Public Board of Directors

Schedule	Thursday 05 July 2018, 09:00 AM — 11:00 AM BST
Venue	Large Training Room, Calderdale Royal Hospital
Organiser	Amber Fox

Agenda

9:00 AM	1. Welcome and introductions: Brian Richardson, Publicly Elected Governor Brian Moore, Publicly Elected Governor/Lead Governor To Note - Presented by Philip Lewer	1
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1. Welcome and introductions: Brian Richardson, Publicly Elected Governor Brian Moore, Publicly Elected Governor/Lead Governor

To Note

Presented by Philip Lewer

2. Apologies for absence:
Anna Basford
Suzanne Dunkley
David Birkenhead

To Note

Presented by Philip Lewer

3. Declaration of Interests

For Review

4. Minutes of the previous meeting held on 7 June 2018

To Approve

Presented by Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 7 June 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	Executive Medical Director
Gary Boothby	Executive Director of Finance and Procurement
Suzanne Dunkley	Executive Director of Workforce and Organisational Development
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Richard Hopkin	Non-Executive Director
Jackie Murphy	Executive Director of Nursing
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director Digital Health
Victoria Pickles	Company Secretary
Amanda McKie	Matron, Learning Disabilities (for item 8)

OBSERVERS

Stephen Baines	Publicly Elected Governor
Peter Bamber	Staff Elected Governor

85/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

86/18 APOLOGIES FOR ABSENCE

There were no apologies for absence.

87/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note. Alastair Graham declared an interest in item 8 – Patient Story as an employee of Royal Mencap.

88/18 MINUTES OF THE MEETING HELD 3 MAY 2018

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

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

89/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

Guardian of safe working – have identified administrative report. Wi

90/18 CHAIR'S REPORT

The Chair reported back on the discussions held with partners as part of his induction

process into the Trust. This had included meeting with all almost all the Chairs of the Trusts across West Yorkshire, and all but one of the local MPs. The Chair also gave feedback from time spent with the volunteers of the Trust.

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

91/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive began by confirming the appointment of Jackie Murphy as Interim Executive Director of Nursing and that the recruitment process for the substantive role is progressing. He informed the Board that the Deputy Chief Executive role will be rotated amongst the executive team.

The Chief Executive informed the Board that the Commissioners, regulators and Joint Overview and Scrutiny Committee had received the letter from the Secretary of State for Health and Social Care and that the Trust is working with them to agree the next steps. He added that with regards to the Judicial Review, the Claimant's solicitors have made a request to the Court for a stay and we are awaiting confirmation as to whether the Court has approved this request.

The Chief Executive gave some headlines from the National Quarter 4 report and the comparison to the Trust's performance:

- Acute trust ED performance in North was 84.2% - we did 87.82%
- RTT for North was 87.75%. we were at 93.75%
- National vacancy rate of 8%, we are at 6.59% with a target of 4.4%
- Agency spend dropped 18%, ours dropped by 28%
- Overall £960m deficit
- 1/3 of providers didn't deliver their financial plans
- Of 234 providers, 102 had deficits (after STF)
- CIP was at 3.7% - we did over 4.5%
- 75% of CIP was recurrent – we were around 50%
- 30 Trusts had larger deficit than CHFT (13 in excess of £50m)
- 36 trusts had worse deterioration than CHFT (5 in excess of £40m)

The Board discussed the importance of using sharing this information more widely.

The Chief Executive highlighted the Lord Carter Report on *NHS Operational Productivity: unwanted variations* and pointed out that there is real learning to be gained from the report and a positive comparison to some of the work of the Trust. He particularly referred to recommendations 37 and 38 and it was agreed to do an assessment as to the Trust's position against these recommendations.

ACTION: Assessment against key recommendations - Chief Operating Officer

Linda Patterson commented that whether or not the NHS receives a new financial settlement the Trust should challenge itself to give its community services the focus and resource that they need and deliver the elements of the Carter recommendations that are within the Trust's gift.

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

9218 PATIENT/STAFF STORY

Amanda Mckie, Matron for Learning Disabilities gave a presentation on the national 'Treat me well' campaign. The 'Treat me well' campaign has been established by Royal Mencap to transform how the NHS treats people with a learning disability in hospital by bringing about practical changes, so people with LD always get the treatment they need and equal access to healthcare they deserve.

Amanda confirmed that the Trust is one of 15 trusts working with Royal Mencap in the first

phase of a three year campaign. Amanda gave two national examples of how making reasonable adjustments could have improved the patient outcome or even prevented the death of a patient with a learning disability.

Alastair Graham commented that he really welcomed the campaign and that the Trust should be very proud that it is one of the pilot sites. He highlighted the importance of making reasonable adjustments for those people who find access to medical care more difficult.

Amanda Mckie asked that all Board members take opportunities to raise awareness of the campaign whenever possible.

The Chair thanked Amanda for her presentation.

OUTCOME: The Board **NOTED** the presentation and congratulated Amanda on her work to support people with a learning disability within the Trust.

93/18 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.

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

It was noted that there were also 13 risks scoring 15 or 16 on the high level risk register.

Two new risk had been added during May:

- Risk 6895 (16) relating to the inability to fulfil core function of the Finance and Procurement Department. This is due to a change to the Trust's key finance ledger system and procurement ordering system by the supplier adversely affecting the functionality of the system in a number of areas.
- Risk 7248 (16) that not all colleagues will complete their designated mandatory training within the rolling 12 month period.

There were three risks with a reduced score:

- 6924 Misplaced nasogastric tube, reduced 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;
- 6598 Essential skills training, reduced from 16 to 9 as a result of 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, reduced from 15 to 12 as the lab system supplier can develop a solution to identify and allow users to select the correct version of the order in the lab system. This was implemented at the end of May.

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

Phil Oldfield confirmed that the financial risks had been discussed at the Finance and Performance Committee and would be reworded to reflect the decision in relation to control total.

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

94/18 GOVERNANCE REPORT

The Company Secretary presented the updated Board work plan.

OUTCOME: The Board **RECEIVED** and **NOTED** the Board of Directors' work plan.

95/18 STRATEGY ON A PAGE

The Company Secretary explained that the plan had been updated following the workshop between the Board of Directors and Governors held on 25 May 2018. She added that one further update had been received following submission of the papers to the meeting. This related to the objective to implement robust plans to improve patient flow and length of stay and reduce the bed base. It was suggested that this be updated to read to improve patient flow and achieve a 10% reduction in stranded (over 7 days) and super stranded (over 21 days) patients. The Chief Operating Officer explained that the Trust is expecting a national direction on this.

The Board discussed whether infection control should be added as an objective. The Medical Director commented that it is included as a quality priority and that there is a lot of work being done to focus on infection control measures. He added that a regular report on infection control is presented to the Board. The Board agreed that this was sufficient but would monitor to ensure that this work is having the required impact.

OUTCOME: Subject to one typographical amend and the inclusion of the re-worded objective the Board **APPROVED** the strategy on a page for 2018.19.

96/18 COMPLIANCE AGAINST THE GENERAL DATA PROTECTION REGULATION

The Managing Director for Digital Health presented the paper setting out the Trust's compliance with the new General Data Protection Regulations. She clarified that the Gantt chart showing the detailed actions was missing from the paper and agreed to circulate this outside the meeting.

ACTION: Circulate appendix – Managing Director Digital Health

The Managing Director for Digital Health explained that it is important to note that the GDPR is an evolution of the Data Protection Act 1998, with which the Trust is already compliant and is aimed at raising IG standards. The Trust has consistently achieved level 2 of the Information Governance toolkit. The Managing Director for Digital Health confirmed that the Trust is compliant with eight of the standards and four remain with work to do. She explained that 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 noncompliance is included on the risk register to ensure monitoring of progress against the action plan. There has been ongoing liaison with the regulators to confirm our position and progress and they believe the Trust is in a good position.

Karen Heaton asked how many information governance breaches had been reported. The Company Secretary explained that this is reported in the Annual Governance Statement and for year ending 2018 there were two Information Commissioner's Officer (ICO) reportable incidents.

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

97/18 HEALTH AND SAFETY ANNUAL REPORT

The Executive Director of Planning, Estates and Facilities introduced the Health and Safety Annual Report which sets out the health and safety performance for the Trust and the key actions required over the next 12 months. The actions are monitored through six-monthly

updates to the Health and Safety Committee. She commented that the challenge is to ensure that there is good progress against the action plan which, in turn, provides a positive healthy and safe working environment for colleagues, patients and visitors.

The Executive Director of Planning, Estates and Facilities explained that security management has been a key area of focus working with the police and counter terrorism bodies. There is now PSCO presence on site and there is a Resilience and Security working group in place.

It was noted that there is good attendance from divisions at the Health and Safety Group, which has resulted in an increase in incident reporting. This has led to a task and finish group being set up to look at actions to address needle stick and sharps incidences.

Some of the actions identified include raising awareness of COSHH (Control of Substances Hazardous to Health) and developing COSHH super users; continuing to strengthen manual handling and the level of training required; work with doctors in relation to training on medical devices; and RIDDOR reporting.

Karen Heaton asked that future reports include benchmarking information.

David Anderson asked whether there had been any incidences of harm resulting from a needle stick injury. The Medical Director responded that there has not been anyone who has acquired an infection as a result but this did not capture any mental health impact from the injury.

The Chief Operating Officer asked that the severity of the incidents being reported be included in future for context and to identify patterns of incident reporting.

Richard Hopkin highlighted the need to clarify the arrangements for health and safety in respect of the wholly owned subsidiary as soon as possible.

ACTION: Clarity on Health and safety arrangements – Executive Director of Planning, Estates and Facilities / Chief Executive

OUTCOME: The Board **APPROVED** the Health and Safety Annual Report.

98/18 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.

Have ensured the correct indicators are aligned to domains and clarified where a numerical target may be more appropriate than a percentage. Moving away from the Carter page towards the model hospital but need to refine these metrics further. A key point that we won't be able to do a historical comparison due to the changes

The key highlights from the report were:

- 62% overall score. All areas are amber and it reflects the challenges at the end of Q4 and the Easter break
- There has been positive movement on sickness absence
- Performance against the Emergency Care Standard in May was 93%
- There has been good performance in the number of cancelled operations and the Trust has achieved a full activity profile from the 2nd week in April.
- The extra capacity has been closed and the Trust is now using the planned number of beds

The key areas of focus will be on infection prevention and control, harm free care, complaints, readmission rates, appointment slot issues and stranded patients.

The Chief Operating Officer also explained that there has been some work to develop a forward look on performance along with a narrative to explain the forecast position and what is

being done to address it. This will be brought to the Board at the next meeting.

ACTION: Performance forward view - Chief Operating Officer

Andy Nelson asked for clarification on the position regarding appointment slot issues. The Chief Operating Officer explained that the number has increased since the introduction of electronic referrals. More work is being done to look at the reasons for this as well as implementing the new national guidance on the 'straight to test' pathway for cancer which will help address some of the issues.

David Anderson asked if there had been any issues with electronic referrals. The Chief Operating Officer explained that she had visited a number of GP practices to thank them for their support in moving to 100% of electronic referrals. She added that since 1 April there had only been a very small number of paper referrals and all have been followed up with the relevant practice.

The Executive Director of Finance highlighted the financial section of the Integrated Performance Report and explained that the position is on track in line with plan at month one.

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

99/18 DIGITAL HEALTH NEXT STEPS AND ELECTRONIC PATIENT RECORD (EPR) STABILISATION

The Managing Director of Digital Health gave an overview of the paper which described the working arrangements and the optimization plan for the Trust's digital agenda. The report set out the three key areas: stabilization work; the work that is underway and are partially funded; and the first draft of the roadmap which requires further engagement.

The Managing Director explained that the stabilization plan presented to the Board in December had been delivered and that the working arrangements going forward had been agreed with Bradford Teaching Hospital NHS Foundation Trust. The next steps are to develop a business case setting out the funding required to deliver the next stages of digitization.

Alastair Graham welcomed the report and asked for clarity on the funding needed to fully exploit the EPR and realise the benefits. The Managing Director clarified that phase 2 is costed and included in budgets however phase 3 requires a business case for additional funding.

Andy Nelson supported the direction of travel and highlighted that implementation of phase 3 would be required to support the stabilization of all the issues that have been identified. The Managing Director added that a meeting was due to be held with NHS Digital to look at the opportunities for support.

The Executive Director for Workforce and OD commented that anecdotally the new EPR is supporting recruitment and there is work to look at whether there are any data to evidence this. Richard Hopkin highlighted the need to consider commercial opportunities from the Trust's learning and experience of implementing and developing the EPR. He asked that the Board send its thanks to Alistair Morris, Chief Clinical Information officer, who would be stepping down from the role.

ACTION: Chair to write to Alistair Morris on behalf of the Board

The Chief Executive added that there is a need to continue to share awareness of what has been achieved by the workforce in implementing the EPR. He commented that members of the Trust had visited other organisations and the Trust compares favourably not only in EPR but in the wider use of digital technology. He added that there needs to be a continued focus on addressing the issues that are still being experienced.

OUTCOME: The Board **RECEIVED** and **APPROVED** to progress work on developing a full business case.

100/18 DELOITTE REPORT ON DIGITAL MATURITY

The Managing Director for Digital Health reported on the visit by Deloitte on 12 February 2018 to assess the Trust's self-assessment on digital maturity. There were two areas where the Trust had under rated and one area over rated. She commented that the report represented a very positive story and was testament to the journey the Trust had been through over the previous two years.

The Chief Executive pointed out that the Trust had started in 113th place in the rankings and had moved to joint 3rd nationally.

OUTCOME: The Board **RECEIVED** the report

101/18 OUTPATIENT TRANSFORMATION REPORT

The Director of Transformation and Partnerships described the launch of the programme of work being undertaken jointly with commissioners to transform outpatient services. She explained that there are two areas of focus: one is optimizing the current outpatient service and the other is to fundamentally change the way in which outpatients services are delivered. This will involve large scale engagement and communication both internally and externally.

Phil Oldfield added that the Finance and Performance Committee had looked at the benchmark report for 2016/17 on outpatient work which had shown some positive indicators at that time and that the Committee had asked for an updated report.

Linda Patterson supported the work and highlighted the links to supported self-management. The Director of Transformation and Partnerships explained that the projects underpinning the programme included looking at virtual clinics, new medicines technology using new treatment pathways, and earlier discharge. She added that the importance of this work is to stimulate further ideas and secure buy-in across the system. The Chief Operating Officer added that there has been significant use of technology in the booking system but there was more that could be done on the use of technology in the clinics. She added that the first of a new forum would be meeting bringing together GPs and consultants to discuss ideas and approaches.

OUTCOME: The Board **NOTED** the programme of work.

102/18 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

David Anderson, Chair of the Quality Committee gave a verbal report following the meeting held on 4 June 18. He explained that the consistent themes were pressure ulcers and healthcare acquired infections. He added that the Committee had received a reports on the discharge event with partners across the health economy; the sexual health service and the preventative work they have done engaging with people in different ways; plans for a stroke assessment area in A&E; and issues within transfusion services responding to the risk identified on the risk register.

OUTCOME: The Board **RECEIVED** the minutes the meeting held on 30 April 2018 and **NOTED** the update from the meeting held on 4 June 2018.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee gave feedback from the meeting on 5 June 2018 and confirmed that finances are on plan at the end of month 1. He explained that there had been discussions on agency spend, which is below trajectory; the financial system issues and the impact on the Trust's ability to pay invoices; the financial risks; national benchmarking on outpatients; and the learning from the discharge event.

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 27 April 2018 and **NOTED** the update from 5 June 2018 meeting**.**

c. Workforce Committee

Karen Heaton, Chair of the Workforce Committee, explained that the Committee had been refocused which will start to embed during the year and proposed revised terms of reference reflecting the change would be presented to the Board in July.

ACTION: Workforce Committee TORs to Board in July – Company Secretary

Karen explained the Committee had taken forward the introduction of hot house topics and the first one had been held this week on apprenticeships with around 30-40 attendees from across the Trust. The Executive Director of Workforce and OD added that this would help to engage staff in devising the strategy going forward. The Executive Director of Finance commented that he had received lots of positive feedback from the event.

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 11 May 2018.

d. Council of Governors

The Chair presented the minutes of the Council of Governors' meeting.

OUTCOME: The Board **RECEIVED** the draft minutes from the meeting held on 4 April 2018.

e. Audit and Risk Committee

Richard Hopkin, Chair of the Audit and Risk Committee reminded the Board that a verbal update from the meeting had been given at the Board meeting in May. A special Audit and Risk Committee had been held on 23 May 2018 to review the Annual Report and Accounts and this had been followed by an extra-ordinary meeting of the Board of Directors on the same day. The minutes of both these meetings would be brought to the Board in July.

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 18 April 2018.

f. Charitable Funds Committee

Richard Hopkin declared an interest in this item as a member of the Calderdale Community Foundation.

The Executive Director of Finance reported that the Trust has created a general trust fund in addition to the individual service and ward based funds, which enables better use of the funds. He added that the value of the funds is reducing year on year which is a positive position.

OUTCOME: The Board **RECEIVED** the draft minutes from the meeting held on 22 May 2018.

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 5 July 2018 commencing at 9.00 am in the Large Training Room, Calderdale Royal Hospital.

The Chair closed the public meeting at 10:40 am.

5. Action Log and Matters Arising

To Note

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 12 June 2018/ APPENDIX B

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
7.6.18 91/18	**CHIEF EXECUTIVE'S REPORT** Assessment of Trust position against key recommendations in the Carter report on unwarranted variation	HB		July 2018		
7.6.18 96/18	**GENERAL DATA PROTECTION REGULATIONS** Appendix to be circulated to Board members	MG / VP	VP circulated appendix	June 2018		15.6.18
7.6.18 97/18	**HEALTH AND SAFETY ANNUAL REPORT** Clarity on arrangements post wholly owned subsidiary go-live	LH / OW		July 2018		
7.6.18 98/18	**INTEGRATED PERFORMANCE REPORT** Performance forward view to be included in report	HB		July 2018		
7.6.18 99/18	**DIGITAL HEALTH NEXT STEPS AND EPR STABILISTION** Chair to write to Alistair Morris with thanks on behalf of the Board	PL	Letter sent	June 2018		13.6.18
7.6.18 102/18	**MINUTES FROM SUBCOMMITTEES** Workforce Committee terms of reference to be presented to Board	VP	Included on this agenda	July 2018		
7.12.17 183/17	**PATIENT STORY** It was agreed to discuss how EPR can support the serious incident investigation and information capture.	JM	1.2.18 Agreed that EPR/Serious Incident Investigation would be presented at a future meeting.	July 2018		
		HB	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.	September 2018		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 12 June 2018/ APPENDIX B

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
7.12.17 187/17	**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		September 2018		
4.1.18 9/18	**PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)** Presentation received. It was agreed that 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.	MG		June 2018 ~~May 2018~~		
1.1.18 13/18 and	**GUARDIAN OF SAFE WORKING** Update received. Concern was expressed regarding the lack of administrative support for the Guardian. It was	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	June 2018		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 12 June 2018/ APPENDIX B

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 65/18	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.		on the Action Log until the matter had been fully resolved.			
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT** Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed that he would investigate this further.	DA		July 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	It was confirmed at the Board meeting on 7 June 2018 that this action had been completed	TBC		
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	OW/PL	The HSMR and SHMI has been shared with staff through a variety of communication methods across the Trust	TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 12 June 2018/ APPENDIX B

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
	with staff continued and wider communications put in place.					
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	Workshop held with the Board of Directors on Thursday 28 June 2018 – development plan to be brought to Board in September	September 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		September 2018		
5.4.18 62/18	**DATA QUALITY ASSURANCE** Receive the outcome of the NHSI Data Quality Assessment and associated recommendations	HB		September 2018		

6. Chairman's Report
a. Council of Governors Meeting – 4.7.18
b. Council of Governors Election Results

To Note

Presented by Philip Lewer

7. Chief Executive’s Report:
a.NHS Confederation - Health and Social Care to the 2030
b.CQC Report

To Note

Presented by Owen Williams

Institute for Fiscal Studies

The Health Foundation

Securing the future: funding health and social care to the 2030s: Executive summary

Edited by
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In association with

NHS CONFEDERATION

Securing the future: funding health and social care to the 2030s

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This is a standalone executive summary written to accompany IFS report 'Securing the future: funding health and social care to the 2030s'

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On 5 July this year the NHS will be 70. In all its 70 years it has rarely been far from the headlines. It has been through more than its fair share of reforms, crises and funding ups and downs. Over that period, the amount we spend on it has risen inexorably. Yet, today, concerns about the adequacy of funding are once again hitting the headlines, as the health and social care systems struggle to cope with growing demand.

Looking forward, funding pressures are only going to grow. The population is getting bigger and older, and expectations are rising along with the costs of meeting them. Our analysis suggests that **UK spending on healthcare will have to rise by an average 3.3% a year over the next 15 years just to maintain NHS provision at current levels, and by at least 4% a year if services are to be improved. Social care funding will need to increase by 3.9% a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities.** If the widely acknowledged problems with England's social care system – of limited eligibility, low quality and the perceived unfairness of the current, uncapped, means test – did result in reform, spending on social care would need to increase at a faster rate.

If we are to have a health and care system that meets the expectations of the population, we need to understand how and why spending has risen over time, where the money is spent, how costs are likely to develop in the future, and how we might go about meeting those costs. That is the purpose behind this collaboration between the Institute for Fiscal Studies and the Health Foundation, in association with the NHS Confederation.

To start to grapple with those challenges, one needs first to grasp the sheer scale of the NHS and social care sector. **Public spending on health in the UK in 2016–17 was £149.2 billion (2018–19 prices). That's more than 7% of national income.** The government spent an additional £21.2 billion on adult social care in the same year. Add in private spending, and the health and social care sector accounts for more than 10% of the entire UK economy.

If it is a large part of the economy, health and care spending represents an even larger fraction of what government does. **19% of all government spending and 30% of spending on public services goes on health**,[1] 21% and 34% if you include adult social care spending.

Along with almost all other countries, we have chosen as a nation to spend an increasing fraction of our national income on health and care because the benefits of doing so are so great. But we have not always done so in a well-planned or coherent way. Periods of feast tend to be followed by famine. The last

[1] We define spending on public services as public spending on everything other than debt interest and transfers through the social security system.

two decades have been an extreme example of that. **Planning for both feast and famine has been inadequate, and the consequences have been unnecessary costs, inefficiencies and uncertainty in the system.** We hope this work will lay the basis for a more coherent system of planning going forward. To achieve that, we will need consensus both on the value of an effective health and social care system and on how to raise revenue to fund it as the economy grows. We can't have it for free. If we are to raise spending as indicated by this analysis then taxes will have to rise.

The history

Annual public spending on health didn't reach £20 billion (in today's prices) until the mid 1960s. It hit £40 billion in the mid 1980s, was at £80 billion by the turn of the century and now sits at £150 billion. **Not only has spending risen in real terms, it has taken a bigger and bigger chunk of the national economy**, rising from around 3% of GDP in the early 1960s to 4% during the 1970s and 1980s, 5% by the year 2000 and more than 7% by 2008. It represents 7.3% of national income today.

Table 1 tells the story of increasing spending since the foundation of the NHS. Spending growth has averaged 3.7% a year. Following a period of very rapid growth between 1996 and 2009, **over the last eight years health spending has grown more slowly than in any comparable period since the NHS was founded**.

The recent period has not, however, been one in which the *relative* priority attached to health spending has diminished. **Relative to other areas of public spending, health spending has actually been *more* favoured since 2010 than**

Table 1. Annual average real growth rates in UK public spending on health, selected periods

Period	Financial years	Average annual real growth rate
Whole period	1949–50 to 2016–17	3.7%
Pre 1979 (various governments)	1949–50 to 1978–79	3.5%
Thatcher and Major Conservative governments	1978–79 to 1996–97	3.3%
Blair and Brown Labour governments	1996–97 to 2009–10	6.0%
Coalition government	2009–10 to 2014–15	1.1%
Cameron and May Conservative governments	2014–15 to 2016–17	2.3%

Source: See Table 1.1 in the report.

it was in the previous decade. Health spending has been rising as a share of total public spending on services by 2.1% a year since 2009–10, compared with a rate of increase of 1.1% a year between 1999–2000 and 2009–10. Health accounted for 23% of public service spending in 1999–2000, 26% in 2009–10 and 30% in 2016–17.

Within the UK, health spending is a devolved responsibility. Funding for public services in Wales, Scotland and Northern Ireland is determined by the Barnett formula, whereby changes in public spending in England result in changes in public spending budgets in Wales, Scotland and Northern Ireland, based on population size. The devolved administrations can then choose how to prioritise spending across health and other public services. Health spending per head is marginally lower in England and Wales than in Scotland and Northern Ireland. **There has, however, been some convergence since 2010, with higher increases in England than elsewhere** as the Westminster government has given a higher priority to protecting health spending than have the devolved parliaments.

Spending on social care has followed a different pattern. Across the UK as a whole, **public spending on adult social care fell by nearly 10% between 2009–10 and 2016–17**, despite significant real increases in spending in Scotland.

In fact, the growth in both health and social care spending has slowed even more dramatically than the headline figures would suggest, once one takes account of relatively rapid population growth. Per-capita health spending has increased by just 0.6% a year between 2009–10 and 2016–17, as compared with 5.4% a year between 1996–97 and 2009–10, and 3.3% per year over the whole period between 1949–50 and 2016–17. Taking account of the ageing of the population since 2010, and the fact that older people make heavier demands on the health service, even this growth almost disappears – **age-adjusted per-capita health spending has risen by just 1% in total, or 0.1% a year, since 2009–10**. Per-capita adult social care spending has fallen by 2.2% per year over the same period.

The UK is certainly not alone in experiencing growing health spending. Across the OECD between 2000 and 2015, healthcare spending per person increased in real terms and outpaced the growth in GDP. This is true in countries with tax-funded health services and social insurance models. **UK spending as a share of GDP in 2015 was in line with the average of the EU15 countries.**

Where the money goes

Over time, all aspects of NHS spending have risen. The biggest element is spending on staff – doctors, nurses and others. Over the last 20 years, there has been an increase of more than 70% in the number of hospital doctors, and of

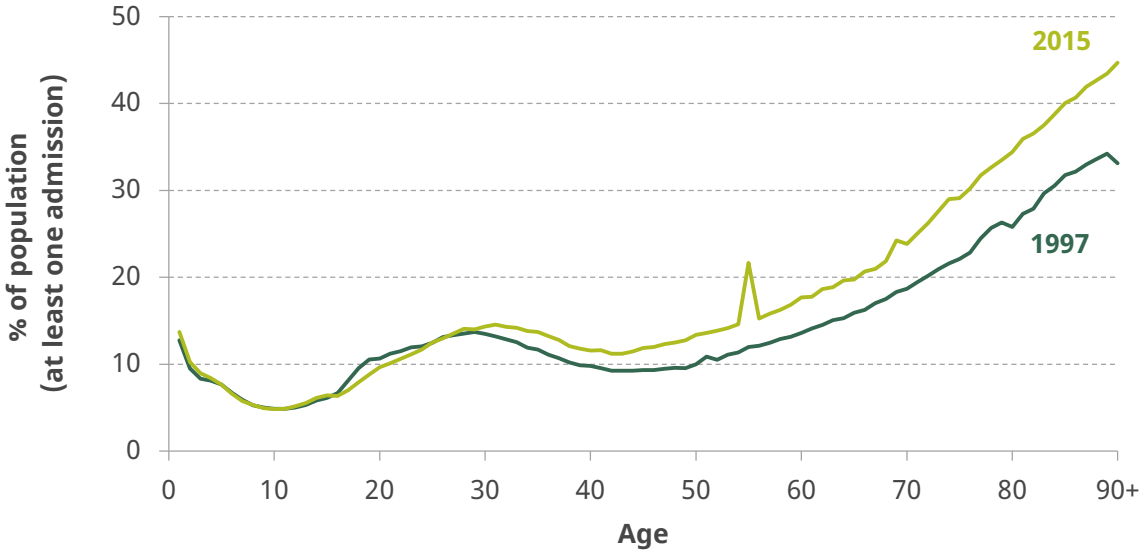
more than 10% in the number of nurses, health visitors and midwives, per 1,000 population. Even so, **overall, the UK has fewer practising doctors per 1,000 people than any other EU15 country**.

Despite the more general increase in staff and doctor numbers, there has been barely any increase in the number of GPs, and in fact **the number of GPs per 1,000 population has been falling since 2010**. This pattern reflects decisions over where in the system money has been spent. Spending on hospitals rose much faster than spending on primary care during the 2000s, and **spending on primary care has actually fallen since 2010** in real terms.

It is unlikely that this rebalancing away from primary and community care makes sense in the long run. The NHS *Five Year Forward View* in 2014 set out a vision for the future of the health service in England. In response to population ageing and the rising burden of chronic disease, it argued for the NHS to provide more care closer to people's homes. It sought to shift care towards earlier diagnosis and more proactive management of health problems to prevent rather than simply manage ill health and hospitalisation. A sustainable, high-quality healthcare system is likely to involve more focus on supporting primary and community services, not less.

One of the great successes of the NHS in England since 2010 is that, despite very tight spending settlements, activity has risen substantially. In other words, productivity has grown and, unusually, **since 2010 measured productivity in the health service has been growing faster than productivity across the economy as a whole**. Whether this could be sustained over a longer period is unclear.

Figure 1. Percentage of population (England) by age who had at least one inpatient admission in 1997 and 2015 (aged 0 omitted)



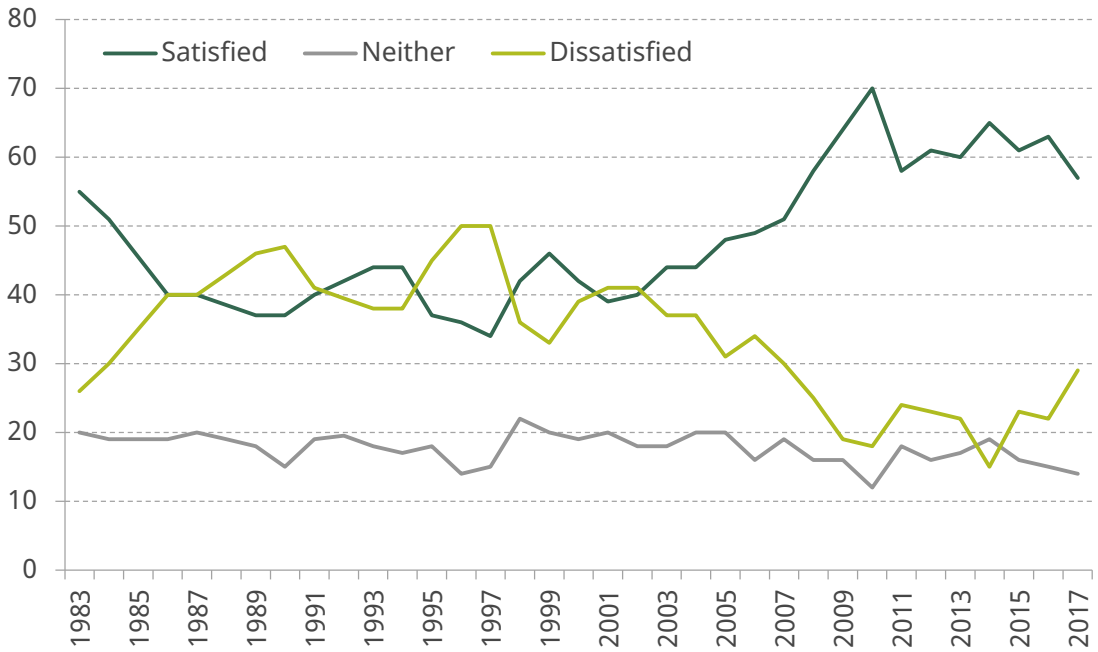
Source: See Figure 2.15 in the report.

This growth in activity over time is of course a key driver of additional costs. As Figure 1 shows over the last 20 years, in addition to a population that is growing and ageing, **there has been an increase in the likelihood of people at any age having an inpatient admission**. The time each person spends in hospital, though, has been coming down continually for decades, partly as a result of new drugs and new surgical procedures. Between 1997 and 2015, for example, the average time spent in hospital per year for people over the age of 75 dropped by more than half a day, despite a 30% increase in the likelihood of spending some time in hospital.

As well as funding more activity, big increases in spending during the 2000s were accompanied by dramatic falls in waiting times. Tighter funding conditions in recent years mean that waiting times have been creeping up again, and targets are being missed. For example, **by March 2018 only 74.4% of inpatients were treated within 18 weeks of referral, against a target of 90%**.

This remains a far better performance than was achieved in the 1990s and, in general, the NHS continues to perform far better on most measures than it did 20 years ago. **Recent increases in waiting times and other pressures on the service have started to mean that public satisfaction levels are beginning to fall.** Even so, public satisfaction remains at historically high levels, far above where it was before the funding increases of the 2000s (Figure 2).

Figure 2. Satisfaction with the NHS, 1983–2017



Source: See Figure 2.25 in the report.

Effectiveness of treatment has also been rising over time, with mortality rates from, for example, cardiovascular disease falling dramatically in recent decades. **Survival rates for a range of cancers have also continued to improve, though the UK still lags behind many international comparators in this respect.**

Future spending

Looking forward, health spending is likely to continue to rise. Simply continuing to provide the services we currently expect will become more expensive as the population grows and ages, prevalence of chronic conditions increases, and the prices of inputs, including the costs of drugs and the wages of doctors and nurses, go up.

Central estimates suggest that **by 2033–34 there will be 4.4 million more people in the UK aged 65 and over. The number aged over 85 is likely to rise by 1.3 million** – that's almost as much as the increase in the entire under-65 population.

The burden of disease is also increasing. The number of people living with a single chronic condition has grown by 4% a year while **the number living with multiple chronic conditions grew by 8% a year between 2003–04 and 2015–16**. Looking forward, more of the UK's population will be living with a chronic disease and very many with multiple conditions. This is because while life expectancy has been increasing, healthy life expectancy has not kept pace and the period of people's lives spent in poor health has increased; particularly for the poorest. As a result, without major progress on the vision set out in the *Five Year Forward View*, **over the next 15 years spending in acute hospitals to treat people with chronic disease is expected to more than double**.

Tackling chronic disease is not just an economic issue. It has a substantial impact on quality of life and wider society. The NHS can do a lot, but **progress on improving the population's health will require action on obesity, smoking, alcohol and the wider social determinants of health**.

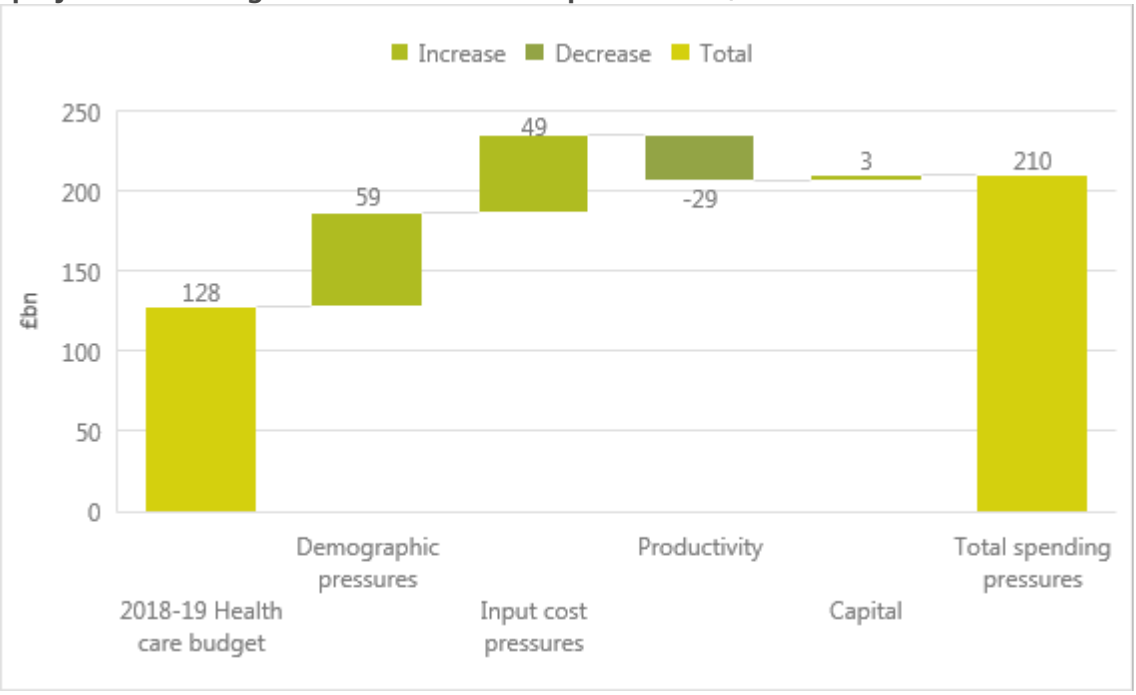
As new treatments are introduced, the cost of drugs used in hospitals is also rising. Assuming new drug costs rise in line with recent experience, **for each person treated in hospital, the cost of their drugs would increase by 5.5% a year going forward**.

Pay will also need to rise at least in line with public sector average earnings if the NHS and the social care system are to recruit and retain the staff they need. The challenge for all healthcare systems is that, as a service sector, healthcare productivity over the longer term has traditionally lagged economy-wide productivity (the so-called Baumol effect). It is true of all healthcare systems, however they are funded (tax or social insurance) and however they are delivered

(public, private or not-for-profit). **The gap between earnings growth and productivity is a key driver of spending pressures.**

Put all these pressures together and **UK health spending is likely to need to rise by around 3.3% a year over the next 15 years just to maintain current service levels**. That would mean an increase in spending of around £95 billion, from £154 billion today to £249 billion in 2033–34. This would increase health spending as a share of GDP from 7.3% to an estimated 8.9%. Figure 3 illustrates the importance of the different factors in pushing up spending over the period to 2033–34.

Figure 3. Contribution of different demand and cost pressures to overall spending projections for England under the status quo scenario, 2018–19 to 2033–34



Source: See Figure 3.8 in the report.

This rate of increase would be below the long-term rate of increase in health spending. It is nevertheless substantially above projected GDP growth. This reflects the importance of ageing and increased chronic disease over the next 15 years.

While spending will need to increase in each of the next 15 years, the scale of funding pressures is greater in the shorter term. After several years of historically low growth in spending, the NHS is under considerable financial strain. This is impacting on quality, with hospitals struggling to meet demand last winter and more than half of all NHS providers in deficit. Maintenance budgets and investment capital have been used to meet day-to-day running costs. Our modelling suggests that **spending increases will need to be front-loaded, with the NHS requiring increases averaging around 4% a year over the next five**

years to maintain provision at current levels and address the backlog of funding problems.

