Public Board of Directors

Schedule	Thursday 5 March 2020, 9:00 — 12:00 GMT
Venue	Calderdale Royal Hospital, Large Training Room, Learning Centre
Organiser	Jacqueline Ryden

Agenda

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25.	Any other business	423
26.	Date and time of next meeting Thursday 7 May 2020, 9:00 am Venue: Boardroom, Huddersfield royal Infirmary	424
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1. Welcome and Introductions:

To Note

Presented by Philip Lewer

2. Apologies for absence

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

Presented by Philip Lewer

STANDING ITEMS

4. Minutes of the previous meeting held on 9 January 2020

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 9 January 2020 at 9:00 am in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Gary Boothby	Executive Director of Finance
Alastair Graham **(AG)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director (from item 08/20)
Dr David Birkenhead	Executive Medical Director
Andy Nelson **(AN)**	Non-Executive Director
Peter Wilkinson **(PW)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director
Helen Barker	Chief Operating Officer

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director, Digital Health
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary
Kirsty Archer	Deputy Director of Finance
Dr Anu Rajgopal	Guardian of Safe Working Hours
Jackie Ryden	Corporate Governance Manager
Ruth Mason	Associate Director of Organisational Development
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Alison Wilson	Contracts and Compliance Manager
Nicola Hosty	Equality and Diversity Manager/Freedom to Speak Up Guardian
Fran Brocklehurst	Health and Safety Officer
John Gledhill	Public Elected Governor
Christine Mills	Public Elected Governor

OBSERVERS

Crispin Pettifer	Hempsons Solicitors
Karen Kendall-Smith	Hempsons Solicitors

01/20 Welcome and introductions

The Chair welcomed everyone to the Public Board of Directors meeting.

The Chair congratulated and thanked the Chief Executive on his recent award of an OBE in the New Year's Honours list for services to healthcare in West Yorkshire, and commented that it is both an honour and a privilege which reflects both on the Board and colleagues in the Trust.

02/20 Apologies for absence

Apologies were received from Richard Hopkin, Suzanne Dunkley, Jude Goddard, Stephen Baines and Lynne Moore.

03/20 Declaration of Interests

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

04/20 Minutes of the previous meeting held on 7 November 2019

The minutes of the previous meeting held on 7 November were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held 7 November 2019.

05/20 Action log and matters arising

The action log was reviewed and updated accordingly. All actions were closed other than the action relating to the Back to the Floor week, which will be scheduled for the Board workshop on 2 April 2020.

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

06/20 Chair's Report

The Chair reported that he continues to meet with Chairs from other Trusts. He has also spent half a day in the Appointments Centre at HRI and will shortly be attending the CHFT induction day for new starters.

The Chair and Chief Executive attended the NHS England / Improvement (NHSE/I) Leadership meeting in Leeds on 18 December 2019. The following points were of particular note:

a) People Plan – a positive, inclusive and compassionate working culture is important together with a staff voice of influence, a safe working environment and flexible working. Focus was also placed on staff retention and culture.
b) NHSE/I are currently working on developing the operating model to combine NHSE and NHSI with a shift to prevention focus, reduction in inequalities and outcomes rather than process together with a shift to regional and system delivery and changing the way they work to be more horizontal in nature
c) NHSE/I are integrating digital in their approach to improvement and transformation.
d) Integrated care systems (ICS) across England are being established but they will not be statutory. Four overarching policy areas are being considered (the role and function of the ICS; working together at Place; collective accountability of partners; and leadership and governance.
e) They are working at national, regional and system level to finalise plans immediately after the election.
f) The twin objectives of the Winter Plan are to maintain patient safety and quality during this period, and to minimise the impact on operational performance, with a particular focus on the emergency pathway.

The Chief Executive indicated that there may be more opportunities for capital moving forward. OW pointed out that as part of the public sector duty everybody needs to understand the implications of the Equality Act when taking decisions relating to a specific cohort of workforce and ensure that no group is favoured. OW emphasised that CHFT will be giving full due regard to this.

OUTCOME: The Board **NOTED** the update on the NHSE/I Leadership Meeting.

07/20 Chief Executive's Report

The Chief Executive presented the first annual review of the West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding, which formalises ways of working across West Yorkshire and Harrogate, and which was originally signed off by all partners in December 2018. In order to ensure the Memorandum of Understanding meets the evolving requirements of the Partnership as an Integrated Care System, an annual review is undertaken, and the first review has been completed and signed by off by the Partnership Board on 3 December 2019. The Board is asked to approve the revised West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU) and authorise the Chief Executive to sign the final version of the MoU.

Prior to the general election there was some uncertainty as to whether the Integrated Care Systems would still be around, but post-election, it is clear that ICSs will be in place for the foreseeable future. With regards to the ICS, OW advised that CHFT is an organisation that serves Places and the people in those Places, and, given our geographical location, we have an influence in both the Calderdale and Kirklees systems. There was a detailed discussion around the statements in section 3.12 of the MoU which set out the agreed ambitions for the Partnership, specifically the bullet point regarding diverse leadership to reflect the broad range of talent in our area. OW remarked that the diversity of the leadership paradigm is important in relation to Black, Asian, Minority, Ethnic (BAME).

OW presented two slides of analysis of the System Population in Calderdale by Local Super Output Areas (LSOA) There are 128 areas in Calderdale and the top ten areas represent nearly 14% of A&E attenders. The first slide analysed A&E attendances since January 2018 by specific electoral wards, deprivation ranking, with percentage of BAME attenders. The second slide showed hospital interactions by household on the same street with predominantly BAME residents since January 2018, with interactions which ranged from 15 – 47 per household. OW re-iterated that we need to use such real time granular management data to reflect the reality of populations with the greatest need and identify specific solutions.

It was agreed that more specificity is needed in relation to the partnership objective, in section 3.12, bullet point 8, within section 3 working together: 'have a more diverse leadership that better reflects the broad range of talent in our area', and the company secretary will feed that back.
Action: AM to feed back to the West Yorkshire and Harrogate Health and Care Partnership that more specificity is required for section 3.12, bullet point 8 of the Memorandum of Understanding.

Following a question from DS regarding section 3.4 on involving the public, OW explained we have had several opportunities with reconfiguration to engage with the public and this will continue.

AG commented how meaningful public engagement can be challenging and requested a progress report on how the ICS will undertake public engagement. AG also commented that the objective relating to diverse leadership lacked the specifics of other objectives and OW advised that he has discussed this with Rob Webster who recognises that the result relating to the diverse leadership objective needs to be more clearly specified.

AN asked how the ICS targets are being incorporated into CHFT specifically. OW explained that work has taken place on a 10 year plan for CHFT and that we need to ensure that we have the right connectivity between the 10 year plan and the ICS plan. This is to be discussed at the forthcoming Executive Development session to take place on 14 January 2020, with a broader conversation at Board level.

PW asked whether any thought had been given to moving leadership people between the

different organisations. OW responded that this does happen, for example a number of CHFT staff are leading work at a West Yorkshire level. but there is more work to be done and a workforce group within the ICS is looking at this.

DB questioned how we can contribute to the public health agenda, particularly in Kirklees. OW added that part of our digital agenda gives us the opportunity for earlier public health interventions and the ability to drive some of that.MG advised that we are already starting a dialogue with Calderdale Council on public health informed by data we have access to.

OUTCOME: The Board **NOTED** the Chief Executive's update and **APPROVED** the revised West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU) subject to there being greater specificity in relation to the following partnership objective, in section 3.12, bullet point 8, within section 3 working together:

- have a more diverse leadership that better reflects the broad range of talent in our area.

08/20 The Cupboard Update

The Associate Director of Organisational Development gave a presentation to update the Board on the developments with the Cupboard, the People Strategy, since its launch in March 2019 including progress since the launch, the three key developments that have taken place and plans for 2020.

The Cupboard is focussed on one culture of care and includes seven key themes on recipe cards which now include links through to operational information.

There are three key strategies:

(i) Recruitment Strategy
(ii) Leadership Development Strategy
(iii) Equality, Diversity and Inclusion Strategy

Nicola Hosty, Equality, Diversity and Inclusion Manager, talked through the Equality, Diversity and Inclusion Strategy, and explained that it is an incremental approach with the aim in 2020 to continue to lay foundations, build connectivity with colleagues and grow members of the equality groups. There will be further work with partners, eg YAS, Fire Services, to grow networks and build learning. Focus will also be placed on inclusive leadership and unconscious bias. The overall aim is to reach a point where diversity and inclusion is threaded through everything we do.

The Associate Director of Workforce and Organisational Development advised that the Cupboard is a live working tool now with a new metrics facility and a new search facility is to be introduced.

KH endorsed The Cupboard adding that it is a significant piece of engagement and will continue to be a supply of information and ideas.

AG asked about the learning sets which had been discussed in the presentation and RM advised that these are initially just in-house but are cross discipline and cross function.

DS asked about the training target for unconscious bias and how the impact of this will be evaluated. This is included in HR essentials and the Assistant Director of Human Resources is currently working on this. Nicola Hosty added that regular follow up sessions will take place following the initial unconscious bias session in order to keep it live.

There was a brief discussion about the hothouse sessions and the need for a broader reach to engage those colleagues who would not normally attend. AN asked about the key themes from the recent Health and Wellbeing Hothouse session and was advised that these were mental health, the ability to take breaks and the appreciation of managers to engage in health and well-being conversations.

One of the challenges of delivering sessions is the logistics of physical space.
JE advised that an Education Committee is being established to focus on the amount of investment available and how to better deploy this to support the leadership and development programme.

PW asked how the Equality, Diversity and Inclusion work linked with external stakeholders. NH advised work is taking place on transgender awareness and AB advised that supporting these leadership behaviours will help across system wide working.

OUTCOME: The Board **NOTED** the update on the developments in The Cupboard.

09/20 Quarter 3 (Q3) Guardian of Safe Working Hours Report

Dr Anu Rajgopal, Guardian of Safe Working Hours presented the Q3 report from October to December 2019. The key updates were:

- Increased number of exception reports from Paediatrics and Orthopaedics. The number of vacancies in Paediatrics has increased and some of the exception reports have been submitted by senior grade doctors on this occasion.
- Improved engagement of trainees at the junior doctor forum with allocation of funding received to enhance junior doctor working at the Trust
- Plans to progress with assessing Trust compliance with the BMA fatigue and facilities charter and monitoring progress through the junior doctor forum.

The junior doctor poll highlighted areas of concern once again regarding food, computers and a general lack of comfort. The junior doctors need to be allocated time to complete mandatory training. They are not all aware that the training is required, and this is to be clarified by Workforce and Organisational Development. Awareness is being raised in various forums, including a newsletter for junior doctors. £30,000 has been allocated to enhance the working life of the junior doctors, and this will be spent on making improvements to the current junior doctor facilities. A further issue was highlighted relating to post shift rest facilities as although there are rules in place, the process is not clear. Dr Rajgopal will be working with the medical education team on this.
Action: HB/SS will discuss the administration and availability of beds for junior doctors outside of the meeting.
Action: MG will look into availability of desk top computers.

Dr Rajgopal explained that there is a plan in Paediatrics to fill the gaps and they are looking at benchmarking to help with this. HB added that in this period Paediatrics was the most pressured speciality nationally. There is recognition in the department that they have not used all the associates that they could have. From an emergency care perspective, analysis shows that the number of paediatric patients not admitted is huge, so further consideration needs to be given to out of hospital provision. The Medical Director reported that he has discussed with the Divisional Director of Family and Specialist Services the number of gaps across the system, which is worsening and is impacting on the consultant workforce and our ability to train the junior doctors due to the unsocial shifts that need to be covered by them.
Action: DB to write to the Post Graduate Dean to highlight the position.

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

10/20 Health and Safety Review

The Non-Executive Director champion for Health and Safety (KH) introduced Alison Wilson, Health and Safety Advisor for Calderdale and Huddersfield Solutions Limited and Fran Brocklehurst, Health and Safety Officer to present the report on the Health and Safety Review.

The paper presented included the 2018/19 annual report for health and safety, the health and safety review and 2019/20 action plan and a proposed new risk relating to health and safety for the Board Assurance Framework.

The paper updated the Board that following an external strategic review of the health and safety management arrangements in CHFT with a particular focus on the health and safety arrangements between the Trust and Calderdale and Huddersfield Solutions Ltd (CHS), Quadriga was commissioned to undertake a strategic review of health and safety management arrangements in the Trust. In particular, the review considered the way in which the Trust exercised oversight of its subsidiary company providing estates services for the Trust in respect of the Huddersfield Royal Infirmary.

The report from the external review undertaken by Quadriga concluded that CHFT faces a number of health, safety and fire related safety issues which require close scrutiny by the Board and a review at senior level to ensure the issues are effectively managed and reduced.

The formation of CHS has resulted in the provision of operational health and safety support to CHFT but no independent strategic health and safety advice. The current arrangements give rise to a conflict of interest with professional monitoring of health and safety standards coming from within CHS. A similar issue was noted relating to strategic fire safety advice however, arrangements are now in place which have resolved this issue.

AW gave assurance that there is a strong robust governance structure in place at both the HRI and CRH sites. Following the creation of CHS and the transfer of previous executive lead for health and safety, the Trust Health and Safety Committee is chaired by the Director of Workforce Organisational Development. The Committee meet on a bi-monthly basis and report into the Audit and Risk Committee (a sub-committee of Trust Board) escalating any areas of concern or significant risk. Each topic specialist provides regular reports to the Committee providing assurance that specific risks are being managed.

The Quadriga report included a list of recommendations which have been incorporated into one action plan which will be monitored bi-monthly at the Health and Safety Committee meetings.

AG declared an interest at this point as Chair of CHS Ltd and commented that the Quadriga report does not entirely present the joint work undertaken by CHS Ltd and CHFT and some of the working in the report could be phrased differently.

HB advised that the recommendation to move the Fire Officer back into CHFT has already been enacted and work is under way on a fire strategy which has been commissioned by Mott MacDonald. Recruitment of a Health and Safety Manager is in hand to provide support and advice to the Health and Safety Champion, Board of Directors and all colleagues.

It was agreed that a meeting is to be arranged with Quadriga to address the inconsistencies in the report and clarify them. KA pointed out that there will be financial implications resulting from the report.

Action: Meeting to be arranged with Quadriga to address the inconsistencies in their report.

KH asked for a progress report to be scheduled on the agenda of the Board of Directors three times a year.
Action: Update on the Health and Safety Review to be presented to the Board on 7 May, 3 September and 5 November 2020.

OUTCOME: The Board **NOTED** the action plan and **APPROVED** the external review and addition of the health and safety risk to the Board Assurance Framework.

11/20 Month 8 Financial Summary

The Deputy Director of Finance presented the month 8 financial summary, the key updates were:

- The year to date deficit is £8.67m, a £0.24m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial Recovery Funding.
- There is some pressure year to date due to higher than planned non pay expenditure including utilities, maintenance contracts, outsourced services and lower than planned VAT recovery.
- These pressures have been offset year to date by lower than planned pay expenditure, although for the last three months pay has been slightly overspent due to Medical pay awards and pressure from additional capacity.
- Clinical income performance (contract and other) is below plan by £1.56m. The Aligned Incentive Contract (AIC) protects the income position by £2.15m resulting overall in a favourable variance of £0.59m, an improvement compared to the position in Month 7. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services.
- CIP achieved year to date is £6.34m, £0.17m more than planned.
- Agency expenditure year to date is £5.35m, £2.16m below the planned level.
- The key focus in the final four months of 2019/20 needs to be on containing overall winter expenditure within the earmarked funding available.
- Forecast continues for delivery of 9.7m deficit after funding.
- Year to date capital expenditure was lower than planned at £4.59m against a planned £7.68m.
- Cash balance is higher than planned which is due to a timing issue and will be in line with plan by the year end. HB asked about the risks related to the Integrated Care System and KA stated that a recent report indicates that it is likely the overall ICS position will be delivered and only 15% of provider sustainability funding is at risk.

AG asked if the delays in capital spend will cause any operational problems. KA explained that the risks are being managed and discussions are progressing regarding the emergency capital spend. OW pointed out that there are potential implications, for example the MRI scanners, but is still hoping that all projects will be delivered.

Following a question from AN, HB advised that we continue to struggle with large numbers of patients awaiting discharge, and that we have used some of the funding to offset this and have kept some in reserve for January to March 2020.

OUTCOME: The Board **NOTED** the Month 8 Financial Summary.

12/20 Climate Change Report

The Managing Director of CHS Ltd gave an update on the climate change agenda and requested a commitment from the Board to an ambition of net zero carbon emissions by 2038 in line with local authorities. The report describes work on climate change that has already been undertaken, the opportunities going forwards and how we can mitigate some

of the climate change consequences. One of the options would be to declare a climate change emergency, as our two local authorities and some other trusts have done

Work has begun on providing a baseline as a Trust, and further work on comparative data is ongoing. It is intended to develop a plan, including key performance indicators, monitor this annually and review it in five years.

There was some confusion about the exact meaning of carbon zero emissions and SS clarified that current legislation defines net zero as 1990 levels.

OW remarked that there is work for us still to do on involvement and engagement of staff, patients, friends, relatives and partners in terms of understanding around net zero carbon emissions therefore at present we should not use the term emergency. There could be implications for car parking or the digital approach. He added that the ambition is good but further clarity on key areas we plan to commit to is needed.

AN offered to help with respect to the opportunities available in this area as part of the reconfiguration building work. AB added that the reconfiguration will have a major impact in reducing our carbon footprint.

Action: SS to bring a more informed plan back to Board in July 2020.

OUTCOME: The Board **NOTED** the Climate Change report.

13/20 Care Quality Commission (CQC) and Use of Resources Update

The Director of Nursing provided an update on the key actions which have been undertaken in the quarter in relation to Care Quality Commission (CQC) work and priorities for quarter 4.

At the end of quarter 3, two 'must do' and three 'should do' actions are still to be embedded; these continue to be areas of specific focus for the CQC Response Group. Progress is monitored on a monthly basis via the 2019 - 2020 Exceptions CQC Action Plan and the CQC Response Group. Two 'must do' actions remain incomplete pending further consideration of the quality and financial impact of the CQC actions. Both actions are on the Trust risk register and the CQC relationship team is kept fully briefed on progress and quality and safety monitoring across these areas. The Director of Nursing is confident that a solution will be reached soon regarding cover of intensive care. The Medicine Division have been made aware that they need to address in their business case the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.

The CQC Core Service Framework Self-Assessment Toolkit has now been rolled out to all CQC Core Services and two areas have been highlighted. The departments concerned have been asked to re-look at their ratings.

The new CHFT CQC Insight Summary Report was presented at the November Risk and Compliance Group. The new approach to managing the monthly Insight report published by CQC was well received.

An interim Assistant Director for Quality and Safety has been appointed to manage the Complaints team. OW reiterated that the complaints are owned by all colleagues and we all need to be able to give a shared, reasonable view of the status.

OUTCOME: The Board **NOTED** the progress on Care Quality Commission (CQC) must-do and should-do actions, the key priorities for quarter 4 to prepare for CQC inspection and the continuous work being undertaken to ensure regulatory compliance across the Trust.

14/20 High Level Risk Register

The Director of Nursing presented the high level risk register which has been to the Quality Committee. The key points to note were:

Two new risks have been identified. The first, risk 7615, is the risk of not meeting the 4 hour emergency care standard due to multiple factors resulting in poor patient experience, delivery of fundamental care standards and reputational risk. It was noted that a sub-group has been set up to look at these particular issues as a sub section of the A&E Delivery Board.

The second, risk 2830, is the risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department, due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability. Discussion took place about this risk and HB confirmed that the issue was bed availability and poor patient experience rather than mental health assessments.

There are two risks with reduced scores which have been removed from the high level risk register. Risk 7345 Referral to District Nursing Service on EPR system – Community Healthcare – risk score reduced from 16 to 4 due to EPR referral being active, and risk 3793 Optovue OCT machine risk. Three risks have been identified to be reviewed in more detail.

AN noted that some of the risks remain at the same score even when some progress is made, and that work is still required on this with reference to some of the long-standing risks. EA agreed that a regular rolling audit of these risks is required to provide the missing assurance.

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

15/20 Integrated Performance Report – November 2019

The Chief Operating Officer presented the key updates for November 2019 and the overall good position of a performance score of 75% was noted. Items highlighted were continued pressures in emergency care, with nine 12 hour trolley breaches in November, for which an internal and external review has been commissioned. It was noted that none of these nine patients came to any harm.

The following was also noted:

- The main focus has been around the exceptionally high number of patients on the transfer of care list, and more escalation capacity than planned has been opened.
- Activity and admissions for non-elective care are above plan for this month, which is replicated nationally, despite the initiatives that have been put in place.
- The Same Day Emergency Care (SDEC) for Frailty has been opened and is working well.
- HB thanked all colleagues for their work during operational pressures noting we remain in silver command.
- Discharge lounge at HRI was opened during November.
- Diagnostic performance was better overall in November and the Trust was just short of achieving 99%.
- Exceptional performance on cancer continued to be delivered in November and the position is very positive.

OUTCOME: The Board **NOTED** the Integrated Performance Report and overall performance score for November 2019.

16/20 Governance Report

The Company Secretary presented the Governance Report which included the revised risk appetite, Board meeting dates for 2020 -21 and an update on the ongoing well-led developmental governance review.

The risk appetite statement was reviewed by Board members at a Board workshop on risk management on 5 December 2019. Following this, the Chief Executive, Director of Nursing and Deputy Director of Finance and Company Secretary met to review the risk appetite in detail following the Board discussion.

The changes to the risk appetite can be summarised as:

- Reduction in risk appetite for the risk categories of financial and assets, innovation and technology, commercial, workforce
- Increase in risk appetite for Quality and Innovation risk category, (with workforce element relating to new roles removed from the workforce category and added to the Quality and Innovation category)
- Addition of legal category and removal of reference to legal services from the regulation category, with a minimal / low risk appetite.

AM advised that NHS England / NHS Improvement guidance advises NHS Trusts to carry out an external governance review every three years to support the effectiveness of leadership and governance arrangements. The review is based around the eight key lines of enquiry for a well-led organisation identified by the Care Quality Commission and is a developmental review of leadership and governance. The first phase of this review commenced during December 2019 and is expected to conclude during February 2020. Following completion of the review actions will be developed in response to the recommendations.

OUTCOME: The Board **APPROVED** the Risk Appetite Statement and **NOTED** the Board meeting dates for 2020-2021 and the Well-Led Governance Review.

17/20 Update from sub-committees and receipt of minutes & papers

Finance and Performance Committee – minutes from the meeting 1.11.19
PL provided an update from the last meeting held on 1.11.19, the key points to note were:

- The referral to treatment (RTT) pilot is underway
- Diagnostics improvements with Echocardiography
- Positive performance for both stroke and cancer

PL noted that a meeting was held at the end of December, which was not quorate. It was confirmed that we are on plan and keeping a watchful eye on finances.

AG remarked that performance which is consistently green is a real achievement and suggested that if this continues for the 12 month period we should mark and celebrate this and thank staff. This was thought to be a good opportunity to celebrate, with the caveat that some of the underlying issues are not quite in place yet.

Audit & Risk Committee – verbal update from meeting held on 30.10.19
Minutes received. AN reported that the Audit and Risk Committee are beginning deeper dives on key risk areas.

Quality Committee – minutes from the meeting held on 4.11.19
DS gave an update from the last meeting on 4.11.19. The key points noted were:

- There is continued emphasis on medication safety, a detailed report had been received and a significant amount of work has been undertaken by the pharmacy team.
- Focus continued on working towards outstanding for CQC and updated terms of reference for the CQC response group were received.
- Reporting from the Quality Committee meetings to the Board is slightly out of sync but will be aligned by the next Board Meeting.

Workforce Committee – minutes from the meetings held on 5.11.19 and 10.12.19
KH, Chair of the Workforce Committee provided an update from the last two meetings. The key points to note were:

- Time to recruit continues to be an issue
- Positive position on Consultant appointments but keeping a watchful eye
- Hothouses continue.
- Staff survey closed.
- Sickness absence rate continues to be sustained
- We would like to see more return to work interviews carried out and dates being recorded.

OW fed back that at a recent meeting with staff governors, the main focus had been on workforce matters and it was suggested that some of the staff governors might attend the Workforce Committee meetings or at least have some input to the agenda. KH has discussed this with the Director of Workforce and OD and they are happy for staff governors to attend the meetings, although there is already a staff representative governor on the committee. KH advised that she is willing to take any questions outside of the meetings themselves.

Charitable Funds Committee – minutes from the meeting held 6.11.19
The Chair provided an update from the last meeting held on 6.11.19. The main item was the sign-off of the audit. There was also discussion on developments following the appointment of the new Charitable Funds Manager.

A&E Delivery Board – minutes from the meetings held on 10.9.19 and 12.11.19
HB provided an update from the meetings held on 10.9.19 and 12.11.19. and noted these were an accurate record.

OUTCOME: The Board **NOTED** the minutes of the various sub-committees.

18/20 Any Other Business

There was no other business.

Date and time of next meeting
Date: Thursday 5 March 2020
Time: 9:00 – 12:30 pm
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

The Chair closed the meeting at 11.58

5. Action log and matters arising

To Approve

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 5 March 2020

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.11.19 129/19	**AOB** Experience from 'back to the floor' week to be shared at a future Board workshop	SD	Scheduled for 2 April 2020 Board Workshop	January 2020		
09.01.20 07/20	**Chief Executive's Report** AM to feed back to the West Yorkshire and Harrogate Health and Care Partnership that more specificity is required for section 3.12, bullet point 8 of the Memorandum of Understanding.	AM	Feedback given to Steven Gregg, Governance Lead, West Yorkshire & Harrogate Health and Care Partnership on 9 January 2020.	January 2020		
09.01.20 09/20	**Quarter 3 Guardian of Safe Working Hours Report** HB/SS to discuss the administration and availability of beds for junior doctors outside of the meeting.	HB/SS	Discussion held - proposed the use of a local hotel for overflow accommodation. The options were reviewed and Cedar Court have a public sector rate which is reasonable and we have supported. The details have been passed to Anu Rajgopal as there are some logistics that need to be worked through by the team overseeing the overall process and she is now progressing with this as the plan.	January 2020		
09.01.20 09/20	**Quarter 3 Guardian of Safe Working Hours Report** MG to look into availability of desk top computers for junior doctors.	MG		January 2020		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 5 March 2020

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
09.01.20 09/20	**Quarter 3 Guardian of Safe Working Hours Report** DB to write to the Post Graduate Dean to highlight the position of the number of vacancies impacting on junior doctor training.	DB	Completed and shared with the Medical education department. The challenging situation at CHFT is acknowledged, but without an immediate resolution. There is a national shortage of Paediatric trainees that have differentially impacted on CHFT as a result of maternity leave or other absence.	January 2020		
09.01.20 10/20	**Health and Safety Review** Meeting to be arranged with Quadriga to address the inconsistencies in their report.	SD/AW	SD, SS and AW discussed the inconsistencies of the Health & Safety review with Quadriga following feedback from Trust Board that robust governance arrangements between CHS and CHFT were in place. Quadriga will include the arrangements within the review and illustrate both governance structures for CHS & CHFT and the Health and Safety Committee reporting structure as an appendices.	January 2020		
09.01.20 10/20	**Health and Safety Review** Board workplan to be updated to reflect - Update on the Health and Safety Review to be presented to the Board on 7 May, 3 September and 5 November 2020.	SD/AW	Action closed. Board workplan updated. H&S Manager to be appointed – and this person will take the lead on the action plan.	January 2020		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 5 March 2020

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
09.01.20 12/20	**Climate Change Report** Board workplan to be updated to reflect SS to bring a more informed plan back to Board in July 2020.	SS	Action closed. Board workplan updated.	January 2020		

6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

To Note

Presented by Owen Williams

WORFORCE FOR THE FUTURE

8. Use of Tele-health in the Respiratory Team – Anita Devine - PRESENTATION

To Note

TRANSFORMING AND IMPROVING PATIENT CARE

9. Nursing and Midwifery Strategy - PRESENTATION

To Note

Presented by Ellen Armistead

10. Strategic Plan on a Page

- 2019/20 Plan on a Page
- 10 Year Strategy Refresh

To Approve

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	5th March 2020
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**Strategic Plans:** 10 Year Plan Update on progress against the 2019/20 Plan
Author:	Director Sponsor: Anna Basford, Director of Transformation and Partnerships
Previous Forums:	Trust Board and Council of Governors Workshop (Nov 2019), Trust Board meeting (Jan 2020), Executive Director workshop (Jan 2020).

Actions Requested:

The Trust Board is requested to:

- Approve the 10 Year Strategic Plan
- Note progress to deliver the 2019/20 Annual Plan.

Purpose of the Report

The purpose of this report is to request approval of CHFT's strategic plan for the next 10 years, and; to provide an update on progress to deliver the 2019/20 annual plan.

Key Points to Note

- The 10 Year Strategic Plan builds on the previous 5-Year Strategy maintaining consistent format and language to support delivery of Compassionate Care underpinned by the Four Pillars of Behaviour.
- The 10 Year plan has been informed by several workshops and discussions involving Trust Board members and the Council of Governors and by a range of colleague involvement and 'Hot-House' events over the past year and public involvement events.
- Subject to approval of the 10 Year Strategic Plan the annual plan for year 1 of this (i.e. 2020/21) will be submitted to the Trust Board meeting in May 2020.
- An update on progress to deliver the 2019/20 plan is attached. This highlights that of the 20 deliverables: 0 - are rated red, 2 - are rated amber, 15 - are rated green and 3 have been fully completed.

EQIA – Equality Impact Assessment

- Development of the 10 Year Strategic Plan has been inclusive and informed by on-going colleague involvement and 'Hot-House' events over the past year and public involvement events.
- The 10 Year plan aims to achieve improved health outcomes for all the communities we serve and colleagues.
- The 10 Year Plan includes the ambition to ensure that patients shape decisions about health services and their personal care.
- The 10 Year Plan includes specific aims to address health inequalities and to celebrate diversity.

As the 10 Year Plan is implemented detailed Equality and Quality Impact Assessments will be undertaken.

Recommendation

Approve the 10 Year Strategic Plan
Note progress to deliver the 2019/20 Strategic Plan.

Calderdale and Huddersfield NHS Foundation Trust
Annual Plan Year ending 2020 – End of year summary

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the Trust's 1-year plan for 2019/20:

- Transforming and improving patient care;
- Keeping the base safe;
- A workforce fit for the future;
- Financial sustainability.

Structure of Report

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

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

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 20 deliverables:
0 - are rated red
2 - are rated amber
15 - are rated green
3 - have been fully completed

Recommendation

Note the assessment of progress against the 2019/20 goals.

Year Ending 2020

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Achieve a regulatory approved proposal for the reconfiguration of hospital and care closer to home services that puts the patient at the centre of care.	Deliver a Single Oversight Framework rating of 2 for the agreed quality and operational performance metrics.	Achieve a retention rate of 90% and reduce vacancy rate to 5% to address recruitment and retention of key roles in CHFT.	Deliver a regulatory compliant financial plan for 2019/20 including CIP.
	Use patient feedback, both positive and negative to describe CHFT services from a patient perspective. Clinical Divisions have a patient experience plan, which incorporates service user involvement in improvements with at least 1 co-design event (service users and staff). Improvement outputs are celebrated and publicised through you said, we did messages.	Achieve a CQC rating of good with outstanding features.	Launch a colleague disability network in Sept 2019 and coordinate all our workforce ED&I activities and networks by March 2020 to improve colleague engagement and inclusion.	Develop a regulatory and Integrated Care System compliant capital plan to meet the organisation's requirements.
	Deliver all GIRFT actions in selected pathways of care to reduce variation and deliver agreed out comes.	Implement the the Quality Improvement Strategy and deliver the 19/20 agreed quality KPIs.	Roll out the health and wellbeing strategy and plan to maintain a 96% attendance rate.	Maintain a Single Oversight Framework rating of 3 or better for financial and Use of Resources performance metrics.
	Transform 10% of out-patient appointments (making best use of digital technology) to avoid the need for patients to visit the hospital.	Develop and ensure delivery of the KPIs by CHS and PFI partner, to provide a safe environment that is efficient and supports effective patient care.	Develop an 'essentials of management' development programme and a CHFT leadership programme to improve our staff engagement score to the national average (7.0 in 2018).	Progress key WYAAT work streams and capital bids including vascular; pharmacy; imaging; pathology; and elective procedures.
	Design and implement an agreed digital strategy that describes a future vision that will improve usability, breadth and continue to support the ongoing needs of a shared care record across the local health and social care community.	Deliver the annual health & safety action plan.	Assess and refresh all people management policies to enable and facilitate 'one culture of compassionate care' by March 2020.	Implement year one of the plan to strengthen budget accountability including roll out of training and performance support arrangements.

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Achieve a regulatory approved proposal for the reconfiguration of hospital and care closer to home services that puts the patient at the centre of care.	**GREEN** On track	The Strategic Outline Case was approved by NHS England in November 2019. Work has commenced to develop the Outline Business Case during 2020.	**Lead: AB** Transformation Programme Board NHSE&I
Use patient feedback, both positive and negative to describe CHFT services from a patient perspective. Clinical Divisions have a patient experience plan, which incorporates service user involvement in improvements with at least 1 co-design event (service users and staff). Improvement outputs are celebrated and publicised through you said, we did messages.	**AMBER** Off track – with plan	A key objective of the nursing and midwifery strategy (Time to Care) is to improve the way the Trust involves service users and incorporates feedback from them. The Trust is ensuring there is senior leadership to support this.	**Lead: EA** Weekly Executive Board Quality Committee Board
Deliver all GIRFT actions in selected pathways of care to reduce variation and deliver agreed out comes.	**GREEN** On track	There is a well-established and comprehensive programme of support and governance for GIRFT implementation. This includes tracking of all actions required. CHFT has been recognised as a national exemplar in respect of GIRFT implementation.	**Lead: DB** Quality Committee Weekly Executive Board
Transform 10% of out-patient appointments (making best use of digital technology) to	**BLUE** Completed	More than 60 outpatient redesign projects have been implemented across the Trust. This work has involved key stakeholders in primary and secondary care, members of the	**Lead: AB** Outpatient Transformation Board

avoid the need for patients to visit the hospital.		public and Healthwatch. This has improved patient experience and impacted on 10% of out-patient attendances to CHFT – reducing the need for patients to visit the hospital. Plans for 2020/21 will increase this to a 20% impact.	
Design and implement an agreed digital strategy that describes a future vision that will improve usability, breadth and continue to support the ongoing needs of a shared care record across the local health and social care community	**GREEN** On track	The engagement plan is set out and agreed around the design of the digital strategy with an aim to acquire board approval in May 2020. The launch and implementation of the strategy will be developed in April as a proposal. Following Board approval a roadmap and workplan will be defined with an intended programme kick-off in Summer 2020.	**Lead: MG** Divisional digital boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.

Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a Single Oversight Framework rating of 2 for the agreed quality and operational performance metrics	**GREEN** On track	CHFT continues to deliver a very strong operational performance. • CHFT is consistently ranked in the top ten best performing Trusts nationally on the emergency care standards. • Cancer performance remains strong. • There has been robust progress on referral to treatment time (RTT) and diagnostic waiting times are on track to deliver agreed plan. • Data quality assurance review has been undertaken and confirmed a strong result.	**Lead: HB** NHS I PRMs Integrated Board Report Audit and Risk Committee

Achieve a CQC rating of good with outstanding features.	**GREEN** On track	Systems and processes for self-assessment have been reviewed all divisions have action plans in place to move up the ratings.	**Lead: EA** Quality Committee Weekly Executive Board
Implement the Quality Improvement Strategy and deliver the 19/20 agreed quality KPIs.	**GREEN** On track	New strategy and KPIs for 20/21 currently in development.	**Lead: EA** Quality Committee Weekly Executive Board
Develop and ensure delivery of the KPIs by CHS and PFI partner, to provide a safe environment that is efficient and supports effective patient care.	**BLUE** Completed	KPIs were developed for services provided by CHS and for CHS. All KPIs both for CHS and our PFI partner are monitored regularly and escalated where appropriate to Joint liaison Committee.	**Lead: GB** Joint Liaison Committee
Deliver the annual health & safety action plan.	**GREEN** On track	Fire Committee established and on track to compete agreed works. Business Continuity plans in place and tested in preparation for Brexit and recent EPR upgrades. Further scenario testing required to provide assurance that business continuity robust	**Lead: SD / HB (Business Continuity)** Quality Committee Board
Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**assurance route**
Achieve a retention rate of 90% and reduce vacancy rate to 5% to address recruitment and retention of key roles in CHFT.	**GREEN** On track	Our current turnover rate is 7.9% and our vacancy rate is 3.8%	***Lead: SD*** Workforce Committee

Launch a colleague disability network in Sept 2019 and coordinate all our workforce ED&I activities and networks by March 2020 to improve colleague engagement and inclusion.	**GREEN** On track	A disability network has been established, and all networks are coordinated into an Inclusion and Advisory Group.	***Lead: SD*** Workforce Committee
Roll out the health and wellbeing strategy and plan to maintain a 96% attendance rate.	**GREEN** On track	Our attendance is currently projected to be 96.3%	***Lead: SD*** Workforce Committee
Develop an 'essentials of management' development programme and a CHFT leadership programme to improve our staff engagement score to the national average (7.0 in 2018).	**AMBER** Off track – with plan	An essential of management development programme has been developed and is ready to roll out from April 2020. Our recent staff engagement score was 6.9 in 2019.	***Lead: SD*** Workforce Committee
Assess and refresh all people management policies to enable and facilitate 'one culture of compassionate care' by March 2020.	**GREEN** On track	Significant progress has been made, and key policies have been reviewed. All minor policies will have been reviewed by May 2020.	***Lead: SD*** Workforce Committee

Goal: Financial sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a regulatory compliant financial plan for 2019/20 including CIP	**GREEN** On track	2019/20 plan was accepted by regulators and the plan has been delivered every month year to date and continues to forecast to be delivered.	**Lead: GB** Turnaround Executive Finance & Performance Committee Estates Sustainability Committee Monthly regulator discussions
Develop a regulatory and Integrated Care System compliant capital plan to meet the organisation's requirements	**BLUE** Completed	2019/20 capital plan was agreed with regulators that has allowed drawdown in relation to reconfiguration business case, emergency capital in support of HRI estate challenges and additional funding for diagnostic imaging equipment.	**Lead: GB** Finance and Performance Committee Estates Sustainability Committee
Maintain a Single Oversight Framework rating of 3 or better for financial and Use of Resources performance metrics	**GREEN** On track	Use of resources metric has remained at 3 all year and is forecast to do so for the remaining months.	**Lead: GB** Finance & Performance Committee Board
Progress key WYAAT work streams and capital bids including vascular; pharmacy; imaging; pathology; wholly owned subsidiary and elective procedures.	**GREEN** On track	Collaborative work is in progress regarding the WYAAT work streams. Regular updates on this have been provided to the Trust Board.	**Lead: ALL** Business cases to be reviewed by Board and WYAAT Committee in Common
Implement year one of the plan to strengthen budget accountability including roll out of training and performance support arrangements	**GREEN** On track	During the year agreement was reached on who needed to undertake financial training. As of 31st January 2020, 61% of budget holders have undertaken the managing our money training. Through-out the year a new escalation process was introduced. For 2020/21 budgets there is clearer understanding of accountability.	**Lead:GB/HB** Weekly Executive Board Turnaround Executive Finance & Performance Committee

10 Year Strategy

Our Vision	***Together we will deliver outstanding compassionate care to the communities we serve***			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
The result	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Sustainability
Our response	Patients and public are able to shape decisions about service developments and their personal care.	We will have achieved and sustained a CQC rating of outstanding.	The Trust will be widely known as one of the best places to work through an embedded one culture of care.	We will be financially sustainable and an exemplar for use of resources.
	We will have an optimal configuration of services and demonstrated improved outcomes for local people.	We will consistently achieve all relevant patient performance targets as featured in the NHS Long Term and ICS plans.	We will foster an open learning culture that focuses on, and demonstrates lessons learnt and sharing best practice.	The Trust will have significantly reduced the use of natural resources.
	Patients and colleagues will be digitally enabled to access and provide care wherever this is needed.	We will be fully compliant with health and safety standards and be faithful to our constitution.	We will have a workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.	
	Working with partners we will regularly use population health data to address health inequalities.		As an anchor institution we will have a workforce that champions, reflects and celebrates our diverse communities.	

FINANCIAL SUSTAINABILITY

11. Month 10 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 March 2020
Meeting:	Board of Directors
Title:	Month 10 Financial Summary
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance and Performance Committee

Actions Requested:
To note

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 10 (January 2019)

Key Points to Note

The year to date deficit is £9.77m, a £0.25m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding.

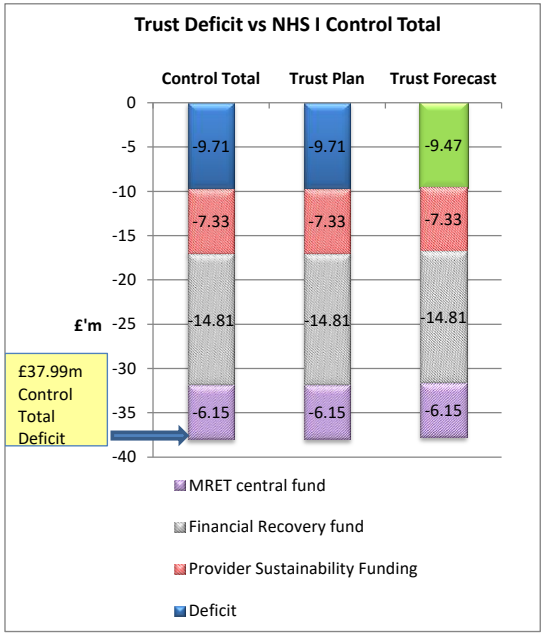
- There is some pressure year to date due to higher than planned non pay expenditure including utilities, outsourced services and maintenance contracts.
- These pressures have been offset year to date by lower than planned pay expenditure, delivered in the face of pressure from Medical pay awards and the opening of additional capacity.
- Clinical income performance (contract and other) is below plan by £0.39m. The Aligned Incentive Contract (AIC) protects the income position by £1.00m resulting overall in a favourable variance of £0.61m, an improvement compared to the position in Month 9. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services.
- CIP achieved year to date is £8.34m, £0.13m more than planned.
- Agency expenditure year to date is £6.17m, £3.28m below the planned level.
- The Trust continues to forecast achievement of Control Total, although this position is at risk now that NHSI and DHSC have advised that Project Echo will not be able to complete in year despite the Trust having completed the necessary steps. The Trust is liaising with regulators and the Integrated Care System on how this pressure can be handled. There remains some uncommitted winter reserve available to manage any winter pressures that continue into the final two months, but all other contingencies are now fully

committed. Appendix: Finance Report Month 10
EQIA – Equality Impact Assessment
All cost improvement and recovery plans will need to undergo both QIA and EQIA on an individual basis prior to implementation.
Recommendation
The Board is asked to note the attached summary

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jan 2020 - Month 10

KEY METRICS

	M10				YTD (JAN 2020)				Forecast 19/20			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	£0.50	£0.51	£0.00		(£10.01)	(£9.77)	£0.25		(£9.71)	(£9.47)	£0.24	
Agency Expenditure	(£1.08)	(£0.45)	£0.63		(£9.45)	(£6.17)	£3.28		(£11.56)	(£6.87)	£4.69	
Capital	£3.22	£0.80	£2.42		£14.16	£6.25	£7.91		£20.21	£13.85	£6.36	
Cash	£1.91	£2.12	£0.21		£1.91	£2.12	£0.21		£1.91	£1.90	(£0.01)	
Borrowing (Cumulative)	£167.87	£161.97	(£5.90)		£167.87	£161.97	(£5.90)		£168.40	£160.92	(£7.47)	
CIP	£1.06	£0.98	(£0.08)		£8.21	£8.34	£0.13		£11.00	£11.00	£0.00	
Use of Resource Metric	2	2			3	3			3	3		



Year to Date Summary

The year to date deficit is £9.77m, a £0.25m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding.

- There is some pressure year to date due to higher than planned non pay expenditure including utilities, outsourced services and maintenance contracts.
- These pressures have been offset year to date by lower than planned pay expenditure, delivered in the face of pressure from Medical pay awards and the opening of additional capacity.
- Clinical income performance (contract and other) is below plan by £0.39m. The Aligned Incentive Contract (AIC) protects the income position by £1.00m resulting overall in a favourable variance of £0.61m, an improvement compared to the position in Month 9. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services.
- CIP achieved year to date is £8.34m, £0.13m more than planned.
- Agency expenditure year to date is £6.17m, £3.28m below the planned level.

Key Variances

- Clinical income is above plan overall, but only as a result of the £1.00m protection offered by the Aligned Incentive Contract (AIC), with lower than planned activity levels across all points of delivery with the exception of A&E. However, AIC protection has continued to reduce with an in month movement of £0.69m.
- Surgical Division continue to show a favourable variance to plan, reflective of lower expenditure linked to lower activity levels. However, the Medicine position has worsened further in month primarily due to the opening of additional capacity and a pressure on High Cost Drugs which is being jointly reviewed by colleagues in Finance and Pharmacy.
- Some non clinical areas are experiencing pressure with unplanned costs in Corporate Division due to medico-legal fees and higher than planned cross charge for services from CHS due to pressure on the cost of utilities.
- There is an adverse variance on Medical staffing expenditure of £0.42m, although this includes £0.70m pressure due to pay awards. Some additional funding has been allocated by DH, but this is insufficient to fully cover the planning gap (a net pressure of £0.46m year to date).
- Nursing pay expenditure is lower than planned year to date by £0.71m, despite the opening of additional capacity, supported by planned winter reserves and a reduction in both agency usage and average hourly rate.

Forecast

The Trust continues to forecast achievement of Control Total, although this position is at risk now that NHSI and DHSC have advised that Project Echo will not be able to complete in year despite the Trust having completed the necessary steps. The Trust is liaising with regulators and the Integrated Care System on how this pressure can be handled. There remains some uncommitted winter reserve available to manage any winter pressures that continue into the final two months, but all other contingencies are now fully committed.

Total Group Financial Overview as at 31st Jan 2020 - Month 10

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	4,560	4,469	(91)
Non-Elective	50,393	49,583	(810)
Daycase	34,797	34,419	(378)
Outpatient	301,807	297,226	(4,580)
A&E	129,246	131,911	2,665
Other NHS Non-Tariff	1,497,481	1,487,210	(10,271)
Other NHS Tariff	107,769	107,740	(29)
Total	**2,126,053**	**2,112,558**	**(13,494)**

TOTAL GROUP: INCOME AND EXPENDITURE

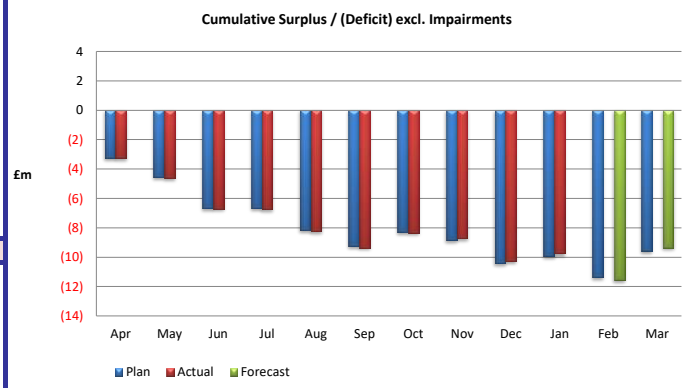
	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£14.71	£14.22	(£0.50)
Non Elective	£92.20	£91.91	(£0.29)
Daycase	£24.66	£23.78	(£0.89)
Outpatients	£38.47	£38.19	(£0.27)
A & E	£18.69	£19.13	£0.43
Other-NHS Clinical	£84.53	£86.41	£1.88
CQUIN	£3.03	£3.02	(£0.02)
Other Income	£39.67	£42.70	£3.03
Total Income	**£315.98**	**£319.35**	**£3.37**
Pay	(£218.40)	(£216.86)	£1.54
Drug Costs	(£30.40)	(£33.46)	(£3.06)
Clinical Support	(£24.75)	(£24.40)	£0.34
Other Costs	(£42.85)	(£45.26)	(£2.41)
PFI Costs	(£10.90)	(£10.90)	£0.00
Total Expenditure	**(£327.28)**	**(£330.87)**	**(£3.59)**
EBITDA	**(£11.30)**	**(£11.52)**	**(£0.22)**
Non Operating Expenditure	(£20.80)	(£20.34)	£0.46
Surplus / (Deficit) Control Total basis*	**(£32.11)**	**(£31.86)**	**£0.25**
Conditional Funding (MRET/PSF/FRF)	£22.09	£22.09	£0.00
Surplus / Deficit*	**(£10.01)**	**(£9.77)**	**£0.25**

* Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£11.39	£12.52	£1.13
Medical	£33.68	£32.41	(£1.28)
Families & Specialist Services	(£4.07)	(£4.04)	£0.03
Community	(£2.42)	(£1.96)	£0.46
Estates & Facilities	(£0.00)	(£0.06)	(£0.06)
Corporate	(£36.24)	(£35.29)	£0.95
THIS	£2.01	£1.76	(£0.25)
PMU	£2.55	£2.95	£0.40
CHS LTD	£0.42	£0.41	(£0.01)
Central Inc/Technical Accounts	(£16.87)	(£18.10)	(£1.24)
Reserves	(£0.78)	(£0.40)	£0.38
Unallocated CIP	£0.31	£0.04	(£0.27)
Surplus / (Deficit)	**(£10.01)**	**(£9.77)**	**£0.25**

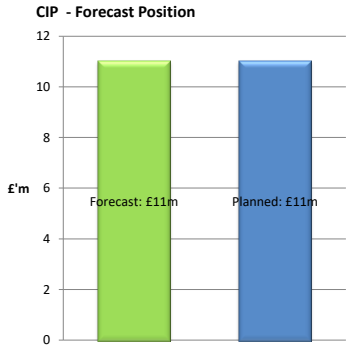
TOTAL GROUP SURPLUS / (DEFICIT)

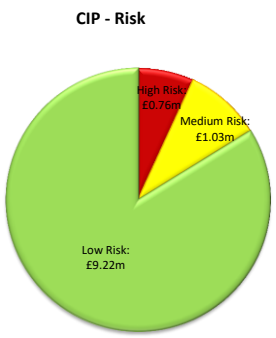


KEY METRICS

	Year To Date			Year End: Forecast		
	M10 Plan	M10 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£10.01)	(£9.77)	£0.25	(£9.71)	(£9.47)	£0.24
Capital	£14.16	£6.25	£7.91	£20.21	£13.85	£6.36
Cash	£1.91	£2.12	£0.21	£1.91	£1.90	(£0.01)
Loans	£167.87	£161.97	(£5.90)	£168.40	£160.92	(£7.47)
CIP	£8.21	£8.34	£0.13	£11.00	£11.00	£0.00
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£11m**

Total Forecast **£11m**

YEAR END 19/20

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,459	5,387	(72)
Non-Elective	60,256	59,535	(721)
Daycase	41,813	41,382	(431)
Outpatient	362,551	358,220	(4,331)
A&E	153,542	158,274	4,732
Other NHS Non- Tariff	1,798,704	1,786,075	(12,630)
Other NHS Tariff	129,454	129,706	252
Total	**2,551,779**	**2,538,577**	**(13,202)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.64	£17.11	(£0.54)
Non Elective	£110.17	£110.14	(£0.03)
Daycase	£29.65	£28.69	(£0.96)
Outpatients	£50.52	£44.22	(£6.30)
A & E	£22.21	£22.97	£0.77
Other-NHS Clinical	£97.06	£105.55	£8.50
CQUIN	£3.63	£3.63	(£0.00)
Other Income	£48.55	£51.84	£3.30
Total Income	**£379.42**	**£384.16**	**£4.73**
Pay	(£262.18)	(£261.28)	£0.90
Drug Costs	(£36.42)	(£40.03)	(£3.62)
Clinical Support	(£29.62)	(£29.37)	£0.25
Other Costs	(£51.31)	(£53.59)	(£2.28)
PFI Costs	(£13.07)	(£13.17)	(£0.09)
Total Expenditure	**(£392.61)**	**(£397.44)**	**(£4.83)**
EBITDA	**(£13.19)**	**(£13.29)**	**(£0.10)**
Non Operating Expenditure	(£24.80)	(£24.47)	£0.33
Surplus / (Deficit) Control Total basis*	**(£37.99)**	**(£37.76)**	**£0.24**
Conditional Funding (MRET/PSF/FRF)	£28.28	£28.28	£0.00
Surplus / Deficit*	**(£9.71)**	**(£9.47)**	**£0.24**

* Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

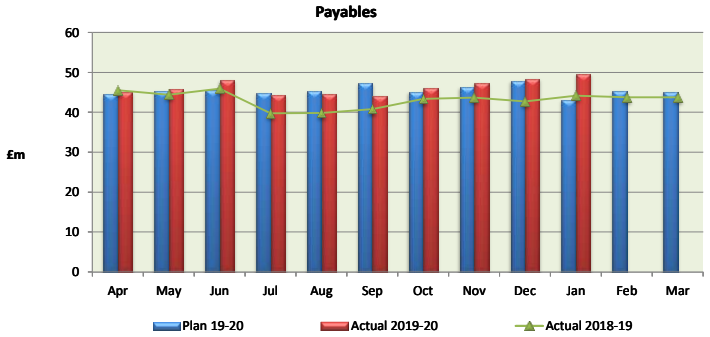
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£13.80	£15.04	£1.24
Medical	£39.91	£38.96	(£0.95)
Families & Specialist Services	(£4.98)	(£5.06)	(£0.08)
Community	(£2.92)	(£2.49)	£0.43
Estates & Facilities	(£0.00)	(£0.06)	(£0.06)
Corporate	(£43.43)	(£42.88)	£0.54
THIS	£2.42	£2.22	(£0.20)
PMU	£2.99	£3.19	£0.20
CHS LTD	£0.62	£0.60	(£0.01)
Central Inc/Technical Accounts	(£17.39)	(£18.93)	(£1.53)
Reserves	(£1.14)	(£0.12)	£1.03
Unallocated CIP	£0.41	£0.04	(£0.37)
Surplus / (Deficit)	**(£9.71)**	**(£9.47)**	**£0.24**

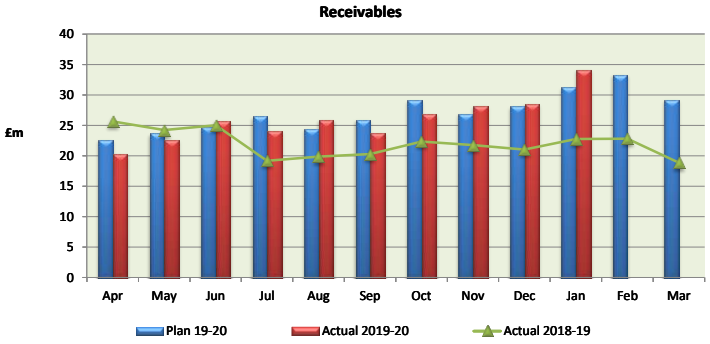
Total Group Financial Overview as at 31st Jan 2020 - Month 10

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

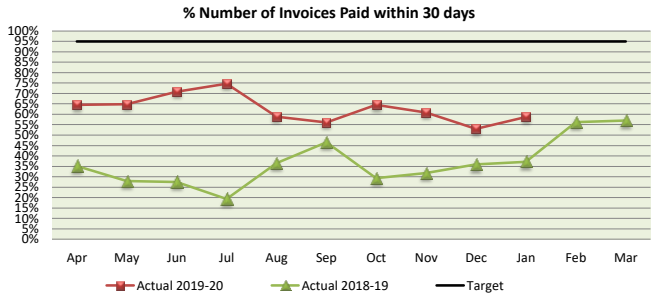
WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables (excl. Current Loans)	(£43.18)	(£49.68)	£6.50	
Receivables	£31.24	£34.18	(£2.94)	



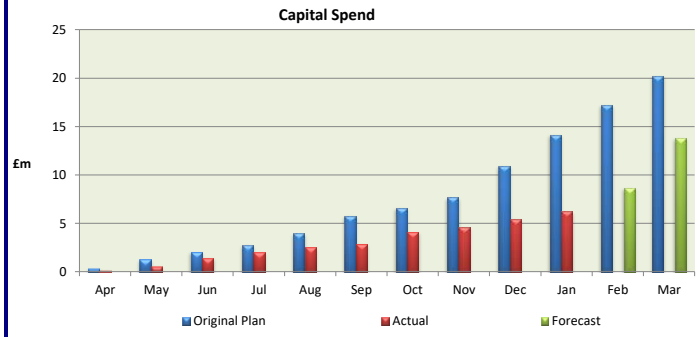


BETTER PAYMENT PRACTICE CODE



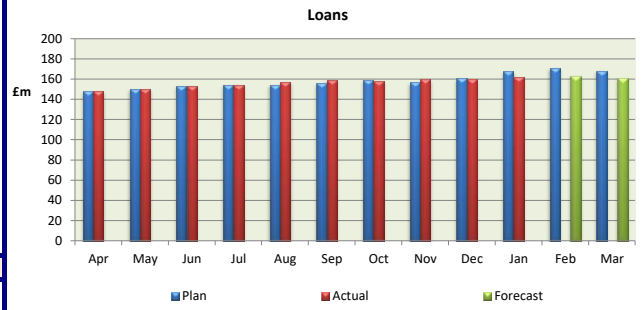
CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital	£14.16	£6.25	£7.91	

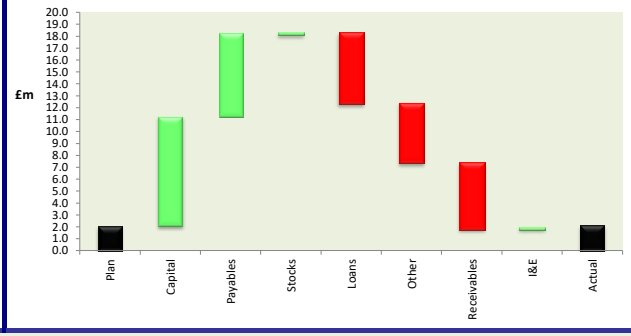


CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£1.91	£2.12	£0.21	
Loans (Cumulative)	£167.87	£161.97	(£5.90)	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £9.77m, a £0.25m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding. This position excludes the I&E impact of the reversal of an impairment (£0.9m favourable variance) and donated assets (£0.09m adverse variance) which are excluded for control total purposes.
- Income position assumes that the Trust will is eligible to receive full year to date allocation of Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) totalling £16.97m year to date, given that the Control Total has been achieved as planned.
- Year to date activity remains below plan for all points of delivery with the exception of A&E and overall Clinical Contract Income is below plan by £0.54m, although in month activity has increased driving a reduction in the protection provided by the AIC contract from £1.69m to £1.00m.
- Year to date Capital expenditure was lower than planned at £6.25m against a planned £14.16m.
- Cash balance is £2.12m, £0.21m higher than the planned £1.91m.
- Year to date the Trust has borrowed £20.03m to support the deficit and PSF / FRF funding that will be paid in arrears.
- Year to date CIP schemes have delivered £8.34m of savings, £0.13m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 against a planned level of 3. Of the five metrics that make up the UOR, all are as planned.

NOTES

- The Trust is forecasting to achieve Control Total with a £9.47m forecast deficit, £0.24m less than planned due to the afore mentioned gain on disposal.
- The Forecast position includes conditional funding of £28.28m, (£6.147m MRET central funding, £7.33m Provider Sustainability Funding and £14.807m Financial Recovery Fund). 15% of the Trust's Q3 & 4 Provider Sustainability Funding (£0.71m) is reliant on the Integrated Care System (ICS) delivering Control Total overall, (delivered for Q1 & 2) and this is also currently forecast to deliver.
- The Trust is forecasting Agency expenditure of £6.87m, considerably below the NHSI ceiling of £14.96m, but offset by an increase in expenditure on Bank staff.
- The Trust is forecasting full delivery of the £11.00m 19/20 CIP target.
- The Trust planned to borrow £26.46m in 19/20 to support Capital and Revenue plans; £9.71m deficit funding, £7.75m advance to cover PSF & FRF funding that will not be paid until next year and £9m Emergency Capital loan. Forecast loan requirements have now reduced by £7.00m due to slippage on emergency capital plans
- The total loan balance at year end is forecast to be £161.01m, £7.38m lower than planned. Two Revenue loans were due for repayment this year: £12.9m loan due for repayment in February 20 has now been extended until August 20 and a further loan for £26.9m due for repayment in January 20 has been extended until July 20. These loan extensions have now been confirmed.
- Capital expenditure is forecast at £13.85m, £6.36m lower than planned and a reduction compared to that reported in Month 9 of £1m due to slippage on Emergency Capital.

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

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

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

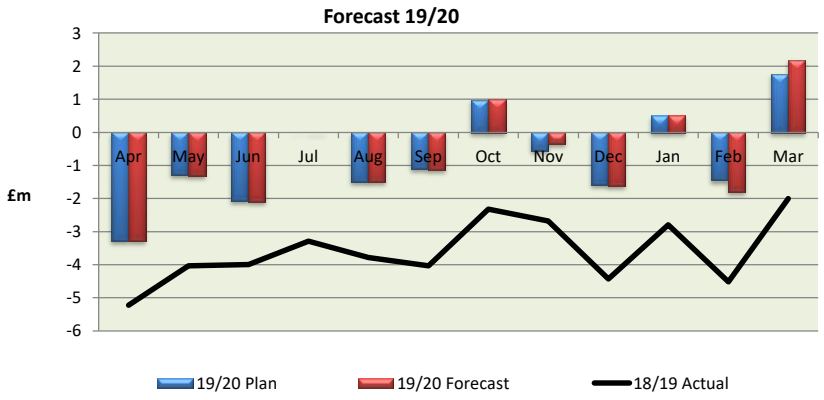
FORECAST

YEAR END 19/20

	Plan £m	Forecast £m	Var £m	
Elective	£17.64	£17.11	(£0.54)	
Non Elective	£110.17	£110.14	(£0.03)	
Daycase	£29.65	£28.69	(£0.96)	
Outpatients	£50.52	£44.22	(£6.30)	
A & E	£22.21	£22.97	£0.77	
Other-NHS Clinical	£97.06	£105.55	£8.50	
CQUIN	£3.63	£3.63	(£0.00)	
Other Income	£48.55	£51.84	£3.30	
Total Income	**£379.42**	**£384.16**	**£4.73**	
Pay	(£262.18)	(£261.28)	£0.90	
Drug Costs	(£36.42)	(£40.03)	(£3.62)	
Clinical Support	(£29.62)	(£29.37)	£0.25	
Other Costs	(£51.31)	(£53.59)	(£2.28)	
PFI Costs	(£13.07)	(£13.17)	(£0.09)	
Total Expenditure	**(£392.61)**	**(£397.44)**	**(£4.83)**	
EBITDA	**(£13.19)**	**(£13.29)**	**(£0.10)**	
Non Operating Expenditure	(£24.80)	(£24.47)	£0.33	
Surplus / (Deficit) Control Total basis*	**(£37.99)**	**(£37.76)**	**£0.24**	
Conditional Funding (MRET/PSF/FRF)	£28.28	£28.28	£0.00	
Surplus / Deficit*	**(£9.71)**	**(£9.47)**	**£0.24**	

*Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

Forecast



The Trust is forecasting a favourable variance of £0.24m against the planned £9.7m deficit, although this includes a £0.23m benefit from a gain on disposal, excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding. The forecast deficit assumes the full allocation of conditional funding available as a result of accepting the 19/20 Control Total, (a £37.99m deficit).

Key Assumptions:

- Efficiency challenge is £11m CIP. The forecast assumes full delivery including high risk elements with a value of £0.76m.
- Aligned Incentive Contract (AIC) with two main commissioners reduces risk of income loss, but for all other commissioners contracts remain on a payment by results basis and are therefore subject to variability based on actual activity levels.
- Agency plan of £11.56m against the NHS I ceiling of £14.96m. At Month 10 forecasting agency expenditure of £6.87m, £4.69m lower than plan but offset by an increase in bank / locum expenditure.
- Contingency Reserves of £2m held, including £1m Winter Reserve, the majority of which has now been committed.
- Further Growth /Winter reserve of £1.6m, plans are now in place for the full allocation of this funding.

Key Variances:

- Medical staffing pay awards have been awarded, backdated to April with arrears paid in September. The cost of these awards is higher than the value planned and are driving a pressure in the forecast of £0.54m (£0.81m pay pressure less additional central funding received of £0.27m).
- Medical Division's underlying position has continued to deteriorate with pressures primarily linked to activity and increased capacity, offset by some improvements in other Divisions.
- £0.5m additional ICS winter funding has been materially committed to additional capacity and discharge facilities.
- The cost of unrecoverable VAT on goods and services purchased outside of the CHS Managed Service at HRI has been higher than expected year to date by £1.15m, in part driven by higher than planned non pay expenditure. The pressure as a result of this VAT recovery issue is mitigated in the forecast, but some of this mitigation is non-recurrent in nature. There is further work to do the ensure that VAT recovery has been maximised, but this is a recurrent cost pressure that will need to be managed through business planning.
- Notified changes to the discount rate on provisions are driving a £0.5m pressure in the forecast.
- Changes to pension rules have resulted in unplanned costs - the Trust has now received three invoices and a further two notifications from the pensions agency totalling £0.52m relating to members of staff that have already retired. It is possible that further charges will follow.

Risks and Opportunities:

- NHSI and DHSC have advised that project Echo will not be able to complete in year despite the Trust having completed all the necessary steps. The Trust is liaising with regulators and the ICS on how this pressure can be handled.
- Impact of changes to VAT rules relating to the Brookson agency contract are expected to be c.£0.2m - covered through contingency reserve. If HMRC sought to recover the VAT retrospectively the cost could increase to close to £2m.
- 15% of Provider Sustainability Funding (PSF) worth £1.10m is dependant on the Integrated Care System (ICS) as a whole achieving its control total. Q1 & 2 have now been delivered, but £0.71m of funding relies on ICS delivery of Q3 & 4 and is not yet confirmed.

12. Annual Plan 2020/21 – PRESENTATION

To Note

Presented by Gary Boothby

KEEPING THE BASE SAFE

13. Safer Staffing Report – Hard Truths Requirement

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	5th March 2020
Meeting:	Board of Directors
Title:	Safer Staffing Report March 2019/20
Author:	Lindsay Rudge, Deputy Director of Nursing Michelle Bamforth, Head Nurse for Workforce and Professional Development
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Not Applicable

Actions Requested: The approve and accept recommendations of the report

Purpose of the Report

The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer in England have continued to issue guidance to optimise nursing, midwifery and care staffing capacity and capability. The purpose of this report is to provide the Board of Directors assurance that the nursing and midwifery workforce has been reviewed in line with national guidance. The report provides details on the nursing and midwifery workforce at Calderdale and Huddersfield NHS Foundation Trust (CHFT). It will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time.

Key Points to Note

- A 6 monthly review has been completed in line with guidance.
- Registered Nurse vacancy position continues to be a risk within the workforce and remains on the risk register.
- The Trust has increased the number of training placements at CHFT.
- The Nursing Associate training programme continues to develop in line with the national plan.
- CHFT continue to utilise digital technology to support analysis of patient's dependency and acuity aligned to the workforce.
- The nurse staffing risk remains on the high level risk register with a score of 16 (risk 6345).

EQIA – Equality Impact Assessment

Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non - English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing staff required to provide safe care. Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the review process.
Recommendation
The Board is asked to accept this paper.

CONTENTS	
1.0	Introduction
2.0	Current Position
3.0	Organisational overview of staffing levels
4.0	Quality impact of Nursing and Midwifery staffing levels
5.0	Bi-Annual Staffing Review: Dec 2019 – Jan 2020
6.0	Conclusions
7.0	Recommendations
8.0	References

1.0 INTRODUCTION

The purpose of this report is to provide the Board of Directors' assurance that the nursing and midwifery workforce has been reviewed in line with national guidance. The report provides details on the nursing and midwifery workforce numbers and skill mix at Calderdale and Huddersfield NHS Foundation Trust (CHFT) over the last six months. It will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time.

The approach undertaken uses intelligence gathered from a range of evidenced based tools and triangulates the findings with safety, quality and patient experience measures to provide a detailed analysis and appraisal of the information provided and where required makes recommendations for improvement. It will outline current compliance to the guidance from National Quality Board (NQB), National Institute for Clinical Excellence (NICE) and NHS Improvement (NHSi) standards in relation to adult and children's inpatient areas (including Maternity Services).

The right nursing and midwifery staffing levels are required to deliver safe, effective, quality care and treatment to patients and families accessing healthcare services.
In nursing, the number of people needed, and the skill required depends on several factors, including but not limited to:

- Patients level of dependency and the complexity of their condition
- Acuity and severity of illness
- Ward or department activity
- Geographical layout of the ward or department;
- Medical staffing model in place
- AHP support available

As a consequence, setting nationally agreed 'staff to bed ratios' for nurse staffing levels is problematic and each area needs to be assessed within the context of the patient case-mix seen and the expected level of activity. As acuity and activity can vary and at times and behave unpredictably, a flexible and transferable nursing workforce model is required to respond to fluctuating demand and operational pressures. Monitoring key safety, quality and experience metrics is essential to evaluating if the nurse staffing levels in a particular area are appropriate. The triangulation of these metrics, alongside the use of a validated evidenced based tools alongside professional judgement are central to making informed decisions about staffing requirements in real-time, or over a period time to ensure the nursing establishment meets patients' expectations and provides safe, quality care.

At CHFT two nationally validated and endorsed methodologies are used

- Safer Nursing Care tool (also known as the Shelford tool);
- Care Hours per Patient Day (CHPPD).

1.1 Background

In July 2016, the National Quality Board updated its guidance for provider Trusts, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery staffing levels. This guidance has been updated in 2018. The nursing workforce establishment levels are developed and underpinned by these standards and in line with recommendations from NHSI' "Developing Workforce Safeguards" (2018). By implementing the recommendations and through robust, effective governance, the board can be assured that workforce decisions promote patient safety, quality, and experience and comply with regulatory standards.

2.0 CURRENT POSITION

It is recognised that there is a shortfall in healthcare workforce numbers across the United Kingdom (UK) and this has a direct impact on peoples care and experience. One of the greatest workforce challenges is seen within nursing, with 41,000 FTE vacancies reported in the NHS alone. This position has worsened from the reported 10% gap in adult nursing in 2017. Furthermore, statistics released in 2018 outlined that 33,000 nurses a year are leaving the NHS in England this is 20% more than left in the same period four years ago. Evidence is growing in this area and demonstrates the number leaving outweighs the number joining. The report published in 2019 by the Health Foundation confirms this in its review of NHS staffing trends.

In addition to the growing shortfall reported, several other national challenges compound this issue and these include (but are not limited to):

- Aging workforce profile;
- Increase in number of nurses and midwives leaving the profession;
- Changes in nurse training & loss of bursary payments;
- Reduction of CPD funding impacting on training & development opportunities;
- No backfill provided for nurse apprenticeship programmes;
- Growing number of advanced nurse practitioner roles to support medical rotas.

Despite the government's efforts to increase the number of nurses and allied health professionals (AHPs) in training by up to 10,000, success is yet to be seen, the number of nurses in undergraduate training has fallen by 4% since 2016. The Long-term plan published in January 2019, sets out commitments to improve health outcomes and quality of care, however it recognised that to achieve this healthcare providers need the right number of staff, with the right skills and that adequate support should be provided to staff in order that they can work effectively. The 'Interim NHS People Plan' sets out areas of focus in nursing and midwifery to increase supply improve retention and build a pipeline route into registered nursing through the recently developed Nursing Associate role.

Given the scale of the problem in nursing, emphasis nationally and at CHFT has been placed on training numbers, course availability and understanding the predicted pipeline data to manage expected turnover and close the vacancy gap. Initiatives to date include (but are not limited to):

- Development of new roles (Nursing Associate);
- Future Nurse Programme
- Funding & availability of clinical placements
- Range of training experience
- Attrition rates

- Quality, success and balance of training (reducing variation);
- Funding level and flexibility in how it is used.

Whilst it is clear in national data that the bursary has impacted upon the number of students placed on a nursing degree, CHFT have been working closely with local HEI and partners to address training numbers of students per intake and increase the practice placement numbers by 30% in 2019/20 .There is also potential for further expansion across Adult, Paediatric and Midwifery fields in the academic year of 20/21. This aligns with the NHS People plan and the specific recommendations in relation to rapid nursing and midwifery under graduate expansion plans.

In September 2019 the bursary was reintroduced for all fields of nursing with specific enhancements for Learning Disability and Mental Health with an expectation that this will further support increasing training numbers.

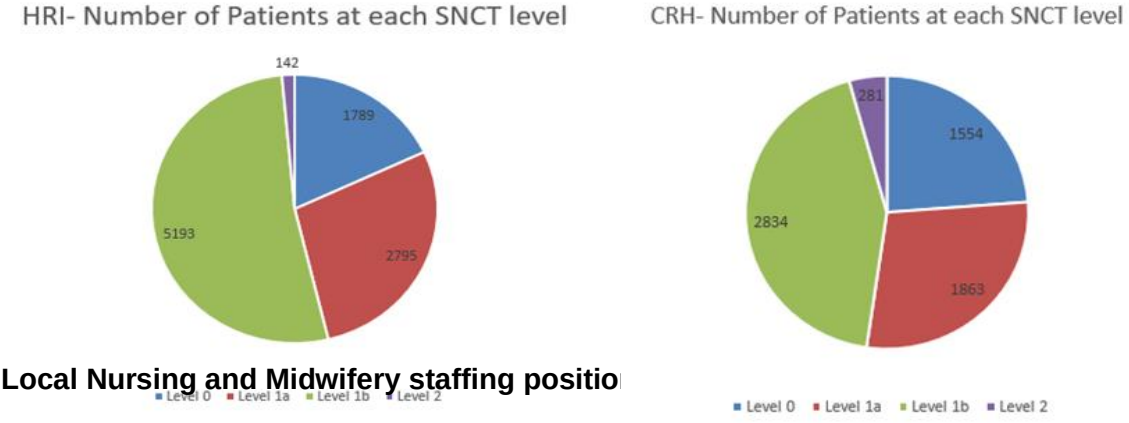
2.1: Patient acuity and dependency

There has been a change in the case-mix of patients in the acuity and dependency of people presenting to the hospital for care and treatment and this is illustrated in Table 4 of this report. This together with the changing landscape of the healthcare system and redesign of services to support patients across the local economy has led to an increase in complexity, dependency and acuity. The majority of patients are being recorded as level 1b (green) indicating a rise in dependency levels. In view of this it's important to consider the configuration of services at CHFT. A high volume of level 1b patients (requiring additional care hrs due to dependency) are seen on the HRI site. This can be aligned to the provision of elderly care services on this site. CRH report a higher number of level 2 patients (requiring critical care support) during the reporting period. Interrogation of the data suggests that this is linked to the Respiratory floor, HASU, CCU and Acute floor running at capacity for their specialised beds to support Non-Invasive Ventilation (NIV), Stroke and Cardiology patients at this time. Table 4 highlights the proportion split of patients by type over the reporting period. The descriptors can be found in Appendix 3 which provides details of the patient types as defined by the Shelford model.

