, delivered by Clinical Support Nurse's (CSN's) Nursing Specialist Group (NSG) reinstated led by deputy chief nurse

6598 Essential Skills Training Previous Risk Score 16 Current Risk Score 9
There is a risk of reporting below target compliance against many of the agreed essential skills, therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely and competently
Reason for Reduction

- significant increases to the compliance rates across all essential skills by 2017/18 year end

7194 Lab System Results - risk of report on wrong patient Previous Risk Score 15 Current Risk Score 12

Risk of multiple (distinct/separate patient) orders being assigned the same lab number in the lab system, due to necessity for lab number recycling in the lab system resulting in samples being assigned to the wrong patient order (in lab system) and ultimately results being reported back on the wrong patient.

Reason for Reduction

- Lab system supplier can develop a solution to identify and allow users to select the correct version of the order in the lab system. PO raised and development work complete. Implementation date 21 May 2018

NEW RISKS

6895 (16) Corporate: Finance

Risk of inability to fulfil core function of the Finance and Procurement Department

In December 2017, the Trust's key finance ledger system and procurement ordering system went through an upgrade with the existing supplier, North East Patches (NEP). The system changeover adversely affected functionality in a number of areas. Many of the initial migration issues have been resolved but the residual system issues cause potential operational risk to the Trust's ability to maintain supply of goods and services essential to operational performance and safety. On this basis the risk was increased on the Trust's risk register on 26 April 2018 from the previous score of 8 to a current score of 16.

7248 (16) Corporate: Workforce

Risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period.

CLOSED RISKS

6658 (20) Corporate : Central Operations Team

Patient flow risk which has reached its target date. New risk to be developed

MAY 2018 – BOARD - SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 29.5.2018

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Dec 17	Jan 18	Feb 18	Mar 18	April 18	May 18
012	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
007	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
007	7134	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/2019	Medical Director (DB)	=16	=16	=16	=16	=16	=16
011	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
011	6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
007	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
007	6949	Keeping the base safe	Blood transfusion service	Divisional Director of FSS (JO'R)			!15	=15	=15	=15
007	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Medical Director (DB)					16	=16
	7046	Keeping the base safe	EPR risk to patient from migration issues	Clinical Lead (AM)	=16	=16	=16	=16	=16	=16
	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital health					16	=16
007	**7248**	**Keeping the base safe**	**Mandatory Training**	**Director of Workforce and OD (SD)**					**16**	**!16**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Dec 17	Jan 18	Feb 18	Mar 18	April 18	May 18
	7169	2018/19 income	Income and expenditure	Director of Finance (GB)				!25	**=25**	**=25**
022	7062	Financial sustainability	Capital programme 2018/19	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
	7049	Financial sustainability	EPR financial risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
	6895	**Financial Sustainability**	**Finance IT systems**	**Director of Finance (GB)**	**=8**	**=8**	**=8**	**=8**	**=16**	**↑16**
Performance and Regulation Risks										
007	6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
012	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20
012	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20

KEY: = Same score as last period, ↓ decreased score since last period, ! New risk since last report to Board ↑ increased score since last period

TRUST RISK PROFILE AS AT 29/5/2018

KEY: = Same score as last period ↓ decreased score since last period
! New risk since last period ↑ increased score since last period

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation	= 6345 Nurse Staffing = 7078 Medical Staffing =7049 EPR financial risk	= 7169 Not delivering 2018/19 financial plan
Likely (4)				= 6596 Timeliness of serious incident investigations =5862 Risk of falls with harm =6300 Risk of being inadequate for some services if CQC improvement actions not delivered =7132 patient scores in ED =7134 sepsis CQUIN =7223 Digital IT systems risk =7248 mandatory training =7046 EPR risk to patient ↑ 6895 Finance core function	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 ICU/ resus estates risk = 7062 Capital programme 2018/19
Possible (3)					= 6011 Blood transfusion process = 5747 Vascular /interventional radiology service = 6949 Blood transfusion service
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE NOVEMBER 2016

Risk Category	This means	Risk Level Appetite	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**

Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**

High Level Risk Register Board Report

29/05/2018 14:40

NHS
The Health Informatics Service
Informing Healthcare

Extreme and Major Risks (15 or over) as 29/05/2018

	Risk No	Div	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Very High	7169	Trustwide	All Departments/Wards	Jan-2018	Financial sustainability	Not achieving the 2018/19 Control Total The Trust financial control total for 2018/19 has been confirmed by NHS Improvement as an £22.6m deficit. The Trust has planned a deficit is £43.1m, a £20.5m variance from the 18/19 control total. By not accepting the control total the Trust loses access to £14.2m Provider Sustainability Funding (PSF). It also raises concerns about the longer term financial sustainability of the Trust.	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Controls around use of agency staffing have been strengthened. Aligned Incentive contract with two main commissioners.	Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges Difficulty in identifying EPR benefits to offset additional committed resource. Volume of agency breaches remain comparatively high and a higher value for each breach.	25 5 x 5	25 5 x 5	15 5 x 3	Final financial plan was submitted to NHS Improvement in April 8 - the planned deficit for the year is £43.1m, a £20.5m variance from the 18/19 control total. This assumes achievement of £18m CIP target of which £17.2m has been identified.	Jun-2018	Mar-2019	FPC	Gary Boothby	Philippa Russell
Very High	2827	Medical	Accident & Emergency	Apr-2011	Developing our workforce	The inability to recruit sufficient middle grade and consultant emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Development of CESR programme ACP development Continued recruitment drive for Consultant and Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention	20 4 x 5	20 5 x 4	12 4 x 3	April 2018 MTI now on programme of support CESR rotation arranged for Anaethetics/ICU in August 2018 New ACP started this month and rota in development May 2018 Junior doctor interviews 18.5.18 FY3 posts being interviewed Consultant interviews set for 15.5.18 (2 applicants) Reviewing junior doctor rota alongside the ACP rota	Jun-2018	Aug-2018	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith

Very High	5806	Estates & Facilities	Estates Department	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks identified within the Estates Risk Register being: Flooring: in ICU at HRI, Ward 19, CCU CRH- a lips and trips hazard • Windows: Ward 6 at HRI and all elevations of the hospital, A& E Resus, creating potential of closure to services from water affecting core services • Theatres / Environment ; HRI Main, DSU and Theatre 6 and CRH Theatres & creating potential for inability to treat patients so missing national targets and affecting patient care • HRI road surfaces, pipework, second water main, aseptic unit improvements with potential to close the entire hospital • Staff Residences Saville Court and Dryclough Close Properties (fire and utilities compliance) • Trust wide roofs which need repairs and edge protection. Without this there is a danger of falling from heights, water closing wards and services, and eclectic failures. • Air Handling Units to prevent any failures in ventilation with a high risk of closing theatre 6, A&E and ICU • Medical Gas Plant to prevent all gas and air from becoming unavailable to all of HRI • Structural as we cannot drill any more large holes into HRI floors without a risk of creating the collapse of floors, and the need for an entire new building • Medical Air Plant to ensure the safe supply of medical air at the right pressure • Electrics upgrade of local distribution boards which without upgrade could fail and result in the closure of departments, wards and services due to lack of electricity supply • Plant room refurbishment to meet Health and Safety Executive requirements • Facet Survey to determine how the Trust meets condition B, a minimum requirement for adequate patient care • Ward upgrade programme to ensure all patients are cared for in adequate facilities • ICU nurse call and fixed life support equipment which could result in a unnecessary fatality in ICU if it fails • Deep clean of patient hoists, commodes, wheelchairs, on a regular basis to prevent infection of users and patients • Pathology Laboratory and Mortuary water supply at HRI to prevent the closure of these departments • Asbestos migration of asbestos dust in the service ducts will affect all maintenance to all wards and departments. • Relocating of learning and development centre, condition of the building below min standards • Electrical 3rd substation both power feeds to the hospital only 1 meter apart if one cable goes it will affect the other and only generator supply will be available for the hospital • BMS heating controls failure will result no control over heating or air condition throughout the hospital • Security result in the loss of fob access and unable to knockdown the hospital in areas. Structural Cladding - Loose Portland Stone creating a hazard	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required.	16 4 x 4	20 5 x 4	6 3 x 2	March 18 Update - The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The Capital Plan for 18/19 is now at the final stages of planning. April 18 Update - The 17/18 Capital plan has concluded within budget, the Risks embedded within this overarching risk still remain active. The 18/19 plan will progress the work already started on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient. May 18 Update - Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. The Capital Plan for 18/19 is now underway. Cash flow forecast and planning has commenced, schemes to ensure continuity are progressing, planning to replace ward flooring across HRI has also commenced.	Jun-2018	Feb-2019	RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies
Very High	6345	Corporate	Resourcing / Recruitment	Jul-2015	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16 4 x 4	20 4 x 5	9 3 x 3	May 2018 Applicants from the International recruitment trip to the Philippines are progressing (119 offers were made in country, since March 2017, with on-going training and tests underway), 7 Nurses have started with the Trust in 2018. Offers have been made for 20 Trainee Nurse Associate roles, a new training role which will support divisions with their nurse staffing supply in the future, all posts were filled and offers were made late April. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued and is progressing with offers during May 2018. Also recruiting to band 5 student nurse posts, advertised to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT (interviews in April 2018). Interest in these posts has been low. Divisions are interviewing for two Physician Associates (PAs) vacancies within Medicine for 2 additional PAs, following withdrawals by two candidates.	May-2018	Dec-2018	WF	Brendan Brown, Jason Eddleston	Rachael Pierce

Very High	6903	Estates & Facilities	Estates Department	Dec-2016	Keeping the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access and funding granted to estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. ICU - Air Handling Unit (AHU) - imminent failure due to end of useful life resulting in inadequate ventilation RESUS - Ventilation - potential danger to staff and patients from nitrous oxide due to the lack of background air changes resulting in harm . (The Trust has been advised by their external independent Authorising Engineer to install mechanical ventilation to the RESUS area to mitigate the risk.) RESUS – Electrical Resilience – lack of support infrastructure/ Medical IT i.e. UPS/IPS to ensure continuity of power supply in the event of a power outage resulting in harm to patients ICU & RESUS - Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access ICU & RESUS - Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions ICU & RESUS - Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections ICU & RESUS - Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases ICU - Building Fabric - infections & failure due to moisture ingress within the plaster/concrete within ICU resulting in poor environmental conditions. ICU - Nurse Call System - Current system now failed, operating on a temporary mobile system RESUS - Medical Engineering Risk - 4 Dameca Anaesthetic Machines - failure due to end of useful life resulting in unplanned disruptions/ harm to patients RESUS - Operational Safety – the current space within each bed bay does not meet the minimum required space for operational safety resulting in harm to patients and staff RESUS – Compliance / Statute Law – All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law resulting in prosecution	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU & RESUS, currently this is not achievable due to inadequate access and budget constraints.	20	5 x 4	20	5 x 4	0	0 x 0	April 18 Update - RECAP - The Trust has been advised by their external independent Authorising Engineer to install mechanical ventilation to the RESUS area, CHFT are aware of these non-conformities therefore Estates have now completed the paper looking at all possible mitigating actions and awaiting funding for the concluding mitigation. (full refurbishment) May 18 Update - Both HRI - RESUS and ICU continue to be monitored in terms of safety, the Thermostatic Mixing Valves (TMVs) that ensure safe water at point of delivery have now been replaced for new technology TMV3 Taps. Estates have the completed the paper looking at all possible mitigating actions and awaiting funding for the concluding mitigation. (full refurbishment)	Jun-2018	Dec-2018	RC	Lesley Hill / David McGarrigan	Chris Davies
Very High	7062	Trustwide	All Departments/Wards	Sep-2017	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2018/19 due to having insufficient cash to meet ongoing commitments resulting in a failure to maintain infrastructure for the organisation.	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.	Limited Contingency available. Uncertainty regarding long term capital planning while FBC is awaiting approval.	20	5 x 4	20	5 x 4	12	4 x 3	The risk in 2018/19 is likely to be much higher than in 2017/18 as internal generated funds will only support Capital expenditure of £7.6m, around half the amount committed for 2017/18. Internally generated funds from Depreciation (£11.93), are also required to cover the cost of repayments on the PFI (£1.61m) and Capital Loans (£2.76m), leaving only £7.56m available for Capital Expenditure. This is planned to be supplemented by: £0.7m planned spend on CRH energy efficient lighting, supported by an interest free Salix loan (£1.2m over 18/19 and 19/20); and £0.7m of PDC awarded (out of a total of £2m across 18/19 and 19/20) for the National Pathology Exchange (NPEX) project. A further £0.2m is assumed to be funded from donations. In the context of the Trust's ageing and ailing HRI estate; medical equipment requirements including MRI investment; and with a number of schemes being pushed back from 2017/18, the risk in 2018/19 is heightened. Emergency capital bids have been submitted for support in 18/19 for: HRI backlog maintenance, ED Resuscitation and ICU Refurbishment £4.9m (plus £4.8m 19/20); MRI scanner, Aseptic Unit and Gamma camera £3.4m (combined). These have not been included within the 18/19 plan as they have not yet been approved.	Jun-2018	Jun-2018	FPC	Gary Boothby	Philippa Russell

Very High	7078	Corporate	Resourcing / Recruitment	Oct-2017	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) "	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20	4 x 5	20	4 x 5	9	3 x 3	May 2018 Medical HR and Medical Education are working together to agree processes for the recruitment and placements of the new GP Trainee Employees. An action plan has been developed and meetings will be held with the GP Training Programme Directors to make the transition as smooth as possible. Job Planning training for Clinical Directors, General Managers and HRBPs will commence in late May/early June. This will comprise of a presentation by Dr Ian Wilson, Deputy Medical Director at Mid-Yorks, followed by system training for the job planning software provided by Allocate trainers. Holding all job plans centrally will improve our ability to map activity against demand and income, and will facilitate reporting for regulatory bodies and the Trust Board. FY3 interviews are scheduled for 12th June. There are a number of specialties working together to develop a programme of opportunities for candidates which include; A&E, Acute Medicine, CCU, Orthopaedic Surgery. It is hoped that by giving these opportunities we will be able to reduce the requirement for agency locum doctors.	Jun-2018	Jan-2019	WF	David Birkenhead	Pauline North
Very High	7049	Trustwide	All Deprtments/Wards	Aig-2017	Financial sustainability	EPR Financial risk with increased costs and decreased income.Due to: Reduction in activity arising from increased time per patient in Outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks.	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership, weekly Theatre scheduling now attended by an Executive. systems to capture activity. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training.	20	4 x 5	20	4 x 5	0	0 x 0	March Update Data quality meeting reviews data capture and system issues with Divisional, Finance and THIS representation. Divisional financial recovery plans to address activity maximisation. Additional costs incurred being monitored with approvals to be taken through Commercial Investment Strategy Group and monthly financial monitoring. Discussions have taken place with regulators, NHSI with regards to the financial pressure incurred as a result of EPR implementation in-year and the impact on achievement of control total. Negotiations with commissioners have settled a position for 2017/18 which is inclusive of an agreed estimate for income impacted by data capture issues, thus mitigating further risk. 2018/19 challenge to Divisions to regain productivity shortfalls. May update This risk is captured in the 2018/19 financial risk 7169 - closure agreed at Risk and Compliance April 2018	Mar-2018	Mar-2018	Gary Boothby	Gary Boothby	Kirsty Archer

High	6895	Corporate	Corporate Finance	Dec-2016	Keeping the base safe	Risk of Inability to fulfil core functions of the Finance and Procurement department, i.e. Internal and external financial reporting; business partnering with Divisional management teams; transactional functions of paying suppliers, raising invoices and placing orders for goods and services; cash management; adherence to procurement legislation. Due to IT Systems failure of financial ledger, fixed asset register, costing system or procurement systems. Resulting in failure to meet statutory deadlines; ensure good governance of the organisation with regard to the financial position and outlook; maintain cash flow to suppliers and staff; maintain supply of goods and services essential to operational performance and safety; comply with procurement legislation leading to legal challenge.	The majority of the Trust's key Finance and Procurement systems are outsourced to a third party and contractual arrangements exist for continuity of service and resilience. In case of failure, the department would revert to saved records and manual systems supported by generic Office software.	In December 2017, the Trust's key finance ledger system and procurement ordering system went through an upgrade with the existing supplier, North East Patches (NEP). The system changeover adversely affected functionality in a number of areas. Many of the initial issues have been resolved but the residual system issues cause potential operational risk to the Trust's ability to maintain supply of goods and services essential to operational performance and safety. The key issues are: - the slower speed of processing invoices for payment which has generated a backlog of outstanding invoices, compounded by the additional volume of queries into the department that this is generating - the lack of a system automated reminder to the requisitioners of goods within the Trust meaning that receipting is not being completed in a timely manner to allow for payment to be made - these issues are compounded by the Trust's ongoing challenges of cash availability meaning that payments are having to be prioritised (See Risk ref 6968)	8 4 x 2	16 4 x 4	8 4 x 2	Further action is being taken as follows: 1. Address additional short term resource requirements in Accounts Payable - additional resource in place supported off site by systems supplier NEP, local resource being prioritised from within wider finance team and additional temporary local resource to be in place from June. 2. Escalation of outstanding issues with system provider, NEP - including site visit and regular senior communication between parties 3. Systems optimisation project to create action plan including engagement and communications roll out - detailed action plan with sub projects, key milestones and KPIs. Fortnightly meeting to ensure oversight. 4. Continued focus on cash management actions through cash committee and divisional cascade	Jun-2018	Jul-2018	FC	Gary Boothby	Kirsty Archer
High	7046	Trustwide	All Departments/Wards	Aug-2017	Keeping the base safe	EPR Clinical risk of patients receiving delayed access to care due to migration issues which placed incorrect location codes to activity, access issues for several members of staff resulting in delays. RTT build issue which does not place patients correctly onto the pathway. Electronic Discharge summary process not adhered to resulting in delayed information to GP. Lack of understanding on use of 'Encounters' leading to activity being connected with the incorrect episode. A 45 day purge of all activity within the Message Centre including correspondence unknown to users resulting in delayed distribution of correspondence. Reductions in outpatient activity & issues with appointment correspondence delaying access to review. Lack of familiarity with the system leading to an increased potential for clinical risk	Remedy on Demand for escalation of all system related issues for resolution. Stabilisation plan. Issues log populated by specialties, clinical and non-clinical staff to ensure all issues, risk, concerns were known and prioritised. All Divisions have own risk register and included in PSQB & Digital Modernisation Boards; high risks and risk changes reviewed at PRMs. Two weekly Operations Board with clear process for escalation. Datix reporting encouraged and all Red Datix received by Medical Director, Chief Nurse & Chief Operating Officer. Clinical Risk Panel established and Stabilisation plan in place SWAT team deployed to undertake Deep Dives/RCAs. DT meeting undertaken as required Visible leadership and feedback. Manual workarounds. Targeted support and training. On going training requirements identified and developed. Additional expert support deployed for Junior Doctor Change. Training & Access process for new and agency staff agreed. Access rights provided for all staff to undertake role as delivered pre-EPR	Response of external partner slow leading to delayed resolution. BAU team capacity & focus on BTHFT readiness Thematic review of incidents complaints, PALs etc. Adequate system build Training Review of access right. Robust audit of end to end pathways and documentation.	16 4 x 4	16 4 x 4	0 0 x 0	May 2018 update This risk was an overacrching risk covering the EPR system implementation. At EPR Risk Panel in April 2018 it was agreed that the individual elements of this risk were captured elsewhere and individual entries in the risk register and appropriately scored or had been resolved. The EPR Risk Panel therefore agreed to close this risk Closure agreed at Risk and Compliance group April 2018	Dec-2017	Mar-2018	QC	David Birkenhead	Alistair Morris

High	7132	Medical	Accident & Emergency	Nov-2017	Keeping the base safe	The Trust EPR system whilst having the facility to record NEWS and PAWS assessments, it does not have the facility to calculate the score. This has therefore become a manual process and is prone to human error and can be missed. The previous IT system automatically calculated and recorded the score. There is a risk to patient safety due to EPR system not automatically calculating and recording the score. This provides the potential for non recording, miscalculation and non detection of deterioration of patients.	PAWS and NEWS assessments are able to be recorded in EPR, however, it is not easily identifiable where on the EPR front screen and calculation is manual. All staff have been made aware of the change and a SOP and training has been provided to mitigate/reduce the risk	Clinical staff not routinely looking at PAWS and NEWS and relying on individual judgement of vital signs recorded.	16 4 x 4	16 4 x 4	2 1 x 2	Immediate mitigation: All staff informed to document PAWS and NEWS as a clinical note with PAWS and NEWS in the title and laminated charts put up in the cubicles in the department. Regular documentation spot checks by lead nurses. Medical staff to evidence use of early warning scores in their clinical decision making. Issue escalated to A Morris and J Murphy to establish if PAWS and NEWS can be on the front page of the ED clinical summary. March 2018 Update Still awaiting update from digital board. Mitigations still in place as above April 2018 Update: Still awaiting update from digital board and also awaiting to see how Bradford are mitigating risk. Mitigation still in place as above. May 2018 Update: Mitigation still in place. Audits in place re: compliance of staff calculating news. Talks on going with nervecenter to ascertain whether we can filter by area in ED and not have all patients on.	Jun-2018	Jul-2018	PSQB	David Birkenhead	Louise Croxall
High	6300	Corporate	Governance and Risk Quality	May-2015	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services. Additionally the CQC has announced a programme of Well Led Inspections which the Trust will be subjected to prior to Autumn 2018 ,there is a risk that we may not meet the required standard resulting in a judgement of "requires improvement".	Follow Up Inspection Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection Action plans progressed for all must and should do actions Separate action plans in place for each core service Reports to the Trust Board on those core services requiring improvement CQC compliance reported in Divisional Board reports to the Quality Committee Mock inspections for core services System for regular assessment of Divisional and Corporate compliance Routine policies and procedures Quality Governance Assurance structure The Risk and Compliance Group has oversight of areas outstanding actions not completed Well Led Inspection A mock PIR for the Well Led domain is taking place to identify further areas for improvement Each division is restarting CQC groups to oversee pre inspection activity A Trust wide CQC Group started meeting in September 2017	The March 16 inspection report placed us in the has shown us to be in the "requires improvement" category. We do not know the date of the next inspection We do not know when core service inspections will take place as these are unannounced visits	16 4 x 4	16 4 x 4	8 4 x 2	March 2018 - working with NHSI to provide information required ahead of the assessment. Unannounced inspections in Maternity, Paediatrics, Critical Care and Emergency Department early March as expected ahead of the planned well led inspection 3rd – 5th April. Further unannounced inspections may take place ahead of this. April 2018 The on site inspection has concluded, data is still being requested by the CQC and we are concluding the last set of data submissions. Actions have been taken in response to some concerns raised at the time and these are being overseen by the CQC Response Group and the Quality Committee. We are expecting the report in June/July. We continue to be in correspondence with the CQC both in concluding the inspection and as part of our usual relationship contacts. May 2018 We have submitted all the data requested to date but may still receive a small number of requests. We continue to develop the action plan and we have reported progress to the Quality Committee. Actions continue to be undertaken in key risk areas.	May-2018	Jul-2018	WEB	Brendan Brown	Juliette Cosgrove

High	6596	Corporate	Governance and Risk Quality	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning - Investigation Pack and plan for each SI investigation, with initial and midpoint meetings with Risk to monitor progress	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors.	16 4 x 4	16 4 x 4	8 4 x 2	March 2018 Learning page (Sharing Learning - Improving Care) transferred to new intranet and promoted via screen saver. Learning newsletter issues - Focus in Infection Prevention including learning from serious incident (safe storage of food) and post infection reviews. Investigation pack awaiting sign off. Winter pressures impacting on timeliness of investigation reports. April 2018 Investigation pack now signed off and being used for new investigations. Paper presented to CCG detailing completed and ongoing actions in response to analysis paper on delayed diagnosis incidents. Investigators training session held in March 2018. May 2018 Further training session on 8th May. New half day introduction to RCA course set up with fully booked first day to run in June 2018.	Jun-2018	Sep-2018	QC	Director of Nursing, Brendan Brown	Angie Legge
High	5862	Medical	All Departments/Wards Medical	Aug-2013	Keeping the base safe	We have a in-patient falls risk due to a number of care planning issues that could be enhanced: patient risk assessments not being completed to support clinical judgements made, failure to use preventative equipment appropriately, low levels of staff training, failure to implement preventative care, limited amount of falls prevention equipment, ward environmental factors, on occasion staffing levels below workforce model exacerbated by increased acuity and dependency of patients. These issues are resulting in a high number of falls incidents, falls with harm, poor patient experience and increased length of hospital stay.	Safety Huddles Falls bundles Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment	Insufficient uptake of education and training of nursing staff, particularly in equipment. On occasion staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	March 2018 Challenges as additional wards open to manage demand on both sites. Ward assurance tool to be used consistently to audit falls assessment and interventions for centralised compliance and actions for individual ward. Increase in number of falls in month n=182. Harm falls n=3 April 2018 Work on Falls improvement continues as per Action Plan. Some extra capacity wards being closed during April. Results of National Audit of Inpatient Falls audit report 2017is now available,with CHFT practice below 50% compliance in the target interventions of visual screening, lying and standing blood pressure, access to mobility aids and medication review. These will influence further improvement work through the Collaborative work.	May-2018	Jul-2018	PSQB	Brendan Brown	Janette Cockroft

High	7223	Corporate	THIS -Operational	Mar-2018	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets, Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 4 x 4	16 4 x 4	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete). April Update: Trend rollout (AV & Encryption) still due to complete at the end of April 18 for CHFT. No further update. May: No further update	Jun-2018	Sep-2018	RC	Mandy Griffin	Rob Birkett
High	7248	Corporate	Workforce Development	Apr-2018	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts. Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our 9 mandatory training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised.	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16 4 x 4	16 4 x 4	4 4 x 1	April 2018: To assist compliance with Moving and Handling Level 2 additional resources are being sought as the Trusts' current capacity is unable to deliver compliance. A Line Manager Bulletin is being issued this month with information for managers about mandatory training. Compliance rates are being monitored and shared with HRBPs. WEB has confirmed the mandatory training compliance should remain at 95% and that Infection Control training should remain annual rather than be amended to every 2 years. A rebranding of 'mandatory training' to 'essential safety training' is proposed o reposition the message about the value of this training.	Jul-2018	Mar-2019	WF	Suzanne Dunkley	Ruth Mason

High	6011	Family & Specialist Services	Blood sciences	May-2014	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust).	Lack of electronic systems Lack of duplicate sampling Training compliance not at 100%	15 5 x 3	15 5 x 3	3 3 x 1	March 2018 Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB) April 2018 Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB) May 2018 Progress has been made and the Trust has agreed to implement the hand held PDA devices. Training will progress shortly in preparation of a roll out training scheme for the whole Trust At present the project is on target. (HLB)	Jun-2018	Mar-2019	PSQB	Julie O'Riordan	Sarah Ramsden
High	5747	Family & Specialist Services	Angiography & Fluoroscopy	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of failing to provide an interventional vascular service due to challenges recruiting substantively to vacant posts at consultant interventional radiologist level resulting in our inability to meet the 6 week referral to treatment target; inability to deliver an appropriate service at CHFT and our inability to provide hot week cover on alternate in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant Part-time short term Locums supporting the service	Failure to appoint to vacant post substantively due to limited availability. Failure to secure long term locum support.	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to seek long term locum cover; 2. Continue to try to recruit to the vacant post; 3. Progressing a regional approach to attract candidates to work regionally; 4. Progressing approach to further contingency using regional-wide approach. February & March 2018 update: Full time locum in place for next 6 weeks; in discussion with neighbouring Trusts to consider long term solution. April 2018 - update : locum in place until 18th May, continuing to pursue full time locum. No support available form neighbouring Trusts. May 2018 Update: Locum secured from 25 May to 1 June 2018. A further fill-in Locum booked for 23 July to 12 October 2018. Continue to pursue Locum cover for gaps in the rota. Still no support available from neighbouring Trusts.	Jun-2018	Sep-2018	DB	Rob Aitchison	Sarah Clenton
High	6715	Corporate	Workforce and Clinical Development	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs.	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy / Alistair Morris, via back office team, December 2018 Establish a joint CHFT / BTHFT clinical documentation group.- lead Jackie Murphy and Alistair Morris timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. The CCIO and CCINO are both leaving their posts which will be advertised	20 4 x 5	15 3 x 5	6 3 x 2	April 2018 The clinical documentation group will meet this month. May 2018 The clinical records group has met and agreed terms of reference. Improved divisional/ clinical representation is necessary. The ward assurance process continues. Cerner have undertaken a site visit; a report should be made available that will support adoption and optimisation.	Aug-2018	Aug-2018	WEB	Brendan Brown	Jackie Murphy

High	6949	Family & Specialist Services	Blood sciences	Mar-2017	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas. 2. Staff rotas changed to a block pattern for night shifts. 3. All substantive vacancies are being advertised and gaps backfilled with locum staffing. 4. Staff development plan in place for training Biomedical Scientists 5. Existing business continuity plan in place	1 & 2. Substantive Biomedical Scientists are working additional shifts on a voluntary basis with no obligation to provide cover and over a sustained period of time with no imminent resolution. 3. Delay in recruiting locums due to impact of Flexible workforce procedures. 4. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments. 5. Business continuity plan has not had a recent test with relevant stakeholders. 6. Failure to understand the reason why CHFT are not an employer of choice for Blood Transfusion/Haematology Biomedical Scientists.	10 5 x 2	15 5 x 3	5 5 x 1	April 2018 Bench top exercise undertaken on 23rd March to test Business Continuity Plan May 2018 The feedback report has been received from the Transfusion BCP desktop. This is still under review in the department with an aim to determine next steps in further testing the plan. DR Boyd has been raising awareness at senior management level over the risk to the transfusion rota. Transfusion staff are recording incidents of near miss invocations of the plan – incidents are currently low in number and the situation is being monitored. Transfusion training of new employees is progressing.	Jun-2018	Dec-2018	DB	Rob Aitchison	Hayley Baker
High	7134	Corporate	Governance and Risk Quality	Nov-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2018/19 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	Awareness and new controls for ward areas Sepsis nurse in post Divisional plan, leads identified -improvement action plan in place -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues Information on patients not receiving the sepsis bundle in a timely manner. Clarity on use of EPR prompts required	16 4 x 4	16 4 x 4	4 4 x 1	April 2018 Some assurance that actions are being taken following triggers for sepsis in EPR. Improvement work continues with sepsis collaborative, focussing on the timeliness of response to patients with sepsis.. New policy has been drafted and will be reviewed by WEB during April 2018. .	May-2018	Jun-2018	DB	David Birkenhead	Rob Moisey

Extreme + Major Risks = 21

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th June 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - JUNE 2018 - BOARD WORKPLAN - The Board work plan has been updated and is presented to the Board for review at (Appendix 1). The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and APPROVE the work plan.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Last updated at Board of Directors Meeting in March 2018	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board work plan has been updated and is presented to the Board for review at (Appendix 1). The Board is asked to consider whether there are any other items they would like to add for the forthcoming year .

Main Body

Purpose:

The Board work plan has been updated and is presented to the Board for review at (Appendix 1).

Background/Overview:

Please see attached

The Issue:

The Board is asked to consider whether there are any other items they would like to add for the forthcoming year.

Next Steps:

Please see attached

Recommendations:

The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and APPROVE the work plan.

Appendix

Attachment:

Annual Workplan 2018-2019 - WORKING DOC.pdf

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
Date of agenda setting/Feedback to Execs	20.3.18	16.4.18	21.5.18	18.6.18	16.7.18	20.8.18	17.9.18	15.10.18	19.11.18			
Date final reports required	28.3.18	25.4.18	30.5.18	27.6.18	25.7.18	29.8.18	26.9.19	24.10.18	28.11.18			
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-	✓	-	-	✓	-	-	✓	-
DIPC report	-	✓	-	-	✓	-	-	✓	-	-	✓	-
High Level Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Care of the acutely ill patient report				TBC			TBC			TBC		
Learning from Deaths – Quarterly Report			✓			✓			✓Q3			✓
Patient Survey				✓								✓
Quarterly Quality Slide Report + Presentation focussed on one topic (may be used as patient/staff story) (NB – Quality Account in Annual Report)		Quality A/cs		✓		✓			✓			✓
Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD)	✓			✓			✓					✓

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
Nursing and Midwifery Staffing – Hard Truths Requirement		✓						✓				
Safeguarding update – Adults & Children		✓ Annual report							✓			
Review of progress against strategy (Qly)						✓			✓			
Plan on a Page Strategy Update			✓									
Quality Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Audit and Risk Committee update & mins		✓	✓		✓			✓		✓	✓	
F&P Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes				✓		✓			✓			✓
Performance Management Framework – update on work from sub-committee workplans		✓										
Guardian of Safe Working Quarterly Report (? Anu Rajgopal to attend if avail – dates tbc)	✓			✓				✓				✓
Governance report: to include such items as:												
- Standing Orders/SFIs/SOD review								✓				
- Non-Executive appointments (+ Nov - SINED & Deputy)								✓				
- Board workplan			✓			✓			✓			✓
- Board skills / competency									✓			
- ~~Code of Governance~~ (to ARC Cttee)	✓											
- Board meeting dates				✓								
- Committee review and annual report												✓
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Declaration of Interests - BOD (annually)												✓

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
- Attendance Register (Apr+Oct 2018)	✓						✓					
- BOD TOR												✓
- Sub Committees Report and TOR		✓										
- Constitutional changes (+as required)								✓				
- Compliance with Licence Conditions (April 2018)	✓											
- Board to Ward Visits Feedback				✓				✓				✓
ANNUAL ITEMS												
Annual Plan	✓											
Annual Plan feedback from Monitor						✓						
Annual report and accounts (private)		✓ EO meeting										
Annual Quality Accounts		✓ EO										
Annual Governance Statement		✓ EO										
Appointment of Deputy Chair / SINED								✓				
Board Development Plan					✓						✓	
Emergency Planning annual report						✓						
Fit and Proper Person Self-Declaration Register	✓											
HPS Annual Report		✓										
HPS Business Plan											✓	
Health and Safety annual report			✓					✓ (update)				
Capital Programme												✓
Equality & Inclusion				✓ (update)						✓(AR)		
DIPC annual report (ALSO SEE REGULAR ITEMS)				✓								

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
Fire Safety annual report						✓						
Medical revalidation & appraisal					✓							
Whistleblowing Annual Report											✓	
Review of Board Sub Committee TOR												✓
Risk Appetite Statement								✓				
Winter Plan						✓			✓			
ONE-OFF ITEMS												
Council of Governors Elections				✓ (results)							✓ (timetable)	
Hospital Pharmacy Transformation Plan (AB)												
Risk Management Strategy										✓		
Workforce Strategy											✓	
LHRP Core Standards (LH/Ian Kilroy)							✓					
Performance management update								✓				
Update on OD and CLIP									✓			
Update on EPR Stabilisation			✓									
Digital Health Agenda			✓									

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
STANDING PRIVATE AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Private minutes of sub-committees – as req'd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the WYAAT meeting							✓		✓			✓
ADDITIONAL PRIVATE ITEMS												
Reforecast financial plan							✓					
Contract update										✓	✓	✓
Board development plan	✓											
Feedback from Board development workshop			✓	✓		✓		✓				
A&E Delivery Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Property Partnership/St Luke's Hospital/PR (as required)												
Equality and Diversity		✓										
Sustainability and Transformation Plan									✓ (update)			
Private Finance and Performance Committee Minutes (private – as appropriate)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee in Common – Programme Directors' Report	✓		✓		✓		✓		✓		✓	
Minutes from Estates Sustainability Committee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th June 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: STRATEGY ON A PAGE 2018-2019 - The Board is asked to approve the Strategy on a Page 2018-2019	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors meeting 03.05.18 Board of Directors and Council of Governors workshop 25.05.18	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The

Main Body

Purpose:

The Board is asked to approve the Strategy on a Page 2018-2019

Background/Overview:

During 2017/18 the Board has received quarterly updates on the progress made against the objectives described in the plan and at its meeting in April received the end of year position. This showed that good progress had been made against all areas of the plan; nine had been fully completed and three required further work.

The Issue:

Please see attached

Next Steps:

The one year view for 2018/19 has been drafted building on this position. This was developed in a workshop with the Governors on 25 May 2018. Once approved by the Board it will be shared across the Trust and presented at the Council of Governors' meeting in July. A revised Board Assurance Framework and reviewed high level risk register will be developed based on the agreed objectives and presented to the Board in July.