Maintaining provision at current levels for 15 years is unlikely to be enough though. Over time, NHS services have improved as incomes and expectations have grown. We know that there are major areas of underprovision at present, not least in mental health. Just meeting waiting list targets and bringing capital spending more in line with OECD averages would also require additional funding relative to our status quo scenario. Put all this together and **a modernised NHS could require funding increases of 4% a year over the next 15 years: 5% a year for the next five years and 3.6% a year for the decade after**.

Our analysis suggests that **over the next five years, capital funding should grow at a faster rate than day-to-day spending**, by 11% a year in real terms compared with 4.7% for resource spending. Capital spending in the UK would increase by £5 billion by 2023–24. Some of this extra capital spending could improve quality of care – for example if it were invested in scanning technologies, which are so important for timely cancer diagnosis. But the principal case for a significant up-front investment in capital is to support the system to improve productivity. The NHS has a large backlog of maintenance, too much of its physical infrastructure is out of date, and there is much more to do to ensure rapid uptake of digital technologies.

Using analysis from the Personal Social Services Research Unit (PSSRU), we find that to keep up with the ageing of the population and growth in young adults living with disabilities will require public funding to increase by 3.9% a year across the UK over the next 15 years, increasing spending by around three-quarters. Spending on social care would increase from 1.1% of GDP in 2018–19 to 1.5% in 2033–34. This is based on maintaining the current system of eligibility and means-testing for social care in each of the four countries of the UK.

The system of means-testing for social care in England has been strongly criticised and the government is planning a Green Paper on social care reform in England in Summer 2018. Extending access to care, improving quality or reforming the means test, for example through capping care costs, would add to the estimated spending pressures.

If England introduced a cap on lifetime care costs and reformed the means test in line with the proposals in the Conservative party manifesto in 2017, this would add £6.7 billion to our estimated social care spending pressures in 2033–34.[2]

The lines between the health and social care systems are blurred by initiatives such as NHS Continuing Healthcare, which provides social care free of charge to the neediest individuals, and the Better Care Fund, which provides grants to local

[2] https://www.health.org.uk/publication/social-care-funding-options.

authorities to fund social care spending. The two systems cannot be considered in isolation.

Over the next 15 years, **if UK health service spending were to increase by 4% a year, in line with our modernised NHS scenario, spending as a fraction of national income would rise from 7.3% of GDP today to 9.9% in 2033–34** (based on the OBR's forecast for GDP growth of an average of 1.9% per year). Overall, that is faster growth than the long-run average, reflecting some catch-up after the recent period of slow growth and, again, demographic change.

This would take spending to around 10% of national income, 1 percentage point more than under the status quo scenario. Social care spending would also increase as a share of national income, from 1.1% to 1.5% of GDP over the next 15 years. Together this means that in 2033–34 in the UK we would devote 2–3 percentage points more of our national income to publicly funded health and care. However, it is important to note that this is not a lot more than countries such as Sweden, Germany and the Netherlands already spend on publicly funded health and social care.

These numbers are in a sense just illustrative. But they are based on the most detailed modelling yet, which builds up likely future costs from a microeconomic analysis of supply and demand factors. This is a different methodology from that used by the Office for Budget Responsibility, for example, which uses a top-down model. The results though are similar. **The OBR estimates that health spending will reach 8.7% of national income by 2033–34**, very slightly lower than our status quo estimate. Part of the difference is because the OBR assumes current plans will be kept to until the end of this parliament. After that, it has spending rising by 4% a year.

Of course, it is not just how much money that is spent that matters, but how well it is spent. Much needs to be done to improve productivity in the NHS. Well-targeted capital investment can be a major help but **the most urgent need is probably for a coherent, long-term workforce strategy**. In the short run, a lack of qualified clinical staff will be the biggest impediment to making effective use of additional funds.

Over the next 15 years, **the English NHS is likely to require 64,000 extra hospital doctors and 171,000 extra nurses** as part of overall workforce growth of 3.2% a year. This would be a big increase, but in line with previous rates of growth: the NHS workforce grew by 2.9% a year in the decade up to 2008.

If the NHS were able to successfully harness digital and other technologies, the workforce pressures would turn out to be lower than this. But if we are to have an effective health service in 15 years' time, we do need to start planning to have the requisite workforce today. **The workforce challenge in social care is just as**

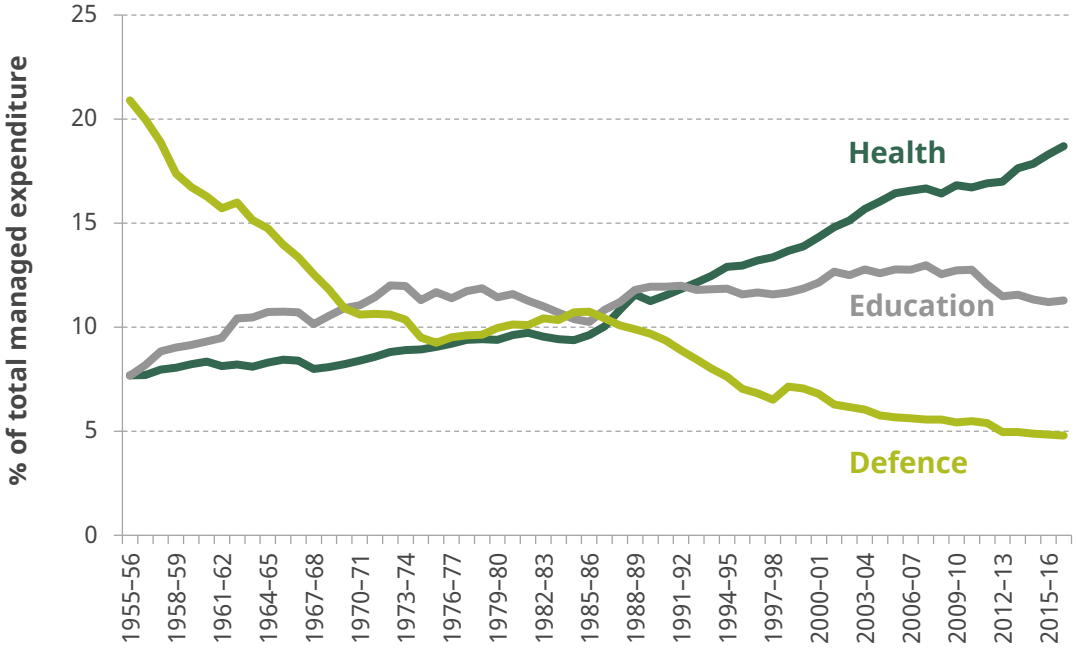
great, with almost half a million more staff required by 2033–34 (an increase of 2.2% a year). Taken together, the increases in demand for health and social care would see the number of people in the workforce employed in these two sectors rise from 10% today to 14% in 2033–34.

Paying for it

It is all very well pointing out that spending is likely to have to rise over the medium term. The question then arises as to how to pay for it. Taking health and social care together, it looks as though spending will need to rise by 2% of GDP over the next 15 years, and by 3% if we want improvements in the services offered. That means finding at least £40 billion of additional funding, and perhaps more than £60 billion.

In the past, we have effectively paid for increased government spending on health by cutting spending on other things. In fact, overall public spending as a fraction of national income is a bit lower today than it was in the late 1970s (39% of GDP today against 41.5% of GDP in 1978–79), despite the fact that health spending rose from 4% of national income to well over 7% over the same period. Spending on social security (including pensions) also rose. This was possible because we are today spending 6% of national income (equivalent to about £120 billion) less on a combination of defence, debt interest and housing than we were 40 years ago. Figure 4 illustrates how huge cuts to defence spending have helped fund a growing welfare state without requiring a sustained increase in the tax burden.

Figure 4. Health, education and defence as shares of total spending



Source: See Figure 4.5 in the report.

Going forward, it is extremely hard to see how we could repeat a similar trick. There is barely any defence or housing budget left to cut. Debt interest spending is likely to rise as interest rates rise. After eight years of austerity, there would appear to be no room to cut other big areas of spending. While increased borrowing could fund rising health spending over the short term, **sustained increases in health and care spending will require increased revenues from somewhere**.

It is unlikely that a significant fraction of any additional health spending can be found from increasing current charges or introducing new ones – not unless we want a fundamentally different NHS. Social care is already highly reliant on private funding and most reform proposals imply less rather than more reliance on individual contributions.

The implication is clear: in the medium term, **if we want even to maintain health and social care provision at current levels, taxes will have to rise.**

It is hard to imagine raising this kind of money without increases in at least one of the three biggest taxes – income tax, National Insurance and VAT. By way of illustration, you can raise about £5 billion by increasing all the main rates of income tax by a penny, about £6 billion by putting a penny on VAT and about £10 billion if you put a penny on each of the main employee, self-employed and employer NI rates.

Of course there are plenty of other options for raising taxes, including the reversal of some of the corporation tax cuts implemented in recent years, some additional taxes on property and wealth, or increases in a myriad of smaller taxes. Any tax rises could take place gradually, as the share of national income required to meet pressures on health and social care increases over time.

To illustrate the scale of change likely to be required, note that on the assumptions about growth underlying this work, average household net incomes would rise by around 17% over the next 15 years. If taxes were to rise by 2% of GDP then net incomes would rise 14% instead and if taxes were to rise by 3% of GDP then net incomes would rise by 12.6%.

Tax increases of this scale are economically feasible. While it is at a historically relatively high level, at more than 34% of GDP, **the tax burden in the UK remains well below that in a number of other, economically successful, European countries**, including Germany and France. There is at least some evidence that such increases might also be politically feasible. In 2016, a plurality of respondents to the British Social Attitudes Survey said they would prefer higher overall taxes and spending, and a clear majority see health spending as the top priority for extra cash. There is also a clear preference among the public that any tax increase

should be via the National Insurance system and/or earmarked specifically for the NHS.

There remain strong arguments in principle against an earmarked, or hypothecated, tax. **One would never want health spending to rise and fall with revenue from a particular tax.** One proposal would set a health budget for a parliament and set a tax rate at a level that was expected to raise enough to cover that budget. If it turned out to raise more, or less, then the Treasury would keep the surplus, or pay the extra from borrowing or general taxation. Something like this, perhaps through a reformed system of National Insurance contributions, could make for a politically feasible way of providing more funding for health and care. But, as ever, there are trade-offs. This would probably introduce additional inefficiencies, and even inequities, into the tax system. It would be hard to make it properly transparent. There would be challenges in a world where health and care spending, and in Scotland some tax decisions, are devolved matters. So **while some form of hypothecation is possible, and may make increased taxation more palatable, it is hardly a panacea**.

There are additional challenges around social care funding. A large fraction of social care is currently paid for privately: 26% of domiciliary care recipients and 44% of care home residents paid for their own care in 2014–15. The state does not play its usual role in providing insurance against bad outcomes and many people face extremely high care costs in old age as a result and many may have unmet care needs. **Any rebalancing of the social care system looks likely to increase pressures on the public purse rather than reduce them.**

8. Patient/Staff Story & Quality Report deep-dive: How EPR has supported serious incident investigations

To Note

Presented by Jackie Murphy

9. High Level Risk Register

To Approve

Presented by Jackie Murphy

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: 5.7.18	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: High Level Risk Register - To present the high level risks on the Trust Risk Register as at 25 June 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 18 June 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 25 June 2018.

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

iii. Details of movement during June regarding financial risks:as follows:

- a new risk 7278 regarding long term financial sustainability has been added to the high level risk register
- three risks have reduced in score below 15 and are removed from the high level risk register and are now being managed within the Finance divisional risk register:

- 2018/19 financial risk, 7169 financial plan
- 2018/19 financial risk, 7062 capital programme)
- EPR finance risk, 7049

Further detail on the reasons for this are given in the enclosed paper.

iv. Following completion of meetings with risk owners where risks remained static all risks have been updated - this has led to the Estates risk, risk 6903 being split into a resuscitation specific risk and an ICU specific risk, shown as 7271.

v. Risk, 6300 relating to the CQC and delivery of improvement actions following the 2016 inspection has been closed following the publication of the report of the 2018 inspection with a "good" rating. .

Next Steps:

There is ongoing discussion about the generic clinical EPR risk, 7046.

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:

Combinmed High Level Risk Register Board - June 2018 - combined.pdf

High Level Risk Register Board Summary – June 2018

Risks at 25 June 2018

High Level	Number of Risks
Very high (Risk Score of 20 , 25)	**7**
High (Risk Score of 15, 16)	**12**
Total	**19**

TOP RISKS

The following risks scored at 25 or 20 on the high level risk register are:
7278 (25) Longer term financial sustainability risk (NEW)
6903 (20): Estates/Resus risk, HRI
7271 (20) HRI ICU collective infrastructure risk (NEW)
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk

The Trust risk appetite is included below.

RISKS WITH REDUCED SCORE

7169 2018/19 Financial Plan Previous Risk Score 25 Current Risk Score 12

Risk of not achieving the 2018/2019 financial plan The Trust financial control total for 2018/19 has been confirmed by NHS Improvement as a £22.0m deficit, the Trust has planned a deficit is £43.1m, a £19.9m variance from the 18/19 control total.

The rationale for reduction is that the risk of loss of income has been largely mitigated by agreement of an Aligned Incentive Contract (AIC) with the two main commissioners, although any out of area activity remains on a payment by results basis and any costs incurred as a result of overtrading against the AIC would not be covered by additional income generation.

7062 Trust overspend on its capital programme for 2018/19 Previous Risk Score 20 Current Risk Score 12

Risk that the Trust will overspend on its capital programme for 2018/19.

The rationale for reduction of the score, following discussion at Finance and Performance Committee and the agreement between Executive and Non Executive Directors, is that the risk of overspend was not significant due to the controls in place. The true risk was the inability to invest capital due to lack of affordability and this therefore drives an Estates / health and safety risk which is already picked up elsewhere on the risk register.

7049 EPR Financial risk Previous Risk Score 20 Current Risk Score 9

EPR Financial risk with increased costs and decreased income

The rationale for reduction of this risk being reduced from a score of 20 to 9 and management within the finance directorate risk register is that the risk of loss of income is being largely mitigated by agreement of an Aligned Incentive Contract (AIC) with the two main commissioners, although any out of area activity remains on a payment by results basis and any costs incurred as a result of overtrading against the AIC would not be covered by additional income generation. Performance monitoring at specialty and divisional level is now enhanced by weekly Executive Director review meeting with divisions. Data quality improvements are ongoing through business as usual channels.

NEW RISKS

7271 (20) Estates and Facilities: Estates
Intensive Care Unit (ICU) at Huddersfield

Following a review of the estates risk 6903 relating to ICU and resuscitation, it was deemed appropriate to separate these risks and have a risk for each on the risk register. Therefore risk 6903 is retained as a resuscitation risk and a new risk, 7271, on ICU has been added. This is therefore not new to the risk register but a disaggregation to allow more effective recording and management of each risk. The risk is:

There is a collective risk in regards to the ICU from individual (12) risks due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients and staff.

7278 (25) Finance
Longer term financial sustainability
The Trust has a planned deficit of £43.1m (£19.9m variance from the 18/19 control total). This includes loss of access to £14.2m Provider Sustainability Funding (PSF). The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raises concerns regarding going concern and value for money. The Trust does not currently have an agreed plan to return to in year balance or surplus.

CLOSED RISKS

6300 (16) CQC Risk
Risk of being inadequate for some services if CQC improvement actions from 2016 inspection not delivered

CHFT has been rated as Good following the recent inspection. Risk 6300, added originally in May 2015, relating to not having made the required improvements by the next inspection has not materialized, has reached its target date and has been closed.

Should any risks arise from delivery of actions from the 2018 inspection these will be added to the risk register through the usual risk management framework as a new risk.

JUNE 2018 –SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 25.6.2018

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Jan 18	Feb 18	Mar 18	April 18	May 18	June 18
10/17	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
06/17	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing (JM)	=16	=16	=16	=16	=16	=16
06/17	7134	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/2019	Medical Director (DB)	=16	=16	=16	=16	=16	=16
09/17	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
09/17	6903	Keeping the base safe	Resuscitation HRI Estates risk	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
05/17	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
10/17	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
06/17	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
10/17	6949	Keeping the base safe	Blood transfusion service	Divisional Director of FSS (JO'R)		!15	=15	=15	=15	=15
05/17	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Medical Director (DB)				!16	=16	=16
	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)				!16	=16	=16
11/17	7248	Keeping the base safe	Mandatory Training	Director of Workforce and OD (SD)				!16	!16	=16
05/17	7046	Keeping the base safe	EPR Clinical Risk	Medical Director (DB)	=16	=16	=16	=16	=16	=16
09/17	**7271**	**Keeping the base safe**	**ICU Huddersfield – collective infrastructure risk from 12 individual risks**	**Director of Estates and Performance (LH)**						**!20**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Jan 18	Feb 18	Mar 18	April 18	May 18	June 18
	6895	Financial Sustainability	Finance IT systems	Director of Finance (GB)	=8	=8	=8	=8	=16	=16
13/17	**7278**	**Financial sustainability**	**Trust planned deficit**	**Director of Finance (GB)**						**!25**
Performance and Regulation Risks										
06/17	6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (JM)	=16	=16	=16	=16	=16	=16
10/17	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
10/17	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 25/6/2018

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 ! 7271 ICU infrastructure	! 7278 Financial sustainability
Likely (4)				= 6596 Timeliness of serious incident investigations =5862 Risk of falls with harm =7132 Patient scores in ED =7134 Sepsis CQUIN =7223 Digital IT systems risk =7248 Mandatory training =6895 Finance core function =7046 EPR Clinical Risk	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 HRI Resus estates risk
Possible (3)					= 6011 Blood transfusion process = 5747 Vascular /interventional radiology service = 6949 Blood transfusion service
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

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**

Trust Board 5 July 2018
High Level Risk Register (15 or over)

Risks at 25/06/2018 12:35:16

NHS The Health Informatics Service Informing Healthcare

	Risk No	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Further Actions	Review	Target	Exec Dir	Lead
Very High	7278	All Departments/Wards	Jun-2018	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £43.1m (£19.9m variance from the 18/19 control total). This includes loss of access to £14.2m Provider Sustainability Funding (PSF). The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raises concerns regarding going concern and value for money. The Trust does not currently have an agreed plan to return to in year balance or surplus.	Working with partner organisations across WYAAT and STP to identify system savings and opportunities 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 Development of Business Case for reconfiguration Development of 25 year financial plans in support of Business Case Finance and Performance Committee in place to monitor performance and steer necessary actions Aligned Incentive contract with two main commissioners. On-going dialogue with NHS Improvement	Pressures on capacity planning due to external factors. Competing STP priorities for resources Progression of transformations plans are reliant on external approval and funding Impact of national workforce shortages e.g. qualified nurses and A&E doctors The Trust does not currently have an agreed plan to return to in year balance or surplus.	25 5 x 5	25 5 x 5	20 5 x 4	**NEW** Long term Financial plan continues to be developed in conjunction with regulators and department of health.	Sep-2018	Mar-2019	Gary Boothby	Philippa Russell
Very High	6903	Estates Department	Dec-2016	Keeping the base safe	Resus - There is a collective risk in regards to Resus from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: 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.) 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 Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections 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 Medical Engineering Risk - 4 Dameca Anaesthetic Machines - failure due to end of useful life resulting in unplanned disruptions/ harm to patients 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 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. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of RESUS, currently this is not achievable due to Capital budget constraints. Refurbishment requires decant for around 6 months, Operational Plans & activity currently do not permit this length of decant.	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 - RESUS continues 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 completed the paper looking at all possible mitigating actions and awaiting funding for the concluding mitigation. (full refurbishment) **June 18 Update -** Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime	Jul-2018	Oct-2019	Lesley Hilll	Chris Davies

Very High	7271		Estates Department	Jun-2018	Keeping the base safe	Intensive care unit (ICU) HRI - There is a collective risk in regards to the ICU from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: • Ventilation – Imminent failure of the ventilation system due to end of useful life resulting in potential danger to staff and patients • Electrical Resilience –UPS/IPS power failure resulting in harm to patients from no functioning equipment • Flooring – causing trips/falls and infection control hazards for staff and patients • Electrical Infrastructure - failure of infrastructure • Plumbing infrastructure - failure with resulting infection hazards for staff and patients • 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 • Building Fabric - infections & failure due to moisture ingress within the plaster/concrete within ICU resulting in poor environmental conditions. • Compliance / Statute Law – Compliance / Statute Law – Failure of equipment or infrastructure could result in HSE intervention	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit. Resulting recommendations are actioned following a risk assessment process.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU, currently this is not achievable due to patient flow and Capital budget constraints.	20 5 x 4	20 5 x 4	0 0 x 0	**NEW** May 18 Update - ICU continues 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 completed the paper looking at all possible mitigating actions and awaiting funding for the concluding mitigation. (full refurbishment) **June 18 Update** - High-level discussions on funding and operational plans to mitigate the above risks by carry out Estates work in Financial Year 20/21 Agreed for inclusion on high level risk register 13.6.18	Sep-2018	Sep-2020	Lesley Hill	Chris Davies
Very High	2827		Accident & Emergency	Apr-2011	Developing our workforce	The inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that 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 Expansion of CESR programme Ongoing ACP development Continued recruitment drive for Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums 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 Inability of School of EM to allocated trainees.	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 **June 2018 update** Consultant recruitment - appointed one applicant ACP, MG, CESR un-changed	Jul-2018	Mar-2019	David Birkenhead	Dr Mark Davies

Very High	5806		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: • 7220 Flooring: cracked, torn, blown flooring screed and vinyl resulting in possible slips, trips, falls • 6734 Pipework: Potential of water borne diseases due to the corrosion of services pipe work • 6735 Structural: if more openings are made through the structure it will make the building unstable. • 6736 Air Handling Units: non-compliance, & increased infection risk to both patients and staff • 6737 Windows: all elevations of the Hospital require replacing, prone to leeks and very drafty • 6739 Roofs: water ingress through roofs resulting in decanting services, wards and departments. • 6761 Ward Upgrade Programmes: Compliance with regulatory standards - Health & Social Care Act • 6762 Day Surgery: Non-compliance with relevant HTM standards • 6763 Environmental Condition: failure to bring areas of the Hospital to a condition B level • 6766 Road Surfaces: South Drive and Tennis Court car park in need of repairs potential for injury to public • 6767 Staff Residences: Properties not statutory compliant for accommodation in regard to fire and utilities. • 6769 Electrics: Statutory compliance to reduce the risk of electric shock and damage to equipment • 6770 Plantroom: Statutory and physical condition of the plant room to H & S regulations • 6332 Asbestos: risk of industrial disease to staff, patients and general public • 6771 Emergency Lighting: Statutory compliance in order to provide adequate emergency lighting • 5963 Equality Act: non-compliance with the Equality Act 2010 due to a inadequate physical access • 6764 Fire Detection: aged fire detection could lead to inadequate fire detection. • 6860 Electrical 3rd substation HV supply only 1 meter apart • 5511 Fire Compartmentation: inadequate fire compartmentation in ceilings; risers and ducts. • 6897 BMS heating controls failure will result no control over heating or air condition throughout the hospital • 6997 Structural Cladding - Loose Portland Stone creating a hazard • 5630 Poor condition of the WCs in HRI's public areas • 6848 Water Safety: non-compliance to statutory law across HRI due to the ageing infrastructure	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. 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.	16 4 x 4	20 5 x 4	6 3 x 2	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. **June 18 Update -** The Capital Plan for 18/19 is now underway, Ward flooring replacement to commence June, Main entrance Infrastructure to commence in July. Work already started on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient.	Jul-2018	Feb-2019	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies

Very High	6345		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	April 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). Interviews have taken place 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 are to be 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 interviews during April 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 advertising for two Physician Associates (PAs) vacancies within Medicine for 2 additional PAs, following withdrawals by two candidates. 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. **June 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), 8 Nurses have started with the Trust in 2018. 23 Trainee Nurse Associates have started their new roles, a training role which will support divisions with their nurse staffing supply in the future, all posts were filled. 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. Application numbers are low and divisions are discussing a new approach advertising by specialty with targeted recruitment support. 43 Student Nurses are currently engaged and under offer ahead of their qualification in September. Advertising is continuing to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT (interviews in June 2018). Divisions are advertising for two Physician Associates (PAs) vacancies within Medicine for 2 additional PAs, following withdrawals by two candidates. 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	Jackie Murphy and Jason Eddleston	Paul Casson

Very High	7078	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	April 2018 A number of CVs have been received from the agreed agencies that we work with on permanent recruitment. Once the departments have shortlisted it is hoped that there may be some suitable candidates to interview for middle grade posts. It is intended that E Rostering in A&E will be launched at the end of April. 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. **June 2018** We have successfully recruited a number of new Consultants. Emergency medicine, Respiratory Medicine, Diabetes and Endocrinology, Colorectal Surgery, Paediatric Ophthalmology and General Radiology. The candidates are currently being cleared to commence and their start date will be confirmed shortly. The EJob Plan Allocate Project Lead has now commenced in post and started to support CDs and GMs to populate Job Plan Data for consultants. A target has been set that all Consultant Job Plans will be in Allocate by the end of September 2018. In accordance with the 2016 Junior Doctor Contract work schedules have been issued to our new trainees 8 weeks prior to them commencing in post, and are now being progressed through pre-employment checks.	Jun-2018	Jan-2019	David Birkenhead	Pauline North
High	7132	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 nerve centre to ascertain whether we can filter by area in ED and not have all patients on. **June 2018 Update:** Awaiting update from nerve centre. Audits still in place. Staff are complying with mitigation in place.	Jul-2018	Jul-2018	David Birkenhead	Louise Croxall

High	7134		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 the 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	16	4	Assess impact of EPR sepsis prompt Improve safety huddles to include sepsis Coordinate activity with the Deteriorating Patient Group NB. See high level risk register 6990 operational lead Assistant Director Quality and Safety 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. **June 2018** 100% of patients now screened for sepsis 95% of patients with sepsis have the sepsis alert completed. Further work on going to look at compliance with BUFALO once sepsis identified – some delays in extracting data from EPR. Work underway to develop sepsis training programme	May-2018	Jun-2018	David Birkenhead	Rob Moisey
High	7223		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	16	8	- 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 **June:** Following the power failure to the HRI Data Centre early June, there is additional work being carried out by Estates to ensure resilliency for power. No further update or change to score.	Jul-2018	Sep-2018	Mandy Griffin	Rob Birkett

High	7248	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. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 mandatory subjects alongside the 41 essential skills. This approach strengthens the importance of completing the essential skills designated to specific roles and by combing the two areas into one enhances the Trusts' requirement to reach 96% across all the training offerings.	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 x 4	16 x 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 to reposition the message about the value of this training. May 2018 Mandatory training and essential skills have now been amalgamated into 'Essential Safety Training'. The intranet portal reflects this.	Jul-2018	Mar-2019	Suzanne Dunkley	Ruth Mason
High	6596	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 x 4	16 x 4	8 x 2	. 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. **June 2018** Half day RCA training held. Response to NHS Improvement consultation on future of patient safety investigations sent. Continued focus on meeting with investigators to keep investigations on track.	Jun-2018	Sep-2018	Jackie Murphy	Angie Legge
High	6895	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. 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	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	8 x 2	16 x 4	8 x 2	**June update:** 1. Additional temporary resource is in place in Accounts payable in addition to off-site processing support to address invoice backlog. A number of material cash receipts have been pursued and are expected in July, this should further ease the Trust's ability to catch up on payment timescales. 2. Regular communication remains in place at a Senior level with the system supplier. A number of residual issues impacting system effectiveness will only be resolved on a further upgrade to the system which is in testing with an expectation of go live in late summer / early autumn. 3. Systems optimisation plan progressed with some improvements now in place and others in train. 4. Raising of cash awareness on-going.	Jul-2018	Jul-2018	Gary Boothby	Kirsty Archer

						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	ongoing challenges of cash availability meaning that payments are having to be prioritised (See Risk ref 6968)									
High	5862		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	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. **June 2018** 2018/19 Trust-wide falls action plan drafted. Post falls investigation safety huddle (FISH) tool tested in Medical division and now available on Datix to help identify clinical practice issues to prevent falls. Annual falls awareness and prevention days planned for July 2018, “Falls Prevention Gets Attention”.	May-2018	Jul-2018	Jackie Murphy	Helen Hodgson
High	6011		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). - Solution identified and purchased - currently for implementation from August 2018. This solution will mitigate the current risk in full.	Lack of electronic system Lack of duplicate sampling Training compliance not at 100%	15 5 x 3	15 5 x 3	3 3 x 1	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) **June 2018** Blood track implementation progressing in line with plan. Key operator training will take place in June and full user training to commence in July. Go live scheduled for mid-August.	Jul-2018	Aug-2018	Julie O'Riordan	Sarah Ramsden and Alison Milner
High	5747		Angiography & Fluoroscopy	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant in post Ad-hoc locums supporting the service Continue to try to recruit to vacant posts	Failure to secure long term locum support. Lack of clarity on regional commissioning arrangements relating to vascular services	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response. April 2018 Locum in place until 18th May, continuing to pursue full time locum. No support available form neighbouring Trusts. May 2018 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. No support available from neighbouring Trusts. **June 2018** Locum cover remains in place until October 2018. Trust contacting NHS England to clarify process timeline for WY model.	Aug-2018	Mar-2019	Rob Aitchison	Sarah Clenton

High	6715	Workforce and Clinical Development	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2	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. **June 2018** The ward assurance process is being tested The training to improve documentation for nurses has been planned and is being encouraged, this will be reported to senior nurse huddle for management Appointment of operational manager to support digital boards Clinical posts being recruited to Training and change team amalgamated to enable focused support	Jul-2018	Nov-2018	Jackie Murphy	Jackie Murphy
High	6949	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 - further work required to establish contingency plan if rota was unfilled at any point in time.	10 5 x 2	15 5 x 3	5 5 x 1	3. Understand blockers to the recruitment process and determine options to expedite the process. 5. Organise a test for Business continuity plan with relevant stakeholders. Update 12/1/2018- BCP test planning meeting arranged for 15th Jan. Planning actual test for last week Feb 2018 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. **June 2018** Test of BCP in department being planned Staff training plan underway The risk is expected to be mitigated or lowered once an additional three staff are on the shift. 1 staff member is now requesting shifts for September another is starting transfusion training Next week for 3 months. Expected to be available for shifts in September, another staff member is expected back from Mat leave Sept. will need re-assessment of competence before back on shift. Expectation October Senior manager are now analysing the training plan to identify any support to expedite.	Jul-2018	Oct-2018	Rob Aitchison	Hayley Baker
High	7046	Departments/Wards	Aug-2017	Keeping the base safe	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	Response of external partner slow leading to delayed resolution. BAU team capacity & focus on stabilisation and build necessary to satisfy organisational priorities such as CQUIN Thematic review of incidents complaints, PALs etc. Adequate system build Training Review of access right. Robust audit of end to end pathways and documentation.	April 2018 The issues that were identified in March have been reported to WEB and action has been taken to identify clinical risk The change prioritisation plans are to be shared with Divisional Digital boards this month The ECDS has been built into the production domain and is awaiting testing There is currently no further action with regard to access and roles other than on an individual basis May 2018 Risk planned for closure as at EPR Risk Panel in April 2018 it was agreed that the individual elements of the risk were captured elsewhere and individual entries in the risk register. Risk and	16 4 x 4	16 4 x 4	0 0 x 0	This risk was an overarching 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	May-2018	THISAlistair.Morris	Apr-2018	Alistair Morris

								Compliance Group supported this. Ongoing discussion with Chief Nurse and NED regarding this risk. June 2018 Ongoing discussions with Managing Director of Digital Health and Director of Nursing regarding this risk								

10. Learning from Deaths – Quarterly Report

To Approve

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: 5.7.18	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Learning from Deaths – Quarterly Report - The Board are asked to approve the contents of the Learning from Deaths Q4 report.	
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: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

The Board are asked to approve the contents of the Learning from Deaths Q4 report.

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:

LfD 17-18 Q4 Report.pdf

LfD (Learning from Deaths) – 2017/18 Q4 Report

From April 2017 to March 2018 there were 1,716 deaths within the Trust. Initial screening reviews (ISR) were performed on 428 (25%) of the adult deaths using the online tool. There have also been a number of deaths reviewed within specialities that have not been captured on the online tool. All deaths within Gastroenterology, the Emergency Department, Critical Care, Stroke, General Surgery and Orthopaedics are reviewed with each speciality reporting to the Mortality Surveillance Group. It is therefore assumed that we are reviewing more than the reported 25% of all deaths although this figure will need to be recalculated manually. Moving forward all specialties have agreed to use the online tool with a drop down menu with additional questions relevant for their specialty. In addition, deaths of all children in our care from birth to 18 years are notified to the Calderdale and Kirklees Safeguarding Children Boards Joint Child Death Overview Panel (JCDOP) and all still born and perinatal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination.

The ISR focussed on quality of care. Of those that have been completed the quality of care was rated as excellent in 30% (128), good in 40% (169), adequate in 18% (78), poor in 8% (35) and very poor care in 0.25% (1) of cases reviewed. Poor or very poor care has triggers further investigation using the structured judgement review process.

The trust's ambition to perform an ISR continues by working with the specialist teams performing mortality reviews to bring them on board with the online tool and further support and training is being provided to consultants who are yet to be involved with completion of ISR.

A total of 89 deaths were escalated for Structured Judgement Reviews (SJR) between April 2017 and March 2018, with all of these 88 cases completed. The table below shows the reason for escalation for a SJR and the number completed.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	total
Escalated from ISR	2	0	0	6	1	5	2	8	1	3	2	0	30
Complaint	0	1	3	2	1	1	0	1	1	3	3	1	17
SI process	0	0	2	3	0	0	4	2	0	1	0	0	12
Elective						3	0	1	0	1	0	0	5
LD	1	1	4	3	0	0	0	1	0	0	1	2	13
Other	0	0	0	0	0	0	0	0	9	0	3	0	12
Completed	3	2	9	14	2	9	6	13	11	8	9	3	89

Dr Sal Uka, Associate Medical Director

LfD (Learning from Deaths) – 2017/18 Q4 Report

In Q4, there 31 SJR's completed and included a random cohort of patients that died during the Christmas and New Year bank holiday period.

Although the SJR in majority of cases have found no avoidability issues, there have been a number of learning themes identified where we can improve the quality of care, these include:

- Timely senior medical reviews
- Appropriate control of symptoms, particularly at the end of life
- Improving communication with patients, family and different healthcare professionals, particular on goals of care
- Earlier recognition of deterioration
- Better fluid management and recording of fluid balance
- Earlier recognition the dying phase and ensure good communication with the family

The majority of these themes are included within the work plans of the Deterioration Programme and the End of Life Groups. Effective communication and documentation of this remains a common theme seen not only in mortality reviews but also in complaints. This may need an alternative approach. Discussions are also taking place on how best to disseminate the learning from reviewing deaths including to individual clinicians. The latter will include areas of notable good practice with comment of areas for improvement.

Learning from Death Panel

The LfD Panel has established two monthly meetings to discuss key learning themes and to include good practice as well as areas requiring improvement. The panel consists of the structured judgement reviewers and some senior nurses. Terms of Reference have been drafted and will include hoe learning is shared across the Trust.

Learning from Death Summit

The first LfD Summit is planned for July 12th and will be held off site. The full programme is to be finalised and invites will include both medical and nursing staff as well as external colleagues. Chris Pointon, the husband of the late Dr Kate Grainger will provide a presentation at the start of the summit and set the scene on the importance of quality care.

Dr Sal Uka, Associate Medical Director

11. Director of Infection, Prevention and Control Annual Report

To Note

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: 5.7.18	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Director of Infection, Prevention and Control Annual Report 2017-18 - This report details the activities of the Infection Prevention and Control Team (IPCT) during the period April 2017 to March 2018.	
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 details the activities of the Infection Prevention and Control Team (IPCT) during the period April 2017 to March 2018.

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 DIPC Annual Report 2017-18.pdf

Calderdale and Huddersfield
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2017-18

Executive Summary

This report details the activities of the Infection Prevention and Control Team (IPCT) during the period April 2017 to March 2018. The Director of Infection Prevention and Control (DIPC) is the Executive Medical Director, and leads the IPCT reporting directly to the Chief Executive.

2017/18 has been a challenging year against national objectives for Meticillin Resistant Staphylococcus *aureus* (MRSA) bloodstream infections and cases of Clostridium *difficile* Toxin positive infection (CDI). There have been five MRSA bloodstream infections against a target of zero preventable infections, and 40 CDI cases against a target ceiling of 21 cases. There has been an increase in the nationally recorded cases of CDI.

Key points:

The Trust complies with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and associated Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed HCAI programme of work and audit for 2017/18 that includes the 10 criteria identified in the code.

- There were 5 trust apportioned Meticillin-Resistant Staphylococcus aureus (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 40 trust apportioned *Clostridium difficile* toxin (CDI) positive cases this year against a ceiling target of 21. There were 22 Trust attributed Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, which is an increase from 13 during 2016/17.
- The trust reported 49 E.coli bacteraemia infections which is similar to previous year in which CHFT reported 48 infections. Analysis of all cases has not demonstrated a common underlying cause. E. coli bloodstream infection is the focus of collaborative work across the healthcare economy, owing to the fact that >80% of E. coli bloodstream infections develop in the community.
- Clostridium *difficile* outbreaks occurred on two wards, both of which have been investigated as Serious Incidents.
- A cluster of MRSA infections on one ward was managed as an outbreak.
- 420 patients were diagnosed with influenza compared to in 2016/17.
- There were 24 wards affected (either closed or restricted) with viral gastroenteritis, resulting in 318 bed days lost.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of hand hygiene compliance for the year was 98.6%.

- The Trust participated in mandatory orthopaedic surgical site infection surveillance (SSIS), 6 patients were identified as carrying Carbenpenemase-producing enterobacteriacae (CPE) via the Trust screening programme during 2017/18.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust Intranet and Internet sites. 13 policies have been approved at Executive Board during 2017/18.

Contents

1. Infection Control Arrangements

The Director of Infection Prevention and Control (DIPC) leads the Infection Prevention and Control Team (IPCT), and is supported by the Matron Lead for IPC and the Infection Prevention and Control Doctor (IPCD).

Assurance pertaining to IPC is received and scrutinised by the Infection Control Committee, chaired by the IPCD, who then reports to the Quality Committee and to the DIPC. The Quality Committee and DIPC report to the Executive Board and the Board of Directors.