To inform the nurse staffing reviews CHFT used the NICE endorsed Shelford Safer Care Nursing Tool (SCNT). The results from this can be found in Appendix 2, and the staffing establishment recommendations in section 5 of this report.

Research published by the National Institute for Health Research in 2019 discusses this further and articulates the rising demand for inpatient nursing care. Clear links are made to the level of acuity and dependency within in-patient services and asserts that there has been a documented rise in this demand.

Table 4:



2.2 Local Nursing and Midwifery staffing positio

The current position for nursing and midwifery staffing at the CHFT remains a continued challenge, with 147.95 FTE registered nursing and midwifery posts currently unfilled (see table 5). These collated figures give an annual turnover rate of between 8-9%. This picture has been consistent over recent years and is documented on the Trust's risk register as a high level risk, rag rated red.

Table 5: (taken from ESR January 2020)

Qualified			
Row Labels	**Sum of Actual (FTE)**	**Sum of Budgeted (FTE)**	**Sum of Vacancies (FTE)**
372 Community L3	208.11	212.35	4.24
372 Corporate L3	59.01	51.38	-7.63
372 Families & Specialist Services L3	374.12	399.57	25.45
372 Health Informatics L3	0.91	0.91	0.00
372 Medical L3	548.57	615.92	67.35
372 Surgery & Anaesthetics L3	404.96	463.49	58.53
Grand Total	**1595.67**	**1743.62**	**147.95**

Unqualified			
Row Labels	**Sum of Actual (FTE)**	**Sum of Budgeted (FTE)**	**Sum of Vacancies (FTE)**
372 Community L3	34.60	30.98	-3.62
372 Corporate L3	21.96	25.20	3.24
372 Families & Specialist Services L3	137.01	155.34	18.33
372 Medical L3	338.85	322.08	-16.77
372 Surgery & Anaesthetics L3	211.07	208.61	-2.46
Grand Total	**743.49**	**742.21**	**-1.28**

In patient areas with higher % of Vacancies:

Ward/Department	**RN Vacancy level >15% of the Registered Workforce**
Medical Division	
Ward 17 HRI	27%
Acute Floor HRI	26%
Ward 15 HRI	24.6
Ward 20 HRI	21.1%
Respiratory floor CRH	20.1%
Ward 5 HRI	19%
Ward 6 HRI	15%
Surgical Division	
Ward 10 HRI	28%

2.3 Sickness and absence rates

In addition to the nursing and midwifery vacancy position sickness and absence rates for registered and unregistered nursing and midwifery staff impacts on the staffing levels achieved at the Trust.

Table 6 indicates that the organisational sickness percentage (%) for qualified registered nurses has increased to 4.5% through quarter 3 of this year, for unqualified colleagues the % rate has increased to >6.5%. The Trust maintains a continued focus on absence management and support to reduce the % of sickness and absence.

Table 6: Organisational nursing sickness % (taken from ESR January 2020)

Qualified Nursing & Midwifery

	Total Absence %											
Division	2018/12	2019/01	2019/02	2019/03	2019/04	2019/05	2019/06	2019/07	2019/08	2019/09	2019/10	2019/11
372 Community L3	7.35%	5.99%	5.33%	4.06%	3.07%	2.88%	2.80%	2.80%	4.77%	4.18%	4.41%	4.18%
372 Corporate L3	1.35%	1.14%	2.11%	3.26%	2.37%	1.62%	1.45%	1.26%	1.71%	2.88%	6.54%	3.04%
372 Families & Specialist Services L3	5.23%	4.10%	3.45%	2.49%	4.01%	5.26%	4.25%	3.97%	3.58%	3.47%	3.97%	4.19%
372 Health Informatics L3												
372 Medical L3	3.93%	3.96%	3.89%	2.45%	2.26%	2.73%	3.41%	3.54%	4.20%	3.77%	4.18%	4.68%
372 Surgery & Anaesthetics L3	4.59%	5.07%	5.27%	5.23%	4.87%	4.38%	2.71%	3.70%	3.35%	3.63%	3.94%	5.07%
Grand Total	**4.66%**	**4.36%**	**4.21%**	**3.39%**	**3.45%**	**3.73%**	**3.27%**	**3.50%**	**3.81%**	**3.68%**	**4.18%**	**4.54%**

Unqualified Nursing

	Total Absence %											
Division	2018/12	2019/01	2019/02	2019/03	2019/04	2019/05	2019/06	2019/07	2019/08	2019/09	2019/10	2019/11
372 Community L3	4.40%	0.98%	0.99%	0.24%	1.61%	1.94%	5.66%	4.12%	10.82%	9.91%	5.07%	7.56%
372 Corporate L3	7.72%	7.05%	10.89%	11.40%	9.09%	2.62%	5.09%	5.63%	14.81%	6.22%	9.04%	3.30%
372 Families & Specialist Services L3	5.50%	5.34%	5.62%	5.74%	4.88%	5.16%	6.56%	5.95%	6.15%	7.82%	6.32%	3.64%
372 Medical L3	4.71%	5.52%	6.05%	4.75%	4.01%	3.77%	5.41%	5.45%	5.54%	6.02%	5.84%	6.99%
372 Surgery & Anaesthetics L3	4.87%	5.85%	6.66%	4.90%	4.54%	6.50%	5.55%	4.13%	4.58%	5.05%	6.75%	7.81%
Grand Total	**5.03%**	**5.49%**	**6.18%**	**5.09%**	**4.41%**	**4.70%**	**5.66%**	**5.11%**	**5.88%**	**6.26%**	**6.25%**	**6.51%**

2.4: Care Hours per Patient Day (CHPPD) data

CHFT use CHPPD which is nationally mandated to inform nurse staffing establishments and monitor its achieved levels against the planned position this is reported monthly in the trusts Integrated Performance report.

Lord Carters review of operational productivity and performance in English acute hospitals in 2015 explored and tested ways in which to provide a single, consistent and nationally comparable way of recording and reporting nursing staffing in inpatient wards and departments. As a result, CHPPD was developed as the single metric to:

- Give a single comparable figure that can simultaneously represent both staffing levels and patient requirements, unlike actual hours or patient requirements alone which has been used traditionally; and

- Facilitate comparisons between wards within a trust and also nationally with wards of the same specialty. As CHPPD has been divided by the number of patients in an area, the value does not increase due to the size of the ward and this facilitates comparisons between wards of different sizes.

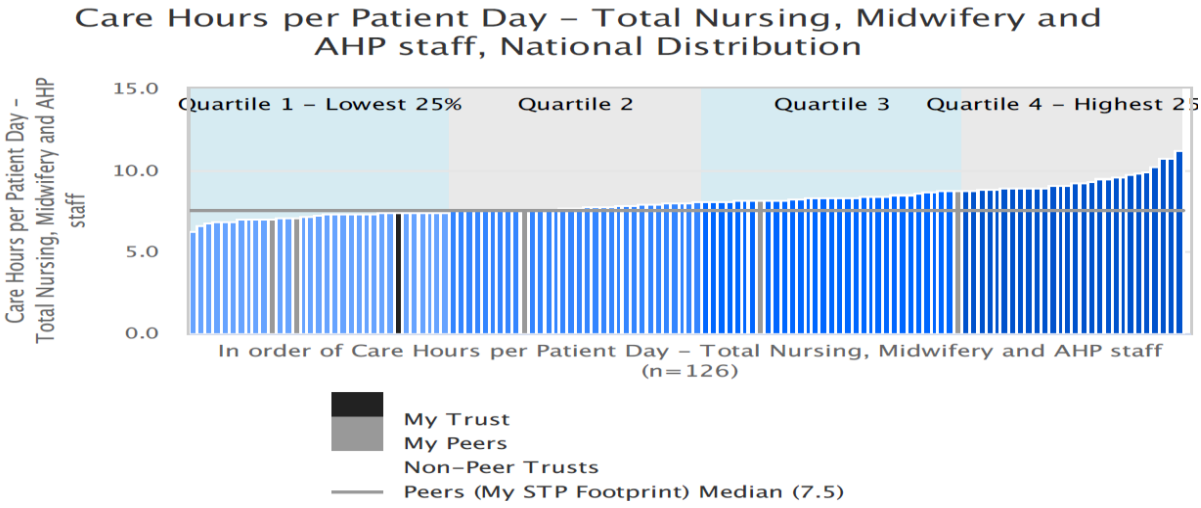
CHPPD measures how many hours of care are provided collectively by registered nurses, healthcare assistants and therapists (if included in the ward establishment model) per patient

in a 24-hour period. CHPPD is calculated by dividing the total number of nursing hours on a ward or department by the number of patients in beds at the midnight census, representing the number of nursing hours that are available to each patient.

$$\text{Care Hours per Patient Day (CHPPD)} = \frac{\text{Hours of RN + Hours of NA over 24 hour period}}{\text{Total Number of In Patients (Midnight Census)}}$$

The average CHPPD levels recorded at CHFT over the last four months have maintained between 7.3 and 7.9., however the achieved level of CHPPD has decreased through Q3. Although this trend can be seen nationally, CHFT are achieving below the national and peer median in this metric, and now sit in the lower quartile, further analysis of this will be undertaken during Q4 (see table 7 below)

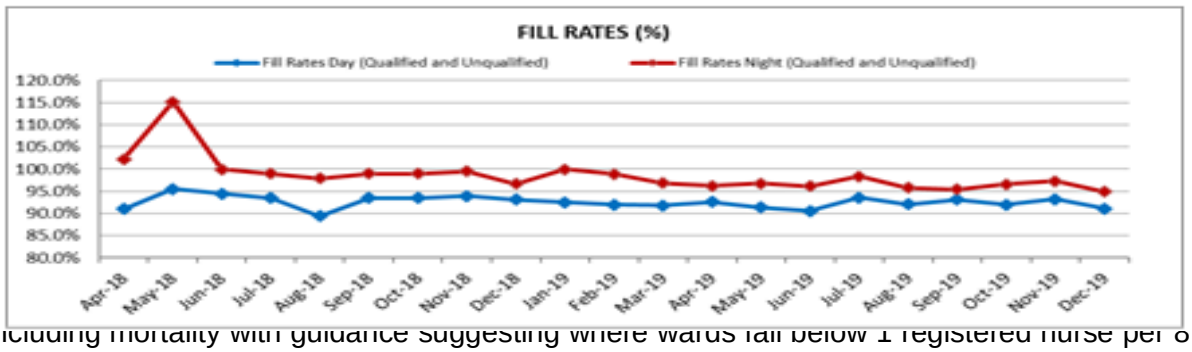
Table 7:



3.0 ORGANISTAIONAL OVERVIEW OF STAFFING LEVELS

The review of staffing numbers at organisational level is an important indication of whether the planned hours expected were matched with the actual hours provided.

Table 8 Combined Fill rates days and nights



T
including mortality with guidance suggesting where wards fall below 1 registered nurse per 8

patients on days and 1 registered nurse per 10 patients on nights there is an increased risk. All budget models at CHFT meet or are above the minimal requirement and the recent acuity and dependency studies (appendix 2) indicate that if these planned staffing levels were realised then patient acuity and dependency needs would be met. Table 9 shows the fill rate of RNs and HCAs which suggests that where we have unfilled RN shifts we are maintaining overall CHPPD by skill mixing with HCA if no availability of RN from flexible workforce or agency to support the delivery of patient care. This was consistent in the 6 month reporting period. The table below provides the last 3 months dataset

Table 9: Fill rates Nov 19 – Jan 20

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

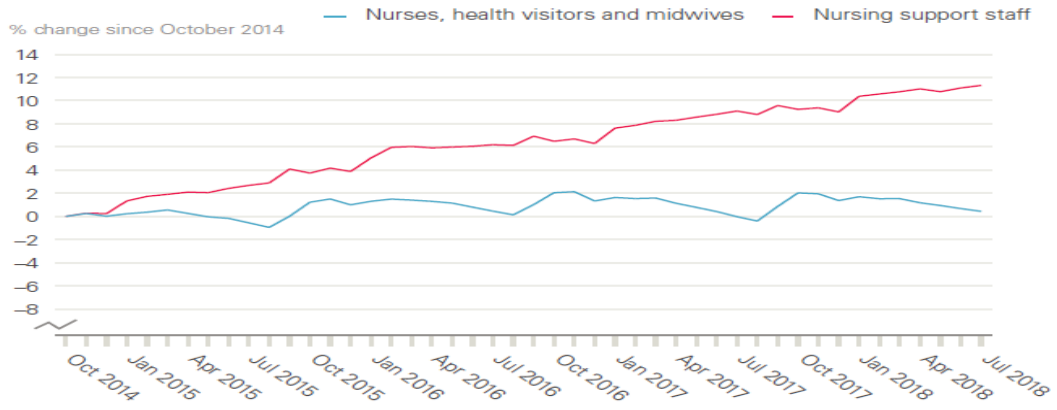
	Total CHPPD (Qualified and Unqualified)						Fill Rates Day (Qualified and Unqualifed)						Fill Rates Night (Qualified and Unqualified)					
	Jan-20		Dec-19		Nov-19		Jan-20		Dec-19		Nov-19		Jan-20		Dec-19		Nov-19	
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	Average fill Rate- Registed Nurses/ Midwives	Average Fill rate Care staff	Average fill Rate- Registed Nurses/ Midwives	Average Fill rate Care staff	Average fill Rate- Registed Nurses/ Midwives	Average Fill rate Care staff	Average fill Rate- Registed Nurses/ Midwives	Average Fill rate Care staff	Average fill Rate- Registed Nurses/ Midwives	Average Fill rate Care staff	Average fill Rate- Registed Nurses/ Midwives	Average Fill rate Care staff
CRH ACUTE FLOOR	7.6	7.3	7.2	7.2	7.2	7.1	99.6%	95.2%	99.9%	101.0%	100.1%	99.4%	96.5%	89.5%	96.6%	99.4%	96.9%	98.3%
HRI ACUTE FLOOR	8.1	7.6	7.9	7.3	8.2	7.6	89.8%	97.1%	89.8%	93.5%	89.2%	90.4%	88.7%	98.2%	88.4%	98.6%	89.4%	102.3%
WARD 5	6.4	6.8	6.5	6.2	6.1	6.1	74.7%	136.6%	72.2%	119.2%	67.5%	136.0%	102.2%	118.5%	95.0%	105.4%	94.6%	111.8%
WARD 15	7.4	7.4	7.4	7.5	7.3	7.7	75.1%	122.4%	74.5%	128.7%	86.0%	125.2%	79.7%	130.0%	74.5%	134.4%	79.3%	133.7%
RESPIRATORY FLOOR	6.5	5.9	6.7	6.0	6.7	6.0	83.9%	94.6%	85.3%	94.0%	82.4%	94.7%	88.4%	102.9%	85.5%	105.1%	88.5%	102.3%
WARD 6	6.8	7.3	6.9	6.9	7.2	6.9	79.0%	131.5%	75.2%	128.3%	75.7%	118.2%	98.1%	129.1%	97.2%	107.5%	95.6%	94.4%
WARD 6C	5.6	4.8	5.9	4.8	6.0	4.9	77.7%	72.8%	70.8%	77.7%	73.3%	67.4%	101.6%	96.8%	98.4%	93.5%	100.0%	100.0%
WARD 6AB	6.4	6.0	6.1	6.2	4.9	5.7	88.3%	102.5%	84.7%	122.1%	105.3%	112.0%	90.8%	99.7%	89.5%	112.9%	117.6%	132.7%
WARD CCU	8.5	7.9	8.8	8.2	8.2	7.6	86.9%	98.7%	88.3%	96.4%	90.2%	77.9%	98.9%	-	100.0%	-	100.1%	-
WARD 7AD	1.2	1.1	7.6	7.0	7.6	6.9	92.9%	100.0%	93.1%	92.3%	104.0%	91.9%	80.0%	100.0%	70.0%	119.6%	66.7%	100.0%
WARD 7BC	1.5	1.4	9.0	8.3	8.7	8.3	82.2%	95.3%	85.7%	95.4%	84.8%	104.0%	97.3%	90.0%	88.4%	126.0%	95.0%	115.0%
WARD 12	5.8	5.7	6.1	6.1	6.0	6.5	87.1%	120.4%	86.6%	125.1%	85.7%	142.1%	93.5%	122.6%	92.6%	129.3%	95.6%	180.3%
WARD 17	7.0	6.2	7.1	6.3	7.1	6.4	78.2%	111.3%	76.0%	110.0%	80.1%	107.0%	79.7%	97.4%	75.7%	111.3%	75.6%	116.7%
WARD 20	6.8	7.3	6.7	6.9	6.5	7.0	87.1%	124.4%	79.6%	124.1%	85.0%	125.4%	86.4%	132.7%	82.3%	129.6%	86.7%	131.1%
WARD 21	8.0	8.2	7.9	7.7	7.8	7.5	84.3%	112.9%	80.4%	94.4%	89.1%	93.3%	93.2%	132.8%	93.7%	131.7%	91.1%	118.4%
ICU	67.2	61.2	32.3	28.1	34.1	30.1	98.3%	64.9%	92.0%	63.1%	91.6%	94.9%	89.1%	-	86.4%	-	83.6%	-
WARD 3	6.2	6.0	6.2	6.0	5.9	5.9	96.8%	98.5%	95.9%	101.3%	93.7%	102.9%	98.4%	95.4%	96.8%	93.2%	98.3%	109.5%
WARD 8A	9.5	7.6	11.7	9.0	8.6	7.5	70.8%	93.1%	75.0%	81.6%	88.1%	89.3%	71.0%	103.2%	67.5%	93.5%	81.4%	96.7%
WARD 8D	6.4	6.5	6.2	6.3	6.3	6.3	100.3%	97.3%	98.4%	98.3%	99.5%	98.2%	100.0%	113.3%	100.0%	126.5%	100.1%	109.5%
WARD 10	6.9	6.7	7.0	6.4	6.5	6.5	97.5%	103.5%	86.6%	106.1%	96.2%	99.8%	82.5%	120.8%	75.1%	112.2%	94.4%	110.0%
WARD 11	5.8	5.5	6.0	5.4	6.0	5.7	92.5%	92.2%	85.4%	93.4%	94.0%	91.3%	90.3%	111.4%	86.7%	108.1%	94.0%	106.4%
WARD 19	7.7	7.9	7.7	7.4	7.6	7.7	94.7%	96.2%	84.6%	98.6%	90.1%	105.3%	98.9%	125.8%	99.1%	107.5%	96.6%	116.7%
WARD 22	5.4	5.7	5.7	5.9	5.4	5.7	99.0%	105.0%	93.7%	102.4%	96.3%	100.5%	100.0%	122.2%	100.0%	129.0%	100.0%	138.2%
SAU HRI	9.3	8.9	9.7	9.3	8.6	8.7	89.5%	100.3%	86.4%	108.2%	93.6%	108.2%	94.7%	119.8%	93.9%	122.3%	94.0%	152.2%
WARD LDRP	22.2	19.8	23.1	20.2	26.6	23.7	90.7%	77.9%	88.8%	72.8%	91.9%	72.3%	90.7%	90.3%	89.4%	92.2%	90.9%	84.1%
WARD NICU	14.3	10.7	13.7	9.7	16.4	12.0	81.1%	47.0%	72.8%	48.6%	77.4%	44.7%	84.6%	56.5%	81.2%	54.8%	80.8%	65.2%
WARD 3ABCD	9.8	8.2	8.3	7.0	8.1	7.2	84.6%	96.0%	82.2%	104.2%	89.0%	92.5%	79.9%	94.4%	82.3%	99.2%	88.1%	103.7%
WARD 4ABD	5.0	4.7	4.6	4.4	5.2	5.0	90.3%	88.8%	93.5%	97.5%	94.5%	93.8%	98.0%	95.9%	96.4%	97.6%	99.4%	96.7%
WARD 4C	7.5	7.1	7.3	6.9	7.3	7.1	87.1%	105.3%	89.0%	92.4%	94.5%	100.0%	101.2%	99.8%	101.6%	102.5%	100.9%	103.9%
Total	**7.5**	**7.1**	**7.9**	**7.3**	**7.8**	**7.4**	**88.0%**	**101.4%**	**85.4%**	**100.9%**	**88.9%**	**100.7%**	**90.1%**	**108.3%**	**88.0%**	**109.1%**	**90.7%**	**111.0%**

KEY:	>100%	100- 90%	89-75%	<74%

The supply of registered nurse staffing has not matched local demand with a continued vacancy level for RNs. There is evidence nationally that there has been a downward shift in skill mix, support staff numbers have increased at a faster than RNs. National data taken from

the Health foundation publication - A critical moment: NHS staffing trends, retention and attrition demonstrates this below

Figure 5: Change in registered nurses, health visitors, midwives and nursing support staff (full-time equivalent) in the NHS in England (HCHS), Ootober 2014 to July 2018



Source: NHS Digital. *NHS Hospital and Community Health Service (HCHS) Monthly Workforce Statistics – July 2018, Provisional Statistics* (2018).

3.1 Rostering and Operational Staffing Reviews

Electronic rosters have been implemented, with all nursing and midwifery staff being able to instantly access and view their rosters from a phone or tablet. Rosters are published 6 weeks in advance which supports a healthy work-life balance and allows for early planning to cover unfilled shifts. The electronic roster links with Bank Staff which supports 24-hour direct booking of nurse bank shifts when these cannot be filled by substantive staff.

A prospective rostering review called “confirm and challenge has been put in place with ward managers, matrons, e-rostering support and divisional leads using the roster perform process to review staffing from the first level approval. This also allows a review of rosters and how these are being managed against the trust key performance indicators (see appendix 4, retrospective dashboard).

Daily staffing meetings are also undertaken using safe care live to assess actual staffing levels aligned to patient acuity and dependency.

A new process has been put in place to support staff management and escalation. In order to optimise use of the substantive nursing and midwifery workforce available, we have implemented innovative systems and processes to support the achievement of acuity-based workforce. The purpose of this programme was to move away from traditional staffing models and flex the workforce (both number and skill mix) to support the actual acuity and dependency of patients, resulting in the right staff, with the right skills, in the right place at the right time to meet patient’s needs.

Staff record live acuity data in Safe Care technology, this is entered 3 times in each 24-hour period within adult and paediatric inpatient areas.

Safe Care links to the roster and provides visibility and transparency of nurse staffing and patient acuity across the organisation. Senior nursing teams are able to identify a shortage or excess of nursing hours based on live patient acuity and can use this information alongside professional judgement to redeploy staff accordingly. The combination of efficient rostering, utilising all contracted hours, improving annual leave management, recruiting to establishment levels, challenge of rosters by senior nurses, peer review through the ward or department key performance indicators and redeployment of staff in accordance with patient acuity, has

resulted in optimum use of nursing hours. This has supported the ward and department areas in managing the identified vacancy gap, sickness and absence and the under establishment known in the registered workforce.

Our ambition is to minimise the number of staff moves and a focussed piece of work will be undertaken to review the current position.

Table 9: is an example of the overall position safe care live can provide operational staff, senior leaders and divisional teams at any point in the day. Shifts are “rag rated” to indicate clinical effectiveness and safety. This is calculated on staff on duty against the planned model and factoring in the live acuity data

Table 9:

4.0 QUALITY IMPACT OF NURSING AND MIDWIFERY STAFFING LEVELS

Red flags are currently reported via the Trusts incident reporting system and are designed to support the nurse in charge of a shift to assess systematically that the available nursing staff for each shift, or at least each 24hour period, is adequate to meet the actual nursing needs of patients on that ward.

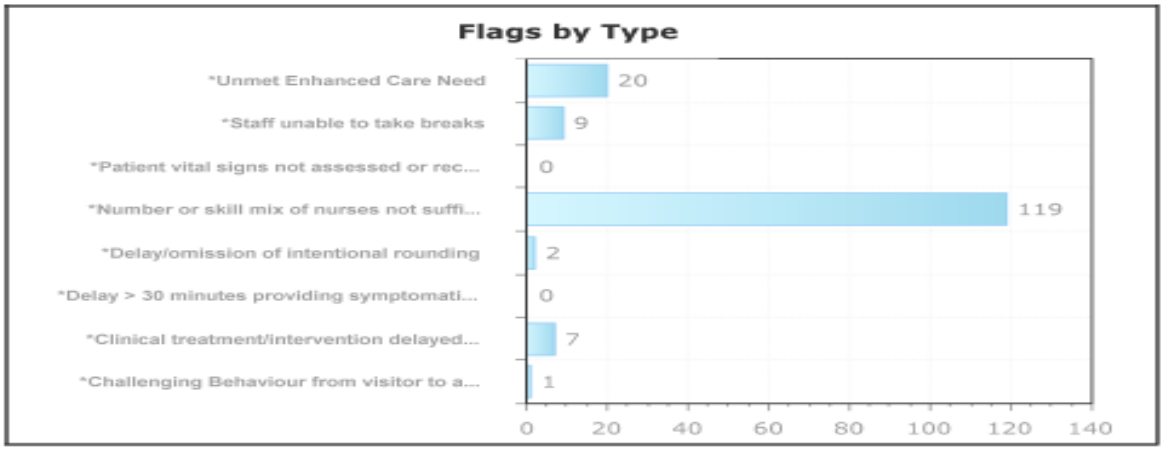
When they are reported an immediate response by the registered nurse in charge of the ward is required and appropriate actions are taken such as allocation or redeployment of additional nursing staff to the ward. These issues are also considered at the daily staffing safety briefs. This allows for increased focus on the quality and safety of daily staffing, giving a real time position on shift utilisation and provides detail on mitigation and actions when staffing falls below planned levels.

The “Red Flags” suggested by NICE, which CHFT report against are:

- Care compromised
- Less than 2 registered nurses per shift
- Shortfall of >25% time on shift without a registered nurse
- Unit in Escalation (maternity specific)
- Lack of suitably trained /skilled staff on duty
- Unmet enhanced care needs
- Staff unable to tale breaks

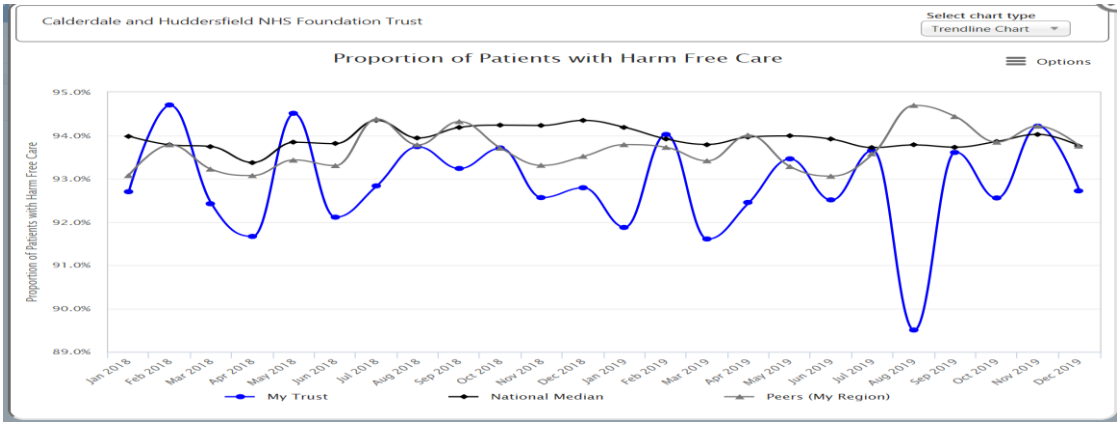
The following tables illustrate the number of “Red Flags “identified over the last three months at CHFT.

Table 10:



It is imperative that nurse staffing data (shift fill rate), is triangulated with the patient outcomes and nurse sensitive indicators. This is collated and presented each month to Trust Board in the IPR. The Nursing and Midwifery Strategy Group is held bi- monthly, and part of the remit of this group is to also identify and highlight any themes/trends being reported on the incident reporting system. The monitoring of this data provides assurance in relation to the quality impact in association with nurse staffing and as outlined in Table 11 below which describes the Trusts national benchmarking position for delivering “harm free care” as reported on the Model Hospital portal

Table 11: Harm Free Care: Model hospital February 2020.



5.0 STAFFING REVIEW: *DECEMBER 2019 – JANUARY 2020*

CHFT have developed an annual staffing review document (see appendix 1). Each year a full and comprehensive staffing review takes place with a 6-monthly bi-annual review.

In December 2019 all in patient, OPD nursing and midwifery workforce models (WFMs) were reviewed by the nursing workforce model review panel.

Elderly care wards reported recommended establishment levels that were a variance to the current planned WFM (see appendix 2). The clinical teams are reporting increased enhanced care requirements and further analysis of the will be undertaken in 2020/21 through the Nursing and Midwifery Workforce Steering Group

5.1 Medical Division

The below table describes where increased acuity and dependency have resulted in recommendations to change existing workforce models to meet patient demand.

Division	Ward Department Service	Increase in dependency	Increase in acuity	CHPPD review	SNCT Variance from planned establishment >4 WTE And /or routine tracking from Safe care Live	Recommended change to WFM via annual planning
Medicine	Ward 12	Yes	x	Yes	x	Yes
	Stroke Floor	Yes	x	Yes	Yes	Yes
	Respiratory Floor	Yes	Yes	Yes	Yes	Yes

5.1.1 ED

The emergency department is currently working with NHSI colleagues using a new methodology for workforce planning to review the nursing workforce model across the departments. This work has been further strengthened by “go see” visits to other departments and the resulting recommended nurse staffing levels will be reported on in subsequent submissions.

CHFT continues to have a risk in relation to Paediatric trained nursing staff within both EDs and this is currently under review. The department has recruited two Registered Nursing Associates and have a further trainee is in post. The corporate education team will work with the division to embed the role within the service and monitor its impact.

5.1.2 Acute Floor (CRH)

The panel reviewed the department’s metrics following reconfiguration of the Acute Floor services last year. The department are performing well and have made significant improvements to staff turnover and vacancy rates. This success can be linked to initiatives such as the Band 6 development programme and a clear learning needs analysis trajectory within the team.

The department proposed an increase in Band 6 establishment to support 7-day senior clinical leadership and sustain the current positive staffing position.

This proposal was supported to progress for review within the annual planning cycle and to be reviewed at the next establishment review.

5.1.3 Medical Elderly Services (Wards 5,8,15 and 20, HRI)

There is a growing demand for enhanced care delivery within the wards (specifically ward 5) and the acuity data suggests the required care hours to meet dependency levels has risen over Q3 and Q4. Further review of the establishments in elderly care is being undertaken to review opportunities for skill mix and new roles within the totality of the ward establishment and this will be reported in the next 6 monthly review.

5.1.4 Ambulatory Unit (HRI)

The department report an increase in activity aligned to the merge of AAU and medical day case unit. Further capacity and demand studies are being undertaken by the division to understand the impact and inform workforce planning

- Proposed model to be developed through the divisional annual planning cycle

5.2 Division of Surgery

There were 2 ward areas where variance in required staffing establishment was identified and validated (wards 11 and 10 within the division of surgery – see appendix 2).

Division	Ward Department Service	Increase in dependency	Increase in acuity	CHPPD review	SNCT Variance from planned establishment >4 WTE	Recommended change to WFM via annual planning
Surgery						
	Ward 10	Yes	Yes	Yes	Yes	Yes
	Ward 11	Yes	Yes	Yes	Yes	Yes

5.3 Community Division

No investment or disinvestment proposed to the current nursing establishment within the community division. The division have moved to a five locality/Hub based model. Services and current workforce have configured to merge to this profile. Further review of the nursing establishment level will be required as this model becomes embedded and will be undertaken through Q1 and Q2 2020.

5.4 Families and Specialist Services Division

The division continue to progress work around the emerging continuity of carer agenda within Midwifery services and updates of this work will be reported in subsequent reports.

The current models meet the guidance and the maternity incentive scheme safety action 5 which includes

- A systematic evidence based process to calculate midwifery staffing establishment
- Midwifery co-coordinator on labour ward / or evidence that the Midwifery Co-ordinator is supernumery and has oversight of all birth activity in the service
- All women in labour receive 1-1 midwifery care

Paediatric services are undertaking a further review of their 2 season workforce model following inability to recruit into posts this winter. The service is also reviewing the role of the nursing associate.

No investment proposed to the current nursing/midwifery establishments within the division of Families and Specialist Services.

6.0 CONCLUSION

Nursing and Midwifery establishments are set, monitored and financed at appropriate levels in the Trust. The Trust continues to respond to both the local and national challenges in relation to the recruitment and retention of the workforce. There are clear governance arrangements and oversight in place to ensure that safe and sustainable staffing levels are achieved to ensure high quality compassionate care across the trust. The nurse staffing risk remains on the high level risk register with a score of 16 (risk number 6345).

In response to this report, during 2020 we will be focusing on collaboration with local HEI and Health Education England (HEE) office to stabilise the vacancy gaps, make evidence based predictions in relation to growth, reduce turnover (retaining skilled staff), improve supply (through undergraduate programmes, apprenticeships, return to practice initiates and overseas recruitment) and prepare for the NMC 'future nurse' standards and consider implementation of the Nursing Associate role. In addition, we will be continuing to work with NHSi on our nursing and midwifery retention programme, which focuses on preceptorship, retire and return, flexible working models and career development.

7.0: RECOMMENDATIONS

The following recommendations from this report are:

- Repeat review process across all inpatient areas and departments through 2020/21
- Review Elderly Care and Respiratory Floor to review workforce models and skill mix and opportunity for role development across the MDT.
- Review of enhanced care demand and service provision.
- Review broader quality metrics associated with RN fill rates and skill mix.
- To continue to support digital opportunities to utilise the EPR and advanced rostering modules to support workforce planning.
- To evaluate the role of the nursing associate within CHFT and support the funded expansion of the number of trainees.

8.0 REFERENCES

Ball, J. Murrelle, T. Rafferty, A. Morrow, E and Griffiths, P (2012): Care left undone during nursing shifts: association with workload and perceived quality indicators. *BMJ Journal.* Vol 23: Issue 2

National Quality Board (2016), *safe, sustainable and productive staffing. An improvement recourse for adult inpatient wards in acute hospitals*

National Quality Board (2016), *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*

National Quality Board (2018), *Updated guidance for safe, sustainable staffing. An improvement resource for adult in patient wards in acute hospitals*

Safer Care Nursing Tool (2014), Shelford Group

NHS Improvement (2018), *Developing workforce safeguards. Supporting providers to deliver high quality care through safe and effective staffing.*

Calderdale and Huddersfield NHS Foundation Trust

Appendix 1: Annual staffing review guidance:

Calderdale and Huddersfield NHS Foundation Trust:

Establishment Review Guidance 2019

Safe Staffing Establishment Reviews - Process

Contents

1.0 Introduction

In 2013, the National Quality Board published *"How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability"*. This report set out expectations about how the NHS would ensure that there are enough nurses to provide quality care to patients. NQB guidance was updated in 2016 & CHFT continue to deliver within this agenda.

2.0 Purpose:

The purpose of this paper is to provide guidance to staff on how to undertake staffing establishment reviews in clinical teams. This is a nationally mandated requirement of providers in the NHS that teams always have appropriate levels of staffing to provide safe and effective care to patients .

3.0 Scope:

This process applies to all members of staff who are involved in the reviewing of clinical team establishments. There are responsibilities contained in this Paper for the following:

Director of Nursing

- Is accountable for ensuring that review of establishments is reviewed as set out in the NQB guidance
- Is responsible for presenting the findings to the Trust Board on a six-monthly basis

Deputy Director of Nursing/ Head nurse for professional & workforce Development

- Is responsible for ensuring there is a process in place to support the review of clinical team's establishments as detailed in this paper.
- Is responsible for authoring the 6 monthly board reports and ensuring the content is reflective of establishment reviews which have taken place.

Associate Directors of nursing for the divisions/ Matrons

- Are responsible for ensuring that establishment reviews have sufficient senior managerial and clinical oversight to validate the findings and implement changes as required.
- Are responsible for coordinating the review process for their clinical area of responsibility and to ensure that anyone who has a delegated role within the review is clear about their responsibilities and is competent to undertake the role
- Are responsible for validating the divisional reviews and presenting these backs to the panel.

Ward Managers/ Team Leaders

- Are responsible for ensuring that establishment reviews are undertaken in keeping with the standards and timelines as described within this document.

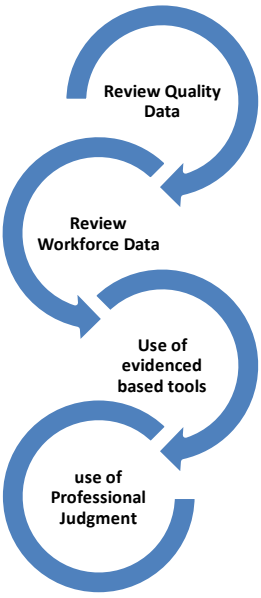
All clinical staff

- Have a responsibility to contribute to the review of establishments, providing clear rationale for their input

4.0 Safe staffing establishment review principles

Establishment reviews need to consider the activity and care each team is required to deliver alongside the capacity and capability there is to deliver safe care. There are many factors that might influence staffing levels.