Recommendations:

The Board is asked to approve the Strategy on a Page 2018-2019

Appendix

Attachment:

5 Year and 1 Year Plan 2018.19 updated following workshop.pdf

5 Year Strategy on a Page and objectives year ending March 2019

5 Year Strategy on a Page

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	Financial sustainability
Our response	Our patients and the public will be involved in their treatment and we will use their feedback to develop services for the future	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape and size with the capability and capacity to deliver safe, high quality services	We will have implemented the five year plan
	We will have commenced implementation of an agreed reconfiguration of integrated hospital and community services	We will be compliant with NHS Improvement standards	We will be widely recognised as an employer of choice through growing our own and attracting talented people to join our team	We will be financially sustainable with the ability to invest for the future
	We will meet all relevant 7 day working standards and our SHMI will be 100 or less	We will consistently achieve all national and local patient performance targets	Engaging our people and involving them in decisions that affect the Trust will be the norm	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust interoperable electronic patient record which is used by patients and clinicians alike	We will be fully compliant with health and safety standards		

compassionate care

Objectives for the Year Ending 2019

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	Financial sustainability
Our response	Achieve a regulatory approved proposal for the reconfiguration of hospital and care closer to home services that puts the patient at the centre of care	Deliver a Single Oversight Framework rating of 2 for the agreed quality and operational performance metrics	Achieve a retention rate of 90% and reduce vacancies by 10% to address recruitment and retention of key roles in CHFT	Deliver a regulatory compliant financial plan for 2018/19 including CIP
	Deliver all GIRFT actions in selected pathways of care to reduce variation and deliver agreed out comes	Achieve a BRAG rating of blue for all actions resulting from the findings of the CQC and Use of Resources inspection	Baseline assess staff and patient equality & diversity experience and develop a plan of action to improve	Develop a regulatory and Integrated Care System compliant capital plan to meet the organisation's requirements
	Continue to meet 7 day NHS England standards (2,5,6 and 8) in agreed specialties	Launch the Quality Improvement Strategy and deliver the 18/19 agreed quality KPIs (including the 3 selected by the Council of Governors see separate page).	Create a health & wellbeing strategy to achieve 96% attendance and improve our overall engagement score	Maintain a Single Oversight Framework rating of 3 or better for financial and Use of Resources performance metrics
	Implement the agreed digital health next step proposal whilst deploying the technical infrastructure to create a shared care record across local health and social care community in Calderdale	Implement year 3 of the health & safety action plan; with specific focus on ensuring each service has tested their business continuity plan, has a COSHH super user (where required) and identified staff have completed risk assessment training	Create an OD Strategy to co-ordinate all workforce activities and develop an action plan to achieve our workforce key performance indicators and improve our overall engagement score	Progress key WYAAT work streams and capital bids including vascular; pharmacy; imaging; pathology; wholly owned subsidiary and elective procedures.
	Implement robust plans to improve patient flow and length of stay and reduce the bed base	Develop & ensure delivery of the KPIs for the WOS to provide a safe environment that is efficient and supports effective patient care		

A Framework for Quality Improvement 2018-19

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** amber fox, PA to Director of THIS
Date: Thursday, 7th June 2018	**Sponsoring Director:** Mandy.griffin, Director of THIS
Title and brief summary: GDPR Update - See Executive Summary	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

This report provides an update to the Board of Directors on compliance of the GDPR. The GDPR was approved in 2016 and has become directly applicable as law in the UK on 25 May 2018. The now current Data Protection Act 2018 (DPA18), fills in the gaps of the GDPR, addressing areas in which flexibility and derogations are permitted. Achievement of compliance with the regulation is overseen by the Data Protection Officer.

A key provision of the GDPR is the principle of 'accountability'. Organisations (data Controllers) must be able to demonstrate compliance with the GDPR principles and in particular that they have appropriate technical and organisational measures in place. For the Organisation, the principle demonstrations of compliance are:

• IGTK Level 2 with some areas achieving level 3
• Extensive existing policies and procedures associated with IG which are currently being updated to reflect specific requirements of GDPR
• Significant review of the Information Asset Register
• Changes to the legal basis for the processing of information
• Changes to the way consent is being requested - Requirement to notify the ICO of breaches within 72 hours
• increased fines for failure to comply
• Updated fair processing notices
• Introduction of a Data Protection Officer (DPO)
• Changes to individuals rights over data held about them
• Changes to timescales for SARs etc
• Organisations must be able to evidence compliance in all areas of GDPR

The Organisation has significant areas of work and continued development to ensure that systems and processes are in place to meet the GDPR requirements as well as communicating what it means for staff and patients.

However this is covered within the GDPR action plan (appendix 1). Overall the Board of Directors should feel assured that the organisation has a significant assurance regarding compliance to the regulations.

Main Body

Purpose:

This report provides an update to the Board of Directors on progress with compliance for the GDPR. The GDPR was approved in 2016 and has become directly applicable as law in the UK on 25 May 2018. The now current Data Protection Act 2018 (DPA18) fills in the gaps of the GDPR, addressing areas in which flexibility and derogations are permitted. Achievement of compliance with the regulation is overseen by the Data Protection Committee.

It is important to note that the GDPR is an evolution of the Data Protection Act 1998 (which the Organisation already complies with) and is aimed at raising IG standards within all industries across the EU. The Organisation has maintained high levels of IG for many years with assurance provided through the achievement of Level 2 compliance with the IG Toolkit (IGTK). The journey to GDPR compliance is therefore evolutionary rather than revolutionary as it is in some other sectors. However, the Information Commissioners Officer (ICO), as the regulator, can impose high penalties for non-compliance of up to €20m for serious breaches.

Background/Overview:

Compliance

A key provision of the GDPR is the principle of 'accountability'. Organisations (data controllers) must be able to demonstrate compliance with the GDPR principles and in particular that they have appropriate technical and organisational measures in place. For the Organisation, the principle demonstrations of compliance are:

• IGTK Level 2 with some areas achieving level 3
• Extensive existing policies and procedures associated with IG which are currently being updated to reflect specific requirements of GDPR
• Significant review of the Information Asset Register

Other key elements of GDPR which have been clarified recently are:

Consent

The issue of consent has caused significant confusion when discussing GDPR in many sectors. Many interpretations were that, as the rules for gaining consent were being tightened by GDPR, then measures would have to be put in place to more explicitly gain patient consent when processing their data. This is only the case where consent is used as the legal basis for data processing, however most healthcare organisations including the
Spectrum expects to use the following:

For processing 'Personal data':

– Article 6(1)(e) – Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller
For processing 'Special category data':
– Article 9(2)(h) – Processing is necessary for the purposes of preventative or occupational medicine, for assessing the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or management of health or social care systems and services on the basis of Union or Member State law or a contract with a health professional

Breach Notification

The organisation is required to report data breaches to the ICO within 72 hours of becoming aware of it. The organisation already has processes in place to deal with data breaches.

Right to Access

The organisation already provides access to copies of Health Records where requested by patients/ other authorised parties. The current charge is up to £50 per record but GDPR requires it to be free which will place a cost pressure on the organisation. Additionally the timeframe for record access is being reduced from 40 days to 30. There is a risk that there may be a surge in applications for records access from 25 May 2018 which may be difficult to meet.

Right to be Forgotten

This element was previously a concern as it was not clear how this could be managed for health records. Recent guidance has confirmed that this is not applicable where the legal basis for processing is Article 9(2)(h) – 'Processing is necessary for …, the provision of health or social care or treatment..' which will be the case in the organisation.

Data Portability

This was another area of concern due to the lack of clear standards for exchange of health records electronically between organisations. This has now also been clarified as only being applicable where the legal basis is consent and the processing is automated which will not be applicable within the organisation.

Privacy by Design

The organisation executes existing processes to include Data Protection Impact Assessments in the design/ procurement of new systems. These processes are being reviewed but are not expected to change significantly.

Data Protection Officer

The role of Data Protection Officer (DPO) has been filled in house by Helen McNae (was IG and RA Manager)

The organisations GDPR action plan shows the organisations position and identified a number of areas for concern with most associated with a lack of national guidance on key issues. In mid-February 2018, further national guidance was released by the Information Governance Alliance (IGA4) which clarified a number of key points. The action plan has been updated accordingly with clearer ownership assigned.

The Issue:

N/A

Next Steps:

Whilst there is no real concern at this stage that the organisation is not meeting its requirements under the new regulations there is a moderate risk that the consequences of non-compliance would be a breach in our statutory duty with the risk of enforcement action and monetary penalties. Therefore the risk of non-compliance is included on the Organisations Risk Register to ensure monitoring of progress against the action plan.

Recommendations:

The Board is invited to receive and note the new Data Protection requirements and the management actions being taken for compliance to the General Data Protection Regulation.

Appendix

Attachment:

There is no PDF document attached to the paper.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Alison Wilson, Head of Compliance & Support Services
Date: Thursday, 7th June 2018	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Annual Health & Safety Report - Report provides an overview of the previous 12 months health & safety performance along with the areas for improvement over the next year	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Annual Health & Safety Report was shared at CHFT's Health & Safety Committee on Weds 16th May 2018. The Committee approved the content of the report and the action plan.	
Governance Requirements: The report provides health and safety performance for Calderdale and Huddersfield NHS Foundation Trust and is aligned to the Trusts 1 year and 5 year strategy to support the organisation "keep the base safe". A 6 monthly update is delivered to the Health and Safety Committee detailing progress on the annual health and safety development plan	
Sustainability Implications: None	

Executive Summary

Summary:

The Health and Safety at Work Act 1974 (H&SAWA) provides the legal framework for health and safety and aims to protect employees, contractors and the public from the risks associated with Trust activities. The act, and its supporting regulations, place responsibilities on the Trust Board and its employees to identify, manage and reduce health and safety related risks.

The 2017-2018 Health and Safety Report provides a retrospective review of the previous year and a summary of developments planned for the following 12 months. The report provides health and safety performance for Calderdale and Huddersfield NHS Foundation Trust and is aligned to the Trusts 1 year and 5 year strategy.

Main Body

Purpose:

The report relates to Health & Safety and staff related incidents over the last 12 month period. It provides CHFT Trust board an overview of the annual health and safety performance and details an action plan for attention during 2018/2019.

Positive progress has been made within CHFT over the last 12 months and it is important we continue to strive and build on our achievements going forward,

Background/Overview:

The Health and Safety at Work Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.
In particular it requires organisations to provide and maintain:
a. A Health and Safety Policy;
b. A system to manage and control risks in connection with the use, handling storage and transport of articles and substances;
c. A safe and secure working environment, including provision and maintenance of access to and egress from premises;
d. Safe and suitable plant, work equipment and systems of work that are without risks;
e. Information, instruction, training and supervision as is necessary;
f. Adequate welfare facilities.

The legislation is enforced by the Health and Safety Executive (HSE) who have far reaching powers to ensure health and safety in organisations.

Under the NHS Constitution staff have extensive legal rights which incorporates the rights for staff to have healthy and safe working conditions.

The Issue:

The challenge is to ensure we continue to make good progress against our Annual Action Plan which, in turn, provides a positive healthy and safe working environment for colleagues, patients and visitors.

Next Steps:

Next steps are captured in the annual action plan which will be report at 6 monthly intervals to the Health & Safety Committee.

The Board is asked to approve the annual report and action plan.

Appendix

Attachment:

CHFT Annual Health & Safety Report 2017-2018.pdf

Calderdale and Huddersfield NHS Foundation Trust

Health & Safety Annual Report
1st April 2017 – 31st March 2018

1. INTRODUCTION

The 2017-2018 Health and Safety Report provides a retrospective review of Calderdale and Huddersfield NHS Foundation Trusts (CHFT) annual performance and a summary of actions planned for the following 12 months which are aligned to the Trusts 1 year and 5 year strategy. A six monthly update is submitted to the Health and Safety Committee detailing progress on the health and safety action plan.

2. BACKGROUND

The Health and Safety at Work Act 1974 (H&SAWA) provides the legal framework for health and safety and aims to protect employees, patients, contractors and the public from the risks associated with Trust activities. The act, and its supporting regulations, place responsibilities on the Trust Board and its employees to identify, manage and reduce health and safety related risks.

3. REPORT

3.1 Policies

The Trust's Health and Safety Policy was approved by the Trust Board in December 2016 which provides an overarching framework. The policy will be reviewed in Quarter 3 2018 ensuring engagement from the Health and Safety Committee and will be signed off by Trust board in December 2018. The Policy will take account of the Wholly Owned Subsidiary (WOS) arrangements ensuring clarity is provided on roles and responsibilities from within the Trust and the WOS.

3.2 Risk Assessments

The Management of Health and Safety at Work Regulations 1999 place a requirement on organisations to undertake suitable and sufficient risk assessments to identify significant risks to the health, safety and welfare of employees and anyone that may be affected by their activities. Specific risk assessments are completed for Fire Safety, Moving and Handling, Estates Engineering tasks and substances that may be hazardous to health. Risk assessment training has been agreed by the Trust's Executive Board as a priority and, in order to manage the significant training demand placed on Trust colleagues, has been developed as a byte sized interactive training of 1 hour sessions which will be delivered across the Trust by the Health and Safety Advisor.

3.3 Incidents reported via The Reporting of Incidents Injuries and Dangerous Occurrence Regulations (2013) (RIDDOR)

RIDDOR places a legal requirement on employers, and others in control of work premises, to report, investigate and maintain records for certain types of injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE). These are classed as work related incidents and fall under the following categories:-

- Work-related accidents which cause death
- Work-related accidents which cause certain serious injuries ('specified injuries') or result in employees being away from work for more than 7 days
- Diagnosis of certain industrial diseases
- Dangerous occurrences (incidents with the potential to cause harm)

During the reporting period a total of 12 staff RIDDOR incidents were reported to the HSE. However, given the size of the organisation more work is required to ensure RIDDOR incidents are being reported accurately through the Datix system, Occupational Health and Managers.

A breakdown of the causes of these incidents is illustrated in table 1 with 2016/17 comparator of the previous year.

Table 1 – STAFF RIDDOR INCIDENT CAUSES

	2016/2017	2017/2018
Slips, trips, falls and collisions	7	8
Lifting accidents	3	2
Abuse on Staff by patients	2	0
Accident caused by some other means	4	2
TOTAL	16	12

Whilst table 1 illustrates a 25% reduction in RIDDOR incidents there are concerns over the accuracy of reporting. As such, there is a requirement to provide Managers with information explaining what are classed as RIDDOR incidents.

Slips, trips and fall incidents continue to remain the main cause of the majority of RIDDOR incidents with an increase of 1.

Table 2 illustrates the type of RIDDOR incidents reported to the HSE.

Table 2 – RIDDOR INCIDENT INJURIES

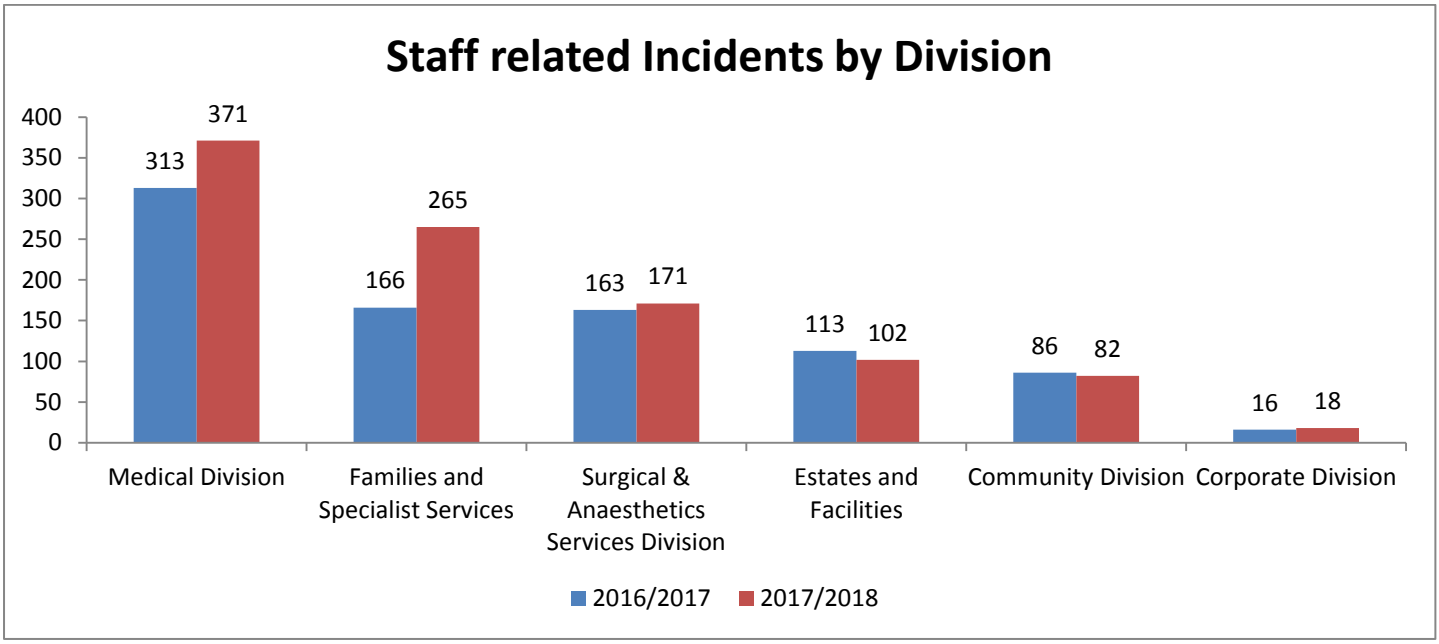
Type of RIDDOR Incident	2017/2018	Injury cause
Specified injuries	4	Slips, trips or falls (2 x fractures) Lost consciousness (1) Burns (1)
Injuries causing over 7 days absence	8	Slips, trips or falls (6) Lifting Patient (1) Other Accidental Injury (1)

3.4 Staff Related Incidents Reported on Datix

Incident reporting has been promoted in 2017/2018 by raising awareness of Datix reporting which has been highlighted at Corporate Induction events and HCA/Apprentices induction.

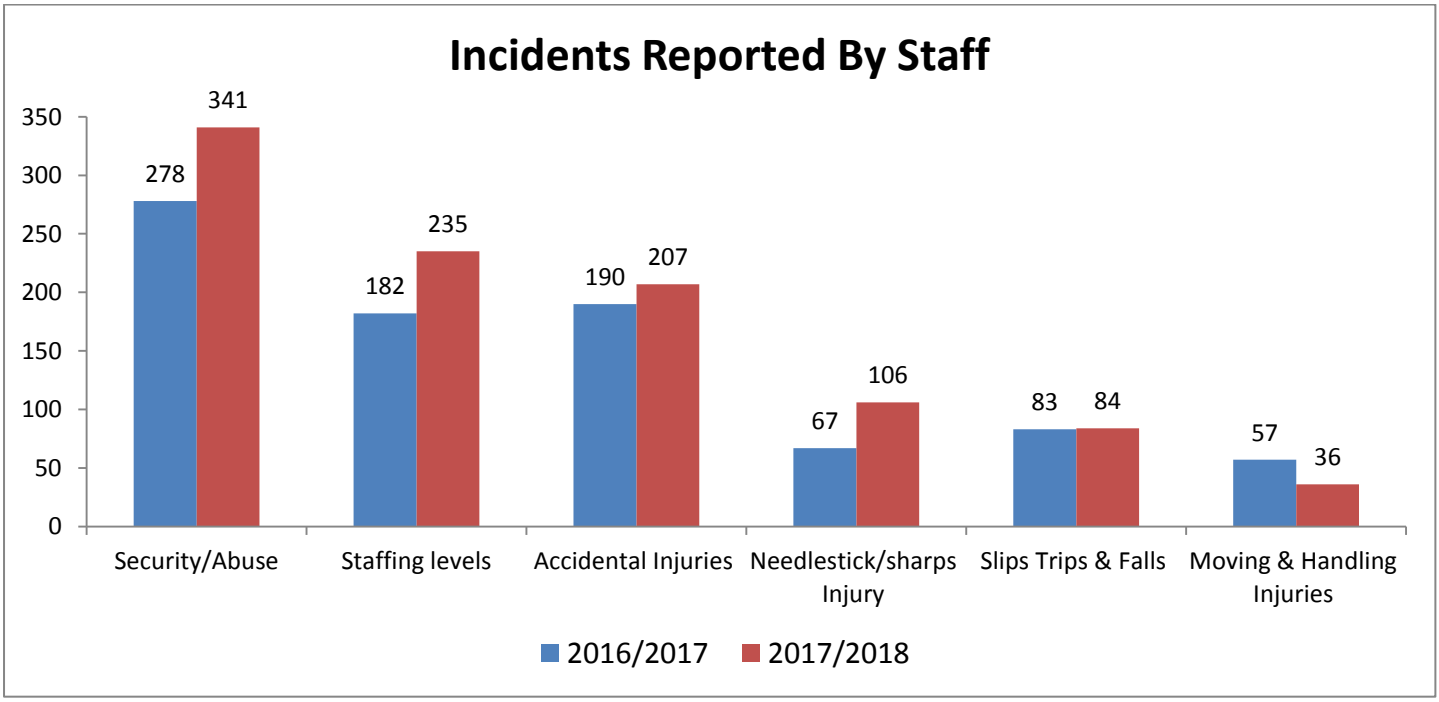
A total of 1009 staff incidents were reported in 2017/18 which is an increase of 18% in 2016/2017 total, which is believed to be due to improved reporting. Table 3 illustrates the number of incidents by Division and whilst there are increases Divisions should be commended for improving reporting.

Table 3 TOTAL NUMBER OF INCIDENTS BY DIVISION



The main incidents indentified / sustained by staff in 2017/2018 are outlined in Table 4:

Table 4 INCIDENTS REPORTED BY STAFF



- **Security / Theft / Abuse & Violence** shows a 23% increase in reporting in 2017/2018 and is the highest type of incident reported. Significant effort was implemented during the year with support from Leeds Teaching Hospitals Security Specialist which saw two Security Partnership events with the Police, British Car-Parking Association, West Yorkshire Fire Brigade, Counter Terrorism, Safeguarding and Councils complemented with monthly PCSO drop in sessions. Further effort from via the Trust Resilience & Security Management Specialist has promoted the reporting of incidents via staff engagement sessions and through the Health and Safety Committee. Further work is planned in 2018/19 which is illustrated in the Resilience & Security Management report and action plan. The plan will be monitored by the Resilience and Security Working Group which is chaired by the a Non-Executive Director of Trust Board.

- **Staffing Levels** shows a 29% increase in reported in 2017/2018 as clincal staff are now reporting all shortage of staff onto Datix as an incident this is due the promoting of incident reporting. This concern is captured at Divisional levels and monitored centrally.

- **Accidental Injuries** shows an increase in reporting by 9% in 2017/2018. These type of incidents tend to fall outside the standard datix categories however, effort and support is being provided to colleagues to ensure improved reporting and trend analysis.

- **Needlestick/Sharps Injuries** shows a 58% increase in reporting in 2017/2018. This is due to the proactive work implemented via the Sharps Injury Task and Finish Group (Health and Safety sub-group) who have visited high risk areas, promoted reporting of incidents and raised awareness amongst colleagues. An overview is detailed in section 3.5 complete with the recognition that further work is necessary in 2018/19.

- **Slips, Trips & Falls** illustrate a slight increase of 1% in 2017/2018; further analysis in this area is required.

- **Moving & Handling Injuries** reported illustrate a 37% reduction from the previous year which is a positive outcome following the transfer of the department into Workforce and Organisational Development.

3.5 Needle-stick and Splash Injuries

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 concentrates on the prevention of sharps injuries in the hospital and healthcare sector and apply to employers, contractors and workers in the this sector. In 2016 a national HSE inspection targeted 40 Healthcare providers (excluding CHFT) and identified common causes of non-compliance where organisations failed to protect staff from the risk of exposure to Blood Borne Viruses. The subsequent HSE report identified:-

- Health and safety breaches were identified in 90% of healthcare organisations visited.
- 83% failed to fully comply with the Regulations.
- Improvement notices were issued to 45% of the organisations inspected

Whilst CHFT were not part of the HSE initiative a proactive approach has been taken based on the findings from the HSE report. Subsequently, a sub-group of the Health and Safety Committee has been initiated to:-

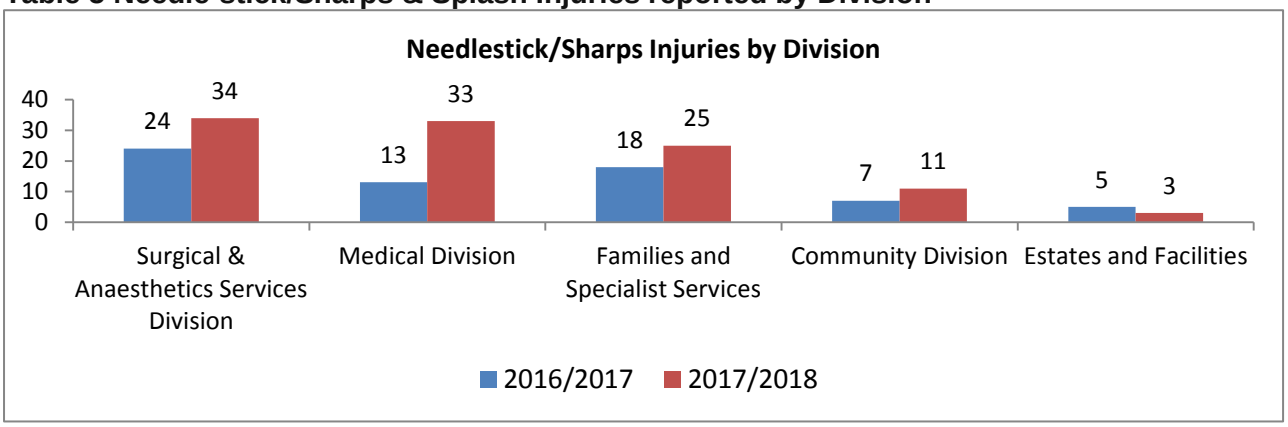
- Ensure accurate reporting of such incidents
- Investigate needle-stick / splash related incidents
- Observe and inspect the workplaces with high numbers of incidents
- Provide support / advice to areas
- Ensure shared learning across the Trust

The sub-group consists of the Health and Safety Advisor, Lead Infection and Prevention Control Matron, Lead Occupational Health Advisor, Staff Side and BBraun Contracts Manager. A number of needle-stick /

sharps audits have been completed with audit findings and recommendations shared with Heads of Departments and General Managers. Divisional engagement is essential in order to make this sub-group a success.

Table 5 illustrates a total of 106 Needle-Stick / Sharps injuries reported on Datix which has increased by 58% from 2016/2017. A total of 143 Needle-Stick/ Sharps injuries were reported to Occupational Health in the same reporting period illustrating a discrepancy of 37 incidents. The promoting of Datix incident reporting is continuing with Occupational Health colleagues and promotional information.

Table 5 Needle-stick/Sharps & Splash Injuries reported by Division



3.6 Employee & Public Injury Claims

Risk Management provide quarterly updates of Employers and Public Liability claims made against the Trust to the Health and Safety Committee. During the reporting period of 2017/2018 a total of 14 Employee Liability claims and 5 Public liability claims were lodged against the Trust, showing an increase in 1 claim since 2016/2017. A total of 6 claims were closed in 2017/2018 as follows:-

4 Employee liability claims:

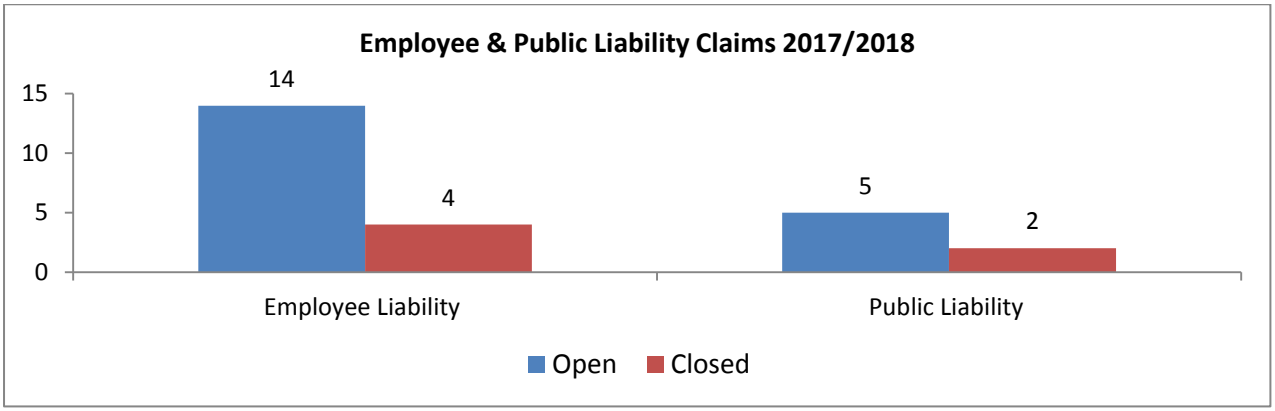
- 1 Re-opened.
- 2 No cost to the Trust-Repudiated.
- 1 External contractors ISS no CHFT NO cost.

2 Public Liability Claims

- Final Damages £12,192 Claimant cost £7000
- No cost to the Trust-repudiated

Table 6 below shows figures for 2016/2017 & 2017/2018.

Table 6



3.7 Health and Safety Training

The mandatory Health & Safety awareness training is continuing for all Trust staff on a 3 yearly basis via ESR and the Trust is currently 96% complaint up to end March 2018. Attention will be paid to updating the ESR health and safety training package 2018/2019.

The Health and Safety Advisor provides face to face training at Corporate Induction which is held twice monthly and continues to receive positive feedback from attendees.

Additionally, one hour byte sized interactive Risk Assessment training is provided by the Health and Safety Advisor on a monthly basis with a total of 2 sessions planned across all Sites per month. This training can also be provided locally for Departments.

4. GOVERNANCE ARRANGEMENTS

4.1 Reporting Arrangements

The Health and Safety Committee is chaired by the Executive Director of Estates & Facilities who is the named Director with responsibility for Health and Safety. However, on the formation of the Wholly Owned Subsidiary (WOS), the Trust will be required to identify a Director who will take responsibility for Health and Safety. The Committee meet on a monthly basis and report into the Quality Committee (a sub-committee of Trust Board) escalating any areas of concern or significant risk. Each topic specialist provides regular reports to the Committee providing assurance that specific risks are being managed. Development of a reporting framework and annual reporting plan has been introduced to this committee.

4.2 Health and Safety Committee Attendance

The membership includes topic specialists, Staff Side Reps, Divisional Reps and is chaired by the Director of Facilities and Estates. This ensures that the Trust consults its employees on health and safety matters, allows the exchange of information, indicates potential areas of safety concern highlighted through the presentation of incident data and provides legislative updates.

Divisional staff attendance has improved significantly over the last 12 months and continued support is required to ensure good attendance continues.

5. SPECIFIC RISKS

5.1 Control of Substances Hazardous to Health (COSHH)

Under the COSHH Regulations 2002 the Trust must either prevent or reduce employees' exposure to substances that are hazardous to their health. The Trust aims to achieve this by:-

- finding out what the health hazards are,
- deciding how to prevent harm to health via COSHH risk assessments,
- providing control measures to reduce harm to health (eg: personal protective equipment)
- making sure the control measures are used accordingly
- keeping all control measures in good working order;
- providing information, instruction and training for employees and others;
- providing monitoring and health surveillance in appropriate cases;
- planning for emergencies

An external Company, Alcumus Sypol, provide the Trusts COSHH risk assessments which are available via an on-line database. They are reviewed at regular intervals or when safety data sheets indicate any changes in the hazards association with the substance. The database and risk assessment inventory is accessible to key Divisional individuals as a "view only" via the Trust intranet. The database enables staff to download and print electronic COSHH risk assessments for hazardous substances used in their area. During 2018 a number of concerns were raised regarding the quality of COSHH risk assessments prompting the Health and Safety Advisor and Pharmacy to work with Alcumus Sypol to rectify the problem. Training is planned to be provided to Divisional COSHH super users to ensure relevant information is shared locally and the Trust remain compliant with the regulations. COSHH super users are being identified by divisions.

Whilst this will meeting the COSHH requirements the Health & Safety Committee felt that electronic assessments would pose a risk to departments who do not access on-line information regularly. A decision was made to provide each area with a hard copy of Departmental COSHH Risk Assessments and an awareness of the COSHH requirements.

5.2 Manual Handling

Manual Handling Operations Regulations 1992 (as amended) (MHOR) define manual handling as: "...any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force. The Trust must comply with the risk assessment requirements set out in the Regulations 1999 as well as the requirement in the Manual Handling Operations Regulations 1992 (MHOR) to carry out a risk assessment on manual handling tasks.

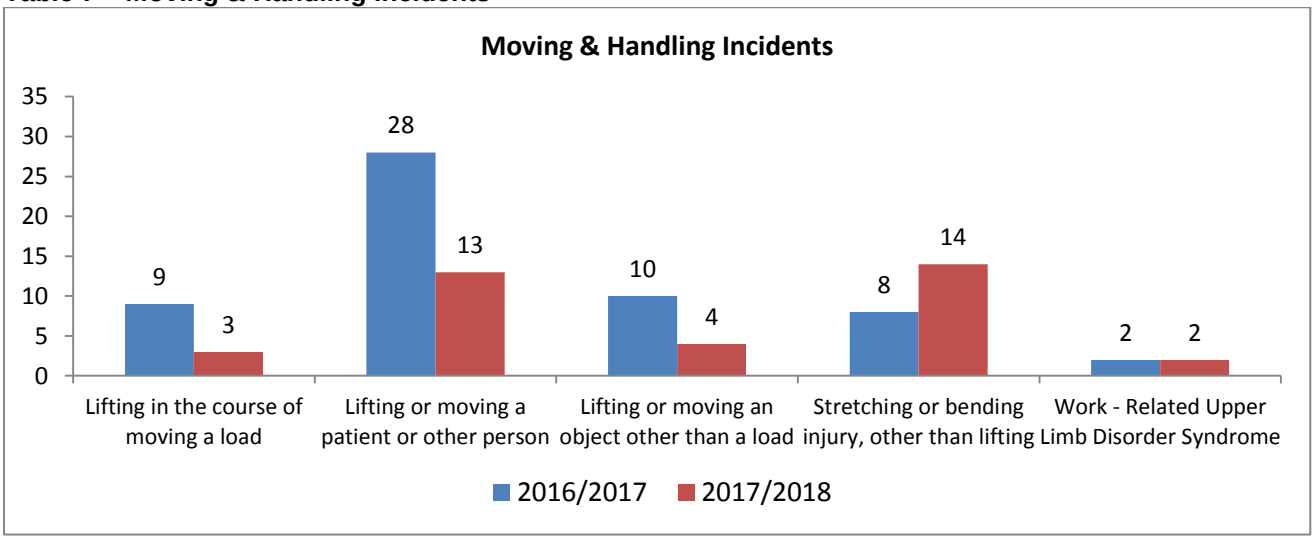
The regulations set out a hierarchy of measures to reduce the risks of manual handling by avoiding hazardous manual handling operations so far as is reasonably practicable. The Trust have reduced risks significantly by replacing manually operated beds / equipment and providing moving and handling aids for specific high risk tasks. However, further work, including training, continues.

The Trust saw a total of 36 staff related manual handling incidents reported via Datix during 2017/2018 with the most significant number being reported as "Stretching / Bending and Lifting or moving a Patient / Person". The overall number of Manual Handling incidents reported in 2017/2018 has decreased by 37% on the previous year.

The Moving & Handling training and policy was transferred to Workforce and Organisational Development in 2018 and the Specialist Advisor regularly reports into the Health and Safety Committee.

Table 7 below shows Manual Handling incidents from 2016/2017 – 2017/2018

Table 7 – Moving & Handling Incidents



The number of incidents by Division is detailed table 8 below:

Table 8 – Moving & Handling Incidents by Division

Incident cause	Community	Estates & Facilities	Families & Specialist Services	Medical	Surgical & Anaesthetics	TOTAL
Lifting whilst moving a load	1	0	1	1	0	**3**
Lifting or moving a patient or other person	0	0	0	12	1	**13**
Lifting or moving an object other than a load	1	1	0	0	2	**4**
Stretching or Bending Injury	2	2	5	3	2	**14**
Work-related upper limb disorder	0	0	1	0	1	**2**
TOTAL	**4**	**3**	**7**	**16**	**6**	**36**

5.3 Medical Engineering

The Medical Devices Regulations 2002(11) require all medical devices to carry the CE marking which is captured within the Medical Devices Management Policy. The Medical Engineering department provide an important service to the Trust and follow the MHRA document "Managing Medical Devices Guidance for healthcare & social services organisations – April 2015" which includes:

- Checking equipment for compliance with appropriate regulations
- Managing the provision of appropriate maintenance and repair for medical devices
- Providing proactive advice on the procurement of suitable medical devices ensuring that devices are of good quality, comply with appropriate standards and are cost efficient, resulting in safe and appropriate equipment for healthcare use.
- Co-ordination & provision of medical devices training
- Monitoring and recording training on the 'Medical Devices Training Database'
- Management of the Medical Equipment library on two

The safe and correct use of medical equipment is important to obtain the right diagnosis so that appropriate treatment can be delivered to the patient. The incorrect use of equipment can result in patient harm, staff injuries and damage to equipment which can impact further patient diagnoses. It is essential that suitably authorised staff receive appropriate competency-based training **before** using the medical equipment.

During 2017/2018 there were 199 incidents involving medical equipment reported via Datix which is a 14% increase in reporting from the reporting period in 2016/2017, this rise is due to the promoting of incident reporting within Divisions.

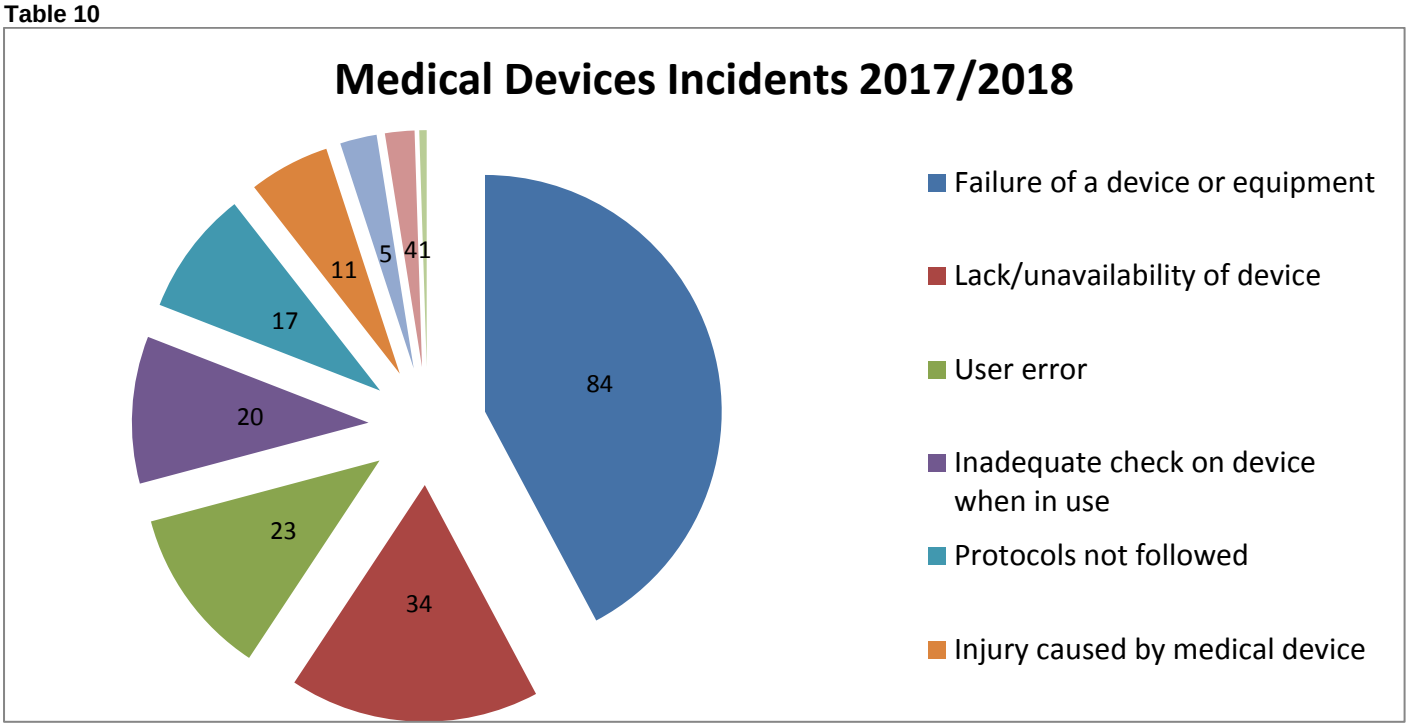
Table 9 below details Medical Device incidents reported by Division.