Full details of the Infection Control arrangements are available in the Trust Policy: Section A – Infection Prevention and Control Arrangements. Terms of Reference for the Infection Control Committee are available here:

See appendix 1, Calderdale and Huddersfield Foundation Trust: **Section A - Infection Prevention and Control Arrangements** *and appendix 2 Infection Control Committee (ICC) terms of reference.*

The Director of Infection Prevention and Control (DIPC) has presented the Trust Board with the following agenda items on IPC during 2017/18:

- The annual DIPC report 2017/18 – endorsed.
- Quarterly DIPC reports – endorsed.
- Quarterly ICC minutes highlighting outbreaks and areas of concern and providing assurance around infection control practice across the organisation.
- Monthly Trust MRSA bacteraemia trajectory progress and areas of concern.
- Monthly Trust Clostridium *difficile* trajectory progress and areas of concern.
- Monthly Trust MSSA and E-coli bacteraemia figures.
- A narrative of any off target indicators is provided in the integrated board report, detailing actions being taken to get us back on plan.

Infection Prevention and Control representative at relevant groups

To provide infection and prevention advice and ensure liaison between the IPCT and key groups, representation is provided at the following:

- Infection Control Performance Board
- Healthcare Economy HCAI meeting
- Divisional Patient Safety Quality Boards (PSQB)
- Medical Devices Committee
- IV Strategy Group
- Urinary Catheter Steering Group
- Sisters Meetings

- Nursing and Midwifery Committee
- Nursing and Midwifery Practice Group
- Water Management and Air quality Group
- Estates and Facilities Capital Planning Group
- Matrons Forum
- Health & Safety Committee
- Patient Safety Group
- Decontamination Committee

Infection Control Budget 2017/18

The Infection Control Team has a budget of £504,978.00 per annum. Of this £29,689.00 is for non-pay including licensing of ICNet surveillance IT system, training expenses, travel and mobile phone costs. The Matron Lead is both the budget holder and budget manager.

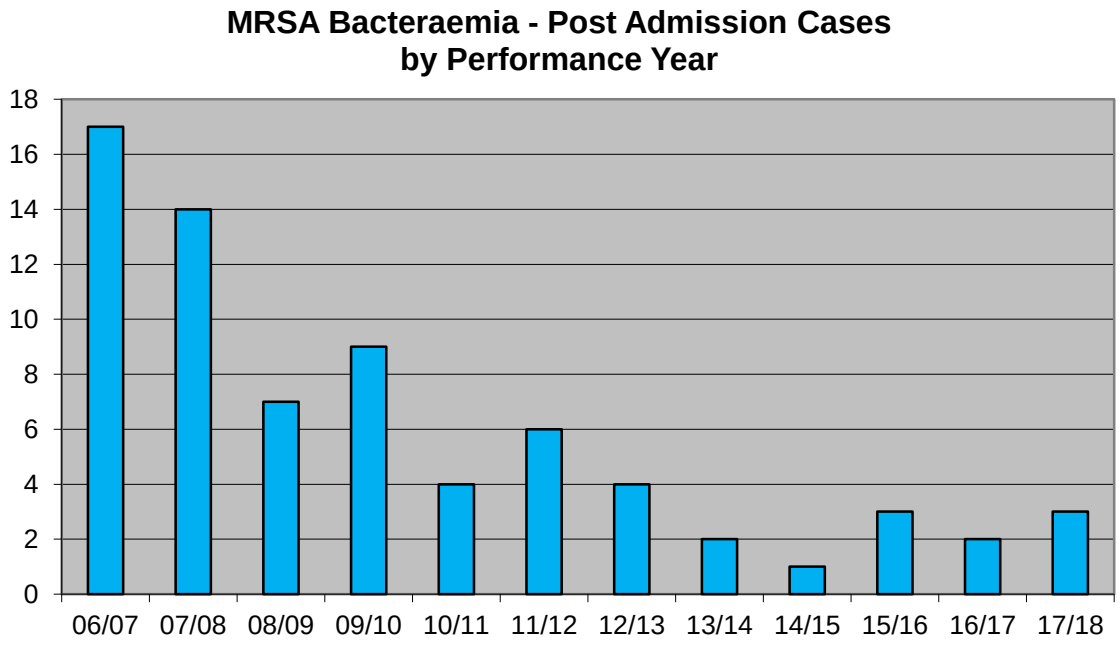
2. Mandatory reporting of HCAI

Mandatory reports are made to Public Health England (PHE) of the following organisms causing the stated infection.

- Staphylococcus aureus bacteraemia (MRSA & MSSA)
- *Escherichia coli* bloodstream infections
- *Clostridium difficile* toxin positive infections diagnosed 48 hours after admission.
- Orthopaedic Surgical Site Infection Surveillance (minimum 3 month period per annum)

Meticillin-resistant Staphylococcus aureus

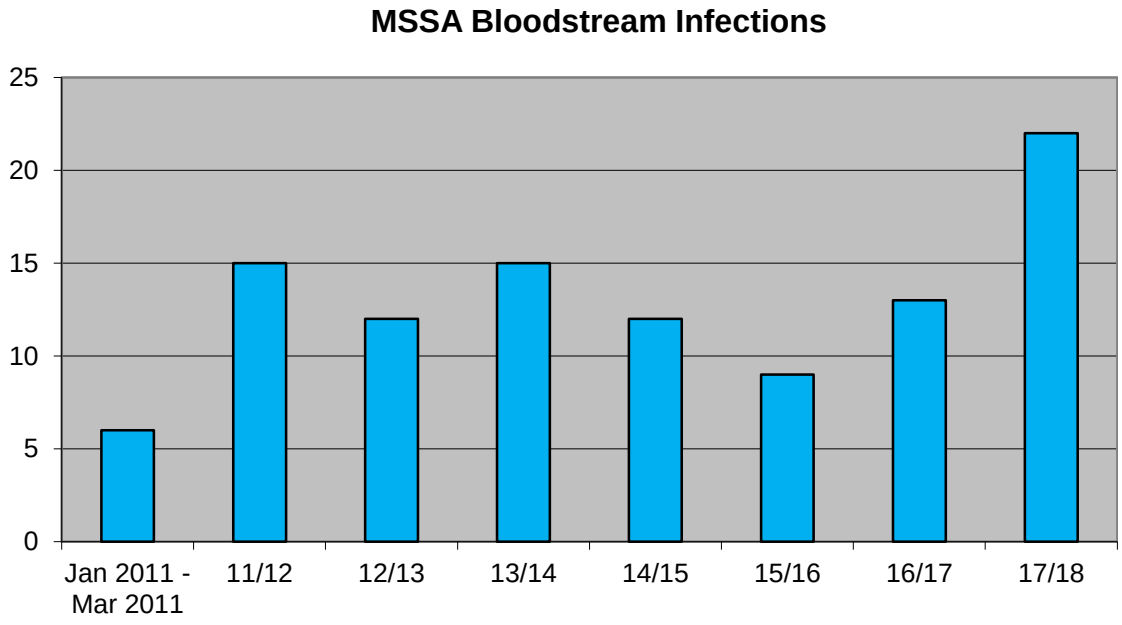
MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia are reported nationally and the Trust had seen a significant reduction over the last few years. There were five cases in 2017/18. which were attributed to the Trust. All cases are subject to a Post Infection Review (PIR) to identify if there were any lapses in care to aid prevention of further cases. Actions were generated and incorporated into the divisional and Trust wide action plans. There were no links between the infections, all were sporadic in nature.



Meticillin-sensitive Staphylococcus aureus

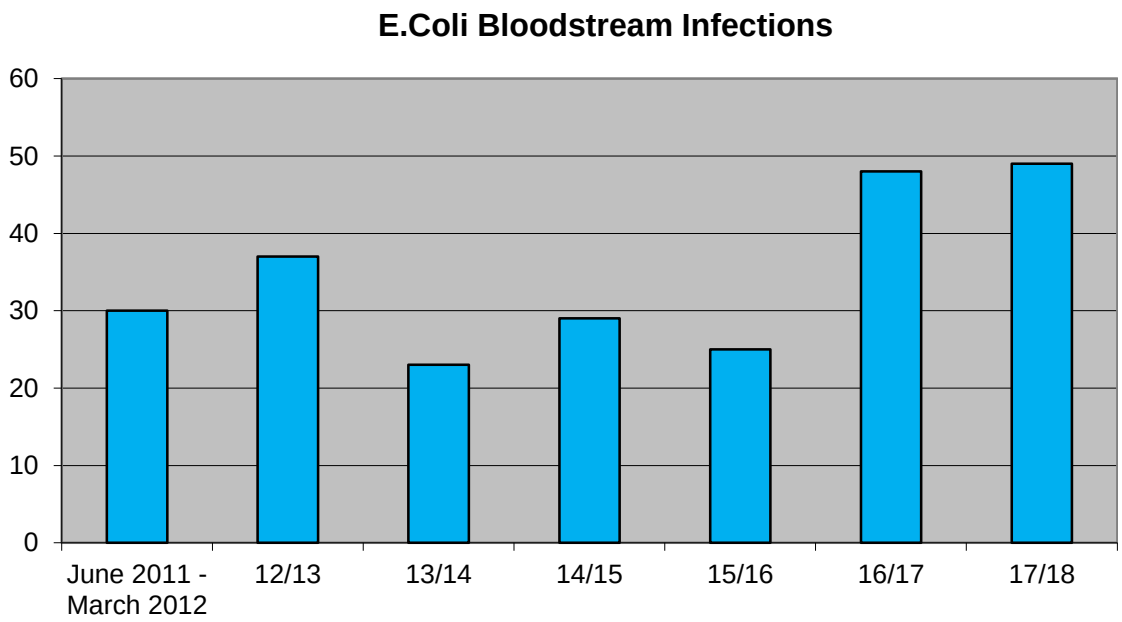
MSSA (Meticillin-sensitive Staphylococcus *aureus*) bloodstream infections are reported nationally although there are no mandated reduction targets set nationally. A local target was set using the 2014-15 out turn of 12 cases. There has been a gradual increase over the last few year and we have seen an increase to 22 cases during 2017/18. A review of all these cases has been completed and recommendations have been included in the Trust Infection Control Action plan.

The chart below shows the number of post admission MSSA bacteraemia.



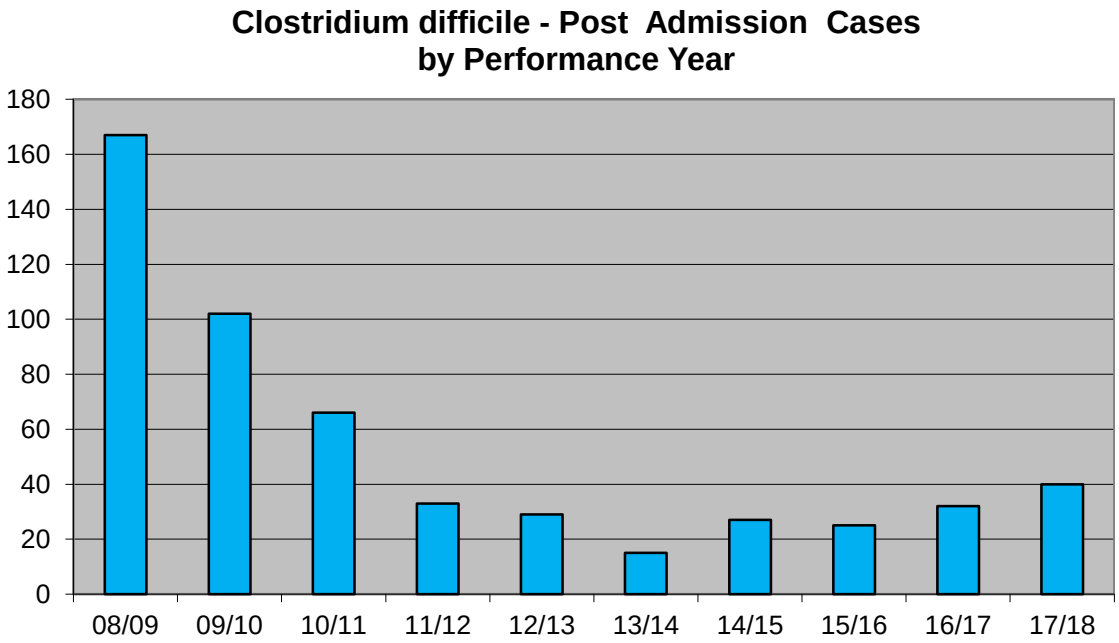
E.coli Bloodstream Infections

There is no national set target for the reduction of E coli bloodstream infections for acute care providers. There were a total of 49 cases this year compared to 48 the previous year. There is a healthcare economy wide action plan which is being led by Kirklees CCG to reduce E. coli bloodstream infections, with a particular focus on urinary catheter care. Actions to support the reduction of E. coli bloodstream infections will be incorporated in the trusts HCAI action plan for 2018/19.



Clostridium *difficile*

Clostridium *difficile* (*C. difficile)* is one of the major causes of infective diarrhoea. The target set for the Trust in 2017-18 was a ceiling of twenty one cases: the Trust reported forty cases. All the cases were subject to investigation by way of root cause analyses (RCA). Of the forty cases, thirteen cases were deemed to have been avoidable. The remaining twenty seven cases there found to have been unavoidable.. Learning from all cases, whether found to be avoidable or not, is incorporated into both the Trust and divisional infection prevention and control action plans. During the year there have been two outbreaks of C. difficile infection that have contributed to the number of cases reported. Throughout this period there has been a national increase in C. difficile cases.



3. Serious Incidents and Outbreaks

- June 2017: Two linked Clostridium *difficile* toxin positive cases (identified on the same ward. Both cases were proven to be identical using DNA fingerprinting techniques The ward was closed and the environment thoroughly decontaminated using Hydrogen Peroxide Vapour (HPV). This incident was investigated as a Serious Incident.

- February 2018: MRSA: five linked cases of MRSA infections or colonisations. One patient had a bloodstream infection; the strain of MRSA could be linked to four other cases of MRSA infection or colonisation on the same ward during the same timeframe. This incident was managed as an outbreak which included a deep clean of the environment, an enhanced MRSA screening protocol and decolonisation treatment

- March 2018: Four cases of Clostridium *difficile* toxin positive infections cases were identified during a two week period: all cases had the same ribotype An outbreak investigation was initiated, that linked the cases to a patient who had been diagnosed with C. difficile infection several weeks prior to the outbreak, bring the total number of patients affected to five. The outbreak was brought under control following using HPV to clean the ward, changes to the antibiotic policy, and education/training around clinical and cleaning practices.

- January to March 2018: An increased incidence of influenza at CHFT commenced at the beginning of January 2018 and continued until the end of March 2018, consistent with the national picture. Multiple wards were affected by patients with influenza, particularly on the elderly wards where there were three separate influenza outbreaks. During December 2017 there were 17 confirmed Influenza cases, this rose rapidly in January through to March with 388 confirmed cases and a further 15 cases in April. This resulted in a 3 month period of increased incidence with a total of 420 confirmed cases. Four patients required critical care beds. A Standard Operating Procedure was developed for risk assessment and patient placement which helped to improved patient flow. Learning from a debrief of the infection prevention and control team following the influenza season will be incorporated into Trust plans for the next influenza season.

4. Preventing Healthcare Associated Infections – Divisional reports

Surgical Division

The year-end position for assigned Clostridium *difficile* cases is 10, showing no increase from last year. Learning from RCAs identified antibiotic prescribing contributed to some of the cases, that clarification of cleaning roles with respect to equipment was required and hand hygiene remains of utmost importance. Of particular note is the cleaning of bed spaces in ICU: there is now greater clarity around who cleans what and this has been fully embedded.

Hand hygiene has remained a challenge in the division this year. Clinical teams have been asked to report hand hygiene compliance accurately and before prompting to ensure a representative picture of practice across all areas. There has been focused work on this led by the Divisional Director with a clear message and approach adopted across the division to ensure appropriate escalation of non-compliance. Matrons remain on high alert to recognise and action issues and this message is reinforced through the Divisional Director and through divisional colleagues at the Patient Safety and Quality Board. There will be a continued focus on this issue as a high priority area in 2018/19.

Frontline Ownership Audits (FLO) audits continue to address environmental issues with all areas scoring Green or Amber FLOs this year. There have been some FLO masterclasses that the ward and department managers have attended to ensure standardisation of the FLO audits. Performance against key indicators in this area is good.

Improvements in practice around aseptic non-touch technique (ANTT) and hand hygiene in operating services have been sustained this year. This will be supported by increased surveillance by the service leads who now have clinical sessions booked into their working week. The teams in operating services have fully embraced a proactive approach to developing a safety culture that ensures environmental standards are maintained.

Work is ongoing to ensure compliance with ANTT training. The year-end position overall within the division was 92.5% with nursing staff at 97.75% with medical staff trained at 77.81%. The medical staff training and compliance continues to be a priority for 2018/19.

Endoscopy services suffered a fire in the past year on the Calderdale Royal Hospital site. A refurbishment is ongoing and will be completed early in the 2018/19 year. The decontamination units on both sites will then be fully operational. The Division has developed an Infection Prevention and Control Action plan for 2018/19. Key priorities include:

• Ongoing focus on hand hygiene

• Maintain environmental standards in all areas

• Reduction in number of post 48 hour C-Diff cases with timely completion of RCAs and dissemination of learning across all teams

The Infection Prevention and Control Team and the Estates and Facilities Team have been invited to monthly matron meetings to facilitate the ongoing work around the action plan.

Medical Division

The Division of Medicine has continued to progress its infection prevention and control agenda to support the Trust action plan. A Divisional action plan has been compiled to focus areas of infection control practice and management with particular emphasis on training compliance for all staff groups and to ensure that we learn from experience.

There have been 3 MRSA bloodstream infections over the past year in the medical division A key area for learning has been the promptness of MRSA screening being undertaken at the time of admission, along with antibiotic prescribing and hand hygiene.
Current elective admission compliance is 98%, current Acute compliance is 84% with a target of at least 95%.

The Trust Clostridium *difficile* ceiling for 2017/18 was 21 for the trust with the Medical Division having 28 cases in total.

Thematic reviews of the cases of C-difficile have highlighted several areas of learning:

- Delay in obtaining a stool specimen
- Completion of the Bristol Stool Chart and assessing patient bowel habits., not always 100% compliant
- Delay in isolation – wards awaiting specimen results before isolation of the symptomatic patients.

- The division had two outbreaks of C. difficile on two different wards within the medical division (one involving two patients, the other involving five patients). Both were managed as outbreaks: lessons learnt were then shared throughout the division and the Trust.

Work continues to improve compliance with the above issues within the Division.
There have been several wards with the Division affected at CHFT with Norovirus on both sites.
There have been continued challenges to comply with side room isolation requirements for all our patients however proactive management from wards and teams have worked hard to minimise risks for our patients.

The Infection Prevention and Control Nurses (IPCNs) have continued to support bespoke "bite size" education sessions to ward areas identified either during incidents or at the Ward Sisters or Matrons requests. These have been well received on the wards.

The division has experienced a high number of influenza cases on both sites. The numbers have been the highest that we have seen for a winter period since the pandemic in 2009. The division had a dedicated ward for influenza patients on each site which helped tremendously with the isolation of these patients.

The Division has taken action to improve the performance levels of nurses and medical staff who undertake ANTT procedures to ensure that they are trained to do so correctly. This is monitored closely each month at the Patient Safety and Quality Board. To improve consistency with reporting standards for the Matrons frontline ownership (FLO) audits the process has changed by which all FLO audits are submitted on the 15th of every month to match with the safety thermometer process. Infection prevention and control remains a fundamental part of the matron's role and as such they play a key role in improving standards at ward level with strong partnership working with the ward sister. An independent FLO audit is now carried out by the IPCT on a quarterly basis for all in-patient wards.

Wards and departments continue to audit hand hygiene compliance and staff are encouraged to report actual practice so that any problems can be identified. Ward staff have been asked to focus on the World Health Organisation (WHO) '5 moments' of hand hygiene when monitoring compliance. One ward within Medicine has been trailing a new data collection tool around hand hygiene and the 5 moments. If this pilot is successful then the plan is to use the tool trust wide.

Families and Specialist Services division:-

Families and Specialist Services Division have an improved performance from last year with no cases of Meticillin–resistant staphylococcus (MRSA), Clostridium difficile (C-diff), and EColi bloodstream infections (E-oli).

The areas requiring FLO audits within the division have been revised and streamlined within pathology and radiology in particular. Attendance at a FLO masterclass for all areas has led to collaboration and embedding of peer reviews with a 'fresh eyes' approach to ensure rigorous audits.

The divisional action plan describes the priority areas and the strategies in place for preventing HCAI's.

Within maternity services the campaign to vaccinate pregnant women against influenza has had another successful year across Calderdale and Greater Huddersfield during 2017/18 meeting the NHS England target for vaccination of pregnant women (55%) and Calderdale once again has the best uptake in West Yorkshire with Greater Huddersfield joint second.

The link Infection Control and Prevention Practitioners continue to actively campaign, encourage and support staff compliance with IPC training requirements and monitor practice. 2017/18 training compliance with ANTT was 95.37%: this compares well exceeding the Trust overall compliance of 91.57%. The IPC training compliance with 'beyond the basics' was 76.53% in FSS with the Trust overall compliance of 73.78%. The division is responding to this with a targeted approach to staff that are not compliant and planning with the IPC team a bespoke training session on audit days to capture medical staff for the face to face training group session.

The children's services were recently reviewed whilst undertaking CHKS accreditation, which measures quality to enhance and improve productivity, performance, patient experience and outcomes. On their visit to the children's areas they found minimal infection control issues and the feedback from children and parents was very positive. The visiting assessors highlighted that areas seen appeared spotless, appropriate, secure, and well-stocked with reasonable storage space. Similarly all equipment seen was in good repair and well maintained.

The IPC quality improvement audits that have been completed in FSS in the last 12 months have demonstrated a sustained high standard of practice. The only area audited as amber was Yorkshire Fertility and the matron is closely monitoring compliance with the devised action plan.

Areas of practice prioritised for improvement include; use of personal protective equipment (PPE) eye protection to reduce the risk of transmission of infection from splash injuries during birth. Maternity have a low compliance within this sphere of practice. Actions have included guidance from the infection prevention and control lead and attendance at monthly briefing meetings to discuss and share best practice and evidence. Midwifery leaders and the link IPC practitioners within the birth environment are leading by example and taking every opportunity to encourage the use of eye protection.

Occupational Health

Influenza – staff immunisation campaign 2017-18

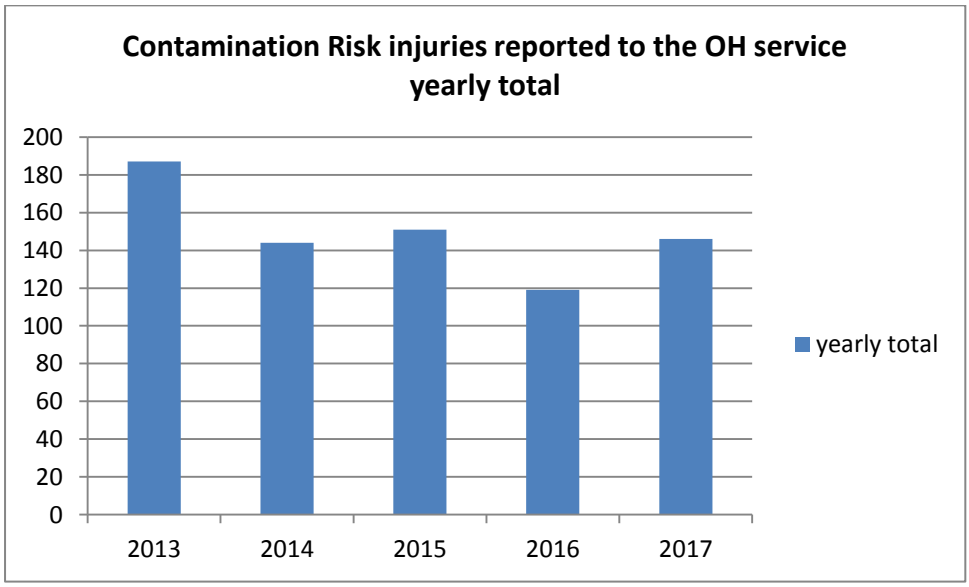
This was the second season that a CQUIN had been attached to the uptake of frontline healthcare workers of the annual flu vaccine. The target uptake was 70% of frontline healthcare workers to have had their flu vaccine by 28th February 2018.
A high profile campaign was launched in October 2017, building on our experiences of past campaigns, and drawing on information from staff engagement events. Additional incentives and prizes were offered, and around 100 peer immunisers trained to be able to offer the vaccines in nearby workplaces on and off site reaching most staff around the clock.

The final uptake of frontline healthcare workers reported to the Department of Health was 70.45%, with Occupational Health recording 4300 doses of vaccine administered during the season. The whole trust (all staff) uptake was 65% (i.e. including non-frontline staff members). This is a reduction in the uptake from the previous year by ~5%.

The influenza steering group is developing the plans for the season 2018-19 which will press forward with a target of 75% uptake by 31 December 2017 which reflects the national CQUIN target for this year.

Contamination Risk Injuries to staff

A quarterly report is made to the Infection control committee of injuries reported to occupational health, and a small working group led by health and safety, interpret and follow up on learning from injuries to further reduce risks.



In 2017, 120 of the injuries reported were “sharps” injuries, and 20 cases were splash injuries.

During 2017/18 there were 5 cases of possible exposure to a source patient who had a blood borne virus. There have been no cases of healthcare worker infection acquisition identified in follow up screening.

Staff Hepatitis B immunisation

Due to international supply constraints of Hepatitis B vaccines, the staff immunisation campaign was suspended in August 2017 on the guidance of the Department of Health. This resulted in staff commencing in post without immunisation to Hepatitis B, or with primary immunisation programmes suspended. Vaccine supply is gradually increasing and provided that supply remains available, a plan is in progress to catch up on these missed vaccines within a priority framework. This is on track to deliver the full immunisation programme by the end of 2018

To date there have been no reported exposure risk incidents involving unimmunised staff.

5. Antimicrobial Prescribing

Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) CQUIN 2017/8

Owing to the increasing global threat associated with antimicrobial resistance, a CQUIN relating to antimicrobial use continued in the year 2017/18 . This has involved the Sepsis Collaborative and the Antimicrobial Management Team (AMT) working closely together. These groups bring together multidisciplinary representation from microbiology, infection prevention & control, and pharmacy, with the medical, surgical and FSS divisions, health informatics and primary care. The Collaborative meets monthly and the monthly Antimicrobial team (AMT) meetings feed into the above.

CQUIN Part 2c: Reduction in antibiotic consumption per 1000 admissions

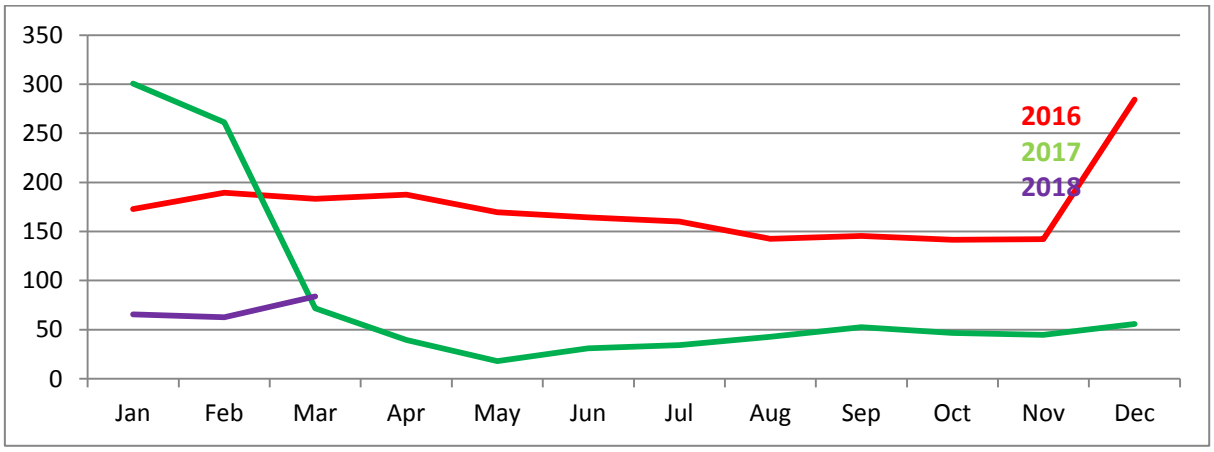
PHE Fingertips Published data to end of Q3 2017-8	Calderdale and Huddersfield NHS Trust	England
Four Quarter Rolling Rate of Total Antibiotic Prescribing per 1000 admissions	4029	4885
Four Quarter Rolling Rate of Piperacillin-Tazobactam Prescribing per 1000 admissions	83.7	88
Four Quarter Rolling Rate of Carbapenem Prescribing per 1000 admissions	62.5	100.5

a) Reduction of 1% or more in Total Antibiotic consumption against the baseline year 2016.
Although there has been a steady rise in the consumption of all antibiotics between 2013/14 and 2016/17, consumption at CHFT has remained below the national average each year.

b) Reduction of 1% or more in Piperacillin-Tazobactam consumption against the baseline year 2016.

In April 2017, a national supply problem with piperacillin-tazobactam led to the removal of this antibiotic from the majority of our guidelines, with the limited stock now available reserved for a few specific indications and on microbiologist recommendation. As a result, we have seen a significant reduction in consumption and remain below the national average.

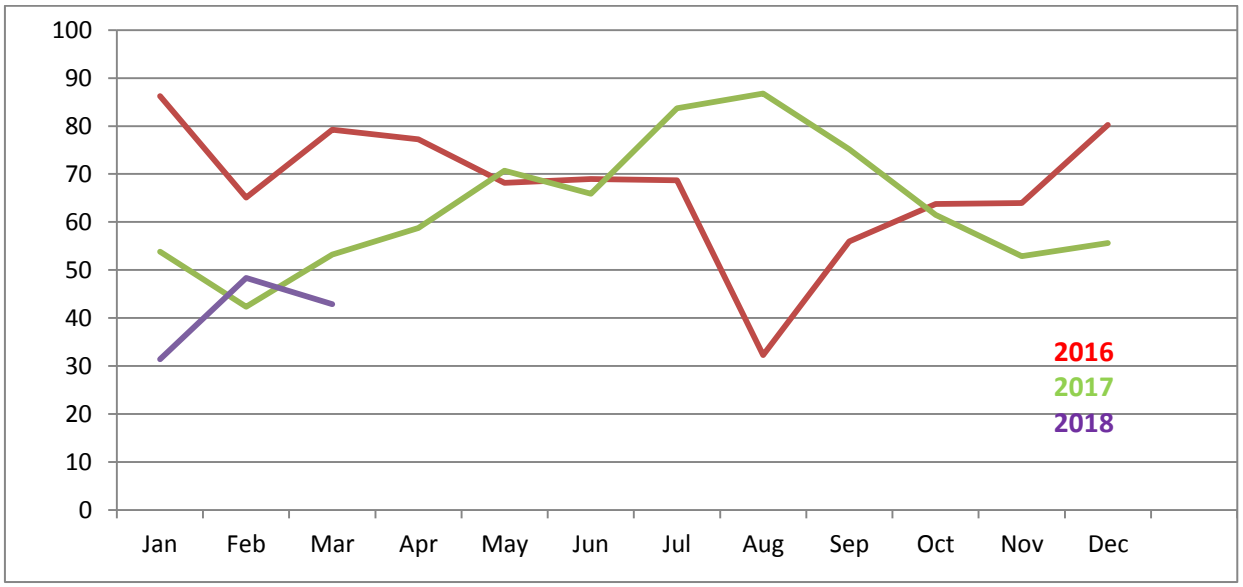
Use of Piperacillin-Tazobactam in CHFT from 2016 – 2018



c) Reduction of 1% or more in Carbapenem consumption against the baseline 2016.

There was a large increase in the use of carbapenems (broad spectrum antibiotics) at CHFT post 2013/14. This has been monitored closely due to continued national concerns regarding Carbapenamase producing enterobacteriacae (CPE). Review of patients on carbapenems has been a focus of virtual antibiotic ward rounds to ensure appropriate use and timely step-down/de-escalation from these antibiotics when clinically indicated. A number of different methods were used to communicate the message regarding the reduction in the use of these antibiotics, and as a result, we are seeing a reduction in consumption and remain below the national average.

Use of Carbapenems, CHFT 2016 - 2018



Part 2d Empiric review of antibiotic prescriptions within 72 hours

2c - Prescriptions Reviewed at 24-72 hours	2017-8	Target
Q1	88.6%	**25%**
Q2	88.6%	**50%**
Q3	90.0%	**75%**
q4	100.0%	**90%**
YTD average	91.8%	**90%**

Targets were met at Quarters 1-4.

Antibiotic Prescribing Guidelines:

Since May 2015 all adult antibiotic prescribing guidelines have been updated and approved by the Medicines Management Committee (MMC) and are available on the Trust Intranet site. There are ongoing challenges due to national supply problems with several antibiotics; guidelines are continually amended to reflect these supply issues.

Antimicrobial Ward Rounds

The Consultant Microbiologists continue to carry out both regular (ICU, vascular, haematology, oncology,) and targeted (supported by pharmacy) ward rounds. Review of broad-spectrum antibiotics such as carbapenems, complex patients, and those on prolonged courses of intravenous antibiotics are prioritised.

Outpatient Parenteral Antibiotic Therapy (OPAT) antibiotics:

An OPAT service is provided for Kirklees and Calderdale patients for up to 12 antibiotic administrations per day in each community area. A multi-disciplinary health economy-wide group has continued to meet regularly. Patients benefit from a weekly "virtual" review by a multi-disciplinary team led by a Consultant Microbiologist.

The table below shows the combined OPAT data from April 2017-March 2018.

Total Referrals	**541**
Bed Days saved	**4530**
Admissions avoided	**279**

Education and Training

Education and Training is provided in a number of ways and aimed at different professional groups including Medical staff (Trust-wide Junior Doctor Inductions, Anaesthetic registrar teaching, Orthopaedic registrar teaching, Trust-wide consultant mandatory training, clinical audit meetings), multi-disciplinary events (Infection Control Link Practitioners Workshops), the pharmacy team and to our potential future staff (third and fifth year Medical students). The recent intake of physician associates in the medical and surgical divisions (October 2017) have received teaching relating to antimicrobial prescribing.

A medicines management newsletter was written and distributed to staff highlighting the importance of Safer Prescribing in EPR with antibiotics as a focus.

Implementation of Electronic Prescribing and Electronic patient records

The Electronic Patient Record (EPR) was launched at the beginning of May 2017. This has enabled the virtual identification and targeting of patients for clinical review and follow up. Documentation

by the microbiologists in EPR has received positive feedback from the clinical teams suggesting an improvement in patient management. The number of drug-related incidents on EPR, including incidents involving antibiotic allergies has fallen since EPR implementation.

Southwest Yorkshire area-prescribing committee (APC) antimicrobial subgroup
The group drawn from clinical and pharmacist representation from CHFT, Mid Yorkshire NHS Trust, CCGs (Kirklees and Calderdale), Locala and primary care, aims to drive antimicrobial stewardship across the whole health economy and ensure that up-to-date guidelines and resources are available to prescribers. The group meets quarterly.

Key Challenges in 2017-8:
There have been challenges due to national supply problems with many antibiotics and guidelines have been amended to reflect these supply issues with alternatives made available.
The launch of EPR and e-prescribing at CHFT at the end of April 2017 has been the biggest challenge last year but the system is firmly embedded in clinical practice now and along with Bradford Teaching Hospitals NHS Foundation Trust we continue to review and improve appropriate prescribing.

Future Challenges
More challenging targets have been set in the Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) CQUIN. This has been updated for the new financial year - the piperacillin-tazobactam element has been replaced with a focus on increasing the proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index. This will require a further update of the local antibiotic guidelines and clinician involvement and engagement. More scrutiny and detail of the review element of the CQUIN is also required and an EPR "powerplan" is planned to support clinicians in this part of the clinical review process and ensure good documentation.

Ongoing shortages of broad-spectrum antibiotics will require us to keep reviewing our local guidelines and ensure prompt communication with our main prescriber groups.

6. Decontamination

The Health Technical Memorandum 2016 supersedes the Choice Framework for local Policy and Procedures (CFPP) series, which was a pilot initiative by the Department of Health.

The CFPP series of documents have reverted to the Health Technical Memorandum title format. This will realign them with HTM 00 – 'Policies and principles of healthcare engineering' and 'HTM 01-05: Decontamination in primary care dental practices' and the naming convention used for other healthcare estates and facilities related technical guidance documents within England. It will also help to address the recommendation to align decontamination guidance across the four nations.

In 01-01 and 01-06 DH will be retaining the Essential Quality Requirements and Best Practice format, this maintains their alignment with HTM 01-05 and the requirement of 'The Health and

Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' which requires that "decontamination policy should demonstrate that it complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice".

A safe decontamination service contributes to successful clinical outcomes and the wellbeing of patients and staff. The trust is required by law to comply with essential levels of safety and quality which are assessed by the CQC. These levels are set in law through registration requirements, one of which covers cleanliness and infection control.

HTM draws on current advice to provide comprehensive guidance on the management and decontamination of surgical instruments used in acute care, which includes clear definitions of what constitutes Essential Quality Requirements (EQR) and Best Practice (BP)

The Trust receives its decontamination service from a third party provider, BBraun Sterilog Yorkshire Limited. They use British and European Standards to demonstrate compliance with the essential requirements of the Medical Devices Directive (MDD 2007/47/EC) and have a quality system in place, ISO13485 against which they are independently audited by the British Standards Institute (BSI). This therefore offers assurance to the Trust that the service delivered is safe and achieves recognised standards.

Within the Decontamination Services Agreement (DSA) there are key performance indicators (KPIs) associated with logistics, quality outcomes and turnaround times that are embedded to ensure the delivered service continues to meet the Trust needs and expectations. The KPI's also ensure national and international guidelines and recommendations are met.

BBraun Sterilog Yorkshire Limited is recognised as having validated processes and as such is fully compliant against all guidelines as detailed via the National Decontamination programme where independent verification by the British Standards Institute (BSI) confirms compliance by a six-monthly review audit and certificated accordingly.

The operating reporting structure for the remainder of the contract term is as follows:

a) Joint Management Board (JMB) (strategic) comprising of the three partnering Trusts & Braun, currently Chaired by the Leeds Hospitals Trust.
b) Project Board (PB) (strategic) comprising of the partnering Trusts and Chaired as above.
c) Technical Review Committee (operational) comprising representatives of the three Trusts & Braun with the Decontamination Manager from Bradford NHS Foundation Trust. Chairing the committee.
d) Service Review Meeting (operational) comprising of site visits by Bbraun personnel

Day to day service delivery is monitored within the organisation to ensure the service maintains a fit for purpose status.

Reviews currently underway.

- Residual protein testing in line with revised HTM guidance
- The use of alkaline detergents to reduce rewash numbers
- Trolley replacement programme for surgical instrument transportation
- Supplementary turnaround process mapping exercise
- Capital equipment replacement programme at the Braun Pudsey facility

Endoscopy

The centralised endoscopy units at HRI and CRH have been designed and built to meet all relevant and current standards of build including Mechanical and Electrical services.