When undertaking the review, each team should ensure that the four factors of an effective review are addressed. These are reviewing quality data, reviewing workforce data, combining data taken from evidence-based workforce tool and applying professional judgement. This is represented below:



5.0 Reviewing Quality Data:

Teams should consider the quality of the care which they are providing with the establishment which has been in place since the last review. Data which may be helpful includes (not exhaustive): pressure ulcers, medication administration errors/omissions, incidents of violence or aggression, Safeguarding (child or adult) referrals), Serious Incidents, levels of 1-1, Observations and feedback from trainees. Any incident analysis which has identified staffing as a contributory factor or root cause should be given increased weight

6.0 Reviewing Workforce Data:

Workforce data has an important role in informing establishment reviews. The ability of teams to provide safe effective care can be positively or negatively affected by workforce factors. Typical factors can include appraisal compliance rates, bank and agency use, vacancy rates, sickness absence, mandatory training, friends and family test, staff survey results.

7.0 Use of evidenced based tools:

As part of any establishment review, there is an expectation that an evidence-based demand tool is utilised to supplement professional judgment and the review of quality measures: At CHFT we use the “Safer nursing care tool” (SNCT), See **Appendix 1**. Going forward the organisation will draw its patient acuity & dependency data from the Allocate/safe care soft wear.

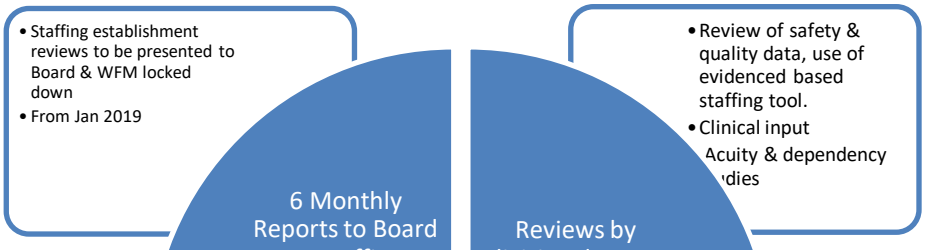
8.0 Use of professional judgement:

Professional judgement is an integral part of any establishment review undertaken. Ideally this should involve all members of the Multi-Disciplinary Team (MDT). Different members of the team may have varying perspectives of the needs of the team. This debate should be encouraged, and the team should aim to work together with the Ward Manager and Matron to agree a position based on all team members views.

9.0 Timeline for establishment reviews:

The Trust Board receives a report of safe staffing establishment reviews in November and May each year***.*** The Trust requirement for divisions is that each team/ward is reviewed annually, and mid-year updates are providing to assure the Board that establishments meet the required needs of patients & service users.

10.0 Timeline detail



11.0 Writing the Review Report

There is a standard template to produce establishment review reports, which can be found at **Appendix 2**. This aims to provide a standardised format which covers the requirements of the Trust for this process. Once the review report is completed it should be discussed within the clinical team and via clinical directorate management team structures – before presentation at panel.

12.0 Review Panel process:

Following the divisional review, the Associate Directors of nursing will present the proposed annual WFM to the corporate nursing team for final approval. The panel will comprise of:

- Chief Nurse/Deputy Chief Nurse
- Head nurse for workforce and professional development
- HR director
- Senior finance manager

If through the establishment review process, it is identified that a change to a ward budget is required, then this must be brought to the review panel with the following people prior to being endorsed as a recommendation to the Trust Board: Any financial impact will be modelled by finance prior to a request for any changes in establishment being. Once WFM are agreed they are to be signed off by the clinical divisions and the Chief Nurse/Deputy Chief nurse.

Calderdale and Huddersfield NHS Foundation Trust

Appendix 2: Acuity Study

		Funded establishments					Numbers per shift				
Ward	Specialit y	Reg	Ureg	Total	Ratio RN:HC	Ratio RN:bed	AM	PM	Night	Recommended establishment SNCT May 2019	Comments and implementation plan:
Acute Floor CRH 46 beds	Med	40.00	32.11	72.11	55/45	1.6	7+6	7+6	7+6 +twili ght	79.44	+ve 0.28 WTE RN's
MAU HRI 45 beds	Med	43.73	34.85	78.58	56/44	1.84	8+7	8+7	8+6	81.10	36 level 3 pts and 83 level 2 pts recorded in October 2019 26% RN vacancy position. Expecting x2 RN in Jan 2020 & deployment of x2 oversesa nurses
Ward 6 HRI 23 beds	Med	19.73	16.4	36.13	55/45	1.65	4+3	4+3	3+3	27.47	??Bed base during reporting period 15% RN vacancy
Ward 12 21 Beds	Med	20.42	8.65	29.07	70/30	1.38	4+2	4+2	3+1	25.79	6.9% RN vacancy
Ward 15 27 beds	Med	22.48	21.64	44.12	51/49	1.63	5+4	4+4	4+4	80.5	High volume of bevel 1b and level 2 pts reported 24.6% RN vacancy
Ward 20 HR 26 beds	Med	22.17	21.44	44.21	52/48	1.7	5+4	4+5	3+3	60.55	21.1% RN vacancy
Ward 17 HRI 24 beds	Med	25.65	13.89	39.54	65/35	1.65	5+5	5+3	3+2	44.41	27% RN vacancy

Ward 7AD CRH 26 beds	Med	20.42	19.13	39.55	52/48		1.52	4+4	4+4	3+3	35.56	
Ward 7BC 26 beds	Med	33.88	19.82	53.70	63/37		2.17	6+4	6+4	6+2	53.92	
Ward 6A/B	Med	17.82	15.72	33.54	53/47		1.4	4+3	3+3	3+3	54.99	Additional capacity beds open during the reporting period
CRH 24 beds												
Ward 6c CRH 16 beds	Med	12.79	7.97	20.76	62/38		1.3	3+2	2+2	2+1	24.12	
Ward 5 HRI 25 beds	Med	20.42	16.40	36.82	55/45		1.47	4+3	4+3	3+3	61.66	All pts level 1a or b, acuity always trending above budgeted model 18.9% RN vacancy
Resp Floor 47 beds	Med	46.36	25.97	72.33	64/36		1.5				58.20	20.1% RN vacancy
Ward 19	Surgery	20.53	16.51	37.04	60/40		1.7	4+3	4+3	3+3	42.71	10.4% RN Vacancy
Ward 21	Surgery	19.73	19.13	38.86	50/50		1.94	4+4	4+4	3+3	31.33	13.6% RN Vacancy
Ward 8A	Surgery	12.85	7.92	20.77			1.3	2+1	2+1	2+1		
Ward 8D	Surgery	12.07	6.03	18.10	50/50		1.29	2+2	2+2	2+0		17% RN Vacancy

Ward 3	Surgery	12.79	8.17	20.96			1.40	3+2	2+1	2+1	19.98	1.0% RN Vacancy
Ward 10	Surgery	18.02	11.27	29.29			1.46	4+2	3+2	3+2	36.27	28% RN Vacancy
Ward 11	Surgery	20.95	13.89	34.84			1.34	4+3	4+3	3+3	41.56	13.4% RN Vacancy
Ward 22	Surgery	14.49	13.89	28.38			1.23				30.28	9.9% RN Vacancy
SAU HRI	Surgery	25.17	9.81	34.98			1.52	4+2	4+2	4+1	24.68	20% RN Vacancy

Calderdale and Huddersfield NHS Foundation Trust

Appendix 3:SCNT acuity scoring

3. A Brief Overview of the Tool

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (*Comprehensive Critical Care, DH 2000*). These classifications have been adapted to support measurement across a range of wards/specialties. The full SNCT is outlined below.

Safer Nursing Care Tool (SNCT)

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • **Early Warning Score** is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** • Increased level of observations and therapeutic interventions • **Early Warning Score** - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation/invasive monitoring • Oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

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Levels of Care	Descriptor
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	**Care requirements may include the following** • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with spinal instability / spinal cord injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration / post-administration care) • Patient and / or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post operative optimisation (pre-op invasive monitoring)/extended post-op care. • Patients requiring non-invasive ventilation/respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway **and** protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ / systems • Respiratory or CNS depression/compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage/sepsis or neuro protection

* this multiplier allows a 22% uplift for annual leave/study leave etc.
Software is being developed that will allow this to be adjusted and will be added to this site when available.

Appendix 4: Retrospective Dashboard example:

	Performance measures 19/20								
Area	Measure	By	Target	Amber Tolerance	Roster Reporting 14/10/19 - 10/11/19	Roster Reporting 11/11/19 8/12/19	Roster Reporting 9/12/19 -	Roster Reporting 6/01/2020 -	Qualification / Exception reporting
Quality	In Charge Shift not Covered	Num	0	2					
	Registered / Unregistered Levels	%	x/y	<10					
Staff	EWTD Compliance (No of instances compliance breached)	Num	0	5					
	Ward Leader Clinical Shifts	Hrs	60-150	52.5 - 59					
	Number of Supervisory Shifts	Num	8-12						
	Site Co-ordinator Shifts worked	Num	2	>1<2					
	Unavailability Total - Registered	%	21-22%	>19 <21 >22 <24					*NOTE* Figures amended to exclude working days.
	Unavailability Total - Un -Registered	%	21-22%	>19 <21 >22 <24					*NOTE* Figures amended to exclude working days.
	A/L % Registered- Week 1	%	14.55%	>12.55-14.54%					
	A/L % Registered- Week 2	%	14.55%	>12.55-14.54%					
	A/L % Registered- Week 3	%	14.55%	>12.55-14.54%					
	A/L % Registered- Week 4	%	14.55%	>12.55-14.54%					
	A/L % Un-Registered- Week 1	%	14.55%	>12.55-14.54%					
	A/L % Un-Registered- Week 2	%	14.55%	>12.55-14.54%					
	A/L % Un-Registered- Week 3	%	14.55%	>12.55-14.54%					
	A/L % Un-Registered- Week 4	%	14.55%	>12.55-14.54%					
	Annual leave taken - Registered Nursing	%	14.55%	>12.55-14.54%					
	Annual leave taken - Un-registered Nursing	%	14.55%	>12.55-14.54%					
	Sickness absence - Registered	%	3.5	<4					
	Sickness absence - Un -registered	%	3.5	<4					
	Unused contracted hours	Hrs	<43	>50 <39					
Processes	Additional duties created	Hrs	50	100					
	Unfilled shifts	%	<10 - 0	<20 - 10					
	Roster completed using Auto Roster	%	50+	>40 -50					
	Roster changes after approval	%	<30	>31-50					
	Next Roster Full Approval Deadline DATE	Date	30.10.17						
	Formal flexible working agreements in place	%	30	<40					

14. Director of Infection Prevention Control Report (DIPC)

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5th March 2020
Meeting:	Board of Directors
Title:	Quarterly DIPC report
Author:	Jean Robinson, Matron Lead IPC
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report

To provide the Board a report on the position of Healthcare Associated Infections (HCAIs).

Key Points to Note

Improving position on E-coli bacteraemia.

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. Information on flu uptake has been analysed by ethnic group and reportedly separately.

Recommendation

The Board is asked to **NOTE** the performance against key IPC targets and **APPROVE** the report.

Calderdale and Huddersfield NHS Foundation Trust

Quarterly DIPC Report
1st April 2019 to 31st January 2020

1. Introduction

This report covers the period from 1st April 2019 – 31st January 2020. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators

2. Performance targets

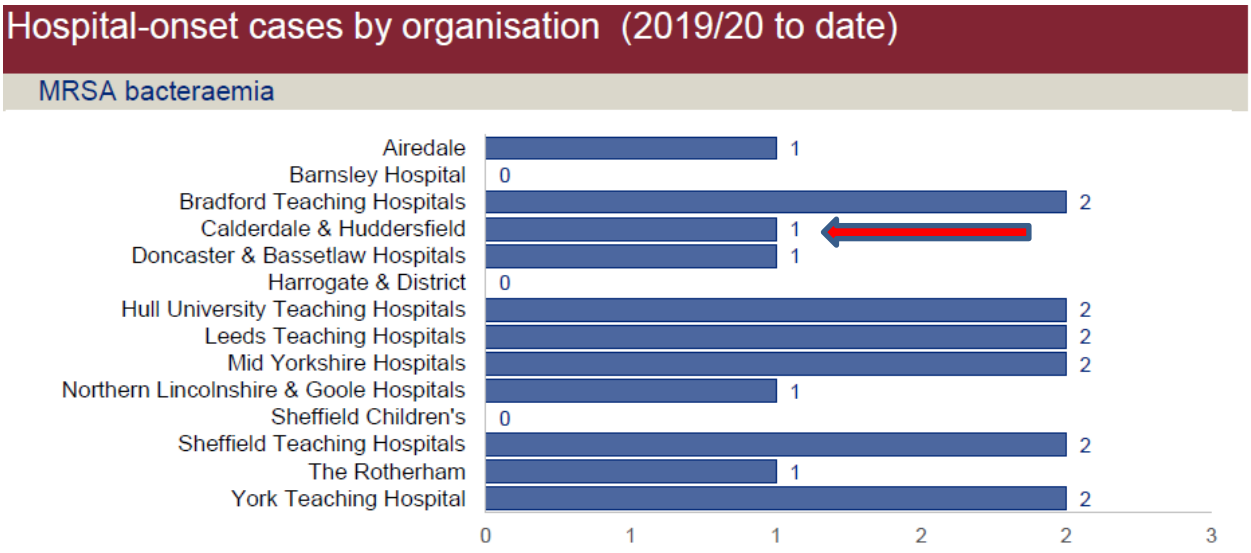
Indicator	End of year ceiling 19/20	Year to date performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**1**	1 post case
C.difficile (trust assigned)	40	**20**	Non Preventable = 14 Preventable = 6 (Total number inlcudes 2 COHA cases)
MSSA bacteraemia (post admission)	None set	**19**	
E.coli bacteraemia (post admission)	None set	23	Favourable position compared to 40 for same time last year.
MRSA screening (electives)	95%	95.2%	
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.36	Rolling 12 months
ANTT Competency assessments (doctors)	90%	45.24%	As of the 1st September all staff undertaking ANTT need to be re-assessed on a 3yrly basis, this now is reflected in the overall compliance. Divisions are working hard to ensure staff are updated with an aim to have 75% compliance by end of March 2020.
ANTT Competency assessments (nursing and AHP)	90%	83.45%	
Hand hygiene	95%	99%	

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	91.3%	
Isolation breaches	**Non set**	391	Compared to 335 for same period time last year.
Cleanliness	Non set	96.5%	

4. MRSA bacteraemia:

There has been 1 MRSA cases attributed to the organisation, this case involved the aspiration of fluid from a patient's knee and on review of the clinical records this case was deemed as unavoidable The chart below compares total numbers of attributed MRSA bloodstream infections to each organisation in Yorkshire & The Humber.



5. MSSA bacteraemia:

There have been 19 post-admission MSSA bacteraemia cases during 1st April to 31st January 2020. A review of cases has been undertaken and there is no common theme. The IPC team will continue to review cases on a monthly basis.

6. Clostridium difficile:

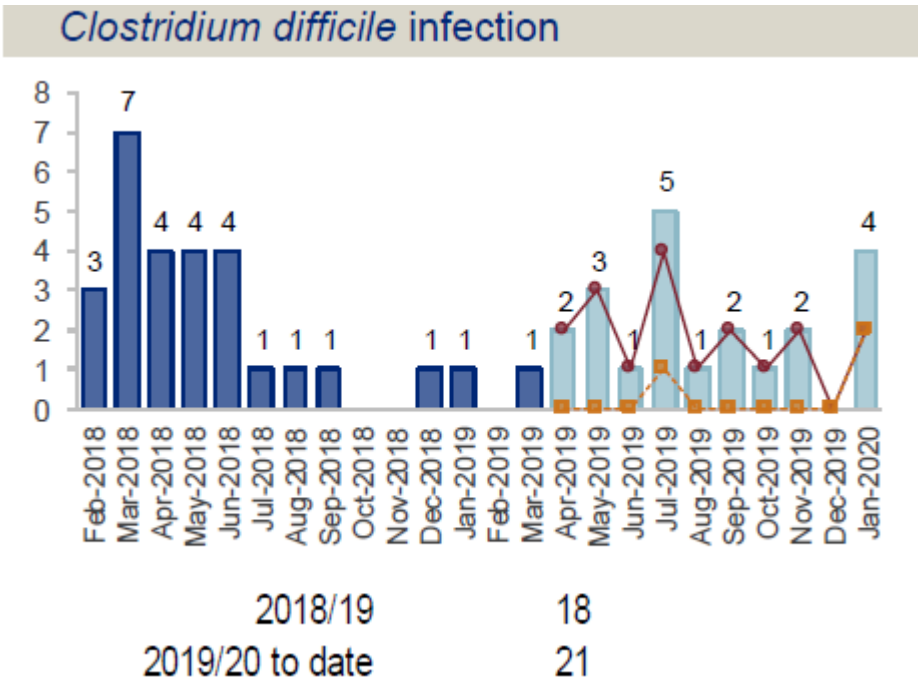
The ceiling for 2019/20 for CHFT is for no more than 40 Trust attributable cases., the current number of cases at the end of January is 20. Actions undertaken are detailed below

- A deep clean and HPV of high-risk wards was undertaken during the period of 1st June to 31st October 2019.
- Of the 6 preventable cases it was identified that there were some antimicrobial prescribing issues, the areas are being supported by the Microbiologists and pharmacy to improve prescribing in line with guidance

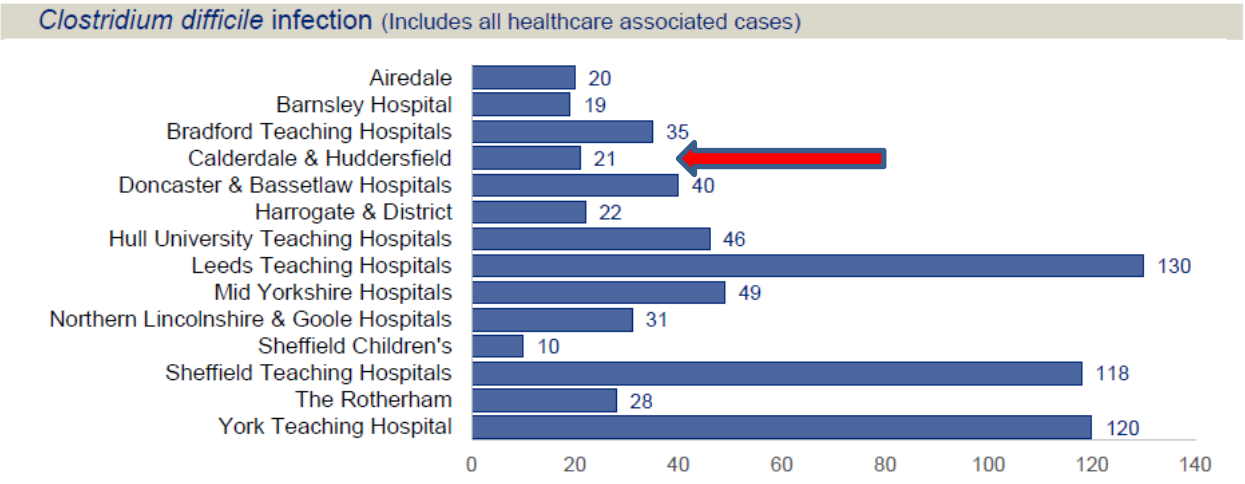
New national criteria for the reporting of C-difficile cases commenced on the 1st April 2019 as follows: -

a) **Healthcare onset healthcare associated (HOHA)**: cases detected in the hospital ≥2 days after admission,
b) **Community onset healthcare associated (COHA):** cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,

The chart below shows CHFT cases 2018/19 and 2019/20

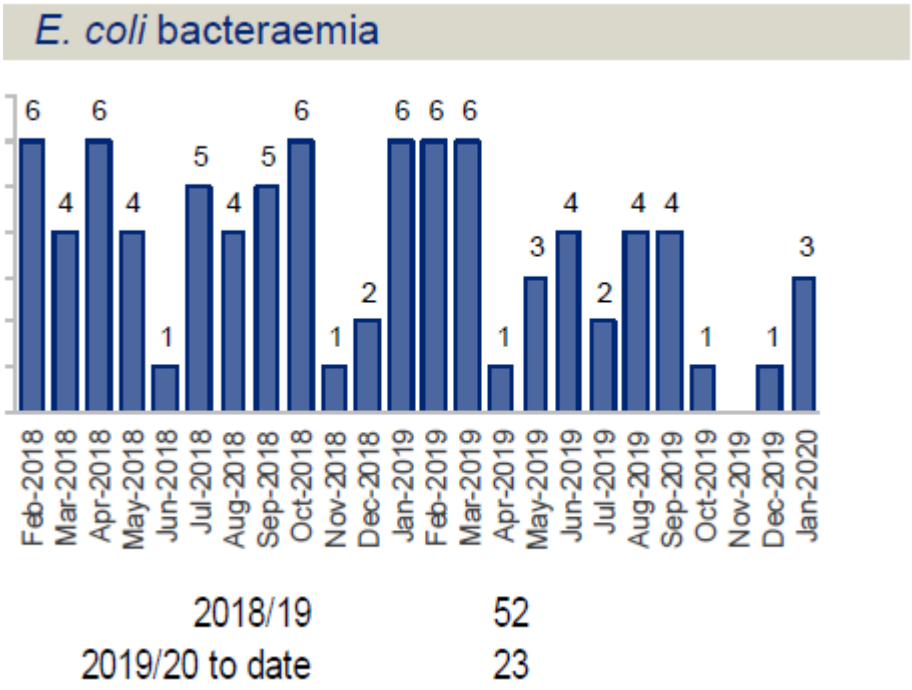


The chart below compares total numbers of attributed C. difficile infections to each organisation across the Yorkshire & Humber region :-



7. E. coli bacteraemia:

There have been 23 post-admission *E. coli* bacteraemia cases since the 1st April 2019, a reduction in 18% compared to last year. Following review of these cases, 8 of the cases were primarily associated with urinary tract infections which were potentially avoidable. Bitesize learning and a newsletter have been produced to support and enable shared learning throughout the organisation. New guidance is due to be published within the next couple of months to aid organisations on how to achieve reductions, with the date for reductions being extended to 2024.



8. Outbreaks & Incidents:

There has been an outbreak of Serratia within the Neonatal Intensive Care Unit (NICU) at Calderdale Royal Hospital. IPC control measures and an action plan are in place which is currently being monitored via the trust Outbreak Control group. This has been reported as an Serious Incident (SUI) and is being investigated in line with trust policy.

An incident within the endoscopy unit was identified in January where a biliary stent became lodged within the lumen of the scope during a procedure. This incident has been investigated, learning has been identified and an action plan produced. This has been reported and is being monitored through the surgical division.

At CHFT we moved to viral PCR testing for gastroenterititis hospital outbreaks in November 2019, this will increase our diagnostic sensitivity and identify a wider range of viral pathogens during outbreaks

WARDS CLOSED & BED DAYS LOST FIGURES					
MONTH	**HOSPITAL SITE**	**Identified**	**WARD**	**DAYS CLOSED**	**BED DAYS LOST**
October	CRH	Norovirus	C5D	6	13
November	HRI	Norovirus	H15	7	35
	HRI	Norovirus	H5	9	9
	CRH	Norovirus/ Campylobacter	C2B	1	2
December	HRI	Norovirus	9 HAF	2	7
	HRI	Norovirus	20A	12	15
February	HRI	Sapovirus	21	6	7

9. Influenza

The staff Flu Immunisation campaign for 2019/20 commenced on the 30th September. There is an ambition to offer the vaccine to 100% of front-line health care workers and achieve an 80% uptake in line with the national target. The current position is 79.3% of frontline staff have had the vaccine. The flu point of care test was made avaialable in both EDs the POCT test led to an early result being avaibale in 530 cases of which 138 were positive to date with a turnaround time of 20 mins impacting on patient flow, management and experience.

10. Isolation Breaches

There have been 391 isolation breaches since 1st April 2019 compared to 335 breaches for the previous year. The majority of the breaches are patients with

- a previous history of MRSA or ESBL at the time of admission to the acute floors, the emergency departments
- patients being transferred, and their infection status not being handed over.

The IPCT will continue to monitor isolation breaches in addition The Isolation Policy has been reviewed with the prioritisation for isolation updated and is awaiting ratification at ICC.

11. Audits:

Quality Improvement Audits

The IPC team continue to support the quality improvement audit program with 43 Quality Improvement environmental audits having been carried out since the beginning 1st April 2019 to 31st January 2020.
Compliance scores: **<75% = RED rating; 76% - 90% = AMBER rating; 91%+ = GREEN rating.**

- 21 of the areas achieved a green rating.
- 20 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- 1 area was deemed as a Red rating which was the Diabetic centre at CRH, an action plan is being developed and a re-audit took place in September and scored a Green rating.

- 1 report pending.

CJD risk assessment audit: This audit is carried out on a quarterly basis by randomly selecting surgical patient records, the average compliance is currently 93%.

FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving.

Quarterly FLO audits: These are completed by the IPCNs on acute areas, the following areas have been highlighted to the Matrons as areas of concern scoring below 75%:-
HRI:- Acute floor; Wards 6,15,20,21,SAU and ED
CRH:- 5 BCD and 3ABCD
Clinical teams develop actions plans to address any areas of concern and these are monitored at divisional level.

12. ANTT: As of the 1st September 2019, all staff who undertake ANTT require re-assessment every three years. This has had an initial impact on the ANTT performance matrix as staff ESR records automatically lapsed to RED if their previous assessment was more than 3 years ago (before 1st September 2016). The current Trust compliance is 77.12% with nursing colleagues at 83.45% and medical colleagues 45.24%. The infection control performance board is monitoring compliance closely to ensure this is at the level expected.

13. Recommendations

The board is asked to note the performance against key IPC targets and approve the report.

15. Care Quality Commission (CQC) and Use of Resources Update - VERBAL

To Note

Presented by Ellen Armistead

16. Quarter 3 Quality Report

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	**Thursday 5 March 2020**
Meeting:	**Board of Directors**
Title of report:	**Quarterly Quality Report – Q3 2019-2020**
Authors:	▪ **Dr Sarina Beacher, Interim Associate Director of Quality and Safety on behalf of the Quality and Safety Team** ▪ **Shelley Rochford, CQC Trust Lead** ▪ **Lisa Fox, Head of Clinical Information** ▪ **Charlotte Anderson, Performance and Information Lead – Quality**
Sponsor:	**Ellen Armistead, Executive Nurse Director/Deputy Chief Executive**
Previous Forums:	**Quality Committee 5 February 2020**

Actions Requested:
- To note

Purpose of the Report

To provide an update on progress against the Trust quality priorities for quarter 3.

Key Messages

The purpose of this quarterly report is to provide the Board of Directors with assurance that the key outcomes/objectives set out in quarter 2 have been achieved.

The report is structured to clearly articulate where the Trust has achieved its quarter 2 objectives, the lessons learnt where possible and if there is further work to be completed in quarter 4 alongside the priorities.

It will provide a RAG review of the following assurance statements:

- Substantial Assurance - Green
- Reasonable Assurance - Amber
- Limited Assurance - Red

The key messages from this report are:

1. CQC remains a high item on the quality agenda with the MD8 (medical staffing), SD9 Emergency Consultant cover and the learning portal providing limited assurance;
2. Pressure ulcer education requires innovating as this action is providing limited assurance to the Trust's wider pressure ulcer work;
3. The Falls agenda (workshops) must be commenced as planned in March to ensure we meet best practice;
4. The Dementia assessment, screen and training requires input to realise the Dementia Strategy;
5. Legal services must commence an audit of files in Quarter 4 and review EPR;
6. Nutrition and Hydration remain a serious concern in relation to compliance of MUST and the overall patient experience;

7. Calderdale and Huddersfield Solutions (CHS) and the Corporate Division have limited assurance in relation to medical device training; 8. We have limited assurance in relation to the development of a database to provide an overview of colleagues with skills in more complex complaints and less experienced complaint handlers as well as limited assurance in relation to the Trust learning from PHSO cases. The report provides an overview of the Trust CQC position along with an update on progress with the three Quality Account priorities and the five CQUINs for 2019-2020.
EQIA – Equality Impact Assessment
An equality impact assessment has been undertaken; preliminary discussions have been planned with the Diversity and Inclusion Lead to consider capturing protected characteristics against incidents, complaints/PALS and claims would work and the governance arrangements around reporting. Other than that aspect, the report does meet all the expected legislation set out in the Equalities Act 2010.
Matters for escalation to board/Recommendation
The Quality Committee are recommended to note the content of the report and activities across the Trust to improve the quality and safety of patient care.

Contents

1. Introduction

The primary aim of Calderdale and Huddersfield Foundation NHS Trust is to treat and care for people in a safe and compassionate environment and to protect them from avoidable harm.

This report has been formatted to ask the question *'Are we assured'* as previous Board papers provided reassurance. As a Trust working towards the Outstanding CQC marker, the question for any Trust committee should be one of '*Am I assured and am I confident that we know where the risks lie'.*

The Board has a structured and comprehensive quality assurance programme supported by a Quality Committee which provides the scrutiny, monitoring and assurance on all the quality programmes that are in place in the organisation. Further assurance is provided by the Trust Council of Governors.

This report provides an update on assurance against the Trust quality priorities for quarter 3.

2. Care Quality Commission (CQC)

2.1 Care Quality Commission (CQC) Exceptions Action Plan

2.1.1 Of the outstanding actions from the 2018 CQC inspection, the Trust still had five actions to complete. These have been defined as must do (MD) and should do (SD).

Action	Quarter 2 Update	Quarter 3 Update	Assurance
SD9 - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	The ED consultant rota currently provides 14 hours/day cover on both sites on five days per week. Since August 2019, in line with the demand profile for the service, a second consultant is on each site from 11am-7.30pm on each site.	Still non-compliant with this standard given our current consultant workforce numbers. We are continuing with attempts to recruit to consultant numbers to deliver this standard.	**Limited Assurance**
CQC Core Service Framework Self-Assessment Review	Review of the CQC Self-Assessment Process across the Trust	Roll out of revised core service self-assessment documents following feedback about health check documents been too generic. A core service specific document has now been trialled. Self-Assessment findings were presented at the December CQC Response Group from: Gynaecology C&YP Services	**Reasonable Assurance**

Action	Quarter 2 Update	Quarter 3 Update	RAG Rating
CQC Insight Report Analysis		The new CHFT CQC Insight Summary Report was presented at the November Risk and Compliance Group. The new approach to managing the monthly Insight report published by CQC was well received. Service position statements and a Trust response are now in place for all flagged indicators. Submissions were received from the service leads as well as details of the governance forums with oversight. This also includes any area flagged as a drop in performance since the last report or any area in which CHFT is performing below the national average.	**Substantial Assurance**
Provider Information Return (PIR) Preparation	Services requested to review all narrative sections of the CQC PIR document as part of the quarterly review programme to ensure we are prepared when the official request is received from CQC.	Most narrative sections of the PIR have been completed by key contacts within divisions and services. The Innovations sections of the PIR have been discussed at all Divisional PSQBs to ensure continuity and sign off at a divisional level. The PIR will remain an ongoing priority piece of work with review and updates been requested on a quarterly basis.	**Reasonable Assurance**

Action	Quarter 2 Update	Quarter 3 Update	RAG Rating
External Well-led Review (AQuA)	A table top assessment was undertaken in quarter 2 in order to provide an analysis of any potential gaps in compliance. This was then used to inform the developmental well-led assessment all trusts are expected to commission every three years.	Progress in Q3 included the submission of the self-assessment well led against eight KLOEs. Analysis of 2018 CQC Report. Board member survey on well-led requirements. Divisional survey to senior management	**Substantial Assurance**
Learning Portal to be live on the CHFT Intranet page.		A learning summit took place in Q3 to explore different ways in which learning can be shared to all staff across the Trust. The information gathered will form the basis of an interactive learning portal which will be accessible to staff via the CHFT Intranet.	**Limited Assurance**
Go See to Outstanding Trusts		A 'go see' visit to Newcastle upon Tyne Hospitals NHS Foundation Trust took place on 8th November 2019. The focus of the 'Go See' was; ° Paediatrics - flow of patients to theatres and managing paediatric patients in ED, ° Quality assurance mechanisms, ° CQC inspection preparation and ° learning from patient experience - handling complaints and learning. Findings were presented at the December CQC Response Group.	**Substantial Assurance**

2.1.2 Following a lengthy period of review and work within the Divisions, the status of the must do and should do actions has been set out below. In brief the two 'must do' and three 'should do' are not yet embedded in the Trust and have resulted as actions for specific focus for the CQC Response Group. Further the

two 'must do' actions remain incomplete pending further consideration of the quality and financial impact of the CQC actions.

2.1.3 The exceptions plan below sets out, in detail, the present position:

Compliance	Quarter 2	Quarter 3	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	Ongoing liaison with NHSI with regards to next steps on reconfiguration plans. Analysis work in conjunction with NHSI to gain greater understanding of premium costs being incurred through current configuration, demand and mix of services.	The Trust has submitted a five-year financial plan through the Integrated Care System and onward to regulators in line with the defined challenging Financial Improvement Trajectory. This trajectory sees a projected reduction in the deficit position but continues to require external funding support to achieve breakeven.	**Substantial Assurance**
MD8 - The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.	This went to the Weekly Executive Board, yet to go to the Finance and Performance Committee. In terms of implementing, once signed off, this can be switched around with rota. The chair of the CQC Response group requested a view on progress as it is not clear how risk is being mitigated.	Further work is needed to make the proposal more palatable financially. Consideration is been made within the trusts planning cycle for 20/21. There is still no mitigation and therefore the risk remains red.	**Limited Assurance**
SD3 - The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	Work progressing on this for CAMHS and ED. As we go forward the strategy needs to ensure how these fits with reconfiguration plans, and to also get patients and public involvement.	Work has progressed with the strategy which is now going for Trust approval and through relevant governance processes.	**Substantial Assurance**
SD6 - The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	Vicky Thersby (Safeguarding Lead) has completed a briefing that can be used by on-call managers to test compliance.	Discussed at nursing huddles to strengthen staff knowledge. Plan to test staff knowledge in Q4. To remain Green.	**Substantial Assurance**

2.2 Priorities for Quarter 4

2.2.1 As part of the new approach to assurance, the CQC lead has set out the priorities for the Trust for Quarter 4 with leads identified to drive the change.

2.2.2 Priorities for Q4:

Priority	Action	Lead
PIR preparation	Ongoing quarterly review and updates of all submissions.	Associate Director of Quality and Safety / Chief Nurse
CQC inspection preparation	CQC Core Service Self-Assessments to be presented at the CQC Response Group for: - End of Life Care - Community - Medical Division	Divisional Teams
Internal peer review	To create a proposal of how the trust can test compliance with fundamental standards through internal peer review. Considering all forms of assurance tool i.e. Ward Exemplar, Assurance Fridays; and benchmark to the systems used in outstanding organisations such as Newcastle and Salford NHS Trusts.	Associate Director of Quality and Safety
Learning portal to be live on the CHFT intranet page	Launch of new CHFT “Learning Portal”.	CQC Compliance Manager
Sharing learning guide to be available for all colleagues	To develop guide on how to identify and share learning across the Trust.	Directorate Secretary
Go see to outstanding trusts	To arrange at least one go see visit to an Outstanding CQC rated Trust.	CQC Compliance Manager

3. Safety Thermometer

3.1 Classic Safety Thermometer

3.1.1 The NHS Safety Thermometer is a national point of care survey which provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients.

3.1.2 The Trust submits data to the Classic (inpatient), Maternity, and Children and Young People's Safety Thermometers. Results and improvement priorities are reported on a monthly basis on the Trust integrated performance report.

Objective	Quarter 2	Progress – Quarter 3	Assurance
% Harm Free Care	92.23%	93.15%	**Reasonable Assurance**

3.2 Maternity Safety Thermometer

3.2.1 The Maternity Safety Thermometer is a measurement tool for improvement that focuses on perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.

3.2.2 The survey is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women's homes and community postnatal clinics.

Objective	Quarter 2	Progress - Quarter 3	Assurance
Re- Launch of ATTAIN		The ATAIN work was relaunched last October 2019. Information boards are in relevant areas for parents to see. The service has now started to re-audit term admissions to NICU to see if it is making a difference.	**Reasonable Assurance**
% Combined Harm Free Care	80.5% compliant	82.53%	**Reasonable Assurance**
% Harm Free Care Physical	80.5% compliant	82.53%	**Reasonable Assurance**
% Harm Free Care Psychological	80.5% compliant	100%	**Reasonable Assurance**

3.3 Children and Young Peoples Safety Thermometer

3.3.1 The Children and Young People's Services Safety Thermometer focusses on deterioration, extravasation, pain and skin integrity.

3.3.2 The Children's Service has consistently performed at a higher level than the national data. The team has undertaken an exercise to validate data; no areas for improvement in data quality were identified.