Table 9

Medical Device Incidents Division	Total
Surgical & Anaesthetics	64
FSS	58
Medical Division	59
Community	10
Estates & Facilities	6
Corporate	2
Total	**199**

Table 10 below details the incident by reason:

Table 10



The Trust has a target of 70% of authorised staff being trained in the use of a new device prior to clinical use and a 95% target for permanent staff sufficiently trained on current devices. In 2017/2018 the Trust compliance figures finished at 80%, which is above the Trust target.

There is currently an action in place to include all Doctors within these reporting figures as it currently only reported on Anaesthetists, a national survey has been issued through the Medical devices network to capture how other Trusts monitor this information, this information will be shared in 2018/2019.

The Medicines and Healthcare Regulatory Agency (MHRA) provides the key compliance document in relation to the management of medical devices, "Managing Medical Devices Guidance for healthcare and social services organisations" (April 2015). The MHRA issues Medical Device Alerts (MDAs) that notify organisations about safety issues with medical equipment and actions that need to be taken to remove or reduce the risks identified. The MHRA issued 45 Medical Device Alerts (MDAs) in the 2017/18 financial year relating to medical devices, all of which were actioned appropriately in accordance with Trust policy.

Table 11 below illustrates medical device training compliance. Work continues towards achieving the Trust's target. Clinical staff report that staff-shortages mean that are unable to attend the training, although a large number of courses are provided throughout the year. Training attendance is monitored on a regular basis at the Health and Safety Committee. Attendees representing all Divisions of the Trust cascade the information back into their areas of responsibility. This issue has been escalated for support to the Trust's Quality Committee.

Table 11 - Medical Device Training by Divisions

Division	Average % of staff trained 2016/2017	Average % of staff trained 2017/2018
FSS	86%	90%
Surgery & Anaesthetics	79%	78%
Medical	70%	74%
Corporate	63%	66%
Community	84%	75%
Estates & Facilities	89%	95%

Well done to FSS division who have achieved an amazing 90% compliance which is an increase on 2016/2017, this achievement has been recognised within the Health & Safety Committee.

6. WORKPLAN AND RECOMMENDATIONS 2017/2018

The following work-plan takes into account the progress made during the last financial year and illustrates actions to be incorporated into the 2018/2019 work plan. Trust Board are requested to accept the following health and safety work plan for 2018/2019.

	Action	Responsibility	Target Date
1	**COSHH** Suitable & Sufficient COSHH risk assessments to be provided to wards & department. COSHH training to be provided to staff to become COSHH super-users giving them a thorough understanding of the Control of Substances Hazardous to Health Regulations 2002.	**Responsibility** - Health & Safety Advisor	Sept 2018
2	**RIDDOR REPORTING** Improve understanding of RIDDOR Injuries, illnesses and dangerous occurrences to ensure accurate reporting and learning. Information to be included in online ESR Health and Safety training and added to the Health & Safety intranet page.	**Responsibility** - Health & Safety Advisor, General Manager Compliance	Sept 2018
3	**Slips, Trips & Falls** Monitor trends in Slips Trips & falls and report findings / learning to H&S committee	**Responsibility** - Health & Safety Advisor,	Aug 2018
4	**Health and Safety Training** / Awareness • Embed risk assessment knowledge and understanding into the organisation by providing Byte sized risk assessment training to be rolled out	**Responsibility** - Health & Safety Advisor	June 2018

	Trust wide • Develop user friendly health and safety intranet information • Update mandatory ESR (online) health & safety training. • Continue to provide health and safety awareness at Trust induction.		Aug 2018 Sept 18 2018/2019
5	**Moving and Handling Training** • Ensure regular moving and handling reports to the Health and Safety Committee • Provide support / escalation of risk if required.	Responsibility – Manual Handling Advisor	Aug 2018
6	**Needle-Stick Injuries** • Continue task and finish group objectives to improve reporting / raise awareness and subsequently reduce incidents. • Report into Health and Safety.	**Responsibility** – Needle-stick Injuries Task and Finish Group.	July 2018
7.	**Health & Safety Arrangements** • Review of Trust Health and Safety Policy • Provide clarity on roles and responsibilities on the introduction of the Wholly Owned Subsidiary.	. **Responsibility**: Health & Safety Advisor, General Manager Compliance **Responsibility**: Executive Director and CEO	Dec 2018 July 2018

Estates & Facilities Division
Health & Safety Department

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 7th June 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - The Board is asked to note the contents of the report and the overall performance score for April.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board, Thursday 31/5/18	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

For 2018/19 to ensure good governance as described in NHSI's Single Oversight Framework (SOF), the Integrated Performance Report (IPR) has been reviewed and a number of new indicators have been introduced and others discontinued, in line with progress and national directive.

Model Hospital Metrics now replace the previous Carter page
Community indicators are no longer a separate section, but fall within the current domain sections

A Data Quality Appendix will be introduced to include a number of indicators previously captured within domains e.g. completed datasets and will also capture work from the Data Quality Group/Board. All SPC charts for each domain are now included in appendices.

April's Performance Score stands at 62%. The SAFE domain is amber as PPH and Category 4 pressure ulcers have missed target again. CARING domain has maintained its amber performance with further work to do on FFT. EFFECTIVE has remained amber although #NoF missed target for the first time in 3 months. The RESPONSIVE domain deteriorated a little, although 2 out of 4 Stroke indicators achieved target, Cancer 62 day screening to treatment was the first main cancer target to miss since October and that was due to low patient numbers with half a breach having an impact. Diagnostics 6 weeks also missed target for the first time since November. In FINANCE, all indicators are on a par with April 2017, with the exception of Capital which is underachieving. Activity is above target for Non-elective and Outpatient levels. In WORKFORCE sickness achieved below 4% for the first time since August, Mandatory Training now includes all 9 Essential Safety areas with the additional 4 areas all green.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note the contents of the report and the overall performance score for April.

Appendix

Attachment:

Integrated Performance Report - April 2018.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

April 2018

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note 1

For 2018/19 to ensure good governance as described in NHSI's Single Oversight Framework (SOF) the Integrated Performance Report (IPR) has been reviewed and a number of new indicators have been introduced

Model Hospital Metrics will replace the Carter page.
Community indicators are no longer a separate section but fall within the current domain sections.
A Data Quality Appendix will be introduced to include a number of indicators previously captured within domains e.g. completed datasets and will also capture work from the Data Quality Group/Board.
All SPC charts for each domain are now included in appendices.

SAFE
Patient safety incidents per 100,000 bed days

CARING
Maternity section has moved to SAFE domain
What our patients are saying now includes 'You said, we did'

EFFECTIVE
C-diff/100,000 bed days
Hospital Standardised WEEKEND Mortality Rate (no longer a requirement as per SOF)
Hospital Standardised WEEKDAY Mortality Rate (no longer a requirement as per SOF)
Submissions to SUS have moved to Data Quality appendix

RESPONSIVE
Ambulance Handover 15 – 30 minutes
% Daily Discharges - Pre 12pm (no longer included – reported at Weekly performance)
Number of outliers (no longer included – open to misinterpretation)
Maternity section moved to SAFE domain
Community Services datasets moves to Data Quality appendix
% EDS moved to SAFE domain
Hospital Cancellations < 6 weeks (Outpatients)
Holding List > 12 weeks

Performance Summary

To Note 2

WORKFORCE

For all 9 individual Mandatory Training elements target weighting reduced. Only overall compliance carries heavier weighting

Mandatory Training - Health, Safety & Wellbeing
Mandatory Training - Equality & Diversity
Mandatory Training - Dementia Awareness
Mandatory Training - Conflict Resolution
Appraisal - Non-Medical Staff – heavy weighting
Appraisal - Medical Staff – heavy weighting
Turnover rate - 12 month
Vacancy rate
Sickness Absence rate (%) - Rolling 12 month (replaces YTD reporting)
Long Term Sickness Absence rate (%) - Rolling 12 month (replaces YTD reporting)
Short Term Sickness Absence rate (%) - Rolling 12 month (replaces YTD reporting)
Average days lost per FTE
Unplanned turnover rate (%)
Retention Rate (%)
Proportion of Temporary (Agency) Staff

EFFICIENCY & FINANCE

Ambulatory
Frailty
Stranded/Super-Stranded 7/21days
Non-electives <= 1 day
Pre-Op LoS
Clinical Cancellations after Pre-OP
Occupied Bed Days
Clinic Utilisation
Theatre Late Starts, Cases per List
Endoscopy utilisation
Cath Lab
Coronary Care Discharges

APPENDICES

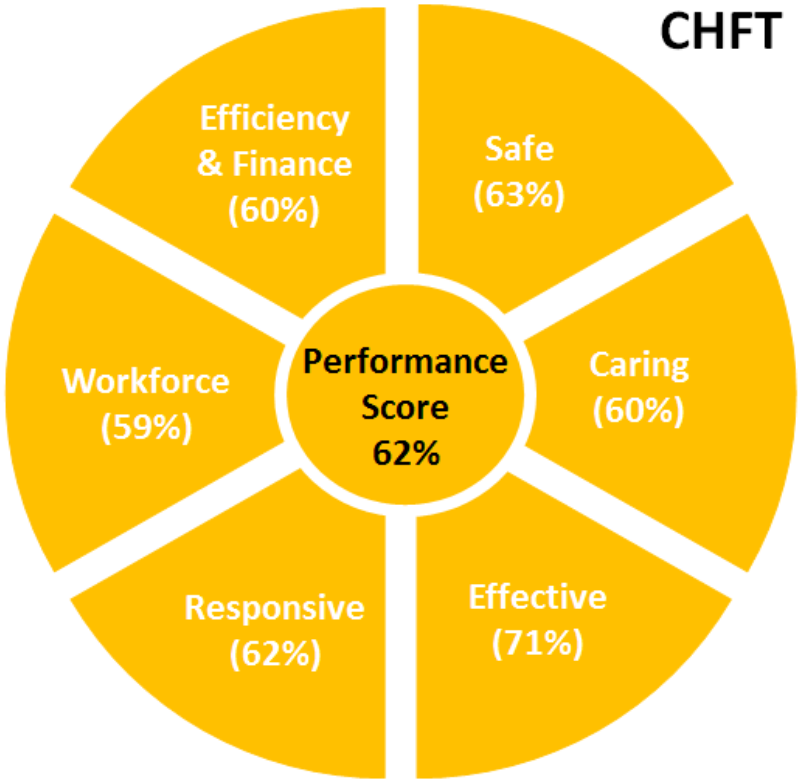
Data Quality
Best Practice Tariff

Performance Summary

April

RAG Movement

April's Performance Score stands at 62%. The SAFE domain is amber as PPH and Category 4 pressure ulcers have missed target again. CARING domain has maintained its amber performance with further work to do on FFT. EFFECTIVE has remained amber although #NoF missed target for the first time in 3 months. The RESPONSIVE domain deteriorated a little although 2 out of 4 Stroke indicators achieved target, Cancer 62 day screening to treatment was the first main cancer target to miss since October and that was due to low patient numbers with half a breach having an impact. Diagnostics 6 weeks also missed target for the first time since November. In FINANCE all indicators are on a par with April 2017 with the exception of Capital which is underachieving. Activity is above target for Non-elective and Outpatient levels. In WORKFORCE sickness achieved below 4% for the first time since August, Mandatory Training now includes all 9 Essential Safety areas with the additional 4 areas all green.

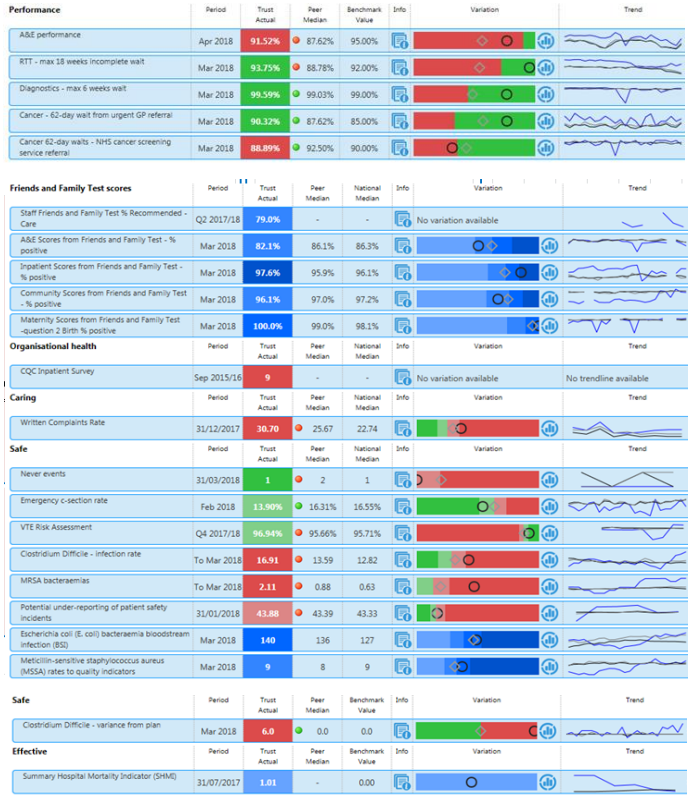


SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT IP FFT Maternity
FFT OP FFT A&E	FFT Community
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Model Hospital



MOST IMPROVED

% Readmitted back in to Hospital within 30 days for Intermediate Care Beds at 1.6% is an excellent improvement considering April 2017 was at 10.5%.

Long Term Sickness Absence rate (%) - in month - best performance at 2.37% in over 12 months.

% Last Minute Cancellations to Elective Surgery at 0.34% is the best position for over 2 years.

MOST DETERIORATED

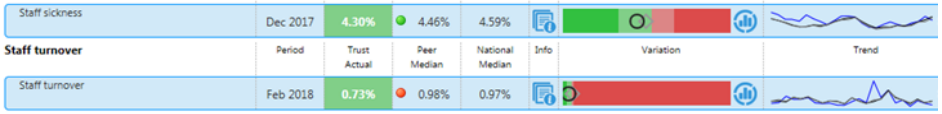
Emergency C-Section Rate - performance at 20.5% has peaked.

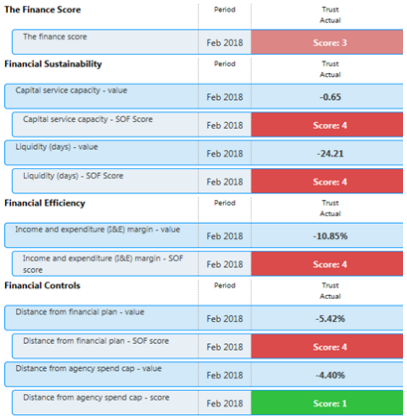
38 Day Referral to Tertiary - at 42% lowest performance since July last year.

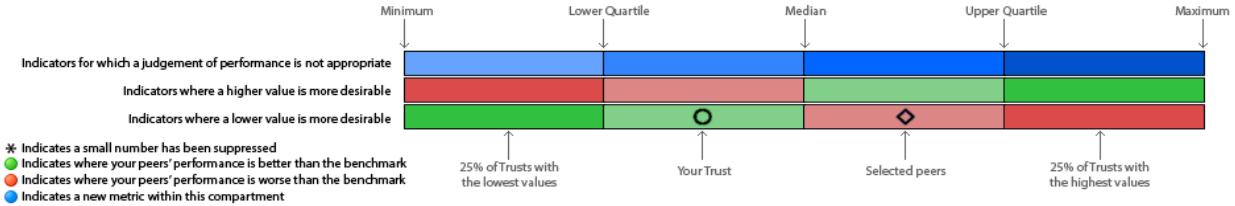
ACTIONS

All cases have been reviewed through weekly governance process with no clear themes or trends for increase: Consultant presence in 75% of cases, further benchmarking to be considered.

The Red2Green methodology to be applied to Urology, Head and Neck and Lower GI pathways is still delayed and will now commence in May.







Executive Summary

The report covers the period from April 2017 to allow comparison with historic performance. However the key messages and targets relate to April 2018 for the financial year 2018/19.

Area	Domain
Safe	• **% Harm Free Care** - Performance at 91.57% was worst position in over 12 months. Ongoing the Medicine division will be tracking old and new harms whilst within the Surgical division the most notable deterioration is within the T&O directorate. The T&O directorate have a number of actions in place to begin to address harm due to pressure ulcer . Matron is in the process of looking at the Tvlips (link nurses) to ensure they have attended module 1 training. 2 HCA's from each orthopaedic ward are also to attend the module 1 training. It is expected to take a couple of months for the PU actions to embed, so performance above 95% not expected again until end of Q1. • **Pressure Ulcers** - Numbers have peaked at 59 in month. The Pressure Ulcer Collaborative continues to meet fortnightly and is chaired by the lead TVN. Support has been provided from the Quality Directorate Quality Improvement Lead to revisit the improvement action plan. • **Emergency C-Section Rate** - Performance at 20.5% has peaked. All cases have been reviewed through weekly governance process with no clear themes or trends for increase: Consultant presence in 75% of cases, further benchmarking to be considered. • **Maternal smoking at delivery** - Performance at 17.2% has peaked. Focus on improving referral conversations, obtain feedback from the cohort of women who refused referral to smoking cessation so we can better understand where to direct improvement efforts.
Caring	• **Complaints closed within timeframe** - Of the 49 complaints closed in April, 37% were closed within target timeframe. With continued support from the Divisional triumvirate, the backlog of breaching complaints is expected to be cleared by the end of May. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 90.7% still below 95.7% target. General Manager Outpatients has completed a 12 month review of trends from April 2017 and comments. Main themes both positive and negative in relation to staff attitude and waiting. Positive feedback from families in OPD received in recent Healthwatch OPD survey in March and associated action plan in progress. Positive feedback re. OPD services from CHKS accreditation visit in April. • **Friends and Family Test A & E Survey -** Response Rate is still around 11% which is below the 13.3% target. % would recommend is just below the 85% achieved for 2017/18 and is below target. Splitting this by site shows that the issues are at the HRI site; the team is looking at the feedback and how this reduction can be addressed. Both CDU's have also taken a dip in their response rate and this has been fed back to clinical teams so that they can drive an improvement here. • **Friends and Family Test Community** - % would recommend has dipped below target. When analysed, the decrease in 'would recommend %' and increase in 'wouldn't recommend %' relate to Specialist Nursing (Immunisation team) where there were a number of negative comments and scores from schoolchildren relating to their immunisation hurting. Although there has been a slight increase in response rate numbers for April, the overall total remains low. From May we will revert to collecting FFT data on a daily basis so we should start to see an improvement in response rates from then. • **% Dementia patients following emergency admission aged 75 and over** - current performance 25% against 90% target. Improvement focus within weekly performance meetings.
Effective	• **E.Coli - Post 48 Hours** - There were 6 cases in April. E.Coli is being managed through a health economy action plan as they look to reduce incidences in the community and hospital environment. The Trust regularly feeds into this plan. Numbers continue within variation and known to be increasing nationally. • **Mortality Reviews** - 24.1% lowest performance since July 2017. Mortality reviews continue to be allocated albeit on a monthly basis for an ISR (Initial Screening Review). The ISR online tool has been shortened and revised to reflect questions relating to quality of care. Face to face training support remains on offer. Senior nurses are also being asked to contribute to these. SJRs are up to date with bi-monthly discussion at the LfD panel. • **% Sign and Symptom as a Primary Diagnosis** - Performance has maintained at 10.4% against 9% target. The audit work continues within specialties and S&S cohorts. Interviews for 3 wte trainee coders have taken place and offers are to be sent out. The team also have a number of individuals on long term sick and maternity leave. 2 Coding Clinical Leads (Consultant PA) have been appointed and they will be key to resolving documentation issues. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - Performance has fallen to 77%. A sustainability plan is in place which includes continuing to use escalation plan for times of Surge in Activity, additional Trauma capacity sought during peak times, 3 additional lists in April in addition to the 19 lists per week as scheduled.

Background Context

The Trust planned well for Easter learning from the Christmas pressures, no elective inpatient activity was planned for the first week in April, the Birth Centre closure was extended to cover the post-bank holiday period and additional medical staff were deployed into key areas reflecting it was also Junior Doctor change week.

Command and control remained in place for the first 2 weeks but was then stepped down as we moved to an OPEL 2 rating with escalation capacity closed from the third week of April.

Whilst bed numbers are now within funded bed plan there is a differential site pressure currently with fewer beds than plan at CRH but more beds than plan at HRI.

Performance fluctuation has reduced with a more stable position however there continues to be very differential ECS performance levels between the 2 sites with CRH delivering a solid level of performance significantly better than 95% but HRI running up to 10% lower and actions to improve this are being discussed as a focus for the teams.

The impact of reconfiguration continues to be reviewed and monitored, culminating in a large scale review in June which will include a comprehensive review of the KPIs attached to the business case.

Demand through 2ww pathways continues to be high and increasing in some specialties. Within Endoscopy this has caused pressures compounded by the current phase of the Decontamination programme (scopes are being processed on one site only and have to be transported back to base) at various times of day. There have been delays in returning scopes and patients have been delayed and this has impacted upon patient experience rather than clinical care but explanations and regular updates are provided to patients to minimise their anxiety and concerns. This will continue until the scheme is completed in September.

Executive Summary

The report covers the period from April 2017 to allow comparison with historic performance. However the key messages and targets relate to April 2018 for the financial year 2018/19.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours 91.52%** in April, (92.9% all types) - an improvement of 6 percentage points on the March position. The team is working with the Acute Directorate to review how admission avoidance is implemented on the HRI site. ED is also working with the frailty team to review the current pathway and impact on CDU and ED. A number of specific actions have been completed in month to improve performance. • **Stroke** - both % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival and % Stroke patients scanned within 1 hour of hospital arrival did not achieve target. Development of a stroke assessment area within ED has been agreed with pilot expected to commence June 2018. • **% Diagnostic Waiting List Within 6 Weeks** - just missed target at 98.81% due to a small number of Cystoscopy patients not seen. • **38 Day Referral to Tertiary** - 42% for April. The Red2Green methodology to be applied to Urology, Head and Neck and Lower GI pathways is still delayed and will now commence in May. • **62 Day Referral From Screening to Treatment** - target was missed by half a breach. Low numbers mean such a margin can cause the target to be missed. • **Appointment Slot Issues on Choose & Book** - small improvement to 35% however action plans are in place with a deep dive presented at May Quality and Performance WEB. Worsening position in part driven by two key themes: Significant pressure in a small number of challenged specialities (e.g. Dermatology, Cardiology and Gastro), 2WW pathways (where patients go straight to test). The development of a referral management sytem for 2WW straight to test pathways (to prevent deferral to provider) will improve performance over the coming months.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Sickness achieved below 4% for the first time since August. Return to Work Interviews improved to 65%. Attendance management sessions are being held across divisions. • **Mandatory Training** now includes all 9 Essential Safety areas with the additional 4 areas all green.
Finance	• **Finance**: Year to Date Summary The year to date deficit is £5.21m, in line with the plan submitted to NHSI. • Clinical contract income is above plan by £0.06m. The Aligned Incentive Contract protects the income position by £0.22m as actual activity is below the planned level. • In spite of the lower activity, there is an underlying adverse variance from plan which has had to be mitigated by the release of £0.34m (1/6th) of the Trust's £2m full year reserves of which £1m was earmarked for winter. • CIP achieved in the year to date is £0.65m against a plan of £0.79m, a £0.14m shortfall. • Agency expenditure was beneath the agency trajectory set by NHSI. Key Variances • Nursing pay expenditure saw an adverse variance of £0.1m in month and was particularly high in the first two weeks of the month, linked to the CQC visit and additonal bed pressures. • The shortfall in CIP delivery was primarily linked to slippage in schemes within the Medical Staffing portfolio and has resulted in an adverse variance of £0.1m on Medical pay expenditure. These schemes are forecast to be delivered in full by year end. • Non Clinical Income was below plan by £0.14m, the majority of which related to lower than planned commercial income for the Health Informatics Service. • These adverse variances have been offset by the release of contingency pay reserves of £0.34m. Forecast • The Trust has not accepted the 18/19 NHS Improvement Control Total of a £22.6m deficit and is therefore not eligible to receive any of the £14.2m Provider Sustainability Funding allocated for this financial year, (previously Sustainability and Transformation Funding). • At this early stage the forecast is to achieve the £43.1m deficit, £20.5m adverse variance from control total as planned.

Background Context

The development of Data Quality trajectories continued alongside ongoing validation work with particular focus on Cystoscopy activity recording which continued to have errors until end of April.

Meetings have taken place between medical specialties to agree options to improve the outstanding stroke metrics and agreement reached on a pilot pathway.

Paediatric services received a 3 day accreditation visit during April - they are seeking to become the first accredited Paediatric service in the country which was subsequently confirmed.

The Maternity team received some great news this month as they were successfully selected from a wide field of bidders to receive additional funding to develop a system to give maternity users access to their own clinical records.

Within Community services the divisional management team are settling into their new leadership roles. A time out is being planned to establish the work that is going on in the division and the key priorities for the division for projects for the next financial year.

Focus on the CQC report and the division's response to its findings will be a priority for May / June.

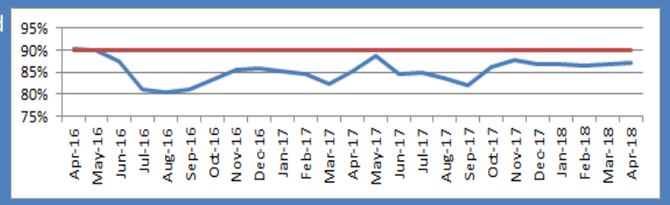
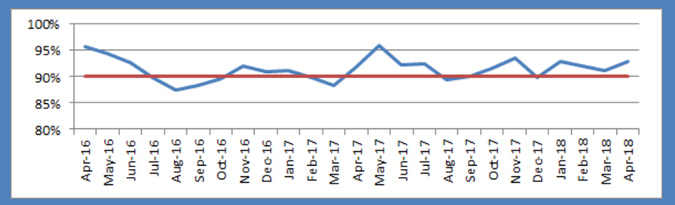
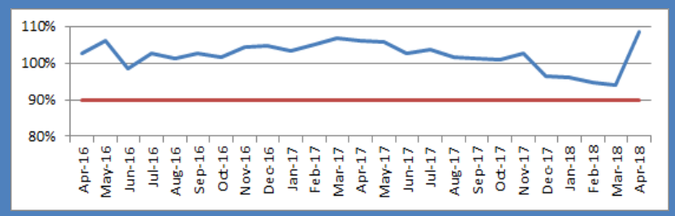
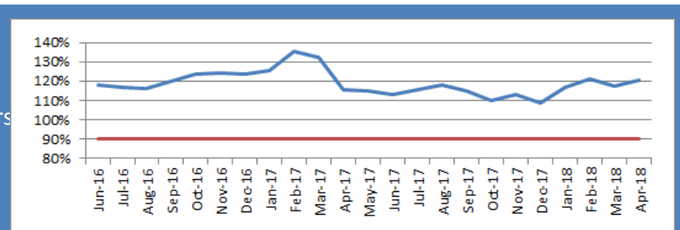
Following an identified theme around discharges to the community division, work has been undertaken with the Medical division to improve discharges.

Focus on understanding the falls data for the division continues and the results of the deep dive will be presented in June.

There has been a review of the Performance Management Framework and changes to weekly performance monitoring including greater emphasis on productivity and efficiency metrics alongside a more detailed forward look at activity - actual and booked.

CIP planning continues with focus on movement to Gateway 2 for all schemes by 24th June. In addition the team has been contributing to the development of System Recovery Plans.

Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	87.12% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - 6a 65.8% - 7a/d 73.6% - 7c 72.6%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team .The low fill rates reported in April 2018 are due to a level of vacancy and the teams not being able to achieve their WFM. Safe staffing levels have been maintained.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	92.84% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - 5b 71.7% - 7c 73.8% - ward 10 67.8%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to team's supporting additional capacity beds, a level of vacancy, a level of sickness and embedding new WFM.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	108.54% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 59.9% - NICU 71.3% - 3a,b,c,d 65.8%	The low HCA fill rates in April are attributed to fluctuating bed capacity, support of additional capacity ward, and a level of HCA vacancy within the FSS division . This is managed on a daily basis against the acuity of the work load. Recruitment plans are in place for all vacant posts. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements and support of reduced RN fill.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	121.01% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	No HCA shifts in April had fill rates less than 75%.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	DAY						NIGHT						Care Hours Per Patient Day								
	Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies	Ward Assurance
	Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual											
CRH ACUTE FLOOR	2,970.00	2,879.58	1,890.00	2,173.28	97.0%	115.0%	2,640.00	2,472.75	1,650.00	1,960.80	93.7%	118.8%	10.8	11.2			2	3	7.11	5.3	84.0%
HRI MAU	1,890.00	1,764.70	1,530.00	1,754.33	93.4%	114.7%	1,320.00	1,430.58	1,320.00	1,344.33	108.4%	101.8%	9.1	9.5			2	14	0	0	84.8%
HRI Ward 5 (previously ward 4)	1,620.00	1,339.58	1,170.00	1,461.13	82.7%	124.9%	990	960.67	990	1,398.00	97.0%	141.2%	6.0	6.4			2	8	2.99	0	76.3%
WARD 15	1,755.00	1,440.83	1,620.00	2,116.50	82.1%	130.6%	1,320.00	1,299.00	1,320.00	1,432.50	98.4%	108.5%	6.6	6.9			1	6	9.3	0.81	88.7%
WARD 5C	945	974.67	810	1,159.45	103.1%	143.1%	660	645.75	330	727.5	97.8%	220.5%	5.2	6.6			0	7	3.28	0.28	92.1%
WARD 6	1,530.00	1,512.58	945	1,139.50	98.9%	120.6%	990	971.55	660	749	98.1%	113.5%	7.3	7.7			0	7	3.24	0.42	86.1%
WARD 6BC	1,530.00	1,464.85	1,530.00	1,526.17	95.7%	99.7%	1,320.00	1,308.77	660	737.17	99.1%	111.7%	5.1	5.1			1	10	5.31	0	94.4%
WARD 5B	1,530.00	1,324.50	810	825.67	86.6%	101.9%	1,320.00	946.00	330	682	71.7%	206.7%	8.1	7.6			1	0	4.66	0	97.8%
WARD 6A	1,170.00	770.2	720	843.57	65.8%	117.2%	660	605.00	330	660.00	91.7%	200.0%	5.3	5.3			0	4	3.56	0.68	89.8%
WARD CCU	1,522.17	1,269.50	366	343.5	83.4%	93.9%	990	990	0	11	100.0%	-	9.4	8.5			0	2	1.47	0.68	97.5%
WARD 7AD	1,620.00	1,192.08	1,530.00	2,005.42	73.6%	131.1%	990	990	990	1,111.00	100.0%	112.2%	7.0	7.2			0	3	1.19	2.19	95.8%
WARD 7B	810	803.83	810	875.42	99.2%	108.1%	660	616	330	341.00	93.3%	103.3%	6.9	7.0			1	3	3	1	96.8%
WARD 7C	1,620.00	1,176.92	810	1,083.17	72.6%	133.7%	1,320.00	974.5	330	726	73.8%	220.0%	12.7	12.3			2	2	2	0.36	96.5%
WARD 8	1,620.00	1,339.58	1,170.00	1,461.13	82.7%	124.9%	990	960.67	990	1,398.00	97.0%	141.2%	6.0	6.4			4	4	5.11	0.47	90.5%
WARD 12	1,395.00	1,179.50	810	1,002.50	84.6%	123.8%	660	671	660	748.5	101.7%	113.4%	5.4	5.5			3	4	1.9	2.5	98.1%
WARD 17	1,980.00	1,545.83	1,170.00	1,145.67	78.1%	97.9%	990	1,001.00	660	671.00	101.1%	101.7%	6.1	5.6			0	5	3.06	0	95.2%
WARD 8C	810	807.08	450	802.92	99.6%	178.4%	660	638.00	330	671.00	96.7%	203.3%	4.9	6.4			1	0	7.09	2.61	95.8%
WARD 20	1,755.00	1,491.92	1,755.00	2,097.25	85.0%	119.5%	1,320.00	1,330.00	1,320.00	1,618.50	100.8%	122.6%	6.4	6.8			2	16	0	0	90.5%
WARD 21	1,485.00	1,148.00	1,485.00	1,414.83	77.3%	95.3%	1,035.00	953.5	1,035.00	1,069.50	92.1%	103.3%	8.7	7.9			2	6	7.51	0.66	88.7%
ICU	3,900.00	3,377.50	795	476	86.6%	59.9%	4,140.00	3,435.50	0	0	83.0%	-	41.7	34.4			12	1	2.55	0	HRI 96.8% CRH 88.8%
WARD 3	915	934.92	795	720	102.2%	90.6%	690	678.5	345	609.5	98.3%	176.7%	7.1	7.6			1	4	0	0.59	96.6%
WARD 8AB	862	784.82	652	655.33	91.0%	100.5%	690	644	345	322	93.3%	93.3%	8.4	8.0			4	2	3.77	0.79	95.1%
WARD 8D	795	769.1	795	635.13	96.7%	79.9%	690	691.50	0	264.5	100.2%	-	7.0	7.2			0	0	2.87	0.77	86.5%
WARD 10	1,260.00	1,050.80	795	905	83.4%	113.8%	1,035.00	701.50	690	690.00	67.8%	100.0%	6.9	6.1			0	2	7.81	0	92.5%
WARD 11	1,536.00	1,443.50	1,064.00	1,152.42	94.0%	108.3%	1,035.00	1,023.50	690	724.5	98.9%	105.0%	5.7	5.7			0	3	1.88	0.2	76.6%
WARD 19	1,590.00	1,281.83	1,140.00	1,457.17	80.6%	127.8%	1,035.00	999.00	1,035.00	1,311.00	96.5%	126.7%	8.0	8.4			10	8	2.93	0	89.9%
WARD 22	1,140.00	1,097.42	1,140.00	1,096.70	96.3%	96.2%	690	678.50	690	690	98.3%	100.0%	5.4	5.2			0	2	0.55	0.73	75.9%
SAU HRI	1,708.00	1,673.00	884	937.55	98.0%	106.1%	1,380.00	1,379.00	345	345	99.9%	100.0%	10.7	10.8			0	2	2.47	0.71	95.5%
WARD LDRP	4,470.23	3,612.20	946.17	754.67	80.8%	79.8%	4,108.67	3,503.17	685.5	618.5	85.3%	90.2%	22.0	18.3			0	0	0	5.56	97.9%
WARD NICU	2,553.17	2,092.05	744.5	530.5	81.9%	71.3%	2,047.00	1,870.50	667	533	91.4%	79.9%	11.9	10.0			0	0	0.94	1.62	99.2%
WARD 1D	1,308.00	1,145.67	348.5	333.5	87.6%	95.7%	690	690	345	356.5	100.0%	103.3%	4.9	4.6			0	0	0	1.19	95.3%
WARD 3ABCD	3,631.33	3,298.83	1,514.00	996.5	90.8%	65.8%	3,087.83	2,988.08	345	345	96.8%	100.0%	12.7	11.3			0	0	0	2.13	97.9%
WARD 4C	1,252.33	1,114.50	354.5	345.17	89.0%	97.4%	690	689	345	343	99.9%	99.4%	7.3	6.9			0	2	3	4.35	94.0%
WARD 9	684.5	699.5	345	345	102.2%	100.0%	686.5	675	345	333.5	98.3%	96.7%	4.8	4.8			0	0	6.01	2.11	100.0%
Trust	**57162.73**	**49801.37**	**33693.67**	**36572.1**	**87.12%**	**108.54%**	**43530**	**40411.5**	**21107.5**	**25542.8**	**92.84%**	**121.01%**	**8.0**	**7.8**							

Hard Truths: Safe Staffing Levels (3)

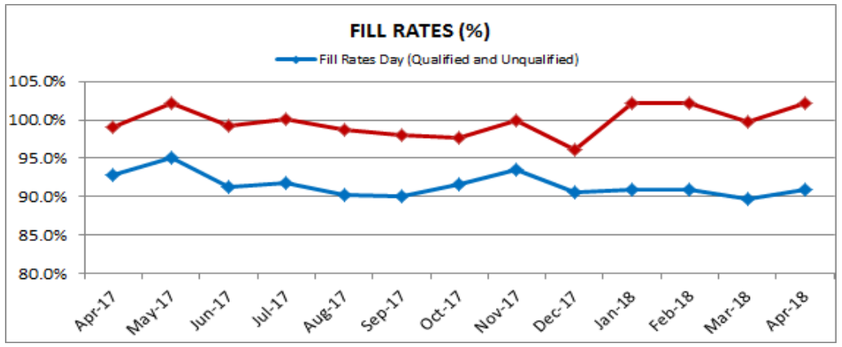
Care Hours per Patient Day

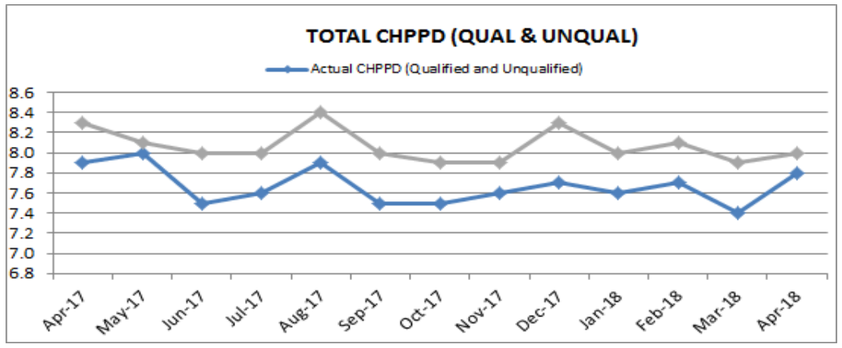
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Feb-18	Mar-18	**Apr-18**
Fill Rates Day (Qualified and Unqualified)	90.96%	89.70%	91.00%
Fill Rates Night (Qualified and Unqualified)	102.24%	99.70%	102.20%

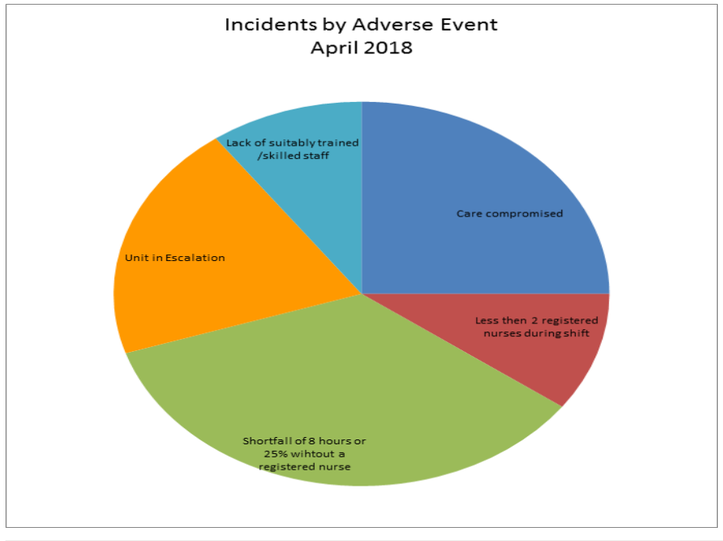
Planned CHPPD (Qualified and Unqualified)	8.1	7.9	8.0
Actual CHPPD (Qualified and Unqualified)	7.7	7.4	7.8

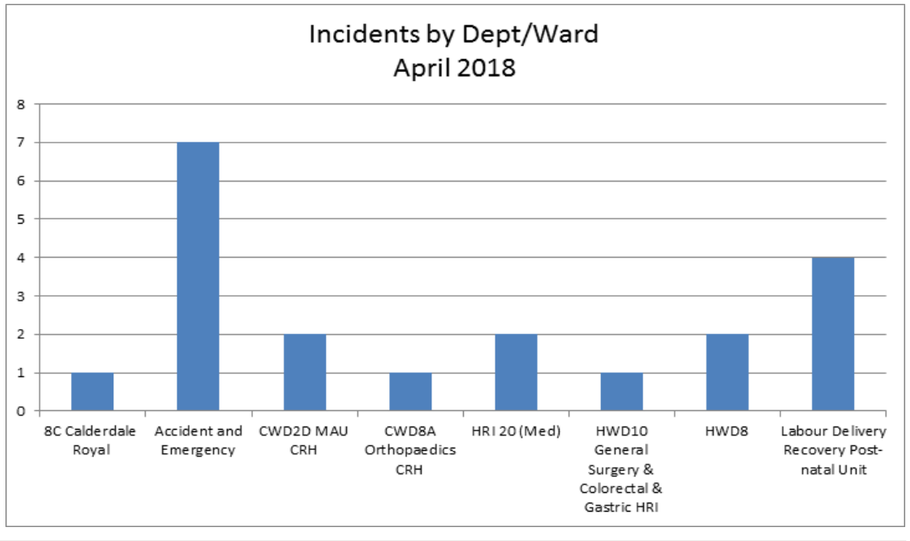
A review of April CHPPD data indicates that the combined (RN and carer staff) metric resulted in 14 clinical areas of the 34 reviewed having CHPPD less than planned. 16 areas reported CHPPD slightly in excess of those planned and 4 areas having CHPPD as planned. Areas with CHPPD more than planned were due to additional 1-1's requested throughout the month due to patient acuity in the departments.