These state of the art units provide a first class, decontamination compliant service to our patients who can be confident the level of care delivered is supported by a rigorous audit regime associated with the service delivery.

The environment in which decontamination is carried out should be one that minimises both the risk of recontamination of flexible scopes and the possibility of generating aerosols. This implies the use of a separate room or rooms for the accommodation of clean (output) and dirty (input) work. These rooms are built into the endoscopy units and are used for this purpose only and access restricted to those staff performing decontamination duties or maintenance regimes.

The policy and guidance specifically designed for flexible endoscope reprocessing HTM 01 – 06 is driven by the aim of ensuring progressive improvement in decontamination performance both in centralised facilities and at a local level giving a continuous reduction in infection rates from both conventional (virus, bacterial fungi and spores) and prion infection disease.

The guidance provides options to flexible endoscope decontamination practices within which choices may be made and a progressive improvement programme established. Coordinated use of the guidance across the quality inspection processes will help the Trust to achieve a satisfactory level of risk control together with equivalent compliance with the “Essential Requirement” of the Medical Devices Regulations.

Additionally, further independent monitoring carried out by the Joint Advisory Group (JAG) which is recognised as a pathway of quality improvement, where acceptable standards for endoscopy units are continually met, and assurance that endoscopy training and quality are consistently achieved and therefore the patient experience and outcomes are of the standard expected.

A planned project to replace the equipment associated with decontamination i.e. Automated Endoscope Reprocessors, (AER's), Reverse Osmosis water treatment plants (RO) and Drying Cabinets is underway with the project completion date of September 2018 being the target date for full services commencement.

ENT

ENT Naso-endoscope reprocessing is carried out at the Huddersfield Royal Infirmary (Acre Mill) via a state of the art unit using automated processes with independent validation at the heart of the process and is in line with Best Practice principles as described in HTM 01-06. Calderdale Royal Hospital currently reprocess locally in the ENT OPD area where manual cleaning takes place after each patient use followed by a daily high level disinfection via the Endoscopy unit daily, which complies with the essential quality requirements of the HTM guidance for this flexible scope type. As part of the replacement Endoscopy equipment programme it is intended that the ENT scopes used at CRH will be reprocessed via endoscopy after each patient use, and the additional assets (scopes) required to facilitate this are being considered.

Decontamination Committee

The Decontamination Committee was established in 2016 and meets bi-monthly, with its core members drawn from multidisciplinary backgrounds including, Infection Control, Estates, Surgery, Medicine, Decontamination, Engie, Procurement, Facilities, General Managers and is Chaired by the Director of Planning, Estates and Facilities.

The aim of the Committee is to undertake the development of high quality decontamination processes, policy and procedures to ensure that a safe, properly managed and effective decontamination & sterilization process is adopted for all re-usable medical devices and equipment after and between each patient use. This is an essential element of routine infection control practice. The purpose of which is to provide a governance arrangement for the organisation to ensure effective and safe delivery of decontamination management and mitigation of risk through both internal and external review processes.

The Committee will support the safe delivery of decontamination in respect of all reusable medical devices and equipment across the wider organisation.

To date the Committee have reviewed compliance in regard to the following:

- Endoscopy / ENT Reusable Medical Devices via the Trusts independent Authorised Engineer Decontamination AE(D)

- BBraun Sterilog via British Standards Institute in recognition of MDD 93/42 EEC Annex V, section 3.2 under article 12

- Laundry in recognition of HSG(95)18 / CFPP 01-04and EN14065

- PPM regimes associated with hard FM services

- Pharmacy Manufacturing Unit compliance

Other work undertaken

- Establishment of validation processes associated with quarterly and annual maintenance regimes for Automatic Endoscope Reprocessors AERs.

The Trust is working with colleagues within the region of West Yorkshire where a sub group has been established that will review the delivery of decontamination services and how best to deliver these in future using commonly agreed processes and procedures. The group is called West Yorkshire Association of Acute Trusts Estates and Facilities Working Group.

The key aims of WYAAT EFWG are to create a shared purpose in providing excellence in the delivery of Estates and Facilities services and therefore:

- Review the decontamination processes across the WYAAT area and produce a process map for each stage which identifies number of instruments processed, process times, provision of decontamination equipment (washers/autoclaves etc).

- Identify the structure of each Sterile Services & Medical Devices in each organisation.

- Share each organisations Decontamination / Medical devices Policy for review and approach to compliance with a view to a standardised approach.

- Review the appointment arrangement for Authorising Engineers (Decontamination) with a view to standardisation

- Review the AP & CP compliance structures of each organisation

- Review the appointments of the ISO accreditation organisations used by each organisation with a view to standardisation

- Review HTM and ISO with a view to standardised approach to compliance

- Review each organisations approach to life cycling of medical equipment

7. Cleaning Services

The provision of cleaning services continues to be delivered by both an in-house service at HRI, Broad Street Plaza and Beechwood Community Health Centre and an outsourced service under the PFI (Private Finance Initiative) agreement by ISS Facilities Healthcare Services at CRH and OCS cleaning services at Acre Mill outpatients HRI.

A 24-hour Rapid Response Team continues to be provided at CRH and HRI for out of hours cleaning at both sites.

The Infection Prevention Quality Improvements audits continue to be successful in driving improvements across the Trust.

The Front line Ownership (FLO) whereby nursing staff at three different levels assess compliance with 10 key infection control areas quickly using a standardised tool continues to be used. Ward and Department Managers assess their areas weekly and report their finding to their Matron. Matrons provide a further monthly check. This helps to identify issues quickly and strengthens the assurance process.

Performance management systems are in place with key performance indicators produced on a monthly basis in line with the national specification for cleanliness. The monthly scores are displayed on each wards public facing board at the entrance to the ward and on the infection control notice board within outpatient departments.

At CRH site a monthly PFI Service Performance meeting is held including attendance by the General Manager for ISS, Facilities Manager for Engie and the General Manager for Calderdale SPC. The service performance report is discussed including audits/spot checks undertaken by the service performance team. This then reports to the Estates and Facilities Board

For Acre Mill HRI a service performance meeting is also held monthly. This is chaired by Savills and attended by service performance team, Engie representative and the manger for OCS cleaning services. Any spot checks undertaken and audits are discussed and concerns highlighted if not rectified. This then reports to the Estates and Facilities Board

The Trusts Service performance team also monitors cleaning on the HRI, Acre Mill and CRH site. The reports for all areas are sent electronically to heads of cleaning services with clear time scales for any concerns to be rectified. The services respond with signed rectified actions.

Schedule 2 monitoring audits are also performed by the Service Performance Team at CRH in accordance with the PFI concessions agreement but do not audit against the 49 elements.

The Facilities Matron has recently retired from the Trust, however there are plans to replace and to continue to work closely with all disciplines including cleaning services across both hospital sites and is the link between clinical and non-clinical teams. The matron attends the Trust Infection Control Performance Board as the Estates and Facilities representative.

Hydrogen Peroxide Vapour (HPV), a powerful bio-decontamination agent which reduces the biomass in the built environment, has continued to be used. The service is funded as part of the contract with Hygiene Solutions. The reactive service remains to be operated in house by cleaning services staff on both hospital sites primarily to provide high level decontamination of isolation rooms, bays, wards and theatres. HPV is used in the final decontamination of a clinical area after discharge of an infected patient to ensure the room is safe for the next patient.

HRI was re accredited in October 2017 as a training centre to deliver British Industry of Cleaning Science (BICSc) cleaning methods and safe systems of work.

Two members of cleaning services gained a BICSc licence to practice allowing them to deliver and assess BICSc training to all members of cleaning services. This will ensure a consistent method of cleaning is delivered to all areas at HRI. The aim is to have 50% of the workforce fully trained before the end of 2018.

HRI cleaning services were audited in April 2017 against the Cleaning Industry Management Standards (CIMS) as their quality management system. CIMS is the first consensus based management standard that outlines the primary characteristics of a successful quality cleaning organisation. HRI achieved the accreditation with honours.

HRI cleaning services began a rotational six monthly deep clean programme for wards, theatres and departments, in February 2018, tagged “moving from a deep clean to a keep clean”. The aim is to have all wards, theatres and departments deep cleaned twice a year.

8. Estates

The trust continued with the ongoing capital programme of improving the estate and resilience; improvement works include:

- Replacing endoscope machines in the Endoscopy units at CRH and HRI
- Upgrading software and new server for both the building management system and the door access system. This allows us to combine ID badges and fobs with better control.
- Replacement of all mixer taps on wards and departments including replacing older showers to help prevent water borne infections.
- Continual replacement of degraded pipework.
- Transfer pathology from mains water supply to separate standalone tank supply to aid the prevention of cross contamination of the water supply.
- Work has started to replace the infrastructure at the main entrance at HRI to include refurbishing the main entrance toilets together with lower ground and basements toilets directly below the main entrance.

In addition, work has continued on the site infrastructure in order to provide a safe environment that is compliant with HTM requirements, improvement works include:-

- Emergency lighting
- Fire detection
- Roof repairs
- Air handling units
- Windows, fire doors.
- Structural investigations
- Work was completed to re-locate the plaster room at HRI to create a new Rapid Assessment Area for the Emergency department, in the location of the old plaster room. This will assist in the transfer of patients from the Ambulance service.
- The floor in the wash=up area of the main kitchen was replaced, together with a new flight dishwasher, this will reduce the number of trips and falls.
- Continuation of the Fire compartmentation throughout HRI, to reduce the spread of fire risk.

Estates maintenance:-
The estates team continue to work through HTM action plans following independent compliance audits for engineering services in 2017/18 to ensure compliance with DH requirements the estates department are committed to replacing/upgrading services to ensure the very highest quality is delivered to patients and staff.

The Water and Air management/safety group ensure scrutiny and clinical governance arrangements are in place for both systems, any concerns/information is subsequently raised at the Estates and Facilities Quality and Safety Board and Infection Control Committee. Water and air Management is controlled and delivered via a written control scheme/Estates Management plan administered by the Authorising Engineer/External Consultant Microbiologist.

Waste management continues to be well managed across both CRH and HRI sites. 'Bag to Bed' continues to be used across all wards to reduce the number of bins, so reducing clutter and noise. Improvements in segregating clinical and medicinal waste streams have also continued.

Patient-led Assessments of the Care Environment (PLACE)

The Patient-led assessments of the care environment (PLACE) are the system used for assessing the quality of the hospital environment and replaced Patient Environment Action Team (PEAT) inspections in April 2013. The annual PLACE assessments put patient views at the centre of the assessment process using information gathered directly from patient assessors to report how well a hospital is performing focusing entirely on the care environment. The PLACE assessments teams are made up of membership councilors, governors, volunteers and staff and results are reported publicly to help drive improvements in the care environment and show how hospitals are performing nationally. In 2017 both HRI and CRH achieved positive results as follows:-

HRI :- Cleanliness 99.8%,	Condition and appearance of the environment 94.83%
CRH:- Cleanliness 98.86%	Condition and appearance of the environment 95.79%

PLACE assessments took place in April and May 2018 and whilst the Trust await verified scores the general consensus was very positive for both sites. The Assessment Teams observed improvements from the previous year in terms of the general environment at HRI and, following the introduction of dementia friendly décor, the ward environments at CRH. The final scores are expected mid-2018.

9. Infection Prevention and Control Audit Programme

The audit programme for 2017/18 was completed and all action points were shared with the divisions for follow-up. This programme included:

- Urinary Catheter annual prevalence audit
- Peripheral Venous Cannula prevalence audit
- Isolation audit
- Commode audit
- Sharps disposal
- CPE screening compliance audit

The Infection Prevention and Control Team (IPCT) are involved in the Quality Improvements audits which are undertaken on an unannounced basis in all clinical areas. The development of this process has interlinked services to provide a cohesive joined-up service; this is led by the Service Performance team.

The annual hand wash roadshow (HWRS) was undertaken throughout the organisation during September 2017. The Trust has 3 core elements for the prevention of cross infection via the hands of staff:

1. The '5 moments of hand hygiene' (WHO) which outlines when hands are to be washed/disinfected
2. Hand hygiene technique showing how to wash/disinfect hands
3. 'Bare below the elbow' to ensure staff are able to effectively wash/disinfect hands

All wards and departments were visited in the acute trust along with a number of health centres to carry out the hand hygiene technique practical, test for dryness using a skin hydration indicator, and to discuss skin care. In addition, during the visits an audit of compliance with 'bare below the elbow' was undertaken and a staff survey exploring hand health was completed.

A staff survey was completed by a total of 341 staff. The survey explored how staff look after their hands, possible causes of dry or sore hands and support available for those affected.

The IPC team assessed 513 staff throughout the organisation during the hand wash road show. The overall compliance was 85%: while this is a reduction on last year, it remains an improvement on the previous years and will remain a focus of Infection Prevention monitoring and intervention in 2018.

Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2017/18:

Section A	Infection Control Arrangements Policy
Section B	Notifiable Diseases Policy
Section C	Standard IPC Precautions Policy
Section F	Decontamination & Disinfection Policy
Section H	hand Hygiene Policy
Section K	Isolation policy
Section M	Management of Clinical sharps Injuries inc BBV Policy
Section P	Care of the Deceased patient Policy
Section S	TB Policy
Section T	MRSA including PVL Policy
Section W	Bed management policy
Section X	Pet Policy
Section Z	Blood Culture Policy

10. Education and training

IPC training remains high on the Trust agenda and Annual updates are mandatory for all staff and are delivered via an online training package that includes questions to assess knowledge and understanding.

Bi-annual face-to-face update sessions continue for all clinical staff ('Beyond the basics' for continuing staff and 'Right from the start' for new starters).

The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Bite size and bespoke training sessions are provided as and when required.

The IPCT also support Aseptic Non Touch Technique (ANTT) training, supporting compliance and safety metrics and zero harm; the Trust overall compliance at the end of March 2018 reported 90% compared to 85% in March 2017.

The IPCT provide comprehensive Infection prevention training for the Junior Dr induction day, including the assessment of ANTT.

Throughout 2017/18, the IPCT teaching sessions consistently score ‘good’ or ‘excellent’ in feedback from participants. The IPCT keeps update to date with current national policies and guidance and attending any relevant study days or conferences.

Appendix 1:

Link to the Infection Prevention & Control Arrangements Policy:

http://www.cht.nhs.uk/home/

Appendix 2:

Calderdale and Huddersfield NHS
NHS Foundation Trust

Terms of Reference	
Committee Name	**Infection Prevention & Control Committee**
Chairperson	Infection Prevention & Control Doctor
Date	June 2018 (review 2021)
Version	3
Receives reports/minutes from:	Occupational Health Estates and Facilities PFI Partners Decontamination Manager Divisions: • Surgery and Anaesthetic Services • Medical • Families and Specialist Services • Community PHE CCGs
Meeting frequency:	Minimum four times per year
Definition of Quorum	Eight members (five of which are not members of the IPC Team), including senior member of Infection Control Team and divisional representation
Membership	Current list available from IPC secretary
Core membership:	All members expected to attend every meeting or send a well-informed deputy in their absence.
Associate Membership:	Will be invited and expected to attend on an adhoc basis dependent on the agenda

Scope of responsibilities (duties): See below

Infection Prevention and control is a high priority within CHFT. The IPCC will ensure adherence and maintenance of standards as set out by the CQC and the Health and Social Care Act 2008.

Remit

- To receive assurance that Calderdale and Huddersfield NHS Foundation Trust provides a safe environment for patients, staff and visitors.
- To receive assurance from the clinical divisions that they are ensuring that the risk of infection within the healthcare setting is minimised
- Monitor performance against national and local objectives to reduce Healthcare Associated Infection (HCAI)

Accountability

- To the Trust Board via the Quality Committee.

Function of the Committee

a) Advice and Reports

- To advise the DIPC on all matters concerning Infection Prevention and Control within the Trust.
- To receive reports / assurance from:
  - Occupation Health
  - Estates and Facilities including PFI partners
  - Decontamination manager
  - Clinical Divisions
- To receive a report from:
  - Calderdale CCG
  - Kirklees CCG
  - Public Health England

b) Policies and Guidelines

- To examine and approve new and updated Infection Prevention and Control Policies and guidelines for the Trust.
- To monitor the implementation and application of the Trust's Infection Prevention and Control Policies.
- To ensure that the Trust implements infection prevention and control advice and guidelines contained in Department of Health documents and professionally approved reports.
- To ensure all staff abide by the Health and Social Care Act (2008), Code of practice on the prevention and control of infections and related guidance

c) Strategy

- To receive and endorse the Annual Infection Prevention and Control Programme and review its results.
- To receive the Trust's Annual HCAI Action Plan and receive quarterly review of progress.
- To lead the Infection Prevention and Control Education Programme for staff development within the Trust.
- To ensure that there is on-going audit and surveillance activity which mirrors the needs of the Trust and supports the Department of Health's strategic programme.

d) Surveillance

- To receive up to date reports and statistics advising the Committee on current status of hospital acquired infection and to make recommendations where appropriate.

e) Outbreak/incident Management

- To discuss and review all matters relating to outbreaks of infection in Trust premises and makes recommendations to address shortcoming and avoid recurrences.
- To draw to the attention of the chief Executive and Trust Board, any serious problems or hazards relating to infection control.

f) Collaboration and Partnerships

- To work closely with the Clinical Commissioning Groups.
- To establish partnerships and work closely with the local social care partners.
- To liaise with external agencies where appropriate e.g. Public Health England.

Composition of the Infection Prevention and Control Committee

The Committee is a multi-disciplinary one that includes senior professionals from key agencies across the Trust. The composition of its membership should assist the Committee to discharge its responsibility for overseeing all aspects of infection prevention and control within the areas managed by Calderdale and Huddersfield NHS Foundation Trust.

The Members of the Infection Control Committee

Infection Prevention and Control Doctor (Chair)

Medical Director & Director of Prevention and Control of Infection

Matron Lead Infection Prevention and Control

Senior Infection Prevention and Control Nurse

Infection Prevention & Control, Calderdale Council

Infection Prevention & Control, Kirklees Council

Public Health England

Senior Nurse, Occupational Health

Associate Director of Nursing - Medicine

Associate Director of Nursing - Surgery and Anaesthetics

Associate Director of Nursing – Families and Specialist Services (FSS)

Director - Estates and Facilities

PFI Partners (Calderdale Royal Hospital and Acre Mill)

Decontamination Manager

Non Executive Director

Other members may be co-opted as appropriate, e.g

- Catering manager
- TB Nurse

Minutes

- Open.
- Sent to the Trust Quality Committee and the Executive Board.
- Distributed to the rest of the organisation via the Divisional Representatives.

Updated June 2018

12. Care of the Acutely Ill Patient

To Note

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: 5.7.18	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient - The Board are asked to note the contents of the CAIP report.	
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:

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and is divided into six themes:

1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

The CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee.

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:

CAIP BoD July 2018.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors July 2018

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and is divided into six themes:

1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

The CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee. Performance is measured in the CAIP dashboard and a brief progress against themes noted below.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** Data released in March showed the SHMI for Oct 2016 to Sept 2017 = **100.81** (categorised as Band 2 – as expected. The next SHMI release will be Thursday 19th July for the period of January to December 2017. **HSMR** Data released in May 18 showed the HSMR for March 17 – Feb 18 is at 84.86 and is showing as a positive outlier (better expected range). **Alerting Conditions** No alerting conditions in the latest release of data **Learning from Death** Initial Screening Reviews continue to be allocated on a monthly basis. The online ISR tool has been revised and will be live on the intranet soon. The	SHMI and HSMR performance continues to be monitored and reported monthly to the Mortality Surveillance Group (MSG). The 'mortality risk' will be reviewed following the next SHMI release. The LfD Panel meet once every two months. Terms of reference are being agreed and will included dissemination of learning across the

	revised tool should be easier and quicker to complete. SU and the members of the LfD team have been attending clinical governance sessions to engage with doctors to complete these. It is anticipated that the completion rate will improve beyond the current level of approximately 30%. Cases escalated for Structured judgement reviews (SJR) have all been reviewed. See LfD quarterly report.	Trust. It has been acknowledged that there needs to be a variety of methods to share learning including individual clinician feedback. A template is being devised for the latter which will include areas of notable good practice as well as areas for improvement. Finally, the LfD policy will need to be reviewed within Q3 and presented to the Board for approval.
2) Reliability in clinical care	AKI and Sepsis continue to be prioritised for evidence-based care bundle improvement work. The focus for Sepsis is now the antibiotics within an hour element, which is showing an improved position. A team from ED has been accepted onto an improvement collaborative run by Haelo to look at antibiotic delivery in ED The AKI group has core membership and is looking at how best to improve the management of AKI patients in the trust. Awareness of how to access the AKI bundle in EPR is being raised.	The Sepsis group will continue to manage the performance of sepsis. Improving compliance around sepsis 6 elements is the focus of the coming months. The ED team will be returning for session 2 in October. The AKI group are continuing to develop agreed guidance to promote better patient care when AKI is alerted on EPR.
3) Early recognition and treatment of deteriorating patients.	The Deterioration Programme continues to focus on Recognition, Response and Prevention. There has been an in month (May 2018) improvement in observations performed on time to 70%. A task and finish group has been set up to implement NEWS2 by March 2019. As	The NEWS 2 T&F group will need to address the practice and behaviours associated with timely and quality patient observations. Whilst an ih-hours version of HOOP is not imminent there needs to be a more coordinated response to patients with a NEWS of 5 or more. There will need

	part of this implementation there will a planned Trust-wide training programme on NEWS2 with emphasis on importance of timely and quality observations. The audit earlier in the year showed that the was over escalation of patients with a NEWS of 5 or more and thus there needs to be a better understanding of who and when to escalate. This will also be addressed by the task and finish group. There has been a small pilot of additional HCA support in-hours to perform simple clinical tasks such as venepuncture. This is yet to be evaluated however this may indicate the resource needed towards an in-hours response to patients who are deteriorating.	to be more thought on this as 'over alerting' was the most quoted reason for junior doctors refusing to use Nervecentre in-hours. Safety Huddles may be one way of preventing further deterioration in patients. The CDs are going to have bespoke Quality Improvement training. As part of this it has been proposed the Safety Huddles is the project that CDs implement across the Trust with collaborative support from each other.
4) End of life care	Working with eth Learning from Deaths teams, the End of life collaborative is supporting some work I the stroke team around patient experience, engaging in a 6 month pilot study with relatives of those patients who have died on the stroke wards. Compliance around DNCAPR review dates and discussion date remains high.	Work is containing regarding how best to incorporate the ICODD (integrated Care of the Dying Document) into EPR
5) Caring for frail patients	The changes to the pilot service delivered by the Calderdale Community team is that Virtual Ward will now in-reach to the HRI site and the CIT team will in reach to the CRH site. This then gives a service to both sites for the Calderdale patients. There has been a significant reduction in activity at CRH for frail patients however this is how the service is designed so this is correct. There will still be some frail patients going to CRH site that walk into ED or if the YAS teams have	The location of frailty beds are currently being reviewed to assess the best place for them going forward. Calderdale Community team have been awarded the 'better care funding' to enable us to respond to YAS referrals in the future to prevent them coming to ED.

	brought them with a possible respiratory or cardiovascular condition.	
6) Clinical coding	The audit work continues within specialties and S&S cohorts. Average diagnosis and average Charlson scores remain consistent. Current performance on these indicators is in line with the top 25% in the country. Percentage of sign and symptoms is still high.	The new 3wte trainee coders will all be in post by mid-July. A Clinical Coding Action plan has been drafted for 2018/19 which looks to address some of the key issues affecting the quality of the coding. This will be finalised in July and progress monitored via Clinical Coding Improvement Steering Group. .

13. Quarterly Quality Report

To Note

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: 5.7.18	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: Quality Report Q1 2018/19 - To provide an assurance to Board members regarding work to improve quality of services and present quality data for Q1 2018/19.	
Action required: Approve	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: Quality Committee 2 July 2018	
Governance Requirements: Relates to patients receiving high quality and safe care.	
Sustainability Implications: None	

Executive Summary

Summary:

Paper and presentation on quality improvement across the Trust as at Q1 2018/19, including CQUINS.

This paper summarises:

i. assurances on quality that have been presented to the Board of Directors between April and June 2018
ii. an update on the three quality account priorities for 2018/19 for quarter 1.
iii. a presentation on quality indicators as at quarter 1 (25.6.18.), 2018/19

Main Body

Purpose:

Presentation of highlights of covering key work being undertaken to improve quality across the Trust by CQC domain with a more detailed quality report included.

Background/Overview:

A quarterly quality report is provided to the Board to share data regarding progress with quality improvement, CQUINs and the 2018/19 quality account priorities.

The Issue:

A presentation on the key quality data as at Q1 2018/19 will be provided at the Board meeting.

The report summarises the information shared with the Board on quality over the last three months.

Information on the 2018/19 quality account priorities of deteriorating patients, patient flow and end of life care at quarter 1 is also included within the enclosed quality report.

Next Steps:

The Board will continue to receive updates on service quality issues through papers presented to the Board.

The next formal update on quality at the end of Q2 will be presented to the Board.

Recommendations:

The Board is asked to note the quality reporting for the first three months of 2018/19, quality data as at quarter 1 2018/19 and the update on the three quality account priorities.

Appendix

Attachment:

APP H - Quality Report for Q1 2018-19 - v1.pdf

QUALITY REPORT for Quarter 1, 2018/19

1. Quality reports to the Board:

During the three month period April to June 2018 five reports relating to quality were presented to the Board which included: an update on mobile technology in maternity, experience of LGBT patients using Trust services and the Trust "Treat me well" pilot for learning disability patients.

1.1 Putting the Patient First Maternity EPR transformation project

In April the Board received a presentation from Family and Specialist Services staff, following success in the bid for a national digital NHS award, on how mobile technology would enable patients to easily access their data on the maternity EPR system, with a pilot planned for May 2018, thereby improving patient experience.

1.2 Experience of Lesbian, Gay, Bi-sexual and transgender (LGBT) patients using Trust services

National research has shown LGBT patients have poorer access and delays in access to healthcare services. At the Board meeting on 3 May 2018 the Board received a presentation on a patient's contrasting experience in 2 services within the Trust.

1.3 Learning Disabilities "Treat me Well Campaign"

The Board received a presentation from the matron for Learning Disabilities (LD) on 7 June 2018 on the national 'Treat me well' campaign. The 'Treat me well' campaign has been established by Royal Mencap to transform how the NHS treats people with a learning disability in hospital by bringing about practical changes, so people with LD always get the treatment they need and equal access to healthcare they deserve. The Trust is one of 15 trusts working with Royal Mencap in the first phase of a three year campaign.

2. Update on 2018/19 Quality Account Priorities, Quarter 1

An update on the three quality account priorities for 2018/19, care of the acutely ill patient (safe), patient flow (effective) and end of life (experience) is given below.

2.1 Care of the Acutely Ill Patient

Timely recognition and response to a patient who is deteriorating is vital to the patient's outcome and experience. The Deterioration Programme focusses on Recognition, Response and Prevention of deterioration in patients.

Recognition is dependent on timely and high quality physiological observations to formulate the patient's NEWS (National Early Warning Score). Patients with a NEWS of 5 or more are within the scope of this project. From previous observational studies it is known that the majority of observations are performed and recorded by HCA's who have been competency assessed to do so. There will be variation in quality of observations but this is difficult to measure. Furthermore whilst there has been an improvement in month (May 2018) only 70% of observations are recorded on time. There has also been a national patient safety alert

asking all Trust's to implement NEWS2 by March 2019. As a Trust we are committed to doing this and are in the process of creating a Task & Finish group for this. We will use this group to not only disseminate the training needed for NEWS2 but also use the same to imbed the importance of timely and quality observations. The latter will include re-training on how to perform quality observations as part of the patient's clinical assessment.

Response is dependent on whether the patient's NEWS score of 5+ triggers in or out of normal working hours. In-hours escalation is to ward based teams whereas out of hours this occurs through HOOP. The latter allows a central coordinator to review escalations and allocate the most suitable person, including themselves, to respond to that patient. A recent audit of all NEWS 5+ showed that approximately only 20% of a NEWS 5+ occurs for the first time and the majority of escalations are for patients who have a plan in place. It is therefore important to ensure that the right patients are escalated to avoid response fatigue. At present there is no central coordination of NEWS 5+ although Critical Care Outreach do maintain a watch list of patients of NEWS 7+ (approx. 400 patient per month) but do not have capacity to do the same for NEWS 5+ (approx. additional 400 patients per month). Previously all patients with NEWS 5+ were screened for sepsis however this has been superseded by the EPR algorithm.

Prevention will focus on the use of Safety Huddles. So far, the use of safety huddles has focussed on falls and pressure ulcers. Using EPR as a tool we are proposing a Trust-wide adoption of a wider remit Safety Huddle that will include patients with NEWS 5+.

The plan moving forward will be to focus on quality and timely patient observations as this is key to identifying patients who are deteriorating. The NEWS2 T&F will ensure that as part of the Trust-wide implementation of this that there is an additional focus on quality and timely patient observations. Parallel to this will be to emphasise that not every patient with a NEWS of 5+ is escalated especially if the patient has a plan in place such as End of Life or ward based care only. There has been a trial of additional HCA support in-hours albeit only on a small scale to see if this improves junior doctors' capacity to respond to tasks such as deteriorating patients in-hours. However the scope of implementing an in-hours centrally coordinated system such as HOOP may not be easily resourced and so the focus will remain on ward based escalation and timely response. Finally, Safety Huddles will be promoted as a way to prevent deterioration in patients who are at risk. This project will be led by Clinical Directors as part of their QI training supported by the Medical Director's Office.

2.2 Patient Flow – Improving timely and safe discharge

Why we chose this

There is a considerable evidence base for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, both in terms of safety, experience and the needs for the patients when they are finally discharged. It also creates financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs and increasing costs to local health economies.

Safe and timely discharge planning for all patients is an essential part of their overall plan of care and treatment. It is estimated that over 20% of discharges require some complex planning and coordination and for the other 80% of patient's good discharge planning is still essential.

To enable the most complex patients have an effective safe discharge and appropriate environment to return to after their stay, the Trust continues to work to enhance and develop the role of the discharge co-ordinator as Trusted Assessors so that these roles continue to be effective and work collaboratively with our partners.

For all of those other patients, improvement in discharge planning is a strong focus within the SAFER Programme with a number of improvement initiatives being implemented throughout 2018/19.

There is now a move towards looking at patients in hospital 7 days (stranded patients) and 21 days and above (super stranded patients). The focus on this group of patients has a compelling narrative that 'is the care episodes we deliver are appropriate however, are they delivered in a timeframe that suits the patient?

Unnecessary waiting can lead to harm / risk factors occurring that impact on people's long term health outcomes and well-being which can mean:

- Hospital acquired infections
- Losing mobility / muscle power
- Losing personal courage / resilience and confidence
- Break-in community / independent support i.e. family expectations / home care assistance
- Further exacerbate confusion, sleep deprivation and disorientation

46 per cent of people over 85 die within one year of hospital admission (Clark et al 2014)

Improvement work

The work being undertaken is through 3 work streams, bed avoidance, bed efficiency and bed alternates.

- Schemes implemented through the work streams to improve discharge are:
- Introduction of Criteria led Discharge
- Discharge Screening
- Trusted Assessor- reablement pathway
- Trusted Assessor- Nursing & Residential homes
- Standardised MDT
- New discharge pathways- Continuing Health Care Pathway- Transitional Pathway for patients who are unable to return home due having limb injuries
- Daily review and monitoring all patients who are medically for discharge
- Further development of the Transfer of Care Database
- Introduction of a weekly MADE

MADE (Multidisciplinary Accelerated Discharge Event)

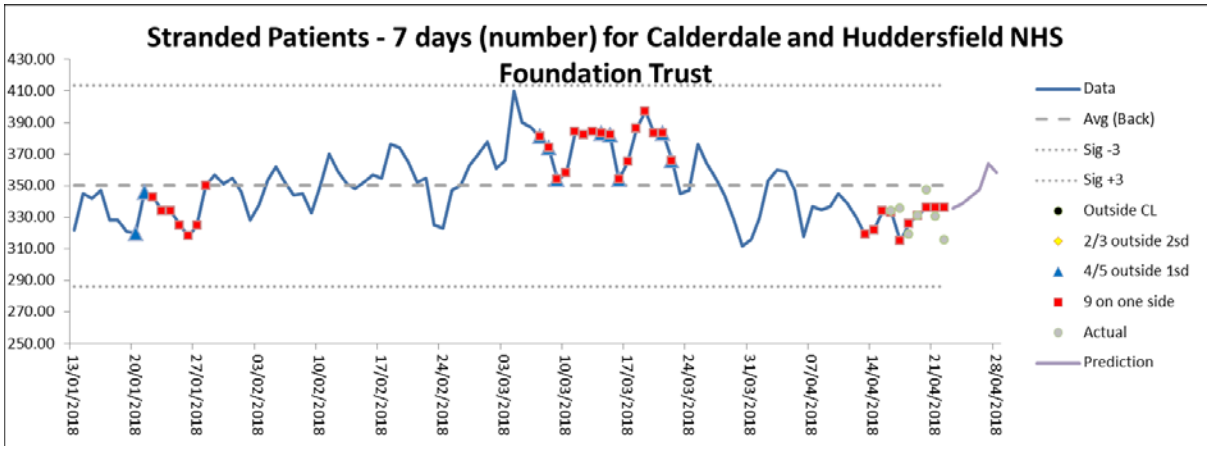
The MADE event was held on the 12th April 2018 in CHFT.
The event was facilitated by NHSI. We were joined by over 25 colleagues from across Primary Care, CCG, Local

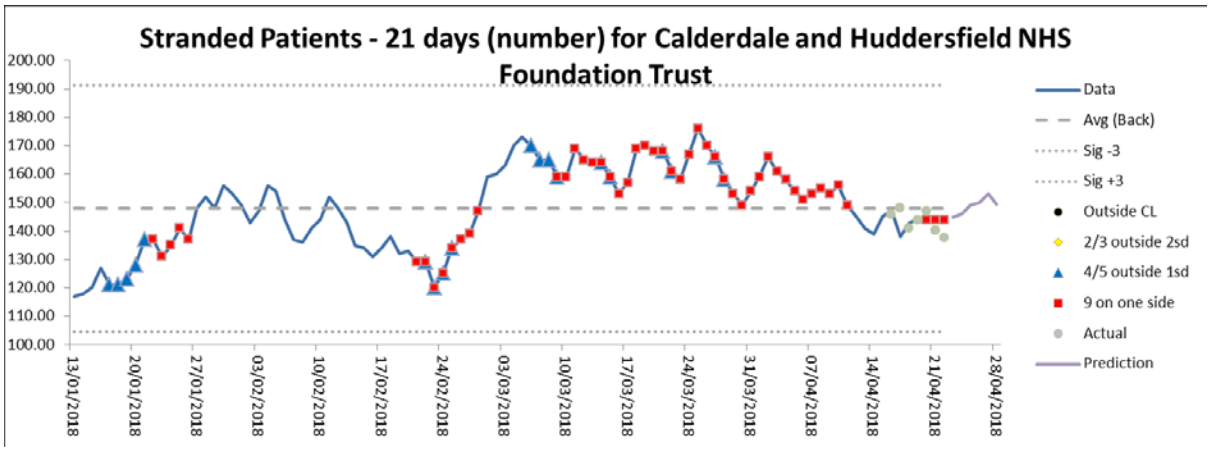
Authority, Locala, AGE UK and NHSI. It was an all-day event and each MADE team was formed with members of the multidisciplinary team from across CHFT and partners and the teams visited 17 wards across the two acute hospital sites.

Each team spent time with the ward medical and nursing teams to understand each patient's pathway with the aim of reducing any delays, expediting discharge and supporting the ward team with any particular challenges they faced with the clinical or discharge pathway.

Each team then discussed their findings with Silver (tactical command) actions and learning captured and metrics were reviewed on the impact of the event on the stranded and super stranded patient group.

Results





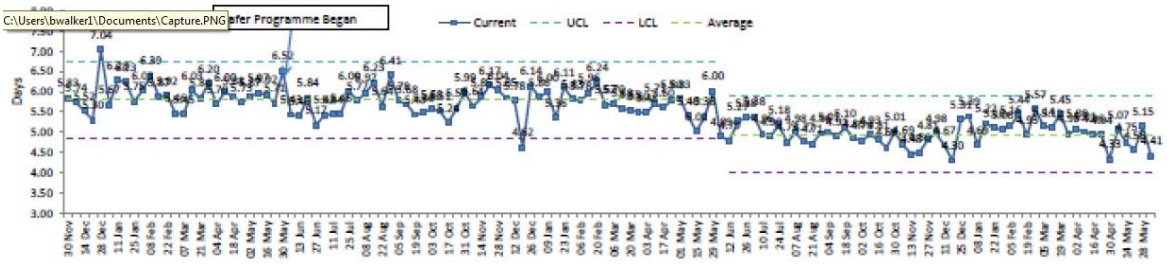
A weekly MADE has now been introduced with all key partners and stakeholders attending, these will be evaluated.

The stranded patient metric is now included as a measure in the SAFER Programme.

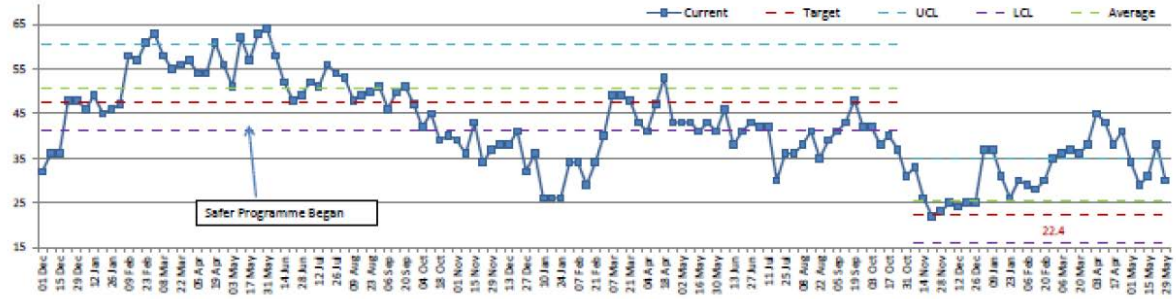
How did we do?

The Trust has a number of KPIs to measure the impact of the work initiated to improve discharge planning.

LOS



Patients in Hospital over 50 days



Patients in hospital who are medically fit for discharge

The winter months of 2017/18 were extremely challenging and what is described as the 'winter pressures' were unprecedented. This was due to a significant higher number of 'flu' cases with associated respiratory problems especially for those patients with chronic respiratory conditions and an increase in demand and acuity. This impacted on the whole system which consequently had an adverse impact on the number of medically stable patients remaining in hospital with social care unable to access services to support patients to be discharged safely and timely. At its highest on average we had 139 medically stable patients fit for discharge in January 2018 which has now reduced to 102 on average in June 2018.