Objective	Quarter 2	Progress - Quarter 3	Assurance
% Harm Free Care	99% compliant	99% Compliant	**Substantial Assurance**

4. Venous Thromboembolism (VTE)

4.1. Venous Thromboembolism (VTE) is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a significant cause of mortality, long-term disability and chronic ill-health problems, many of which are avoidable. It has been estimated that the management of hospital associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long-term care. Long term complications that reduce the quality of life add to the human cost and overall burden of VTE.

4.2 VTE Prevention is supported by national standards that facilitate high quality care and NICE guidelines for reducing risk in patients admitted to hospital.

VTE Outcome	Quarter 2	Progress- Quarter 3	Assurance
To meet the 95% target of patients being risk assessed for developing a VTE	Achieved	KPI - 95%+ compliance achieved for all months in Quarter 3 2019. Regular VTE slot on induction for all new starters. VTE committee liaised with Divisional Quality Governance Leads around areas of low compliance. In November the Patient Safety Group supported the committee's proposal that if areas under perform for three consecutive months, that an action plan is produced and is fed into the next committee meeting.	**Substantial Assurance**
Maintain the level of Hospital acquired VTE episodes, not more than 20% of all VTE episodes	Achieved	October Total of 31 VTE episodes - 4 confirmed HA = 13% November Total of 29 VTE episodes - 4 confirmed HA = 14% December Data incomplete – Awaiting action from Radiology	**Substantial Assurance**
No Avoidable hospital acquired VTE Deaths	Achieved	Achieved	**Substantial Assurance**
Audit actions plan and schedule of re audit	Completed - Pharmacy audit of VTE risk assessment and prescribing of thromboprophylaxis. Is VTE prophylaxis being correctly prescribed for all postpartum women upon discharge?' Management of suspected PE in pregnant patients.	Plan a re-audit this year of all action plans- ongoing Pharmacy led audit on VTE prevention and prescribing prophylaxis	**Reasonable Assurance**

5. Pressure Ulcers

5.1 Pressure ulcers are a key indicator of the quality and experience of patient care. Many pressure ulcers are preventable, so when they do occur, they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating. Preventing them will improve care for all vulnerable patients.

Objective	Quarter 2	Progress - Quarter 3	Assurance
Reduction in pressure ulcers	There was an overall reduction from Quarter 1 to 2 in pressure ulcers across the Trust.	Reduction has been sustained in October and November. December's data is still being validated.	**Reasonable Assurance**
No Category 4 declared	No Category 4 pressure ulcers were declared in Q2.	No Category 4 pressure ulcers were declared in Q3 to date. December's data is still being validated.	**Reasonable Assurance**
Reduction in Hospital Acquired Pressure Ulcers caused by medical devices	There was a reduction in acquired pressure ulcers caused by medical devices in Q2 (11).	Reduction has been sustained in October and November. December's data is still being validated.	**Reasonable Assurance**
Reduction in Category 3 Pressure Ulcers	There was a reduction in category 3 pressure ulcer (8).	Reduction has been sustained in October and November. December's data is still being validated.	**Reasonable Assurance**
Education and Training- PUSH Tool / Safety Huddles		Remains ad hoc and Divisions are working with team to strengthen use of PUSH tool and safety huddles- however the PUSH tool is now under review by the collaborative. Education programme to commence April 2020.	**Limited Assurance**
Documentation		Ongoing; audited monthly via ward assurance- now standing agenda item on Pressure Ulcer Collaborative.	**Reasonable Assurance**
Resources / Policies		New TVN team commenced October 2019- review of all policies now underway.	**Reasonable Assurance**

6. Falls

6.1 Falls cause distress and harm to patients, families and their carers. The Trust has a Trust-wide Falls Reduction action plan delivery which is overseen by a monthly Falls Collaborative, chaired by a dedicated clinical falls lead who is a consultant within Older People's services.

6.2 The action plan is based on some aspects of the previous National Audit which highlighted some areas for improvement including lying and standing BP, medication review and vision.

6.3 Since April 2019, the Trust has been working towards achieving the inpatient Falls Reduction CQUIN. The three high-impact actions measured to achieve the CQUIN are:

- Lying and standing blood pressure
- Mobility assessment within 24 hours
- Medication review re anxiolytics rationale for prescribing/administering

Falls CQUIN / Objectives	Quarter 2	Progress- Quarter 3	Assurance
Lying and standing blood pressure	20%	37%	**Reasonable Assurance**
Mobility assessment within 24 hours	69%	Available 29th February 2020	
Medication review re anxiolytics rationale for prescribing and administering	97%	Available 29th February 2020	
Falls workshops	September 2019 workshop completed	Unable to deliver February workshop due to staffing resources, now due March 2020	**Limited Assurance**

7. Assessment and Dementia Screening

7.1 The Assessment and Dementia screening process is an essential part of medical clerking for all patients aged 75 and over. This is a cognitive assessment that measures the following aspects:

- an assessment for delirium; followed by
- a screen for depression; and if the delirium assessment is negative it is followed by
- the dementia screen.

7.2 If delirium is diagnosed, the cognitive assessment does not progress to the dementia screen. The dementia screen is a nationally monitored standard requiring 90% compliance.

7.3 The dementia screen is not intended to be an indicator for investigation whilst the person is in hospital. Its function is to prompt a message for the GP to be aware that a positive screen may lead them to refer the patient to mental health memory services for full investigation.

Objective	Quarter 2	Progress - Quarter 3	Assurance
Dementia screen	47% (against national requirement of 90%)	40% (against national requirement of 90%)	**Limited Assurance**
Person centred dementia care training	No update provided	The training remains the same on ESR, it's the video 'Barbara's Story'. The person-centred dementia care training currently provided does not target large numbers but will still be on the agenda for clinical staff.	**Limited Assurance**
Dementia strategy	In progress	Approved by Patient Experience and Caring Group; awaiting Nursing and Midwifery Committee and EB Quality Board approval	**Reasonable Assurance**
Dementia training	Community 99.58% Corporate 98.63% FSS 99.63% Health Informatics 97.24% Medical 99.07% PMU 100% Surg &Anaesthetics 98.51%	Overall compliance for Dementia training is 99.06%.	**Substantial Assurance**

8. Nutrition and Hydration

8.1 During quarter 2, a mock CQC style nutrition and hydration peer review took place. The purpose of this review was to test out the Trusts compliance with Nutrition and Hydration standards. The focus of the review was:

- Parenteral and enteral care of nutritional complex patients, reviewing the co-ordination of service provision.
- Nutrition and hydration standards compliance for all patients of different ages.
- Decision making and End of Life Care relating to nutrition and hydration.

The Trust invited a team from Leeds Teaching Hospitals NHS Trust to support this review. It has been recommended that the following actions are taken in response to the findings from the External Peer Review:

- The Nutritional Steering Group and Artificial Nutrition Steering group to be accountable for progressing Action plans to address issues.
- Response required from the Gastroenterology Team about recommendations for enteral and parental nutrition.
- A review to take place of the current CHFT audit programme in relation to artificial nutrition to ensure this meets the best practice audit standards.
- Updates regarding action plans and progress on improvement work to be presented by the Divisional ADNs at the October CQC Response Group.
- Internal Peer Review to be organised to check progress of actions.

8.2 Following the External Review in quarter 2 we note that there continues to be issues with staff not recording MUST / Fluid & Food Balance charts in the correct place on EPR which is contributing to some of the low compliance. However, following further conversations with the nutrition team, the main risk for the Trust is around non-compliance with all aspects of nutrition and hydration.

8.3 The scores are as follows:

- Nutrition and Hydration overall score 29.3%
- Ward Assurance 29.3%
- Training NG Tube 86.8%
- Training MUST 87.8%

Objective	Quarter 2	Progress - Quarter 3	Assurance
All patients (>LoS 8hrs) have a completed fluid balance chart?	10.1%	23.3%	**Limited Assurance**
Nutritional support care plans will be evident for all adults' patients with MUST of 2 or above?	88.2%	85.5%	**Substantial Assurance**
Patients with a MUST score of 2 or above will be referred to a dietician	2.7%	4.4%	**Limited Assurance**
Food charts will be completed for patients with a MUST of 2 or above	31.9%	16.9%	**Limited Assurance**
All adult patients will receive a MUST assessment within 24 hours admission/ transfer to the ward?	15.0%	16.6%	**Limited Assurance**

9. Outpatients and Records

9.1.1 The Trust undertook a significant programme of work to understand outpatients and appointments issues from the perspective of multiple stakeholders. A 'deep dive' was undertaken to ensure all issues related to outpatients and appointments were identified and have developed a comprehensive action plan to drive improvement.

9.1.2 By way of additional assurance, the Trust commissioned an external, independent review of issues raised by the CQC and others about current outpatient provision at the Trust. This focused on identification of current risks and the consequent priorities for the Trust and the experiences of users of the outpatient service (patients and clinicians) and staff engaged in managing the service.

9.1.3 Four issues were identified from the external independent review. These were; number of patient lists managed across the outpatient system; training of staff managing the outpatient system; the number of cancelled appointments and clinics and communication with patients.

9.1.4 The developed action plan was categorised into the three key issues which were identified from the deep dive:

Objective	Quarter 2	Progress- Quarter 3	Assurance
Issues related to EPR and digital patient communications		A task and finish group meet fortnightly to track the ongoing delivery against the developed action plan. Progress and assurance are being monitored by the Weekly Executive Board. Many of the technical issues have been fixed or where this has not been possible further training is being developed for operational staff.	**Reasonable Assurance**
User issues		There has been clear progress during quarter 3, of 50 actions there is now a RAG rating of – 1 Blue, 13 Green, 20 Amber and15 Red. The 50-point action plan developed includes the recommendations of the internal deep dive and the external independent review.	**Reasonable Assurance**
Access issues – capacity / demand		Opportunity to become outstanding with innovative ideas such as safety huddles pre and post clinic.	**Reasonable Assurance**

9.2 Priority Outpatients & Records – Quarter 4:

Priority	Outcome	Lead
Continue to progress work on action plan with aim to have all outstanding work completed before the end of the quarter		**Head of Planned Access**
Ensure completed actions have clear evidence to show the issue has been resolved		**Head of Planned Access**
Review impact the work has had on key metrics such as FFT, incidents and complaints		**Head of Planned Access**

10. Sepsis

10.1 The Sepsis Collaborative did not set outcomes specifically for Q2.

Objective	Quarter 2	Progress - Quarter 3	Assurance
Sepsis Lead Nurse appointment		Appointed	**Substantial Assurance**
EPR Sepsis bundle/PowerPoint presentation		Ongoing	**Reasonable Assurance**

11. Complaints

11.1.1 The PALS and Complaints Team have developed and launched a new poster and updated the information leaflets following feedback from Governors and patients. These have been distributed via the Associate Director of Nursing team. The posters were designed with the Trust CQC lead to ensure that these met best practice. The team is in the process of recruiting to two positions to consolidate the service provided.

11.1.2 In addition to the intranet site which was launched in Q2, the interim Assistant Complaints Manager and team have agreed to review the educational programme for staff relating to first line management of complaints. This will be aimed primarily at front line staff who are usually the first port of call for complaints to be lodged within the Divisions.

11.1.3 During quarter 3 the PALS team had 824 contacts, a decrease from 898 contacts in Q2 2019-2020.

11.2 End of Quarter 3 Complaints Summary:

End of Q3 Complaints Summary	Number
Live complaints	66
Breaching complaints	9
Complaints under investigation with PHSO	9
Complaints received	126
Complaints closed	175
PHSO complaints received	0
PHSO complaints closed	0
PALS contacts received	824

Objective	Quarter 2	Progress – Quarter 3	Assurance
Senior divisional decision makers should receive all complaints and allocate accordingly	Implemented	Implemented; complaints weekly tracker shows allocation in a timely manner. Need audit to check embeddedness due to be undertake at the end of Q4.	**Substantial Assurance**
Survey Monkey survey to be set up to establish baseline confidence in handling complex complaints, to be repeated in 6/12 (Feb 2020) following training intervention	Not implemented	Survey now to be completed by Microsoft Forms, which is more cost effective. Staff trained on use of this survey, now to be completed and sent out.	**Substantial Assurance**

Objective	Quarter 2	Progress – Quarter 3	Assurance
Database to be developed to provide an overview of colleagues with skills in more complex complaints and less experienced complaint handlers	Not implemented	No progress made.	**Limited Assurance**
Debrief and learning from the WB complaint– an extremely difficult complaint for the Trust. Learning should be taken from this complaint as to what went well/what did not go well and see how this can be used to help investigators	Complaint still under investigation	Complaint concluded. Report sent to the complainant. Learning debrief to be arranged.	**Reasonable Assurance**
The Trust should review its complaints training offer to include training in communication skills, strategies to build confidence in having difficult conversations and duty of candour as well as process	Bespoke Training for areas within the Trust delivered as required	Bespoke training for areas within the Trust delivered as required.	**Reasonable Assurance**
The Trust should review current systems and processes for sharing learning from complaints. The Trust should undertake a 'go see' to organisations recognised as being exemplars in relation to sharing learning from complaints	Not implemented	'Go See' undertaken at Newcastle Upon Tyne Hospitals NHS Foundation Trust. Now need to implement best practice within the organisation.	**Reasonable Assurance**
Audit of learning from PHSO cases	In progress	Audit has not yet been undertaken due to focus on backlog of breaching responses, implementation was due end December 2019. Plan to be undertaken and presented with end of year complaints report.	**Limited Assurance**

12. Legal

12.1 Legal Services

12.1.1 Legal Services have been in 'supportive measures' since March 2019. A backlog of inquest and claims work dating back to October 2018 arising from full time Band 5 Legal Services Team Leader being on long term sick leave since early 2018 (not replaced). This led to limited supervision of the Band 3 Legal Services Apprentice, at a time when there was an increase in Coroner and claims work.

There was also a backlog of lost property claims. Additional administrative support has been put in to manage cases; this is now resolved and all in time.

12.2 Clinical Negligence

- 179 active clinical negligence claims
- 23 new clinical negligence claims were received.
- 1 clinical negligence claim was concluded; liability was denied (claimant's allegation not supported by records or expert) and Claimant discontinued

12.3 Employee and Public Liability (EL/PL) Claims

- 23 active EL/PL claims
- 1 EL/PL claim was received
- 2 EL/PL claims were concluded; 1 was repudiated and 1 was settled
- Damages totalled £5,750

12.4 Lost Property

- 9 active lost property claims
- 11 lost property claims were received
- 11 lost property claims were concluded
- £2,755 paid in respect of lost property claims

12.5 Inquests

- 49 active inquests
- 16 inquests were opened
- 31 inquests files were closed
- 2 Regulation 28 were responded to

Objective	Quarter 2	Progress – Quarter 3	Assurance
System in place to ensure effect communication within the Legal Services Department	KPIs set and implemented	98% compliant with department KPIs	**Reasonable assurance**
Datix Module for Legal Services reviewed and updated	Not implemented	Datix reviewed with Trust Datix Lead, stages streamlined, and actions set up for Inquests. Further work required in Q4.	**Reasonable assurance**
Audit of Legal Services files on Datix	Not implemented	Not implemented	**Limited assurance**

Objective	Quarter 2	Progress – Quarter 3	Assurance
SOP for DP7 requests	Not Implemented	In Q3 the role and responsibility for managing all DP7 requests was given to Legal Services. Currently no SOP in Trust for handling these.	**Reasonable assurance**.
Disclaimers for personal property on EPR	Not implemented	Not implemented, discussions being undertaken with EPR Team in relation to this.	**Limited assurance**

12.6 Legal Service Learning (from Q2)

12.6.1 Sharing Learning from Clinical Negligence Claims

Documentation has played a key role in the settlement of the claims in Quarter 2. When a claim for clinical negligence is being pursued the legal teams (both the Trust's and the Claimant's) will have medical and nursing documentation available to them to assess the claim. This documentation will also be sent to external experts.

Often the care that is provided is good; however, if the documentation is poor this will lead legal teams to decide that reasonable care was not provided and that the claimant's damages were preventable.

Whilst everyone is familiar with the term "*if it is not written down then if did not happen",* consideration should be given to how we document; is documentation ambiguous for example regular checks undertaken. Consideration should also be given to the type of documentation we use; do the risk assessment tools your ward or department use accurately capture the patient at risk?

12.6.2 Sharing Learning from Employee and Public Liability Claims

Good health and safety can be a vital tool to help the Trust comply with legislation and reduce accidents and incidents. As we can see from the open and closed employee liability claims, they can occur in several ways and with such a broad spectrum of potential claims scenarios to protect against, it is important to take practical steps to reduce risk.

Whilst the Trust may not be able to prevent claims occurring, there are steps that can be taken to reduce the likelihood of a successful claim being made. The correct training processes teamed with good record keeping and regular risk assessments can make a significant difference to the number and value of claims received. Ideally, a robust health & safety plan should incorporate some of the following elements:

- Risk assessments performed wherever a situation could potentially result in injury. Full written records should be kept of each assessment, and each risk should be addressed based on its seriousness.
- Adequate training should be provided to new employees and refresher training regularly provided to existing employees. And don't forget each training event needs the participants to sign that they have attended and understood the training.
- Occupational health referrals can help to keep track of employees' fitness and identify work processes which may cause physical strain to them, allowing you to put systems in place to prevent injury.
- Incident investigations carried out after an accident has happened helps understand what happened and how the incident could be prevented in future. You should interview anyone involved and collect photographic evidence.

13. Incidents

13.1 Serious Incidents (SIs)

13.1.1 Patient Safety Incidents and Serious Incident by month reported

Serious incidents account for 0.34% of all Patient Safety Incidents reported for 2019/20.

13.1.2 Summary of Patient safety Incidents and Incidents with Severe Harm or Death April 2019 to December 2019 and number of SIs reported by month

Month reported	No of Patient Safety Incidents	No of Patient Safety Incidents with severe harm or death	SIs By the month externally reported
Apr 2019	1031	4	0
May 2019	1049	6	6
Jun 2019	929	3	3
Jul 2019	1053	2	2
Aug 2019	981	4	1
Sep 2019	964	3	7
Oct 2019	1141	5	3
Nov 2019	998	4	6
Dec 2019	976	4	3

13.1.3 Types of SI Declared in Q3 by StEIS category and Division

Month reported	ID	Division	Description	Level of harm	STEIS Ref	STEIS Category
October 2019	176099	FSS	Septic arthritis in child	Severe harm	2019/21881	Sub-optimal care of the deteriorating patient
	176331	FSS	Cooled baby HSIB	Moderate harm	2019/22427	Maternity/obstetric incident : baby only
	176348	Med	Fall	Severe harm	2019/22415	Slips/trips/falls
November 2019	177153	SAS	Avulsed ureter	Severe harm	2019/24005	Surgical/invasive procedure
	176317	Med	Fall	Severe harm	2019/24522	Slips/trips/falls
	177221	FSS	Serratia	No Harm	2019/24554	HCAI/Infection control incident
	177369	SAS	Fall from operating table	Moderate harm	2019/24510	Accident
	177517	FSS	Cooled baby HSIB	Moderate harm	2019/24527	Maternity/obstetric incident : baby only
	174623	Med	Sepsis	Catastrophic or Death	2019/25604	Diagnostic incident including delay (including failure to act on test results)
December 2019	178346	Med	9 x 12 hour trolley breaches ED	No Harm	2019/26093	Treatment delay
	178809	Med	Sepsis	Catastrophic or Death	2019/27167	Sub-optimal care of the deteriorating patient
	179241	SAS	Wrong site block	Minor Harm	2019/27821	Surgical/invasive procedure and NEVER EVENT

13.2 Never Event

13.2.1 The last case in the table above is a Never Event reported in December 2019; an administration of a Wrong Site Block (regional anaesthesia). Shoulder surgery was performed on the correct side. Early findings are that there was a failure to perform a 'Stop Before You Block' (SBYB) moment which is a nationally recognised procedure to mitigate the risk of performing a wrong site block and a further contributory factor was the block being done by a different anaesthetist to the one doing the case.

This incident was categorised as Minor Harm and declared as a Serious Incident. The patient was informed post-surgery of the error in accordance with our Duty of Candour arrangements.

The Anaesthetic Directorate assessed their compliance to the Healthcare Safety Inspection Branch (HSIB) publication 'Administering a Wrong Site Nerve Block', (HSIB, 2018) which can be read in full here: https://www.hsib.org.uk/investigations-cases/administering-wrong-site-nerve-block/

Theatres took the following actions in response to the original publication and are revisiting this action plan in addition to recommendations of the serious incident investigation:

- Posters are displayed in theatres
- Stop Before You Block (SBYB) moment implemented
- HSIB recommendation to use coloured surgical drapes to support correct site marking is not relevant to CHFT as the block is done prior to draping
- Consideration given to marking for regional blocks, but this could be confused with operation site marking
- Raise awareness of SBYB – The Department of Anaesthesia reported conducting a survey that showed 56% of the anaesthetists who responded consider that they use SBYB every time.

In addition, the Trust's regional anaesthesia lead has made recommendations to prevent recurrence and is updating the Regional Anaesthesia Trust guideline to reflect these changes and arranging for presentation of these at the clinical governance forum. These suggestions include that:

- All lists requiring a regional anaesthetist should be staffed by a regional anaesthetist.
- If for staffing reasons a regionalist cannot be appointed to cover the list, then the surgeon should be informed in advance. The surgeon can amend the list or may be happy to proceed with a case/list without a block where this is not essential.
- If the above are implemented the situation should not arise, but if it does and anticipated assistance is required from a regionalist then the regionalist should be present prior to induction of general anaesthesia and for the WHO safety checklist.

The feasibility and impact on medical rotas of these suggestions are to be evaluated. As part of the West Yorkshire Association of Acute Trusts, sharing of learning from other organisations who have had similar incidents will also be used to inform the SI investigation.

13.3 Summary of Progress with SI Actions

13.3.1 The status of open actions associated with serious incident investigations is reported to Quality Committee on a quarterly basis. In summary, as of 12th January 2020, there were 87 open actions against serious incident investigations. The Trust maintains an improved position on delivery of actions and recognises the moving picture of closure of actions delivered from previous investigations and new actions added from investigations concluded in Q3. Oversight of the risk profile of actions is considered at Quality Committee.

13.4 Learning from Safety Incidents in Quarter 3

13.4.1 There were four serious incident reports submitted to the Clinical Commissioning Group (CCG) in November 2019:

164932 – Patient lost to follow up for oral dysplasia - development of oral cancer requiring invasive surgery.

- Lack of robust and standardised system and process for ordering follow-up appointments and lack of a failsafe process to verify this has happened.
- Lack of clarity of roles and responsibilities of clinic staff in the above process.

The findings of this investigation have been shared with all Divisions as the process for placing an order for a follow-up appointment on EPR is the same across the Trust. The Incomplete Orders (IO) list on EPR has incomplete (open ended) records on which are undergoing administrative and clinical validation. Priority has been given to high risk appointment types and this work is monitored through the Outpatient Appointment workstream and is recorded on the risk register.

173005 – Post-operative paralytic ileus following caesarean section, respiratory arrest.

The patient had an emergency caesarean section for abnormal CTG and failure to progress in labour; this procedure was indicated and unavoidable. The patient went on to develop a paralytic ileus which is a known complication of abdominal surgery. This was further complicated by the inability to pass an NG tube to empty and decompress the stomach. This resulted in likely silent aspirations of gastric contents that then caused the respiratory arrest with successful resuscitation.

The investigation identified areas that could have been improved however concluded that these did not directly contribute to the respiratory arrest. Lessons learned were:

- Importance of having a key clinician having oversight of a patient's care when there is involvement of multiple specialisms.
- It is essential to document a rationale if there is a decision to deviate from guidance
- Analgesia should be carefully considered in the background of possible post-operative paralytic ileus
- There should be a clear plan put in place for diabetic management following an emergency caesarean section

165282 – Healthcare Safety Investigation Branch (HSIB) investigation - Cooled baby, deceased

The HSIB made recommendations in respect of:

- Implementation, monitoring and audit of national guidance
- Continuous and cumulative risk assessment
- Ensuring mothers take informed decisions on the place of birthing
- Reviewing the Fresh Eyes approach
- Ensuring documentation is comprehensive
- Ensuring availability of equipment
- Review of staffing model
- Ensure recognition and management of risk at the Birth Centre

166220 – HSIB investigation. Cooled baby, deceased

The HSIB made recommendations in respect of:

- Gathering and contemporaneous recording of telephone advice given in a structured manner
- Giving advice directly to the mother where possible, and if not, the person receiving the advice should be in the same room as the mother

The Families and Specialist Services (FSS) Division put in place an immediate action plan when any serious incident is reported, and those being managed in the HSIB process to ensure that any evident risk and learning is acted upon without delay. Further actions are agreed in response to any additional recommendations made by the HSIB investigation.

The overarching Maternity Improvement Action Plan collates recommendations from all serious incidents, HSIB investigations, Quality Improvement work and clinical audits into one comprehensive action plan. Oversight is through FSS Division, with assurance to Quality Committee.

14. Medicine Safety

14.1 The Medication Safety and Compliance group continues to raise awareness of the importance of safe storage and handling of medication.

Objective	Quarter 2	Progress- Quarter 3	Assurance
Non-compliance of the medicines management 'must do's	Requirement of clear escalation process for non-compliant areas. Senior nurses to be reminded of responsibilities	The Trust Medicines Code has been updated and includes a process for the escalation and management of the staff responsible in any non-compliant areas Presentation to senior nurses of responsibilities and process of escalation Letters issued from ADNs to senior nurses reminding staff of responsibilities Celebration of high performing areas	**Substantial Assurance**
Non-secure storage of medication cupboard keys in those areas not open 24/7	Review of medication key security and installation of digital key safes	Non-compliant areas identified. Business case for digital key safes / successful funding bid to Commercial Investment and Strategy Group. Procurement of key safes. Priority areas for installation highlighted.	**Reasonable Assurance**
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant (audit completed July/ results shared September 19)	Require improvement in completion of medicines must do's/ compliance with fridge temp monitoring standards	Audit results disseminated to nursing and midwifery staff Issue highlighted in Safe Medicines newsletter Monitoring sheet revised to include colour code when temperature out of range Spot check of medicines management standards by pharmacy teams. Awaiting review of ward managers annual medicines management audit to identify if improvements to previous practices - Feb 20	**Reasonable Assurance**
Thermometers in meds fridges not calibrated within required time limits. No assurance that temperature recording is accurate	Medical engineering to recalibrate fridge thermometers	100% thermometers now calibrated and requirements for future annual calibrations have been added to Med Eng. work plan	**Substantial Assurance**
Non-compliance with Controlled drug recording in pharmacy: Controlled drugs register not complete when controlled drugs	Legally must record the details of any schedule 2 CDs supplied by pharmacy in CD register	Pharmacy SOP updated Staff informed of requirements Spot checks on CD registers confirm that this detail is now being recorded	**Substantial Assurance**

are collected by patients/ carers or HCPs.	including the following detail: •Details of person collecting schedule 2 CD (patient, patient rep or HCP) •Whether proof of identity was requested Y/N •Whether proof of identity was provided Y/N		

14.2 Issues to escalate

Currently the Trust does not monitor ambient temperatures in areas where medications are stored. The requirement to store medications at appropriate temperatures is included in NHSE Health Building Note 14-02- Medicines Storage in Clinical Areas and hence the Trust currently have no assurance that these medicines are kept at the correct temperatures (and are therefore 100% efficacious).

Priorities for quarter 4 are:

- To continue to improve safe storage and administration of medicines across the Trust.
- Produce an 'overarching' Medication Error Policy to include in Medicines Code which encompasses all HCPs and is fair and consistent.

15. Medical Device Training

15.1 All information relating to Trust compliance is available. For the purposes of this report the key highlights are as follows:

Department / Division	November 2019	December 2019	Assurance
CHS	62%	61%	**Limited Assurance**
Community and Central Operations	88%	86%	**Substantial Assurance**
Corporate	67%	65%	**Limited Assurance**
FSS	88%	88%	**Substantial Assurance**
Medicine	76%	76%	**Substantial Assurance**
Surgery	76%	76%	**Substantial Assurance**

16. External Agency Visits, Inspections and Accreditations

16.1 External agency visits, inspections and accreditations Q3 2019-2020:

Subject of Review	Inspection Date	Risk Register	Progress Monitoring and Escalation
Neonatal Network Peer Review	October 2019	No risks identified	Actions which were agreed during the review have been received. Action plan to be produced and monitored through neonatal forum.
Neurophysiology IQUIPS visit	26 November 2019		It is the opinion of the assessment team that this service is observed to be clinically competent, however the control of the Quality Management System is poor and requires robust improvement actions and time to action and embed within the service and is shown within the mandatory findings. The service has a Clinical Service Manager who looks after Neurophysiology and Cardiac Physiology and after the recent departure of the band 7 lead for accreditation, staff have been concentrating on reducing waiting times and clinical activity and therefore monitoring and communication systems have started to break down. The division have established a weekly workgroup to address all the mandatory requirements from IQUIP's, who will be returning to reassess us against the compliance with these on 2nd March 2020
ISAS Radiology Accreditation	Online submission 13 December 2019	No risks identified	Evidenced submitted on 13 December 2019 (on time). Awaiting outcome of review / assessment.
National Bowel Cancer Screening Programme	27 and 28 Nov 2019	No risks identified	Draft report received 9 January 2020. The final report including any recommendations will be available mid-February 2020.
Cellular Pathology and Mortuaries UKAS ISO 15189	3 and 4 December 2019	No risks identified	Visit took place 3rd and 4th December 2019. No concerns. Action plan in place, and work on-going against this and on target. All required evidence returned w/c 13 January 2020 and awaiting response.
British Association for Cardiovascular Prevention & Rehab (BACPR) / National Audit of Cardiac Rehab (NACR)	December 2019	No risks identified	Data submitted in November 2019 and accreditation achieved in December 2019.

16.2 Work continues to promote the Trust External Agency Visits, Inspections and Accreditations Policy to ensure colleagues are fully supported to prepare for and manage visits and that governance processes to provide assurance about progress against any actions or gaps identified are robust.

17. Essential Skills Training

17.1.1 In order to have a workforce which delivers safe and compassionate care, the Trust has identified nine core subjects of essential safety training applicable to all colleagues in the Trust and role specific training compliance. All subjects are always required to be at a consistent compliance rate of 90%.

17.1.2 Role Specific Essential Safety Training subjects:

95% + Stretch Target	
90% - 94.99%	
85% - 89.99%	
-84.99%	

Overall compliance is 95.12%, please see below per subject.

Subject	No. Outstanding	14 Jan 2020	21 Jan 2020	Difference	Rating
Dementia Awareness	52	98.91%	99.04%	0.13%	
Health & Safety	91	98.24%	98.31%	0.07%	
Equality & Diversity	124	97.33%	97.70%	0.37%	
Conflict Resolution	194	95.98%	96.40%	0.42%	
Fire Safety	299	94.33%	94.46%	0.13%	
Infection Control	299	94.20%	94.46%	0.26%	
Data Security Awareness	338	93.39%	93.73%	0.34%	
Safeguarding Children	386	92.63%	92.79%	0.16%	
Safeguarding Adults	400	92.35%	92.52%	0.17%	
Moving and Handling	443	92.22%	91.79%	-0.43%	

18. Quality Accounts

18.1.1 There are three Quality Account priorities for 2019-2020:

- Improving clinical outcomes linked to waiting times in the Emergency Department (Safe).
- Ensuring that the new national guidance around observations for deteriorating patients (NEWS2), National Early Warning Scores, is implemented and understood by frontline staff to ensure effective and reliable care is always given (Effective).
- Mental Health in the Emergency Department - Improving psychological and social support for mental health patients in the Emergency Department (Caring).

Priority One: Clinical outcomes linked to waiting times in the Emergency Department (SAFE)
We have over quarter 1 & 2 progressed several processes to improve clinical outcomes for patients; we have partially implemented streaming nurses at the front door. These nurses are senior nurses who are able to send patients to the most effective areas of the department and the hospital so they receive the most appropriate care in a timely manner and undergo any investigations they require.

Those patients that have a prolonged wait within the Emergency Department are now flagged on a daily basis and are issued with a letter apologising for their length of wait, this allows them to bring to our attention any issues they may have had during their stay.

Those patients with a prolonged stay are having their observations repeated and a review by either the Emergency Department doctor or a medical doctor.

We currently have recruited to all our Band 5 nursing posts and our clinical educator is working with each of these staff members undertaking clinical supervision so that we can monitor and teach correct practices, this includes reviewing patients with extended waits within the department.

Each patient with an extended wait is also discussed in the morning and lunchtime safety huddle by the consultant in charge.

For quarter 4 the prolonged waits will need to be looked at by the wider hospital to see if they can look at reducing the length of time patients are waiting for beds.

Priority Two: Ensuring that the new national guidance around observations for deteriorating patients (NEWS2), National Early Warning Scores, is implemented and understood by frontline staff to ensure effective and reliable care is given at all times.

In 2019/20 we will:

- embed the changes needed within Nervecentre and the electronic record, EPR, to allow the NEWS2 score to be recorded
- support all clinical colleagues to access the online e-learning training for NEWS2
- revise the escalation policy with respect to raised NEWS
- facilitate additional training of nursing staff to ensure that physiological observations are timely and of high quality
- review and evaluate the use of the Confusion score and support any training required

- analyse outcome data from patients with raised NEWS

NEWS 2 has now been successfully implemented at CHFT. As before all areas that record patient physiological observations through Nervecentre continue to do so with all NEWS2 results visible within the EPR. Implementation was without any particular difficulties once the technologies were realigned. All adult physiological observations now include a C score as part of their routine set of observations. In line with this the escalation policy has been revised, agreed and published on the intranet. There will need to be further evaluation of NEWS2 including the C (New onset confusion) score in 2019/20.

Priority Three: Mental Health in the Emergency Department - Improving psychological and social support for mental health patients in the Emergency Department.

The department trailed the use of a mental health nurse to work in the department to support mental health patients during their stay in the department, unfortunately this was not particularly successful as many of the shifts were unable to be filled.

The department continues to assess mental health patients appropriately and get mental health liaison involved early in the patient pathway. Mental health liaison then provide psychological and social support. Mental health liaison will also come back to the department to re-review patients upon request.

Appropriate designed mental health room in place which is a quiet space for mental health patients remains within the department but is quieter than the main area.

Risk assessments and recognition in place when mental health patients require 1:1 support.

Continue to escalate to mental health provision when there are long waits for mental health assessment and finding patients an appropriate bed. RCAs completed when an over 12 hour wait occurs and shared with the mental health teams.

19. Commissioning for Quality and Innovation (CQUINs)

19.1.1 There are five CQUIN areas for 2019-2020:

- CCG 1a and b Antimicrobial resistance
- CCG 2 Staff Flu Vaccinations
- CCG 3 Alcohol and Tobacco
- CCG 7 Three high impact actions to prevent Hospital Falls
- CCG 11 Same Day Emergency Care

19.1.2 Quarter 3 data collection period still in progress, update not expected until end of February 2020.

19.1.3 Q1 and Q2 performance:

Objective	Quarter 1	Quarter 2	Assurance
CCG 1a Antimicrobial resistance	8%	43%	**Reasonable Assurance**
CCG 1 b Antimicrobial resistance	85%	86%	**Reasonable Assurance**
CCG 2 Staff Flu Vaccinations	NA	62% (against a target of 80%)	**Reasonable Assurance**
CCG 3 Tobacco & Alcohol Screening	57.8%	58.3%	**Limited Assurance**
CCG 3 Tobacco Advice	25.1%	21.2%	**Limited Assurance**
CCG 3 Alcohol Advice	28.7%	28.8%	**Limited Assurance**
CCG 7 Three high impact actions to prevent Hospital Falls	12%	13%	**Limited Assurance**
CCG 11 Same Day Emergency Care (PE)	100%	98.3%	**Full Assurance**
CCG 11 Same Day Emergency Care (AF)	91.4%	94.6%	**Full Assurance**
CCG 11 Same Day Emergency Care (CAP)	97.7%	92.0%	**Full Assurance**

17. Public Sector Equality Duty Annual Report (Equality and Inclusion) PSED

To Approve

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 March 2020
Meeting:	Board of Directors
Title:	Public Sector Equality Duty Annual Report – January to December 2019
Author:	Vanessa Henderson, Membership Engagement Manger/Nikki Hosty, Freedom to Speak Up/Equality, Diversity & Inclusion Manager
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce & OD
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report

The CHFT annual Public Sector Equality Duty Report aims to eliminate discrimination, advance equality of opportunity and foster good relations between people.
The duty applies to the public sector and also to others carrying out public functions. The duty applies to all nine areas of discrimination listed in the Equality Act 2010.

Key Points to Note

The report highlights the activities CHFT have been working on to address additional needs of patients and colleagues who identify under the nine protected characteristics.

EQIA – Equality Impact Assessment

All equality groups have been consulted on the Equality, Diversity and Inclusion approach we are taking in the Trust. Many colleagues have been involved in the activities delivered for patients and colleagues. We are raising awareness of difference, integrating difference and identifying barriers and removing them for patients and colleagues.

Recommendation

The Board is asked to approve the Public Sector Equality Duty Annual Report for 2019.

Public Sector Equality Duty
Annual Report
January to December 2019

CONTENTS

1 Introduction

This equality report for the period January to December 2019 provides assurance to the Board that Calderdale and Huddersfield NHS Foundation Trust (CHFT) continues to meet its responsibilities under the Equality Act 2010 and in particular that it meets the requirements of the Public Sector Equality Duty.