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 Datix. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There were **21 Trust Wide Red shifts** declared in **April 2018.**
As illustrated above the most frequently recorded red flagged incident is related to "Short fall of 25% of nursing Hrs on shift"
No datix's reported in March 2018 have resulted in patient harm.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments. A range of actions are being developed and undertaken to recruit and retain the nursing workforce, and to develop data collection and reporting to support the nursing workforce.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce and going forward the fill rates for individual areas will improve as these team members become established in the workforce numbers. Focused recruitment continues for this specific area.
2. Further recruitment event planned for May 2018.
3. Applications from international recruitment projects are progressing well and the first 8 nurses have arrived in the Trust, with a further 5 planned for deployment in May/June 2018.
4. A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. 57 candidates have now been transferred onto the OET programme.
5. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NAs who started in post in April 2017. A proposal has being developed to up-scale the project in line with the national and regional workforce plans. A second cohort of 20 trainees will begin the programme in June 2018.
6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce. This has been further enhanced by the development of a yearlong graduate programme to support and develop new starters.
7. 4 Additional clinical educators have been recruited to the medical division. They will have a real focus on supporting new graduates and overseas nurses to the workforce.
8. A new module of E roster called safe care is currently being introduced across the divisions, benefits will be better reporting of red flag events, real-time data of staffing position against acuity.
9. Daily staffing meetings continue led by a senior nurse with matrons from each division. The focus of these meetings is to assess risk across all areas and approve Bank and agency requests using a risk based approach to safe staffing. As safe care tool is rolled out we will see a clear audit trail of decision making and this will be mapped against Quality Indicators to monitor impact of decision making.
10. Fill rates for HCAs continues to be high in some areas due to use of 1:1s and conversion of RN shifts to HCA shifts. Work is progressing regarding the Enhanced Care Support workers, with senior clinical leadership of this team starting to have a real impact.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** amber fox, PA to Director of THIS
Date: Thursday, 7th June 2018	**Sponsoring Director:** Mandy.griffin, Director of THIS
Title and brief summary: Digital Health – Future Partnership Working - See Executive Summary	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: EPR Transformation Board / Digital Health Forum	
Governance Requirements: N/a	
Sustainability Implications: None	

Executive Summary

Summary:

In January 2018 Calderdale and Huddersfield NHS Foundation Trust and Bradford Teaching Hospitals Foundation Trust developed a proposal that described a shared vision as the basis for a strategic partnership agreement with Cerner UK.
The strategic partnership is founded on:

- A shared EPR Objective - “The primary case for an EPR is to improve patient safety, improve outcomes and improve the experience our patients.”
- A shared strategic objective of being fully digital.
- Proven success of a single instance deployed between two Trusts that can host other Trusts.
- Both Trusts’ interest in a strategic relationship to progress their digital ambitions.

The Trusts and Cerner share three key objectives. The Trusts propose a multi-stream approach whereby progress is made in parallel on each workstream to achieve benefits at pace. Each Trust would benefit from the other’s Trust leadership in the work stream from design through implementation.

The strategic Partnership proposal was presented and agreed at the Joint EPR transformation board on the 27th March 2018. This confirmed CHFT's ambition to lead on Optimisation - Usability & Digital Breadth. The priorities being to ensure that the stabilisation plan presented to this Board in December 2017 was completed and that the optimisation plan included in the strategic partnership proposal formed part of a Digital Health - next steps document. This document would be used to seek agreement from the CHFT Board of Directors to develop a business case describing a package of work for 2018/19.

The key driver of the next steps is to reverse the EPR cost impact seen in 2017/18, secure the original benefits case and enable further benefits to be realised.

The Board is asked to receive:

• Strategic Partnership proposal
• Digital Health Next Steps Document
• Transformation Board Minutes of 27th March 2018 agreeing the proposal

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

N/A

Next Steps:

See attached

Recommendations:

• Board to note the agreed Strategic Partnership proposal and future working arrangements with BTHFT and Cerner UK
• Note and agree the content of the Next Steps document
• Approve the development of a full business case for the defined package of work as described in the Next

Stamp document

Appendix

Attachment:

Digital Health - Future Partnership Working.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

NHS
Calderdale and Huddersfield
NHS Foundation Trust

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Cerner

Strategic Partnership Proposal Overview

31 January 2018

Calderdale and Huddersfield Foundation Trust (CHFT) and Bradford Teaching Hospitals Foundation Trust (BTHFT) propose the following shared vision as the basis for a strategic partnership agreement with Cerner UK.

Alignment

Cerner and the Trusts are aligned as follows:

- *through the successful implementation* of a joint Electronic Patient Record (EPR). This joint instance and implementation shows thought leadership in collaboration, demonstrating in practice the aims of both the Global Digital Exemplar programme and the Five Year Forward View.
- *in a desire for a strategic partnership* to the benefit of the Trusts and Cerner, through leadership and expertise in healthcare applied to the Cerner Millenium product for all clients.
- as the Trusts together represent a significant *patient population and includes teaching* status (at BTHFT).

Foundation

The strategic partnership is founded in:

- the shared EPR Objective - "*The primary case for an EPR is to improve patient safety, improve outcomes and improve the experience our patients*."
- the shared strategic objective of being fully digital.
- proven success of a single instance deployed between two Trusts that can host other Trusts.
- both Trusts' interest in a strategic relationship to progress their digital ambitions.

Objectives & Priorities

The Trusts and Cerner share three key objectives. The Trusts propose a multi-stream approach whereby progress is made in parallel on each workstream and achieve benefits at pace. Each Trust would benefit from the other's Trust leadership in the work stream from design through implementation.

1. Showcase site for Cerner in the UK
2. Potentially influencing force for other GDEs and Trusts
3. Complementary short and medium term goals that will together progress all partners:
    - Progressing the optimisation of EPR to increase **Usability and Digital Breadth**

- Discovering and embedding logic from **Quality Improvement** supporting teaching and research
- Applying **Population Health** to the Local Health Economies in conjunction with the applied health work of the Bradford Institute of Health Research (BIHR)

The table below summarises the parallel work stream approach. Priorities will be agreed via a structured road-mapping session.

Work stream **Optimisation - Usability & Digital Breadth**	**Quality Improvement (supporting Teaching & Research)**	**Population Health (with BIHR)**
Lead Site: CHFT **Follower Site:** BTHFT	**Lead Site & Follower Site:** BTHFT in collaboration with CHFT	**Lead Site:** BTHFT **Follower Site:** CHFT
Details are provided in the appendix.	TBC - Hot-spot monitoring, enhanced alerting & opiate reversal	HealtheIntent

Working Arrangements

As outlined above, the Trusts propose one Trust lead and one follow for each of the three work streams.

Each Trust is expected to commit to proceeding with the priority albeit at different go-live points in time. Commitment will be made via a business case process.

As there is a leader and a follower, each Trust will participate in design stages to ensure the follower can adopt the same configuration with minimal or no re-work. As each Trust is expected to share the benefits of the configuration, each of the Trusts and Cerner will collectively and equitably contribute to the base resourcing needs to support the arrangement. This may include staff and/or infrastructure.

Commercial Arrangements

Each of the three work streams will have a different commercial arrangement. In all of these we would expect to negotiate an appropriate commercial arrangement reflective of the partnership approach.

Appendix: Optimisation - Usability & Digital Breadth

The table below shows the solutions under consideration and order of preference. Some may run in parallel due to contract maturity and clinical priorities. Hardware and infrastructure will be considered under a separately.

	Solution	Priority CHFT	Priority BTHFT	Implementation Target CHFT	Implementation Target BTHFT	Outcome
	Stabilisation					
1	HIE/MIG	Now	In progress	June 2018	TBD	Enable full interoperability across the local health and social care organisations.
2	Message Centre	Now	NA	June 2018	NA	All results are sent straight into the Electronic Patient record and into the message centre of the requesting clinician
4	In-touch integration	Now	NA	June 2018	NA	Allow patients to self-check in and reduce the need for the additional reception staff.
3	Regular Day attender	Now	High	Oct 2018	March 2018	Improved the current workflow and enable a safer patient experience
5	Voice recognition	Now	Medium	Oct 2018	TBD	Correspondence can be validated and sent direct from clinic
6	Consent	Now	Low	Oct 2018	TBD	Automate consent forms and remove the need to print
7	Scanning solution into EPR	Now	NA	Oct 2018	NA	Enable the EPR to become the one source of the truth and updated in real time
8	Removal of Legacy systems	Now	NA	April 2019	TBD	Automate consent forms and remove the need to print
9	NerveCentre in A&E	Now	NA	April 2019	NA	Enable mobile alerting for Sepsis as most cases originate in ED
10	Document Build	Now	NA	May 2019	NA	Enable the EPR to become on single source of the truth and updated in real time
	Current Projects					
1	Blood tracking (Haemonetics)	NA	NA	May 2018 (phase 1)	NA	All blood will be barcoded and identifiable.
2	Ophthalmology (Medisoft)	NA	Low	Aug 2018	TBD	Full bi-directional integration to the EPR
3	Sepsis NerveCentre	TBC	NA	April 2019	NA	Enable mobile alerting
4	PACs	NA	NA	Oct 2019	NA	The sharing of images across the Yorkshire region
	Optimisation					
1	Cardiology (All systems)	Year 1	Medium	Oct 2018	TBD	To enable access to all results and reporting within EPR
2	Pathology	Year 1	NA (in progress)	Oct 2018	TBD	To enable access to all results and reporting within EPR
3	Radiology (HSS	Year 1	NA	Oct 2018	NA	To enable access to all results and

	Solution	Priority CHFT	Priority BTHFT	Implementation Target CHFT	Implementation Target BTHFT	Outcome
	RIS)					reporting within EPR
4	Patient Portal	Year 1	Medium	Oct 2018	TBD	Eliminate the need to send any correspondence/ information to patients
5	Neurophysiology	Year 2	Medium	April 2019	TBD	To enable access to all results and reporting within EPR
6	Audiology	Year 2	Low	April 2019	TBD	To enable access to all results and reporting within EPR
7	Endoscopy reporting	Year 2	Medium	April 2019	TBD	To enable access to all results and reporting within EPR
8	Oncology (PPM)	Year 2	Regional solution	April 2019	Regional solution	Improve stability across multiple organisations (MDT)
9	Infection Control Solution	Year 2	Future	April 2019	TBD	Reduce number of incidents and improve patient safety
10	ICU (Ward watcher)	Year 3	Future	April 2020	TBD	Improve Patient safety
11	Integration of medical devices	Year 3	Future	April 2020	TBD	Improved Quality and safety enable the transfer of results straight into EPR
12	ICE	Year 3	High	April 2020	TBD	GPs to place orders direct into EPR
13	e-prescribing advances	Year 3	Future	April 2020	TBD	Improved patient safety by Closed loop / dose range checking.
14	Chemo-prescribing (Varian)	Year 3	Future	April 2020	TBD	Full integration that will enable improved patient safety
15	Theatres	Year 3	Future	April 2020	TBD	Introduce anaesthetic module as overall package
16	Maternity	Year 4	Future	April 2021	TBD	Cerner used for all patient encounters across the trust
17	Pharmacy (Ascribe)	Year 4	Future	April 2021	TBD	Reduce/eliminate medication errors
18	NICU	Year 4	Future	April 2021	TBD	Eliminate the need of an integration solution
19	NICU BadgerNet	Year 4	Regional solution	April 2021	Regional solution	Eliminate the need of an integration solution patients

Project Name: Digital Health – Next steps

Sponsoring Division: The Health Informatics Service (THIS)

Author: Mandy Griffin

Version 0.2

April 2018

Amendment History

Issue	Date	Author	Reason
0.1	19/04/2018	Mandy Griffin	First draft
0.2	08/05/2018	Mandy Griffin	Amendments
0.3	11/05/2018	Mandy Griffin	Final Amendments

Distribution List

Name	Department / Organisation
Geoff Segal	Cerner
Bob Black	Cerner
Jackie Murphy	CHFT
Alistair Morris	CHFT
Stuart Baron	CHFT
Helen Barker	CHFT
Andy Nelson	CHFT Non Executive

1. Executive Summary

Calderdale and Huddersfield NHS Foundation Trust (CHFT) deployed the Cerner Millennium Electronic Patient Record (EPR) on the 1st May 2017, having entered into a joint partnership with Bradford Teaching Hospitals Foundation Trust (BTHFT). The EPR system went 'live' at BTHFT on 22nd September 2017. This has since been described by Cerner as the largest and broadest big-bang deployment of Millennium in England to date.

There are two ways to implement an EPR either incrementally, over several years, or all in one go. The Trust chose the latter in order to meet our aspiration to be the safest organization in the NHS, Delivering excellent care by putting patients and care given at the centre of everything we do. This was a massive change for the Trust and its workforce and has taken time to stabilise. Many other Trusts who have procured Cerner haven't got a full EPR yet despite having been deploying functionality over multiple years.

This report describes the immediate needs and next steps in achieving stabilisation in areas where issues still remain unresolved. The longer term journey will be described in the 2018-2023 Digital Health Strategy that will be presented to the Trust Board in July 2018. The proposed investment for the next steps is yet to be defined and funding arrangements agreed however it is expected to cover a period of 7 years this is in line with the contract period remaining with Cerner. More details will be presented in the Full Business Case.

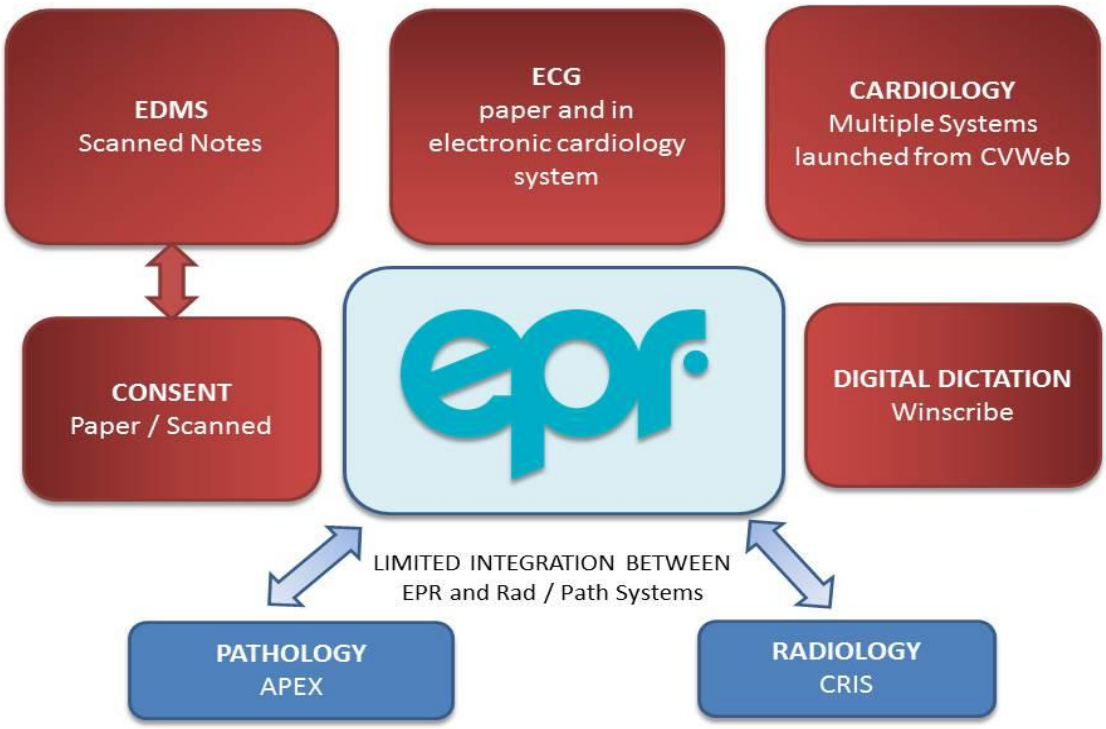
a. Introduction

Beyond the Trusts vision for patient safety, CHFT has an ambition to become the showcase / reference site for Cerner in the UK as well as a desire to influence and lead the NHS digital agenda by being recognised as a Global Digital Exemplar site (GDE) by NHS England which could ultimately attract additional funding. The Trust has demonstrated considerable progress when measured against NHS England's Digital Maturity Assessment. Over a 2-year period CHFT has risen from 113th in the country to a position of 13th. Deloitte on behalf of NHS England recently conducted a site survey to verify this significant improvement. A representative of Deloitte spoke of the impressive nature of the digital health strategy and the capability within the Trust to delivery it.

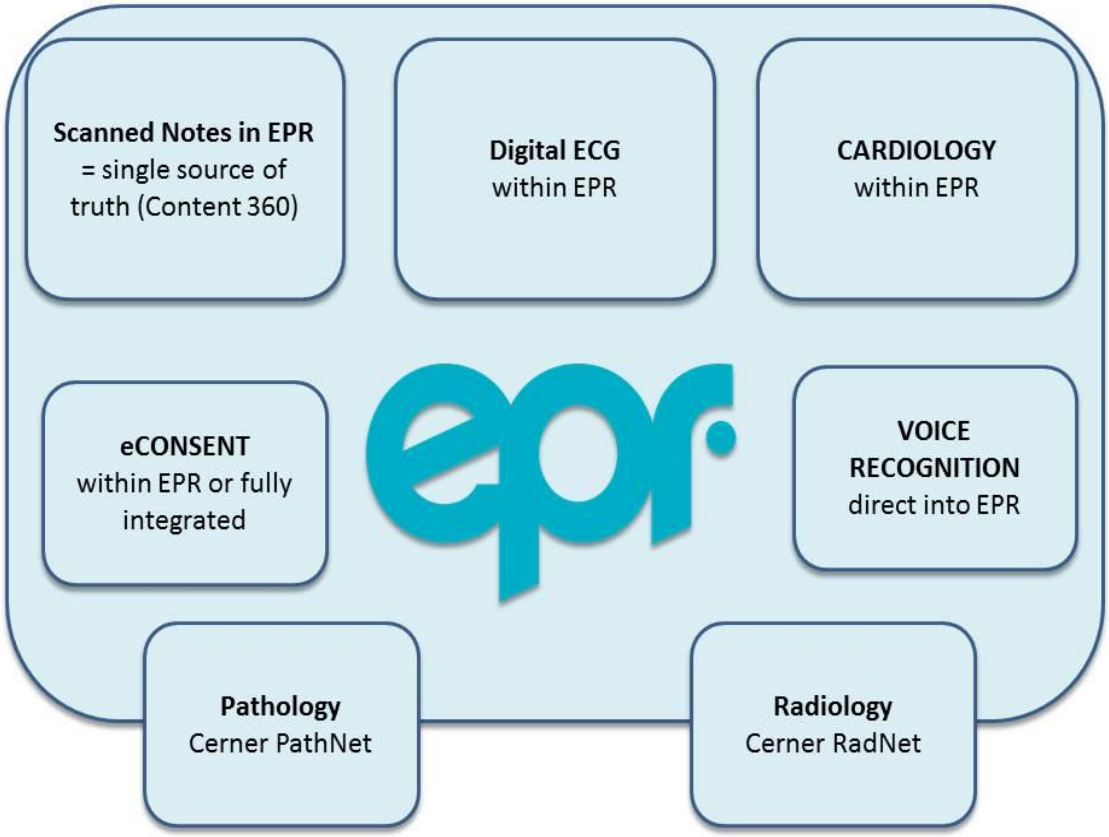
CHFT envisioned an enterprise wide electronic patient record as the core clinical system and a single repository for all patient related clinical information. This vision was a key driver for the implementation project, which resulted in all contracted functional scope being adopted across all departments within the Trust, from day one of go-live. Even in departments where existing systems have been retained, staff have adopted the use of Millennium for many of their workflows.

The diagrams below show the current state and the outcome of adopting our proposed Next Steps.

Current Overview of EPR at CHFT



Overview following Next Steps



The level of organisational adoption already achieved at CHFT gives the Trust a distinct advantage for rapid progression to a fully paperless environment. While the Trust is already paper-light, with doctors, nurses and other health professionals documenting in the electronic record rather than on paper, there are still a substantial number of forms and documents that remain to be digitised.

Since go-live a number of outstanding issues remain unresolved, this is predominately within the Outpatients Department, where there is a continued reliance on legacy systems and solutions that are not integrated. In some situations, clinicians are required to simultaneously access multiple systems in order to obtain a full and safe view of patient information. This takes additional time, impacting productivity and patient satisfaction and does carry risk.

Both BTHFT and CHFT aspire to improve efficiency, patient safety and health outcome and fully recognise the role that information technology has in this regard. Following successful 'go lives' of the single instance, both trusts agreed in January 2018 to a multi-stream approach in order to realise benefits quickly and economies of scale. It was clear that both Trusts could enjoy mutual benefit across a range of work streams by collaborating and sharing the leadership role. The table below describes the 3 workstreams and the lead trust for each:

WORKSTREAM	CHFT	BTHFT
Optimisation - Usability & Digital Breadth	Lead	follower
Quality Improvement (supporting Teaching & Research)	Follower	Lead
Population Health (with BIHR)	follower	Lead

2. Proposed Approach

The Trust has been working closely with Cerner colleagues to develop and agree an optimising strategy that will help resolve these ongoing issues. The strategy describes a phased approach that will address the issues systematically as prioritised by the trust. This programme is designed to address the on-going issues with correspondence and 'Message Centre' and the ongoing need to open multiple systems to ensure that patient information is complete. This currently takes additional time, impacting on patient safety, productivity and staff satisfaction

Phase 1

A stabilization plan was presented to the Board of Directors in December 2017. In January 2018 the number of outstanding items/ actions on the stabilisation action plan stood at 99, as of April 2018 the list has reduced to one this will be addressed by achieving those actions described in phase 2

Phase 2

The EPR team, trust operational managers and Cerner are addressing a number of projects and management actions some of these will have cost implications and will involve some further negotiations they include:-

1. The build and implementation of the Cerner standard Regular Day Attender (RDA) solution
2. Deployment of an interim Message centre solution
3. Deployment of the Medical Interoperability Gateway (MIG)
4. Deployment of an Electronic Blood Tracking Solution
5. Full integration of Medisoft
6. Identifying an e-consent solution
7. Approval/agreement of the full catalogue of standard Documentation

The aim would be to ensure all the above are completed and deployed by April 1st 2019 in parallel with phase 3 thereby securing the required level of EPR optimisation and digital breadth to address the identified operational and patient safety challenges.

Phase 3

The solutions described in this paper would cover the third phase and would focus on obtaining / improving functionality with:-

1. Voice recognition
2. ECG Management
3. Cardiovascular Image Management
4. Scanning solution
5. Pathology

6. Radiology

Details of these priorities are described in Appendix A.

3. Cost / Benefits Assessment

The objectives of this proposal is to reverse the EPR cost impact seen in 2017/18, secure the original benefits case and enable further benefits to be realised.

A number of discussions have already taken place in relation to funding and payment options. However, it is hoped that Cerner will fully recognise the significant benefits to them of working closely with the Trust on this programme and agree that additional charges will be minimal. In return the Trust would serve as the national UK reference site and actively support the national GDE programme.

The Trust will seek to review the commercial offering from Cerner and external parties following the Board's consideration of this proposal. The discussion and negotiation with potential suppliers will look to mitigate additional capital and revenue costs to the Trust and evaluate the best financial model to enable the delivery of the proposal. Once the commercial proposals have been reviewed and evaluated further approval will be sought from the Trust Board prior to commitment.

It is important to note that The Trust did identify the following investment objectives in the original Business Case. These objectives have continued to remain fundamental to the success of this programme.

Investment Objective	Definition	Current status
Facilitate the delivery of new models of care	By 2017 to provide the technical and organisational infrastructure to underpin the transformation of care processes by the EPR	The infrastructure was upgraded and refreshed prior to EPR deployment. This was always part of the 5 year digital strategy.
Improve the quality of care and clinical safety	By 2018 to have demonstrated tangible improvement in these measures through the use of the electronic patient record. (HIMSS 6)	A Gap analysis completed in December confirmed a HIMSS score of 4.5 against the European average of 3.The actions to reach a stage 6 involves ensuring radiology images can be accessed through EPR. The gap analysis was complete against 2017 standards new standards were introduced in 2018. Added to this is the Digital Maturity Assessment score that now ranks us 3rd across

Investment Objective	Definition	Current status
		the NHS, both confirming our high levels of automation and adoption. The trust has already seen significant benefits in patient safety and care. The ability for all members of the multidisciplinary teams to view the patient record from wherever they are located has enhanced clinical conversations and decision making.
Provide staff with a single point of access to all relevant information about a patient	By 2017 to extend the access for all staff to the information they need to do their job	Delivered in context of the scope of the EPR particularly inpatients this has been achieved. The next steps proposal will remove the need to open multiple systems.
Support an improvement in the efficiency, and thus productivity, of the operation of the Trust	By 2018 to have realised the identified benefits thus both improving service quality and reducing cost	Access of the single record anywhere anytime has improved service and quality. The trust has seen reduction in costs in areas such as clinical records, however an increase in cost in the appointment centre and clinic areas through a decrease in productivity has offset any possible saving. The next steps proposal seeks to address this.
Reduce LoS by improving discharge processes	By 2018 to have evidence of further improvements in the reduction of LoS	Since the implementation of the EPR the LoS has improved Pre EPR 5.17 post 4.69
Financial stability by generating cash –releasing benefits	By 2018 to have net benefit from the EPR programme	True cash releasing benefits have not yet been identified other that

Investment Objective	Definition	Current status
		through consumables, stationary and the clinical records department. The next steps proposal seeks to reverse this.
Improve the patient experience	By 2017 to have evidenced improvement in the patient experience through use of the integrated record	The multiple access feature of the EPR has improved the patient experience as more than one clinician can view the record at any time. Giving access to care plans including medications from anywhere at any time. The patient no longer needs to repeat their personal details once admitted.
Facilitate the seamless flow of information to follow the patient between the Trust and other partner organisations	By 2017 to have all relevant information on a patient follow them on their care pathway across the health economy	The patient record can currently be shared electronically with GPs and BTHFT. The MIG is being implemented to allow further interoperability across the health economy

The Trust has already seen significant benefits in patient safety and care. The ability for all members of the multidisciplinary teams to view the patient record from wherever they are located has enhanced clinical conversations and decision making.

The EPR system also enables clinicians to reduce variation in care such as the treatment of sepsis and prevention of venous thromboembolism (VTE). It has prevented patients having to undergo unnecessary investigations as the record indicates when tests have been requested. We are able to respond in a much more timely way to complaints and all investigators now have access to patient records which will enhance the timeliness and quality of investigations.

The core scope of the Cerner solution was always to provide an EPR solution to replace and supplement current systems. However due to pressures on delivering an agreed cutover and a drive to mitigate increasing costs the trust reduced the scope, consequently some of the objectives set, were not achieved. This next steps proposal has been designed to address this as well extend its breath to capitalise on the previously expected cash releasing benefits described below. The intention will be to describe these benefits in detail within the full business.

BENEFIT	2016/17	2017/18	Recurrent benefit	Total Benefits by 2025
Totals	**£0**	**£2,980**	**£2,980**	**£23,840**
	£0	£0	£200 (18/19+)	£1,600
Currently funded roles				£738
Total savings				**£26,178**

4. Capacity/resource implications

With the exception of the Voice Recognition (VR) system the intention would be to deliver all of the next steps as a work package managed through a dedicated project board / team. VR has less dependency on the configuration of the current EPR system and has a shorter development timeline compared to other parts of the strategy. A project for Cardiology ECG Management, while initiated as part of the package, could be delivered within a shorter timeframe, potentially by Dec 2018.

The EPR Business As Usual team will not be able to absorb this programme of work, however they will work closely with the project team to ensure skills and knowledge are retained/ transferred once the systems become fully operational. There will be a need to recruit and implement a dedicated programme team. This will include a combination of trust, THIS and contracting /Agency. It is likely that at least 3 of the analyst roles will be agency to ensure the correct skills are accessible

There is also a plan in place to consolidate THIS EPR Education and Training and Change teams to support on-going optimisation and realise some greater economies of scale. The implementation of the Digital Health team is expected to play a significant part in this programme by utilizing previous engagement tools and by identifying clinical champions. There will be the potential to take commercial advantage and opportunity from this resource in the future.

5. Conclusion

The vision of a single source of the truth through an EPR was at the very heart of the Cerner implementation. This report concludes that:

- The organisation continues to rely on legacy systems and solutions that are not integrated with the EPR, this perpetuates the existing clinical risk where important information is available, but in different clinical systems.
- PACs agfa is included in both options as the business case has been approved and work is already in progress to migrate to the new solution.
- This programme is designed to address the on-going issues with correspondence and 'Message Centre' and the ongoing need to open multiple systems to ensure that patient information is complete. This currently takes additional time, impacting on patient safety, productivity and staff satisfaction
- There will be a need to recruit and implement a dedicated programme team. This will include a combination of trust, THIS and contracting staff.

- It is important that the Trust secures the required level of EPR optimisation and Digital breadth to address the identified operational and patient safety challenges.
- The level of organisational adoption already achieved at CHFT gives the Trust a distinct advantage for rapid progression to a fully paperless environment
- The changes proposed in this report are aligned and supportive of the Trusts ambition to become the Cerner UK reference site and be recognized as a Global Digital Exemplar by NHS England

6. Recommendations

The Board is asked to:

- Confirm agreement with the priorities and associated rationale
- Approve Option 2
- Agree to receive the Full Business Case at a future Board meet

Appendix A

The narrative below gives some context as to why CHFT are focusing on the solutions identified in this first phase.

Voice recognition (VR)
The proposed solution will allow for up to 800 unique users across 40 specialties. This will support clinic letter production as well as clinical entries directly into the EPR. The VR system will automatically launch through Cerner Millennium eliminating the need to open a separate system. The content that is generated from the VR process can be submitted directly from the consultant, alternatively the content can be held by an administrator should further updates be required.

Currently, Homerton University Hospital and Imperial College Hospital in London and the John Radcliffe Hospital in Oxford are all using this system. Uptake within these 3 sites has been averaging 80% and has had a significant impact on clinic productivity and clinic letter turnarounds.

The solution will contribute to the stabilisation of the CHFT EPR particularly in the Outpatients clinics and ward rounds and will reduce the need to open multiple systems.

The Trust is currently using Winscribe digital dictation. Despite several attempts it has not been possible to integrate either the digital dictation or voice recognition functions with the Cerner Millennium product.

Cardiology ECG Management and Cardiovascular Image Management

There are currently a number of different, fragmented Cardiology Information systems within the Trust that are not integrated with each other or the EPR system, resulting in siloed patient information that is not readily available both to cardiologists as well as the rest of the clinical teams in the hospital.

The Cerner ECG Management and Cardiovascular Image Management solutions are embedded within the EPR, allowing for a holistic patient record across diagnostic activities, therapeutic interventions and follow-up regimens.

Electrocardiograms (ECG) are digitised and accessed within the EPR providing all clinicians with the ability to receive and view ECG tracings in a more meaningful way eliminating the need for a separate ECG management module or looking at paper printouts. The proposed solution includes provision of 28 Motara Model 280 ECG Carts and 2 Motara Model 380 ECG Carts enabling ECGs to be directly recorded within the patient record and therefore available, via PowerChart ECG, to all clinicians throughout the Trust who have permission to view the patient record.

Currently the ECG element is deployed in Oxford University Hospitals, The Wirral NHS Foundation Trust and Barts Health NHS Trust.

The Cerner Cardiovascular Imaging Management solution is “first of type” in the UK and has been demonstrated to clinicians within CHFT where it received positive feedback. CHFT could be an early adopter and developer of the system for the UK.

Scanning solution (Content360 solution suite)

Currently CHFT use a separate EDMS scanned record. This is launched separately and carries the clinical risk of missing patient information that has been scanned. In order to have a complete record in EPR, Cerner support a scanning solution that provides document capture, storage, and retrieval ensuring that images are available when and where they are needed.

At the point of care the solution is able to scan content directly into a patient individual record. There is also a facility to scan and extract index values from groups of images, automate the process of posting documents to the electronic patient chart and capture and automatically transfer electronic documents from 3rd party systems into the patient record. We will explore options on reports across all systems including neurophysiology and Endoscopy.

Sandwell and West Birmingham NHS Trust is in progress of deploying the solution whilst outside of the UK, Cork University Hospital has also undergone a successful deployment of the solution. A variation of the solution has also been deployed within Oxford University Hospitals.

Pathology (Pathnet)

The Pathnet solution helps manage all laboratory samples by establishing and maintaining accurate tracking, processing and results recording processes. The system improves the quality of patient care through the verification of key patient demographics, test results and operational quality controls. It is also able to increase the speed of results reporting and automates clinical, financial and managerial processes, within all laboratory disciplines.

The current system (APEX) does not fully integrate with Cerner causing issues with results returning to message centre.

The solution is deployed in The Wirral NHS Foundation Trust, Oxford University Hospitals and Royal Free in London.

The Pathology system within CHFT sits on an old platform with an extended maintenance contract. The contract with DXC for the iLabs/APEX product expires this year. An immediate decision is required in order to confirm the future of systems within the Pathology Department.

Radiology (Radnet)

The Cerner radiology solution provides the radiology department with a fully integrated Radiology Information System. The current HSS CRIS system is integrated but is currently causing issues with results in message centre. The Cerner solution would resolve this.

The current Cerner Radiology solution is deployed in The Wirral NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust.

Joint Electronic Patient Record

Transformation Board Meeting Minutes

Date:	27th March 2018	**Time:**	9.00am – 11.00am
Venue:	Room 4, Acre Mill, Huddersfield	**Chair:**	Clive Kay, Chief Executive, BTHFT (CK)
Attendees:	Alistair Morris, CCIO, CHFT (AM) Bob Black, Client Results Executive, Cerner (BB) Bryan Gill, Medical Director, BTHFT (BG) Clive Kay, Chief Executive, BTHFT (CK) Mandy Griffin, Director of Informatics, CHFT (MG) Paul Southern, Associate Medical Director - Informatics, BTHFT (PS) Sandra Shannon, Acting Chief Operating Officer, BTHFT (SS)		
Apologies:	Owen Williams, Chief Executive, CHFT (OW) Marina Bloj, Governor Representative, BTHFT (MB) (Invited Attendee) Cindy Fedell, Director of Informatics, BTHFT (CF) Gary Boothby, Director of Finance, CHFT (GBo) Matthew Horner, Director of Finance, BTHFT (MH) Brendan Brown, Director of Nursing, CHFT (BBr) Jackie Murphy, Deputy Director of Nursing – Modernisation, CHFT (JM) (optional)		
In attendance:	Vicki Miller, Consulting Manager, Enterprise Consulting, Cerner (VM) Sarah Vallance, PA, CHFT (SV) (Minute Taker) Wale Lawal, Healthcare Executive, Cerner, (WL) (Optional Attendee) Bob Black, Healthcare Executive, Cerner (BB)		

	Agenda Item/Discussion	Action
1.0	**Apologies for Absence** CK opened the meeting. Apologies were noted.	