Overview at Q1 2018/19

- The number of beds open as of 6 June 2018 was 644, this is on plan, with a divisional split of 135 medicine and 188 surgical beds. This compares to 680 in June 2017 and 698 in June 2016. A significant reduction in bed stock. The main areas of improvement evident in the data are an improvement in discharge.

- LOS (length of stay) for unplanned care is 4.7 days over the last three weeks (June 2018). This is amongst the lowest recorded and maintains a statistically significant reduction in this metric after June 2017. However, there is a slight caution as the number of admissions has increased, which may indicate a number of shorter stay patients have been admitted, lowering mean LOS.

- Stranded patient metric shows a holding of improvement at CRH after March 2018 (current number 135) and a stabilisation of the HRI position at 218 patients, significantly more than at CRH.
- The number of 'medically stable patients is 102, but with a bias towards HRI, with a 67/35 split.
- Number of patients staying over 50 days continues to maintain improvements made with a current count of 30 patients.

2.3. End of Life

Why we chose this

Improving end of life care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die, when their death is expected, it is vital that they receive appropriate end of life care.

The Trust is looking to sensitively establish that during these times a patients relatives felt that the needs of their loved one were meet in a compassionate and appropriate way.

Improvement work - Bereavement Survey

The bereavement survey is part of the Trust Learning from Deaths (LfD) programme. This programme supports a quality improvement plan relating to death and dying primarily for improved patient and family/carer experience and patient outcomes.

Each year, CHFT currently takes part in an annual bereavement survey, whereby Next of Kin (NOK) for deaths occurring in the month of May are sent a survey to comment on their experiences. Of the 90 surveys sent, the trust has a 30% response rate –i.e 27 forms being returned which is a small number when you considering that the Trust has 1500+ deaths a year.

In order to gather more meaningful feedback to both highlight the areas of excellent care and some areas that we can improve on, a 6 month pilot audit is being undertaken on our four stroke wards at CRH. The NOK of patients who have died from January to June 2018 will receive a bereavement survey 3 months after death. They will also receive a bereavement card a couple of weeks after the death of their loved one, which has been designed to offer support and inform them of the upcoming survey.

Below is what is written in the card:

> *On behalf of Ward XXX at CHFT we would like to offer our sincere condolences to you and your family following the recent death of your loved one.*
>
> *In a few weeks' time we will send you a bereavement questionnaire. We would truly appreciate your feedback as this will help us in the future.*

If you would prefer not to receive this questionnaire please send the enclosed form in the prepaid envelope. Our thoughts are with you at this difficult time.

As of June 18 there has been 25 surveys sent out with 9 returned (36%). On the bereavement survey there is a sentence at the bottom to encourage relatives to add their name and number if they would like us to contact them about the care their loved one received – we have had 5 out of the 9 that have responded. It has been a positive experience being able to talk with bereaved relatives to find out what we do well and areas to improve. The feedback on the whole so far has been positive with some areas we could improve in a quick timeframe, such as more chairs.

The last feedback forms will be sent out at the end of September with the hope of collating the data by the end of 2018.

The role of the trial is to ascertain whether it would be possible to send out bereavement cards and surveys for all deaths within the Trust to ensure we are truly gaining a representative sample of experiences within our Trust. We would also like to be able to add a number on the bereavement card for relatives to ring to offer support which is something we are currently working through.

Reporting
Reporting on End of Life Care is via the Clinical Outcomes Group.

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Quarterly Quality Report
Q1 2018-19

Quality Committee
2 July 2018

Board of Directors
5 July 2018

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Summary

Indicator	Target	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
HSMR (rolling 12 mnth)	100	113.94	106.12	103.74	101.90	93.63	91.59	86.10	82.74
SHMI	100	113.88	112.21	113.34	112.88	101.60	100.87	Not yet Available	Not yet Available
A&E within 4Hr Performance (Incl. CH)	95%	94.10%	94.40%	93.81%	94.42%	90.58%	92.75%	91.09%	TBC
% VTE Risk Assessments	95%	95.10%	95.10%	95.10%	95.34%	91.44%	92.26%	97.00%	96.93%
MRSA	0	0	0	1	1	2	1	0	2
C. Difficile	6	6	11	6	9	6	6	11	17
Friends and Family Response Rate (Inpatient)	26%	32.79%	34.96%	33.50%	33.98%	24.17%	32.01%	33.93%	39.34%
Friends and Family Response Rate (A&E)	13%	14.50%	12.41%	13.73%	10.03%	7.90%	12.15%	10.62%	10.50%
Staff Sickness (YTD)	< 4.00% - Green 4.01 -4.5 Amber >4.5% Red	4.45%	4.19%	4.38%	4.24%	3.84%	3.92%	4.37%	TBC

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Quality Account Priorities

Care of the Acutely Ill Patient: Improving outcomes through recognition, response and prevention of deterioration in patients

Recognition

- Recording of NEWS of 5 or more – some improvement in May with 70% of observations being recorded on time.
- Task and finish group being established to respond to NPSA Alert (NEWS2) received in Q1 requiring Trusts to implement NEWS2 by March 2019 , which improves the detection of clinical deterioration due to sepsis in adults.

Response – Audit shown most escalation of NEWS 5+ scores is for patients with a plan in place (only 20% occurs for first time), ongoing work to escalate the right patients and avoid alert fatigue

Prevention - extending safety huddles to include patients with NEWS 5+

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Quality Account Priorities

Patient Flow – Improving Timely & Safe Discharge (right patient, right place, right time)

- •MADE (Multi-disciplinary accelerated discharge event) held in April with local partners and NHS I.
- •Visited 17 wards and teams to understand patient pathways to reduce delays, expedite discharge and challenges,
- •Stranded patient metric now part of SAFER Programme measures and weekly MADE introduced.
- •Stranded patient metric shows a holding of improvement at CRH after March 2018 (current number 135) and a stabilisation of the HRI position at 218 patients, significantly more than at CRH.

- Length of stay (LOS) for unplanned care is 4.7 days over the last three weeks (June 2018) - amongst the lowest recorded and maintains a statistically significant reduction in this metric after June 2017 – increase in number of admissions may reduce the mean.

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Quality Account Priorities

Experience – End of Life – Learning from Deaths

- Bereavement survey – 6 month pilot audit on 4 stroke wards at CRH for next of kin for patients who died between January and June 2018 being sent bereavement card and then a survey to obtain meaningful feedback on care (option to opt out)
- At June 2018, 25 surveys sent out, 9 returned (36%) – positive feedback on the whole

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CQUIN

CQUINS

Advice and Guidance CQUIN progressing well.

Haelo Sepsis quality improvement project to treat red flag sepsis in one hour in ED – first Haelo workshop held in June

Reduction in antibiotic consumption per 1,000 admissions – challenges in reducing consumptions rates

Preventing ill health by risky behaviours - alcohol and tobacco – no improvement noted. Gathering more baseline data to better understand our position.

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Safe

- **Pressure Ulcers**
- Increase in category 2 pressure ulcers reported over last 12 months reflective of national position related to better reporting
- Datix being refreshed to include moisture lesion as reporting category.
- Manual handling and management of continence current focus of improvement work through the Pressure Ulcer Collaborative
- QI lead in Quality Directorate supporting Pressure Ulcer Collaborative and continues to work through improvement plan
- Currently revisiting validation process and reporting through IPR – includes review of orange panel effectiveness

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Safe

- **Medicines Management**

- CQC actions on medicines management underway on storage, security, recording and administration of medicines and fridge temperature checks - fundamental five introduced, a daily check undertaken by the nurse in charge to ensure that the 5 basic safety checks are undertaken, including a check of CD drugs and fridge temperatures. Being captured electronically from June.

- **Safety Thermometer** - The target of 95% of patients being free of harm on safety thermometer day not achieved. Performance = 92.5%
- "old" pressure ulcers / patients admitted with pressure ulcers
- Hospital acquired pressure ulcers, VTEs and urinary infections and catheters

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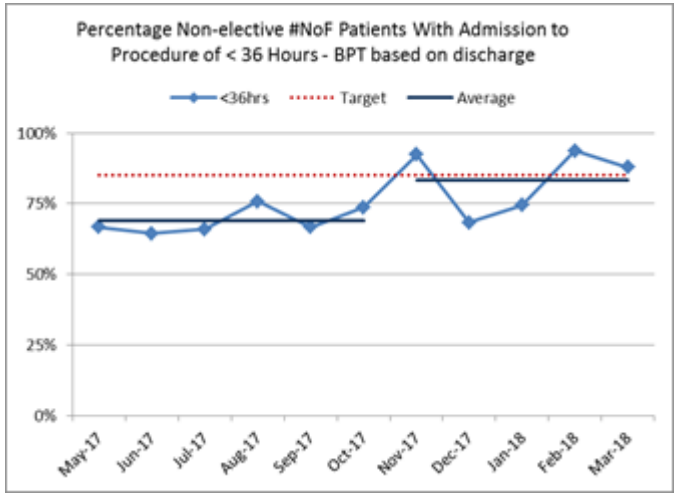
Effective

- Fracture Neck of Femur – first quarter to hit the 85% target of patients to theatre within 36 hours.



- **Healthcare Associated Infections**

  No MRSA infections

- **Mortality**

  HSMR and SHMI continue to reduce.

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Caring

- **National surveys:**

- **2017 National Adult In Patients Survey results published June 2018**
  - Scored about the same for all but 1 question where Trust was better than most Trusts for support from health or social care after leaving hospital
  - Increase in scores in patients being asked about the quality of their care
  - Improved scores on patients being given understandable responses from doctors on important questions, emotional support from hospital staff, family / home circumstances being taken into account when planning discharge, written information on medicines, information on how to complain
  - CHFT continued to score well on a number of privacy and dignity questions, as well as fluids and admission dates.

  - Results being analysed and will be reviewed by the Patient Experience and Caring Group, Identifying any opportunities for improvement.

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Caring

- **Friends and Family Test (FFT)**
  - Within Surgery division FFT for May for in patients for all but 1 ward achieved a supergreen rating, indicating it is in the top 20% of benchmarked organisations, with highest score on ward 14 of 81.6%
  - Community division continues work to increase opportunities for patients to response to improve the response rate to FFT, moving from using text messages to a web-based tool or postcard; some increase has been noted

- **Patient Experience**

Work ongoing to develop divisional patient experience plans linked to Trust-wide priorities identified by the Patient Experience and Caring Group – such as engagement and inclusion, responding to feedback, including national and local surveys

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Caring

- **Complaints**
- WEB discussion on complaints held 14 June 2018, with further report planned for September
- Revised report template improving quality of responses to complainants
- 22% complaints overdue , majority up to 1 month overdue (24), 6 complaints 1-2 months overdue, 2 between 2-3 months overdue (tracker as at 22.6.18.)
- 20 of 32 overdue complaints in medical division.
- Improvement work to include introducing quarterly meetings with complaints team and senior divisional management, tracking reasons for delays, online training being developed, complaints panels

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Responsive

- **Emergency Care 4 hour standard** – improving position from 87.82% in Q1 2017/18, on track to achieve 92.75% in Q1 2017/18, better than any quarters in 2017/18

- **Cancer Group** – first meeting held in May, purpose is to ensure cancer pathways support performance and improve patient experience, sub-group of Quality Committee

- **Cancer Pathways** - Introducing an improvement methodology known as Red to Green, will monitor the days when the pathway was on plan (Green) and when delays were occurring (Red)

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Well Led

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We've been inspected and rated by CQC as...

Good

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018

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And here is what they found

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Well Led

CQC

- Trust action plan on 23 must dos and 36 should dos being developed to submit to CQC by 20 July 2018
- Divisional improvement and sustainability plans for core services being developed
- CQC response group established end of June 2018 to monitor delivery of the Trust action plan and report to Quality Committee
- **Development**
- Further CLIP leadership programme underway
- Band 6 and 7 leadership development programme

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Well Led

Quality Improvement

- Development of Quality Strategy and engagement with colleagues continues - current focus on linking Quality Strategy with organisational development and Trust strategies
- Developing quality improvement (QI) capacity and capability:

- 4 staff completed NHS Improvement Quality, service improvement and re-design (QSIR) practitioner programme on QI methodology
- Quality Improvement Manager undertaking further programme to deliver in-house training, with training plan being developed by end of September for delivery from November 2018
- Exploring Life QI project management platform for Trust online home for QI projects and QI resources

14. Governance Report
a.Board to Ward Visits Feedback
b.Board meeting dates proposal
c.Approval of terms of reference:
-Quality Committee
-Workforce Committee
-Finance and Performance Committee

To Approve

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: 5.7.18	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: Governance Report - GOVERNANCE REPORT - JUNE 2018 - This report brings together a number of governance items for review and approval by the Board.	
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: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
a. Board to Ward Visits Feedback
b. Board meeting dates proposal
c. Approval of terms of reference:
- Quality Committee
- Workforce Committee
- Finance & Performance Committee

Main Body

Purpose:

The Trust has a cycle of governance and this report sets out those areas that are due for review by the Board this month.

Background/Overview:

a. Board to Ward Visits Feedback
The attached is a summary of the Board to Ward visits feedback between April and June 2018. There are 18 upcoming visits being scheduled for the next quarter which are described in the report.

b. Board meeting dates proposal
The attached is a proposal of the future Board of Directors meetings up to March 2020. The proposal describes when the public sessions will take place and when the Board will be held in private only. These private sessions will be focussed around strategy development. Should urgent items require to be taken we will have a short public section of these meetings by exception.

c. Approval of terms of reference. As part of the annual review of committees, each one has reviewed its terms of reference and revised versions are presented to the Board for approval.
- Quality Committee
- Workforce Committee
- Finance & Performance Committee

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to:
- NOTE the Board to Ward Visits Feedback
- APPROVE the proposal for future Board meeting dates
- APPROVE the terms of reference for the Quality Committee, Workforce Committee and Finance & Performance Committee

Appendix

Attachment:

APP I - Governance Report.pdf

BOARD TO WARD VISITS – APRIL – JUNE 2018

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
APRIL 2018							
18.4.18	9.00	Andy Nelson	Vicky Pickles	Ward 8d - CRH	Jan Carter	Linda Denham	Overall it was a pleasure to visit a positive and welcoming ward that appeared to be well managed. The team seemed to work well and the environment was clean and organised. Patient information was up to date and clear. There was a focus board on sepsis and information about the staff on the ward. The team described a positive experience and it certainly felt that things ran well. Both Barbara and Qusva spoke confidently and enthusiastically about the ward. They were clearly proud of the ward and demonstrate good, positive leadership.
23.4.18	11.30	Richard Hopkin	Lesley Hill	Medical Engineering, HRI	Lesley Hill	Luke Whitley	We met with Luke Whiteley the team leader for the service at HRI. We discussed: • What the service does (testing, repair, maintenance) • Number of items (19,000) • How we know where they are • What we do with new equipment • How trial equipment is managed • The team • What would make things better- more staff

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							• The draft external review that has been done by the managers for the Leeds and Bradford services • The teams desire to have the same quality accreditation as Leeds and Bradford • How the team is kept up to speed with what is happening within the Trust Bed Repair Team We met with Steve Barker, bed repair technician. We discussed: • What the service does • Servicing vs repair of equipment • Salvaging spare parts from equipment that is beyond repair • How it used to be with external contractors doing repairs • Some of the issues we face with beds and equipment going missing There were no specific actions from the visit.
MAY 2018							
11.5.18	3.00	Karen Heaton	Suzanne Dunkley	Pathology, HRI	Sarah Ramsden		We met with Sarah Ramsden who showed us around the Department. I was absolutely blown away by the tech, the

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							team and your passion. Big thanks too to Ryan, Karen and the two Michaels. What committed, talented and amazing people. I can now better understand your requests for staff at vacancy control and will speak to Rob next week about your apprenticeship ratio. I love what you are doing to grown your own and now appreciate the short term issue. Finally, I have just spoken to Mandy Griffin, MD of THIS and she has confirmed there are some listening events planned very soon at which we can discuss your EPR issues and needs. There's a big buildathon planned soon and after that we should be in a position to look at more specific issues. It was an absolute pleasure to meet you and I hope that you are able to come to one of our Workforce Committee Hot House topics, which start in June. Much admiration.
JUNE 2018							
5.6.18	12.30	Phil Oldfield	Gary Boothby	Ophthalmology, HRI	Qusva Ilyas		General discussion regarding the services offered within OP Visit focussed around a tour of the department.

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							Qusva showed the new equipment (Gallileo) purchased and showed the results that this provides. Qusva described the clinical pathway and the various triage and skill mix that takes place. She would encourage more of this to support staff development along with efficiency but there is some reluctance from medical colleagues on this. There was a view that activity continues to grow and there may be a need for more space in the future. This may include more community clinics. Extended working hours and evening clinical are successful and popular with patients. Saturday morning clinics also take place to meet demand rather than patient choice. Notice boards were up to date and the environment was clean including stickers to confirm when items had been cleaned. Facilities were in good order. Awaiting a fence for children's play area which showed evidence of taking account of the patients' needs A number of staff absences were discussed but mainly linked to maternity. Where

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							there was long term sick (only 1) this is linked to a retirement. Short term is being managed. Regarding appraisal and mandatory training there was a must do attitude and not achieving was not an option. Phil and I were made to feel welcome. Qusva and Helen were both very professional and understood the need to change models of care to stay relevant. Qusva and the senior matron did not have any questions for Phil or I Qusva had raised an opportunity with the senior management team around further pump priming for staff training and GB was to check on progress of this. Qusva also flagged an opportunity to split the rooms where wet AMD injections take place which could then lead to increased throughput and efficiency. GB to flag with management team.

UPCOMING VISITS

1. SAU – HRI
2. Stroke floor Ward 7 - CRH
3. Comms Department, HRI
4. Gynae – CRH
5. Infection Control Team
6. Huddersfield Pharmacy Specials, HRI
7. OT Department – CRH
8. Ward 8, HRI
9. THIS: Oak House
10. THIS: Acre House
11. Quality Team, Glen Acre House
12. ED, HRI
13. ED, CRH
14. Paediatrics: Ward 3, CRH
15. Paediatrics: Ward 18, HRI
16. Fracture Clinic, HRI
17. Occupational Health, CRH
18. Sexual Health, Broad Street

Board of Directors Meetings Dates Proposal

Public / Private

2018 Dates		
Dates	**Location**	**Private / Public**
Thursday 23 August	Boardroom, CRH	Public
Thursday 6 September	Large Training Room, CRH	Public
Thursday 4 October	Boardroom, HRI	Private
Thursday 1 November	Large Training Room, CRH	Public
Thursday 6 December	Boardroom, HRI	Private
2019 Dates		
Dates	**Location**	**Private / Public**
Thursday 3 January	Large Training Room, CRH	Public
Thursday 7 February	Boardroom, HRI	Private
Thursday 7 March	Discussion Room 1, LC HRI	Public
Thursday 4 April	Large Training Room, CRH	Private
Thursday 2 May	Large Training Room, CRH	Public
Thursday 6 June	Boardroom, HRI	Private
Thursday 4 July	Large Training Room, CRH	Public
Thursday 1 August	Boardroom, HRI	Private
Thursday 5 September	Large Training Room, CRH	Public
Thursday 3 October	Boardroom, HRI	Private
Thursday 7 November	Large Training Room, CRH	Public
Thursday 5 December	Boardroom, HRI	Private
2020 Dates		
Dates	**Location**	**Private / Public**
Thursday 2 January	Large Training Room, CRH	Public
Thursday 6 February	Boardroom, HRI	Private
Thursday 5 March	Large Training Room, CRH	Public

QUALITY COMMITTEE

TERMS OF REFERENCE

Version: **1.1** **1.3** **1.3** **1.4** **1.5** **2**	(first draft circulated for review to Chair / Director of Nursing) Amendments prior to Trust Board Amendments after submission to Quality Committee Further amendments Further amendments Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3
Appendices	**1.** List of members **2.** Sub groups **3.** Reports aligned to CQC domains
Approved by:	Board of Directors (Date)
Date issued:	January 2018
Date approved:	4 June 2018 by Quality Committee
Review date:	January 2019

QUALITY COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Quality Committee. The Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority

2.1. The Quality Committee is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board

2.2. The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4. The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1. The purpose of the Quality Committee is:

- To provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care
- To ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

3.2. The Quality Committee is responsible for:

- Reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.
- Seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.
- The ongoing monitoring of compliance with national quality standards and local requirements.

4. Duties

The duties of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

Quality improvement

4.1. To review proposed quality improvement priorities and monitor progress and compliance against defined quality priorities.

4.2. To maintain a focus on patient experience through a number of data sources including stories; friends and family test; national surveys and seek assurance that the Trust is learning from experience.

4.3. To oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication and review progress against these.

4.4. To review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding progress with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

4.5. To receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

4.6. To establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

Governance and risk

4.7. Ensure all quality risks are appropriately managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the high level risk register and Board Assurance Framework

4.8. Promote a just and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

4.9. Seek assurance on the process for reviewing and reporting incidents and serious incidents and sharing the learning from these.

4.10. Seek assurance against compliance with NICE guidelines / guidance and any rationale for non or partial compliance

4.11. Seek assurance that there are effective systems of governance, performance and internal control in relation to clinical services, research and development through an annual governance review.

4.12. Review performance against the quality and safety aspects of the Integrated Performance Report

4.13. Undertake an annual review of the quality impact assessment process to gain assurance that the risks to any impact on quality arising from proposed cost improvements have been managed and mitigated.

4.14. Ensure any procedural , policy or strategy documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural Documents (Policy for Policies) and any key national standards and best practice

4.15. Receive a quarterly report from each of the sub-groups to the Committee.

4.16. Establish an annual work plan which the Committee will review quarterly

4.17. Produce an annual report against delivery of the terms of reference of the Quality Committee.

Quality and safety reporting

4.18. In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

Audit and assurance

4.19. To approve and oversee delivery of the clinical audit plan and a review of its findings.

4.20. To receive all reports regarding the Trust produced by the Care Quality Commission and other external bodies, e.g. Royal Colleges, and seek assurance on the delivery of actions to address recommendations

4.21. Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions

4.22. To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken to address these.

4.23. Gain assurance from divisions that they implement the activity required to achieve compliance with service quality and governance standards.

5. Membership and attendance

5.1. The Committee shall consist of the following members:

- Three Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Executive Director of Nursing
- Chief Operating Officer
- Medical Director
- Executive Director of Planning, Estates and Facilities
- Executive Director of Workforce and Organisational Development

5.2. The following shall be required to attend all meetings of the Committee:

- Assistant Director of Quality and Safety
- Deputy Director of Nursing
- Head of Governance and Risk
- Governance administrator (notes)

5.3. The Chair of the Board of Directors will appoint a representative of the Council of Governors to attend each meeting as an observer. The appointment will be reviewed each year.

5.4. The following shall be required to attend the meetings focused on divisional performance (one meeting per quarter):

- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Surgery & Anaesthetics
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Medicine Division
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Families and Specialist Services
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Community Division

5.5. Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.6. A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive and one an Executive Director.

5.7. Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Administrator of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.8. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1. The Committee shall be supported by the Administrator, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation
- Maintaining a record of attendance.

7. Frequency of meetings

7.1. The Committee will meet every month and at least nine times per year.

8. Reporting

8.1. The Committee Administrator will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2. An action schedule will be articulated to members following each meeting and must be duly completed and returned to the Administrator for circulation with the agenda and associated papers.

8.3. The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4. Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next Trust Board of Directors meeting.

8.5. A summary report will be presented to the next Trust Board meeting.

9. Review

9.1. As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2. The terms of reference of the Committee shall be reviewed by the Trust Board of Directors at least annually.

10. Monitoring effectiveness

10.1. In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

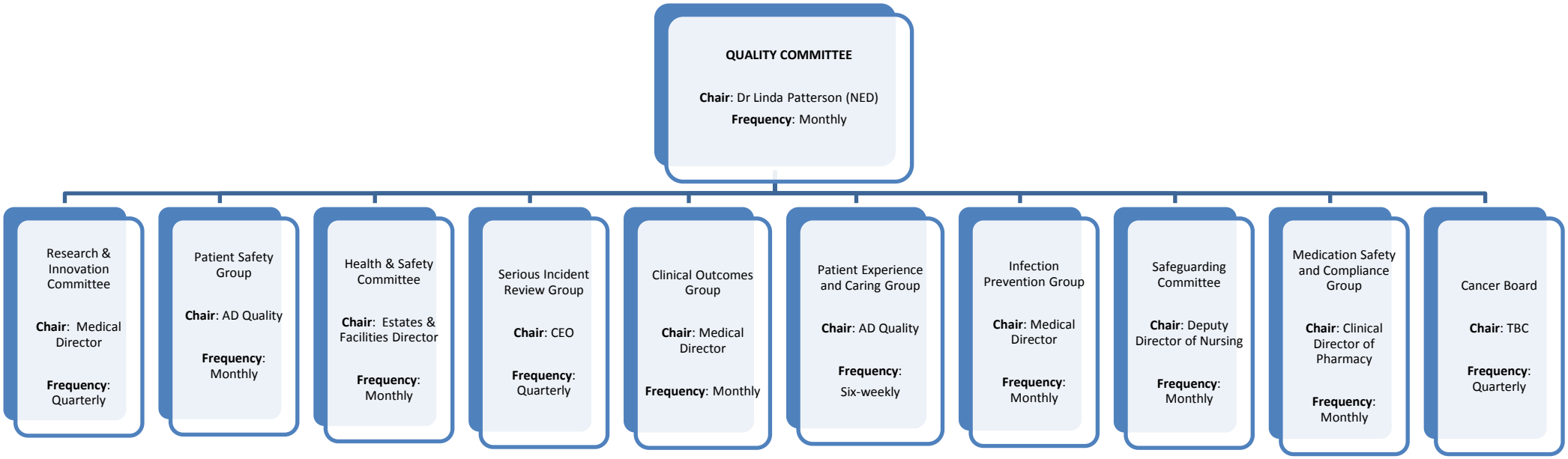
- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 5 working days prior to the meetings;
- The action point from each meeting are circulated within two working days, on 80% of occasions

Appendix 1
Members and required attendees of the Committee

Title	Required at
Non-Executive Director ***(Chair)***	All meetings
Non-Executive Director ***(Vice Chair)***	All meetings
Non-Executive Director	All meetings
Executive Director of Nursing	All meetings
Chief Operating Officer	All meetings
Medical Director	All meetings
Executive Director of Planning, Estates & Facilities	All meetings
Executive Director of Workforce & Organisational Development	All meetings
Assistant Director of Quality and Safety	All meetings
Deputy Director of Nursing - Corporate	All meetings
Head of Governance and Risk	All meetings
Council of Governors	All meetings
Governance Administrator ***(Minutes)***	All meetings

Quarterly Representation	Required at
Surgical Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
FSS Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
Medical Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
Community Division Director of Operations / Associate Director of Nursing	Quarterly meetings

Appendix 2
Sub-groups



Appendix 3
Reports aligned to CQC domains

CQC domain	Reporting to Quality Committee via
Safe	▪ Safeguarding (Six monthly and annual reports) ▪ Patient Safety Group (Two reports per quarter) ▪ Health and Safety (Two reports per quarter) ▪ Board Assurance Framework (Quarterly) ▪ Corporate risk register (Two reports per quarter) ▪ Medication Safety and Compliance Group (Monthly) ▪ Falls Collaborative (Six monthly) <u>As required</u>: ▪ Prevention of future death reports, ▪ Incident reports / action plans.
Effective	▪ Organ donation (Annual reports) ▪ NICE guidance compliance (Six monthly) ▪ Clinical audit plan (Six monthly report) ▪ Clinical Outcomes Group (Two reports per quarter) ▪ Mortality Surveillance Group (Two reports per quarter) <u>As required:</u> ▪ Service specific reports / invited service reviews as required – detailed in workplan
Experience	▪ Patient Experience and Caring Group (Two reports per quarter)
Responsive	▪ Cancer Board minutes (Quarterly) ▪ Quarterly report (Quarterly) ▪ Quality Account ▪ Quality Annual report
Well-Led	▪ CQC report (Monthly) ▪ Research and Innovation (Six monthly report) ▪ Quality Impact Assessment process (Annual) ▪ Divisional Patient Safety and Quality Board Reports (Quarterly) ▪ Serious Incident Review Group (Quarterly) ▪ Infection Control Committee minutes (Quarterly)
Overall	▪ Quality Performance Report (Monthly)

WORKFORCE COMMITTEE

TERMS OF REFERENCE

Version:	2.4 Amendments following review by Committee Chair and Director of Workforce and Organisational Development
Approved by:	Board of Directors
Date approved:	**
Date issued:	**
Review date:	May 2019

WORKFORCE COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Workforce Committee ("the Committee").

2. Authority

2.1 The Committee is constituted as a Standing Committee of the Board of Directors ("the Board"). Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

3.2 The Committee will assure the Board of the achievement of the objectives set out in the 'A workforce fit for the future' section of the Trust's 5-year strategy.

3.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

4. Duties

4.1 The Committee is required to:-

4.1.1 Consider and recommend to the Board, the Trust's overarching workforce strategy and associated activity/implementation plan.

4.1.2 To obtain assurance of the delivery of the strategy through the associated activity/implementation plan.

4.1.3 Consider and recommend to the Board the key workforce performance targets for the Trust and

4.1.4 To receive regular reports to assure itself that these targets are being achieved and to request and receive exception reports where this is not the case.

4.1.5 Review the workforce risks of the high level risk register and the Board Assurance Framework.

4.1.6 Hold the Executive Director of Workforce and Organisational Development to account for appraising it in relation to risk, risk mitigation and future

activity/plans.

4.1.7 Receive reports in relation to internal and external quality and performance targets relating to workforce.

4.1.8 To assure the Board that these targets are being achieved and to request and receive exception reports where this is not the case.

4.1.9 To conduct reviews and analysis of strategic workforce issues and to agree operational response.

5. Membership and attendance

5.1 The Chair of the Committee is a Non-Executive Director and at least one other Committee member will be a Non-Executive Director.

5.2 The following is the proposed list of invitees to the bi-monthly strategic sessions:-

Group one: Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance and their Deputies plus any member of the Executive group with a special interest in the subject.

Group two: A maximum of 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 Deputy Director of Workforce and Organisational Development, Workforce and Organisational Development Assistant/Associate Directors and Human Resource Business Partners.

Group four: Staff side representatives.

Group five: Network colleagues from colleague engagement network and 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.

5.3 The following is a proposed list of invitees to the quarterly Committee sessions:-

Group one: Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance and their Deputies.

Group two: A maximum of 3 x Non-Executive Directors, 2 x Governors as invited by the Chair of the Workforce Committee.

Group three: Deputy Director of Workforce and Organisational Development, Workforce and Organisational Development Assistant/Associate Directors and, Human Resources Business Partners.

Group four: Staff side 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.

5.4 A quorum will be four members and must include at least one Non-Executive and one Executive Director.

5.5 Attendance is required at 75% of meetings, Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.6 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Secretary, whose duties in this respect will include:-

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance

7. Frequency of meetings

7.1 The Committee will meet bi-monthly (once every 2 months) to discuss strategic issues and quarterly to carry out a deep dive review of workforce performance and metrics.

8. Reporting

8.1 The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next board of directors meeting.

8.5 A summary report will be presented to the next board meeting.

9. Review

9.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

Calderdale and Huddersfield NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Version:	1.1 - first draft circulated for review to Chair / CE / DoF / DDof 1.2 - comments received OW / CB / AH 1.3 - Amendments from the Board of Directors 2.1 – Reviewed and updated for membership and to reflect planning cycle 3.1 – Reviewed and updated to include a Performance Delivery and Assurance Section
Approved by:	Board of Directors
Date approved:	
Date issued:	
Review date:	

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee to be known as the Finance and Performance Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases.

The Committee will assist in ensuring that Board members have a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

3. Authority

The Finance and Performance Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

4. Role and duties of the Committee

The Finance and Performance Committee will provide the Board with assurance that finance and performance is being monitored and managed across the organisation and that progress is being made in the implementation of the Annual Plan. The Committee will also make recommendations on investment.

The duties of the Committee can be categorised as follows:

4.1. **Finance and Financial Performance**

- Provide assurance that the finances and financial performance reporting systems of the organisation are robust through detailed review of the Monthly Financial Report.
- Seek assurance from the executive that any appropriate management action has been taken to return the Trust's financial performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
- Provide assurance to the Board that cost improvement plans to support organisational changes are being delivered through the receipt of regular reports from the Turnaround Executive.
- Review the Trust's Long Term Financial Model and any NHS Improvement submissions to test assumptions and provide assurance that the returns represent a true and fair view of the financial performance for the period under review.
- Review all significant financial risks on the high level risk register and the Board Assurance Framework.
- Review the Single Oversight Framework finance and use of resources metric, in light of overall financial performance.
- Examine any matter referred to the Committee by the Trust Board.

4.2 **Performance Delivery and Assurance**

- Provide assurance that the performance reporting systems of the organisation are robust through detailed review of the regulatory performance and other KPIs as they relate to resource utilisation and income through Integrated Board Report on a monthly basis.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

- Keep the content of the Trust's Integrated Board Report under review, ensuring that it includes appropriate performance metrics and detail of exceptions to provide assurance to the Board on all aspects of organisational performance against its Strategic Objectives.
- Seek assurance from the executive that any appropriate management action has been taken to return the trust performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
- Provide assurance to the Board that the performance of Clinical Divisions and corporate teams are in line with agreed annual plans and receive escalation where recovery plans do not resolve any adverse variance
- Review all significant operational risks as they pertain to financial and regulatory standards on the high level risk register and the Board Assurance Framework.

4.3 Business and commercial development

- Ensure compliance with Monitor's Risk Evaluation for Investment Decisions (REID) guidance and Treasury Management guidance.
- Approve and set control limit for capital
- Review the Trust's Annual Business Plan, 5 Year Plan, 5 Year Capital Plan and Financial Model and recommend to the Board for approval.
- Prioritise capital programme under discrete headings (based on high level business case proposals from divisions):
  - Equipment replacement
  - Unavoidable major schemes
  - IM&T
  - Significant strategic importance
  - Estates (maintenance/ upgrades)
  - Aspirational
- Understand and agree revenue consequences of schemes and monitor cash flow implications
- Receive an update from Commercial Investment Strategy Group on business case approvals ensuring that outcomes and benefits are clearly defined, are measurable and support the delivery of key objectives for the Trust. Ensuring only those below £5M are approved by the Group and those above £5M are recommended to the Board for approval.
- Approve and keep under review the Trust's investment and borrowing strategy and policies.
- Periodically review the market analysis for the Trust.
- Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.
- Agree investment / dis-investment in services (with full understanding of financial and service implications of these decisions e.g. overheads)

4.4 Treasury Management

- Maintain an oversight of the Trust's Treasury Management activities, ensuring compliance with Trust's policies.
- Review borrowing arrangements and liabilities
- Review and monitor the Trust's Treasury Management Policy *(approval is through the Audit & Risk Committee)*.
- Review the activities undertaken at Cash Management Committees

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

4.5 **Procurement**

- Review the activities undertaken by Procurement and the contributions made along with performance against key national metrics.

5. Membership and Attendees

5.1. The Committee shall consist of the following members:

- Non – Executive Director (Chair)
- Non – Executive Director (Vice Chair)
- Non – Executive Director
- Chief Executive
- Executive Director of Finance
- Chief Operating Officer
- Director of Transformation and Partnerships.

5.2. The Deputy Director of Finance and the Company Secretary will regularly attend. All other non-executive and executive directors will be invited to attend along with a Membership Councillor. Executive Directors and other senior management staff may be required to attend discussions when the Committee is discussing areas of performance or operation that are their responsibility.

6. Attendance

6.1. Attendance is required by members at 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

6.2. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardies the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. Administration

7.1. The Committee shall be supported by the Secretary to the Executive Director of Finance, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee;
- Taking the minutes and keeping a record of matters arising and issue to be carried forward;
- Advising the group on scheduled agenda items;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

8. Meetings

8.1. Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar;

8.2. Items for the agenda must be sent to the Committee Secretary a minimum of 8 days prior to the meeting: urgent items may be raised under any other business;

8.3. An action schedule will be circulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers; and

8.4. The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

9. Reporting

9.1. The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board when approved.

9.2. The Chair of the Finance and Performance Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.

9.3. The Capital Management Group, the Commercial Investment Strategy Group and Cash Committee will provide minutes of its meetings to the Committee along with reports as agreed.

10. Quorum

A quorum is determined as being four of the members in attendance but must include the Chair or Vice-Chair and one Executive Director.

11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

12. Monitoring Effectiveness

In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 7 days prior to the meetings;
- The action schedule was circulated within 48 hours, on 80% of occasions

15. Integrated Performance Report

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: 5.7.18	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: QUALITY & PERFORMANCE REPORT - Quality and Performance Report - May 2018	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board, Finance & Performance Committee, Quality Committee	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

May's Performance Score has improved to 69%. All domains have improved in-month. The SAFE domain is now green following improvements in Harm Free Care including pressure ulcers. CARING domain has improved in FFT (Outpatients and A&E). Small improvement in #NoF means EFFECTIVE domain is now green. The RESPONSIVE domain has improved with all key Cancer targets back on track although Diagnostics 6 weeks missed target again due to Cystoscopy performance. All FINANCE indicators maintained April's performance. Activity is above target for Day Cases, Non-elective and Outpatient levels. In WORKFORCE appraisals for Medical staff achieved target and sickness/absence performance has improved.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note the contents of the report and the overall performance score for May.

Appendix

Attachment:

APP J - Quality & Performance Report - May 18.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

May 2018

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

Sometimes the previous month's % in the Performance Summary is different in the next month's report. This usually happens when there are late changes to indicator values due to validation.