The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the general equality duty. The report also contains the Equality in our Workforce Report, at Appendix 1.

Our purpose is to provide outstanding Compassionate Care to the communities that we serve. We will do that by creating One culture of Care in our Workforce, ensuring that our values and behaviours (our 4 pillars) are embedded in everything we do.

Equality, diversity and inclusion activities and principles are fundamental to the Trust's work to improve the experience and health outcomes for everyone in its care.

This report highlights our approach and work to address any additional needs of those patients or colleagues who identify with a range of protected characteristics. Examples of what we have been doing at CHFT to address these needs are included in the report. The examples are, however, only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

NHS Employers defines Equality, Diversity and Inclusion in the following way:
"Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included."

By adopting this definition we can be clear with both patients and colleagues about what we mean by equality, diversity and inclusion and therefore develop a shared understanding of what we are trying to achieve.

2 The Legal and Compliance Framework

2.1 Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single, legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like CHFT to publish relevant information to demonstrate their compliance with the duty.

The Act applies to service users and Trust employees who identify with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the general equality duty published on our website by 30 March each year;

- Equality Objectives (which are specific and measurable) published for the first time by 5 April 2012, reviewed annually and re-published at least every four years.

2.2 Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Equality and diversity considerations are specifically addressed as part of its key line of enquiry around a Trust's responsiveness to patient needs. The CQC asks "Are services planned and delivered to meet the needs of people?" and "Do services take account of needs of different people, including those in vulnerable circumstances?"

The Trust was rated as 'Good' at the last inspection in April 2018.

3 Our progress in 2019

3.1 Embedding equality, diversity and inclusion

For the period 2016 to 2020 we identified four priority outcomes (from the 18 outcomes against which we are required to assess and grade ourselves under the EDS2) as follows:

1.2 Individual people's health needs are assessed and met in appropriate and effective ways.

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.

3.4 When at work, colleagues are free from abuse, harassment, bullying and violence from any source.

4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.

Some examples of what we have done in 2019 to achieve these outcomes are shown below (it should be noted that this is not an exhaustive list and these are only examples of the work going on around the Trust).

To support Executive Directors in the Trust objective of ensuring that Board papers identify equality-related impacts a training session was delivered by the Equality, Diversity and Inclusion Manager.

Disability – Physical
The upgrade of the public toilets in the main entrance on the HRI site during 2019 included the introduction of a semi-accessible toilet in the same area.

Disability – Hearing Impairment
We continue to closely monitor the quality of British Sign Language (BSL) provision from our local provider, Topp Language Solutions. Fulfilment rates are monitored by our Procurement team and the rates during 2019 have been consistently high. Topp meet regularly with the local deaf community to get the views of users on the service they provide.

Disability – Mental Health
One of the priorities in our Quality Account for 2019/20 was to improve psychological and social support for mental health patients in the Emergency Department (ED).

We set ourselves specific objectives to achieve this, and good progress has been made against these during 2019, as follows.

South West Yorkshire NHS Partnership Trust (our local Mental Health Trust) has helped us to identify any environmental risks within our EDs, and changes have been made where possible.

Ligature light rooms have now been created in the ED on both our hospital sites and we are introducing a clear standard operating procedure to ensure staff have access to the best guidance on how to appropriately support and manage patients requiring access to these rooms.

We have continued to work with the mental health liaison team to ensure timely review and care planning for mental health patients and the mental health liaison team remains a core member of the trust's Mental Health Strategy and Operations group.

Disability – Learning
The Matron for the service and the Falls Collaborative have jointly reviewed the national falls guidance published in August 2019 against current policy and process at CHFT. As a result it has been agreed that in future the Learning Disability policy will contain a section on falls.

The national guidance also recommends having accessible information for DEXA (bone density) scans in a variety of formats, offering appointments at quieter times, having a supporter present and having access to specialist equipment such as a hoist. Since the review the Matron has been working with the lead for the Radiology Department to put plans in place to comply with the guidance.

The Trust's Treat Me Well group met regularly throughout 2019, and the group has agreed its priorities for 2020, which are training for staff, quiet areas across the Trust and Changing Places toilets. (People with profound and multiple learning disabilities, as well people with other physical disabilities such as spinal injuries, muscular dystrophy and multiple sclerosis, often need extra equipment and space to allow them to use the toilet safely and comfortably. These needs are met by Changing Places toilets.)

As part of the reconfiguration of hospital services, a Changing Places toilet has been built into the plans for the Emergency Department at Calderdale Royal Hospital.

Supported by government funding, work also started in 2019 to identify potential locations at Huddersfield Royal Infirmary for a Changing Places toilet.

Age – Older
The Trust has for many years supported and promoted the nationally recognised Butterfly scheme for patients living with dementia. We re-launched the scheme in September 2019, at an event attended by dementia champions who promote the scheme in their clinical areas. The event was a great success and was attended by a carer who shared her experiences.

Following the event, the principles of the Butterfly scheme and relevant documentation were reinforced in key areas such as the EDs and assessment areas.

During 2019 our engagement support workers became further embedded on our wards, providing diversional and therapeutic care and activities for our dementia patients. The enhanced care and support team have also continued to provide increased 1:1 care for our most vulnerable patients during the acute period of their care.

The Memory café is open on Wednesday mornings and is situated within the therapy department at HRI. This provides a meeting place for dementia patients and carers to socialise and get involved in themed events outside the ward environment. This initiative has been very successful and there are now plans to extend the sessions to other days.

Dementia awareness training is currently offered as a 'one-off' e-learning package but a review of national guidance in 2019 identified that the training should be repeated every three years. A draft training strategy has now been developed which reflects this.

Age – Younger
In May 2019 CHFT became part of the first transition collaborative with NHS Improvement looking at supporting young people transitioning to adult services.

The first cohort of patients was selected from our neuro-disability clinics. The Ready, Steady, Go transition documentation was introduced and tested and feedback received from the young people involved, parents, professionals and GPs. We also produced two videos showing what it is like for a young person with a chronic illness to go through the transition process.

There have now been three cohorts in total, with very positive results and feedback from the young people involved.

In November 2019 the inaugural meeting of the Trust's Youth Forum took place. The forum was created to allow a diverse range of children and young people to access and influence our services.

The first meeting generated a wealth of feedback, not only about children's services, but also about Trust services overall. Further meetings are planned and it is hoped to expand the group further.

Race
During 2019 a task and finish group was established to undertake a comprehensive review of the Trust's interpreting policy to ensure we are meeting the needs of our patients whose first language is not English, and also patients needing BSL provision. The policy has been updated and is currently going through our equality impact assessment process.

The Trust is reviewing the demand profile of its BAME population with specific focus on Emergency Department attendances and elderly care. Data analysis shared with the Trust Board indicated that there are geographical hotspots that suggest current service models do not meet the needs of this population. Therefore further work has been commissioned, through the system wide Urgent & Emergency care programme, to explore further with this group and ensure new models are co-produced to better meet their needs.

Religion/Belief
During 2019 our chaplaincy has been working with medical teams at their audit meetings to discuss End of Life Care with particular regard to religious and cultural expectations. Called 'Thinking Aloud', the venture has been characterised by open and humble thinking.

The chaplaincy has also been working on an "End of Life Faith Card" which looks at the religious and cultural needs patients and their carers may have. The card will further enhance End of Life Care and will be introduced across the Trust in early 2020.

In November 2019 our chaplaincy joined with honorary chaplains and friends from the two Sikh Temples to celebrate Guru Nanak's 550th anniversary. This was done with prayer in both Hope Centres and a generous distribution of food in the main entrances.

Pregnancy/Maternity and Race
Better Births, the report of the National Maternity Review was published in February 2016 and set out a clear vision: for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centered on their individual needs and circumstances.

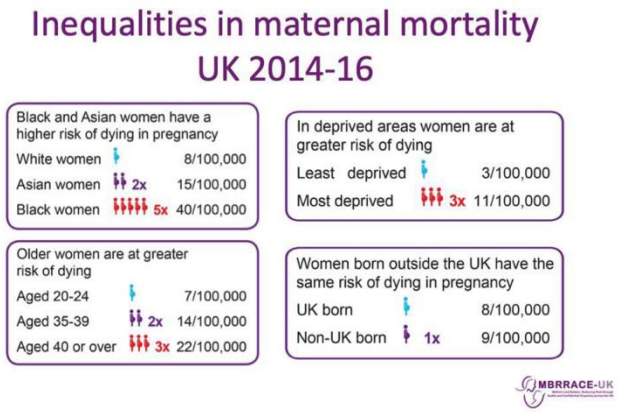
There are seven Better Birth workstreams, one of which is the continuity of carer workstream, which aims to support improving outcomes for all women and babies.

Trusts have the following targets to achieve:

- 35% of pregnant women will be on a continuity of carer model by March 2020
- Most women (51%) will receive continuity of carer by 2021

- By 2024, 75% of women from Black/Black British and Asian/Asian British communities and women from the most deprived areas will receive continuity of carer from their midwife throughout pregnancy, labour and the postnatal period.

It is well known that pregnant women from BAME communities have worse outcomes in pregnancy.



Although the target is for 75% of women from BAME communities to receive continuity of carer by 2024, at CHFT work started during 2019 to plan and implement continuity of carer teams for BAME women. There will be teams of up to eight midwives, with each woman having a named midwife and being cared for in labour by a midwife known to her. This is likely to have a significant impact on overall outcomes and reduce health inequalities.

3.2 EDS2 (Equality Delivery System 2)

CHFT supports EDS2, a framework that helps the Trust, in discussion with local partners including local people, review and improve performance for people with protected characteristics. During 2019 we have collaborated with CCGs and Trusts in the local area to deliver an engaging, interactive and informative event discussing initiatives such as Project Search, Youth Forum, End of Life Care for different cultures and Learning Disability transition of care.

3.3 Engagement Activities

As a Foundation Trust, CHFT has a Council of Governors, which is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change.

The Trust has a large public membership which is compared with its local population to ensure that it is representative of the diverse communities that we serve. The data (see Appendix 2) shows that we continue to have under representation in three different sectors of our communities, namely younger people, males and those with an ethnic group of Asian/Asian British. These groups will be given special focus during recruitment activities in 2020.

The Trust continues to focus on efforts to engage with as wide a range of service users and stakeholders as possible. In 2019 the Trust's Membership and Engagement Strategy for the three year period 2020-2023 was reviewed and a number of priorities were identified for the next 12 months. These were:

We will analyse our membership on a regular basis, and have targeted campaigns to recruit members from any group that is under-represented	We will actively promote membership and raise the profile of our governors and the Council of Governors in a variety of settings and forums	We will have a Patient Panel through which members and members of the public can feed back on service changes and forward plans
Within our public membership body we will have a youth membership constituency	Our governors will have opportunities, and the necessary skills, to actively seek out the views of members and the public on material issues or changes being discussed at the Trust	
We will have established links with local organisations through whom we can recruit members		

The full strategy is attached at Appendix 3.

4 Strengthening Equality, Diversity and Inclusion – Workforce

4.1 Why Equality, Diversity and Inclusion is important to us

The UK's population is changing, and so is its workforce. Nationally and locally we have far more cultures and we are living much longer than previously.

In addition, the rise of social media and higher customer expectations mean that patients and colleagues expect more involvement in the decisions that affect them and require more information in formats that suit them quicker than ever before.

The Trust's vision is to provide compassionate care to the populations of Calderdale and Kirklees. To do this, we need to adopt one culture of care, where we care for each other in the same way that we care for our patients. We need to understand the different needs of those changing populations, and our workforce and what compassionate care looks like to them. By understanding our patients' and colleagues' different needs, we can adapt our environment and services to better suit them.

Our intent in respect of our focus on Equality, Diversity & Inclusion is that will have happy, productive, motivated people where colleagues can be themselves and we will provide a supportive environment to enable them to succeed in their aspirations.

Not only will this have a positive impact on us and our colleagues, but on our patients too. Truly compassionate care involves understanding the particular needs of each individual patient. Having a whole range of different people working at CHFT means a whole range of ideas and solutions that in the end, deliver truly inclusive and compassionate care.

Our vision for our workforce is that there will be a more diverse range of people with the right skills working at CHFT and that they are able to develop to their full potential. We will see an increase in both the diversity of our 'talent pipeline' and of our senior managers and more disabled people will be attracted and retained with comprehensive workplace adjustments and a supportive culture.

4.2 The benefits of Equality, Diversity and Inclusion

A diverse and inclusive work environment can help our organisation better understand and meet different patient expectations and improve their experience. We will also be able to attract and retain a whole range of people from different walks of life, with different experiences.

We aim to create an inclusive culture where all employees feel engaged, valued and included.

Our vision is that CHFT provides a healthy, inclusive and compassionate environment for colleagues who feel supported by their line managers. There will also be greater accountability and engagement from senior managers in the equality, diversity and inclusion (EDI) agenda, taking ownership of the issues affecting different diverse groups of staff.

We aim to have an organisation where all employees value an inclusive culture, feel comfortable to be themselves where we value one another and celebrate 'One Culture of Care'.

This plan embraces our values and vision, and explains what we are working towards, our goals, commitments and activities, as well as mechanisms and timescales for reporting our progress.

It involves big and small change. But the biggest change of all is the culture change that requires leadership and accountability from everyone in the Trust.

Our approach will be to focus on getting the basics right, have good quality conversations with the right people at the right time, encouraging curiosity and challenge whilst making improvements for colleagues, patients and stakeholders. At CHFT equality, diversity and inclusion is really important to us. We've developed a 5 year plan to embed equality, diversity and inclusion into everything we do in our Trust:

- We will have a workforce that champions and celebrates our diverse communities. Our board and senior clinical and non clinical teams will be fully inclusive

- We will support current and future colleagues and enable them to make the most of their skills and talents
- We will engage a whole range of colleagues to create an inclusive culture where all staff feel engaged and valued
- We will engage and work with our partner organisations to share best practice, learn from one another, build relationships and work together for the benefit of colleagues and the communities we serve

How we will collaborate with staff and patients on our plans
In line with our principles, we will develop consistent communications with both patients and staff to identify progress against current actions and identify any new actions that arise as part of their feedback. A BAME network already exists as does a patient forum. A key action identified in this strategy is to ensure that we treat each protected characteristic as important as the next and that we collaborate with staff and patients to continuously improve. We will therefore explore ways to create opportunities to work with staff and patients from each characteristic to identify ways to improve.

As a Trust our aim is to engage colleagues in a whole range of Diversity & Inclusion activities in order to bring our staff together, learn from one another and enhance levels of awareness around all types of difference - this year we have taken part in a Candy Dance challenge, we have implemented LGBTQ pledge where colleagues sign up to wear a visible symbol of support for LGBT patients, colleagues, friends and family, we have attended local Pride events at Hebden Bridge and Halifax, we launched our Colleague Disability Action Group - engaging colleagues in identifying barriers and providing recommendations for change, our BAME forum goes from strength to strength with the Mayor of Huddersfield attending one of the sessions, we launched our Inclusion Facebook page 'CHuFT about Inclusion' and we held a number of activities during National Inclusion Week ranging from 'Let's Talk about Race', Introduction to Sign Language and Transgender Awareness workshops.

4.3 Equality and Diversity Training

CHFT is committed to ensuring that it provides a high quality service for all of its patients and is an employer of choice in the local area. It also has a legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between protected groups.

Our Equality, Diversity and Inclusion (ED&I) education approach aims to raise awareness of equality and inclusion via peer to peer communications and support.

We will consider ways to expand knowledge and awareness of unconscious bias among all employees and provide practical advice on how colleagues can supportively challenge one another.

We aim to reduce the stigma associated with mental health by promoting mental and physical wellbeing among all our employees.

We will employ leaders who enable employees with health problems and disabilities to live and work as productively as they can.

Our vision is that our employees will feel supported to realise their full potential.

Equality and diversity training is mandatory for all employees. Compliance rates are monitored by Executive Board as part of the Weekly Essential Safety Training paper. Colleagues are required to repeat their equality and diversity training every three years and essential safety training compliance is closely monitored at a divisional level by HR Business Partner colleagues.

4.4 Equality, Diversity & Inclusion Activity

BAME Network – our BAME network goes from strength to strength with over 100 colleagues becoming a member of the group. This forum enables colleagues to network with others, take part in reverse mentoring and promote development opportunities. Our CEO attends every network session.

Project Search – CHFT works with Calderdale Council and Calderdale College to provide real-life work experience combined with training in employability and independent-living skills to help young people with learning disabilities and autism spectrum conditions make successful transitions to productive adult life. The Project SEARCH model involves an extensive period of skills training and career exploration, innovative adaptations, long-term job coaching, and continuous feedback from instructors, job coaches and employers. As a result, at the completion of the training programme, students with significant learning disabilities are employed in non-traditional, complex and rewarding jobs. In addition, the presence of a Project SEARCH programme can bring about long-term changes in business culture that have far-reaching positive effects on attitudes about recruiting people with disabilities and the range of jobs in which they can be successful.

LGBTQ Pledge - The purpose of the pledge is to make a positive difference by promoting a message of inclusion. Many LGBT+ people say that they do not have anyone they can turn to or confide in. As advocates, people who work in healthcare can play a key role in making things better. Therefore we have developed the LGBTQ pledge where colleagues pledge to wear a rainbow lanyard, a positive visible symbol where colleagues can show that CHFT offers open, non-judgemental and inclusive care for people and their families, who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means that we are inclusive of all identities, regardless of how people define themselves.) By choosing to wear this lanyard, we are sending a message that “you can talk to me” about issues of gender and sexuality. Wearing the lanyard does not mean we will have all the answers but most importantly we are prepared to listen and signpost to relevant information. 450 colleagues have signed the LGBTQ pledge.

Colleague Disability Action Group – our national staff survey results highlighted that colleagues with a disability are less engaged than others so we have developed a Colleague Disability Action Group to enable the Trust to identify issues that disadvantage disabled colleagues and take positive action to create equitable change.

Working Carers Passport – A Carer Passport provides a way for you to explain to your manager about your situation so they understand the flexibility you need. Then if you change manager or team, the Carer Passport provides a straightforward way to carry that flexibility and support into your next role, without having to repeat the same conversations. A Carer Passport is a discussion about flexibility. This conversation will generally involve balancing the needs of the individual with the needs of the business. It does not normally involve a formal change to your contract of employment.

Inclusion Representatives – CHFT have engaged a number of volunteers this year who promote all things inclusion. They go above and beyond their role to promote awareness of Equality, Diversity & Inclusion. We believe peer to peer conversations and engagement is a really powerful way to educate one another and work better together

Candy Dance – this year CHFT colleagues took on the Candy Dance challenge. Over 50 colleagues of all different walks of life came together, danced together and promoted how when we work together, we can get results, have fun and learn from one another.

5 Conclusions/Looking ahead to 2020

The Trust continues to strive to help colleagues feel confident and competent when caring for or dealing with people with any of the protected characteristics, and to ensure that equality and diversity considerations are an everyday, intrinsic part of being a valued Trust colleague and of delivering excellent, compassionate care.

In 2020 the Trust will focus on its revised Membership and Engagement strategy, which will generate more engagement with hard to reach/under-represented groups.

In order to continue to improve in terms of patient-facing E&D there are plans to identify a nurse lead during 2020.

6 Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats, eg large print, braille, languages other than English, please contact our Membership and Engagement Manager on 01484 347342 or e-mail equalityanddiversity@cht.nhs.uk

APPENDIX 1

EQUALITY IN OUR WORKFORCE REPORT

1. Introduction

Equality and diversity related to the workforce is led by the Director of Workforce and Organisational Development. This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 31 December 2019. In accordance with the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

The Trust published its Workforce Race Equality Standard (WRES) in September 2019. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES became operational from 1 April 2015. The standard has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BAME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust also published its Workforce Disability Equality Standard (WDES) in September 2019. Again, the WDES is a national equality standard for employment against which all NHS organisations are assessed.

2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 31 December 2019 against the same date in the previous four financial years.

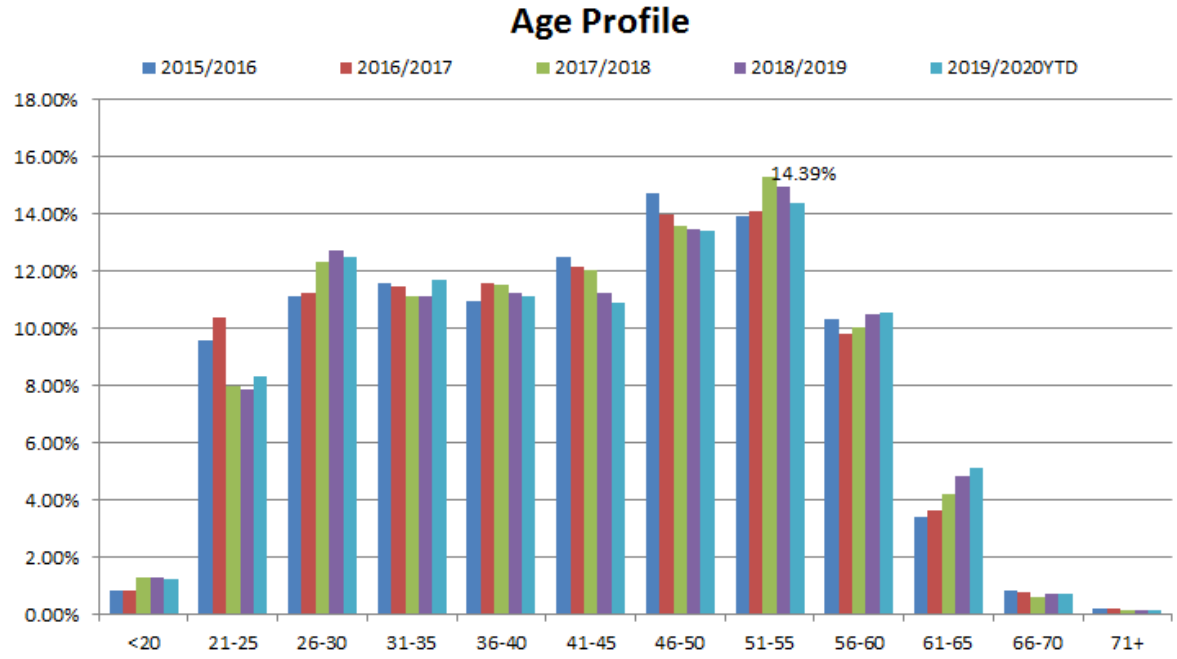
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

We have analysed the Trust's workforce information from the last four years using key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

- Age
- Disability
- Ethnicity
- Gender
- Religious Belief
- Sexual Orientation

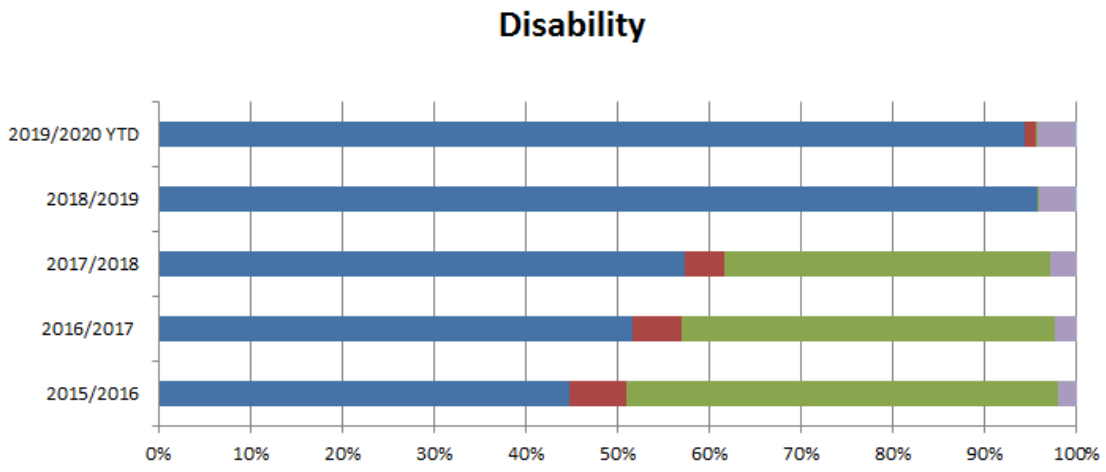
Age Profile

The highest proportion of Trust employees (14.39%) are in the age bracket 51-55.



Disability

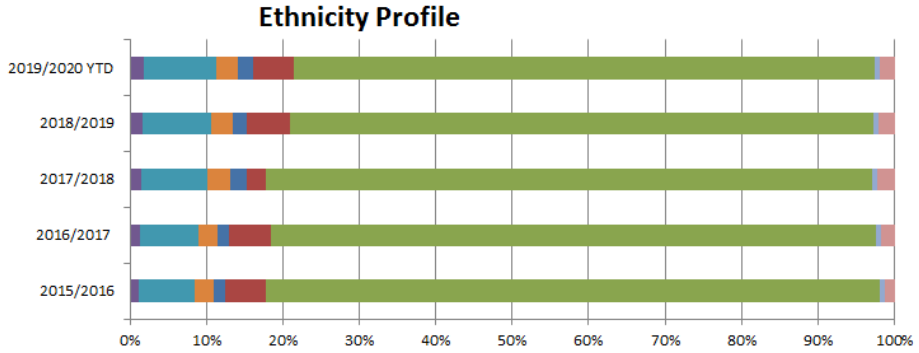
Information on the profile of the Trust's workforce in terms of disability is not sufficiently clear in order to provide a valid analysis of the data. Data quality has improved over the last 5 years, with a significant data quality exercise taking place in 2018; however detail level data on type of disability is currently not available. These are reviewed on an on-going basis and continuous improvements made.



	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020 YTD
No	44.80%	51.70%	57.30%	95.80%	94.35%
Not Declared	6.10%	5.30%	4.44%	0.03%	1.28%
Unknown	47.10%	40.70%	35.52%	0.07%	0.21%
Yes	2.00%	2.30%	2.80%	4.06%	4.12%
Prefer not to say	0.00%	0.00%	0.00%	0.05%	0.05%

Ethnicity

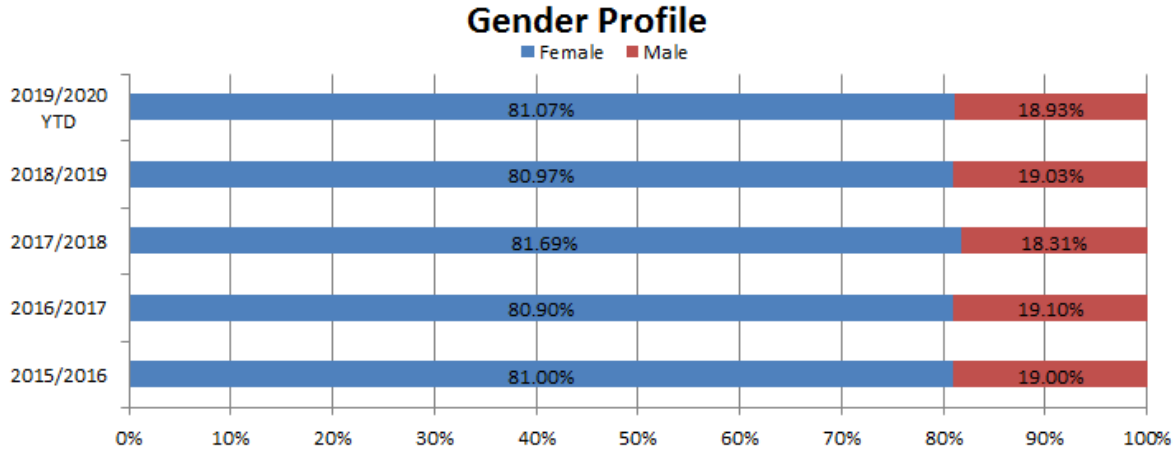
The ethnicity profile of the Trust has not shown much change over the last 4 years, the largest profile remain white British (76.01%)



	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020 YTD
Any other ethnic group (including Chinese)	1.10%	1.30%	1.54%	1.61%	1.79%
Asian and Asian British	7.30%	7.60%	8.65%	9.08%	9.45%
Black and Black British	2.50%	2.50%	3.00%	2.78%	2.86%
Mixed Race (dual heritage)	1.50%	1.60%	2.06%	1.89%	1.97%
Not Known	5.40%	5.50%	2.57%	5.52%	5.38%
White - British	80.10%	79.00%	79.20%	76.32%	76.01%
White - Irish	0.70%	0.70%	0.75%	0.69%	0.65%
White (not British or Irish - includes White unspecified)	1.20%	1.80%	2.23%	2.12%	1.89%

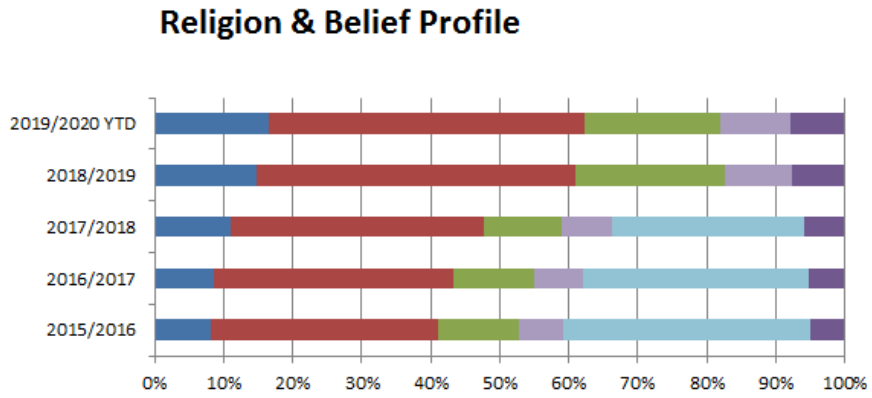
Gender

The gender split in the Trust has not shown much change over the reporting period, with the proportion of men significantly lower than the national workforce average. However, the health and social care sector traditionally employs more women than men.



Religion & Belief

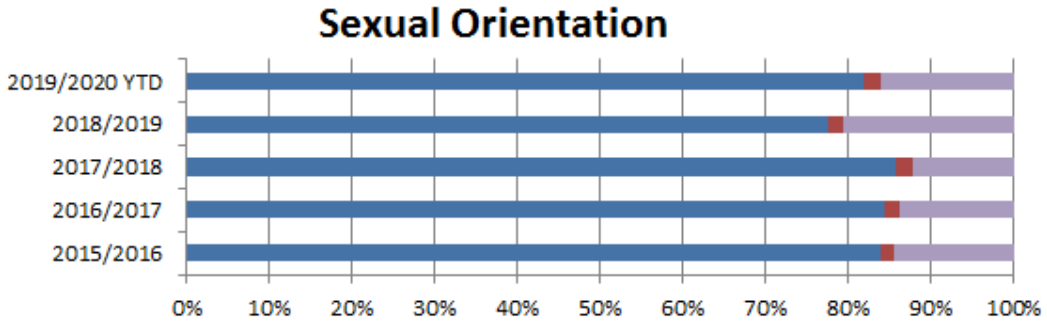
Data quality has continued to improve; however there is still 20% of the workforce where information around religious belief has been chosen to remain undisclosed.



	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020 YTD
Atheism	8%	9%	11%	15%	16%
Christianity	33%	35%	37%	46%	46%
I do not wish to disclose my religion/belief	12%	12%	11%	22%	20%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	6%	7%	7%	10%	10%
Not Known	36%	33%	28%	0%	0%
Other	5%	5%	6%	8%	8%

Sexual Orientation

Data quality on Sexual Orientation of the colleagues in the Trust has fallen compared to the previous 18/19 Ytd figure, (27.3%), and there is approximately 34% of the workforce where information around sexual orientation is unknown.



	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020 YTD
Heterosexual	53.69%	56.86%	61.69%	77.51%	64.04%
Lesbian, Gay or Bisexual	0.98%	1.16%	1.51%	1.88%	1.61%
Undecided	0.00%	0.00%	0.00%	0.04%	0.03%
I do not wish to disclose	9.32%	9.38%	8.81%	20.55%	12.55%
Undecided	0.00%	0.00%	0.00%	0.04%	0.03%

3. Staff joining the Trust

This section shows demographic data for the recruitment of staff and has been broken down using equality and diversity indicators. All information in this section is sourced from Trac, an online recruitment tool used by Calderdale and Huddersfield NHS Foundation Trust.

The charts below reflect all recruitment activity for the period 1 January 2019 to 31 December 2019, and provide a breakdown (%) of applicants, applicants shortlisted and applicants recruited.

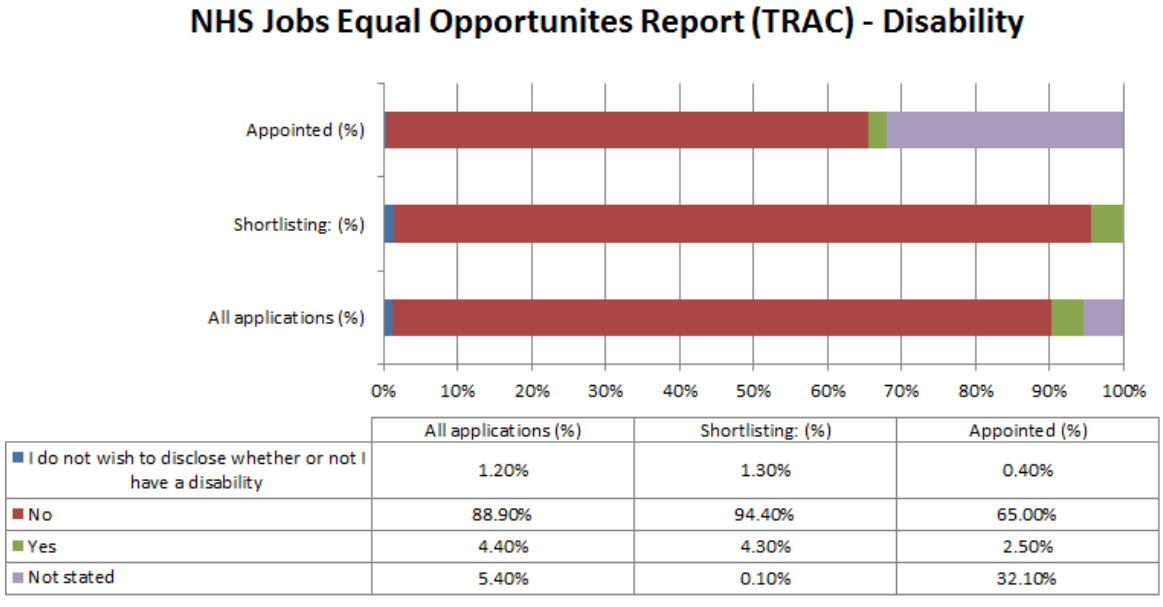
Age Profile

The majority of applications come from the 20-24 and 25-29 age groups. This is also the case with those shortlisted and appointed.

Age Group	Applications	%	Shortlisted	%	Appointed	%
Under 20	508	3.60%	294	3.40%	61	4.40%
20 - 24	2742	19.60%	1756	20.30%	280	20.10%
25 - 29	3223	23.00%	2033	23.50%	338	24.30%
30 - 34	2350	16.80%	1528	17.70%	220	15.80%
35 - 39	1455	10.40%	877	10.10%	147	10.60%
40 - 44	1052	7.50%	629	7.30%	94	6.80%
45 - 49	983	7.00%	541	6.30%	84	6.00%
50 - 54	923	6.60%	541	6.30%	77	5.50%
55 - 59	506	3.60%	284	3.30%	50	3.60%
60 - 64	227	1.60%	131	1.50%	33	2.40%
65+	47	0.30%	25	0.30%	7	0.50%

Disability

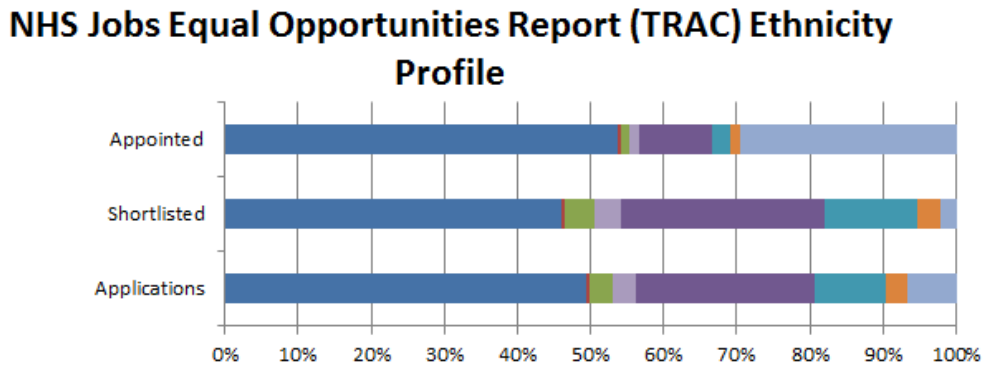
4.40% of the 14024 applicants, 4.30% of the 8643 shortlisted and 2.50% of the 1391 appointed declared as disabled.