2.0	**Previous Actions & Minutes** The 29th January 2018 minutes were approved as circulated. The following action item updates were provided. **29 January 2018 8.0 Working in Partnership - MG to co-ordinate a meeting with CF and BB to review Cerner service requests and to develop a plan with timelines. –** On agenda. **29 June 2017 8.0 Working in Partnership - BG to set up an Action Group to look at producing a Case Study of the joint EPR Programme. –** On agenda. **31 January 2017 3.2 Future Functionality Review - Meet to establish 'Getting it Right First Time (GIRFT) initiative to understand where this fits in EPR –** On agenda. **19 April 2017 4.2 Programme Status Report – training update - To consider a joint venture between BTHFT and CHFT for business as usual training. 29 January 2017 BB to send guidance to the Trusts.** BB unsure of this action, it was agreed to discuss further outside of the meeting with MG. **13 October 2017 3.2 Cerner Outstanding Issues - MG to provide a paper at the next meeting providing an update on progress of the issues list. –** On agenda.	
3.0 **3.1**	**Matters Arising** **HIE / MIG** AM confirmed that CHFT have purchased the MIG to bypass TPP, OW is the lead on this project with Rob Birkett, and a PID is currently being developed. PS confirmed that BTHFT are working with Embed the CCG IT provider and CF is leading on this. He did confirm that there was no clinical risk to BTHFT.	
3.2	**Governance** MG explained that CF had circulated the Governance document yesterday; the adjustments that had been requested have been made and could be viewed through the track changes. MG suggested that as colleagues may not have had time to view the document that the group approve on-line by COP Tuesday 3rd April. Approval to be sent to CF/MG/CK. The group had a discussion on the frequency of the Transformation Board meetings, it was agreed that that they will continue to be bi-monthly until the partnership agreement has been confirmed, and they will then change to quarterly.	All

	MG confirmed that the Programme Board will continue to meet monthly. It was agreed that the next meeting of the transformation board would be Friday 1st June at BRI, time and room to be confirmed.	
3.3	**Transformation Board Work Plan** MG highlighted the work plan grid and explained that it is a work in progress as it will need to match the Governance plan. It was agreed to change the date from May to June and to swap the Adoption & Usage and Risk & Clinical Hazards dates round as Risks and Clinical Hazards was on the agenda for this meeting.	MG/CF
3.4	**EPR Case Study** BG commented that the first instance was to look at the key findings of the partnership meeting. AM /PS are to meet with the Non Executives to capture the essence. It was agreed to bring an update to the next meeting.	BG
3.5	**GIRFT Fit with EPR** BG commented that he had been invited to the Carter Meeting in June & he and DB need to discuss further. He agreed to bring an update to the September meeting.	
4.0 **4.1**	**Delivery of Objectives** **Benefits Realisation** MG commented that this had been discussed at Programme Board, the benefits are different in each trust and it had been agreed to share learning and best practice however the trusts would work independently as BTHFT had 102 benefits listed against 30 for CHFT. MG explained that it would be difficult for the trusts work together, CHFT have set up a change team,BTHFT are looking at doing something slightly different. It was confirmed that escalations would be brought to this meeting. The group had a discussion on the benefits/disadvantages of working separately on the benefits. It was agreed to share the common big items and keep the trust specific ones separately. It was agreed that BTHFT would share the GE report that they had received on their benefits. BG/PS to action.	BG/PS

5.0 **5.1**	**Assurance** **Programme Board Update** MG commented that Message Centre issues have been escalated; they are looking at an interim solution. The priority is the Emergency Care Data Set (ECDS), this work has to be completed by the 1st April and so the BAU team have been focusing on this work. Benefits have already been discussed.	
5.2	**Programme Status Report** MG commented that this is a weekly report that is run by the BAU team and had been discussed at Programme Board. The group discussed the report and it was asked if it could be made a bit more user friendly and it was agreed that timelines should be included rather than stating "to be determined". MG to ensure report is more user friendly for next meeting.	MG
5.3	**Outstanding Issue Plan** MG explained that in August 2017 (12 weeks after go live for CHFT) a paper had been presented to the board on the outstanding issues; MG gave an update of the issues. It was agreed that for Voice Recognition BTHFT would be included in plans to visit Oxford to view the Cerner system in use. There was a discussion on Medisoft; AM confirmed that BTHFT ophthalmologists had been invited along to any meetings that CHFT were having however there had been little take up. It was agreed that it would be a benefit for both trusts to look at this even if they decided to go live in a phased approach. BB was asked to feedback on Royal Berkshire charging issue.	
5.4	**Incident Report** BB explained that at go-live there were over 3,000 issues logged on Remedy on Demand (ROD) and that this has reduced to approximately 600 at the time of writing the report. He explained that the number of incidents being reported to Cerner will remain high until the BAU team gain more confidence and knowledge of the system. The team have attended a number of courses at Cerner and although this has taken them out of the office they are picking the system up well and so logs will start to reduce. BB confirmed that monthly meetings were taking place to look at the status of all	

	items and that they are having weekly calls with the team as well. He thought that the number of incidents reported to Cerner were not excessively high and are in comparison to a trust with a single site for the first year. There was a discussion on the perception of logging a job on ROD and the response that is currently given. It was agreed that communication is required on the role of Remedy; the process needs to be described so that staff know how to log a job and that they receive a response describing the process rather than a standard response which gives no update. WL commented that Cerner have an ideas portal, he would share the content and how they respond to requests with the team.	MG/CF WL
6.0	**Roadmap** AM commented that Deloitte (on behalf of NHS Digital) had been to visit CHFT to view the digital maturity, he also explained that HIMMS had been looking at CHFT's EMRAM status. The group had a discussion on the HIMSS stages as there had been significant changes to the standard that will make achieving a stage 6 much more difficult. Existing stage 6 trusts my struggle when re-assed in 3 years. . The group discussed the benefit around obtaining HIMSS status and agreed that its focus was on improving patient safety. MG commented that both organisations were looking at developing their digital strategies.	
7.0	**Risks & Hazards** AM gave an overview of the position for CHFT, he explained that a Risk Panel meeting had been established approximately 6 months ago and the focus was moving the clinical hazards onto the corporate risk register. PS commented that BTHFT was just starting with this process. PS confirmed that a monthly joint risk meeting had been arranged to ensure all joint EPR risks were being captured especially around Capacity and the BAU team. AM commented that the SI on correspondence for CHFT was being finalised and would bring the report to the next meeting. It was also agreed to share recommendations from both Correspondence investigations to ensure they have similar recommendations. Governance Leads from both organisations to pick this up. The group had a discussion on correspondence and it was agreed partners need to	AM/BG AM/PS

	be included in this to see what work can be done to streamline and improve the current system. CHFT have already set up a group to do this It was confirmed that joint risks would be brought to Transformation Board and that further work was needed with Primary care to help improve the correspondence system.	
8.0	**Working in Partnership** MG presented s proposal that had been developed and agreed by CHFT and Bradford. The proposal explained a multi-streamed approach to the work going forward. The paper is the shared vision and the basis for a strategic partnership agreement with Cerner BB commented that the draft commercial terms for the proposal were being developed as it is quite a unique approach, having two trusts working in parallel on complimentary strategies and gaining benefits from each other. The document describing the commercial arrangements should be released next week.BB to share the commercial proposal.	
9.0	**Items to Escalate to the Risk Register** No items	
10.0	**Any Other Business** No items	
11.0	**Date & Time of Next Meeting** The next meeting will be held on 1st June 2018, 1.30 – 3.30pm at Teaching room 1, BRI.	

Action Item ID	Action Item	Target Date	Respon sibility	Status
27 March 2018 3.2 Governance	The group agreed to approve the revised Governance document on-line by COP Tuesday 3rd April. Approval to be sent to CF/MG/CK.	3 April 2018	All	*Open*
27 March 2018 3.3 Transformation Board Work Plan	It was agreed to change the date from May to June and to swap the Adoption & Usage and Risk & Clinical Hazards dates round as Risks and Clinical Hazards was on the agenda for this meeting.	April 2018	CF	*Open*
27 March 2018 4.1 Benefit Realisation	It was agreed that BTHFT would share the GE report that they had received on their benefits.	April 2018	BG/PS	*Open*
27 March 2018 5.2 Programme Status Report	The group discussed the report and asked if it could be made a bit more user friendly and it was agreed that timelines should be included rather than stating "to be determined".	June 2018	MG	*Open*
27 March 2018 5.3 Outstanding Issues	Medisoft - BB was asked to feedback on Royal Berkshire charging issue. PS to discuss with Rachel from BTHFT	April 2018 April 2018	BB PS	*Open* *Open*
27 March 2018 5.4	It was agreed that communication is required on the role of Remedy; the process	June 2018	MG/CF	*Open*

Action Item ID	Action Item	Target Date	Responsibility	Status
Incident Report	needs to be described so that staff know how to log a job and they receive a response as to the process it will go through rather than a standard response which gives no update. WL commented that Cerner have an ideas portal, he would share that format with the team.	June 2018	WL	*Open*
27 March 2018 7.0 Risks & Hazards	It was confirmed that joint risks would be brought to Transformation Board and that further work was needed with Primary care to help improve the correspondence system. It was also agreed to share recommendations from both Correspondence investigations to ensure they have similar recommendations. Governance Leads from both organisations to pick this up.	June 2018 June 2018	PS/AM BG/AM	*Open* *Open*
27 March 8.0 Working in Partnership	BB to share the commercial proposal	June 2018	BB	*Open*
29 June 2017 8.0 Working in Partnership	BG to set up an Action Group to look at producing a Case Study of the joint EPR Programme. 27.03 agreed to bring update to June Meeting	June 2018	BG	*On agenda*
31 January 2017 3.2 Future Functionality	Meet to establish 'Getting it Right First Time (GIRFT) initiative to understand where this	September	BG	*Open*

Action Item ID	Action Item	Target Date	Responsibility	Status
Review	fits in EPR 27.03 BG agreed to bring update to September meeting	2018		
19 April 2017 4.2 Programme Status Report – training update	To consider a joint venture between BTHFT and CHFT for business as usual training. 29 January 2017 BB to send guidance to the Trusts.	March 2018	BB	Open
29 January 2018 8.0 Working in Partnership	MG to co-ordinate a meeting with CF and BB to review Cerner service requests and to develop a plan with timelines.	March 2018	MG	*Closed*
13 October 2017 3.2 Cerner Outstanding Issues	MG to provide a paper at the next meeting providing an update on progress of the issues list.	March 2018	MG	Closed - duplicate
13 October 2017 2.0 Previous Actions & Minutes	CF to work with colleagues to propose a process to complete a road-mapping exercise.	Next meeting	CF	Closed
13 October 2017 3.1 TPP Status Update	PS collaborating with AM will speak to the LMCs within the next two weeks for the letter to TPP regarding information governance agreement to be produced and signed by the Trusts, LMC's and CCG's.	End of October 2017	PS	Closed
16 September 2017 2.0 Previous Actions & Minutes	BB to send the Cerner IP Strategic Partnership agreement to the Trusts for review.	30 November 2017	BB	Closed
31 January 2017 3.2 Future Functionality Review	Find out how both Trusts could standardise Clinical coding procedures	December 2017	MG	Closed

Action Item ID	Action Item	Target Date	Responsibility	Status
16 September 2017 3.1 Health Integration Exchange (HIE)	The two CCIOs with the Medical Directors will draft a note with GPs to be provided to TPP.	13 October 2017	PS	Closed. See new action item.
1 September 2017 5.0 Risks 4.3 Business as Usual Update	PS with AM to draft a list of functionality in scope of the EPR to cascade to clinicians.	13 October 2017 ~~15th September 2017~~	PS	Closed.
16 September 2017 3.1 Health Integration Exchange (HIE)	BB to find out whether other trusts have a rolling monthly contract with the MIG.	13 October 2017	BB	Closed
16 September 2017 4.0 Business As Usual	MG with CF will cost out the substantive proposal for final approval.	13 October 2017	MG	Closed
28th July 2017 5.0 Risk	WL to speak with the CCIOs to address the risk around situations where there is no EPR encounter for a patient before the next meeting in September 2017.	13 October 2017 15th September 2017	WL	Closed

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** amber fox, PA to Director of THIS
Date: Thursday, 7th June 2018	**Sponsoring Director:** Mandy.griffin, Director of THIS
Title and brief summary: Deloitte report on Digital Maturity - See Executive Summary	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

This report and the work connected were subject to the Terms and Conditions of a contract between NHS England and Deloitte LLP. The report is produced for the use of NHS England for the purpose of assisting management with their assessment of the evidence supporting a sample of Digital Maturity Tool self-assessment submissions.

The Digital Maturity Index was established by NHS England in 2016. In completing the Digital Maturity self-assessment tool on a regular basis, providers were able to demonstrate their digital maturity position whilst enabling NHS England to track and validate progress towards operations which are “paper free at the point of care” as part of the NHS vision for digital technology.

The attached site Report summarises the self-assessment responses provided by Calderdale & Huddersfield NHS Foundation Trust (CHFT) in respect of its services and the summary outcomes of the testing of a non-statistical sample of 34 questions from the 200 included in the Digital Maturity Tool.

The Trust was visited on 20th February 2018, to consider the logical rationale of the trust response and to ensure the trust could provide evidence to support that response.

This year’s self-assessment submission showed a significant increase in digital maturity, primarily driven by responses in the Medicines Optimisation section. This change was predominately due to the rollout of the Cerner Millennium EPR system.

Main Body

Purpose:

See Executive Summary

Background/Overview:

Outcome

The assessment identified that the rationale provided by the Trust supported the self-assessment response for the vast majority of sample questions tested, with only three exceptions identified. The three exceptions were:

1, You receive assurance on a regular basis that your suppliers and digital assets are secure. The self-assessment was “Disagree Completely”. However, we noted that Service Auditor Reports are received from third parties which provide assurance over the controls that the third parties provide. Therefore, due to some levels of assurance being provided to the Trust, we have concluded that this response could have been more positive than the Trust response.

2, Your organisation uses digital systems to manage staff rostering. The self-assessment was “Mostly Agree”. The Trust use the digital rostering system Allocate to manage rosters for all nurses across the Trust. However, we observed that the assignment of shifts must still be entered manually on the system. In addition rostering for doctors is not done on Allocate and this remains a paper-based system. As rostering for doctors is not yet done on Allocate, and this remains a paper-based system, we have concluded that this response could have been more negative than the Trust response.

3, Business-critical digital services are supported by documented disaster recovery processes, with clear roles & responsibilities assigned. The self-assessment response was “Mostly Agree”. The Trust has in place a formal documented Business Continuity plan intended to facilitate the recovery of business processes in the event of disruption. The plan contains a detailed section regarding IT Disaster Recovery, with key information such as roles and responsibilities and target times for recovery of critical systems included. We saw evidence to suggest that 'Agree Completely' could have been the response.

Further details of the 34 questions that were sampled are available on the attached report.

The Issue:

N/A

Next Steps:

N/A

Recommendations:

The Board of Directors is asked to note the content of this report.

Appendix

Attachment:

NHS England - Digital Maturity QA - Site Visit Report - CHFT.PDF

Deloitte.

NHS England

Digital Maturity Assessment: Quality Assurance Site Report

Calderdale & Huddersfield NHS Foundation Trust

Date of Visit	20 February 2018		
Sites	Calderdale Royal Hospital Salterhebble Halifax HX3 0PW	Huddersfield Royal Infirmary Acre Street Huddersfield HD3 3EA	Acre Mills Outpatients Acre Street Huddersfield HD3 3EB
Principal contacts	Mandy Griffin (Managing Director for Digital Health) Jackie Murphy (Director of Nursing for Digital Health) Alistair Morris (Chief Clinical Information Officer & Paediatric Consultant)		
Deloitte visit team	Ben Beresford James Wilcock Dr. Vineta Bhalla		

27 April 2018

Deloitte LLP
1 City Square
Leeds LS1 2AL

www.deloitte.co.uk
regeorge@deloitte.co.uk

27 April 2018

FAO: Mandy Griffin
The Health Informatics Service
Calderdale & Huddersfield NHS Foundation Trust
Oak House, Woodvale Office Park
Brighouse HD6 4AB

Release of our Digital Maturity Assessment: Quality Assurance Site Report dated 27 April 2018 ("the Report") addressed to NHS England ("our Client")

You have requested a copy of the Report for information purposes only in connection with supporting the Digital Maturity Programme (the "Purpose"). The Report was documented on the basis of a one day visit and assessment of evidence provided. The Report is confidential and our Client has sought our consent for the Report to be disclosed to you. We will agree to disclose the Report to you and, at our discretion, provide information or explanations in relation to the Report (together "the Information"), on the basis of the following:

a) The Report was prepared solely for the use of our Client and was not prepared for your use or with your interests in mind;

b) We have not updated the Report since its release to our Client and are not obliged to do so. Events may have occurred after the date of the Report which would change its content, had they been known when the Report was prepared;

c) You will not disclose or make available the Information to any other party except as required by law or regulation;

d) If you choose to rely upon the Information, you do so entirely at your own risk and without recourse to the Deloitte Parties. The Deloitte Parties have no liability or responsibility to you in contract or tort or otherwise for any loss, damage, cost or expense caused by your use of or reliance on the Information; and

e) You agree not to bring, or threaten to bring, any actions, proceedings or claims against any of the Deloitte Parties in connection with the provision of the Information to you.

The "Deloitte Parties" means all entities (including Deloitte LLP) that are members of the Deloitte Touche Tohmatsu Limited ("DTTL") worldwide network and each of their subsidiaries, predecessors, successors and assignees, and all partners, principals, members, owners, directors, employees, affiliates and agents of all such entities.

The Deloitte Parties may (individually or collectively) in their own right enforce the provisions of this agreement which refer to the Deloitte Parties. This letter (including all contractual and non-contractual rights and obligations arising out of or relating thereto) is governed by English law and the English Courts shall have exclusive jurisdiction to settle any dispute that may arise in connection with it.

Yours faithfully

Rebecca George

Partner

Deloitte LLP

Introduction and Context

The Digital Maturity Index was established by NHS England in 2016. In completing the Digital Maturity self-assessment tool on a regular basis, providers were able to demonstrate their digital maturity position whilst enabling NHS England to track and validate progress towards operations which are "paper free at the point of care" as part of the NHS vision for digital technology.

NHS England continues to progress this Digital Maturity Programme in order to assess changes to and advances in digital maturity at NHS provider organisations. The responses reflect digital maturity self-assessments completed by providers based on a Digital Maturity Self-Assessment tool and have been compared to baseline data. The Digital Maturity programme team has developed, as part of the QA work package, a QA approach to assess the content of the provider self-assessment responses.

This Site Report summarises the self-assessment responses provided by Calderdale & Huddersfield NHS Foundation Trust (CHFT) in respect of its services and the summary outcomes of our testing of a non-statistical sample of 34 questions from the 200 included in the Digital Maturity Tool.

We visited the Trust on 20 February 2018. We would like to take this opportunity to thank the Trust for hosting the site visit, and the strong levels of engagement with the QA process and with our team and lines of enquiry.

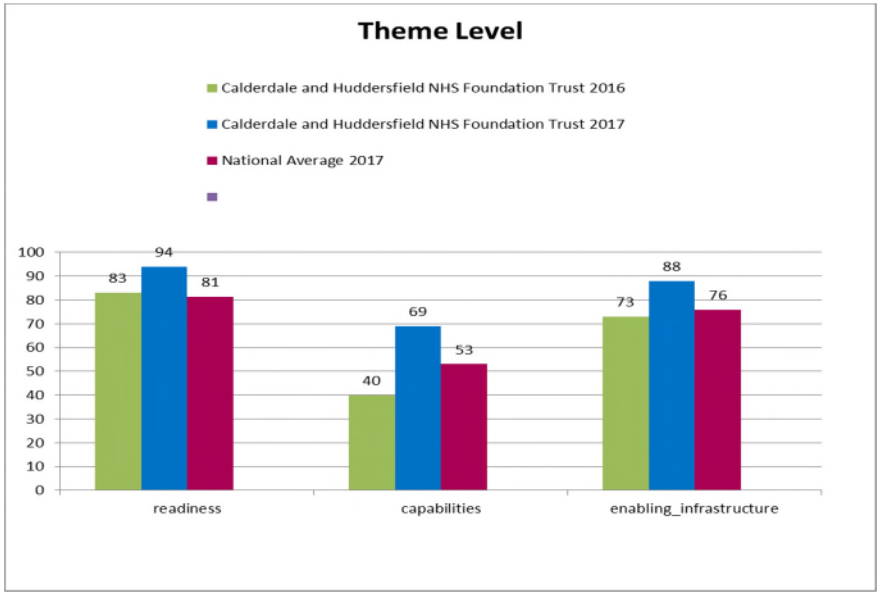
Approach

Prior to our site visit, we undertook a desktop analysis of the self-assessment Digital Maturity Tool submission in order to determine areas of focus, within the Digital Maturity Tool question sample, for the site visit.

At our visit we considered the extent to which the rationale given by the Trust, in our judgement, supported the responses provided. We then assessed the extent to which documentary and observed evidence provided validated the Trust responses. The summary results set out in this report are therefore based upon results from testing the logical rationale to support sampled responses; testing the availability of documentary evidence and the consistency of evidence to support self-assessment responses. In addition, the corroboration of test results was supported through a walkthrough of a sample of relevant clinical/administrative processes. On this basis, we reached the following conclusions for these two tests for each sample question:

- **Logical rationale to support Trust response** – the ability to follow the explanations given by the provider and conclude that, in our judgement, it supported the response submitted within the self-assessment Tool. For each sample question, we have concluded with one of *Agree, Partially Agree* or *Disagree*.
- **Consistent evidence to support Trust response** – the ability to confirm the availability of documentary evidence which was consistent with the response provided within the self-assessment Tool, or we were able to corroborate responses through process walkthrough. For each sample question, we have concluded with one of *Available*, *Partially Available* or *Not Available*.

Summary of Self-Assessment



CHFT has approximately 6,000 dedicated staff, working across two hospital sites, covering a population of 500,000 citizens. The Trust provides predominantly Acute along with some Community services.

The Trust has undergone a significant period of modernisation in the last three years, culminating in a 'big bang' rollout of their Cerner Millennium EPR. This period also included the implementation of the Nervecenter e-Observations system, Bluespier theatre management system, and the back-scanning of 250,000 volumes of clinical notes onto an Electronic Document Management System (EDMS).

The Trust has opted to keep a small number of other clinical systems, namely the Medisoft Ophthalmology and Athena K2 Maternity system. The Trust is working closely with Cerner to develop interfaces between these applications and the EPR.

This year's self-assessment submission showed a significant increase in digital maturity, primarily driven by responses in the Medicines Optimisation section. This change was due to the rollout of the e-Prescribing functionality within the Cerner Millennium EPR system to process prescriptions digitally. In addition, the use of Cerner Millennium EPR to record clinical observations, notes and care plans going forward were key drivers behind the self-assessed enhancements in the Records, Assessments & Plans responses.

The scores for Readiness, Capabilities and Enabling Infrastructure are broken down overleaf.

CDDFT Section-level Scores		
DMI Tool Section	**2016**	**2017**
Readiness		
Strategic Alignment	88	100
Leadership	95	100
Resourcing	85	95
Governance	85	100
Information Governance	63	76

CDDFT Section-level Scores		
DMI Tool Section	**2016**	**2017**
Capabilities		
Records, Assessments & Plans	36	76
Transfers of Care	55	81
Orders & Results Management	67	80
Medicines Optimisation	11	85
Decision Support	36	57
Remote & Assistive Care	50	40
Asset & Resource Optimisation	35	57
Business & Clinical Intelligence*	n/a	66
Standards	29	75

CDDFT Section-level Scores		
DMI Tool Section	**2016**	**2017**
Enabling Infrastructure		
Enabling Infrastructure	73	88

* Business & Clinical Intelligence was a new section added to the DMI tool for 2017.

Source: NHS England Digital Maturity Programme Team

Cerner Millennium EPR Implementation 'Case Study'

The Trust procured Cerner Millennium jointly with neighbouring Trust Bradford Teaching Hospitals NHS Foundation Trust, based on a collaborative agreement allowing for the Cerner contract to provide services to both Trusts. The Trust identified that sound governance arrangements, with independent programme milestone reviews, were key in ensuring a successful partnership. At CHFT the deployment involved 600 'EPR Friends' – staff members who had received additional training and who offered guidance on the system's use – as well as 170 'EPR Floorwalkers', who had worked on similar projects across the country, along with implementation support from Cerner. There were also 600 'EPR Volunteers', who provided help to patients and members of the public during the go-live process.

The 'big bang' approach, tailored with in-depth training of staff and the general public, appears to have been successful. Despite being one of the newest partners to implement Cerner Millennium in the country, CHFT rank first out of all UK Cerner partners on EPR Chart opens, documents signed, medications administered from EPR, diagnoses created, and allergies documented per month.

Summary Findings

Our assessment identified that the rationale provided by the Trust supported the self-assessment response for the vast majority of sample questions we tested, with only three exceptions identified where we partially agreed with the response given. Our assessment conclusions for the tested self-assessment questions is summarised in the following table:

	Rationale to Support Responses			Evidence to Support Responses			
	Agree	**Partially Agree**	**Disagree**	**Available**	**Partially Available**	**Not Available**	**N/A**
Readiness	7	1	0	7	1	0	0
Capabilities	21	1	0	22	0	0	0
Enabling Infrastructure	3	1	0	4	0	0	0
Total	**31**	**3**	**0**	**33**	**1**	**0**	**0**

Based on the evidence and our discussions, we noted the following exceptions where we only partially agreed or disagreed with the Trust's rationale:

- R5.5 - *You receive assurance on a regular basis that your suppliers and digital assets are secure.* The self-assessment was "Disagree Completely". However, we noted that Service Auditor Reports are received from third parties which provide assurance over the controls that the third parties provide. Therefore, due to some levels of assurance being provided to the Trust, we have concluded that this response could have been more positive than the Trust response.
- C7.4 – *Your organisation uses digital systems to manage staff rostering.* The self-assessment was "Mostly Agree". The Trust use the digital rostering system Allocate to manage rosters for all nurses across the Trust. However, we observed that the assignment of shifts must still be entered manually on the system. In addition rostering for doctors is not done on Allocate and this remains a paper-based system. As rostering for doctors is not yet done on Allocate, and this remains a paper-based system, we have concluded that this response could have been more negative than the Trust response.
- I1.9 - *Business-critical digital services are supported by documented disaster recovery processes, with clear roles & responsibilities assigned.* The self-assessment response was "Mostly Agree". The Trust has in place a formal documented Business Continuity plan intended to facilitate the recovery of business processes in the event of disruption. The plan contains a detailed section regarding IT Disaster Recovery, with key information such as roles and responsibilities and target times for recovery of critical systems included. We saw evidence to suggest that 'Agree Completely' could have been the response.

Next Steps

CHFT are focussing on the optimisation of its EPR, and is working closely with Cerner and its other suppliers to develop interfaces between the EPR and standalone clinical systems. The Trust is also considering options to improve interoperability with other providers in the region, for example Mental Health and Ambulance services.