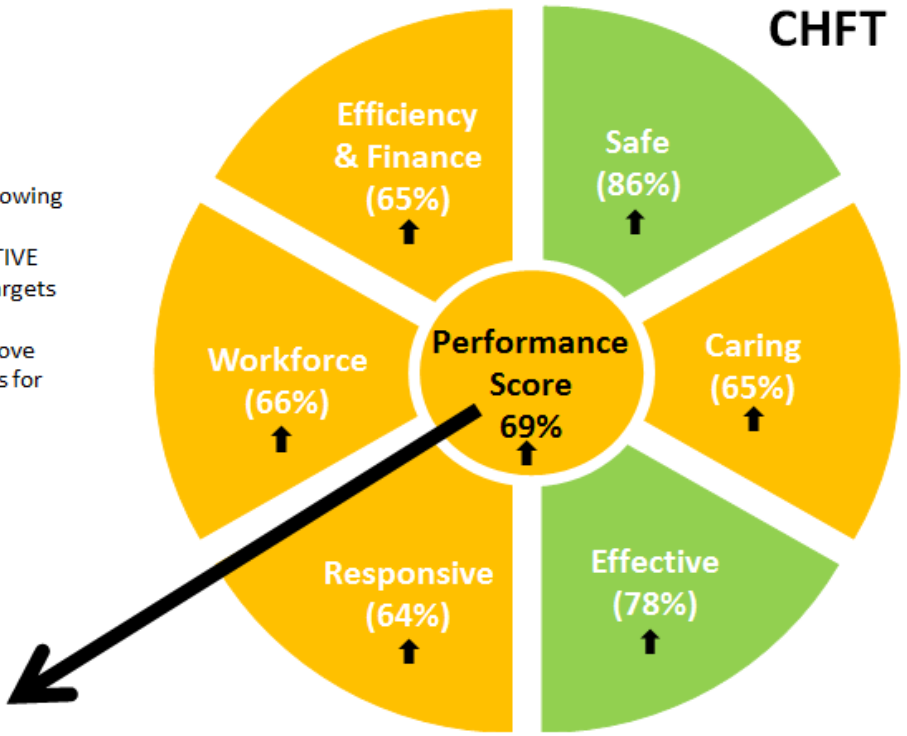
We have now included monthly sickness/absence rates and return to work interviews which were excluded in last month's performance summary. This has resulted in April's performance improving from 62% to 64% due to good performance in month for long term sickness.

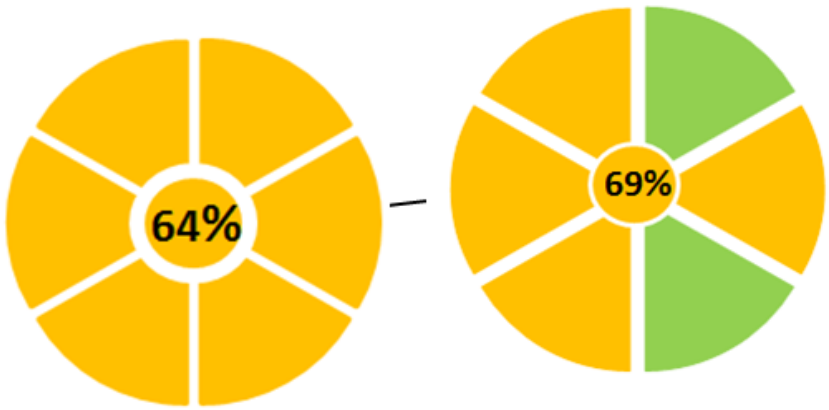
Performance Summary

May

RAG Movement

May's Performance Score has improved to 69%. The SAFE domain is now green following improvements in Harm Free Care including pressure ulcers. CARING domain has improved in FFT (Outpatients and A&E). Small improvement in #NoF means EFFECTIVE domain is now green. The RESPONSIVE domain has improved with all key Cancer targets back on track although Diagnostics 6 weeks missed target again due to Cystoscopy performance. All FINANCE indicators maintained April's performance. Activity is above target for Day Cases, Non-elective and Outpatient levels. In WORKFORCE appraisals for Medical staff achieved target and sickness/absence performance has improved.





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

Performance	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
A&E performance	May 2018	93.23%	88.73%	95.00%			
RTT - max 18 weeks incomplete wait	Apr 2018	93.77%	89.16%	92.00%			
Diagnostics - max 6 weeks wait	Apr 2018	98.80%	99.02%	99.00%			
Cancer - 62-day wait from urgent GP referral	Mar 2018	90.32%	87.62%	85.00%			
Cancer 62-day waits - NHS cancer screening service referral	Mar 2018	88.89%	92.50%	90.00%			

Safe	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Clostridium Difficile - variance from plan	May 2018	3.0	0.0	0.0			

Effective	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Summary Hospital Mortality Indicator (SHMI)	31/07/2017	1.01	-	0.00			

Temporary staff	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Proportion of Temporary Staff	Feb 2018	6.65%	5.73%	4.97%			

Staff sickness	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff sickness	Feb 2018	4.45%	4.35%	4.38%			

Staff turnover	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff turnover	Apr 2018	0.59%	1.06%	1.02%			

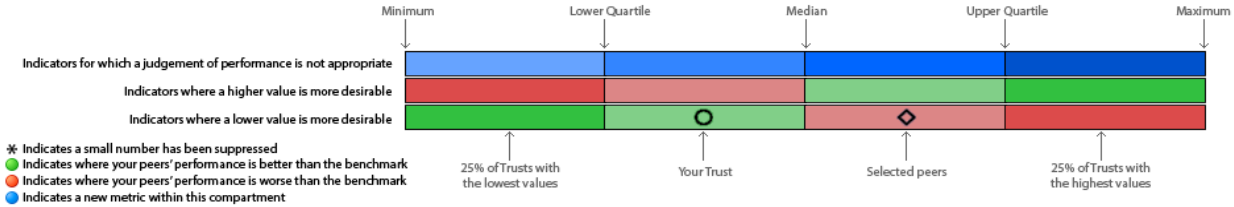
The Finance Score	Period	Trust Actual
The finance score	Feb 2018	Score: 3
Financial Sustainability	**Period**	**Trust Actual**
Capital service capacity - value	Feb 2018	-0.65
Capital service capacity - SOF Score	Feb 2018	Score: 4
Liquidity (days) - value	Feb 2018	-24.21
Liquidity (days) - SOF Score	Feb 2018	Score: 4
Financial Efficiency	**Period**	**Trust Actual**
Income and expenditure (I&E) margin - value	Feb 2018	-10.85%
Income and expenditure (I&E) margin - SOF score	Feb 2018	Score: 4
Financial Controls	**Period**	**Trust Actual**
Distance from financial plan - value	Feb 2018	-5.42%
Distance from financial plan - SOF score	Feb 2018	Score: 4
Distance from agency spend cap - value	Feb 2018	-4.40%
Distance from agency spend cap - score	Feb 2018	Score: 1

Friends and Family Test scores	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff Friends and Family Test % Recommended - Care	Q4 2017/18	79.4%	-	-		No variation available	
A&E Scores from Friends and Family Test - % positive	Apr 2018	84.7%	87.6%	88.0%			
Inpatient Scores from Friends and Family Test - % positive	Apr 2018	96.8%	96.3%	96.3%			
Community Scores from Friends and Family Test - % positive	Apr 2018	93.9%	95.7%	96.5%			
Maternity Scores from Friends and Family Test -question 2 Birth % positive	Apr 2018	98.3%	98.4%	98.4%			

Organisational health	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
CQC Inpatient Survey	Sep 2015/16	9	-	-		No variation available	No trendline available

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Written Complaints Rate	31/03/2018	30.76	27.73	24.93			

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Never events	31/03/2018	1	2	1			
Emergency c-section rate	Mar 2018	13.65%	16.24%	16.17%			
VTE Risk Assessment	Q4 2017/18	96.94%	95.70%	95.71%			
Clostridium Difficile - infection rate	To May 2018	19.58	13.47	12.92			
MRSA bacteraemias	To Mar 2018	2.11	0.88	0.63			
Potential under-reporting of patient safety incidents	31/01/2018	43.88	43.39	-		No variation available	No trendline available
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	May 2018	143	136	127			
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	May 2018	7	9	9			



* Indicates a small number has been suppressed
Indicates where your peers' performance is better than the benchmark
Indicates where your peers' performance is worse than the benchmark
Indicates a new metric within this compartment

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
% Harm Free Care - Performance has improved significantly to 94.41%, just below the 95% target.	Friends and Family Test Community Survey - % would recommend the Service results for May show that 92.6% of respondents would recommend our services.	When analysed, the decrease in 'would recommend %' relates to intermediate care and community therapies. The division are investigating the reasons.
Long Term Sickness Absence rate (%) - in month - best performance at 2.37% in over 12 months.	38 Day Referral to Tertiary - at 31% lowest performance since July last year.	Targeted work to commence with H&N services to improve pathway performance. In particular need to improve initial diagnostic tests to ensure that earlier results achieved to enable more timely discussion at Specialist MDT. Improving capacity for Lower GI patients to be seen within 7 days. For Urology pathway capacity at Tertiary centre means that the numbers of patients treated within 62 days is reducing. Escalation has occurred and Cancer Alliance aware of challenges. The Red2Green methodology in Urology, Head and Neck and Lower GI pathways will now commence in Q2.
% Last Minute Cancellations to Elective Surgery has maintained its lowest 2 months in 2 years.	% PPH ≥ 1500ml - all deliveries Performance is at worst level in over 12 months.	Analysis to be done of all 25 PPH cases in-month. Early Analysis shows that a significant number of women who had a PPH had several risk factors with 72% of PPH being either Forceps/Caesarean Sections in Month. Caesarean Section review under way which will be fed back in July (Correlation between high caesarean section rate and high PPH rate).

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance has improved significantly to 94.41%, just below the 95% target. The Medicine division has carried out focussed work on auditing standards specifically related to UTIs with catheter, VTE and falls, and ensuring senior nursing staff are involved in safety thermometer audits. • **% PPH ≥ 1500ml - all deliveries** - Performance is at worst level in over 12 months. Analysis to be done of all 25 PPH cases in-month. Early Analysis shows that a significant number of women who had a PPH had several risk factors with 72% of PPH being either Forceps/Caesarean Sections in Month. Caesarean Section review under way which will be fed back in July (Correlatetion between high caesarean section rate and high PPH rate).
Caring	• **Complaints closed within timeframe** - Of the 63 complaints closed in May, 48% were closed within target timeframe. The backlog of breaching complaints was still 27 at the end of May with plans to clear in June. A deep-dive was presented at WEB identifiying further improvements that can be made. Escalation of backlog of complaints to Quality Committee. • **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 has fallen to lowest position (9.6%) since May last year whereas % would recommend is only just below target. The negative comments from FFT have been shared on the public "you said, we did" board. A band 7 member of staff has been employed with the specific aims of leading on patient experience including concerns, compliments and FFT. On analysing the FFT forms some tick boxes have been left blank and upon investigation these omissions score negatively against the • **Friends and Family Test Community** - results for May show that 92.6% of respondents would recommend our services. When analysed, the decrease in 'would recommend %' relates to intermediate care and community therapies. The division are investigating the reasons. • **% Dementia patients following emergency admission aged 75 and over** - current performance at 31% is showing some improvement but still some distance from 90% target. Improvement focus within weekly performance meetings.
Effective	• **E.Coli - Post 48 Hours** - There were 4 cases in May. E.Coli reduction is being addressed as a health economy issue with the majority of cases admitted septic from the community. A Trust action plan is in development with the aim to reduce the incidence associated with the urinary tract. • **Mortality Reviews** - 18.5% again is the 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 improved in month and is almost at target. The audit work continues within specialties and S&S cohorts. The new 3wte trainee coders will all be in post by mid-July. A Clinical Coding Action plan has been drafted for 2018/19 which looks to address some of the key issues affecting the quality of the coding. This will be finalised in July and progress monitored via Clinical Coding Improvement Steering Group. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - Performance has improved and is just below the 85% target. Expect performance to be back on track by July following the Trauma surge in May.

Background Context

Weekly performance meetings have been reviewed and a revised, Divisionally focused forum is now in place. Several Data Quality issues have been identified in the weekly information which led to weekly over-reporting of concerns and is currently under review.

Elective care data quality has been self-assessed using the NHSI toolkit and the Trust is awaiting feedback from the regulators on any required actions.

We have seen a further significant improvement in the ECS which is now at 93.23%, 8 percentage points above the March position of 85.29%.

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.

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

This has allowed teams to redistribute the workforce and retract the use of 2 locum consultants. The medical day case unit continues to amalgamate into ambulatory care at HRI and as a result e-prescribing has become easier and systems are now working well.

Maternity has had an increased complexity in casemix with higher volumes of greater risk deliveries. There is a high number of Midwifery staff on maternity leave leading to high levels of escalation for staffing during the month with mitigations enacted.

An IPC action plan has been implemented with Divisonal specific plans also in place monitored through a re-launched Infection Control Committee.

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 May 2017 to allow comparison with historic performance. However the key messages and targets relate to May 2018 for the financial year 2018/19.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** 93.23% in May, (94.3% all types) - an improvement of 8 percentage points since the March position. The improvement is partly due to the revision of LCD streaming criteria. The ED team continues to turn around the patients that can be seen in a GP setting. ED co-ordinator training is scheduled for July for all band 7 and band 6 qualified nurses. 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. • **Stroke** - we have seen a deterioration in patients spending 90% of their stay on the stroke unit and patients admitted to the stroke unit within 4 hours. Analysis of the four hour breaches shows that a significant proportion of these are due to delays in diagnosis. The directorate has continued to work with the ED team to agree a solution for the stroke assessment beds. • **Breach of Patient Charter (rebooked within 28 days of cancellation)** - Patient scheduled for a joint procedure involving Consultant Urologist and Interventional Radiologist 30th April. For this date and subsequent date 1 of the 2 clinicians was unavailable due to unforeseen circumstances. In addition limited Radiologist availability means that only 2 sessions per month are accessible for these procedures. The patient finally had successful procedure 5th June completed jointly by the 2 specialities. Reviewing this situation and limited Radiology support, the specialty, in future will consider exploring options external to the Trust to minimise impact on patients. • **% Diagnostic Waiting List Within 6 Weeks** - just missed target at 98.81% due to a small volume of Cystoscopy patients who had not been included in the month's waiting list for the Unit. This has been rectified and a wider review conducted with no further issues highlighted . • **38 Day Referral to Tertiary** - 31% for May. Targeted work to commence with H&N services to improve pathway performance. In particular need to improve initial diagnostic tests to ensure that earlier results achieved to enable more timely discussion at Specialist MDT. Improving capacity for Lower GI patients to be seen within 7 days. For Urology pathway capacity at Tertiary centre means that the numbers of patients treated within 62 days is reducing. Escalation has occurred and Cancer Alliance aware of challenges. The Red2Green methodology in Urology, Head and Neck and Lower GI pathways will now commence in Q2. Within the Medical division teams are continuing to focus on reducing the time to diagnosis and a traffic light system will be in place from 1st July to reduce the time waiting for MDT discussion. • **Appointment Slot Issues on Choose & Book** - deteriorated to 38%. Worsening position over recent months 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. National Line now directs ASIs to provider, Single point of contact in place for GP queries.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Sickness has improved further in-month however Return to Work Interviews have fallen in the same period. Only Community deteriorated from the 4 clinical divisions. An attendance management session has been arranged for 11th July in the division. • **Essential Safety Training** compliance has fallen slightly and is now amber. Following discussions with the Executive Team, analysis has been undertaken to understand the number of colleagues whose training is due to expire in Q4 2018/2019 and review the possibility of encouraging colleagues to complete this before Q4 due to the winter pressures that will impact the availability of colleagues.
Finance	• **Finance**: **Year to Date Summary** The year to date deficit is £9.24m, in line with the plan submitted to NHSI. • Clinical contract income is above plan by £0.02m. In month activity increased slightly so that the Aligned Incentive Contract is now only protecting the income position by £0.01m. • There remains an underlying adverse variance from plan which has had to be mitigated by the release of £0.51m (a quarter) of the Trust's £2m full year reserves of which £1m was earmarked for winter. • CIP achieved in the year to date is £1.54m against a plan of £1.67m, a £0.13m shortfall. • Agency expenditure was beneath the agency trajectory set by NHSI. **Key Variances** • Medical pay expenditure is showing an adverse variance to plan of £0.48m year to date. This is in part due to slippage on CIP schemes which have resulted in an adverse variance of £0.13m and there are prior year costs of £0.04m relating to back pay, the remaining £0.31m is due to operational pressures particularly in Obs & Gynae, Urology, ENT, Medical Specialties and A&E. • Nursing pay expenditure reduced in Month 2, but remained above plan with a year to date adverse variance of £0.15m. However, Nursing agency costs reduced by £0.15m compared to the previous month with no further increase in bank expenditure. • The shortfall in CIP delivery was primarily linked to slippage in schemes within the Medical Staffing portfolio . These schemes are forecast to be delivered in full by year end. • These adverse variances have been offset by the release of contingency reserves of £0.50m. **Forecast** • The Trust has not accepted the 18/19 NHS Improvement Control Total of a £23.2m 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). • The control total value has been adjusted by £0.61m (increased deficit) compared to the value reported in Month 1. This is to reflect the control total flexibility that was originally described by NHS Improvement as only being accessible to Trusts that achieved their 17/18 control total, but has now been agreed for all Trusts in our region. This reduces the gap to control total from £20.5m to £19.9m. • At this early stage the forecast is to achieve the £43.1m deficit, £19.9m adverse variance from control total as planned.

Background Context

Thornbury agency reductions started in-month and the bank uplift for qualified staff has been continued. Weekly nurse staffing meetings are in place in addition to confirm and challenge meetings at Divisional level.

Twice daily matron reports provide assurance around safe satffing levels

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

The proposal for the stroke assessment bed in ED received sign-off at DMB on 25th May and the pilot is due to commence on Monday 25th June.

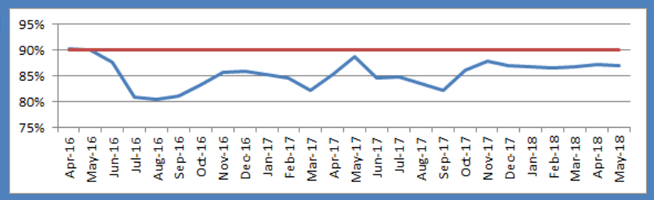
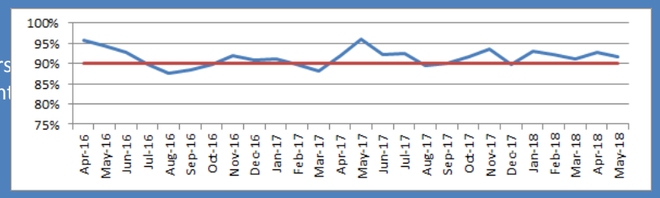
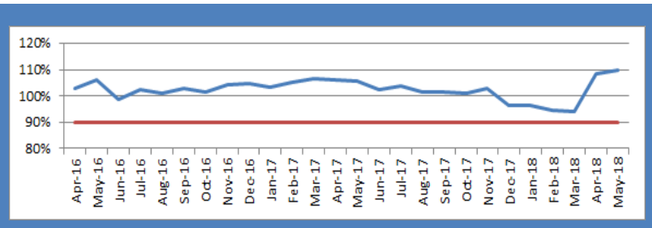
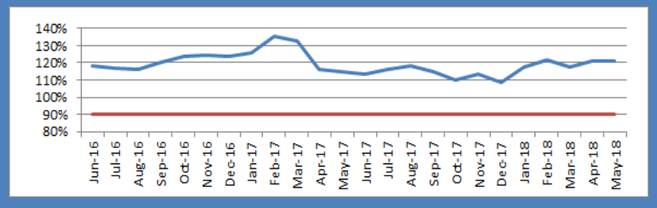
Within Community services the management team is focusing on the response to the CQC report and establishing priorities for the next two years.

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.

There is weekly focus on Mandatory training and appraisal activity

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.	87.06% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - 8c 43.3%	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 on 8c are due to the unit closing mid-month.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.76% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - 7b/c 69% - 8c 53.2% - ward 10 63.4%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to a level of vacancy and ward closure.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	109.75% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 64.9% - NICU 53.4% - LDRP 74.7% - ward 3 65.8%	The low HCA fill rates in May are attributed to fluctuating bed capacity 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.	121.22% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	No HCA shifts during in May 2018 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 - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed 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	3,099.00	2,999.42	1,935.83	2,161.42	96.8%	111.7%	2,711.50	2,501.00	1,705.00	1,922.50	92.2%	112.8%	9.1	9.2			1	1	11.9	0.42	84.4%
HRI MAU	2,009.27	1,951.23	1,801.00	2,003.83	97.1%	111.3%	1,584.00	1,559.92	1,363.52	1,324.25	98.5%	97.1%	8.1	8.2			2	16	3.8	2.95	91.3%
HRI Ward 5 (previously ward 4)	1,563.67	1,325.83	1,139.75	1,510.42	84.8%	132.5%	1023	1,021.75	1023	1,297.83	99.9%	126.9%	5.8	6.2			0	7	4.35	0	95.6%
WARD 15	1,729.33	1,471.50	1,480.17	2,043.43	85.1%	138.1%	1,364.00	1,286.25	1,364.00	1,719.00	94.3%	126.0%	6.8	7.5			1	11	7.03	0	95.4%
WARD 5C	1037	970.7	810	1,167.67	93.6%	144.2%	682	671.00	341	705	98.4%	206.7%	5.2	6.4			0	2	3.4	0	92.0%
WARD 6	1,598.30	1,498.97	889.4167	1,250.67	93.8%	140.6%	1023	1001	682	806.5	97.8%	118.3%	7.8	8.5			1	3	2.13	0.72	79.0%
WARD 6BC	1,649.42	1,548.25	1,586.58	1,485.58	93.9%	93.6%	1,364.00	1,298.00	682	766.5	95.2%	112.4%	5.0	4.8			4	4	5.19	3.23	94.3%
WARD 5B	1,017.67	1,317.83	825	882.5	129.5%	107.0%	1,364.00	1,056.00	341	660	77.4%	193.5%	6.4	7.0			1	0	0	0	94.8%
WARD 6A	973.00	791.5	750.5333	811.5	81.3%	108.1%	682	649.00	682	572.00	95.2%	83.9%	5.5	5.1			0	2	3.66	0	95.4%
WARD CCU	1,697.33	1,278.42	387	361.5	75.3%	93.4%	1023	1023	0	22	100.0%	-	10.8	9.3			0	0	2.14	0.77	96.8%
WARD 7AD	1,691.33	1,306.17	1,672.50	2,165.33	77.2%	129.5%	1023	1001	1023	1,177.00	97.8%	115.1%	6.9	7.2			0	4	1.54	2.19	88.8%
WARD 7BC	1,076.92	969.08	957.25	1,124.83	90.0%	117.5%	1,133.00	781.5	385	584	69.0%	151.7%	5.4	5.2			0	8	3.89	0	95.8%
WARD 8	1,390.17	1,155.17	1,277.33	1,574.67	83.1%	123.3%	1023	893.00	1012	1,267.50	87.3%	125.2%	6.7	7.0			2	4	4.17	1.63	81.7%
WARD 12	1,566.50	1,335.50	802.75	1,041.83	85.3%	129.8%	979	737	385	858	75.3%	222.9%	5.5	5.9			3	6	2.32	3.36	93.2%
WARD 17	1,963.17	1,524.00	1,136.00	1,241.00	77.6%	109.2%	1023	1,001.00	682	898.50	97.8%	131.7%	6.0	5.9			1	3	3.26	0	96.9%
WARD 8C	868.8333	376.83333	387.6667	432.5	43.4%	111.6%	682	363.00	341	364.50	53.2%	106.9%	18.2	12.3			1	1	2	0.92	93.6%
WARD 20	1,799.18	1,523.00	1,756.75	2,248.75	84.6%	128.0%	1,362.75	1,319.25	1,364.00	1,650.50	`	121.0%	6.3	6.8			2	7	8.47	1.32	88.4%
WARD 21	1,545.00	1,180.50	1,498.17	1,507.00	76.4%	100.6%	1,057.50	989	1,069.50	1,071.50	93.5%	100.2%	8.5	7.8			2	7	5.73	0	89.1%
ICU	4,070.08	3,519.58	778.5	505.5	86.5%	64.9%	4,278.00	3,509.50	0	11.5	82.0%	-	54.0	44.7			0	1	0.43	0	97.9%
WARD 3	953.1667	923.33333	761.5	766.3333	96.9%	100.6%	711.5	711.5	356.5	380.8333	100.0%	106.8%	6.9	6.9			0	2	0.14	0.37	92.9%
WARD 8AB	951.3333	780.53333	388.5	658	82.0%	169.4%	713	632.5	356.5	575	88.7%	161.3%	8.0	8.8			0	3	1.52	0	97.8%
WARD 8D	807.65	819.98333	819	718.3333	101.5%	87.7%	690	736.00	0	287.5	106.7%	-	6.3	6.9			0	1	1.87	0.23	91.1%
WARD 10	1,367.08	1,125.08	833	1026.417	82.3%	123.2%	1,069.50	678.50	713	1,054.00	63.4%	147.8%	7.6	7.4			0	1	7.07	1.5	90.0%
WARD 11	1,542.95	1,522.20	1,214.92	1,290.42	98.7%	106.2%	1,068.50	1,056.75	690	805	98.9%	116.7%	6.2	6.4			0	2	1.07	2.16	95.1%
WARD 19	1,696.47	1,344.13	1,224.58	1,503.65	79.2%	122.8%	1,069.50	1,068.50	1,069.50	1,362.17	99.9%	127.4%	7.4	7.7			7	10	0.13	0	96.8%
WARD 22	1,161.50	1,154.08	1,172.50	1,224.58	99.4%	104.4%	713	703.50	713	837.75	98.7%	117.5%	5.4	5.6	1		0	3	0.03	1.12	85.1%
SAU HRI	1,828.25	1,704.25	1011.5	1074.3	93.2%	106.2%	1,426.00	1,426.00	356.5	380	100.0%	106.6%	11.1	11.0			0	0	6.85	0	87.7%
WARD LDRP	4,699.93	3,754.48	1001.5	748.1667	79.9%	74.7%	4,278.00	3,509.67	713	692.1667	82.0%	97.1%	20.6	16.8			0	0	0	5.08	94.4%
WARD NICU	2,620.83	2,100.18	818.1667	436.6667	80.1%	53.4%	2,139.00	1,925.50	713	576	90.0%	80.8%	12.1	9.7			0	0	0.15	2.06	99.3%
WARD 1D	1,323.00	1,204.50	359.5	344.5	91.0%	95.8%	713	694.6667	356	379.5	97.4%	106.6%	4.9	4.6			0	0	0	0.19	99.2%
WARD 3ABCD	3,767.17	3,329.33	1,531.50	1008	88.4%	65.8%	2,495.00	3,047.50	356	414	122.1%	116.3%	10.3	9.8			0	2	0	2.61	94.6%
WARD 4C	1,268.00	1,159.42	366.5	374.3333	91.4%	102.1%	713	713	356	345	100.0%	96.9%	9.1	8.7			0	1	0	2.21	85.7%
WARD 9	717.4167	703.41667	367	337	98.0%	91.8%	713	713	356	356.5	100.0%	100.1%	4.7	4.6			0	0	0.67	2.71	97.9%
Trust	**57049.92**	**49668.42**	**33741.87**	**37030.6**	**87.06%**	**109.75%**	**43893.75**	**40277.8**	**21550.02**	**26124**	**91.76%**	**121.22%**	**7.80**	**7.70**							

Hard Truths: Safe Staffing Levels (3)

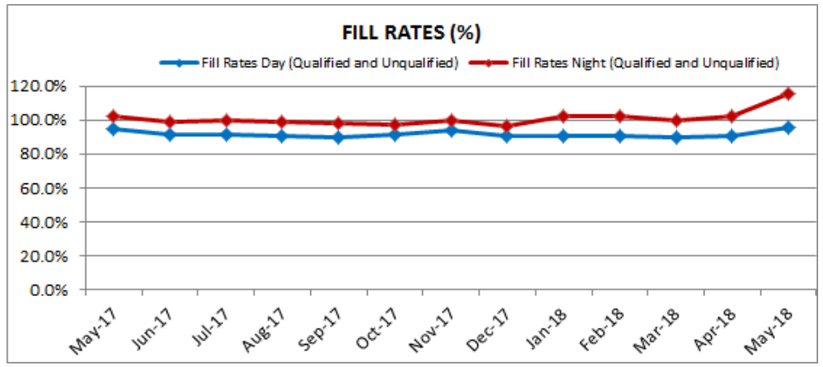
Care Hours per Patient Day

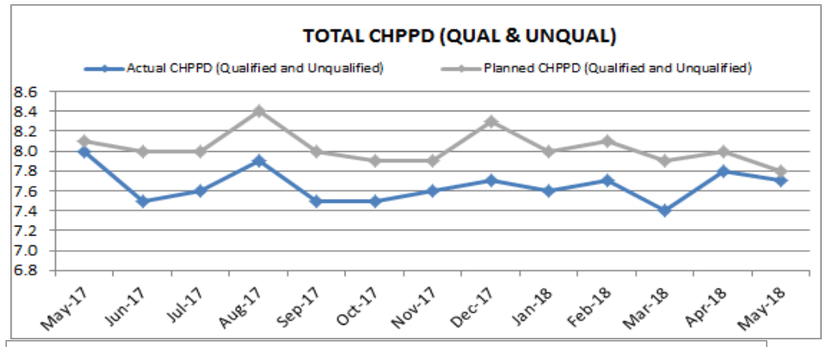
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Mar-18	Apr-18	**May-18**
Fill Rates Day (Qualified and Unqualified)	89.70%	91.00%	95.49%
Fill Rates Night (Qualified and Unqualified)	99.70%	102.20%	115.19%

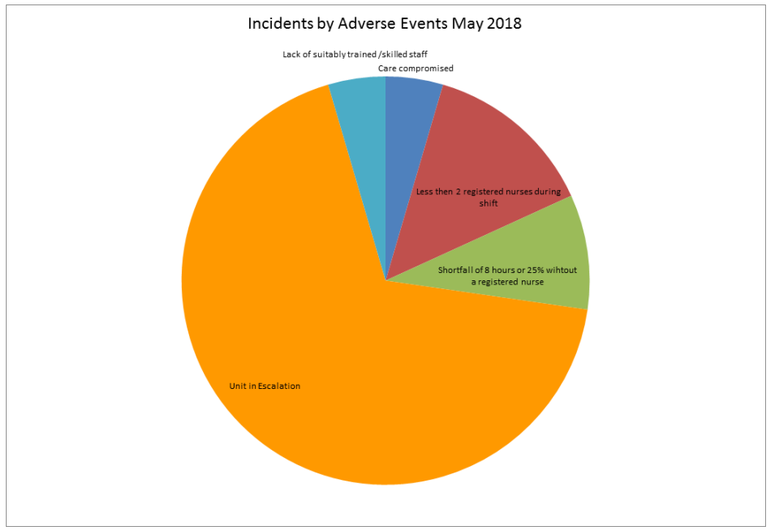
Planned CHPPD (Qualified and Unqualified)	7.9	8.0	7.8
Actual CHPPD (Qualified and Unqualified)	7.4	7.8	7.7

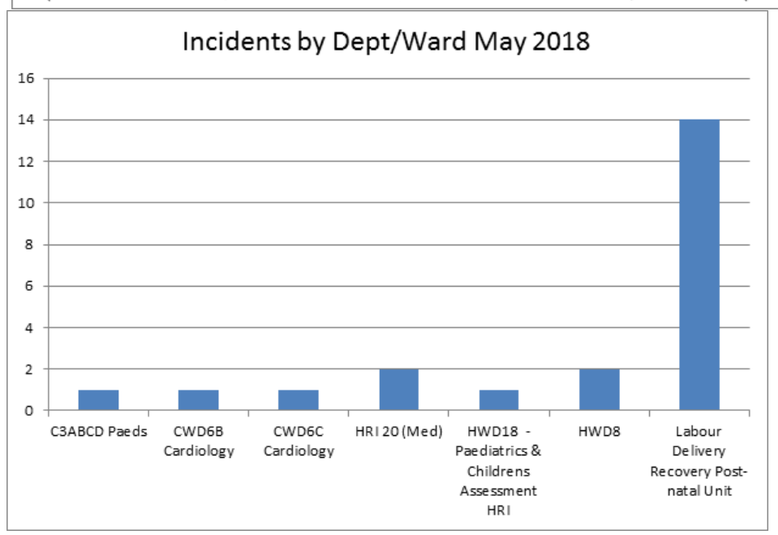
A review of May CHPPD data indicates that the combined (RN and carer staff) metric resulted in 16 clinical areas of the 33 reviewed having CHPPD less than planned. 15 areas reported CHPPD slightly in excess of those planned and 2 areas having CHPPD as planned. Areas with CHPPD more than planned were 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 reviewed monthly through the Nursing workforce strategy group.
There were **22 Trust Wide Red shifts** declared in **May.**
As illustrated above the most frequently recorded red flagged incident is related to "unit in escalation".
No datix's reported in May 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. Focused recruitment continues for this specific area.
2. Further recruitment event planned for September 2018.
3. Applications from international recruitment projects are progressing well and the first 8 nurses have arrived in Trust, with a further 8 planned for deployment in June/July 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. The Trust is working with the recruitment agent to appraise its potential to recruit ILETS/OET compliant nurses. This work stream is progressing well with x2 nurses identified for deployment in July 2018.
6. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA 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 commenced training on 4th June.
7. 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 new module of E roster called safe care. This is currently being introduced across the divisions, benefits will be better reporting of red flag events, real-time data of staffing position against acuity

16. Month 2 Financial Summary

To Approve

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: 5.7.18	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: FINANCE HEADLINE MESSAGE – MONTH 2 - A summary of the financial position as reported to NHS Improvement in Month 2.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Turnaround Executive	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

See attached paper

Main Body

Purpose:

See attached paper

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

BOD Financial summary - Month 2.pdf

FINANCE HEADLINE MESSAGE – MONTH 2
BOARD OF DIRECTORS
5 JULY 2018

Year to Date Summary

- The year to date deficit is £9.24m, in line with the plan submitted to NHSI.
- Total clinical income is just above plan by £0.02m. In month activity increased slightly so that the Aligned Incentive Contract is now only protecting the income position by £0.01m (see Appendix 1 for detail).
- There remains an underlying adverse variance from plan which has had to be mitigated by the release of £0.5m (a quarter) of the Trust's £2m full year reserves of which £1m is earmarked for winter.
- CIP achieved in the year to date is £1.54m against a plan of £1.67m, a £0.13m shortfall.
- Agency expenditure was beneath the agency trajectory set by NHSI.

Month 2 - Year to date	Plan £'m	Actual £'m	Variance £'m
Total Deficit	**(9.24)**	**(9.24)**	**0.00**

Key Variances

- Medical pay expenditure is showing an adverse variance to plan of £0.48m year to date. This is in part due to slippage on CIP schemes which have resulted in an adverse variance of £0.13m and there are prior year costs of £0.04m relating to back pay, the remaining £0.31m is due to operational pressures particularly in Obstetrics and Gynaecology, Urology, ENT, Medical Specialties and A&E.
- Nursing pay expenditure reduced in Month 2, but remained above plan with a year to date adverse variance of £0.15m. However, Nursing agency costs reduced by £0.15m compared to the previous month with no further increase in bank expenditure.
- The shortfall in CIP delivery was primarily linked to slippage in schemes within the Medical Staffing portfolio. These schemes are forecast to be delivered in full by year end.
- These adverse variances have been offset by the release of contingency reserves of £0.50m.

Forecast

- The Trust has not accepted the 18/19 NHS Improvement Control Total of a £23.2m 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).
- The control total value has been adjusted by £0.61m (increased deficit) compared to the value reported in Month 1. This is to reflect the control total flexibility that was originally described by NHS Improvement as only being accessible to Trusts that achieved their 17/18 control total, but has now been agreed for all Trusts in our region. This reduces the gap to control total from £20.5m to £19.9m.
- At this early stage the forecast is to achieve the £43.1m deficit, £19.9m adverse variance from control total as planned.

CLINICAL CONTRACT UPDATE – MONTH 2

Summary

- The 2018/19 Contracts with Greater Huddersfield CCG (GHCCG) and Calderdale CCG (CCCG) have been agreed on an Aligned Incentive Contract (AIC) basis at a fixed value. All other CCG and NHS England contracts continue to be on a cost-per-case basis.
- The year-to-date month 2 clinical contract position across all Commissioners is summarised as:

Point of Delivery	Activity			Income		
	Plan	Actual	Variance	Plan (£'m)	Actual (£'m)	Variance (£'m)
Daycase	5,929	5,900	-29	4.26	4.33	0.07
Elective	1,000	911	-89	3.17	2.83	-0.34
Non-Elective	9,333	9,595	262	16.70	16.72	0.02
A&E	26,098	25,322	-776	3.16	3.18	0.02
Outpatient	59,509	62,500	2,991	7.07	7.23	0.16
Other NHS Tariff	21,015	21,264	249	3.40	3.39	-0.01
Other NHS Non-Tariff	274,540	288,552	14,011	11.84	12.05	0.21
CQUIN	0	0	0	1.13	1.13	0.00
Sub-total - pre AIC adjustment	**397,424**	**414,043**	**16,619**	**50.74**	**50.86**	**0.12**
AIC Adjustment	-	-	-	-	0.01	0.01
Net Reported Position	**397,424**	**414,043**	**16,619**	**50.74**	**50.87**	**0.13**

- The AIC contract positions for GHCCG and CCCG are only £0.01m below plan and income is therefore protected by the AIC adjustment to this level. This represents increased activity and income levels 'in-month' and has therefore brought the AIC close to contract value.
- The net reported income position, relating to all other CCGs and NHS England, is £0.13m above plan. This is mainly driven by activity above plan within North Kirklees CCG and NHS England specialised high cost drugs.

Greater Huddersfield CCG and Calderdale CCG AIC Positions

- The under-performance against the AIC can be summarised by CCG as follows:

Point of Delivery	GHCCG		CCCG		TOTAL	
	Activity Variance	Income Variance (£'m)	Activity Variance	Income Variance (£'m)	Activity Variance	Income Variance (£'m)
Daycase	114	0.07	-42	0.03	71	0.10
Elective	-26	-0.09	-54	-0.20	-80	-0.29
Non-Elective	27	-0.06	193	0.02	221	-0.04
A&E	-453	-0.01	-275	0.03	-729	0.02
Outpatient	1,258	0.05	1,966	0.16	3,224	0.21
Other NHS Tariff	231	0.01	149	-0.05	380	-0.03
Other NHS Non-Tariff	10,208	0.05	3,322	-0.03	13,530	0.02
CQUIN	0	0.00	0	0.00	0	0.00
Total	**11,359**	**0.03**	**5,258**	**-0.03**	**16,616**	**-0.01**

- The main areas of under-performance continue to be elective inpatients, non-elective and critical care. These are off-set by over-performances within outpatient activity.
- Calderdale CCG has seen worse performance than Greater Huddersfield and the main areas driving this difference are elective inpatients, critical care and maternity pathway activity, offset by higher levels of outpatient activity.