	All applications (%)	Shortlisting: (%)	Appointed (%)
I do not wish to disclose whether or not I have a disability	1.20%	1.30%	0.40%
No	88.90%	94.40%	65.00%
Yes	4.40%	4.30%	2.50%
Not stated	5.40%	0.10%	32.10%

Ethnicity

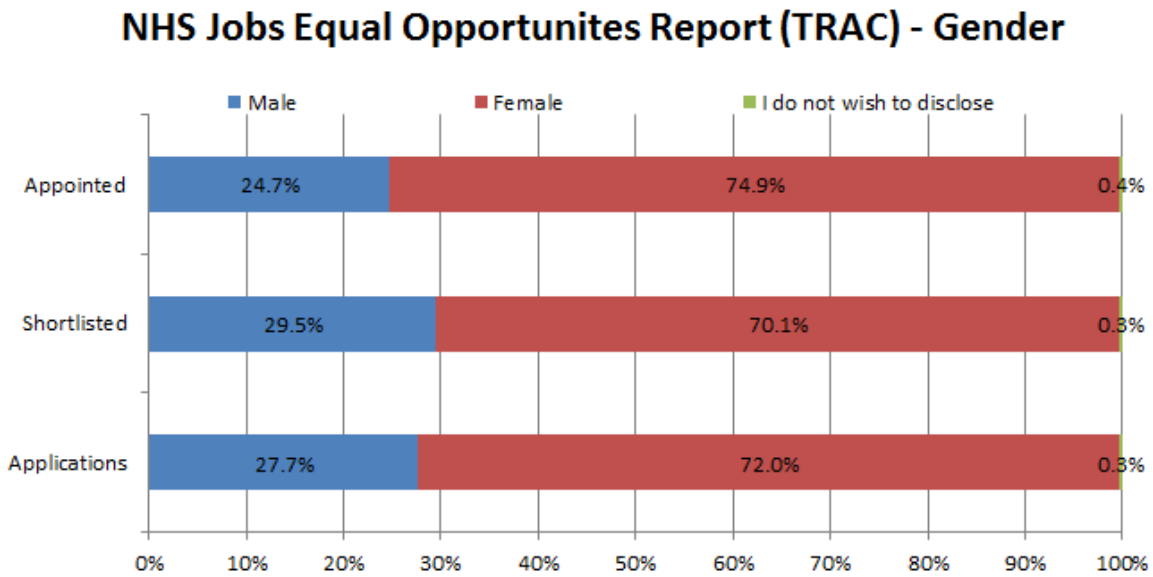
Over 45% of all applications, applicants shortlisted and applicants recruited identify as ‘White – British’. 24.4% of applicants recruited identify as ‘Asian & Asian British’ but the number actually recruited drops to 9.8%



	Applications	Shortlisted	Appointed
WHITE - British	49.4%	46.0%	53.6%
WHITE - Irish	0.4%	0.4%	0.4%
WHITE - Any other white background	3.3%	4.0%	1.3%
Mixed Race	3.1%	3.7%	1.4%
Asian & Asian British	24.4%	28.0%	9.8%
Black & Black British	9.8%	12.6%	2.5%
Any other group (Including Chinese)	2.9%	3.3%	1.4%
Undisclosed	6.7%	2.1%	29.5%

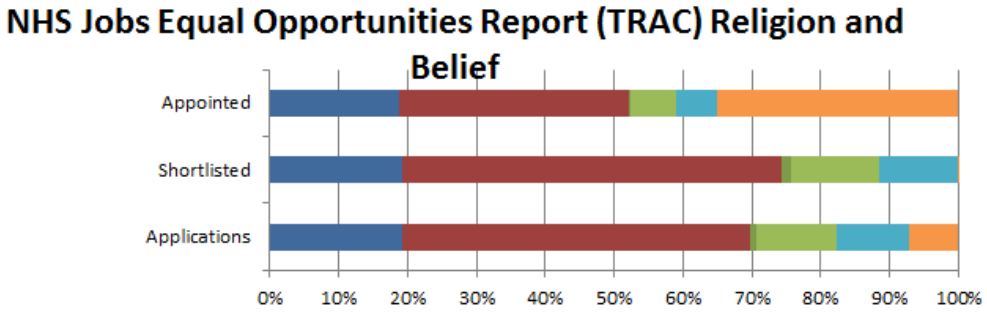
Gender

The majority of applications, applicants shortlisted and applicants recruited are female.



Religion & Belief

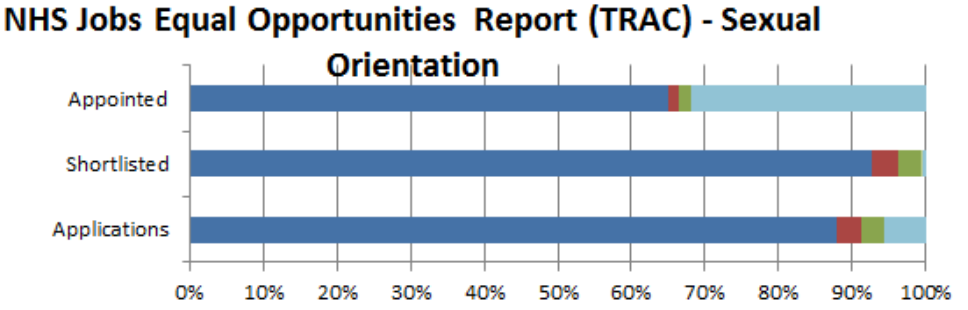
Over 30% of all applicants, applicants shortlisted and applicants recruited identify as Christian.



	Applications	Shortlisted	Appointed
Atheism	14.62%	13.85%	16.97%
Christianity	38.01%	39.60%	30.27%
Buddhism	0.86%	0.91%	0.36%
Other	8.75%	9.20%	5.90%
I do not wish to disclose my religion/belief	7.99%	8.32%	5.46%
Not stated	5.37%	0.06%	31.78%

Sexual Orientation

The majority of applications, applicants shortlisted and applicants recruited identify as heterosexual.



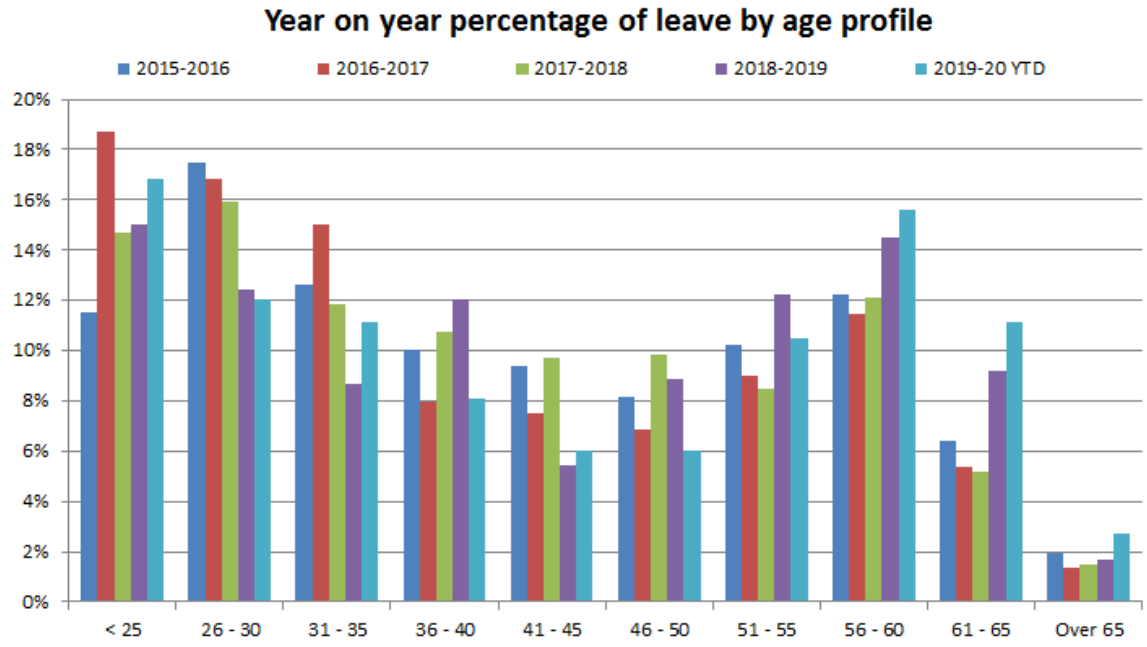
	Applications	Shortlisted	Appointed
Heterosexual or Straight	88.02%	92.70%	64.99%
Lesbian, Gay or Bisexual	3.29%	3.54%	1.58%
I do not wish to describe my sexual orientation.	2.98%	3.22%	1.58%
Other sexual orientation not listed	0.12%	0.16%	0.07%
Undisclosed	5.59%	0.38%	31.78%

4. Staff leaving the Trust

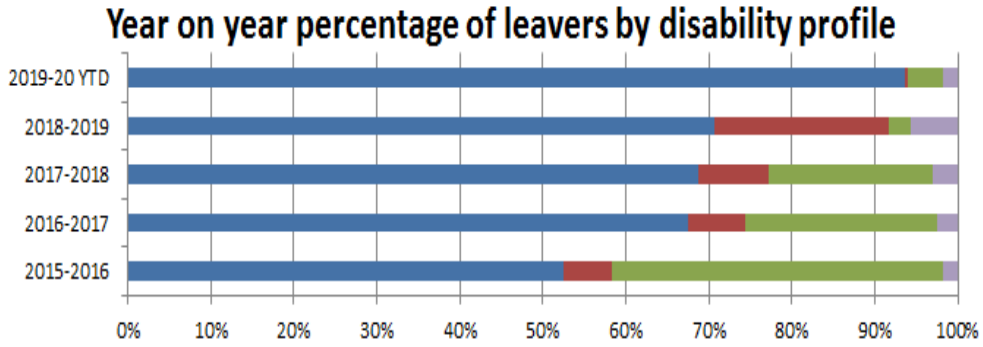
This section shows data regarding staff that left the Trust between 1 April 2015 and 31 December 2019; broken down using the equality and diversity indicators.

Age Profile

During the current year to date, turnover is highest amongst staff aged under 25 age group (16.8%) closely followed by the 56-60 age group (15.6%).

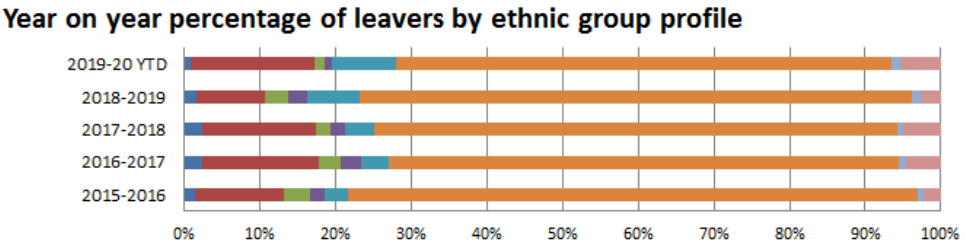


Disability



	2015-2016	2016-2017	2017-2018	2018-2019	2019-20 YTD
No	52.44%	67.38%	68.79%	70.68%	93.69%
Not Known	5.86%	6.84%	8.33%	21.05%	0.30%
Yes	39.84%	23.09%	19.85%	2.63%	4.20%
Not Declared	1.86%	2.58%	3.03%	5.64%	1.80%

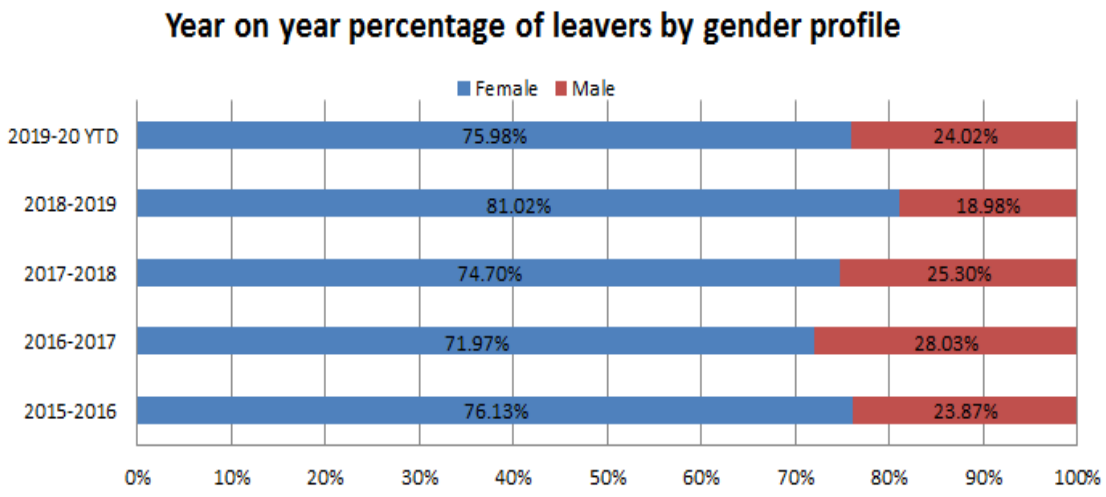
Ethnicity



	2015-2016	2016-2017	2017-2018	2018-2019	2019-20 YTD
Any other ethnic group (including Chinese)	1.33%	2.35%	2.27%	1.50%	0.90%
Asian and Asian British	11.89%	15.47%	15.15%	9.21%	16.22%
Black and Black British	3.37%	2.91%	1.97%	3.01%	1.50%
Mixed race (dual heritage)	1.86%	2.58%	1.82%	2.44%	0.90%
Not Known	3.19%	3.70%	3.79%	6.95%	8.41%
White - British	75.24%	67.49%	69.24%	73.12%	65.47%
White - Irish	0.89%	0.90%	0.76%	1.13%	1.50%
White (not British or Irish - includes White unspecified)	2.22%	4.60%	5.00%	2.63%	5.11%

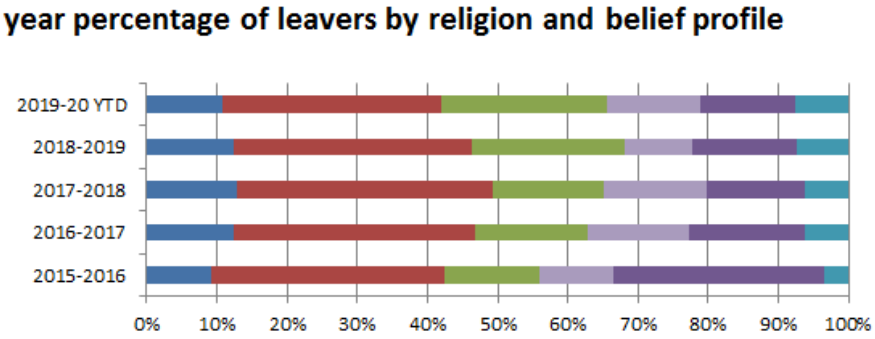
Gender

75.9% of turnover is female employees, however with the Trust employing a significantly higher amount of female employees to male this is expected.



Religion & Belief

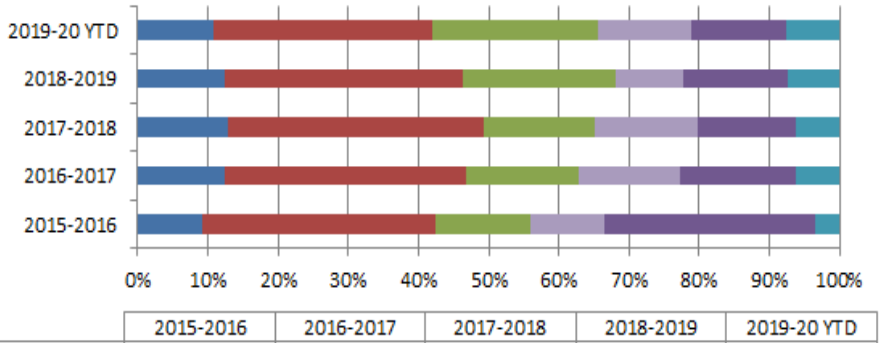
As with 2018-19, the majority of leavers in 2019-20 are Christians (31.2%),



	2015-2016	2016-2017	2017-2018	2018-2019	2019-20 YTD
Atheism	9.14%	12.33%	12.88%	12.41%	10.81%
Christianity	33.36%	34.42%	36.36%	34.02%	31.23%
I do not wish to disclose my religion/belief	13.40%	16.14%	15.91%	21.62%	23.42%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	10.56%	14.46%	14.55%	9.77%	13.51%
Not Known	29.99%	16.48%	14.09%	14.85%	13.51%
Other	3.55%	6.17%	6.21%	7.33%	7.51%

Sexual Orientation

The majority of leavers in 2019-20 are Heterosexual. (62%) The percentage of Leaver with 'Not Known' sexual orientation has decreased from 15% to 13.5%.



	2015-2016	2016-2017	2017-2018	2018-2019	2019-20 YTD
Atheism	9.14%	12.33%	12.88%	12.41%	10.81%
Christianity	33.36%	34.42%	36.36%	34.02%	31.23%
I do not wish to disclose my religion/belief	13.40%	16.14%	15.91%	21.62%	23.42%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	10.56%	14.46%	14.55%	9.77%	13.51%
Not Known	29.99%	16.48%	14.09%	14.85%	13.51%
Other	3.55%	6.17%	6.21%	7.33%	7.51%

5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust employees as at 31 December 2019. This section looks at the organisation pay and measures this against the key equality and workforce indicators.

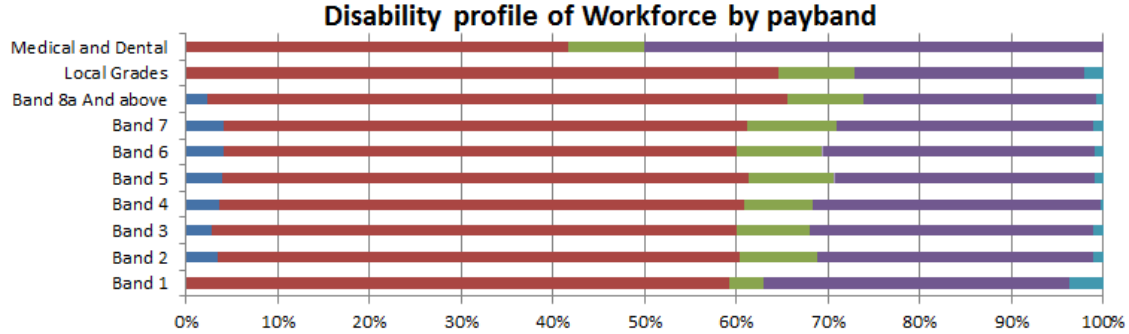
Age Profile

The most common pay band in the Trust is Agenda for Change band 2 with 23% of colleagues in this band. Within band 2 15% of people are in the age bands 51-55 and 56-60 years old.

Age Band	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Other	Medical and Dental
<25	7.41%	10.70%	14.15%	3.70%	14.06%	3.88%	1.50%	0.00%	48.82%	8.09%
26 - 30	0.00%	10.63%	10.52%	9.52%	16.18%	13.48%	8.14%	1.89%	9.45%	19.90%
31 - 35	3.70%	9.51%	9.94%	7.94%	12.59%	15.83%	11.35%	10.23%	11.81%	13.27%
36 - 40	3.70%	8.80%	8.99%	8.20%	10.83%	14.81%	12.21%	17.05%	2.36%	13.75%
41 - 45	11.11%	6.97%	11.09%	11.64%	11.57%	11.34%	14.35%	15.91%	5.51%	13.43%
46 - 50	11.11%	11.62%	13.77%	18.25%	10.69%	14.61%	17.99%	20.45%	7.09%	13.11%
51 - 55	22.22%	15.00%	12.43%	20.90%	10.32%	15.32%	20.34%	26.52%	7.09%	9.22%
56 - 60	22.22%	15.00%	12.24%	14.81%	9.30%	7.76%	10.71%	5.68%	6.30%	5.34%
61 - 65	11.11%	10.35%	6.12%	3.97%	3.95%	2.66%	2.36%	1.89%	0.79%	2.91%
Over 65	7.41%	1.41%	0.76%	1.06%	0.51%	0.31%	1.07%	0.38%	0.79%	0.97%

Disability

Information on the profile of the Trust's workforce in terms of disability has improved over the last 5 years and from work completed for the WDES submission, however there is still 29% of the workforce where information around disability is unknown and colleagues continue "Not specify" their status. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Yes	0.00%	3.45%	2.87%	3.70%	3.95%	4.09%	4.07%	2.27%	0.00%	0.00%
No	59.26%	56.90%	57.17%	57.14%	57.39%	55.98%	57.17%	63.26%	64.58%	41.67%
Not Declared	3.70%	8.45%	8.03%	7.41%	9.30%	9.30%	9.64%	8.33%	8.33%	8.33%
Prefer Not To Answer	0.00%	0.07%	0.00%	0.00%	0.15%	0.10%	0.00%	0.00%	0.00%	0.00%
Unspecified	33.33%	29.93%	30.78%	31.48%	28.26%	29.62%	28.05%	25.38%	25.00%	50.00%
Not Known	3.70%	1.20%	1.15%	0.26%	0.95%	0.92%	1.07%	0.76%	2.08%	0.00%

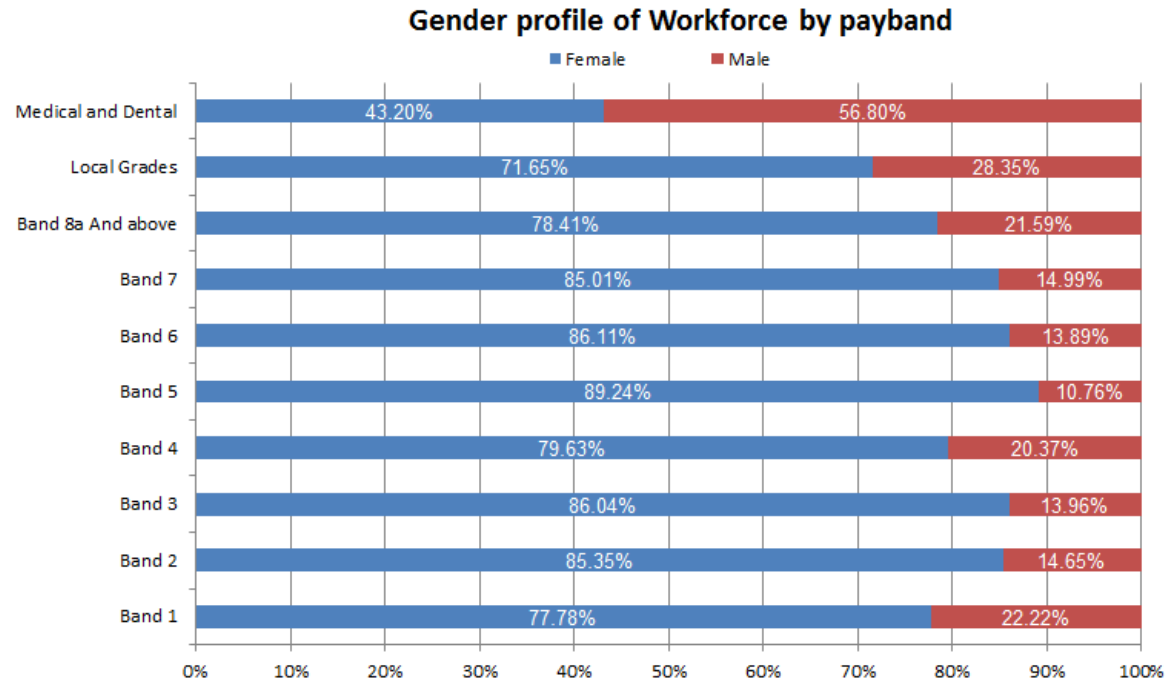
Ethnicity

Over all the Agenda for Change pay scales, the majority of colleagues were White British. Medical and Dental have a more even split between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

Ethnicity	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
White - British	0.00%	0.92%	0.19%	0.53%	2.34%	1.12%	0.43%	0.38%	0.00%	7.61%
White - Irish	3.70%	6.06%	6.12%	3.70%	10.32%	5.62%	4.50%	2.65%	7.09%	35.11%
White (not British or Irish - includes White unspecified)	14.81%	4.15%	1.53%	2.65%	3.37%	1.33%	1.71%	0.38%	1.57%	4.37%
Asian and Asian British	0.00%	2.39%	2.10%	2.12%	1.54%	1.23%	1.71%	1.89%	3.94%	3.07%
Black and Black British	18.52%	8.80%	5.54%	4.50%	3.88%	2.76%	2.57%	1.52%	19.69%	5.18%
Mixed race (dual heritage)	55.56%	75.07%	82.60%	84.92%	75.55%	86.01%	88.44%	92.05%	66.14%	39.16%
Any other ethnic group (including Chinese)	7.41%	1.76%	1.34%	1.06%	2.20%	1.02%	0.43%	0.76%	0.79%	5.50%
Not Known	0.00%	0.85%	0.57%	0.53%	0.81%	0.92%	0.21%	0.38%	0.79%	0.00%

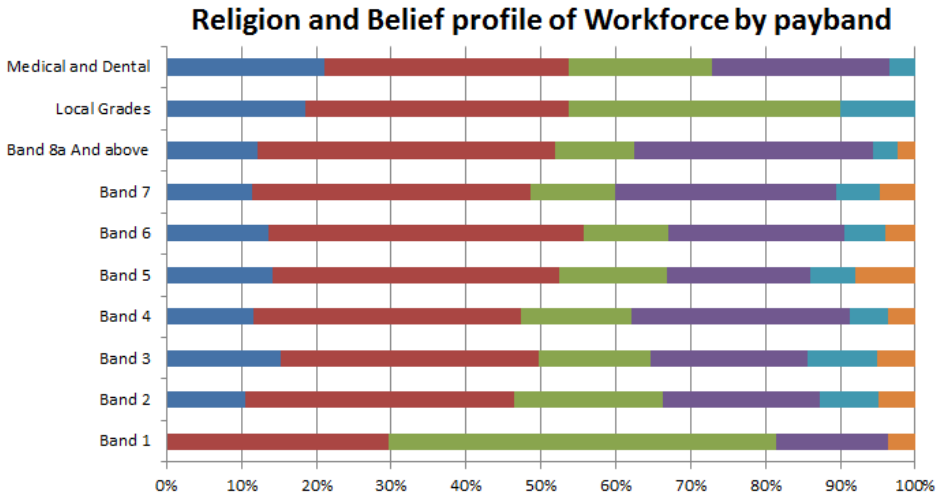
Gender

Men are over-represented in the Medical and Dental pay band (56.8%) compared with the workforce profile as a whole, where the majority of colleagues are female (81.07%)



Religion & Belief

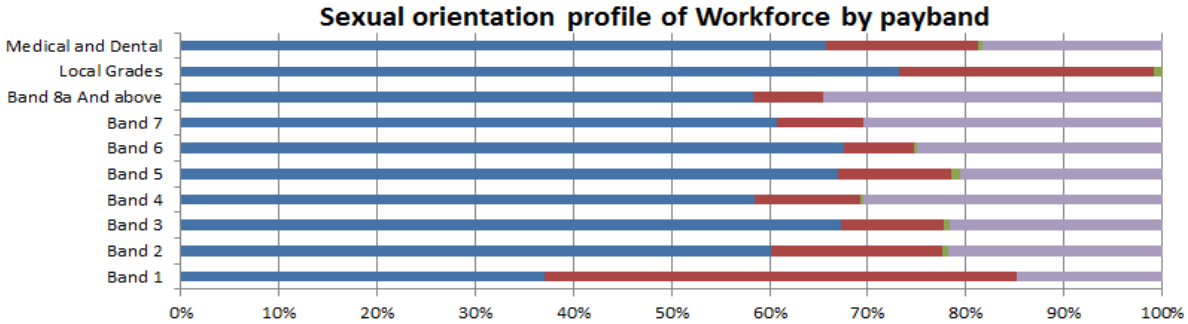
Progress is been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	0.00%	10.07%	14.55%	11.22%	13.14%	13.06%	10.84%	11.85%	16.30%	10.74%
Christianity	29.63%	34.12%	32.73%	34.44%	35.37%	40.57%	35.58%	38.89%	31.11%	16.61%
I do not wish to disclose my religion/belief	51.85%	19.07%	14.18%	14.29%	13.28%	10.90%	10.84%	10.37%	31.85%	9.77%
Not Known	14.81%	19.88%	20.00%	28.06%	17.75%	22.59%	28.22%	31.11%	0.00%	12.09%
Other	0.00%	7.59%	8.73%	4.85%	5.56%	5.21%	5.52%	3.33%	8.89%	1.71%
Non Christian religion (Buddisnm, Hinduism, Islam, Judaism, Sikhism)	3.70%	4.63%	4.91%	3.57%	7.45%	3.83%	4.50%	2.22%	0.00%	0.00%

Sexual Orientation

"Heterosexual" is the predominant selection across all pay bands. There is still a relatively high proportion of each pay band who do not which to disclose their sexual orientation (the most significant being in Band 1 (37.04%) and also where the information is "Not Known" with all bands from 1 to 8a and above having at least 14% with this criteria



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Heterosexual	37.04%	60.21%	67.30%	58.47%	66.98%	67.52%	60.81%	58.33%	73.23%	65.70%
I do not wish to disclose my sexual orientation	48.15%	17.46%	10.52%	10.85%	11.57%	7.15%	8.78%	7.20%	25.98%	15.53%
Lesbian, Gay or Bisexual	0.00%	0.56%	0.57%	0.26%	0.81%	0.41%	0.00%	0.00%	0.79%	0.49%
Not Known	14.81%	21.76%	21.61%	30.42%	20.64%	24.92%	30.41%	34.47%	0.00%	18.28%

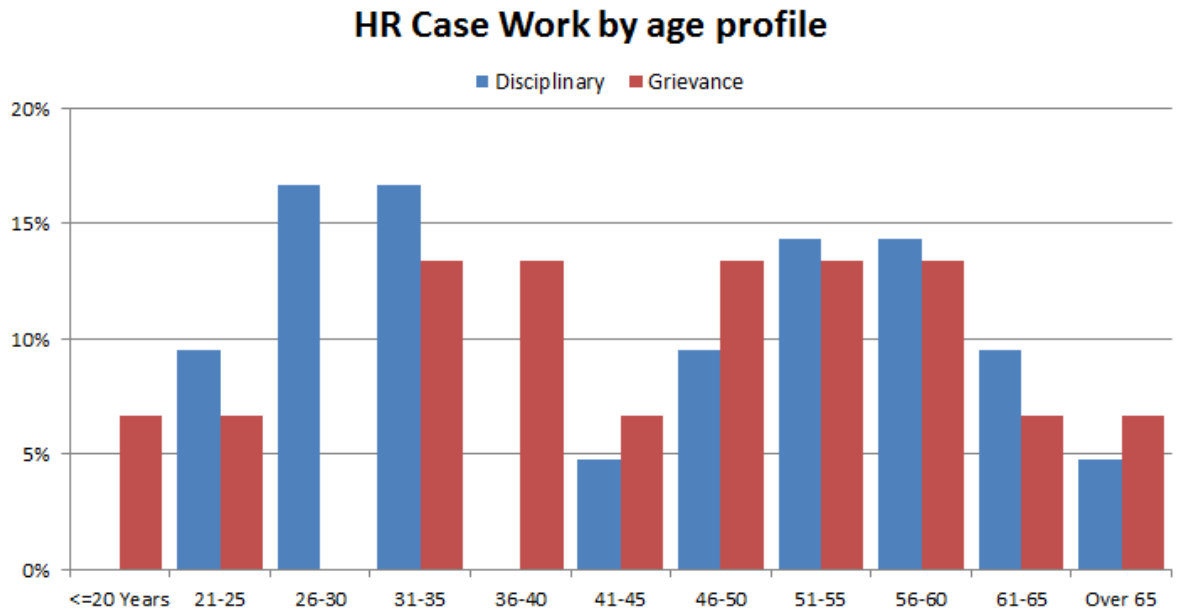
6. Disciplinary, grievance and bullying and harassment

Overall, between January 2019 and December 2019 there were:

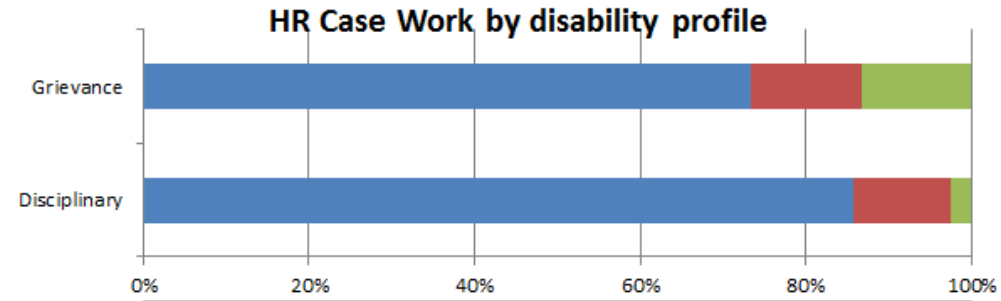
- 42 disciplinary investigations.
- 10 grievance investigations
- 5 bullying and harassment investigations

To protect the anonymity of the data we have merged the bullying and grievance cases together. This section looks at the number employee relation cases and measures this against the key equality and workforce indicators.

Age Profile

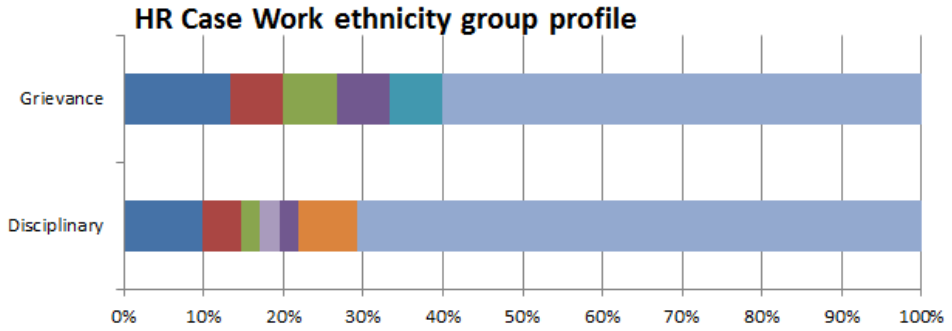


Disability



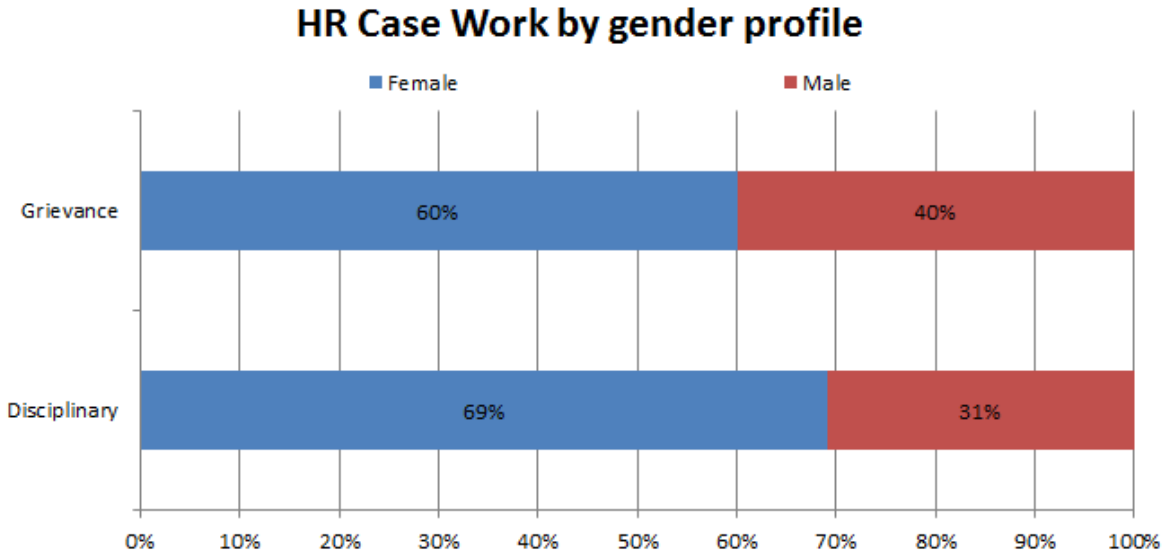
	Disciplinary	Grievance
No	86%	73%
Unspecified	12%	13%
Yes	2%	13%

Ethnicity

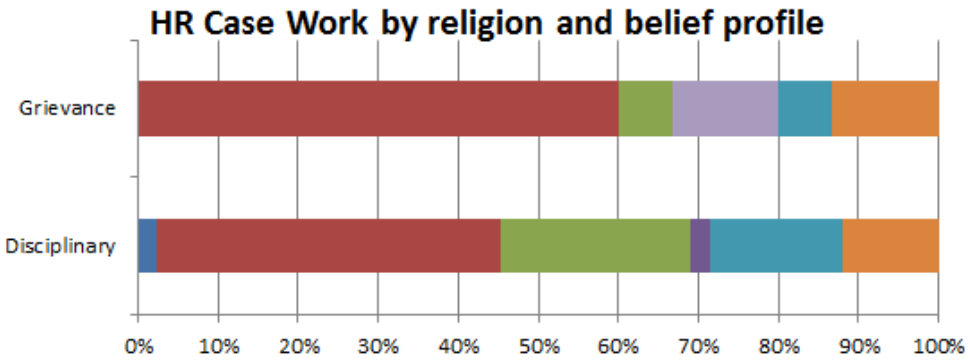


	Disciplinary	Grievance
Any other ethnic group	10%	13%
Any other white background	5%	7%
Asian or Asian British - Pakistani	2%	7%
Black or Black British - Caribbean	2%	0%
Mixed White and Asian	2%	7%
Not stated	0%	7%
White - British	7%	0%
White - Irish	69%	60%

Gender

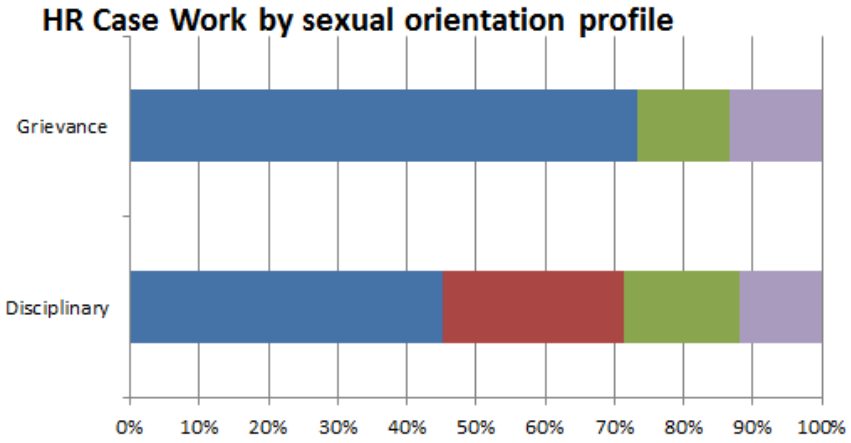


Religion & Belief



	Disciplinary	Grievance
Atheism	2%	0%
Christianity	43%	60%
I do not wish to disclose my religion/belief	24%	7%
Islam	0%	13%
Other	2%	0%
Unknown	17%	7%
Unspecified	12%	13%

Sexual Orientation



	Disciplinary	Grievance
Heterosexual or Straight	45%	73%
Not stated (person asked but declined to provide a response)	26%	0%
Unknown	17%	13%
Unspecified	12%	13%

7. Policies and programmes in place to address equality issues

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees. The Trust policies apply to all employees regardless of gender, ethnicity, disability and sexual orientation.