Testing Results

We sought to test the rationale and evidence to support self-assessment responses based on a sample of 34 Tool questions across the four main sections and each sub-section. The sampled questions are denoted by the position in the Digital Maturity Tool and annotated by R for Readiness, C for Capabilities, and I for Infrastructure.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
R1.1 Your organisation has a clearly defined digital strategy which is aligned to clinical and corporate objectives.	Agree Completely	Agree	Available	We found that the Trust has in place a Five Year plan for digital transformation, which was created in 2016 and is updated on an annual basis. Digital Health is a standing item for Board meetings. The Trust has regular specific Digital Health meetings on a monthly basis to monitor progress against the plan. Progress against the Five Year plan is ultimately monitored by the Board and reported to the Finance Committee.
R2.3 You have clinical leadership, represented by a board-level or equivalent position, involved in the digital agenda.	Agree Completely	Agree	Available	The primary representative for clinical leadership is the Chief Clinical Information Officer/Paediatric Consultant. The CCIO is heavily involved in the decision making process for the digital agenda. The Director of Nursing for Digital Health is also directly involved in the decisions over the digital agenda, ensuring that nursing staff are also adequately represented.
R2.8 Your organisation engages with health and care professionals to ensure digital solutions meet evolving organisational needs.	Agree Completely	Agree	Available	Our discussion with the Chief Executive found that the regular meetings to monitor and update the digital strategy plan are required to include both clinical and technical staff to ensure clinical objectives are being considered. This was not limited to clinical leadership; the Trust has valued input from clinical and operational staff across the Trust to support digital transformation. Such input drove the Trust's decision to keep a small number of clinical systems, e.g. AthenaK2 for the maternity department, instead of replacing these with the Cerner EPR, as the Trust has noted a high level of staff satisfaction in the use of these systems.
R3.8 There is financial strategy to support the investment in digital technology you require over the next 2-3 years.	Mostly Agree	Agree	Available	We found that the digital transformation plan has been financially assessed and subsequently provided with the funding of £3million per year across the current Five Year plan. The full implementation of EPR across the Trust is estimated to cost around £25million and the Trust will require further funding support going forward.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
R4.3 Digital projects are underpinned by valid business cases and fully-engaged business owners.	Agree Completely	Agree	Available	All digital projects at the Trust are underpinned by business cases. We were provided a copy of the Full Business Case for the Trust's EPR programme and confirmed it aligned to HMT's Five Case model for business cases. We observed a strong level of staff engagement with digital technology initiatives. We were informed of teething issues encountered with recently deployed systems, but staff maintained strong support of the deployments for long-term advancement.
R4.4 Following deployment, your organisation evaluates the benefits of digital projects using a consistent approach.	Agree Completely	Agree	Available	High-level anticipated benefits are captured and quantified as part of the Trust's digital project business cases. These were identified for the Trust's "Integrated Electronic Patient Record Full Business Case" for the Cerner Millennium implementation, with each benefit being aligned to a Trust strategic objective. The Business Case details how the Trust sought overseas and UK evidence from previous EPR implementations to support its benefit profile. Post-implementation, we understand the Trust adopts a consistent benefits management approach to evaluate and track the benefits of digital projects. A Benefits Register is initiated and maintained throughout the life of the programme, and a Benefits Realisation Plan is developed during the implementation phase to identify how the benefits will be delivered, and tracked post-implementation to ensure that the identified benefits are being realised.
R5.2 Governance structures are in place to manage key information risks and cyber threats.	Agree Completely	Agree	Available	The Trust has several governance measures in place to manage information risks and cyber threats. The Trust has a dedicated Cyber Security Manager and there are further plans in place to appoint a Data Protection Officer by the end of March 2018 in compliance with the incoming GDPR regulations. The Trust has a dedicated Information Governance Group, which is an executive committee, chaired by the Medical Director. Cyber Security has become a standing item for discussion at Board meetings since the May 2017 'Wannacry' cyber-attack on a number of NHS Trusts. CHFT was not affected. The Trust has three ISO accreditations related to its management of information: 9001, 27001 and 22000.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
R5.5 You receive assurance on a regular basis that your suppliers and digital assets are secure.	Disagree Completely	Partially Agree	Partially Available	With the exception of Cerner, the Trust's third party providers do not assign a Clinical Safety Officer to the Trust's instance. Therefore it is a challenge to the Trust to obtain assurance that their digital assets are properly secure. We noted that Service Auditor Reports are received from some third parties in order to provide assurance over the controls that the third parties provide. These are not received from all third parties to whom the Trust outsource services. Therefore, due to some levels of assurance being provided to the Trust, we have concluded that this response could have been more positive than the Trust response.
C1.1-3 What proportion of each of the following types of records is available digitally in your organisation: • Clinical Notes • Clinical Observations • Care Plans	- 81% - 100% - 81% - 100% - 81% - 100%	Agree	Available	The Trust has implemented the new Cerner Millennium EPR system and as such all clinical observations, notes and care plans since 2017 are recorded and available digitally. The Trust has implemented an Electronic Document Management System (EDMS) in order to store and archive historic clinical notes, observations and care plans. These were previously stored on site. We understand that the medical records storage facility is now handling greatly reduced amounts of paper documentation. The Trust retains approximately 260,000 records on paper many of which are legacy records pertaining to deceased patients. It was estimated that around 80-90% of the scanning of paper records has been completed.
C1.10 When using digital records, health and care professionals can find what they need quickly and easily.	Mostly Agree	Agree	Available	We understand that the digital health records that have now been stored in the EDMS system are not organised in the same way as paper records were. The records are grouped by 'episodes' which are described as separate periods of treatment. There is also no way to search the records for key words or filter by location or date/time as the records are scanned images. Despite this method of grouping records, the user interface for EDMS was confirmed to be straightforward and easy to use, displaying easily accessible tabs for treatment episodes which can be easily explored by users. When compared to the turnaround time to retrieve paper medical records of around 24 hours (as confirmed by staff in the records department), this represents a significant improvement in speed. Overall whilst the organisation of records in EDMS is not fully optimised, it is a marked improvement on retrieving paper records and as such we concur with the Trust response of 'Mostly Agree'.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C1.11 Healthcare professionals use digital systems to capture relevant patient information at the point of collection.	Agree Completely	Agree	Available	There are no longer paper records taken of any patient information at the point of collection within CHFT. Recording of this data is undertaken directly into the relevant system.
C1.12 Information is collected/recorded once.	Mostly Agree	Agree	Available	During the site visit we observed that in the majority of cases information is only recorded once and that this is done directly into the relevant digital systems. This can be either directly into the Cerner EPR, as is the case for many users of the system, or alternatively information is recorded into another clinical system which is configured to transfer the information directly into the EPR. We observed some slight exceptions to this during our visit, the first of which was the Bluespier system that the Trust uses to manage their operating theatre procedures. We observed that the system duplicates a paper theatre register which is still maintained by staff in the theatre, although it is currently being discussed whether it is possible for all of the theatre recording to be done purely digitally. The second exception we noted was with the AthenaK2 maternity system which records some information that is also recorded on the EPR, although this is limited to certain pieces of information such as allergies to specific medications. Due to these noted exceptions we concur with the Trust response of 'Mostly Agree'.
C2.1 What proportion of referrals received for non-urgent assessment are automatically integrated into digital workflows?	61% - 80%	Agree	Available	We confirmed that the majority of non-urgent assessment referrals are automatically integrated into digital workflows as they are received by email from GPs and entered directly into the Cerner EPR, which initiates a workflow for treatment. It was however noted that some referrals are still received from GPs via a paper letter although this is an uncommon circumstance. In the event that a paper referral is received these will required scanning into the EDMS system and logging manually within EPR in order to initiate a workflow. The Trust confirmed that they are currently measuring a 69.1% rate of digital referrals. Due to the above statistics and observations made we agree with the Trust response of '61%-80%'.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C2.16 At inpatient and day case discharge, what proportion of discharge summaries are shared digitally with GPs?	81% - 100%	Agree	Available	All discharge summaries and clinical correspondence letters are shared digitally with GPs through the GP portal that has been implemented for distribution of such correspondence. Once the Trust have uploaded documentation and practice detail, the GP portal is configured to automatically route the correspondence to the practice. Discharge summaries are generated automatically from the records and information held within the EPR and are reviewed by clinicians prior to being sent. Letters are generated in the same way and are reviewed by clinicians who have the option to include any further necessary information prior to sending. Both letters and discharge summaries are populated into standard formats saved within EPR from which users can select the most appropriate given the circumstances. Due to these observations and enquiries we agree with the Trust response of '81%-100%'
C2.17 At outpatient appointment, what proportion of letters are shared digitally with GPs?	81% - 100%	Agree	Available	As documented above, all letters are shared electronically with GPs. We therefore agree with the Trust response of '81%-100%'.
C3.5 Digital orders are created in a structured format and held as a part of the patient's electronic health record.	Agree Completely	Agree	Available	Prescriptions and other orders for medication are submitted through the e-Prescribing functionality within the Cerner EPR system, which automatically enters the details of the prescription into the patient's digital care record. This care record will follow the same structured format for all prescriptions and patients. Pharmacy medication orders and inventory management utilises the Ascribe system, which is not currently integrated with the EPR system. Orders submitted through this system utilise standard formats required by the system. Due to the structured way in which both prescribing and ordering of medications are recorded and dealt with, we agree with the Trust response provided.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C3.10 Requests received by diagnostic services are automatically integrated into digital workflows to enable booking, triaging or scheduling.	Mostly Agree	Agree	Available	We observed that the majority of diagnostic service requests are automatically integrated into digital workflows as they are received by email from services and entered directly into the Cerner EPR, which initiates a workflow for booking, triaging and scheduling. Some requests are still received as a paper letter, although this is increasingly rare. In the event that a paper referral is received these will required scanning into the EDMS system and logging manually within EPR in order to initiate a workflow. The Trust confirmed that they are currently measuring a 69.1% rate of digital referrals and requests.
C3.16 Health and care professionals have digital access to all relevant diagnostic test results and images for patients and service users under their care.	Mostly Agree	Agree	Available	We observed that most departments record diagnostic results and images either directly into the EPR, scan paper documents into the EDMS system or alternatively the system into which results and similar information is entered feeds the data directly into EPR. Records in the EPR or on EDMS are then readily accessible by health and care professionals relating to the patients under their care. We noted an exception to this process as the Medisoft system used for Ophthalmology services across the Trust is not linked in to the EPR.
C4.2 What proportion of inpatient medications are prescribed digitally in your organisation?	81% - 100%	Agree	Available	All departments now use the e-Prescribing functionality within the Cerner EPR system to process prescriptions for all patients. Staff on wards are able to use the prescribing functionality to prescribe medication, monitor when patients are due to be given medicine and recording of key actions into the EPR. It is noted that even where systems are not fully integrated with the EPR, such as AthenaK2 for Maternity or Medisoft for Ophthalmology services, the e-Prescribing functionality is still used as this information is logged in the patient's records and viewable across the entire Trust.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C4.3 What proportion of discharge medications are prescribed digitally in your organisation?	81% - 100%	Agree	Available	As above, all departments now use the e-Prescribing functionality within the Cerner EPR system to process prescriptions for all patients. Staff in outpatient clinics also use Cerner to input details of and generate prescriptions which can be sent through to the hospital pharmacy for collection by the patient. Discharge medication is also prescribed in the same way for inpatients leaving the hospital. It is noted that even where systems are not fully integrated with Cerner, such as AthenaK2 for Maternity or Medisoft for Ophthalmology services, the e-Prescribing functionality is still used as this information is logged in the patient's records and viewable across the entire Trust.
C4.4 What proportion of outpatient medications are prescribed digitally in your organisation?	81% - 100%	Agree	Available	As above, all departments now use the e-Prescribing functionality within the Cerner EPR system to process prescriptions for all patients. Staff in outpatient clinics also use the Cerner EPR to input details of and generate prescriptions which can be sent through to the hospital pharmacy for collection by the patient. Discharge medication is prescribed in the same way for inpatients leaving the hospital. It is noted that even where systems are not fully integrated with Cerner, such as AthenaK2 for Maternity or Medisoft for Ophthalmology services, the e-Prescribing functionality is still used as this information is logged in the patient's records and viewable across the entire Trust.
C4.5 Digital prescribing is routinely performed across all specialties, departments and sites.	Agree Completely	Agree	Available	As above, all departments now use the e-Prescribing functionality within the Cerner EPR system to process prescriptions for patients. Staff on wards are able to use the prescribing functionality to both prescribe medication and monitor when inpatients are due to be given medicine before logging this directly into Cerner EPR when it has been done. Staff in outpatient clinics also use Cerner EPR to input details of and generate prescriptions which can be sent through to the hospital pharmacy for collection by the patient. It is noted that even where systems are not fully integrated with the EPR, such as AthenaK2 for Maternity or Medisoft for Ophthalmology services, the e-Prescribing functionality is still used as this information is logged in the patient's records and viewable across the entire Trust. Due to the thorough use of digital prescribing we agree with the Trust's response.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C5.4 Digital systems alert health and care professionals outside your organisation to relevant operational information about their patients and service users.	Mostly Agree	Agree	Available	We understand that when the Trust implemented the Cerner EPR system they also implemented a Health Information Exchange (HIE) solution. The HIE allows GPs to have 'read only' access into Cerner Millennium which enables them to view relevant operational information about the patients under their care. It was noted that the system does not have functionality to alert GPs directly regarding follow-ups that are required but rather only displays information recorded in the system. Any such follow-up requests are sent through the separate GP portal solution. It was also noted that some information is not available to GPs through the HIE, such as details recorded in other clinical systems such as AthenaK2 or Medisoft. Due to the majority of information being readily viewable by GPs through this solution we agree with the Trust's response.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C5.7 Digital systems provide automatic prompts for the next action required by multi-step care plans, pathways, and protocols.	Mostly Agree	Agree	Available	The Trust have worked with Cerner in the development of functionality within the EPR system, which enables the system to suggest next steps for treatment when users are recording that a patient has completed a certain treatment or has been prescribed a certain medication. An example we observed on-screen was a patient being prescribed insulin after a diagnosis of diabetes, which prompted an automatic suggested referral to the diabetes team at the Trust. We also viewed capability of the system to electronically check out outpatients when they have been seen by a clinician, meaning that they do not have to stop at reception to note that their appointment is complete. When checking out a patient, the Cerner EPR system will also suggest a follow-up appointments depending on the condition concerned and whether it is likely to require a multi-step pathway for treatment. The prompts built into the system are customised by the Trust through direct work with Cerner and as such help to automate and standardise the care that is being provided across the Trust. Finally we noted that while the functionality of suggested prescriptions is available to all departments, not all departments make full use of the Cerner EPR to record all aspects of treatment, such as Maternity (records in AthenaK2) and Ophthalmology (Medisoft). These departments therefore do not benefit from automatic prompts of next actions. As most departments across the Trust benefit from the automated prompts, we agree with the Trust's response.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C6.3 Remote/virtual clinical consultations and clinical advice are available to patients and service users.	Neither Agree nor Disagree	Agree	Available	The Trust have implemented new teleconferencing measures in conference rooms and lecture theatres across a number of Trust sites. The Trust have 35 endpoints that are equipped with this technology across their hospital sites, and there is functionality to link in with their primary and community care locations. GP surgeries for example can communicate with the Trust using these endpoints. We understand that the Trust do not yet use the solution to offer virtual consultations or advice to patients however they are currently in the process of investigating the implementation of this as the technology is in place to enable them to do so. Due to the extent to which the Trust make use of the solutions that they have in place to offer virtual consultations, they responded to this question with 'Neither Agree nor Disagree', and we concur with this response.
C7.2 Patient flow is tracked digitally in real time across all departments and sites to identify bottlenecks and delays.	Mostly Agree	Agree	Available	The Trust monitors patient flow across all departments at the hospital through reports on their 'Knowledge Portal' which is accessible through the Trust's intranet, although it was noted that not all of these reports are generated in real time. The Knowledge Portal contains a total of approximately 50 reporting models, approximately five of which are updated every 15 minutes which the Trust identifies as real-time. The remaining models are updated on a nightly basis. The real time updates pull data directly from the Cerner system, whereas the daily updates come from the Data Warehouse. The models that update in real time include the current compliance with the A&E 4-hour target, patient flow and bed occupancy, and are used by the Trust to monitor and identify delays.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C7.4 Your organisation uses digital systems to manage staff rostering.	Mostly Agree	Partially Agree	Available	The Trust utilise a digital rostering system known as Allocate in order to manage rosters for all nurses across the Trust. Rostering for the nurses is done directly onto the system and does not duplicate a paper rostering system. However we observed that the Allocate system is not used for auto-rostering functionality and that assignment of shifts must still be done manually on the system by the manager responsible for this. In addition rostering for doctors is not done on Allocate and this remains a paper-based system. As rostering for doctors is not yet done on Allocate, and this remains a paper-based system, we have concluded that this response could have been more negative than the Trust response.
C8.3 Management have access to real time or near real time dashboards displaying information about the performance of the services they manage.	Agree Completely	Agree	Available	The Trust monitors data across all departments at the Trust through reports on their 'Knowledge Portal' which is accessible through the Trust's intranet. The solution is built on Qlikview and currently the Trust have approximately 50 standard reporting models that they have configured, five of which are updated in real time. Those not updated in real time are updated on a nightly basis from the Data Warehouse. The reports include aspects such as current A&E performance against the national 4-hour target, bed occupancy, patient flow, arrivals for the day, as well as various others. These reports are accessible by management staff that request access to them and we were able to confirm the increase in usage of the reports across the Trust over the last five years, as this is also recorded and monitored. For example, the viewing of reports has increased from 411 in April 2013 to 5,622 in January 2018, and the number of unique users has increased from 44 to 329 over the same period.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
C8.4 Health and care professionals have access to real time or near real time dashboards displaying information about the caseload/patients under their care.	Mostly Agree	Agree	Available	For inpatients the staff have access to such dashboards for patients across all departments. For example the e-Prescribing functionality within the Cerner EPR provides an overview of all patients on a particular ward including when they last received medications, what they received and when they are next due to be administered. In addition to this we observed the real time dashboard within the AthenaK2 management system for the Maternity department which allows midwives to monitor all women currently on the ward, including the stage of labour that they are at and the treatment they require. We also observed the dashboards in place for outpatient services at the Trust, including electronic check-in and check-out facilities. Patients enter their details at digital checkpoints when arriving at the clinic for their appointment, which feeds into dashboard that are monitored by clinical staff. The dashboard keeps track of waiting times and the current stage the patient is at. They can be signed off as 'seen by nurse' or 'seen by doctor' by the relevant staff, and can be electronically checked out which will remove them from this list. As the majority of departments and teams have this dashboard functionality, we agree with the Trust's response.
C9.7 Where there is a need to electronically identify patients and service users, products and places the mechanism used is compliant with GS1.	Neither Agree nor Disagree	Agree	Available	Inpatients are provided with wristbands that have barcodes which can be scanned and will display the patient's medication history and requirements in the Cerner EPR. Clinical staff can then easily record any observations or administration of medication against this record, limiting the room for errors in recording. We observed that medications provided by the pharmacy to the wards are also equipped with barcodes which can be scanned in the same way and will track the ward's available supplies of medications in the EPR. However this is not utilised all of the time and often medications are re-ordered when necessary. In addition to this we observed that medical devices such as theatre equipment are not tracked using barcode scanning functionality. The Trust assessed their response to this question as 'Neither Agree nor Disagree' due to not being selected as a GS1 'pilot site', resulting in a lack of full deployment of these measures. Given the result of our observations and enquiries detailed above, we concur with this response.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
I1.3 Health and care professionals are equipped with mobile devices to access clinical applications and information at the point of care.	Agree Completely	Agree	Available	Both laptops and tablets are widely available across all wards on which clinicians and nurses are providing care to patients that cannot leave their beds and thus where mobile devices are required. Laptops are kept on mobile carts which can be logged into by any staff member using the 'tap in, tap out' access with their SmartCards. iPads are also provided to nurses to enable them to conveniently access and record patient details when providing care to patients on wards when a laptop/medicine cart is not required, for example when they are only required to enter observations notes. Due to the widespread use and availability of mobile devices where required at the point of care across the Trust we agree with the Trust's response.
I1.4 Health and care professionals have single sign-on access and authentication to clinical applications.	Agree Completely	Agree	Available	The Trust have fully implemented single sign-on access to all clinical systems using the same credentials that a user utilises for their domain account. In addition to this it was also noted that the Trust have also implemented what they describe as a 'tap in, tap out' system for access to shared desktop and laptop terminals across the Trust sites. There are no longer any dedicated single-user desktops or laptops at Trust sites, as all can be accessed by all staff members using their designated SmartCards which instantly log a user onto the system and allow them to resume a session that they left at another terminal. As the Trust have now completely implemented a convenient single sign-on solution across all sites and departments, we agree with the Trust's response.
I1.6 Software used on NHS-owned IT infrastructure is approved and recorded on a software asset and licence register that confirms it is appropriately licensed for such use.	Agree Completely	Agree	Available	Through review of the document containing the standards for IT Asset Management, we confirmed that all such infrastructure is appropriately recorded on a dedicated register. The standards are reviewed and updated on an annual basis in order to ensure that the Trust's management of its records in this area are properly updated.

Maturity self-assessment (sampled questions)		Deloitte assessment		
Digital Maturity Tool reference	**Trust Response**	**Logical rationale to support response**	**Consistent evidence to support response**	**Comments**
I1.9 Business-critical digital services are supported by documented disaster recovery processes, with clear roles & responsibilities assigned.	Mostly Agree	Partially Agree	Available	The Trust has in place a formally documented Business Continuity plan intended to facilitate the recovery of business processes in the event of disruption. The plan contains a detailed section regarding IT Disaster Recovery, with key information such as roles, responsibilities and target times for recovery of critical systems included. We were able to observe a copy of this document. We saw evidence to suggest that 'Agree Completely' would have been the most appropriate response.

Statement of Responsibility

Deloitte LLP
Leeds

April 2018

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Lisa Williams, Assistant Director
Date: Thursday, 7th June 2018	**Sponsoring Director:** Anna Basford, Director of Transformation & Partnerships
Title and brief summary: Outpatient Transformation Report - The purpose of this paper is to update the Board on the work being undertaken in relation to the Outpatient Transformation Workstream.	
Action required: Note	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: Weekly Executive Board 17 May 2018	
Governance Requirements: Transforming and improving patient care	
Sustainability Implications: None	

Executive Summary

Summary:

The paper provides an overview of both the national and local intention towards future models of outpatient care, and details the project groups approach to creating a system wide model that challenges traditional boundaries through changing roles and maximising the opportunities of technology.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

Please see attached

Appendix

Attachment:

BOD OPT Report June.pdf

Calderdale and Huddersfield NHS Foundation Trust

Report to the Board of Directors

Outpatient Transformation

1. Purpose of the Paper

The purpose of this paper is to update the Board on the work being undertaken in relation to the Outpatient Transformation Workstream. The paper provides an overview of both the national and local intention towards future models of outpatient care, and details the project groups approach to creating a system wide model that challenges traditional boundaries through changing roles and maximising the opportunities of technology.

2. Background

Like many areas in the country, health and social care services in Calderdale and Greater Huddersfield are subject to a growing demand, through population growth and increasingly complex needs. The current models of outpatient care across the health economy are unsustainable financially and inefficient for patients who need fast access to elective care, or support with their ongoing treatment or surveillance due to a long term condition.

In 2017/18 CHFT recorded 351,400 physical attendances at outpatient clinics across the sites, a third of which were new patients and two thirds patients returning for one or more follow up appointments (first app 115,800, follow-up app 235,600 including procedures).

3. National Context

NHSI has recently launched an Outpatients Improvement Programme with over 100 Trusts benchmarking at specialty level enabling Trusts to work together regionally and nationally to optimise digital solutions as an alternative. CHFT has been invited to participate in this programme.

4. West Yorkshire Context

The West Yorkshire and Harrogate Health Care Partnership (WYHCP) has clearly stated their ambition to reduce unnecessary follow-up appointments by 20%, by ensuring a ‘needs based’ approach and embracing new technologies. The view of the CCG Joint Committee is that face-to-face follow-ups will no longer be the norm, and the concept of the traditional outpatient model is outdated.

The West Yorkshire wide emerging ideas are based on a principle that outpatient’s attendances at secondary care centres should be preserved for those for whom clinical need relies on the technology or skill of the secondary care environment. Adoption of communication technology and sharing of information and images will be a critical success factor. The programme will therefore explore models of direct access, viewing all outpatients differently.

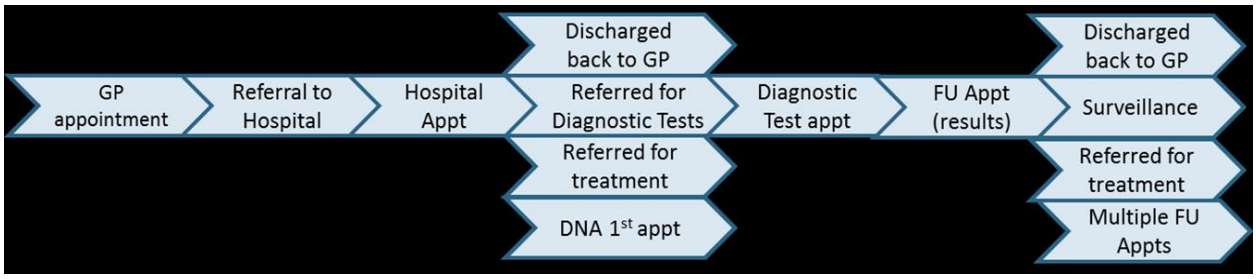
5. Patient Experience Feedback

Our communities have told us through Healthwatch surveys, RCRTPP engagement events, and the Health and Wellbeing Board that they want to see a different model that encompasses:

- Technology used to reduce travel time and unnecessary journeys
- As many services as possible close to home in local settings such as GP practices, with improved access
- Services co-ordinated and wrapped around the person's needs, involving a range of partners
- Travel and transport and parking issues addressed
- More information about health conditions and what is available to ensure people can make choices and have support to self-management
- Multi-agency single point of access

6. Current Model

CHFT and local private providers, operate a tradition model of outpatients delivered in a secondary care setting.



7. Work to date

In 2017/18 several specialties performed pilot/ trial periods of new ways of working to test different concepts, and provide data to determine the quality and cost benefits associated with the change in pathway. This included robust clinical triage, pending list reviews, one stop clinics, straight to test guidelines, discharge at diagnostics, and alternative models for follow-up care.

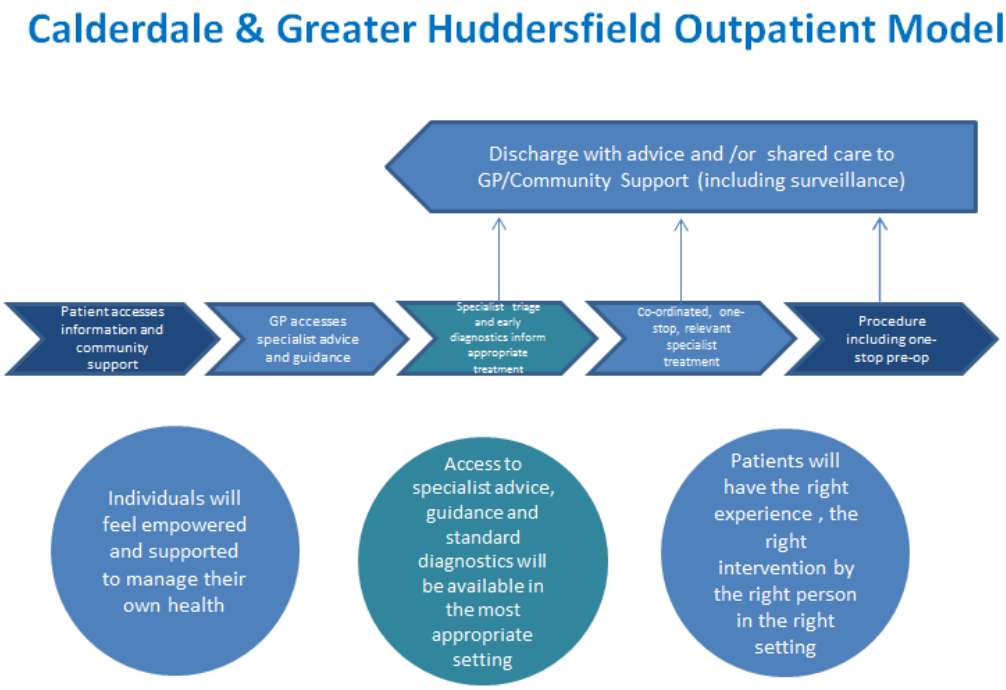
Following an internal review in February, the team has expanded the ambition for change with an aim to reduce 20% of physical attendances within a secondary care setting by 2020, and has agreed a system wide governance structure/ project team to ensure people receive the right care, from the right person, at the right time, in the right place, and teams to work together with patients to understand and diagnose system issues.

8. Proposed Model

The aim of the programme is to change the outpatient offer from a traditional approach where patients are referred into secondary care and follow up through a consultant pathway or hospital based surveillance programme, to one where individuals are empowered with fast

access to advice and support, self-management information, and where needed are able to see the right clinician as quickly as possible.

The diagram below provides an overview of the proposed future outpatient offer for Calderdale and Huddersfield across the system.



The team has undertaken 'Go See's' and is further exploring schemes in areas such as Wales, Stockport, Morecambe Bay, Airedale, and learning from programmes evaluated by the Nuffield Institute in both England and the USA. Appendix 1 provides a suite of principles and interventions developed from our learning and also ideas generated internally from our clinical teams.

Whilst our partners in the CCG are already engaged from a clinical and commissioning level, we recognise the scale of change required to deliver this ambitious programme, and have therefore engaged colleagues from the GP Federations in both Calderdale and Greater Huddersfield and invited members to participate in the OPT Board and speciality groups.

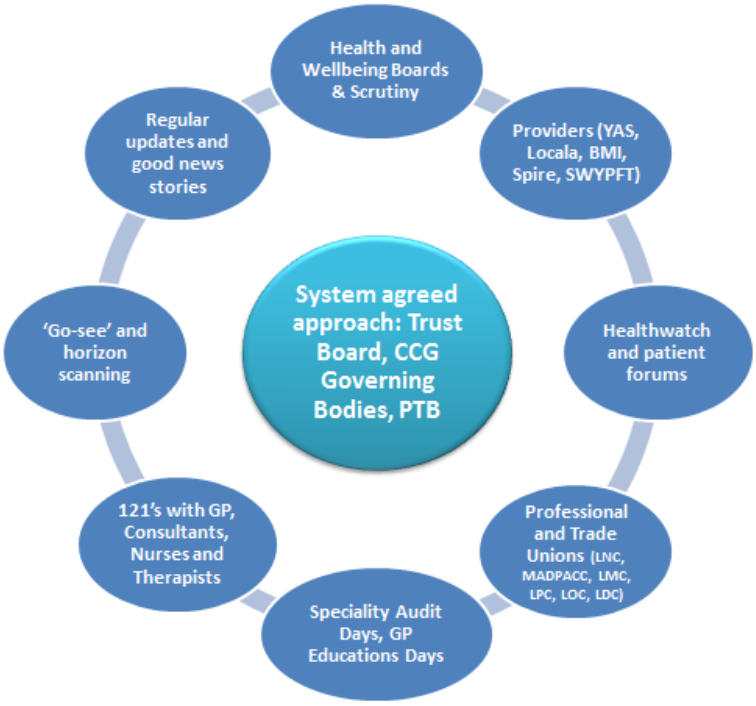
9. System-wide Engagement Plan

Significant change across the system requires engagement with a broad and diverse range of stakeholders, employing a combination of processes both formal and informal. The team has therefore commenced a system wide engagement plan with the aim of working with partners to enable:

- A 20% reduction in outpatient attendances
- High quality patient safety and outcomes
- Improved patient experience
- Improved working lives

- Efficiency and value for money
- Optimised use of digital technology

Key Stakeholders include:



*Please note: *PTB - Partnership Transformation Board*
MADPACC – Medical and Dental Pay and Conditions Committee
LMC – Local Medical Committee
LNC – Local Negotiating Committee
LOC – Local Optical Committee
LDC – Local Dental Committee

The key deliverables of the engagement plan are:

- Target stakeholders and use variety of engagement methods (121s, groups etc.)
- Identify and agree opportunity and case for change by service (3Rs – Reality, Response & Result methodology)
- Co-produce and agree new pathways
- Joint clinical and management leadership to implement
- Joint governance, monitoring and stakeholder feedback

A series of clinical forums have been undertaken within the Trust throughout May with further events planned in June/ July.

10. Next Steps

1. The OPT Board met for the first time on Wednesday 23rd May 2018 where the Terms of Reference and Project Initiation Document (PID) were agreed. The board includes senior clinical and non-clinical members from CHFT, Calderdale and Greater

Huddersfield CCG's, Pennine GP Alliance, My Health Huddersfield Federation of GP's, Heathwatch, and CHFT's Council of Governors.

2. System wide engagement plan developed with internal sessions planned throughout June/ July.

3. Further Go See's planned to Trusts implementing new pathways.

4. Timetable agreed for consistent communication to system leaders through organisational boards.

5. Speciality development programme/ timeline to be confirmed at the next OPT Board with associated GW1/GW2 trajectory. The timetable will reflect feedback and ideas generated through clinical engagement.

6. Terms of Reference for the Elective Care Improvement Board to be amended to facilitate a forum to drive local provider change and implementation (forum includes Locala, BMI and Spire). Joint presentation by CHFT/CCG at the June meeting to launch the programme as the group's first priority scheme.

11. Recommendation

The Board are asked to:

1. Note the contents of this report and support the next steps

Calderdale and Huddersfield
NHS Foundation Trust

Appendix 1

Driver	Intervention
A service that our patients want	- Increased use of technology - Ease of access when needed - No unnecessary appointments - No delays – quick tests - More control/ empowerment - Rapid response
Changing behaviours	- Clinical engagement - Strong clinical leaders in each speciality - Secondary/ primary care clinical collaboration - Support and drive - Clinical champions - Proof of concept
Avoid unnecessary referrals	- Increase advice & guidance use (digital capability) - Review of legacy patients/ waiting list - Clinical triage Advice & guidance Straight to test Telephone triage OPD - Straight to test Direct access for GPs Clinical pathways (colonoscopy) - Telephone triage Consultant Nurse led/ middle grade - Retrospective referral peer review
Deliver care in the most appropriate setting	- Maximise the use of multi-disciplinary skills - Clear pathways of care - Shared care - Peer support and review
Reducing the number of appointments	- One stop clinics (cardiology, urology, breast) - Discharge at diagnostics (results by letter) - Nurse led follow up - Telephone follow up - Digital consultant to consultant referrals - Virtual clinics Virtual MDT Telephone/ skype - Community pathway (headaches) - Patient initiated follow up (PIFU)
Increased use of technology	- Maximise opportunities for virtual care - Shared records - Remote MDT's - Work with THIS to identify the 'art of the possible'

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th June 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from the sub-committees.

Main Body

Purpose:

The Board is asked to receive the updates and minutes from the sub-committees.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from the sub-committees.

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

QUALITY COMMITTEE

Monday, 30th April 2018
Acre Mill Room 4, Huddersfield Royal Infirmary

056/18 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Anderson **(DA)**	Non-Executive Director
Helen Barker **(HB)**	Chief Operating Officer
Dr David Birkenhead **(DB)**	Medical Director
Paul Butterworth **(PB)**	Governor
Juliette Cosgrove **(JC)**	Assistant Director of Quality and Safety
Alistair Graham **(AG)**	Non-Executive Director
Lesley Hill **(LH)**	Director of Planning, Performance, Estates and Facilities
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Dr Mary Kiely **(MK)**	Consultant in Palliative Medicine **(item 071/18)**
Phil Lewer **(PL)**	Chairman **(Observing)**
Dr Rob Moisey **(RM)**	Consultant in Acute Medicine **(item 063/18)**
Dr Sal Uka **(SU)**	Consultant Paediatrician and Associate Medical Director **(item 071/18)**
Dr Ashwin Verma **(AV)**	Divisional Director – Medical Division **(for item 063/18)**

057/18 APOLOGIES

Brendan Brown	Chief Nurse and Deputy Chief Executive
Lynn Moore	Governor

058/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

059/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 26th February 2018 were approved as a correct record, with the exception that the section on safeguarding reports at item 041/18 reads:

- *Safeguarding reports – LR requested that the frequency of the Safeguarding Committee meetings is modified from monthly to bi-monthly. This was agreed by the Committee.*

060/18 ACTION LOG AND MATTERS ARISING

The action log (appendix B) can be found at the end of the minutes.

061/18 CQC REPORT

Juliette Cosgrove (Assistant Director of Quality and Safety) presented appendix D1 which detailed the three inspections undergone by the Trust, the key issues that were identified during the inspections and the Trust's post inspection response.

Discussion ensued on whether there were any concerns with the Community Place prior to inspection, and it was stated that the divisional management team were aware to some extent and anticipated a better response regarding some issues that were raised. It was also asked if there were any implications for patients with the closing of the Community Place. There were three or four patients in place at the time and the immediate cohort of the patients were well-managed. Discussion also took place on the due date of the CQC draft report, which is expected in the third or fourth week in May. It was also stated that no further communication or unannounced information has been received from the CQC. A copy of the well-led action plan was also available at appendix D2.

A note of accuracy from the paper was noted: Lindsay Rudge (Deputy Director of Nursing) was also present at the interview with the Director of Infection Prevention and Control and Sepsis Lead on Wednesday 4 April 2018.

OUTCOME: The Quality Committee received and noted the content of the report.

062/18 SEPSIS UPDATE

The Assistant Director of Quality and Safety presented a six month update on sepsis (appendix E), summarising that:

- The sepsis collaborative group is meeting on a monthly basis with good clinical engagement. Following confirmation that the Electronic Patient Record (EPR) sepsis trigger can be recognised as a screening for sepsis, full compliance will be able to be demonstrated. Further work will look at the response to patients that alert for sepsis to assess where there are gaps in assessment and compliance with the bundle.
- The emergency department's (ED) sepsis screening remains above the 90% target. The initiation of treatment in the ED's target of 90% has also improved with the treatment within one hour performance at 93% in quarter 4 compared to 75% in quarter 3.
- Inpatient screening performance has also improved using the EPR continuous screening of all patients and is 100%. The initiation of treatment of inpatients target of 90% has not been met and stood at 53% in quarter 3 and shown improvement of 76% in quarter 4.
- The ED have submitted an application - 'improvement of sepsis recognition and response with ED' led by Dr Huw Masson (Consultant in ED) for the next Improvement Science for Leaders (QUEST). If successful, the 12 month programme will commence in June 2018.
- The existing sepsis policy has been reviewed against the updated NICE guidance and new EPR processes in place.

Discussion ensued on whether the data included both adults and children, and this was confirmed. It was noted that a significant amount of work has gone into sepsis over a number of years and good progress has been made to date. It was stated that, compared to a few months ago, this report now provides assurance that patients are being screened and receiving treatment.

OUTCOME: The Quality Committee received and noted the content of the report and agreed that a further report will be provided in six months' time to monitor if the approach is maintained.

ACTION: Further update to be noted on the work plan for October 2018.

063/18 RECONFIGURATION OF CARDIOLOGY, RESPIRATORY AND ELDERLY MEDICINE SERVICES UPDATE

Dr Ashwin Verma (Divisional Director for the medical division) and Dr Rob Moisey (Consultant and Clinical Director in Acute Medicine) were in attendance to present an update on the reconfiguration of the cardiology, respiratory and elderly care services

(appendix F).

The reconfiguration of the above services was successfully completed on Monday 11 December 2017. The changes co-ordinated seven ward moves over 23 days, including five wards across site. More than 60 patients safely moved sites in a multi-service and multi-agency operation, and the full impact of the service changes will take longer to realise and evaluate. The move so far has enabled:

- A consultant of the week model in cardiology, which went live on 1 April 2018.
- A consultant of the week model in respiratory scheduled to go live on 1 May 2018.
- Increased referrals from the emergency department into the frailty team at HRI have improved the number of patients receiving a complex geriatric assessment and multi-disciplinary team review.
- % of avoided admissions of frail elderly patients presenting at the emergency department has increased significantly.
- Smarter working across catheter labs and coronary care units has reduced nursing costs (pilot ongoing).
- Social care workers from both Calderdale and Huddersfield are now working together on site at HRI providing focused support to the elderly care areas.
- Improved response rates in the last three months of Friends and Family Test (FFT) data for elderly services.

It was stated that although cardiology and respiratory are on the Calderdale site, there is an outreach onto the Huddersfield site on a daily basis. The case mix of patients arriving in the emergency department and Medical Assessment Unit has changed. It was also reported that there have been no complaints or serious incidents relating to reconfiguration, and this is in part to do with staff. It was also asked whether junior medical colleagues were satisfied with the way they were deployed, and it was stated that they have been generally supportive.

The final report will be submitted to the Weekly Executive Board in June 2018 which will provide final reassurances on business as usual, and will be formally reported to the Trust Board in July 2018.

Helen Barker (Chief Operating Officer) stated that this was an example of solid clinical leadership and would like to thank RM and Sharon Appleby (Transformation Programme Manager) for their work. The Quality Committee also conveyed thanks to all involved with the reconfiguration.

OUTCOME: The Quality Committee received and noted the content of the report.

064/18 SERIOUS INCIDENT REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix G summarising new serious incidents reported to the Clinical Commissioning Groups in January and February 2018, of which there were nine:

- January 2018 (1 fall, 1 abscond/attempted harm, 1 potential misdiagnosis, and 1 neonatal death)
- February 2018 (2 falls, 1 failure to act on adverse test result, 1 infection, 1 pulmonary embolus)

The emerging theme for the two months has been falls, which is also the most common serious incident declared in the past 12 months. Further details of all cases are included in the paper in the new A4 summary template. All actions have been followed up by divisional boards.

The review of actions presented in February 2018 identified two serious incidents where the

summary of the final report had not been included in the Quality Committee papers. The summaries of these have been amended to the new format and included in this paper. These were shared with the division at the time:

- 137194 (2016/28120) – Fall – completed June 2017
- 137309 (2016/30858) – Deteriorating patient – completed June 2017

Paul Butterworth (Governor) enquired as to whether incident 2017/30128 was reported to the police and AMcC confirmed that this had taken place. Dr Linda Patterson (Non-executive Director and Chair of the Committee) stated that this should be noted in the summary.

Discussion ensued on falls, and Alistair Graham (Non-Executive Director) stated that previous improvements were being made with falls; however, incidents continue to be seen. JC stated that there is a difference between falls and falls with harm. Some falls are totally unavoidable, whereas some falls have clear evidence of gaps in care. Falls will continue to be monitored.

The Chair noted that the details listed under incident 152944 (2018/4336) did not reflect the title of the incident.
ACTION: Incident to be amended with correct information.

Discussion took place regarding incident 137309 (2016/30858), and it was noted that the learning from this should be shared across divisions, and the issues from this incident need to be monitored as record-keeping is an ongoing theme. It was noted that the clinical records group and the ward assurance programme have now been re-established and will be monitoring. It was queried whether this was related to agency staff, however, it was stated that this was not a theme in this incident.

AMcC reported that a consultation into the future of patient safety investigations has been launched by NHS Improvement (NHSI), and a report will be submitted to the next meeting on Monday, 4 June 2018.

065/18 HIGH LEVEL RISK REGISTER

AMcC presented appendix H1 which summarised the changes to the high level risk register as at 23 April 2018.

- Eight risks scoring 25 or 20 (7169, 6903, 7062, 7078, 6658, 2827, 5806 and 6345)
- Three risks with a reduced score (7194, 6829 and 6598)
- Two new risks (7169 and 7248)
- Six closed EPR risks (7049, 7046, 7148, 7047, 6441 and 7147)

Risk 6990 has been closed and replaced by risk 7134 – there were two sepsis risks, one Trustwide and one in the division and the leads for this have been re-confirmed.

Risk 6977 regarding 2017/18 mandatory training has been closed and a new risk regarding mandatory training has been added, risk 7248.

A copy of the risk register (appendix H2) was also provided.

OUTCOME: The Quality Committee received and noted the content of the report

066/18 PATIENT SAFETY GROUP REPORT

AMcC presented appendix I which highlighted key points from two Patient Safety Group meetings held on 15 February and 15 March 2018:

- Improved reporting from sub-groups including the Medical Devices Group which has now been refreshed
- Improvements have also been seen with the Point of Care Testing (POCT) group and the Hospital Transfusion Committee (updates of which will be provided in the next report)
- Thrombosis Committee report received with a Trust compliance rate of 96.57%. Discussion ensued on the Hospital Acquired Thrombosis (HAT) data incidents not being reported on Datix. An action relating to the issue was raised and is being followed up with the Associate Medical Director.
- Divisions were thanked for undertaking a significant amount of work to sign off incidents in the last year. More incidents were closed than reported in the last year and an upward trend in incident reporting was also noted.

OUTCOME: The Quality Committee received and noted the content of the report

067/18 HEALTH AND SAFETY COMMITTEE REPORT

Lesley Hill (Director of Planning, Performance, Estates and Facilities) presented appendix J which highlighted key points from two Health and Safety Committee meetings held on 21 March and 18 April 2018:

- Medical device training – Trust compliance remains at 82%, however divisions are showing slight increases in compliance. The Families and Specialist Services (FSS) division have had a substantial increase to 93%. There still is a concern that training statistics exclude doctors/consultants, therefore a task and finish group is being set up with a view to recommending how this can be undertaken, and LH is working with Mr Neeraj Bhasin (Associate Medical Director) on this.
- IRPOG (Ionising Radiation Protection Operation Group) and NIRPOG (Non-Ionising Radiation Protection Operation Group) – the lack of attendance by Radiation Protection Supervisors (RPS) and Laser Protection Supervisors (LPS) has been escalated to divisional leads.
- Manual handling training - Concerns were raised regarding non-attendance for moving and handling courses and information has been cascaded to ward areas

Discussion ensued on progress with nasogastric (Ng) tube training and it was stated that additional training has taken place, but there is still some work to be done. LR reported that she has met with the nutritional nurse and is confident with compliance in high-use areas, and that Ng tube training will be taken into areas as an e-learning package has been purchased and uptake is being pursued and progressed. Dr Sal Uka (Consultant Paediatrician and Associate Medical Director) stated that there needs to be clarity regarding Ng tube training as there are different stages which involve different people. LR indicated that the nutrition steering group is being re-established and will bring this work forward corporately. It was also noted that Ng tube training is still on the risk register and will be reviewed.

OUTCOME: The Quality Committee received and noted the content of the report

068/18 SAFEGUARDING ANNUAL REPORT 2017-2018

Lindsay Rudge (Deputy Director of Nursing) presented appendix K, a detailed combined children and adults report that describes safeguarding activity, how the children and adults team work together and how the Trust and discharge its statutory duties. The Safeguarding strategy as part of this report will describe priorities for 2018-19. This is the fifth annual report which will be submitted to the Trust Board.

The report detailed governance arrangements for safeguarding, position and further work with PREVENT; adult safeguarding; learning disability; pressure ulcers; mental capacity and deprivation of liberty safeguards (MCA/DoLS); mental health and changes to sections 135

and 136 of the mental health act; safeguarding children and young people and the significant piece of work completed by reviewing the Safeguarding Supervision Policy and the implementation of a supervision strategy; child sexual exploitation; increased compliance in Female Genital Mutilation (FGM) training; and domestic abuse. LR stated that there is a review with Clinical Commissioning Group (CCG) colleagues regarding the ongoing stability of the domestic abuse hub service.

Recommendations following the April 2016 CQC Children Looked After (CLA) inspection in Calderdale and the Kirklees Looked After Children and Safeguarding CQC inspection in January 2018 were also detailed in the report.

PB asked when funding would end for the domestic abuse hub and LR stated that this has been commissioned for the next 12 months at a reduced rate, however, the service will have reduced resources from August 2018. If this generates a risk, the issue will be placed on the risk register.

Following a national story on junior medical colleagues' awareness of MCA/DoLS, LP asked whether training was satisfactory. It was stated that compliance is average, however, there may be some concern due to the law being complex, nevertheless, colleagues should know who to contact if there was an issue. LR reported that in the last six to 12 months, there has been an opportunity for junior medical staff to have a detailed discussion on this, but some assurance could be sought to check this approach.

OUTCOME: The Quality Committee approved the annual report and the safeguarding strategy for 2018/19 contained within the report.

PB commended the report and stated that it should take a lead in the Trust as a good example of learning.