17. Cardiology Respiratory and Elderly Medicine Reconfiguration Update

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: 5.7.18	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Medical Services Reconfiguration: A 6 Months review - The purpose of this paper is to provide an update on the clinical services in the Medical Division reconfiguration project.	
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: -	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this paper is to provide an update on the clinical services in the Medical Division reconfiguration project. A review of the services to establish if the assumed benefits have been realised was scheduled for 6 months post implementation. The timeframe was chosen to enable a fair analysis using a data set that minimises bias through seasonal activity and allows settling down of clinical teams. The paper provides an overview of methodology used to complete the review, a summary of the impact on the clinical services including feedback from staff and patients, and a review of the KPI's. The paper also identifies next steps, followed by a review of the aims and objectives for the project to see if these have been met.

The aims and objectives for this complex project have either been met of have a platform now set for delivering the improvements. The KPI's re-enforce this position by either demonstrating improvements or no deterioration to patients services. Our patients welcomed the changes and described how improved communications with their Consultants helped with the understanding of their treatment plans; however travel, for some family and friends of Elderly patients in particular, has remained an issue, preferring the service more local. Whilst a few staff found travelling difficult, this has been mainly been resolved through reallocation of jobs on the site of choice. Many staff articulated improvements in training and supervision and improved continuity of clinical care supporting earlier discharge.

There have been challenges to the front end services which are being worked through; however there have been good working relationships with YAS and evidence that the modelling and data predictions were accurate which kept the services safe during transition. Patients flow has improved and the three reconfigured services have articulated positive clinical benefits. Importantly, the project has allowed further service improvement initiatives to both expand and mature as the teams grow in confidence to enact more transformation changes in the future.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board are asked to note the contents of this paper and support the next steps as identified by the services.

Appendix

Attachment:

APP L - Medical Services Reconfiguration BOD June 18.pdf

Medical Services Reconfiguration: A 6 Months review

1. Purpose of the Paper

The purpose of this paper is to provide an update on the clinical services in the Medical Division reconfiguration project. A review of the services to establish if the assumed benefits have been realised was scheduled for 6 months post implementation. The timeframe was chosen to enable a fair analysis using a data set that minimises bias through seasonal activity and allows settling down of clinical teams. The paper provides an overview of methodology used to complete the review, a summary of the impact on the clinical services including feedback from staff and patients, and a review of the KPI's. The paper also identifies next steps, followed by a review of the aims and objectives for the project to see if these have been met.

2. Background

The reconfiguration of Cardiology, Elderly Care and Respiratory in-patients services was completed 12th December 2017. The time around the move held many challenges for staff, primarily as it took place in the winter months which presented usual seasonal issues around staffing additional capacity. The three months following the move also had unprecedented activity which had a particular impact on the clinical services central to the changes.

The early days of the move was identified as a stressful time for many staff, particularly the nursing staff on the elderly care wards at HRI. This was, in part, due to smaller ward teams coming together into single large ward and in part due to the high number of vacancies compounded by an increased bed base. Staff during this time also identified problems with IT connectivity, access to PC's and delays in repairs and small works being completed. Our staff during this period worked extremely hard to ensure patients safety and experience whilst in our care was not compromised. The lessons learnt from this period are captured in the project closure document which is being circulated for future reference.

Following the settling down period all three clinical services were engaged in a variety of ways to get an understanding of the impact of the change and the future plans.

3. Methodology

A range of qualitative and quantitative methods were used in the review. This included feedback from matrons and ward managers with particular reference to the views of staff, patients and families/carers, a Divisional workshop, engagement with wider affected services in the Trust and external partners (YAS). Although continued to be reviewed, the data collection for the KPI's is a routine 'business as usual' for the Division. The findings from the three reconfigured services and supporting services affected by the change are summarised below

4. Cardiology

The cardiology inpatients services are established at CRH. The consolidation of the clinical teams allowed the Consultant of the Week (COW) model to start 1st April '18. The model allows continuity of care by having the same Consultant review ward patients each day. This ensures quicker decision making and supports earlier discharge from Cardiology beds. The COW model also supports phone advice to other areas to support admission avoidance. The service has also implemented a full 7 day working for cardiology clinical teams

The service is now meeting the 60% target for the NSTEMI patients having Angio +/- PCI within 72 hours of admission (based on MINAP patient list). This is primarily due all in-patients being at CRH

with a reduction of approximately 220 inter-hospital transfers from HRI (per year). The team have now also implemented service improvements in the catheter lab pathways resulting in a shift from in-patient to day case from 60%-90%. The pathway has improved the experience of patients with less waiting time on the day for procedures and less service initiated cancellations.

The review identified only a very few patients require clinical transfer from HRI to CRH for specialist cardiology services. This is less than anticipated and therefore the daily on-site presence for cardiology nurses at HRI was found not to be required. The nurses now travel across site as required throughout the day. This capacity has allowed development of the nurse led One Stop Arrhythmia Clinics and Virtual MDT for post pacemaker patients which started in April 2018. The clinic reduces unnecessary appointments for patients, has audited well and is looking to expand.

What our patients say: For Cardiology services, patients fed back they "like knowing who their consultant of the week is", specifically, they get to know them and get a better understanding of their own condition and the management plan.

What our staff say: There were some experienced staff that transferred from HRI to CRH with the service then subsequently left to work back at HRI; however the recruitment position has improved as the single site service is more attractive. Staff describe the COW model as positive with consistency of medical review making patient management easier. The junior doctor's spoke of feeling "far more supported now" and spoke of how the "training has improved". Previously the Trust had quite poor feedback from the deanery and it is anticipated this will improve in the next report

Next Steps: The service has benefited from the consolidation of staff and facilities and is working on several service improvement initiatives, including improving the pathway for a nurse led Chest Pain clinic to reduce waits and improve triage, implement Heart Failure clinics & repatriation of primary PCI & ablation.

5. Respiratory services

Due to the consolidation of clinical teams and successful recruitment, on the 21st May the respiratory team have been able to implement the Consultant of the week model to provide continuity of care and improves discharge rates. This minimises the reliance on agency staff. The COW model also allows phone advice to other areas to support admission avoidance.

All patients presenting to hospital now have access to the respiratory 'hot clinic', this was previously only available to Calderdale patients. The clinic offers rapid access to Consultants that reduces admissions and allows patients to be managed at home where appropriate.

As in cardiology, daily in-reach for Respiratory clinical staff at HRI has been reduced as the numbers of patients requiring the service were found to be low. A daily review is always available and nurse's travel across site when required. The COW is also available on the phone for advice

Subject to recruitment, the clinical team now has the opportunity for a Respiratory model moving to 7 days working, which will allow a set-up of a full acute Respiratory unit. The number of specialist beds in respiratory services will further increase at this point.

What our patients say: Having the same doctor every day is a real positive as patients get to know them

What our staff say: Post the move, 9 staff left the ward to relocate back to HRI. All these moves were for travelling time reasons only and staff were sad to leave. Recruitment is easier as the service is expanding and there are more development opportunities. The teams have settled down and are working well together.

Nursing team's spoke of feeling they are working towards a single patient's plan, which doesn't constantly change based on different consultants doing the daily ward round. This means nurses can discharge plan better and get the patients home sooner.

Next Steps: Due to the consolidation of the service, the Respiratory team has been able to develop a further range of service improvement initiatives which they are now working up:

- There is a proposal for the Huddersfield commissioners to match the Calderdale model – with more early supportive discharge, increased in-reach into A&E and hot clinic access (access to a consultant clinic for urgent appointments) from community to avoid A&E and potential admission
- Virtual MDT for Nodule Clinic patients
- Telephone consultations for Asthma & COPD patients – to pilot for in Sept when new consultant starts
- The triaging of ERS referrals with a potential to reduce unnecessary out-patients appointments

6. Elderly Care services

The consolidation of the elderly care team has allowed the development of a Specialist geriatrician rota that supports 7 day working. The rota is expected to be live in the autumn. The benefits of a 7 day geriatrician review for patients will be to support consistency of discharge and avoid admissions. There will be more support for YAS 'silver phone' to provide advice and guidance to avoid unnecessary hospital attendances. The Consultant teams have expressed views the co-location of wards at HRI improves ability for consultants to provide cross cover ensuring more consistent patient reviews.

The frailty team at HRI was expanded above substantive funding over winter to support the reconfiguration and seasonal activity. The aim was to improve the care of frail older patients and provide an enhanced response early in the patient's journey.

Prior to reconfiguration, there was no frailty service for patients attending CRH. The benefits of the Frailty service so far are:

- Patients identified as frail (as defined by Rockwood score) in the front end care are referred into the frailty team and commence a Complex Geriatric Assessment which is either partially or fully completed. The number of patients being seen in this service has increased from average 175 per month (Apr-Nov'17) to an average of 320 per month (Jan-April '18)
- All assessed patients are reviewed and discussed at the MDT twice daily expediting discharge and avoiding re-admissions
- 31% of referred patients now have an admission avoided. The length of stay for these patients has also fallen from an average of 1.4 days to 1.1 days. This demonstrates how the frailty service is improving the experience of our elderly patients by facilitating timely discharge back home or to a community setting.
- The number of re-referrals back to the frailty team (through re-admission) has also increased from an average of 16 to 44 per month. This is above what would be expected and is being further investigated.
- Post reconfiguration, the frailty team support the 'Silver phone' which is an advice and guidance line for YAS and GP's to support decision regarding acute admissions. This has proved very popular.

The consultants are providing in-reach to CRH by phone or site presence however there was a concern raised that a number of patients who have recovered from a different primary condition and

are frail, may not be getting sufficient review. The level of in-reach is currently being reviewed including expansion of the frailty team.

The ward areas/ estates at HRI have benefits and challenges for managing frail elderly patients. Although an improved number of side rooms from CRH there are less on-suite facilities. Some ward areas have reduced visibility which was addressed through workforce models. Benefits from the estates have included more space for patient therapy areas and for socialisation particularly at mealtimes.

The wards at HRI have worked hard to come together as teams and have implemented improvements post-reconfiguration for all patients. These include:

- All ward areas now having engagement workers to provide support and socialisation for patients
- All patients, clinically fit enough, are dressed and have meals together (PJ paralysis initiative). At CRH there was limited room for communal eating.
- Nutritional assistants are on every ward

A high level of vacancies of ward nursing staff remains; however this is inconsistent across the wards (between 15% and 50%). The overall vacancy rate is in line with pre-reconfiguration figures. The 4 elderly care wards flex the substantive staff between themselves ensuring all wards have nursing staff experienced in elderly care patients.

Four of the Elderly Care wards are each taking a lead on an initiative to improve patient's safety and experience, including nutrition, tissue viability (pressure sores) & falls. Each ward will become the champion for the improvement and will provide support, training and guidance for the other wards

What our patients say: The impact of the frailty team at HRI is viewed as having a positive benefit by patients. The family from a patient from Todmorden who was brought by YAS to HRI spoke of being "overwhelmed at the lengths [the staff] went to ensuring [the patient] was cared for in the right place" (App1). The patient was a frequent attender who quickly became delirious post admission. This always protracted a hospital stay. The frailty team made sure the family had the support required to return the patient home from ED. There was no previous frailty provision at CRH to enable this

What our staff say: "The wards are now working more as a team, supporting each other". "After a difficult start, trying to manage the winter capacity, the staff are getting on well and working as a team". "The elderly care services have benefited from improved therapists presence on the wards. This is for response times and continuity of therapist. This has not been without challenge for staff changing working patterns and some have increased weekend commitments" "The therapy staff have adapted well and just got on with it"

Next Steps: A workshop in February with the Elderly Care team identified 5 areas for service improvement, building on the opportunities from centralising the wards. These are:

- Expansion of the frailty support: The main aims are to scope and find a solution to supporting a frailty service at CRH, to increase the hours of the current service, to expand into acute wards and provide a direct referral route from primary care.
- To pilot and recommend a model for 'Home First' in Calderdale: This is a CCG supported initiative to support admissions avoidance and better care for patients at home
- Improvements in dementia care; The aims are to upskill staff using innovation and technology to develop training packages and to improve nutrition and hydration for patients
- Improved flow through better MDT: To be achieved by having consistency of MDT, standardising handover for nursing staff and embedding Board rounds.

- Maximising the benefits of EPR: Particularly around MDT and assessment information capture.

All Workstreams have a clinical and operational lead and a developed implementation plan.

7. ED/ AMU

ED and AMU teams were a key part of the project team and the impact of the changes was modelled and risks assessed. The review looked at the impact and if the planned mitigation was effective.

HRI: The case mix of patients on each hospital site was predicted to change however the extent of the impact at HRI ED was underestimated. The increased dependency of patients in ED/AMU at HRI is higher than anticipated with 81% frailty and both nursing and medical staff reported significant changes in the type of care they are providing. Following feedback, the Divison are working with the deanery to ensure junior medical staff get the breadth of experience required. The frailty team is seen as a key presence in ED and AMU and feedback indicates this is a key support for ward staff.

The impact on the delivery of the 95% 4 hour target remains unclear and further work is ongoing. There is an increase in the number of ED breaches due to waits for medical beds; however this fluctuates with a peak in March ’18 and may be due to seasonal pressures.

CRH: The increased acuity of patients at CRH is as predicted with critical care reporting no adverse incidents and the contingency for additional ICU capacity working as planned.

The ED/ AMU teams are reviewing rotas and rotation for Middle Grades, junior doctors and nurses to address the needs for different workforce models cross sites. These should be in place in the next 2 months.

8. Triage of patients by YAS

The triage of patients by YAS is perceived to be working well by ED staff. YAS operational teams have indicated good relationships with ED staff and a process of continual learning with no issues for escalation.

The average daily patient transfers required from HRI to CRH and from CRH to HRI was estimated to be 1.7 and 1.4 respectively. The actual numbers of transfers are <1 per day each way indicating YAS triage is working well and patients are self-presenting to the specialist sites.

9. Patients Flow

Patients flow was improved by the service change. There was an unprecedented rise in normal seasonal activity that pushed the opening of extra capacity across the Trust. Respiratory, which saw a larger increase in number and acuity of patients were able to flex to cover 5D. Cardiology had reduced length of stay that improved flow through the beds.

“Having frail elderly patients at HRI supported by the frailty team and Patients Flow supporting infrastructure [LA, Locala] avoided the need for opening further unplanned capacity” (Patients Flow team)

10. Critical Care

CRH ICU staff describe the service as 'feeling' busier, however has only reached the planned escalation capacity a few times. HRIs issues have been minimal, other than flexing to ensure more optimal nursing cover at CRH,

The critical care team describe how "the Outreach workload at CRH has increased since the reconfiguration, but with no significant issues and Patient safety has not been compromised"

NIV use at HRI has been dealt with appropriately, and patient safety maintained. From the NIV audit at HRI since the reconfiguration there have been 4 patients requiring NIV out of the designated areas. These took place between December 2017 – January 2018 with no cases since.

11. Impact on Patient Numbers

The number of patients who would be impacted by the service change was estimated in the case for change. The review assessed if these estimates were found to be correct. All information was triangulated and agreed with YAS.

Huddersfield postcode patients: It was estimated between 2180-2840 patients a year who previously attended HRI by ambulance would be taken to CRH . The data extrapolated from January-May 2018 actuals indicates 2640 patients per annum. This is in line with estimates

Calderdale postcode patients: It was estimated 1880-3022 patients who attended CRH by ambulance would go to HRI. The variance in the estimates was due to the level of potential ambiguity in identifying 'frailty'. The higher value represents all patients 75 and over. The data extrapolated from January-May 2018 actuals indicates 1968 patients per annum. The triage YAS is using is working well and in line with the co-developed clinical model. Patients 75 and over, who do not have frailty as the primary clinical condition, remain treated on the closest site or the site with the appropriate clinical service.

The findings indicated estimates to be correct and benefited from close working and prospective audit with YAS during the planning phase.

12. Impact on Staff

6 months on, informal staff feedback is, in the main is positive, however travel remains the key issue for a few staff. Following the initial move several staff found roles back on the original hospital sites due to difficulties travelling. These were found to be staff with childcare or other dependents as well as staff who found it difficult to access transport. No staff left the Trust citing the reconfiguration as the primary reason.

For the services affected, an analysis of turnover for April17'-May '18 demonstrated only normal monthly variation for staff turnover, with overall, 69.67 WTE staff leaving and 62.32 WTE commencing employment with the Trust.

13. Complaints and Incidents

There were no incidents or complaints from families during the ward moves. There have subsequently been no formal complaints about the location of the services following reconfiguration; however a Ward Manager from Elderly Care spoke of occasional comments from families who would prefer the service at CRH.

There have been further DATIX incidents or complaints attributed to the reconfiguration.

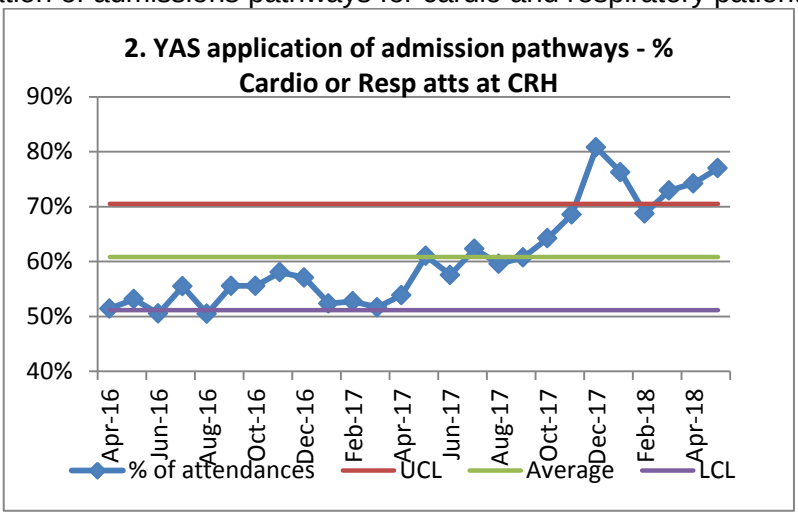
Next Steps: There were patients engagement sessions pre reconfiguration and a follow up session with Cardiology, Respiratory and Elderly care patients is planned for September to get formal feedback on the current models.

14. KPI's

Key performance indicators were developed during the planning phase to monitor both risks and benefits of the change. None of the KPI's have shown significant deterioration in performance compared to last year (Appendix 2) and early indications show that for the majority performance has improved. SPC charts and run rate graphs have been developed as appropriate as part of a dashboard to monitor performance. The dashboard is a live document which is being worked through a PDSA cycle and is used as a tool to constantly review the quality and impact of reconfiguration. Some of the SPC charts are included below. For reference, the green line shows an average level of performance with the red and purple lines indicating where there has been a significant improvement or deterioration in performance. We would expect performance to lie between the upper and lower levels with anything outside of these flagging the need for investigation.

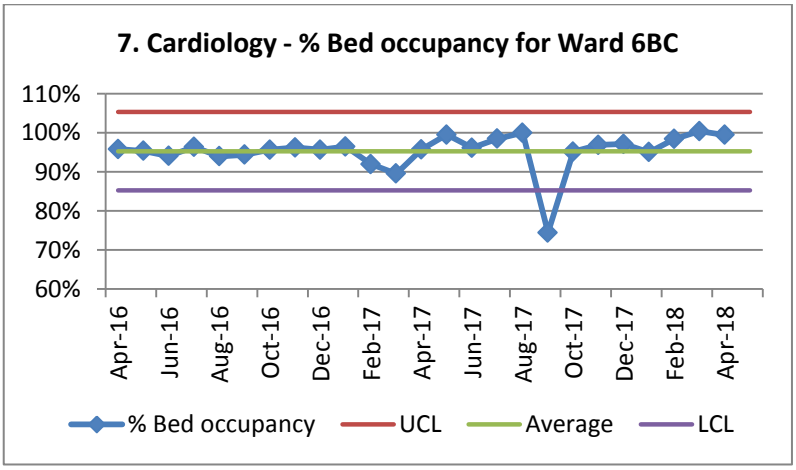
<u>We set out to improve the following</u>;

1. YAS application of admissions pathways for cardio and respiratory patients:



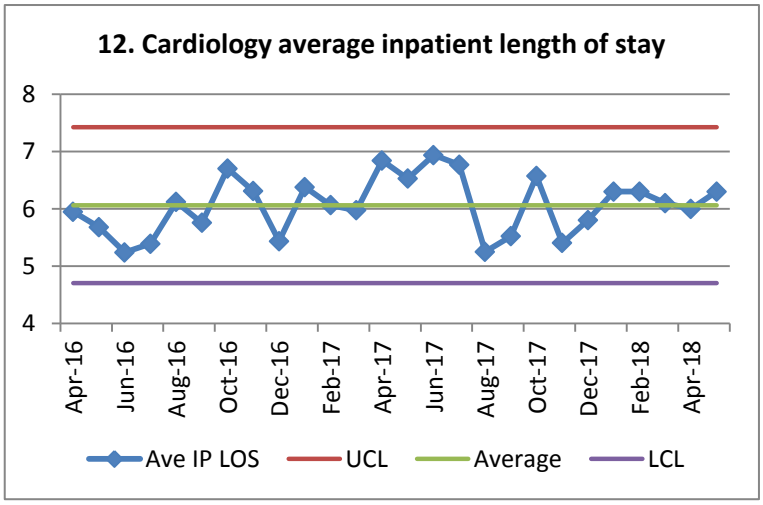
There is an upwards trend demonstrating YAS is improving in its application of the admissions pathway

2. % bed occupancy for cardiology and respiratory



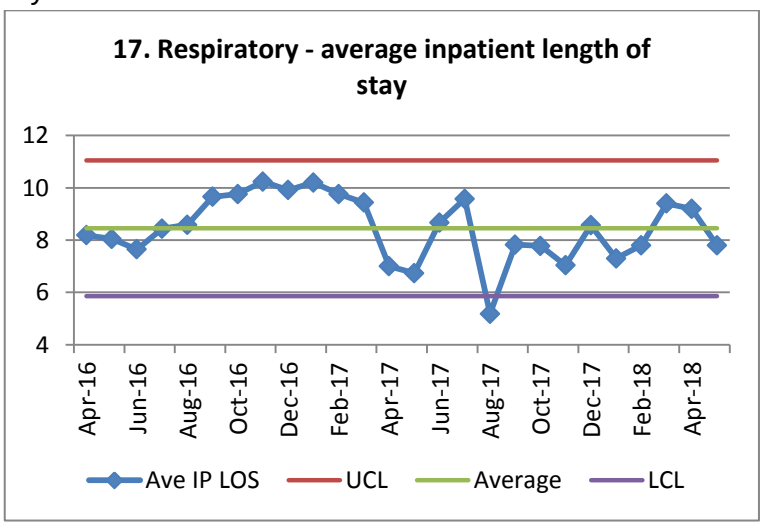
Performance since reconfiguration is demonstrating performance within normal variation but with a trend of improvement

3. LOS for cardiology



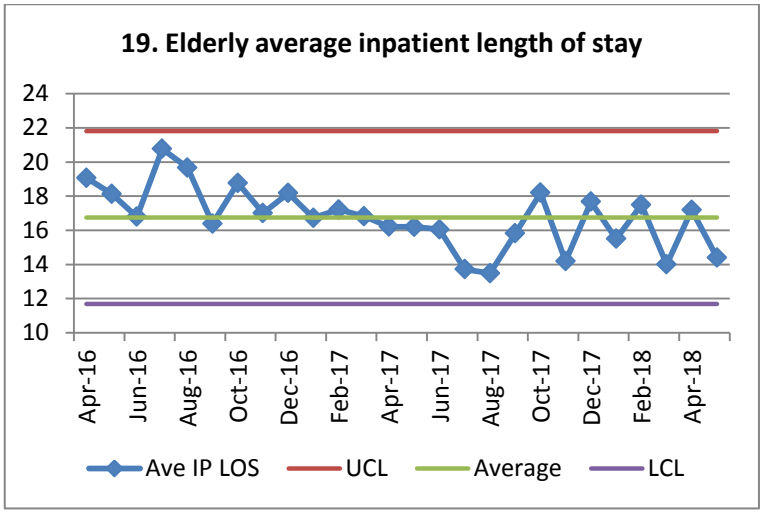
This shows no statistical improvement however data may be influenced by the move from more in-pts stays for angio and PCI to day case. This increases the acuity of the ward patients. Further work needs to be done

4. LOS Respiratory



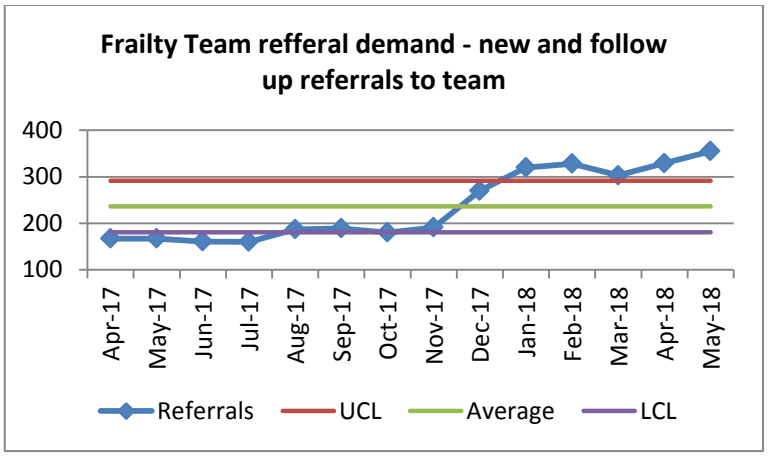
Performance shows no statistical difference. Improvements are expected following the COW model end of May ‘18

5. LOS Elderly care



Performance is variable and may be influenced by seasonal additional capacity, particularly in March '18. 7 day geriatrician rota will improve performance.

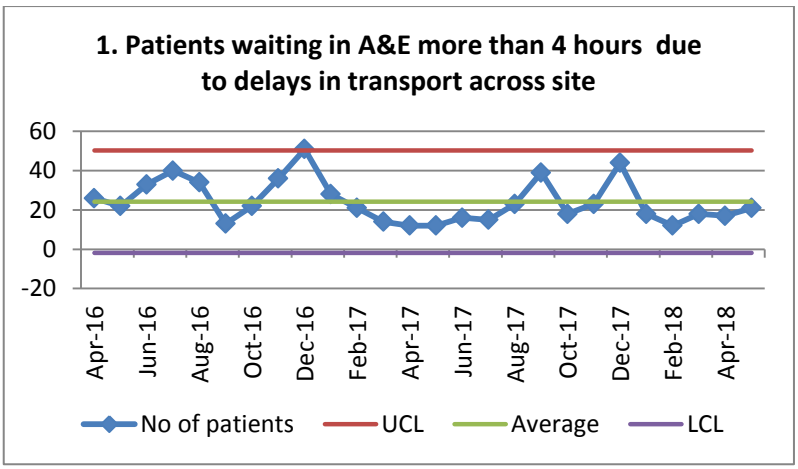
6. Frailty team referral demand



As expected the number of referrals increased in line with the increased number of patients through ED

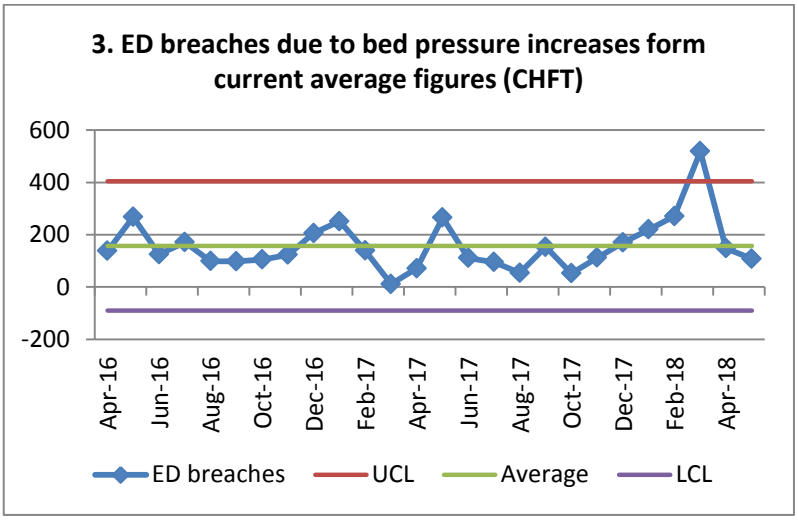
<u>We set out to monitor the following to ensure there was no deterioration in performance;</u>

1. Patients waiting in A&E more than 4 hours due to delays in transport:



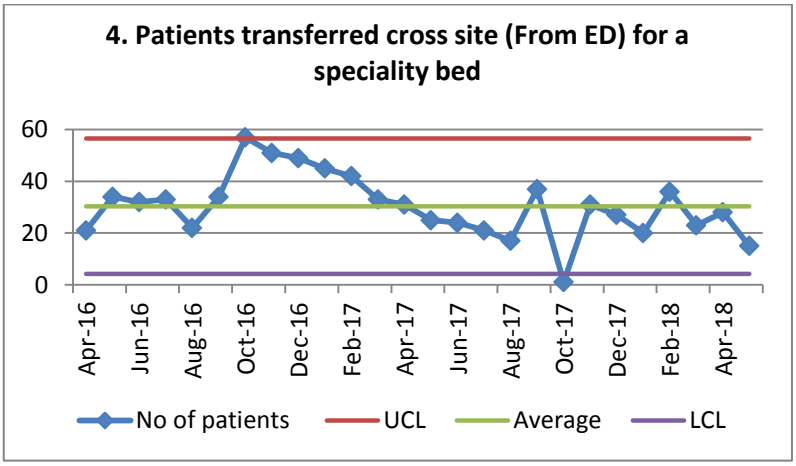
There was no increase in delays due to transfer of patients across site.

2. ED breaches due to bed pressures (blip in March 2018 but otherwise improving)



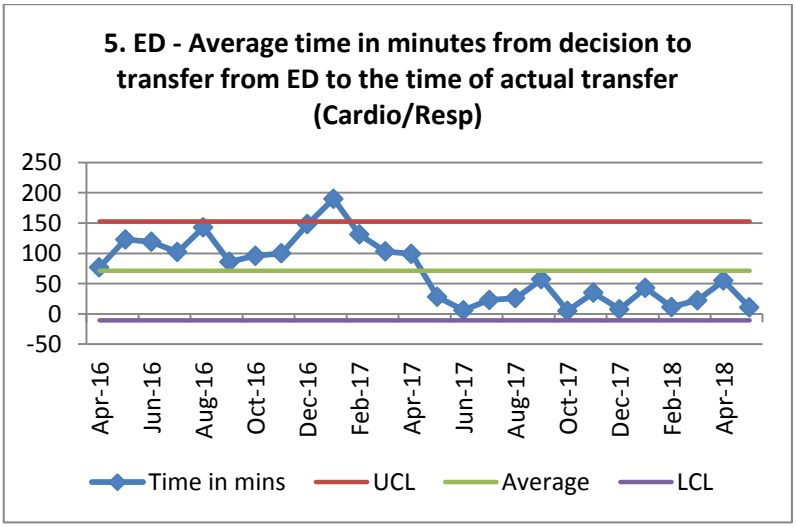
Performance is within normal variation with the exception of March '18 which was due to unprecedented levels of activity.

3. Patients transferred cross site from ED for a specialty bed



Pre-reconfiguration the number of patients being transferred across site showed a trend of reduction and was predictable. The current numbers are more variable however remain with planned activity with YAS.

4. Time from decision to transfer from ED to the time of actual transfer to Cardio/Resp



The improvements in transfer wait times have been maintained post reconfiguration.

All the above show either improvements or no deterioration however there are a number of actions in place which will further improve performance across a number of the above indicators;

- Embedding the consultant of the week model in Cardiology and Respiratory. The expected outcome of this is that length of stay will reduce across both specialties. As a result of this it is likely that harm free care will also improve.

- Development of the Frailty team through the winter planning and UCB. The proposal sets out to increase and develop the Frailty team so that more patients can be seen in the front end and comprehensive geriatric assessments completed for all patients. This will in turn reduce admissions, length of stay and readmissions.

KPI's continue to be monitored through the Directorate and Divisional processes.

15. Update on Aims and Objectives:

The project aims and objectives were agreed following engagement with patients, staff and external partners. The following table outlines if the changes made have met these expectations.

	Aims	**Was this achieved?**
1	Make sure we can offer the same high standard of care to every patient, where ever they live.	Yes, consistent service provision
2	Get better at assessing and supporting patients to avoid admitting and keeping them in hospital unnecessarily	Yes, frailty service at HRI increases home first
3	Give the best care for patients by making sure they are admitted into the most appropriate specialty bed or day case area	Yes,
4	Ensure patients receive same care and input wherever they enter the service, whatever day of the week'.	Partially: Pending consultant recruitment
	Objective	**Was this achieved?**
1	To develop new and sustainable models of care, using capacity differently, reducing variation and making best use of facilities, staffing, technology and equipment	Yes
2	For patients and staff to support development of the best service model	Yes
3	To Optimise community services to provide care closer to or at home	Partially: further work to do
4	To respond to the Invited Service Reviews by implementation of recommendations including providing single site service provision for acute Respiratory and Elderly Medicine services	Yes

5	To create the foundations to support the delivery of 7 day specialist consultant cover on Cardiology, Respiratory and Elderly Medical	Yes
6	Innovate and create wider system solutions with other health providers and the third sector	Partially: Foundations set for further service improvement work
7	Improve efficiencies in the end to end services to support the Health Economy cost reduction and bed reduction strategy	Yes; Reduced Cardiology beds, improved flow

Summary

The aims and objectives for this complex project have either been met of have a platform now set for delivering the improvements. The KPI's re-enforce this position by either demonstrating improvements or no deterioration to patients services. Our patients welcomed the changes and described how improved communications with their Consultants helped with the understanding of their treatment plans; however travel, for some family and friends of Elderly patients in particular, has remained an issue, preferring the service more local. Whilst a few staff found travelling difficult, this has been mainly been resolved through reallocation of jobs on the site of choice. Many staff articulated improvements in training and supervision and improved continuity of clinical care supporting earlier discharge.

There have been challenges to the front end services which are being worked through; however there have been good working relationships with YAS and evidence that the modelling and data predictions were accurate which kept the services safe during transition. Patients flow has improved and the three reconfigured services have articulated positive clinical benefits. Importantly, the project has allowed further service improvement initiatives to both expand and mature as the teams grow in confidence to enact more transformation changes in the future.

17. Recommendation

The Board are asked to note the contents of this paper and support the next steps as identified by the services

Patients story:

This is a patient from Todmorden who had previously being getting admitted with UTI, falls etc. It became clear when looking back through the notes and speaking to family that he suffers with delirium each time he is admitted and this is what is increasing his length of stay. We spoke to family and to him who was just starting to become very confused and agreed home today was the best place for him to be. We spoke to CRISIS who had no capacity to do a discharge to assess and then spoke to Virtual ward that could not visit today but asked them to prioritise a call tomorrow which they agreed to do. We then spoke to his family and private care providers and agreed that we would take him home with our therapy staff and do his assessments at home today as he also had a stair lift and given his delirium it would be good to do this in his own environment where he would feel better orientated. It went well and we have left him at home to be cared for with a plan in place RC 31st May 2018. The family said they were overwhelmed at the lengths we went to ensuring he was cared for in the right place. The repercussions would have been worse for him and us if we hadn't got him home on the day.