LR noted that there was an error on page 18 of the report relating to children's incidents, and will re-submit an amended report.
ACTION: LR to amend information on children's incidents

069/18 CLINICAL OUTCOMES GROUP REPORT

Dr David Birkenhead (Medical Director) presented appendix L summarising key points raised at meetings held in January, February and March 2018:

- Clinical Audit Programme 2017/2018 - The Trust is registered for all mandatory audits but is not necessarily contributing to them all.
- National mortality guidance – there are conflicting views from NHS England, the Secretary of State and the Royal College of Physicians on Trusts publishing the mortality avoidability rate in their reports to Board. This continues to be an ongoing challenge
- Infection Prevention and Control – 5 Meticillin-resistant staphylococcus aureus (MRSA) bacteraemias have been reported for the last year against a target of 0, and 40 clostridium difficile (C.diff) cases against a target of 21. This continues to be a challenge and there is work to be done.
- Acute Kidney Injury – collaborative now set up
- Care of the Acutely Ill Patient (CAIP) - coding for signs and symptoms remains high at 10.30%, and Do not attempt cardiopulmonary resuscitation (DNACPR) discussions are continuing to improve.

OUTCOME: The Quality Committee received and noted the content of the report

070/18 MORTALITY SURVEILLANCE GROUP REPORT

DB presented appendix M summarising key points raised at meetings held in February, March and April 2018:

- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) – HSMR now at 101.87 and may be below 100 for the next position, but will await formal notification. SHMI is below 100 at 87.79% and significantly better than average in UK.
- Learning from death (LfD) – the model aims to align quality improvement themes identified from mortality reviews, End of Life, involvement of Specialist Palliative Care, death certification and a family/carer engagement pilot in Stroke. A LfD summit half-day event is being planned to disseminate the learning and progress being made.
- Stillborn, perinatal and child deaths – sustained reduction of stillborn deaths since 2011 and now have better understanding of.

OUTCOME: The Quality Committee received and noted the content of the report

071/18 LEARNING FROM DEATH UMBRELLA REPORT

Doctors Sal Uka (Consultant Paediatrician and Associate Medical Director) and Dr Mary Kiely (Consultant in Palliative Medicine) were in attendance to present appendix N which proposes a new learning from death umbrella model which outlines how learning from death can be broadened to encompass other aspects of death and dying.

The rationale for implementing this new model is to ensure a more cohesive approach to quality improvement, not only for improved patient outcomes but also patient and family/experience. Each work stream (mortality reviews, end of life care, specialist palliative care, death certification and family/carer engagement pilot in stroke) is described in detail in the report.

MK described the specialist palliative care and end of life care work streams and SU stated that this is an evolving process. SU invited the Committee to a 'learning from deaths summit' to be held on Thursday, 12 July 2018 at 1:00 – 5:00 pm – venue to be confirmed. The event plans on using the learning from death umbrella model as engagement learning for colleagues who are interested in quality improvement relating to death and dying.

OUTCOME: The Quality Committee received and noted the content of the report

072/18 PATIENT EXPERIENCE AND CARING GROUP REPORT

JC presented appendix O which summarised items discussed at meetings in February and March 2018 including:

- Q2 and Q3 complaints reports shared
- National survey results – posters displaying key messages designed in three areas – children and young people, maternity and the emergency department.
- Always event - the surgical assessment unit (SAU) is involved in an NHS England-led initiative and will be working with patients / families to identify an event that is fundamental to their care.
- Noiseless project – Sleep policy is to be developed and will be shared once completed
- Divisional reports – good reports from divisions on positive activities taking place to improve patient experience

Discussion ensued on progress with Schwarz rounds and it was stated that contracts have now been signed in Workforce and Organisational Development and training has been undertaken.

ACTION: Report to be submitted in six months' time.

OUTCOME: The Quality Committee received and noted the content of the report

073/18 QUALITY AND PERFORMANCE REPORT

Helen Barker (Chief Operating Officer) presented appendix P which highlighted that the performance score in March 2018 has improved by 5 percentage points to 62%. The safe domain returned to green, the caring domain has maintained its amber performance but did not achieve the FFT levels expected in A&E and Community. The effective domain improved mainly due to no MRSAs unlike February. The responsive domain deteriorated with only one out of four stroke indicators achieving target. Cancer maintained its good performance, and efficiency and finance improved slightly with better theatre utilisation. March was a busy period with additional open beds, staff continuing to be stretched and infection control issues across-site, when a conscious decision was made to keep bays closed.

In December 2017, a deep dive was carried out to estimate the most likely improved overall performance for March 2018 by improving a small number of indicators. It was forecast that performance would score 62%, and the score achieved in March 2018 was 61.5%. The domain scores were:

	Dec 2017	Estimate	March 2018
Safe	61%	72%	78%
Caring	53%	74%	61%
Effective	68%	73%	73%
Responsive	66%	69%	67%
Workforce	29%	35%	56%
Efficiency & Finance	44%	50%	38%

Work is to be carried out to review thresholds and numerical trends which may move indicators into different domains. A year on year comparison will not be able to be carried out due to thresholds potentially being different.

OUTCOME: The Quality Committee received and noted the content of the report.

074/18 QUALITY PRIORITIES

AMcC presented appendix Q outlining the three quality priorities for 2018/19 as:

- Care of the acutely ill patient (safe domain)
- Patient Flow (responsive domain)
- End of Life Care (experience domain)

OUTCOME: The Quality Committee noted the content of the report.

075/18 SUB-GROUP TERMS OF REFERENCE – MEDICATION SAFETY AND COMPLIANCE GROUP

LR presented appendix R, the terms of reference for the medication safety and compliance group. This was previously the Medicines Management Committee and the new terms of reference describes the new group. The first meeting is due to take place on 1 May 2018, and the terms of reference may need some amendments. LR also reported that it may take some time before reporting is seen at this Committee due to the infancy of the group.

OUTCOME: The Quality Committee accepted the terms of reference and will await reporting from the new group.

076/18 SUB-GROUP TERMS OF REFERENCE – DIVISIONAL PATIENT SAFETY AND QUALITY BOARDS

The terms of reference for all divisional Patient Safety and Quality Boards (PSQB) were presented. HB asked if a review of all PSQB agendas has taken place and JC confirmed that this has been done.

HB queried the titles of the former Families and Specialist Services (FSS) directorates - Children, Women's and Families (CWF) and Diagnostic and Therapeutic Services (DaTS) on the terms of reference and stated that they should be titled Families and Specialist Services (FSS).

OUTCOME: The Quality Committee accepted the terms of reference subject to amendment to FSS title

ACTIONS: To obtain terms of reference for Estates and Facilities
To amend title for FSS terms of reference

077/18 SUB-GROUP TERMS OF REFERENCE – SERIOUS INCIDENT REVIEW GROUP

AMcC presented appendix T which was approved.

OUTCOME: The Quality Committee accepted the terms of reference.

078/18 ANY OTHER BUSINESS

There was no other business.

079/18 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Sepsis update received
- Update provided on reconfiguration. Formal report to be submitted to the Board in July 2018.
- Report on CQC inspections received

080/18 EVALUATION OF MEETING

What went well…..

- Meeting ended on time
- There was good clinical input
- There was a wide-ranging agenda and had challenges in appropriate places

What could be better…….

- If reports summarised content of reports

081/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan, appendix U was accepted.

NEXT MEETING

Monday, 4 June 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**
Q4 PSQB Reporting

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 30th APRIL 2018

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
DUE THIS MONTH				
29.1.18 (024/18) 26.2.18 (041/18) 30.4.18 (060/18)	**TERMS OF REFERENCE (ToR)** The amended terms of reference (appendix D) were reviewed	~~All~~ ~~Helen Barker~~ ~~Helen Barker~~ Michelle Augustine	**Action 29.01.18:** To return to next meeting, with revisions **Action 26.2.18:** HB to follow-up with SD re WOD representative **Action 26.2.18**: HB to follow-up with VP re. Committee quorum **Update 30.4.18:** The ToR (appendix C) was accepted. **Action 30.4.18:** Actions to be followed up	**Due 4 June 2018**
26.2.18 (051/18)	**CANCER GROUP** It was reported that a new Cancer Board is due to be formed, which will ultimately report to the Quality Committee. The governance arrangements are yet to be made, however, it was suggested that a representative from the Cancer Board attends the next meeting to give an update.	Helen Barker	**Action 26.2.18:** A representative from the Cancer Board to attend the next meeting **Update April 2018**: To be deferred due to the inaugural meeting not yet taken place. **Update 30.4.18**: Discussion ensued as to whether the Cancer Group is a sub-committee of the Quality Committee and whether the Cancer Group should report to the Clinical Outcomes Group or the Quality Committee.	**ONGOING**
30.4.18 (064/18)	**SERIOUS INCIDENT REPORT**	Andrea McCourt	It was noted that the details listed under incident 152944 (2018/4336) did not reflect the title of the incident. **Action 30.4.18**: Incident to be amended with correct information.	**Due 4 June 2018**
30.4.18 (068/18)	**SAFEGUARDING ANNUAL REPORT**	Lindsay Rudge	LR noted that there was an error on page 18 of the report relating to children's incidents, and will re-submit an amended report. **Action 30.4.18**: LR to amend information on children's incidents	**Due 4 June 2018**
30.4.18 (076/18)	**SUB GROUP TERMS OF REFERENCE**	Michelle Augustine	**Action 30.4.18**: To obtain terms of reference for Estates and Facilities **Action 30.4.18**: To amend title for FSS terms of reference	**Due 4 June 2018**
GOING FORWARD				
27.2.17 (050/17) 3.7.17 (108/17) 3.1.18 (005/18)	**MEDICAL DIVISION PSQB REPORT – FALLS**		**ACTION 27.02.17:** Progress report on falls to be presented in May. **Update May 2017:** Due to the Quality Committee meeting on Wednesday, 3rd May 2017 being stood down due to EPR implementation, and the meeting on Wednesday, 31st May 2017 being dedicated to PSQB reporting, this will be deferred to the 3rd July 2017 meeting. **Action 03.07.17:** That the members of the falls team (Janette Cockroft, Lisa Fox and Andrew Hardy) are invited to give an update to the Board of Directors (preferably 3rd August 2017) – Michelle to forward action to Kathy Bray for Board of Directors meeting – COMPLETED 11th July 2017 **Update July 2017:** The falls briefing paper was presented, and the falls team were commended for the positive impact their work has created. **Action 03.07.17:** A report to be submitted in 6 months' time	

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 30th APRIL 2018

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
		Falls Lead	(Wednesday, 3rd January 2018), but will be brought back sooner if there are any significant changes **Update 03.01.18:** See item 005/18 **Action 03.01.18**: To receive an update from the Falls Collaborative in six months' time	**DUE 2nd July 2018**
04.12.17 (209/17)	**CLINICAL AUDIT PROGRAMME**	Neeraj Bhasin	**Action 04.12.17:** To feedback ongoing work on audits overall and provide assurance that national mandatory audits are being prioritised over local **Update:** To be deferred to 2nd July meeting – by chair's agreement	**DUE 2nd July 2018**
02.10.17 (171/17)	**NG TUBE TRAINING** *(via Health & Safety Committee Report)*	Joanne Middleton	**Action 02.10.17:** To identify which areas are targeted for high risk Ng tube training **Update 30.10.17:** Jo Middleton to provide an update on nasogastric tube training at the meeting on Monday, 29th January 2018. **Update 29.01.18:** See item 023/18c Progress to be reviewed in 6 months' and to also consider NG tube training's future position on risk register.	**DUE 30th July 2018**
30.4.18 (062/18)	**SEPSIS UPDATE**	TBC	**Action 30.4.18**: Further update to be noted on the work plan for October 2018.	**DUE 29 October 2018**
30.04.18 (072/18)	**PATIENT EXPERIENCE AND CARING REPORT – Schwarz Rounds**	Workforce and OD	Discussion ensued on progress with Schwarz rounds and it was stated that contracts have now been signed in Workforce and Organisational Development and training has been undertaken. **Action 30.4.18**: Report to be submitted in six months' time.	**DUE 29 October 2018**
CLOSED				
26.02.18 (051/18)	**FRIENDS AND FAMILY TEST** A concern regarding FFT cards was raised, as to whether patients were identifiable from the bed allocation numbers that were included on the cards.	Lindsay Rudge	**Action 26.2.18:** LR to follow this up **Update 30.4.18:** LR updated that the allocation numbers on the Friends and Family Test (FFT) cards are used to cross-reference if a patient from the bed has been given a card. LR has also spoken to all divisional leads and the display of the numbers on the cards will be resolved. LR also stated that this will be fed directly back to Lynn Moore who raised the concern.	**CLOSED 30th April 2018**

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 27 April 2018, 10.00am – 1.00pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnership
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director – In part, joined via conference call
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive

IN ATTENDANCE

Sharon Appleby	Transformation Programme Manager, PMO- for Item 088/18 (061/18) only
Kirsty Archer	Deputy Director of Finance
Matt Barker	Head of Procurement – for Item 098/18 only
Stuart Baron	Associate Director of Finance
Brian Moore	Lead Governor (Observer)
Lindsay Rudge	Deputy Chief Nurse - for Item 088/18 (061/18) only
Betty Sewell	PA (Minutes)

ITEM

085/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

086/18 APOLOGIES FOR ABSENCE

There were no apologies to note.

087/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

088/18 MINUTES OF THE MEETING HELD 3 APRIL 2018

The Committee approved the minutes of the meetings held 3 April as an accurate record.

089/18 MATTERS ARISING AND ACTION LOG

The following Matters Arising were updated:

061/18: Nursing Costs – Following feedback from nursing colleagues and the feeling of inequality with regard to banding rates, follow up communications explaining the rationale were initiated and no further enquiries have been received, this will continue to be monitored. The learning from this is that where we have a differential we must make sure we have clear communications – **action closed**.

ACTION LOG

173/16: EPR Update – a date is still to be agreed, the Committee were informed that a piece of work is being undertaken, the status of this work will be checked out and the date can then be agreed – **PO/GB/MG**

013/18: Control Totals 18/19 - The Director of Finance reported that around 70% of organisations are not accepting their Control Totals so far which were set last year. Following the submission of our Plan further information will be available for the next meeting – **GB**

061/18: Nursing Review Report - The Deputy Chief Nurse, Lindsay Rudge presented the Committee with the main points from a very comprehensive report. Firstly, Lindsay acknowledged the hard work from all colleagues for their contribution to this report. It was noted that the review was commissioned to specifically clarify the reasons for cost variation in the nursing and midwifery workforce and make recommendations for opportunity to reduce costs and generate efficiency savings that do not compromise patient safety and quality. In summary, the key findings of the reviews concluded that:

- Nursing establishment levels at CHFT are in line with National Qualitative Board (NQB) guidance.
- That Board level reporting on safer staffing is undertaken in line with National Guidance
- Discussions with senior team and clinical colleagues affirmed that establishment levels were fair, appropriate and that terms were engaged with the establishment review process.
- The review found no excess staffing levels and concluded that there is clear governance over how establishment levels are calculated
- Review existing internal quality improvement and efficiency programmes where current work on these pathways is being described.
- Deliver the planned reduction in agency spend (18/19 Nursing Workforce portfolio).

Attention was drawn to the fact that this review was based on 2015/16 Model Hospital data and during the completion of this report 2016/17 data was refreshed which was also reviewed.

The Committee were asked to endorse the external Nursing Qualitative review and its recommendations, approve the implementation of the review action plan and approve the continuation of the Nursing and Midwifery Workforce Steering Group 18/19 plan to deliver overall Nursing spend reduction.

It was noted that we are starting to implement changes and had 'turned off' Thornbury for night-shifts Monday to Thursday and other agencies of the equivalent value, daily staffing meetings are Chaired by the Deputy Chief Nurse and approvals come through that route. Prior to the implementation to withdraw Thornbury we engaged with Ward Managers and we discussed with them what we are trying to achieve and they were asked to look at reviewing rosters with extra scrutiny at roster sign-off.

Discussions took place with regard to establishment and it was acknowledged that further scrutiny is required but that this is only one of the recommendations. It was noted that there was a general observation that it was hard to know from the report how this work is progressing and if actions are being implemented and the question was asked from the point of view of Governance how can we be sure this work is being driven through and how can we be transparent about how we go forward.

Further in depth discussions took place with regard to agency and establishment, headroom and fill rate. It was noted that a control piece is required with regard to the fill rate and the number of requests, this has been picked up within the weekly Turnaround Executive and there is no reason to believe we have a safety concern.

The Chair thanked Lindsay for a very complex and comprehensive report, it was noted that the three main drivers were:-

- The use of Agency
- Rostering
- Average length of stay

It was noted that it would be useful to think about the target of improvements in year and the trajectory so that the Committee has clear sight to see the progress.

ACTION: The Chief Operating Officer confirmed that different elements feed into different Committees and it would be useful to identify what elements need to come to Finance & Performance Committee – **HB/PO**

074/18: Capital Plan Risk Assessment – The Associate Director of Finance provided the Committee with an overview of the capital programme, associated risks along with the residual risk remaining within the Trust where identified capital risks are unaffordable within the capital plan. An almost identical paper has been to both the Capital Management Group and the Commercial Investment & Strategy Committee for engagement.

It was noted that the Trust has submitted emergency capital requests to NHS I for HRI backlog maintenance, ED Resuscitation Refurbishment and ICU Refurbishment and FSS equipment replacement. In addition, capital bids have been submitted to the Sustainability and Transformation Plan (STP) for three schemes.

The Director of Finance explained that NHS I advised the Trust to include Emergency Capital requests within the Plan which is due to be submitted by mid-day Monday 30 April and information was received too late to make changes, however, we have agreed with the NHS I to include a narrative within the Plan.

Discussions took place with regard to the Risk Scores against the items not within the Capital Plan, it was noted that further discussions need to take place between the Chief Operating Officer and the Director of Planning, Facilities and Estates in relation to the A&E Refurbishment to decide what needs to be done. Assurance was given to the Committee that the Capital Plan had received clinical backing, however, even though it has had clinical support the lack of investment cannot be sustained

Further discussions took place with regard to the mitigation of the risk and how we can prioritise and think longer term and how can we start to negotiate contracts earlier.

ACTION: To draft a 5 Year Capital Plan which would go to the Audit & Risk Committee – **SB/RH (3-4 months' time).**

Overview of NHS National Debt - The Associate Director of Finance provided the Committee with an overview of the national NHS debt position in the context of the Trust's financial liabilities and borrowing. The paper outlined the significant level of debt within the NHS, a figure of £8bn borrowing. It concludes that the Trust is in the top third of borrowing as at 31 March 2017 and whilst national analysis is not available for 2017/18 or 2018/19 the planned scale of borrowing for CHFT is significant. Financial recovery is required to reverse the current borrowing trend both nationally and for the Trust.

In depth discussions took place with regard to the Trust's performance. finances and A&E attendance and whether there is any correlation with the level of borrowing and volume of activity, it was suggested that when NHS I publish the Qtr. 4 results this information would be available.

In terms of taking forward, it was agreed that a report would come back to the Committee with the timing to be agreed.

ACTION: To provide the Committee with a report which will triangulate performance activity and financials compared with national performance – **OW/GB/HB/PO, timing to be agreed**.

043/18: Sustainability and Transformation Fund Review 2017/18 – The Deputy Director of Finance presented a paper which focused on the question of parity in assessing performance against the STF eligibility criteria. The review used a small sample of Trusts which included Leeds Teaching Hospitals NHS Trust, Salford Royal NHS FT and Barts Health NHS Trust. The STF continues to be paid on a quarterly basis with 70% paid for achieving a financial control total and a further 30% being available where a financial control total and the national specified A&E 4 hour performance has been delivered. It was noted that achievement of the financial control total is the leading measure. If the control total is not reached in a quarter this precludes receipt of the entire STF irrespective of A&E performance. The specific criteria relevant to the A&E element of the scheme were outlined and described within the paper.

It was noted that CHFT were disadvantaged for being part of the Accelerator Zone and the setting of the trajectory from March 2017. Discussions took place with regard to the negotiating and setting of the A&E targets and how some organisations can draw on different parts of the system. It was also noted that if we had received the £1m STF it would have only been a cosmetic improvement to the bottom line and a cash benefit.

The Committee **NOTED** the contents of the review.

097/18 2018/19 PLAN UPDATE

The Director of Finance reported that it is the intention to submit the Plan which was shared with this Committee last month. A meeting with our Regulators took place this week and they asked a number of questions with regard to the agency trajectory they also asked for assurance on our Winter planning but they did not impose any changes with regard to the Plan.

The Chief Executive commented that the level of Cost Improvement Planning (CIP)

must be as recurring as possible and with the Aligned Incentive Contract (AIC) look at what we can do to take cost out which will then have an impact on the underlying deficit, we must strive to be better than forecast.

The Director of Finance gave some feedback following his attendance at the NHS Providers Finance & Commercial Directors Network session, It was noted that discussions focussed on the submission of 'realistic plans'.

Andy Nelson joined the meeting via conference call.

The Committee supported the **RECOMMENDATION** of the 2018/19 Plan to the Board.

094/18 MONTH 12 FINANCE REPORT

The Deputy Director of Finance reported that at year-end the gap to our Control Total was £7.97m which is in line with the position agreed with NHSI and excludes STF funding. It was noted that we had a very late notification of the decision to allocate the Trust a £2.89m 'bonus' STF funding as part of a general distribution to organisations that agreed their 17/18 Control Totals.

The adverse movement in Month 12 was discussed with regard to divisional performance and it was noted that this would be picked up at the Divisional Performance Reviews with the first meeting taking place later today.

With regard to Capital and Cash, the majority of the capital overspend was due to an additional £1m capital expenditure in support of the revenue position as agreed by NHSI. The additional capital expenditure was not cash backed and is therefore a working capital pressure which will be taken into 18/19 this will be monitored by the Committee.

The Committee **NOTED** the Month 12 financial position.

090/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer asked the Committee to note the contents of the report; however, the focus would be on the Performance Improvement for Qtr. 4.

The Committee **NOTED** the contents of the report and the overall performance score for March.

091/18 PERFORMANCE IMPROVEMENT QTR 4, 2017/18

The Chief Operating Officer reminded the Committee that following December's Performance Score of 54% we set projections to concentrate on improving a small number of indicators which would potentially improve performance to March 2018. The best case would be a 72% Performance Score but the most likely score would be 62% which was achieved but not in the way it was predicted. The following headlines were noted:-

- Safety moved into Green
- Efficiency & Finance delivered a Red
- Workforce delivered an Amber

The high level differences were noted as follows:-

- From a Caring domain we forecast 74% but achieved 61%, this related to 2 FFTs in A&E and the FFT in Community.
- In Responsive we forecast a likely score of 69% but achieved 67%, areas of concern were the number of outliers and one of the stroke indicators. Cancelled ops were also highlighted noting that it relates to other theatre scheduling issues which meant we had a high number of cancelled ops particularly around day surgery.
- Workforce – sickness deteriorated in month but mandatory training increased the performance percentage.
- Finance fell to 17% due to agency spend.
- Activity – Day Case and A&E were down

It was noted that a change to the profile for Weekly Performance meetings with Divisions is due to take place which will include Helen Barker and Gary Boothby taking Division by Division to get into the detail.

The Committee **NOTED** the contents of the report.

092/18 FUTURE KPIs FOR THE IPR 2018/19

The Chief Operating Officer presented a paper which followed a review of the IPR; the paper detailed a number of proposed changes with the majority within the Workforce element with additional KPIs within Efficiency and Finance. These changes will be incorporated within the IPR for Qtr. 1.

It was noted that from a Non-Executive point of view the Carter Dashboard is a useful document however, there will be a move for it to look like the Model Hospital and some elements will be kept in.

It was agreed that these are sensible changes, if anyone had any further comments they were advised to contact Helen Barker prior to the implementation.

The Committee **NOTED** the contents of the report.

093/18 MULTI-DISCIPLINARY ACCELERATED DISCHARGE EVENT (MADE)

The Chief Operating Officer updated the Committee and would bring back to the next meeting a more formal paper. In summary it was a really successful event which included participants from different organisations and included 18 wards, there were key learnings and positive feedback from the Regulators in terms of our approach and openness. It was agreed that going forward we would hold a MADE event once a month.

095/18 HEADS OF TERMS FOR THE 2018/19 CONTRACT

The Director of Finance presented a paper for information, it was noted that the Contract had been signed and included a number of thresholds which refer to the increase and decrease of activity, however, the contract value is protected for any under-performance.

Discussions took place with regard to a reduction in the cost base, it was noted that this would be the challenge to provide the same safe care in a planned way. It was

suggested that there should be a standing item on the Agenda which demonstrates 'cost out'.

ACTION: To consider a standing agenda item (Cost Out) – **PO/GB – To be agreed**
Discussions took place with regard to depth of coding and it was agreed that a summary should be brought back to the Committee periodically.

ACTION: To provide the Committee with assurance with regard to depth of coding - **SB/Julian Bates, 29 June 2018**

096/18 2018/19 PLAN AND HISTORICAL TRENDS

The Director of Finance presented a paper which provided various data on activity, expenditure, income, staffing levels and bed numbers over a number of years. The trend information was provided both for information but also for assurance that the 2018/19 Plan is both realistic and deliverable. It is also linked to how the Finance & Performance report will change from next month to include historical trend data. It was acknowledged that the report included a vast amount of data and the Committee were asked to reflect on the detail the key question is how we drive productivity going forward.

The Committee **RECEIVED** the paper.

098/18 PROCUREMENT UPDATE

The Head of Procurement gave a presentation to the Committee with a performance focus and how we are performing against key targets from the Procurement perspective. The savings target for 2018/19 was highlighted which has seen an increase of approx. 10% year on year. It was noted that from a savings point of view, Procurement is in a positive position, With regard to the metrics the focus going forward will be in the areas demonstrating room for improvement and 'go sees' with similar sized Trusts will be arranged.

A question was asked about the Electronic Purchase Order (EPO) metric and the significant dip in February and March, it was noted that the Oracle system was upgraded at the beginning of the year and as a result some orders had been lost as part of the migration process. The Director of Finance clarified that the moving between systems is a risk for next year; the Committee were assured that the payment of invoices had not been duplicated and that there are controls in the system. With regard to cost reduction spend it was agreed that with the better use of the NHS buying power there is scope to generate extra saving opportunities. It was confirmed that the benchmarking tool is against consumables and other Trusts with the majority of our spend going through NHS Supply Chain.

It was acknowledged that the presentation under-plays the contribution to Trust-wide cost savings by the Procurement team and that it is important that this is communicated.

It was also noted that the Wholly Owned Subsidiary (WOS) would allow Procurement to compete with other organisations with regard to resource. The intention is to become a more commercial function and develop the right sort of skills. Further discussions took place with regard to the Procurement Vision and the comment that this needs expanding to include the aims of the WOS. With regard to

capital projects, it was noted that some Divisions seem to work in isolation instead of utilising the skills of the Procurement team. Procurement should make sure they are pro-actively having discussions with Divisions in preparatory work for procuring medical equipment etc.

It was acknowledged that EDI is an area where it was agreed we could do more and we are targeting other Trusts which are performing in these areas.

ACTION: To follow up with Divisions at their Performance Reviews with regard to them not working in isolation but to pro-actively involve the Procurement Team - **HB/GB**

100/18 MONTH 12 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee received the Month 12 commentary on the financial return which would be submitted to NHS Improvement.

The Committee **APPROVED** the Month 12 commentary.

101/18 REVIEW OF F&P COMMITTEE TERMS OF REFERENCE

The Chief Operating Officer had included an additional section under Performance Assurance; additional comments would be fed-back to Helen Barker outside the meeting.

ACTION: It was highlighted the that we have the same 3 Non-Execs on both F&P and Audit & Risk Committee, this would be picked up by the respective Chairs – **PO/RH/PL**

102/18 WORK PLAN

The following items were noted for addition to the Work Plan:-

- Cost Out/Cost Reduction (part of CIP)
- Monitoring the Nursing Costs

103/18 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following areas of discussion for cascading to the Board:

- Nursing review – good discussions took place with regard to the use of agency, rostering and the average length of stay
- Capital programme and the mitigation of risk especially the high risk items either in the plan or not in the plan
- Development of 5 year Capital Plan going to ARC
- Funding and levels of debt – are we comparing like for like and the impact on costs and operations - how we negotiate effectively the STF and the trajectories
- Consistency with other providers and lack of transparency around certain elements with an action to look at Leeds post year end.
- Formally recommend to the Board the 18/19 Plan recognising discussions with NHSI and to deal with additional capital through a side letter.
- Year-end performance is in line with plan

- Divisional issues in month, need to understand the underlying position
- IPR and the suggested KPIs moving forward
- MADE Event update
- 2018/19 Aligned Incentive Contract – the key element this year is to drive efficiency and drive cost out
- Coding to keep focus going forward – see indicators on depth of coding
- Historical Trends - the Committee were encouraged to review historical trends to help understand productivity
- Procurement savings and involvement of the decision making process
- ToR – recommendation to the Board

104/18 REVIEW OF MEETING

The Committee agreed that overall a number of items had been covered, not only looking back and learning but also discussing how we can change things going forward.

105/18 ANY OTHER BUSINESS

The Director of Finance advised the Committee that a new risk has been added to the Risk Register with a risk rating of '16' in relation to the upgraded finance ledger system and procurement ordering system (NEP). We are experiencing a number of challenges which are now affecting clinical supplies. An action plan will be presented at Turnaround Executive.

DATE AND TIME OF NEXT MEETING

Tuesday 5 June, 9.00 am – 12.00 noon

Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Friday 11 May 2018, 1.00pm – 3pm, Room 4, 3rd Floor, Acre Mill Outpatients, Huddersfield

PRESENT:

David Anderson	Non-Executive Director
Stephen Baines	Council of Governors
Suzanne Dunkley	Executive Director of Workforce and Organisational Development
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director (Chair)

IN ATTENDANCE:

Asif Ameen	Director of Operations
Claire Wilson	Assistant Director of Human Resources (for agenda item 57/18)

50/18 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

51/18 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer – Asif attending
David Birkenhead, Medical Director
Brendan Brown, Chief Nurse
Chris Burton, Staff Side Chair
Jason Eddleston, Director of Workforce and Organisational Development
Vicky Pickles, Corporate Secretary

52/18 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

53/18 **MINUTES OF MEETING HELD ON 16 MARCH 2018:**

The minutes of the meeting held on 16 March 2018 were approved as a correct record.

54/18 **ACTION LOG (items due this month)**

Items due this month were discussed in the meeting.

MAIN AGENDA ITEMS

FOR ASSURANCE

55/18 **NEW WORKFORCE COMMITTEE MEETING SCHEDULES - DATES AND ATTENDEES**

SD outlined the proposed changes to the design of the Workforce Committee. These changes are required to increase the Committee's effectiveness in providing assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. The Committee will agree actions and interventions to improve the performance and engagement of the Trust's workforce.

The Committee will meet bi-monthly to discuss strategic issues ('hot house' sessions) and quarterly to carry out a deep dive review of workforce performance and metrics.

Following discussion about attendees of the hot house sessions it was agreed to extend participation to include a wide-spread of staff groups.

KH, as Chair of the Committee, expressed full support of the re-design of the Committee. KH and SD will meet monthly to review progress and set agendas.

Proposed list of invitees to the 'hot house' sessions:	
Group one	Chief Operating Officer, Chief Nurse, Medical Director, Director of Finance and their Deputies plus any member of the Executive Team with a special interest in the subject
Group two	3 x Non-Executive Directors, 2 x Governors as invited by the Chair of the Workforce Committee
Group three	Workforce and Organisational Development team members who lead on the hot house topic, plus Assistant Directors, Deputy Director and Human Resources Business Partners
Group four	Staff representatives
Group five	Network colleagues from colleague engagement network, BAME network
Group six	A minimum of 3 apprentices
Group seven	5 'free' places to any member of staff who has a particular interest in the subject
Group eight	National leaders in the subject field and/or representatives from best practice organisations
Proposed list of invitees to the quarterly Committee sessions:	
Group one	Chief Operating Officer, Chief Nurse, Medical Director, Director of Finance and their Deputies
Group two	3 x Non-Executive Directors, 2 x Governors as invited by the Chair of the Workforce Committee
Group three	Assistant Directors, Deputy Director and Human Resources Business Partners – Workforce and Organisational Development
Group four	Staff representatives
Group five	Divisional Directors and Directors of Operations from each Division
Group six	5 'free' places to any member of staff, with a minimum of 3 apprentices

Committee members discussed the new approach and were supportive of it, endorsing the escalation route to Divisional PRMs and alignment to other workforce related activities across the Trust. A discussion took place about connectivity between how the Workforce Committee fits with other committees and meetings in terms of activity and governance. It was agreed that this would be pulled together and be shared so that this is clear.

ACTION: TR to list all Committee meeting dates on agendas
SD to add additional invitees to hot house session invitees
SD to collate details of existing committee meetings and forums

OUTCOME: The Committee **RECEIVED** and **ENDORSED** the approach.

56/18 **PROPOSED HOT HOUSE TOPICS FOR 2018/2019**

SD outlined the schedule of the Hot House Topics:-

June 2018	Apprenticeships
August 2018	Health and Wellbeing
October 2018	Equality, Diversity and Inclusion
December 2018	Recruitment and Retention
February 2019	Learning and Development

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the schedule.

57/18 **NEW MONTHLY WORKFORCE REPORT, INCLUDING APRIL REPORT AND PRIORITIES TO ENSURE WORKFORCE TRAJECTORIES**

The report had been circulated with papers to the Committee meeting.

CW explained the new format of the Workforce Performance Report. The new format was really well received.

Discussion took place on specific points with actions being noted:-

Overseas nurses - 7 nurses from the Philippines overseas recruitment exercise have commenced in post. 119 offers were made.
Action: To identify how many nurses are expected to commence.

Sickness absence
ACTION: Identify cost of sickness absence in the next workforce report.

Employee relations
ACTIONS: Full picture to be outlined in more detail so that the average days data isn't skewed by one case
Identify when each disciplinary case opened
Provide breakdown by gender and ethnicity
Provide full 12 months trend, April 2017 – March 2018

Equality and Diversity
ACTION: Provide full breakdown of ethnicity for the Trust - benchmark against local population of Calderdale/Kirklees (use Huddersfield wards if possible)

The Committee agreed to receive the bandings, staff survey data KPI and equality and diversity data annually as proposed.

Colleague engagement and the staff survey in relation to IIP (qualitative data more than quantitative).
ACTION: Assess any quantitative data that could be shared as KPIs

Workforce Business Intelligence data and trend to link into "Hot topic" sessions.

The data analysis from the Workforce Performance Report may also highlight trends where a deep dive in Divisions/areas of the Trust may be determined.

Noted now more starters than leavers than previously.

"The Model Hospital" data – currently working with NHSI as we know the FTE data in "The Model Hospital" is incorrect in terms of FTE data (out by approximately 860 FTE – mainly on nursing and midwifery and medical staff.)

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

58/18 **QUARTERLY WORKFORCE DEEP DIVE - PROPOSED RUNNING ORDER AND HOW THE COMMITTEE CAN ASSURE ITSELF OF PROGRESS**

SD put forward the proposal of a quarterly workforce deep dive. SD explained that the Committee will conduct reviews of achievements against workforce targets and take remedial action if necessary. Whilst this will be undertaken in the form of monthly reports at the 'hot house' bi-monthly meetings, the quarterly deep dive sessions will act as an escalation point for Divisional monthly PRMs and a review of key performance against workforce targets.

The Quarterly Workforce Deep Dive will take place:-

Q1 - July 2018
Q2 - October 2018
Q3 - January 2019
Q4 - April 2019 (+ Q1 2019/20 scene setting)

OUTCOME: The Committee **RECEIVED** and **ENDORSED** the approach.

59/18 **REVISED WORKFORCE COMMITTEE TERMS OF REFERENCE**

The revised Terms of Reference had been circulated with papers to the Committee meeting.

The Workforce (Well Led) Committee has been renamed the Workforce Committee as the 'well led' termination caused some confusion at both the recent NHSI and CQC inspections.

The focus of the Workforce Committee has been redesigned to add greater clarity to its purpose and further improve its effectiveness.

The Committee agreed at its meeting in March 2018 that there would be two main roles for the Committee going forward and that it would meet bi-monthly to discuss strategic issues and quarterly to carry out a deep dive review of workforce performance and metrics.

The Committee were supportive and agreed the revised terms of reference subject to the following amendment:-

Attendance at hot house topics and bi-monthly strategic sessions to read 'a maximum of three Non-Executive Directors'.

ACTION: TR to amend the Terms of Reference and submit to June 2018 Board of Directors requesting approval.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the revised terms of reference.

ITEMS TO RECEIVE AND NOTE

60/18 **ANY OTHER BUSINESS:**

No other business was raised.

61/18 **MATTERS FOR ESCALATION:**

Revised Terms of Reference to submit to June 2018 Board of Directors meeting.

62/18 **DATE AND TIME OF NEXT MEETING:**

Tuesday 10 July 2018, 2.30pm – 4.30pm, Room 4, Acre Mills Outpatients, Huddersfield

Calderdale and Huddersfield NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD ON WEDNESDAY 4 APRIL 2018 IN THE BOARDROOM, SUB-BASEMENT, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Outgoing Chair
Philip Lewer	Chair
Dianne Hughes	Public elected – Constituency 3
Kate Wileman	Public elected – Constituency 2
Veronica Maher	Public elected – Constituency 4
Stephen Baines	Public elected – Constituency 5
Brian Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Paul Butterworth	Public elected – Constituency 6
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8 /Lead Governor
Dr Peter Bamber	Staff Elected – Constituency 9
Linzi Smith	Staff Elected – Constituency 11
Sian Grbin	Staff-elected – Constituency 13
Megan Swift	Nominated Stakeholder – Calderdale Metropolitan Council
Felicity Astin	Nominated Stakeholder - University of Huddersfield
Rory Deighton	Healthwatch Kirklees

IN ATTENDANCE:	**(*For part of the meeting due to CQC Feedback)**
David Anderson	Non-Executive Director/SINED
Helen Barker	Chief Operating Officer *
Anna Basford	Director of Transformation and Partnership *
David Birkenhead	Executive Medical Director *
Gary Boothby	Executive Director of Finance *
Kathy Bray	Board Secretary
Suzanne Dunkley	Executive Director of Workforce and OD *
Mandy Griffin	Managing Director – Digital Health *
Lesley Hill	Executive Director of Planning, Estates & Facilities *
Richard Hopkin	Non-Executive Director
Ruth Mason	Associate Director of OD and Training (item 9)
Amanda McKie	Matron – Complex Care Needs Co-ordinator (item 4)
Andy Nelson	Non-Executive Director
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive

APOLOGIES:

Apologies for absence were received from:

Rosemary Hedges	Public elected – Constituency 1
Di Wharmby	Public elected – Constituency 1
Alison Schofield	Public elected – Constituency 7

Katy Reiter	Public elected – Constituency 2
John Richardson	Public elected – Constituency 3
Nasim Banu Esmail	Public elected – Constituency 4
Michelle Rich	Public elected – Constituency 8
Theodora Nwaeze	Staff-elected – Constituency 12
Chris Reeve	Nominated Stakeholder – Locala
Salma Yasmeen	Nominated Stakeholder – South West Yorkshire Partnership FT
Brendan Brown	Executive Director of Nursing/Deputy Chief Executive
Karen Heaton	Non-Executive Director
Phil Oldfield	Non-Executive Director

The Chairman opened the meeting by thanking everyone for attending and introducing Philip Lewer who had taken over the role of Chair for the Trust with effect from 1 April 2018. It was noted that due to a CQC Feedback session the Executive Directors would be leaving at 5.30 pm.