The patient would not have been seen at all by frailty pre reconfiguration.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Appendix B Current KPI dashboard

Indicator Evaluation Summary

Compare Dec 16 to Nov 17 with Dec 17 to date

Ind	Area	KPI	Rationale	Whats happening to KPI ? Improving	No Change	Worsening	Data not available
1	Emergency Department	Patients waiting in A&E more than 4 hours in ED due to delays in transport across site - Trust	Low - good	YES			
2	Emergency Department	YAS application of admissions pathways - % Cardio or Resp atts at CRH Site	Higher - good	YES			
3	Emergency Department	ED breaches due to bed pressures increases from current average figures	Low - good (to check)		YES		
4	Emergency Department	Patients transferred cross site (from ED) for a Specialty Bed (ie from HRI to CRH)	Low - good	YES			
5	Emergency Department - Cardiology/Respiratory	ED - Time from decision to transfer from ED to the time of the actual transfer Cardio/Resp - Average time in mins	Low - good	YES			
6	Emergency Department - Cardiology/Respiratory	ED - Time from decision to transfer from ED to the time of the actual transfer Cardio/Resp - Longest time in mins	Low - good	YES			
7	Cardiology Inpatients	Cardiology Specialty - Avg Daily Beds Occupied	High - good (to check)	YES			
8	Cardiology Inpatients	Cardiology Specialty - Occupied Bed Days	High - good (to check)	YES			
9	Cardiology Inpatients	CCU - Ward % Bed Occupancy	High - good (to check)	YES			
10	Cardiology Inpatients	% of NSTEMI patients having Angio +/- PCI within 72 hours of admission (based on MINAP patient list)	High - good (to check)				YES
11	Cardiology Inpatients	Cardiology % Day Cases	High - good	YES			
12	Cardiology Inpatients	Cardiology - Avg IP LOS	Low - good		YES		
13	Cardiology Inpatients	Cardiology - % Harm Free Care	High - good		YES		
14	Respiratory Inpatients	Respiratory Specialty - Avg Daily Beds Occupied	High - good (to check)	YES			
15	Respiratory Inpatients	Respiratory Specialty - Occupied Bed Days	High - good (to check)	YES			
16	Respiratory Inpatients	Respiratory Outlier bed days - Non Resp Wards	Low - good (to check)			YES	
17	Respiratory Inpatients	Respiratory - Avg IP LOS	Low - good	YES			
18	Respiratory Inpatients	Respiratory - % Harm Free Care	High - good		YES		
19	Elderly Inpatients	Elderly Avg IP LOS	Low - good		YES		
20	Elderly Inpatients	Elderly - % Harm Free Care	High - good		YES		
21	Overall	Critical care: Number of non-clinical patients transferred across site / to another facility	Low - good		YES		
22	Overall	Financial Savings Delivered	High - good				YES
23	Frailty	Frailty Team Referral Demand - New & F/UP referrals to Team	High - good				YES
24	Frailty	Time from referral to being seen < 2 Hours	High - good				YES
25	Frailty	Admissions Avoided - due to Frailty Team intervention	High - good				YES
26	Frailty	Frailty Team - Average Team LOS (in days)	Low - good				YES
27	Frailty	Readmissions back to Frailty Team	Low - good				YES

Note - interpretation of indicators needs ratifying by clinicians / service

Summary

KPI Improving	12
KPI No change	7
KPI Worsening	1
KPI more data required	7
Total	**27**

18. Guardian of Safe Working Hours Report

To Note

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Anu Rajgopal, Consultant Medical Microbiology
Date: 5.7.18	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Guardian of safe working hours Q2 report 2018 - To provide assurance to the Board around safe working for junior doctors and raise any significant issues.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

See attached

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

See attached

Next Steps:

See attached

Recommendations:

For approval

Appendix

Attachment:

report final.pdf

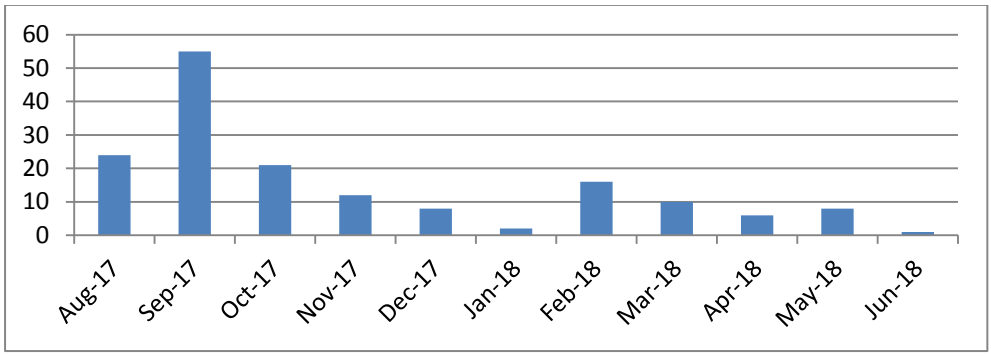
Guardian of safe working hours (GOSWH); CHFT

Quarter 2 report 2018

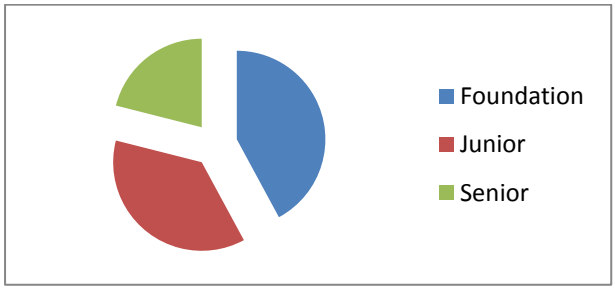
a) Exception reports (16th March- 27th June 2018)

There are 19 exceptions recorded during this period.
Only 7 have been completed on Allocate, the remainder are still pending despite numerous reminders. I have sent out email reminders and Allocate instructions to supervisors and will escalate to the relevant clinical directors if they remain outstanding

Exception reports by month

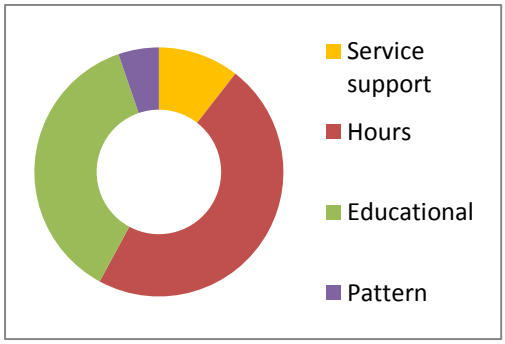


Exception reports by grade

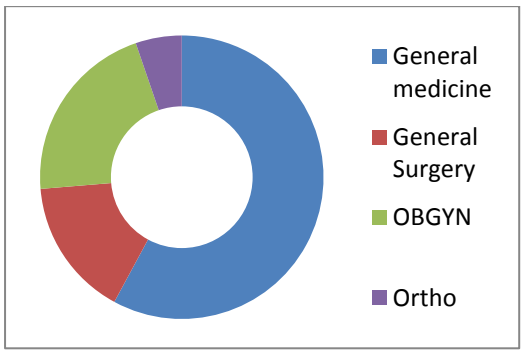


There is an increasing trend of ERs from junior and senior trainees, majority of which are around missed educational opportunities

Type of exceptions



Exception report by rota



Main issues arising and steps taken to resolve them

The proportion of exceptions from medicine has increased in this quarter. This was mainly due to reports from the gastroenterology foundation trainee who often was left with no registrar support in the afternoons. The directorate is aware and registrar rotas have been made accessible to foundation trainees. Since this, no further ERs have been reported.

There were also a few exception reports from another oncology foundation trainee who was required to cover gaps on elderly care wards as a last minute swap and hence missed educational opportunities on the oncology ward. This is being monitored currently.

All 4 ERs from senior trainees were from Obstetrics and Gynaecology. This rota had significant gaps, mainly deanery and some LTFT trainees. I have met with the registrar rota designer and spoken to the clinical director regarding this. The directorate is in the process of recruiting MTI trainees and the rotation matrix circulated from August 2018 has 2 new ST3 trainees on the rota.

Information on vacancies and locum bookings

This will be provided in the next quarter. All our rotas for August are compliant.

Junior doctor awards

Following conversations at the last JDF (March 2018) and feedback from the CQC inspector, there are plans to set up junior doctor awards next year. This was supported at the CHFT directors' meeting in May.

Improving working lives of junior doctors

The medical director has commissioned a small working party to look at how we may be able to improve working lives for junior doctors at CHFT. This was on the back of the BMA fatigue and facilities charter presented at MADPACC earlier in May. As a start, we are setting up a survey for junior doctors to identify any particular issues and have set up an action log to measure compliance with elements in the BMA charter.

Fines

No fines have been issued this quarter

Administrative support for GOSWH

This has now been identified and is in place. We are working to produce a document of roles/responsibilities and standard operating procedures.

Anu Rajgopal

Guardian of safe working hours

June 2018

19. Update from sub-committees and receipt of minutes & papers
Quality Committee – verbal update from meeting 2.7.18 minutes from meeting 4.6.18
Finance and Performance Committee – minutes from t...

To Note

QUALITY COMMITTEE

Monday, 4 June 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

082/18 WELCOME AND INTRODUCTIONS

Present

Dr David Anderson **(DA)**	Non-Executive Director **(Chair)**
Helen Barker **(HB)**	Chief Operating Officer
Dr David Birkenhead **(DB)**	Medical Director
Paul Butterworth **(PB)**	Governor
Alistair Graham **(AG)**	Non-Executive Director
Lesley Hill **(LH)**	Director of Planning, Performance, Estates and Facilities
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Jo Middleton **(JMidd)**	Interim Assistant Director of Quality and Safety
Lynn Moore **(LyM)**	Governor
Liz Morley **(LzM)**	Associate Director of Nursing - Community
Jackie Murphy **(JMy)**	Interim Chief Nurse
Dr Julie O'Riordan **(JOR)**	Divisional Director – FSS Division
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Andrew Mooraby **(AM)**	Associate Director of Nursing – Medical Division
Mel Addy **(MA)**	Director of Operations – Surgical Division
Anne-Marie Henshaw **(AMH)**	Associate Director of Nursing – FSS Division
Dr Lindsay Short **(LS)**	Consultant – Genito-Urinary Medicine – Sexual Health

083/18 APOLOGIES

Dr Linda Patterson	Non-Executive Director
Dr Ashwin Verma	Divisional Director – Medical Division
Asif Ameen	Director of Operations – Medical Division

084/18 DECLARATIONS OF INTEREST

Alistair Graham declared an interest in the Wholly Owned Subsidiary (WOS) at item 089/18.

085/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 30 April 2018 were approved as a correct record.

086/18 ACTION LOG AND MATTERS ARISING

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

087/18 CQC REPORT

JMidd (Interim Assistant Director of Quality and Safety) gave a verbal update that the draft report was received for factual accuracy and returned to the CQC, and that a swift turnaround is anticipated with the publishing of final report. The CQC meeting will recommence to review the CQC 'must do' actions, and a review of the well-led inspection is also taking place, the results of which will be compiled into a report. JMidd reported that the action plans from the CQC meetings will be reported here, and then escalated to Board.

088/18 QUALITY AND PERFORMANCE REPORT

HB (Chief Operating Officer) presented appendix E and reported on the change to the report based on discussions with sub-groups in terms of correct metrics.

Some indicators have been relocated within domains with numerical activity now being reported rather than percentages, and further metrics have been introduced within efficiency and finance. HB also reported that a year on year comparison would be unable to be done due to the different thresholds.

April's performance score stands at 62%. The safe domain is amber as post-partum haemorrhage and category 4 pressure ulcers have missed their target. The caring domain has maintained its amber performance with further work to do on Friends and Family Test (FFT). The effective domain has remained amber although fractured neck of femur has missed its target for the first time in three months. The responsive domain slightly deteriorated although two out of four stroke indicators achieved target. Cancer 62-day screening to treatment was the first main cancer target to miss since October 2017 and that was due to low patient numbers with half a breach having an impact. Diagnostics six weeks also missed target for the first time since November 2017. In finance, all indicators were 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 2017, and mandatory training now includes all nine essential safety areas with the additional four areas all green.

LR reported that a deep-dive will be carried out on the FFT outpatients survey, which will be taken to the Weekly Executive Board (WEB) and work has been commissioned for divisions to review users of the outpatient services. Community FFT has reverted to the old sampling methodology which should improve the response rate. AMH reported on the emergency caesarean section rates and the further work to be done on themes or trends in relation to this month's performance.

DB reported on infection control and the eight Clostridium difficile (C.diff) cases to date, which is being focussed on due to a reduction not being seen. Escherichia coli (E.coli) reduction will be challenging. The Summary Hospital-level Mortality Indicator (SHMI) update was delayed due to data quality issues, and predictions should be below 100.

HB reported on the Multi-Agency Discharge Event (MADE) which covered 15 wards. There was a positive attitude taken by the teams and ward staff in terms of improvement mentality and receptiveness of learning. The key action will be to have MADE events once a month.

Discussion ensued on complaints closed within timeframe. There have been assurances from divisions that the backlog of breaching complaints is expected to be cleared by the end of May. A presentation is to be submitted to the Weekly Executive Board (WEB) regarding the timeliness of responses to complaints.

Discussion also took place on the percentage of dementia patients following emergency admission aged 75 and over. Current performance is 25% against a 90% target. LR reported that the leadership has been reviewed and this is being tracked weekly through divisional level meetings. The performance is not where it needs to be and looking at reasons why performance has slipped.

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

089/18 Q4 ESTATES AND FACILITIES DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT

LH reported on appendix F:

- Work ongoing for the set-up of the Wholly Owned Subsidiary (WOS) for CHFT. Dialogue continues with colleagues and unions with a planned go-live date of 31 August 2018.
- The division is currently looking at the Apprenticeship Scheme available in the Trust and looking at current staff undertaking apprentice courses, mainly in customer service and supervisory to support their job roles.
- Chris Bentley retired from her Estates and Facilities matron post in March, with Janette Cockroft filling the post.
- 2018/19 Capital Plan agreed and will include improvement work at HRI.
- Catering at HRI will be introducing snack platters on a number of wards at HRI from 1 June 2018.
- The facilities team are liaising with A&E colleagues regarding concerns for priority choices for patient moves on the Electronic Patient Record (EPR). All are currently being requested as urgent, when not necessarily needed and impacting on other areas.
- Emergency Preparedness, Business Continuity and Security – Good progress has been made with testing business continuity plans in several areas of the Trust, with further exercises planned for areas at CRH.
- Two top risks are in relation to a collective risk regarding the HRI estates and a collective risk for Intensive Care Unit (ICU) and resuscitation.

Discussion ensued on the 2018/19 capital programme and the risk in relation to the current HRI estates failing due to age and condition. It was asked if there was a strategy in place to try to ensure that the most urgent work is completed. LH reported that the 6 facet survey (areas identified which are below condition B and need updating to meet statutory compliance) has been re-stratified against funding available. The last survey took place five years ago and would be helpful to have a new survey.

It was suggested that the incident categories at table 1 of the report is amended to state that incidents were toward staff.

One of the new risks in relation to manual handling training (7070) was discussed, and it was asked whether this was attributable to the manual handling-related pressure ulcers. LR reported that the update given by tissue viability in January 2017 acknowledged that there were some incidents that were related to equipment (slide sheets) where pressure ulcers may have developed as a result of shearing. There may be a correlation with pressure ulcers and manual handling, however, the above risk is more around the impact on staff and staff injuries due to the lack of manual handling training, and not related to pressure ulcers. It was asked if there could be an integrated report on manual handling and tissue viability incidents.

PB raised a concern, which was raised by the CQC, regarding fire doors being wedged open, and whether this has been actioned. LH reported that the division is working with wards around fire safety, and that a deep dive has taken place to review fire folders on wards and departments and areas lacking fire wardens.

DA raised the issue of the disposal of Acre House, Glen Acre and Acre House Avenue. LH reported that this was taken to the Executive Board. There are issues regarding the re-housing of staff from both buildings, which will make this a long process.

The withdrawal of litigation against the closing of the hospital was mentioned. The judicial review has been put on hold for another three months.

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

090/18 Q4 FAMILIES AND SPECIALIST SERVICES DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT

Dr Lindsay Short was in attendance to give a presentation on the Calderdale Integrated Sexual Health clinics and their locations; work undertaken including contraception, STI diagnosis and management, HIV treatment, education, teaching, condom distribution and research; collaborative work with the local authority, community pharmacy, youth workers, drug and alcohol services and sexual assault referral centres, and future plans and developments. Discussion ensued on links with child abuse and community, and LS responded that there are lots of links with safeguarding, social services, police and vulnerable people.

LS was thanked for attending the meeting at such short notice and for the immense progression of the service.

JOR reported on appendix G highlighting the key points:

- Significant pressure on the phlebotomy service due to in-patient and out-patient demand soaring, leading to poor patient experience. Work is ongoing.
- The trustwide Point of Care Testing meeting is to be re-instated to improve governance, as it is unclear who has had training and what actions have been taken around point of care testing.
- Eleven incidents have been raised over the last 12 months in relation to Plaster of Paris pressure ulcers. A meeting with Tissue Viability has taken place and a number of actions agreed to determine if the department is an outlier. Work is ongoing with matrons to commission a cluster investigation.
- An incident trigger list has been created, with some directorates creating a list of incidents that would only relate to them, in addition to the generic list.
- A review of the Paediatric Surgical Forum is taking place to ensure that both the FSS and surgical divisions have shared governance processes.
- Children's services are now participating in the children and young people's safety thermometer.
- The top risks are in relation to failure to provide an interventional vascular service - this risk may not improve in the near future, and the inability to deliver a two-site blood transfusion / haematology service. Work ongoing with business plan and staffing.

Discussion ensued on the scoring of the blood transfusion risk. The division were asked at the Performance Review Meeting (PRM) to review the wording and description of the risk. This action will return to the PRM and will be escalated to this Group, if necessary.

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

091/18 Q4 SURGERY AND ANAESTHETICS DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT

JMidd presented appendix H summarising:

- Complaints - The division has continued to prioritise performance regarding timeliness and quality of responses. The total number of complaints breaching timescale significantly reduced by the end of Q4, however there are concerns regarding the sustainability of this position.
- Fractured neck of femur - Improvements continued through Q4 to reduction in delays due to clinical pathways. Performance against most elements of best practice tariff (BPT) has remained strong through Q4.
- Joint Advisory Group (JAG) accreditation – the Endoscopy User Group re-established in Q4 and the Group successfully submitted the Global Rating Scale (GRS) in April. Another visit is planned for November 2018, which the team are confident will go well.
- Cancer performance - The Red2Green methodology is being tested and tracks key milestones and ensures patients are progressing at the pace required to achieve the

target. Divisional leads attended the new Cancer board meeting in May and can now share learning and improvement work. It was reported that a presentation was given to the Weekly Executive Board this week and requested that outcomes and updates are presented to this Committee.

- Getting It Right First Time (GIRFT) – The division need a robust reporting system into the Patient Safety and Quality Board (PSQB) meetings, which will take place from quarter 1 (April to June)
- Operating services – work continued on providing assurance for WHO checklist monitoring, as the CQC were concerned with the compliance rate. Go-sees have taken place and practices now embedded. The team are also working with surgical colleagues to devise test models for improving theatre productivity
- Head and neck services - continue to focus on timeliness of complaint responses and have sustained an improved position.
- Trauma and orthopaedics – testing an optimised list in elective orthopaedics and feedback has been good. This will continue into quarter 1.
- General and specialist services – ward 14 has been open through quarter 4 to support operational pressures across the organisation, and is now functioning as a short stay ward. Nursing Quality Indicators (NQIs) have demonstrated that high quality care has been delivered and the ward has not received any formal complaints through quarter 4.
- Critical care - The team were pleased to welcome CQC inspectors during quarter 4 for the unannounced inspection, and work has continued on the improvement plan post CQC. Compliance with training in critical care qualification is now the best in the region with 61% of registered nurses having a post-registration award in Critical Care Nursing against a GPICS (Guidelines for the Provision of Intensive Care Services) recommendation of 50%. Monthly follow up clinics with psychological support for patients continue to receive positive feedback from service users. There are plans to establish a coffee morning through quarter 1 to develop patient engagement.
- Risks – directorates have been requested to update on progress against their 12+ risks at PSQB meetings
- Staffing – No themes were identified in quarter 4, however, as Operating Services move to Allocate, there are concerns that many staff are working to flexible working arrangements that sit outside the agreed process. The shift to Allocate will mean that teams must work to the agreed workforce model which will need managing with individuals.
- Learning from incidents – five incidents were closed in quarter 4, all of which were included in the report.
- Harm free care – this continued to deteriorate in March and it is expected that improvements will need some time to become embedded and performance is expected to reflect this.
- Infection Prevention Control – the division continue to work through the revised and robust action plan.

Discussion ensued on the return to work interview compliance and whether the decrease was due interviews not taking place or whether it was due to something else. JMidd reported that the data in the report was for the previous quarter, however, it was noted that there is good practice with return to work interviews. Colleagues are asked to provide a phone call or message within 72 hours, unless the situation requires a face-to-face interview.

DA asked whether the risk of not having a substantive consultant leading the glaucoma pathway is being mitigated. MA reported that although there is no permanent member of staff, a consultant with expertise is available who comes to deal with complex glaucoma patients. If he stops coming, the service may not continue. It was noted that there is a national shortage of glaucoma consultants.

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

092/18 Q4 COMMUNITY DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT

LzM presented appendix I summarising:

- Following Organisational discussions, the decision was made to close Community Place in March 2018. All staff have now been deployed.
- A trend analysis of incident reporting identified a theme around discharges which will form a work stream within the SAFER Patient Flow Programme Board.
- The division undertook a time-out session to review portfolios and strengthen clinical nurse leadership. The division now have three Matrons responsible for a number of services lines which complements the interim Head of Therapies portfolios.
- Risks – five top risks were reviewed, one risk (7012) may be reduced due to vacancy being recruited to, and another risk (7232) has been reduced due to nursing framework being put on hold
- Sickness – absence rate is currently achieving target.
- Mandatory training - Percentage compliance is over 90% in all the five key elements.
- Incidents – one red incident was reported on Community Place from a fractured neck of femur following a fall. The top themes of incidents are pressure ulcers and falls. A new response service has started which should impact on falls reduction programme.
- Complaints – one was received in quarter 4 relating to care provided by Outpatient Physiotherapy, where the patient believes they have had to have corrective surgery due to negligent treatment. The complaint will not be upheld.
- Preferred place of death – there were seven patients who did not die in their preferred place in March 2018. These have been reviewed by the clinical team leader and all patients received the appropriate care in the right place for them at the time. No further action required.

Discussion ensued on concerns raised regarding waiting times for children's therapies. It was reported that this was due to vacancies, which have now been recruited to, and the concerns have now been resolved.

Discussion also ensued on the Community Parkinson's service being delivered by one clinical nurse specialist, due to long-term sickness. The service is being supported by the Community matrons with advice being given by the HRI nurse specialist. It was asked whether any trained staff could be used to provide the service. This could be done for certain elements of the service, however, that is dependent on how long that can be sustained.

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

093/18 Q4 MEDICAL DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT

AM presented appendix J summarising:

- Falls – there was a similar level of performance in quarter 4 as there was in quarter 3, the total number of falls reduced and also a reduction in significant harm injuries. There was a slight increase in quarter 4, but when compared to previous quarters, it compared favourably. There has been an overall improvement in falls, and this is seen within the teams. There is a focus on falls alarms, how to monitor falls and about providing a full package of care.

- Pressure ulcers – during quarter 3, the division noted an increase in incidents being reported, however, once reviewed, it was discovered that incorrect coding in admission areas caused them to be recorded in the division. Working is ongoing with the Risk team to review. The division still have a high prevalence of pressure ulcers than hoped, and going forward, the senior nursing team and tissue viability nurses will work with two wards to address the recurring themes that have been identified from pressure ulcer investigations.

- Sepsis CQUIN – screening in both the Emergency Department and inpatients is now improving, and the timely administration of antibiotics has sustained performance. The Sepsis Collaborative group, which is clinically led by Dr Rob Moisey, meets monthly to ensure performance is maintained and improved.

- Infection Control - The division saw an increase in the number of C. Diff cases for the month of March. The infection control action plan, which forms part of a more comprehensive and robust action plan, has focussed work on all elements to prevent future reoccurrence and to see improvements

- Elderly and Respiratory Invited Service Reviews - Action plans have now been completed and closed.

- Stroke – Only one of the four performance targets for stroke were achieved, and a review of the three missed targets has been undertaken. The directorate had a proposal for the location of stroke assessment beds, and it was agreed that within the Emergency Department at CRH, there will be a dedicated assessment cubicle for stroke, which will hopefully see performance improves. This was a fundamental issue that the stroke team were pushing for.

- Risk registers – the division's risks include additional risks in terms of EPR. In quarter 4, the register will be reviewed and cleansed. The division recognised that the risk register was not embedded as a tool to use for business, and now doing work to embed risk registers into all work and will become a live document. This is work in progress.

- Appraisal and Mandatory training – progress has been made in the division, with trajectories being further ahead this year than last.

- Incidents – there was an increase in incidents and a decrease in the closing of incidents, however, mechanisms are in place to close.

- Complaints – the division have done focussed work to close overdue responses, but there is a surge in the number of new complaints. This is work in progress.

Discussion ensued on falls and pressure ulcers. It was asked whether they were caused by people with mobility problems, and if so, would there not be a higher probability for pressure ulcers? It was stated that pressure ulcers are more prone to people who are immobile and care plans are in place to manage those patients, however, there has also been a reduction in harm falls, but still noting slips at bedsides as people are becoming more mobile. It was also stated that an update on pressure ulcers, which is due at this Committee in July, may have more detail regarding incidence of pressure ulcers.

Discussion also ensued on who was accountable for colleagues receiving pay progression and increments despite not being 100% compliant with mandatory training and/or having a recent appraisal. It was stated that the process for directly linking appraisals to increments was not robust; however, there is now an improved connection between training and increments. It was also stated that this matter would be followed up through the Workforce (Well-led) Committee

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

094/18 INFECTION CONTROL COMMITTEE MINUTES

The infection control committee minutes from the meeting held on Wednesday, 25 April 2018 were circulated.

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

095/18 NHS RESOLUTION – MATERNITY ACTIONS

AMH presented appendix L, which reported on the Trust's progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions.

Trusts that meet the required progress against all 10 maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet the 10 out of 10 threshold may be eligible for a discretionary payment from the incentive fund to help them to make progress against one or more of the 10 actions. Such a payment would be at a much lower level than the 10% contribution to the incentive fund

As of today, the Trust fully meets nine out of the 10 maternity safety actions and partially meets one out of 10 maternity safety actions.

Significant progress has been made against the maternity safety action that has been partially met (evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year), and it is anticipated that the Trust will fully meet this standard by Q3 2018-2019.

If the Trust fully meets all 10 safety actions, reimbursement could be up to approximately £800,000.

AMH reported that the final position of the report will be submitted to the Weekly Executive Board (WEB) meeting this week.

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

096/18 SERIOUS INCIDENTS OUTSTANDING ACTIONS

AMcC presented an updated report on outstanding actions from completed serious incidents.

- The cross-divisional action reported from the previous report has now been addressed.
- There is one new collaborative action for the surgical division due for completion at the end of May 2018. The action is to ensure a paper is presented to the PSQB meeting reviewing the failsafe process for each specialty in the division, in respect of radiological reports being checked and acted upon, assessing whether the assurance is robust and making recommendations to be followed up in the division if not.
- There are four cross-organisational actions which require discussion with other organisations.
- Outstanding actions and actions completed for each division were detailed (FSS – 4; Surgery and Anaesthetics – 9 and Medical division – 49)
- Three actions outstanding for six months (one in FSS division and two in medical division)

It was noted that this is an improving position on serious incidents. The report was very much welcomed and the Committee asked that colleagues and teams supported the report.

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

097/18 CONSULTATION ON THE FUTURE OF PATIENT SAFETY INVESTIGATIONS

AMcC presented appendix N which summarises the key points being consulted on regarding the future of patient safety investigations, which may signal changes to timescales for investigation reports.

The Committee were asked for any comments, which need to be received by the end of the week in time for the consultation closure on 12 June 2018.

098/18 ANY OTHER BUSINESS

There was no other business.

099/18 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Pressure ulcers – individual teams are aware of pressure ulcers, with multiple factors contributing to incidents.
- Discharge team event – MADE event
- Sexual health presentation from Dr Lindsay Short
- Significant risk in blood transfusion risk

100/18 EVALUATION OF MEETING

What went well…..
The meeting had a very busy agenda, however, there were 10 minutes spare at the end.

101/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan was accepted.

HB reported that there may be implications for the Quality Committee if the Board meeting cycles change.

NEXT MEETING

Monday, 2 July 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 4 JUNE 2018

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
DUE				
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**
GOING FORWARD				
27.2.17 (050/17) 3.7.17 (108/17) 3.1.18 (005/18)	**MEDICAL DIVISION PSQB REPORT – FALLS**	Falls Lead	**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 (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 **Update**: New falls lead will be in post from July	**DUE 30 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**

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 4 JUNE 2018

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
CLOSED				
~~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 **Update 4.6.18**: Terms of reference now approved with amendments and to be sent to Board of Director for approval	**CLOSED 4 June 2018**
26.2.18 (051/18)	**CANCER BOARD** 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. **Update 4.6.18:** The Board met last week and agreed that they would report to the Quality Committee, via minutes, on a quarterly basis.	**CLOSED 4 June 2018**
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. **Update**: AMcC reported that the incident was a fall. The description of the incident was correct; however the title indicated a pulmonary embolism.	**CLOSED 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 **Update 4.6.18:** Amended copy of report received.	**CLOSED 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 **Update 4.6.18**: A copy of the Estates and Facilities terms of reference have been received, and the titles of the FSS terms of reference have now been amended.	**CLOSED 4 June 2018**

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Tuesday 05 June 2018, 09.00am – 12.00noon Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Katharine Fletcher	General Manager - Outpatients - for Item 049/18 only
Brian Moore	Lead Governor (Observer)
Betty Sewell	PA (Minutes)

ITEM

106/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

107/18 APOLOGIES FOR ABSENCE

Apologies noted for: Owen Williams, Anna Basford and Andy Nelson

108/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

109/18 MINUTES OF THE MEETING HELD 27 APRIL 2018

The Committee approved the minutes of the meetings held 27 April as an accurate record.

110/18 MATTERS ARISING AND ACTION LOG

The following Matters Arising were updated:

013/18: Control Total - The Director of Finance updated the Committee with regard to wider discussions which are taking place, it was noted that internal discussions continue with regard to our decision to accept our Control Total.

095/18: AIC – The Director of Finance confirmed that we are still looking at Governance and working through tracking; this is due to go to the System Resilience Group (SRG) and will come back to Committee next meeting.

098/18: Procurement Update – The Chief Operating Officer confirmed that the message to pro-actively involve Procurement has been rolled out through the Divisional Performance Reviews – **Action closed.**

ACTION LOG

173/16: EPR Update – a date is still to be finalised, Helen Barker agreed to pick up with Mandy Griffin so that a date can be scheduled on the Work Plan – **HB/MG**

024/18: Integrated Performance Report (IPR) – The Chief Operating Officer confirmed that conversations had taken place and following the changes to the IPR it was agreed that this would not go to a formal Board – **Action closed**.

043/18: Sustainability and Transformation Fund Review 2017/18 – The Director of Finance reminded the Committee of previous papers and discussions which had taken place at recent Committee meetings which outlined the treatment of STF payments and at that moment in time there were no clear inconsistencies. However, it was noted that there is now evidence of clear inconsistencies within the system which have been identified and examples were highlighted and noted by the Committee – **Action closed**.

049/18: Outpatients National Benchmarking – The General Manager for Outpatients, Katharine Fletcher informed the Committee that the Trust had taken part in the first Outpatient Benchmarking exercise of its kind. It was noted that this covered data for 2016/17. The data collection and format was explained and it was highlighted that there was limited information around Finance which emphasised that there is still work to do for next year's submission. The national key findings were highlighted and the Committee received the presentation.

Discussions took place with regard to cancellation of appointments by patients which is slightly below the national average and a deep-dive is taking place. With regard to Trust initiated cancellations we are slightly above the national average and a deep dive has also been requested, the findings will be received by the Quality & Performance Executive. With regard to the Appointment Slot Issues (ASIs) we are slightly above the national average, these are new referrals which at the point of booking could not get an appointment; a further review is taking place. With regard to the Workforce slides it was noted that the Workforce model has changed since the submission of this data, this will have an effect on the information for next year. It was also noted that work with Payroll will start sooner this year to enable the data to be collated more efficiently.

The Committee acknowledged the positive position of CHFT and thanked Katharine for the presentation, however, it was felt it would be useful to compare 2017/18 data against the benchmarks.

The Committee agreed that they would like to see a report which shows where we are now, where we would want to be in 5 years' time and to look at the cost of outpatient appointments and service models.

ACTION: It was agreed that a scoping exercise would be undertaken for the next meeting with a view of bringing a report back to the Committee in September – **HB/AB/RA/KF**

077/18: Multi-disciplinary Accelerated Discharge Event (MADE) – The Chief Operating Officer reported that the joint NHSI/CHFT event took place on the 12 April 2018 at both sites. The purpose of the event was to:-

- Unblock delays in real-time and simplify processes across the whole system
- Increase flow as part of an escalation process
- Bring system partners together to collaborate, develop a single version of the truth and provide mutual support

The key point for the Trust was the direct correlation of an increase in 'stranded' and 'super-stranded' patients which then had a negative effect our emergency care. The key learnings from this were identified as follows:

- Our risk appetite at ward level to get patients back to pre-admission state of health rather than being safe for discharge.
- A lack of understanding of what Community homecare support is accessible.
- A lack of clear internal professional standards.
- A lack of consistent board rounds.
- The estimated date of discharge was inconsistent.
- The opportunity to implement clear pathways and care bundles

The key actions agreed are as follows:-

- Implement a monthly MADE event
- To place Coaches on key wards to help with risk, key pathways and management of escalation etc.
- Establish a programme of process driven approach
- Introduce a 'myth busting' campaign
- To write a Directory of Services for Community provision for ward staff
- Our Social Care management team are undertaking work around non-sequential assessment planning
- To set a KPI to reduce 'stranded' and 'super-stranded' patients by 10% this year.

Discussions took place with regard to the issues around delayed discharge and especially the stranded/super-stranded patients, it was noted that this is a national focus.

The Chief Operating Officer stated that the event had been a success, the feedback from the Regulators who facilitated the event found our culture was good and they felt it was a positive experience.

It was acknowledged by the Committee that the event had identified a number of actions which would be dropped into the SAFER Programme.

With regard to next steps for the Committee, it was agreed that it would be beneficial to review where we are now and what we are trying to achieve over the next 6-9 months with the potential impact to finance and operations. Helen Barker confirmed that the stranded and super-stranded patients are included in future IPR reporting.

ACTION: It was agreed that a summary of what goes to the SAFER programme translated to Finance would come to this Committee at the end of every Quarter, this includes details of stranded, super-stranded and other length of stay - **HB**

111/18 MONTH 01 FINANCE REPORT

The Director of Finance highlighted the changes which have simplified the pack, taking on board the feedback on trends and trajectory data.

It was reported that at Month 01 we are on plan, the agency trajectory was below plan. It was highlighted that our overall activity in value terms was slightly down,

however, we were protected under the Aligned Incentive Contract (AIC). Despite activity being down our spend varied significantly between the first 2 weeks of the month and the last 2 weeks of the month based on the number of beds opened and the additional planning for Easter. It was also highlighted that we had under-performed on CIP due to timing issues on some phased portfolios, these schemes are forecast to be delivered in full by year end. The cash challenges were also called out to the Committee, some challenges link to the implementation of the new system, however, our overall cash challenge is linked to our weak cash position.

Discussions took place with regard to the high spend on pay. With regard to agency, it was noted that the decision to turn off Thornbury during the week had led to a step change which has had a marked impact; this will be extended shortly to include Sunday evening shifts.

It was also noted that there has been a positive impact on the nursing bank staff, particularly for un-qualified nursing; however, there is still more work to do for medical staff.

The Director of Finance explained that the Trust had received a letter from NHS I detailing additional CIP reporting measures required by them.

ACTION: It was agreed that Helen Barker, Suzanne Dunkley and Gary Boothby would review our exposure with regard to the new rules from NHS I which will go to Turnaround Executive.

With regard to the increase in the bad debt provision in month, The Deputy Director of Finance reassured the Committee that we are being pro-active in key risk areas which has been extended to include high value/low volume areas such as Maternity Pathways which will have a similar Account Manager approach also there is work within WYAAT to streamline the inter-WYAAT payables. It was noted that PMU aged debt had increased and there will be a focus in this area, with regard to THIS there are issues but this is being dealt with by their Service Account Managers.

The Committee **NOTED** the Month 01 financial position.

112/18 TRUST FINANCE RISKS 2018/19

The Director of Finance reported that there are currently three risks on the Trust Risk Register concerning the Trust's financial performance, namely Capital, Cash and I&E.

Discussions took place with regard to Capital and it was agreed that this risk is predominantly not a financial risk but a health and safety risk and should be transferred to Estates & Facilities. The Cash risk should remain at a score of 12, and following further discussions it was agreed to present two separate risks relating to I&E as follows:-

1. Achieving our planned deficit which should be a low risk, Kirsty Archer will review metrics for a low risk score.
2. Funding and longer term sustainability should be given a Risk Score of 25

113/18 FINANCE & PROCUREMENT IT SYSTEM RISK – ACTION PLAN

The Deputy Director of Finance provided the Committee with a summary of the residual system issues following the upgrade to the finance ledger system and the procurement ordering system which could potentially cause operational risk to the Trust's ability to maintain supply of goods and services essential to operational performance and safety. The paper outlined the key issues involving Accounts Payable and the actions which have been put in place to address those issues.

The cost of the additional staffing was confirmed as minimal, the additional resource will be reviewed monthly to make sure that it is sufficient to deal with the backlog. In addition, a general communication campaign will be progressed to promote the importance of receipting goods to enable invoices to be paid.

ACTION: It was suggested that this should be picked up by the Audit Committee with regard to the risks and what the learnings are with regard to the preparation for the upgrade and how this has been managed - **RH**

114/18 CIP UPDATE

The Director of Finance commented that discussions had taken place at Turnaround Executive yesterday and it was agreed that all schemes should be at Gateway 2 by the end of June.

115/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer explained that following a review of the IPR a number of new metrics and indicators had been introduced and as a result 2017/18 and 2018/19 cannot be compared. In addition the Model Hospital metrics will replace the Carter Dashboard. It was noted that a data quality self-assessment had been carried out and we are awaiting a response from NHS I, a more detailed data quality section will be included into the IPR.

For Month 01 we had an overall performance score of 62% with all elements 'amber', it was felt that following a challenging Qtr. 4 and a Bank Holiday in April, this was a solid start to the year. The three most improved elements linked to this Committee were:-

- Re-admissions back into hospital for intermediate care
- Long-term sickness absence
- Cancelled ops

Other areas highlighted in the benchmarking section included:-

- The Emergency Care Standard data to be re-submitted due to an error
- We are outliers for ambulance hand-over in less than 15 mins. an action plan has been requested.
- A zero length of stay is a particular focus with a high number of patients staying for less than one day an audit is being undertaken by Clinical Director, Rob Moisey.
- A further 12 beds have been closed ahead of plan, however, this has highlighted a site issue and the bed model will be re-assessed.
- Theatre Utilisation is slightly up with further improvement anticipated in May.
- Surgical Procedure Unit is an area which is still down and a specific piece of work is being undertaken by the Division as to whether to exit completely.

- A Divisional deep-dive has been requested for Cancellations for Clinical Reasons.

The Chief Operating Officer focused the Committee on Radiology following a concern of a possible growing waiting list.

It was noted that a high-level review had taken place within Radiology as our referrals were up but activity flat. The review highlighted our main activity growth is CT scans mainly from A&E; it was shown that this is not real growth but duplication or change of pathway not translating through to activity. The review also highlighted that MRI referrals and activity are down, Obstetric ultrasound and general radiology are both down on referrals and activity and Non-obstetric ultrasound referrals are down, however, they are very high volume and it doesn't take much to affect a breach, this is being carefully managed.

It was agreed with the Division at Annual Planning that capacity would not be taken out but that this would be monitored with an expectation of an improvement in the turnaround time. We now have a 10 day referral to report on our cancer pathways which is helping with our 62 day wait.

Discussions took place with regard to asking the Division back to the Committee to discuss capacity, it was agreed that further trend analysis would be required before the request is made. The Chief Operating Officer assured the Committee that the Weekly Performance Meetings (PRMs) with individual Divisions are allowing a closer monitoring of specialty trends.

Discussions also took place as to how to collate the GIRFT and other benchmarking activities and how to keep this Committee sighted on themes and opportunities from a financial view point.

ACTION: To schedule on the Work Plan – **GB/HB**

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

116/18 DRAFT MINUTES FROM SUB-COMMITTEES

The Committee received and noted the following sub-committee minutes:-

Draft Cash Committee – 12 April 2018
Draft Capital Management Group – 10 May 2018

117/18 WORK PLAN

The following items were noted for the Work Plan:-

- To defer the CNST Review until September 2018
- EPR to be re-scheduled
- Risks – make the changes and circulate for information
- Operational Benchmarking – proposal
- SAFER - Quarterly basis
- GIRFT
- Self-Assessment Feedback

11818 MATTERS TO CASCADE TO THE BOARD

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

- Control Total not agreed
- Outpatients National Benchmarking
- MADE event
- Finance Report at Mth 01 on plan
- Underperformance on CIP due to timing
- Changes in agency and the impact on the nursing bank staff
- Cash challenge
- Financial risks
- IPR refresh

119/18 REVIEW OF MEETING

The Committee agreed that the Outpatient Benchmarking presentation was well presented and it was good to hear from frontline staff. It was agreed that Divisions would be asked to attend F&P Committee should issues need escalating from weekly PRMs.

120/18 ANY OTHER BUSINESS

There were no items to note.

DATE AND TIME OF NEXT MEETING

FRIDAY 29 June, 10.00am – 1.00pm

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

20. Date and time of next meeting
Thursday 23 August 2018 commencing at 12.30 pm
Venue: Boardroom, Calderdale Royal Hospital

To Note

Presented by Philip Lewer