He advised those present that discussion had taken place during the private Governors session held prior to this meeting regarding the financial pressures/reforecast, Judical Review and issues discussed at recent private meetings of the Board of Directors meetings.

14/17 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

15/18 DENNIS' STORY

Amanda McKie, Matron – Complex Care Needs Co-ordinator attended the meeting to give a presentation entitled 'Dennis' Story' which highlighted the awareness of caring for patients with a learning disability, Do Not Attempt Cardiac Pulmonary Resuscitation (DNA CPR) and the Mental Health Capacity Act.

Amanda gave a brief background to the work undertaken in recent years to raise the profile on people with learning disabilities and the national strategy changes which had been put in place to acknowledge the different needs of these patients. Nationally this was a big agenda which had led to changes in practice including an external review of all deaths to identify any cases/actions which could have been avoided and a review of the DNA CPR process for these patients. It was noted that the Trust was a trail blazer in this field.

The video which had been made by the Trust and was used in training, told the story of Dennis, a very independent man who had learning disabilities and cerebral palsy who was being cared for in a home. He had been admitted to the Trust through A/E Department and responded well to treatment. On his return to the home, the staff and family were upset to find that Dennis had been put on a DNA CRP plan without their knowledge. It was noted that this was a medical decision but best practice states that this is communicated with the patient and their family so they have a better understanding of what this means.

Those present thanked Amanda for the informative presentation.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the information presented by Amanda McKie

16/18 MINUTES OF THE LAST MEETING – 17 JANUARY 2018

The minutes of the last meeting held on 17 January 2018 were approved as an accurate record.

17/18 MATTERS ARISING

71/17 – GOVERNORS ATTENDANCE AT FORMAL COUNCIL OF GOVERNOR MEETINGS

The Chairman confirmed that he had now had discussions and sent an email to Governors who had not regularly attended formal meetings.

Brian Moore asked that the Governors present vote on whether members who had not attended two formal meetings, as specified in the Constitution should be excluded. Following a majority decision it was agreed that Michelle Rich and Katie Reiter would be excluded from the Council of Governors with effect from 19 July 2018.

This was in line with the Constitution and allowed the seats to go forward for election in the next round of elections. Those present felt that this was the right thing to do as it was not fair to Trust staff or the public if seats are not represented. All present agreed.

ACTION: CHAIRMAN/LEAD GOVERNOR

OUTCOME: The Council of Governors **AGREED** that two members should be excluded from the Council of Governors

76/17 – RAISING IT ISSUES

It was noted that the Managing Director, Digital Health had actioned this outside the meeting.

OUTCOME: Completed

7/18b – QUALITY PRIORITIES FOR QUALITY ACCOUNTS 2017-18 AND 2018-19

Further feedback on the two mandated indicators were requested and the Company Secretary agreed to circulate this to Governors. (Following the meeting an email was circulated to Governors advising on the mandated indicators which were: 4 hour emergency care standard and the 18 weeks referral to treatment standard).

ACTION: COMPANY SECRETARY (COMPLETED 4.4.18)

18/18 CHAIRMAN'S REPORT

a. UPDATE FROM CHAIRS INFORMATION EXCHANGE MEETING – 26.3.18

The Chairman reported on the minutes from the meeting held on the 26 March 2018 which had been included with the agenda (Appendix B). The next meeting was scheduled to be held on the 25 June 2018.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the Chairs Information Exchange Minutes – 26.3.18

19/18 PERFORMANCE AND STRATEGY

19/18a - FINANCIAL POSITION AND FORECAST

The Executive Director of Finance presented the Month 10 finance report, as at 31 January 2018.

The key points were:-

- Reported year to date deficit position of £30.81m,
- On a control total basis(excluding the impact of loss of Sustainability and Transformation funding (STF)) the reported year to date deficit position is £25.70m an adverse variance of £8.70m compared with the control total of £17.00m;
- Delivery of CIP is £13.12m this is below the planned level of £13.69m;
- Capital expenditure is £3.51 below plan due to revised timescales;
- Cash position is £1.92m, in line with the planned level;
- A Use of Resources score of level 3, in line with the plan.

As at Month 10 the gap to our control total is £8.70m. This is the level of financial improvement that the Trust required in order to be eligible for STF funding. £5.04m of STF funding has been lost based on Q1 & 2 A&E performance and financial performance in M7-10. This is driving a total variance from control total of £13.74m, (excluding technical items excluded for control total purposes). However, the reported position includes a number of non-recurrent benefits that in part offset the underlying operational deficit. The underlying financial shortfall against the financial plan in the year to date is £18.2m excluding the impact of Sustainable Transformation Funding.

OUTCOME: The Council of Governors **NOTED** the financial position and forecast.

19/18b - PERFORMANCE & QUALITY (Including Good News Stories)
The Chief Operating Officer presented the quality and performance report. The key issues from the report included:

- February's Performance Score has deteriorated by 3 percentage points to 57%.
- All domains have deteriorated with the exception of RESPONSIVE and WORKFORCE which saw improvements in 3 of the 5 Mandatory Training focus areas counterbalancing a deterioration in short-term sickness.
- Within the RESPONSIVE domain Stroke and Cancer maintained good performance.
- The CARING domain has worsened due to FFT performance.
- The EFFECTIVE domain has returned to AMBER due to 2 MRSAs in-month. EFFICIENCY & FINANCE has deteriorated with a couple of efficiency targets being missed in-month.

The good news stories paper was received and noted.

OUTCOME: The Council of Governors **NOTED** the performance and quality data and good news stories.

20/18 STRATEGIC PLAN & QUALITY PRIORITIES UPDATE
The Chairman reported that as agreed in the Annual Workplan, the Executive Directors had been requested to give an update on the following areas at this meeting:

20/18a - WORKFORCE & OD UPDATE
Suzanne Dunkley, Executive Director of Workforce and OD advised that progress continued on the action plan for the workforce strategy which had been circulated in November 2017. She updated those present on the key areas of performance.

Paul Butterworth asked if a spreadsheet with a breakdown of timescales for training

could be prepared but it was pointed out that the 112,000 training requirements identified were dependant on the role and included mandatory training.

20/18b - LEADERSHIP DEVELOPMENT

Ruth Mason, Associate Director of Training & OD reported on the various offerings developed within the Trust to meet the leadership development needs. This included an update around:

- Apprenticeship Schemes
- Nursing development courses
- Suite of courses around essential management skills
- CLIP programme
- Work Together to Get Results focus
- Monthly Star Awards

20/18c - CARE OF THE ACUTELY ILL PATIENT

The Executive Medical Director updated on the continuing work of the workstreams to improve patient outcomes. The key areas included:

- Hospital Mortality – positive outcomes and expected mortality rates to continue to fall.
- EPR – metrics continue to fall i.e. identification of patient deterioration and early intervention.
- Care Bundles - improved standardisation of care implemented to support early discharge and avoidance of hospital admissions.
- Falls and Pressure Sores – improvements in outcomes being seen.

Discussion took place regarding admission avoidance and the Chief Executive explained the work which was being undertaken both within and outside the trust, working with CCGs, Locala and GPs to replicate a community model as seen in Calderdale.

20/18d - SAFER PATIENT PROGRAMME

The Chief Operating Officer updated on the progress with the Safer Patient Programme. The key issues included:

- Increase in ambulatory care – good patient experience feedback
- Medical Day Cases at CRH – moved into Ambulatory Unit
- Frailty Team – work continues
- Community Place – more work was being done with Commissioners and LA to look at a rehabilitation model outside hospital, with care closer to home, rather than a community model in hospital.
- Electronic Digital Data – The Chief Executive updated on a pilot being undertaken with Calderdale Council to have shared electronic information. The benefits that this would bring in the future to the whole health and social care system were noted.

OUTCOME: The Council of Governors **RECEIVED and APPROVED** the strategic plan and quality priorities update.

20/18e – FULL BUSINESS CASE

The Director of Transformation and Partnerships reported that no further updates were available. The judicial review had been requested and it was therefore unlikely to hear from the Secretary of State until this process had been finalised later in the summer.

21/18 UPDATE ON WHOLLY OWNED SUBSIDIARY

The Director of Planning, Estates and Facilities updated the Governors on the discussion held at the public Board of Directors meeting held on 1 March 2018.

It was reported that a company had been set up with Companies House and the initial name of the company was "Calderdale and Huddersfield Solutions". This would enable employees to become members of the NHS Scheme, use of logo and set up bank accounts and tax arrangements.

The following Board members had been appointed to serve on the shadow board for this company:
Alastair Graham, Interim Chair
Suzanne Dunkley, Interim Non-Executive Director
Lesley Hill, Interim Managing Director

The Director of Workforce and OD advised that meetings continued with staff and staff side representatives to explore different TUPE models and that the relationship to date had been positive.

It was noted that a letter had been received both by the Board and Governors from "999 Call the NHS" and it was agreed that once a response had been formulated this would be shared with the Governors.

Following discussion the Governors present felt that an extra-ordinary private meeting should be convened to discuss this in more detail and it was agreed that the Board Secretary should arrange a date and notified Governors of the details, along with the response to "999 Call the NHS".
ACTION: Board Secretary – (after the meeting this was arranged for Tuesday 8 May 2018)

OUTCOME: The Council of Governors **RECEIVED** the information provided.

22/18 ANNUAL PLAN 2018-19

The Executive Director of Finance summarised the Trusts' draft Annual Plan. It was noted that the final document required submission to NHS Improvement by 30 April 2018 following agreement by the Board of Directors on the 5 April 2018.

The key points from the draft Annual Plan were noted:

- Agree seasonal profiling of operational plans and final bed plans to allow full triangulation with workforce and finance
- Conclude contract terms with commissioners
- Finalise CIP plans and allocation to close gap to £18m
- Agree agency trajectory at divisional level
- NHSI on site review of operational and financial plan 25 April
- Progress discussions with NHSI on national capital support for essential investments
- Submit final 2018/19 plans to NHSI for 30 April deadline

GOVERNANCE

23/18 COUNCIL OF GOVERNORS REGISTER

The updated register of members as at 1 April 2018 was received for information. It was noted that there had been no changes to the Register since it was tabled at the last meeting on the 17 January 2018.

OUTCOME: The Council of Governors **NOTED** the updated Register.

24/18 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The Chairman requested that any amendments be notified to the Board Secretary

as soon as possible.

OUTCOME: The Council of Governors **APPROVED** the Register of Interests

25/18 NON-EXECUTIVE DIRECTOR APPRAISALS FEEDBACK

The Chairman presented a paper reporting on the appraisals of the Non-Executive Directors (NEDs) carried out between January and March 2018 by the Chair with input from the Executive team.

It was noted that all the Non-Executive Directors were assessed to be carrying out their duties to a satisfactory standard and fulfilling their time commitment to the Trust.

OUTCOME: The Council of Governors **APPROVED** the Chairman's Appraisal of the Non-Executive Directors.

26/18 PROCESS FOR ELECTION OF LEAD GOVERNOR

The process and timeline for the appointment of Lead Governor had been circulated for approval. All present noted the contents of the paper and supported the process which would commence week commencing 9 April 2018 and conclude with the formal announcement at the AGM on the 19 July 2018. The appointment would be effective from 20 July 2018.

OUTCOME: The Membership Council **APPROVED** the process for the election process for the appointment of Deputy Chair/Lead Governor process.

27/18 SELF-ASSESSMENT PROCESS

The Company Secretary reported that the Membership Office will circulate information to the Governors to complete the annual self-appraisal and the results will be feedback to the Governors' meeting in July 2018.

ACTION: Company Secretary/Membership Office

28/18 REVIEW OF COUNCIL OF GOVERNORS' FORMAL MEETING ATTENDANCES

The Company Secretary requested all Governors to check their attendance and advise of any discrepancies before the information is published in the Annual Report in May 2018.

ACTION: All Governors

As discussed earlier in the meeting it was agreed that two Governors would be asked to stand down to allow their seats to go forward in the next round of elections.

ACTION: Chair/Board Secretary

29/18 REVIEW DETAILS FOR JOINT BOD/COG ANNUAL GENERAL MEETING

The Council of Governors' are aware that the Joint Board/Council of Governors' Annual General Meeting will be held on Thursday 19 July 2018. It is expected that the meeting will take place in the Large Training Room, Learning Centre, Calderdale Royal Hospital commencing at 6.00 pm.

30/18 UPDATE FROM BOARD SUB COMMITTEES

30/18a - QUALITY COMMITTEE

Lynn Moore highlighted the discussions which had taken place at the last Quality Committee. These included:

Serious Incident Reporting – never event – work on going
EPR - Appointment letters discussed and work on going

30/18b - ORGAN DONATION COMMITTEE

In the absence of John Richardson the Chairman updated on the current issues discussed at the Organ Donation Committee which included:

- Year to date 6 donations had been received, 5 family declines and 1 coroner decline.
- Funding secured to promote organ donation advertisement on lease vehicles with banner 'wraps'

30/18c - CHARITABLE FUNDS COMMITTEE

Kate Wileman and the Chairman updated on the current issues being discussed by the Charitable Funds Committee which included:

- Agreement to have corporate trustee training for Board
- Work by Huddersfield University Students on public views on donation fedback to Board
- Todmorden – sub committee funded benches, food bank and support for mental health initiatives for the people of Todmorden.

30/18d - PATIENT EXPERIENCE AND CARING GROUP

Lynn More highlighted the discussions which had taken place at the Patient Experience and Caring Group and these included:
Noise at night reviewed
Fire brigade involvement in preventing falls
New privacy curtains process implemented 'daisy'
My name is…. reminder to staff to use this required

30/18e - NOMINATION AND REMUNERATION COMMITTEE (CoG)

Brian Moore reported that as the Council of Governors were aware the Nominations and Remuneration Committee (COG) held interviews for the post of Chair on Friday 2 February 2018 and Philip Lewer had been offered the post subject to ratification by the Council of Governors.

Those present formally welcomed Philip to the Trust and approved the appointment which had commenced on the 1 April 2018.

OUTCOME: The Council of Governors **RECEIVED** the Sub Committees/Groups updates and **APPROVED** the ratification of the appointment of Philip Lewer to the position of Chair.

31/18 CHAIR'S APPRAISAL

Dr David Anderson, Senior Independent Non-Executive Director/Non-Executive Director gave feedback on the Chair Appraisal Process. It was noted that this was Andrew's seventh and appraisal and had been his final year in office.

Overall the appraisal had identified positive feedback from the Board and Council of Governors and a reflection of his seven years in post were summaried:

- The Board is in its strongest position now as he leaves and the Trust a very different organisation
- Compassionate care and focus on patient needs embedded
- Executive Team very strong and work collectively
- Board has kept its nerve and always done right thing facing considerable

challenges
- Awaiting CQC judgement from the recent CQC Inspection.

Brian Moore, Lead Governor thanked everyone for their help in assisting with the smooth running of this process.

OUTCOME: The Council of Governors **APPROVED** the Chair Appraisal

32/18 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Council Calendar – updated calendar received and the contents were noted.

33/18 ANY OTHER BUSINESS

33/18a – Thanks to Andrew Haigh

Owen Williams and Brian Moore formally thanked Andrew Haigh on behalf of the Board and Governors for his commitment and work over the past 7 years as Chairman of the Calderdale and Huddersfield Trust and wished his every success in the future.

33/18b – Wi-Fi

Stephen Baines reported that he had been unable to connect to the Wi-Fi in the Boardroom. It was agreed that this would be reported to Mandy Griffin, Managing Director – Digital Health.

ACTION: Board Secretary

There was no other business to note.

34/18 DATE AND TIME OF NEXT MEETING

Wednesday 4 July 2018 commencing at 4.00 pm in the Boardroom, Sub-Basement, Huddersfield Royal Infirmary

The Chair thanked everyone for their contribution and closed the meeting at 6.30 pm.

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Wednesday 18 April 2018 in the Boardroom, Calderdale Royal Hospital commencing at 10:30 am

Richard Hopkin	Chair, Non-Executive Director
Phil Oldfield	Non-Executive Director
Andy Nelson	Non-Executive Director

IN ATTENDANCE

Dr Peter Bamber	Council of Governors representative
Gary Boothby	Executive Director of Finance
Leanne Sobratree	Internal Audit Manager
Helen Kemp-Taylor	Head of Internal Audit for Audit Yorkshire
Andrea McCourt	Head of Governance and Risk
Clare Partridge.	Engagement Lead, KPMG
Adele Jowett	Local Counter Fraud Specialist
Victoria Pickles	Company Secretary

Item

14/18 APOLOGIES FOR ABSENCE

There were no apologies for absence

The Chair welcomed everyone to the meeting.

15/18 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

16/18 MINUTES OF THE MEETING HELD ON 24 JANUARY 2018

The minutes were approved as a true record.

17/18 ACTION LOG AND MATTERS ARISING

a. 46/16 PAYROLL – GOVERNORS EXPENSES QUERY

The lead governor had queried whether the Governors would be submitting expense claims through the electronic system. The Executive Director of Finance had agreed to inestigate and had found that the only way to do this would be to give Governors bank contracts. Given the relatively low number and low value of claims it was agreed to allow governors to continue to make paper-based claims.

b. 63/17(1) DECLARATION OF INTERESTS SYSTEM/COMMUNICATIONS

The Company Secretary explained that this was going through the approvals process and discussion with the Health Informatics Service.

c. 71/19 – IA FOLLOWUP – STORAGE AND TRANSPORT OF MEDICINES

Concern was expressed that the recommendation within the Audit suggested more keys be available and ARC questioned whether this would really address the issues. The Internal Audit Manager had reviewed the position and confirmed that the issue was in relation to the recording of keys and appropriate recommendation had been made.

18/18 INTERNAL AUDIT FOLLOW-UP REPORT – MEDICAL DEVICES

The Internal Audit Manager presented the follow-up report on medical devices. The outstanding action related to whether training progress should form part of the ward

manager's appraisal objectives. It was noted that this had not been progressed as medical device training covers all departments not just wards. Further work had been undertaken to increase both the uptake and reporting of training compliance. This included:

- Monthly information in the Board Performance Report
- Monthly information by Division, which includes staffing lists with who needs what training
- Monthly best 10 and worst 10 departments/wards/services with regards to medical device training

Medical device training is also routinely discussed at WEB meetings and at the monthly divisional Performance Review Meetings (PRM). Divisional and Clinical Directors are also performance managed on its delivery.

The report set out the current performance of 81%, which is higher than any of the other WYAAT trusts.

Phil Oldfield asked about escalation for areas not complying. The Executive Director of Finance explained that the PRMs are the place where performance issues are discussed and action agreed.

OUTCOME: The Committee NOTED the actions to address medical device training.

19/18 COMPANY SECRETARY'S BUSINESS

19/18a SELF ASSESSMENT OF AUDIT AND RISK COMMITTEE EFFECTIVENESS AND ACTION PLAN

The Company Secretary presented the summary of the Committee's self-assessment and resulting action plan. The two key areas of work to be addressed are the relationship between the ARC and the other committees; and the risk management process and how we track actions. The Company Secretary suggested that a proposal be brought to ARC in July around setting up a yearly meeting of the Committee Chairs to discuss their effectiveness and any issues rather than continuing to take the sub-committee minutes which are already reported to Board. She explained that further work was planned with the Head of Governance and Risk to review the risk management process. Andy Nelson suggested that a Board workshop be arranged to consider risk management.

ACTION: Company Secretary

OUTCOME: The Committee NOTED the self-assessment findings, APPROVED the action plan and AGREED to receive an update at the meeting in July.

19/18b BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework had been updated following the last Board meeting. It was noted that following the approval of the updated Five Year Strategic Plan and Strategy on a Page the BAF would be reviewed to identify any potential changes to the long term strategic risks.

Discussion took place about the Electronic Patient Record Risk (EPR) and the fact that there are a number of fixes still outstanding and a significant back log of change requests. It was noted that risks relating to EPR are discussed at the divisional digital boards. Andy Nelson explained that there would be a focused 'buildathon' event in May to address some of the backlog of required fixes. He added that he had asked for two papers to be brought to the Board relating to EPR: progress against the stabilisation plan and benefits realisation; and system integration. Peter Bamber also agreed to discuss an item being brought to the Council of Governors meeting in July.

ACTION: Governor / Company Secretary

The Committee discussed the overall risk scores and the need to clearly see where action is being taken, the evidence for this and the impact on the risk scores.

ACTION: Company Secretary

Phil Oldfield asked that the controls and assurance columns be reviewed.
The Head of Internal Audit explained that there would be a risk management audit that would review the Trust's BAF and risk register and compare these to other Trusts.

The External Auditor highlighted the importance of checking risk scores back to the risk appetite. Richard Hopkin explained that further work on risk appetite was planned for the Board workshop in May.

OUTCOME: The Committee NOTED the Board Assurance Framework.

19/18c COMPLIANCE AND CODE OF GOVERNANCE
The Company Secretary presented the draft code of governance compliance. She explained that feedback had been received from the governors on two specific areas and these had been updated to read as follows:

B.5.6 Ex - Governors should canvass the opinion of the trust's members and the public. - There are mechanisms in place for Council of Governors' to seek the views of the public. The membership strategy sets out how we engage with the public members. This requires further development and to address this, a review of membership engagement will be completed with the Council of Governors by end July 2018.

B.5.7 Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.
There are a number of mechanisms in place to enable the Board of Directors to seek the views of the Council of Governors' on the business plan and other strategic issues. The executive and non-executive directors regularly attend the Council of Governors'; presentations on the annual plan and the quality account are given to Council of Governors'. A development workshop between the Board of Directors and the Council of Governors' is held twice a year to look at strategy and planning. Concerns have been raised by Governors on their engagement in the plans for the creation of the Wholly Owned Subsidiary for estates, facilities and procurement and a separate meeting of the Council of Governors has been arranged dedicated to this item.

Andy Nelson asked about the statement regarding the Trust being a going concern. The External Auditor explained that there is agreed wording for trusts in a deficit position. This would come to the ARC for approval at its meeting in May.

OUTCOME: The Committee APPROVED the amended wording to the code of governance.

19/19d ANNUAL GOVERNANCE STATEMENT
It was noted that the Annual Governance Statement would be shared for comment outside the meeting prior to being presented for approval at the special Audit and Risk Committee to approve the Annual Report and Accounts in May.

OUTCOME: The Committee NOTED the process for reviewing the Annual Governance Statement.

20/18 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

20/18a. WAIVING OF STANDING ORDERS

The Executive Director of Finance reported that during this quarter, 4 orders were placed as a result of standing orders being waived, at a total cost of £118,000. There was 1 amendment to an earlier single source this quarter at a total cost of £15,000.
It was noted that one tender had been waived more than once relating to some support for our work on addressing nurse agency use.
Andy Nelson asked how we mitigate not being locked in to a supplier. The Executive Director of Finance explained that the procurement team provide the governance on this.

OUTCOME: The Committee APPROVED the waiving of standing orders

20/18b. LOSSES AND SPECIAL PAYMENTS

The Executive Director of Finance reported that losses and special payments over the quarter totalled £41.9K. The losses 'other' of £25.5k consists of some expensive emergency medicines which expired. The Trust holds approximately £1.2m of stock over 11,000 lines which are closely monitored. Pharmacy have to manage a balance of keeping drugs that may be infrequently used and may eventually expire against ensuring that medicines are available when they are critically needed. Expired stock is reported to Pharmacy Management Board each month. The Trust is working on a virtual pharmacy store across WYAAT, York and Hull for short term stocks. It was noted that we already buy medicines on a regional procurement contract. The business case for this service sets out benefits around cash and skill mix. The tender has gone out to the market for them to influence the development of the specification to see what the art of the possible is.

It was noted that the £14.6k for Q4 Public/Employer's liability claims is made up of six repayments to NHS Resolution for damages or costs and the total value of losses and special payments to quarter 4 2017/18 is 16% higher than the value at the same quarter 2016/17 but 2017/18 full year compared to 2016/17 is overall 13% lower.

OUTCOME: The Committee NOTED the losses and special payments report.

20/18 INTERNAL AUDIT

20/18a. INTERNAL AUDIT FOLLOW-UP REPORT

The Internal Audit Manager presented the follow up report. She explained that there has been slight increase in the number of overdue recommendations although the high risk recommendations have fallen. There will be an electronic system going forward and will involve executive follow-up. There needs to be tighter grip on this to ensure there is still the WEB oversight. The internal audit plan has been shared with WEB.

20/18b. INTERNAL AUDIT PROGRESS REPORT

The Internal Audit Manager presented the report showing seven audit reports have been agreed with management since the last Audit Committee. A further two reports have been issued in draft. The Internal Audit Manager highlighted some changes to the plan: the vanguard audit has been cancelled as this has been removed as a national priority; For the ENT report there were 23 actions, of which 20 have been actioned and the three outstanding are low risk and will be picked up as part of the Getting it Right First Time Review therefore the additional work on this has been removed.

Andy Nelson asked how this impacts on the number of days as there are some budget overruns. The Head of Internal Audit explained that there are a number of audits which are always due to be undertaken at the end of quarter four and therefore the plan is back ended to ensure it is possible to give an opinion on the full year. Andy Nelson asked that this is more clearly identified in future reports. Richard Hopkin asked if there were any lessons to be learned on phasing. The Head of Internal Audit responded that they try to bring work forward but this is not always possible. The Executive Director of Finance commented that

the Trust also needs to play its part by sticking to the plan timetable as far as possible.

The following reports were finalised.

Report No	Report	Final	Draft	Opinion
CH/12/2018	Sepsis	✓		Limited
CH/13/2018	Pharmacy and Medicines Management - Controlled Drugs	✓		Significant
CH/14/2018	THIS – Compliance with ISO Standard 9001 and 27000 (Part 2 of 3)	✓		Full
CH/15/2018	Consultant Job Plan	✓		Limited
CH/16/2018	Information Governance Toolkit	✓		Limited
CH/17/2018	Payroll		✓	Limited
CH/18/2018	THIS – Compliance with ISO Standard 20000 (Part 3 of 3)	✓		Full
CH/19/2018	Patient Flow		✓	Limited
CH/20/2018	Ambulatory Care	✓		Significant

Discussion took place regarding the audits with limited assurance:

- **Sepsis** – it was noted that the timing of the audit was as EPR was being implemented. If the audit was to be repeated now it was likely that there would be a different picture as the EPR raises a flag automatically on a deteriorating patient which then requires clinical input. A quick follow-up audit would be undertaken.

  ACTION: Internal Audit Manager

- **Information Governance Toolkit –** The Internal Audit Manager explained that the audit is done in advance of the self-assessment being uploaded to the system to inform the final upload. The Company Secretary proposed that future plans include a follow-up audit post submission to check its accuracy.

- **Payroll –** The Internal Audit Manager explained that although the report had been given limited assurance, there had been significant improvements made since the last audit. While there were still weaknesses in control, a number of controls had been added throughout the year following Leeds taking over the payroll. She added that she believed significant assurance was achievable next year. There had been an issue with retention of documents which is easily remediable. Concerns around an isolated incident relating to a significant weakness in the overtime approval system had been referred to Counter Fraud. It was agreed to include a recommendation in relation to data validation.

- **Patient Flow** – It was noted that the audit had looked at whether the Trust is proactive in planning for discharge from the point that a patient is admitted into a Trust hospital. The Internal Audit review did identify weaknesses in the setting of a realistic Expected Date of Discharge (EDD) in a timely manner. In addition, it was noted that discharge checklists and medication lists are not completed the day prior to discharge. The audit also identified instances where patients have been sent home without discharge medication and the Trust's Transport department have subsequently arranged transport or taxis to deliver medication to the patient. It was noted that previous reviews of Patient Flow have been undertaken by Internal Audit and it is evident that

improvements have been made in this area. Although there were a lot of recommendations, a task and finish group has been set up to drive through these actions.

The Internal Audit Manager set out the process for agreeing the plan for 2018/19 and explained that it had been discussed at Weekly Executive Board. Further engagement with senior leads would be taking place and any amendments would be brought back to ARC in July. The plan includes a similar number of days but this has to be flexible. It was noted that additional audits on the embeddedness of mandatory training and benchmarking across Audit Yorkshire trusts may be included.

ACTION: Internal Audit Manager

Phil Oldfield queried whether an item on the oracle system should be included. There was also a request to add a review of clinical audit processes to the 18/19 plan. The Committee also suggested possible audits as GDPR compliance, EPR cost impact and benefit; business continuity; and use of the knowledge portal.

ACTION: Internal Audit Manager

Andy Nelson asked that future versions of the plan give more detail on what the audit will look at and how the item links to the BAF or the high level risk register.

OUTCOME: The Committee RECEIVED the Internal Audit Progress Report noting the limited assurance opinions and RECEIVED the 2018/19 Internal Audit Plan

21/18 LOCAL COUNTER FRAUD SERVICE (LCFS)

a. PROGRESS REPORT

The Local Counter Fraud Officer presented the LCFS progress report. The report set out the progress against the approved work plan. A brief update on the progress with current investigations was shared with the Committee, together with an update on the two specific cases under investigation. She highlighted some learning from investigations in relation to budget holders and managers.

OUTCOME: The Committee RECEIVED the progress report

b. COUNTER FRAUD WORK PLAN 2018-19

The Local Counter Fraud Officer presented the work plan and highlighted that she had built relationships with staff across the Trust over the years meaning people know to report suspected fraud to her. It was noted that the plan focuses on the re-enforcement of the work already in place to ensure that it is embedded in the organisation and can be flexed where required.

OUTCOME: The Committee RECEIVED the Work Plan

22/18 EXTERNAL AUDIT

a. TECHNICAL UPDATE

The External Auditor presented the technical update and there were no issues of concern to note. She highlighted the sections in relation to year end accounts which are currently being produced.

It was agreed that the Technical Update would be circulated to the remaining Board members for information.

ACTION: Company Secretary

OUTCOME: The Committee RECEIVED the update

22/18b. KPMG EXTERNAL AUDIT PLAN 2017-18 UPDATE

The External Auditor explained that most of the planned work was complete. There was some assurance on payroll. EPR remains under discussion as to what level of impairment is required. She added that there had been a lot of discussion on the wholly owned subsidiary in relation to the accounting treatment of this to ensure it is compliant with accounting standards. The Executive Director of Finance added that a presentation had been given to Finance and Performance Committee on the risk areas in relation to the accounts and that these had been fully shared with KPMG.

OUTCOME: The Committee RECEIVED the update

23/18 INFORMATION TO RECEIVE

The following information was received and noted and discussed.

- Quality Committee Minutes – 29.1.18, 26.2.18
- Information Governance & Records Strategy Committee Minutes 19.3.18
- Risk & Compliance Group Minutes – 15.1.18, 12.3.18 – development area was compliance registers.
- THIS Executive Meeting Summary Notes – 15.1.18 and 21.2.18.

The Committee highlighted that this related to item 19/18a Self-Assessment and the work required to provide better assurance on the work of the other sub-committees.

24/18 ANY OTHER BUSINESS

There were no other items of business.

25/18 MATTERS TO CASCADE TO BOARD

The Committee noted the following items to be brought to the attention of the Board at its next meeting:

- Reporting from sub-committees
- Membership of committees to be reviewed.
- BAF process to be strengthened and more attention paid to scoring. Risk appetite needs to be updated. Benchmarking report to be done. EPR focus on stabilisation and integration with other systems.
- Limited assurance reports x 5 – particularly response on sepsis and ongoing payroll issues.

DATE AND TIME OF NEXT MEETING

Wednesday 23 May 2018 at 11.00 am – Boardroom, Trust Offices, Calderdale Royal Hospital
Wednesday 11 July 2018 at 11.00 am – Medium Training Room, Learning Centre, CRH.

REVIEW OF MEETING

All present were content with the issues covered and the depth of discussion.
It was reflected that there had been a good discussion around the BAF. The good quality of papers was noted particularly the internal audit papers.

The Chair closed the meeting at 12.30 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carol Harrison, Charitable Funds Manager
Date: Thursday, 7th June 2018	**Sponsoring Director:** Linda Cordingley, Executive Assistant to Chief Executive
Title and brief summary: Charitable Funds - Minutes of previous meeting - DRAFT - Minutes of meeting held on 22 May 2018. Draft as still to be agreed at next Charitable Funds Committee meeting. To be included as a fast track item.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Not applicable	
Governance Requirements: Governance	
Sustainability Implications: None	

Executive Summary

Summary:

Minutes of previous Charitable Funds Committee meeting (22 May 2018), in DRAFT form, to be noted by Board.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to review for reference.

Appendix

Attachment:

Minutes 22 May 2018.pdf

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Tuesday, 22 May 2018

Present: Philip Lewer, Gary Boothby, David Birkenhead, David Anderson, Phil Oldfield

In attendance: Lyn Walsh, Carol Harrison, Steve Duncan, Rob Billson and Jonny Richardson Glenn (Community Foundation for Calderdale and Healthy Minds)

Apologies: Brendan Brown, Cllr Megan Swift

1. Welcome to new members
When the Community Foundation for Calderdale gentlemen were present, introductions were made around the table.

2. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

3. Minutes of the last meeting
The minutes of the last meeting held on 21 February 2018 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

4. Matters arising
~ *Launch of new brand on Intranet, fundraiser recruitment, Todmorden sub committee (good news story), – remind Vicky Pickles* – Lyn chased VP with regard to these items.

~ *Brand launch* – VP says planned for June once the problems with the new intranet are solved.

~ *Fundraiser recruitment* – VP says on hold. Gary agreed to pick up with Philip and Vicky. The result would be circulated outside the meeting.

~ *Todmorden good news story* – Lyn agreed to liaise with Communications with regard to a possible article in Trust News as this had not been actioned.

~ *A Ormerod/Tod sub committee meeting, 23.04.18 – update* – Philip gave a summary of the meeting. This had also been covered in the minutes that had been circulated to the Committee shortly after the meeting in April.

Action (1):
Gary to discuss Fundraiser recruitment with Philip and Vicky.

Action (2):
Lyn to liaise with Communications re Todmorden good news article.

5. Risk Register update
Lyn had approached VP re getting advice regarding the Risk Register but, as VP does not manage this, she recommended that Lyn approached Andrea McCourt.

Action (3):
Lyn to seek advice from Andrea McCourt re Risk Register.

6. Terms of Reference review
Lyn presented the current Terms of Reference. It was agreed that no amendments were required and that they would be reviewed again in twelve months' time.

7. Accounts Overview inc. SOFA/Balance Sheet 2017/18
Lyn presented this paper and its contents were noted. The Committee asked for more details on fund movements/expenditure and it was agreed to bring a paper to the next meeting.

Action (4):
Lyn/Carol to bring paper covering funds and their movements to the next meeting.

8. Further release of funds to General Purpose funds
Gary outlined the General Purpose funds' expenditure in 2017/18 and current balance and recommended that we release a further £100,000 to these funds from the General Reserve fund. This would enable expenditure to continue in 2018/19, in particular for those areas without funds or where larger sums of money were required.

Action (5):
Carol to action £100,000 transfer from General Reserve fund to General Purpose funds.

9. Community Foundation for Calderdale - presentation
Steve Duncan, Rob Billson and Jonny Richardson Glenn gave a comprehensive presentation, supported by a paper (Wellbeing in Todmorden 2016-2018) which was circulated. They updated the Committee on the use of the £75,000 grant and asked for a further contribution of £37,500 for Healthy Minds which they (Community Foundation for Calderdale) would match. The gentlemen left the room while a decision was made.
The Committee agreed to the request for £37,500 subject to receipt of impact and financial information (accounts at end of 6 months and at year end) and also an outline of an exit strategy.

Action (6):

Carol to release £37,500 to the Foundation once the Committee has given approval.

10. Minutes from the Staff Lottery Committee meeting held on 6 March 2018

These were noted.

11. Any other business

There was no other business to be discussed.

12. Date and time of next meeting

The next meeting will be on Tuesday, 28 August 2018 at 1 pm in Meeting Room 2, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
28 August 2018
Action Log - 2018/19

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	21.02 - 1	Chase VP re brand launch on Intranet	**LW**	Feb-18	ongoing
Matters arising	21.02 - 2	Chase VP re fundraiser recruitment	**LW**	Feb-18	replaced by 22.05-1
Matters arising	21.02 -7	Remind VP re good news story for Comms.	**LW**	Feb-18	ongoing
Risk Register review	21.02 - 9	Amend Risk Register after consulting VP	**ZQ/LW**	May-18	replaced by 22.05-3
Matters arising	22.05 - 1	Discuss fundraiser recruitment with VP	**GB**	Aug-18	
Matters arising	22.05 - 2	Contact Comms re Tod good news article	**LW**	Aug-18	
Risk Register update	22.05 - 3	Amend Risk Register after consulting A McCourt	**LW**	Aug-18	
Accounts Overview	22.05 - 4	Funds paper to go to next meeting	**LW/CH**	Aug-18	
Further release of funds to General Purpose funds	22.05 - 5	Release monies to General Purpose funds	**CH**	May-18	completed
Comm. Foundation of Calderdale	22.05 - 6	Release monies once Committee happy	**CH**		