An Equality, Diversity and Inclusion lead has been appointed by the Trust to ensure that the Trust board and all staff understand their collective and individual responsibilities and ensure compliance within the legal framework.

The Trust strives to widen participation into apprenticeship opportunities through ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation into the employment market. CHFT is a lead employer for Calderdale Project Search, an initiative to support young people with learning disabilities to gain valuable work experience. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing. In most cases, completion of an apprenticeship at CHFT leads to a substantive position and therefore the opportunity to further develop and progress via advanced and higher apprenticeships. So far in 2019/20 CHFT have filled 74 entry level vacancies with apprentices and supported 43 existing staff to undertake an apprenticeship as part of their career development.

Work is progressing within the Trust to ensure that we have accurate information about the workforce. This involves encouraging all colleagues to update their personal information via ESR Employee Self Service. The focus in early 2019 was on Disability Status in line with the Workforce Disability Equality Standard (WDES) which is a set of specific measures that will enable the Trust to compare the experiences of disabled and non-disabled staff. This was published in August 2019.

The Trust is committed to interviewing all applicants with a disability who meet the minimum criteria for a job vacancy and considering them on their abilities; to ensuring there is a mechanism in place to discuss the development of disabled employees; to making every effort when employees become disabled to make sure they stay in employment and, to taking action to ensure that all employees develop the appropriate level of disability awareness needed.

The Trust published its annual Workforce Race Equality Standard (WRES) in September 2019. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black, Asian and Minority Ethnic (BAME) staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust is rolling out a unique and innovative programme, which allows all participants to learn from each other. The aim of the Inclusive Mentoring Programme is to support colleagues from Black, Asian and Minority Ethnic (BAME) groups by providing development opportunities and to offer support and advice on career progression.

As part of the Trust's BAME network, the Trust is committed to ensuring that a BAME representative is allocated to all interview panels for Bands 6, 7 and 8a posts to ensure equity and transparency during the selection process.

As a Trust our aim is to engage colleagues in a whole range of Diversity & Inclusion activities in order to bring our staff together, learn from one another and enhance levels of awareness around all types of difference. This year we have taken part in a Candy Dance challenge, implemented the LGBTQ pledge where colleagues sign up to wear a visible symbol of support for LGBT patients, colleagues, friends and family, and have attended local Pride events at Hebden Bridge and Halifax. We launched our Colleague Disability Action Group: engaging colleagues in identifying barriers and providing recommendations for change. Our BAME forum goes from strength to strength with the Mayor of Huddersfield attending one of the sessions and we launched our Inclusion Facebook page 'CHuFT about Inclusion' and held a number of activities during National Inclusion Week ranging from 'Let's Talk about Race', Introduction to Sign Language and Transgender Awareness workshops.

8. Improving workforce equality data

In 2019, we have:

- Improved the quality of diversity information stored within the Electronic Staff Record (ESR).
- Encouraged colleagues to update their personal information via ESR Self Service.
- The Trust continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in August 2019 and the Workforce Disability Equality Standard (WDES) in September 2019.

APPENDIX 2

MEMBERSHIP DATA

Membership Representation as at December 2019 by Age, Ethnicity & Gender

	Members	% of total members	Eligible membership*	% of eligible membership
Age (years)				
17-21	35	0.5%	51927	8.2%
22+	7619	99.5%	571194	90.2%
Ethnicity				
White	6557	85.7%	529668	83.3%
Mixed	155	2.0%	9659	1.5%
Asian or Asian British	694	9.1%	79829	12.6%
Black or Black British	212	2.8%	10162	1.6%
Other	36	0.5%	3935	0.6%
Gender				
Male	5008	65.4%	325492	51.4%
Female	2645	34.6%	307761	48.6%
Transgender	1	0.01%	Not available	Not available

* 2011 Census Data

Please note these totals are approximate as not all Trust members declare their age or ethnicity.

APPENDIX 3

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Our membership and engagement strategy

Calderdale and Huddersfield NHS Foundation Trust

This strategy outlines what we will do over the next three years to achieve our vision for membership and engagement, which is that we will be directly accountable to local people by making the best use of our membership communities. It describes the methods we intend to use to create and maintain a representative membership and strengthen engagement and communication with members over the three-year period.

Our membership community

CHFT became a Foundation Trust in 2006, and as such, we are required to have a membership community. A fundamental part of being a NHS Foundation Trust is the way the organisation is structured, based upon the involvement of local people, patients, carers, partner organisations and staff employed by the Trust.

There are three main components to the way a NHS Foundation Trust is structured:

- A membership community made up of local people, patients, carers and staff employed by the Trust
- A Council of Governors consisting of public and staff governors elected from the membership community and also appointed representatives from the Trust's key partners in health and social care
- A Board of Directors made up of a chairman and non-executive directors

One of the greatest benefits of being a NHS Foundation Trust is that the structure helps us to work much more closely with local people and service users to help us respond to the needs of our communities.

We encourage membership applications from all sectors of our communities, to develop a wide and diverse membership, and we try to provide different ways for the people we serve to contribute to the success of our organisation. Through this strategy we aim to build on our existing membership to develop an active and engaged membership community that helps us with our forward plans.

The core benefit of becoming a member is that members have a voice and can be involved in shaping the way services are provided and contribute to the future direction of the organisation. Our strategy describes a number of ways in which we will develop in this area.

You can find out more about membership and how you can become a member via our website: https://www.cht.nhs.uk/about-us/membership-and-the-council-of-governors/

Our governors provide the link between members and the Trust and it is the role of the Council of Governors to represent the interests of members and hold the non-executive directors to account for the performance of the Board. It is crucial that governors have the skills and opportunities to engage with members, and our strategy has a particular focus on this area also.

Three Year Membership & Engagement Strategy – 2020 to 2023

Our vision	**Together we will deliver outstanding compassionate care to the communities we serve**		
Our overall membership objective	**We will be directly accountable to local people by making the best use of our membership communities**		
Our goals (the result)	**Our membership community will be active and engaged; be representative of our local communities and increase year on year**	**Our governors will have regular, meaningful, two-way engagement with our membership community and members of the public**	**Our membership community will have a voice and opportunities to get involved and contribute to the organisation, our services and our plans for the future**
Our response	We will have a recruitment and engagement plan for the next three years with annual targets for increasing membership numbers	We will have a recruitment and engagement plan for the next three years outlining all our engagement activities	We will have a series of regular events for members
	We will analyse our membership on a regular basis, and have targeted campaigns to recruit members from any group that is under-represented	We will actively promote membership and raise the profile of our governors and the Council of Governors in a variety of settings and forums	Members will have more opportunities to get involved in service changes and improvement projects
	Within our public membership body we will have a youth membership constituency	Our governors will have opportunities, and the necessary skills, to actively seek out the views of members and the public on material issues or changes being discussed at the Trust	Members will have more opportunities to express their views on service changes and improvement projects
	We will have a number of incentives to attract new members		
	We will have an accurate, up-to-date membership database which allows us to target members who wish to be actively engaged	Our governors will have opportunities to feed back to members and the public information about the trust, its vision, performance and material strategic proposals made by the trust board	Members will have the opportunity to comment on any forward plans
	We will have established links with local organisations through whom we can recruit members		We will have a Patient Panel through which members and members of the public can feed back on service changes and forward plans
		We will have new methods of communicating/engaging with our members, including making more use of social media channels	

18. Risk Management Strategy

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 March 2020
Meeting:	Board of Directors
Title:	Risk Management Strategy
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Ellen Armistead, Director of Nursing
Previous Forums:	Audit and Risk Committee (see key points) 29 January 2020

Actions Requested:
To approve

Purpose of the Report

To review and approve the revised Risk Management Strategy to ensure that it is valid and up to date for the Trust.

Key Points to Note

The Risk Management Strategy confirms the objectives and organisational framework for risk management systems within the Trust and details roles, responsibilities and processes for risk management.

The Risk Management Strategy is reviewed on an annual basis to ensure it reflects the current roles and responsibilities for risk management and the current governance structure.

Consultation has taken place via the following groups:

- Risk and Compliance Group, 13 January 2020
- Audit and Risk Committee, 29 January 2020
- Quality Committee, 5 February 2020
- Weekly Executive Board meeting on 20 February 2020
-

The revised Risk Management Strategy is attached with changes to the strategy in red font for ease of reference and include:

- Revised Four Pillars table (page 14)
- Addition of text to Board of Directors – see 7.2
- Executive Directors (8.4) Chief Operating Officer confirmed as responsible for fire safety
- Updated flow chart for the management of risk to align with the Risk Management Policy (page 28)
- Updated appendices: Appendix 2 Governance Structure, Appendix 4 Risk Management Specialists, Appendix 6 Incident Grading Matrix and Appendix 7 Risk Appetite

The governance structure will be updated during the year to reflect any changes to reporting to sub-Committees, which are expected for the Quality Committee.

EQIA – Equality Impact Assessment
The purpose of the strategy is to provide a framework for the management of risk to minimise risk and maximise quality of service to patients and stakeholders. There are no concerns that this strategy could have a differential impact on people with protected characteristics.
Recommendation
The Board is asked to approve the Risk Management Strategy.

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP – 2020-017
Review Date: March 2021
Review Lead: Company Secretary

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Facilities Management

RISK MANAGEMENT GROUP STRATEGY

2020-2021

Version 3

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP – 2020-017
Review Date: March 2021
Review Lead: Company Secretary

Document Summary Table		
Unique Identifier Number	G-101-2017	
Status	Approved	
Version	2	
Implementation Date	January 2017	
Current/Last Review Dates	N/A	
Next Formal Review	March 2021	
Sponsor	Director of Nursing	
Author	Company Secretary	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		
Executive Board		20 February 2020
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Quality Committee	Non-Executive Director	5 February 2020
Risk and Compliance Group	Company Secretary/ Assistant Director of Quality and Safety	13 January 2020
Audit and Risk Committee	Non-Executive Director	29 January 2020
Other Stakeholders Consulted		
N/A		
Does this document map to other Regulator requirements?		
Regulator details		
CQC		Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 16: Complaints Regulation 17: Good Governance Regulation 19: Fit and Proper Persons
NHS Improvement		Single Oversight Framework

Document Version Control	
Version no	
1	Risk Management Strategy incorporating Raising Concerns / Freedom to Speak Up
1.1	Minor amendment made to section 9.5 to include additional information in relation to compliance registers following internal audit report
2	Addition of section relating to Calderdale & Huddersfield Solutions and amendments to roles and responsibilities.
3	Addition of section on Board of Directors (8.1). Additions to roles and responsibilities re Fire Safety, change reference from Head of Governance and Risk to Senior Risk Manager, addition of numbers to risk levels in risk appetite. Updated appendices: 2 - Governance Structure, 3 - Supporting Policies, 4 - Risk Management Specialists, 6 - Incident Grading Matrix, 7 - Risk Appetite

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP – 2020-017
Review Date: March 2021
Review Lead: Company Secretary

CONTENTS

Appendices

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1. Introduction

This policy is intended for use across Calderdale and Huddersfield NHS Foundation Trust (CHFT), which includes Calderdale and Huddersfield Solutions Limited (CHS). Where responsibilities state all staff, managers senior managers and directors, this also includes CHS staff groups.

The purpose of this Risk Management (RM) Strategy is to confirm the objectives and organisational framework for risk management systems within the Trust. It details roles, responsibilities and processes for risk management in order to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The underpinning risk management processes will ensure that risks are identified and managed, and reported appropriately through the organisation as part of the Trust's system of internal control. Definitions of risk and risk management are given at Appendix 1.

The strategy is relevant to all staff, including those on temporary contracts, contractors, membership councillors, and bank/agency staff, volunteers and Private Finance Initiative (PFI) partners. It is also relevant to all those who partner with or work with the Trust.

2. Vision and Statement of Intent

2.1 Risk Management and Strategic Objectives

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

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

Our strategic objectives to deliver this aim are to:

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

Risk management is central to implementing this strategy as the business of healthcare is by its very nature a high risk activity. The process of risk management is an essential control mechanism to identify and manage risks which may threaten the ability of the Trust to meet its objectives, and, as a consequence it increases the likelihood of the Trust achieving its objectives and strategic aim.

Risk and risk management is not about doing nothing for fear that we might make a mistake. Rather, risk policy and risk management are concerned with promoting an understanding of an organisation's strategy, operating environment and the associated risks and putting in place appropriate processes and procedures to identify, assess and manage risk. Risk identification, assessment, management and assurance is best understood as a constant cycle of activity: risks emerge, alter their significance and scale and may disappear without warning. Anticipation and early action to manage risk is the best defence. Her Majesty's Treasury offers guidance to all organisations in receipt of public funding as to how they may incorporate good practice. This guidance concludes it is essential that an organisation should:

- Understand the risks associated with all elements of its strategy and operating environment
- Have in place a framework for risk identification, risk assessment, risk management and assurance and the assignment of responsibilities
- Have a clear policy and attitude to risk appetite and ensure that these are defined and communicated to all relevant parties
- Review the adequacy and effectiveness of control processes for responding to risks

The Trust recognises that providing healthcare and the activities associated with the treatment and care of patients incurs clinical and non-clinical risk, both for the organisation and its stakeholders: our patients, staff, visitors, partners in the health and social care community and commissioners.

Risk Management is an integral part of the Trust Board's system of internal control and its effectiveness is reviewed annually by internal and external auditors. Key strategic risks are identified and monitored by the Board and operational risks are managed on a day to day basis by staff throughout the Trust. The Board Assurance Framework and Corporate / high level Risk Register provide a central record of how the Trust is managing its risks.

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

2.2 Risk Management Three Lines of Defence

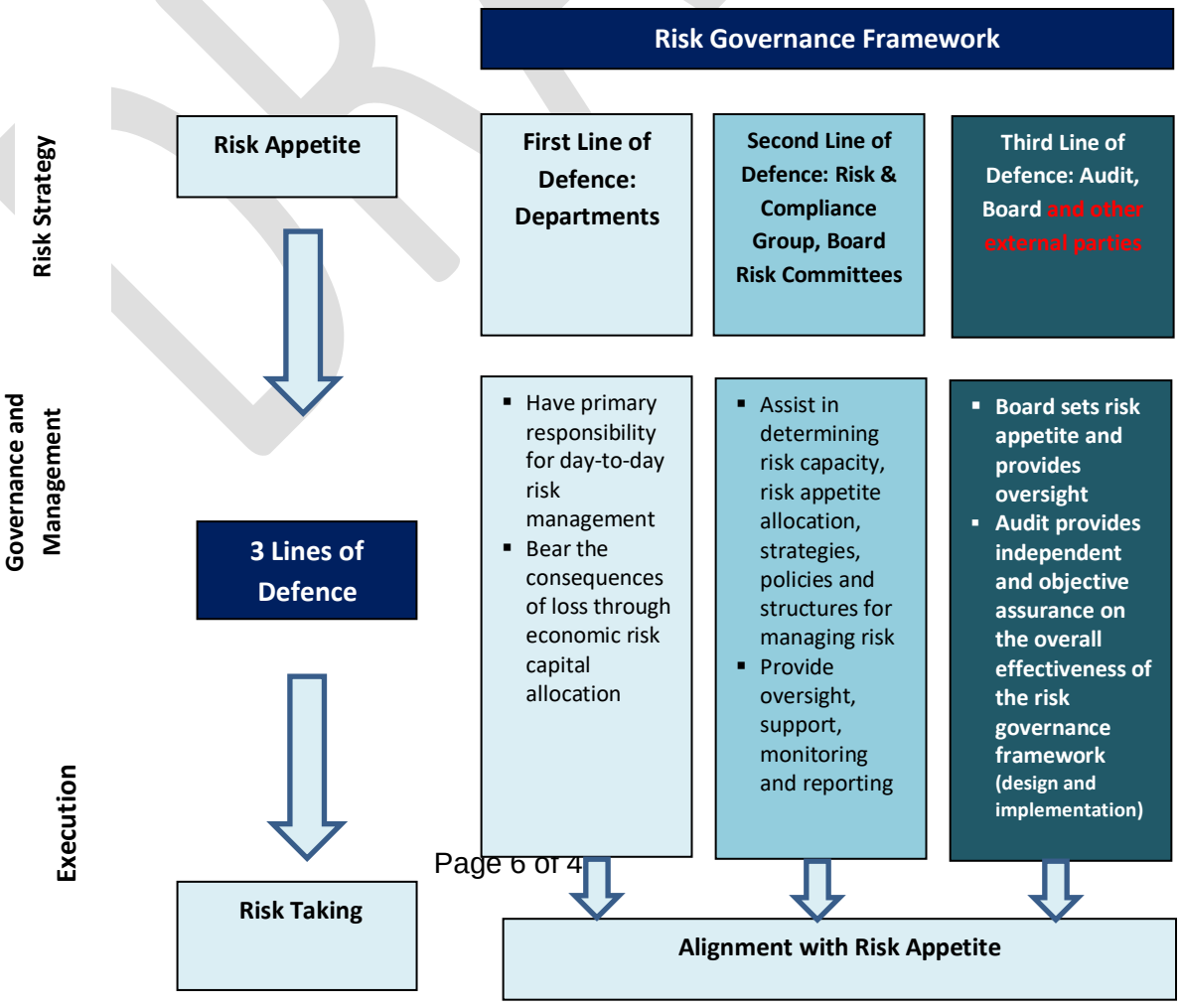
To ensure the effectiveness of the Trust's risk management processes the board and senior management team need to be able to rely on three lines of defence, including the monitoring and assurance functions with the organisation. This is depicted overleaf and explained below:

First line of defence – our front-line staff are the first line of defence. They must understand their roles and responsibilities for risk management using Trust processes and they must own and manage risk, as well as implementing operational management at directorate and divisional level. These are the teams with ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

Second line of defence – the second line of defence consists of the functions that reflect risk management, quality and compliance (which monitors and facilitates the implementation of effective risk management practices by operational management) and the processes that assist the risk owners to report adequate risk related information up and down the organisation. This line of defence includes the governance and management committees that provide assurance that risks are actively and appropriately managed.

Third line of defence – the third line of defence is provided by independent audit, such as internal and external auditors, who through a risk-based approach provide independent assurance to Board and senior management team about how effectively the Trust assesses and manages its risks, how effective the first and second lines of defence are and looks at all aspects of risk across all organisational objectives.

Figure 1 – Risk Management Three Lines of Defence



The Trust will ensure that its risk management arrangements meet the requirements of a number of national bodies including NHS Improvement, the Care Quality Commission (CQC), the Health and Safety Executive (HSE), Environmental Agency, NHS Resolution, our insurers, other agencies and systems supporting a safety culture, such as the National Reporting Learning System and all other regulatory and scrutiny bodies.

On behalf of the Board, the Chief Executive signs annually, a Governance Statement for the Department of Health which outlines how the organisation identifies, evaluates and controls risks together with confirmation that the effectiveness of the system of internal control has been reviewed.

2.3 Vision and Statement of Intent

The Trust's vision of this strategy is for risk management to be regarded as a highly valuable and useful tool to help the Trust achieve its objectives, with:

Risk management systems understood by staff
Risk management systems embedded into everyday working practice across all parts of the organisation
The Board and its committees assured that risks are managed to achieve the Trust's objectives

The Trust will aim continually to improve the content and maturity of the risk management framework.

2.4 Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach. Risk may adversely affect patients, staff, contractors, the public and the fabric of buildings. In managing risks the Trust is providing a safe environment in which patients can be cared for, staff can work and the public can visit

- Risks are managed to an acceptable level as defined in the Trust risk appetite (see section 6), meaning that staff have a clear understanding of exposure and the action being taken to manage significant risks

- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated. A flowchart of risk escalation is given at section 9.4

- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively – see section 9 for further details

- All staff recognise their personal contribution to risk management

- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

2.5 Risk Scope

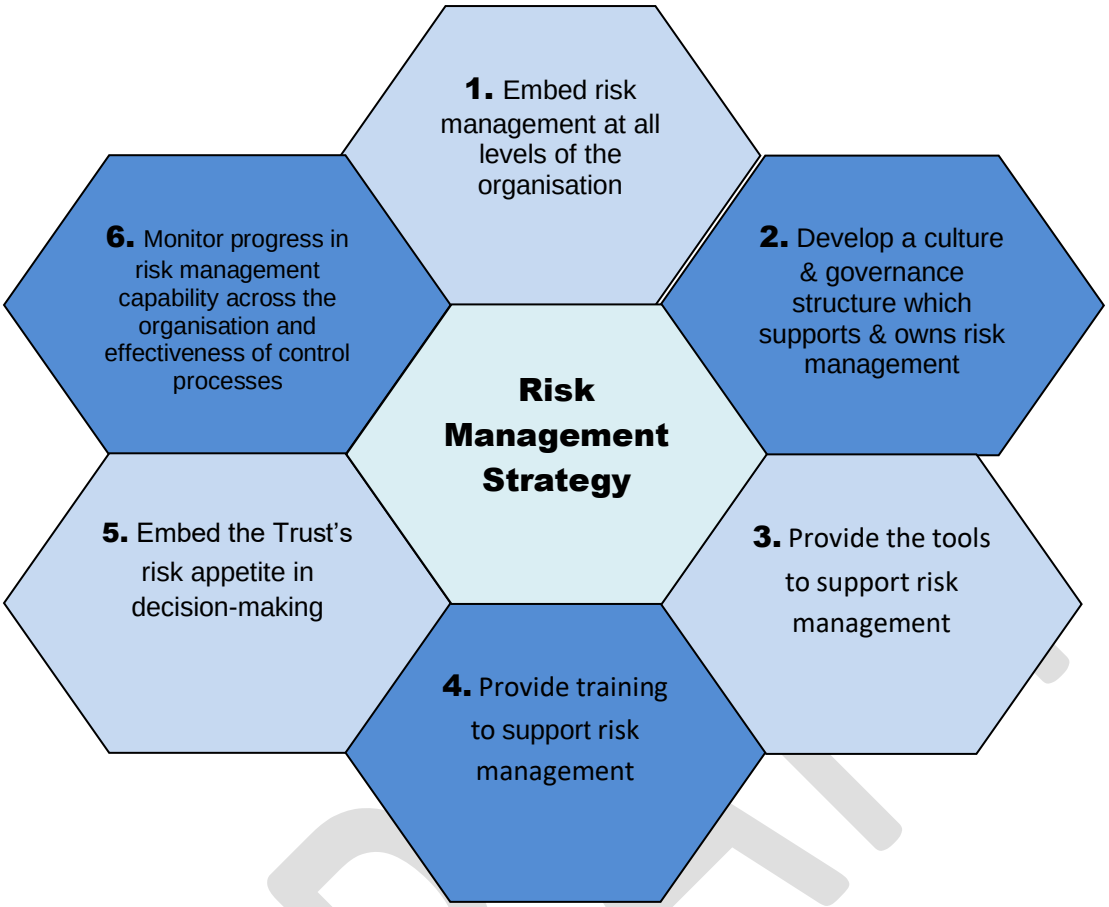
This Risk Management Strategy and the Risk Management Policy apply to all categories of risk, both clinical and non-clinical risks. These include, though are not limited to:

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

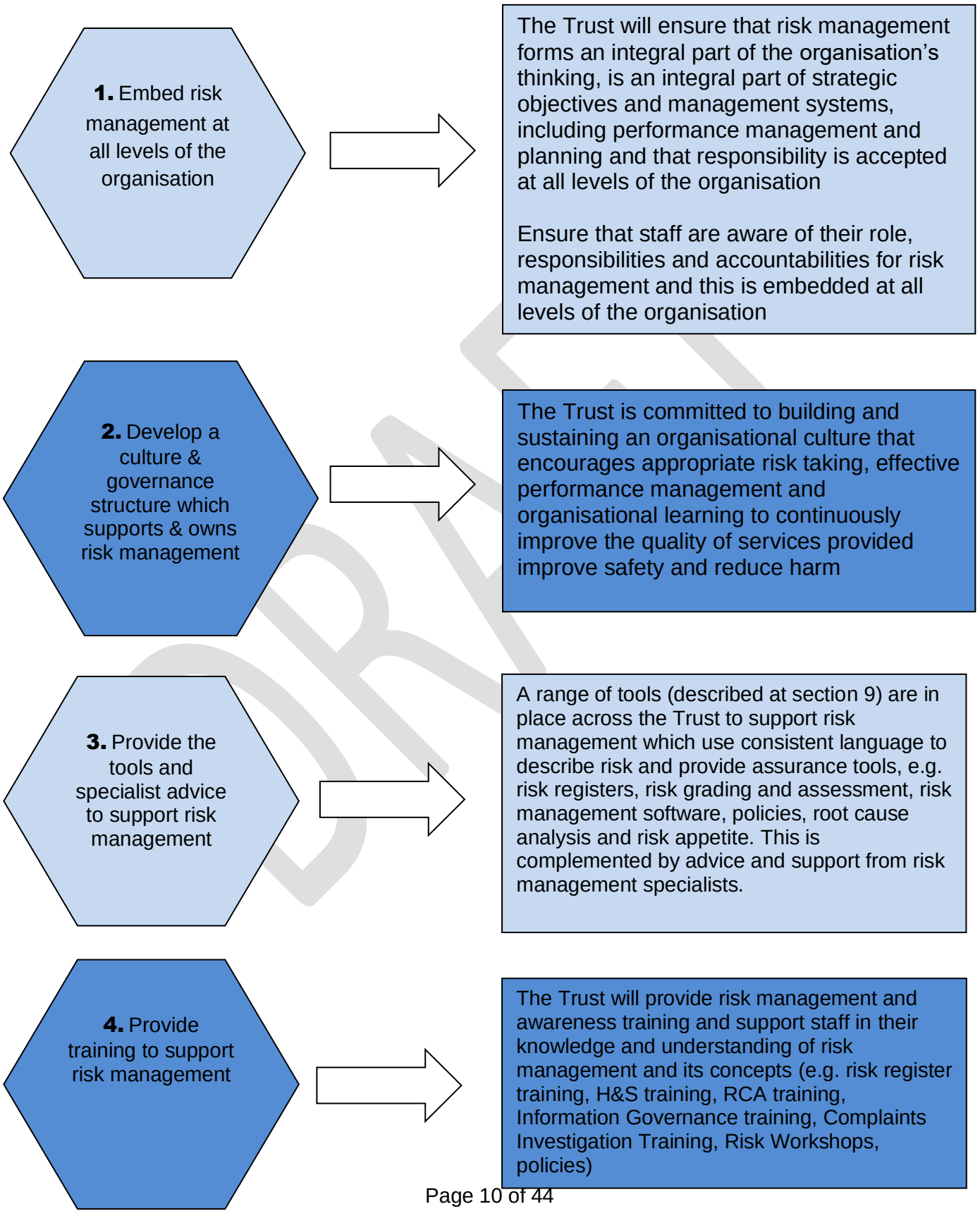
3. Components of the Trust Risk Management Strategy

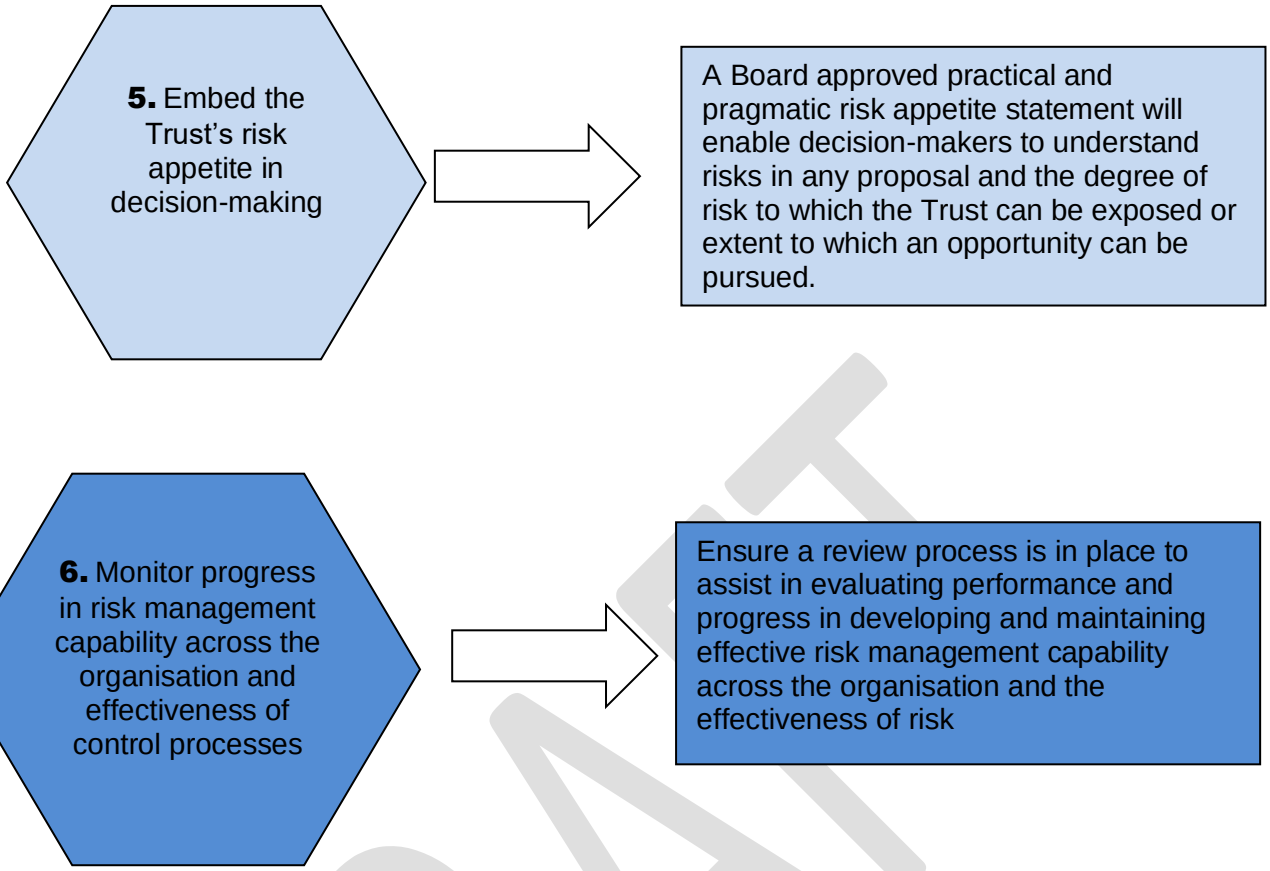
The components of the Trust's Risk Management Strategy to deliver this vision are given below.

These components will enable the organisation to manage inherent risks within the current systems and processes. The organisation will decide how to manage these risks in line with its risk appetite (see section 6) and risk management processes, see Appendix 1. It is acknowledged that risks may emerge from external sources, particularly during times of change or when new systems or revised regulation is introduced, and the organisation will remain alert to these sources of risk.


1. Embed risk management at all levels of the organisation
2. Develop a culture & governance structure which supports & owns risk management
3. Provide the tools to support risk management
4. Provide training to support risk management
5. Embed the Trust's risk appetite in decision-making
6. Monitor progress in risk management capability across the organisation and effectiveness of control processes
Risk Management Strategy

Details of each component are given below:



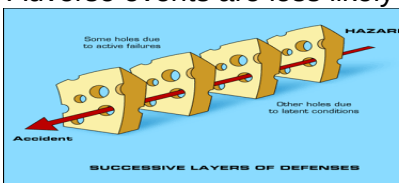

5. Embed the Trust's risk appetite in decision-making
A Board approved practical and pragmatic risk appetite statement will enable decision-makers to understand risks in any proposal and the degree of risk to which the Trust can be exposed or extent to which an opportunity can be pursued.
6. Monitor progress in risk management capability across the organisation and effectiveness of control processes
Ensure a review process is in place to assist in evaluating performance and progress in developing and maintaining effective risk management capability across the organisation and the effectiveness of risk

4. Benefits of managing risk

The Trust is committed to the effective management of risks which, among others, has the following benefits for the Trust:

Achievement of objectives is more likely

Adverse events are less likely



Opportunities can be better identified and explored

Outcomes are better: safety, effectiveness, efficiency

We reduce firefighting and fewer costly surprises and re-work

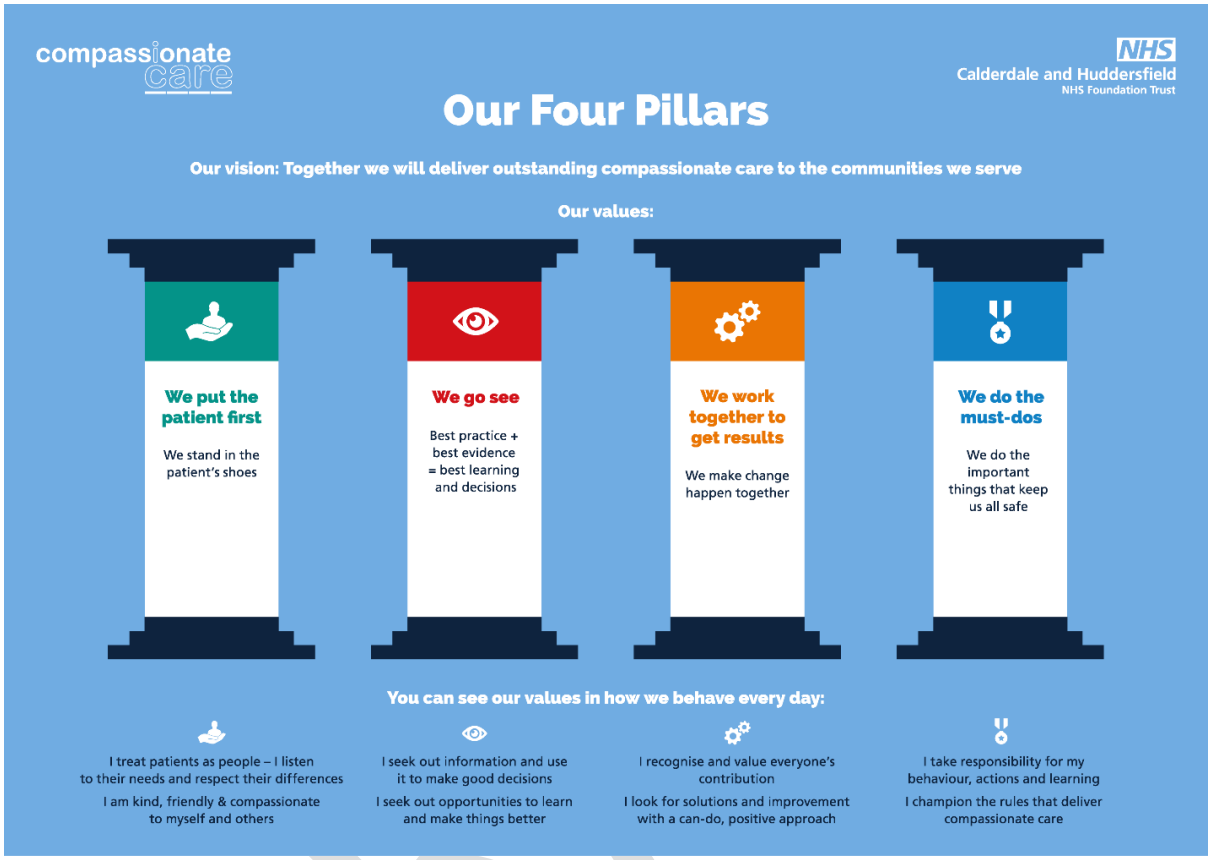
Performance is improved

Decision-making is better informed, more open and transparent

Reputation is protected and enhanced

5. The way we work

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



A pro-active approach to managing risk

The Trust aims to embed a culture in which true pro-active risk reduction takes place by aiming to anticipate and prevent risks, complementing the more traditional reactive approach to risk management by looking ahead and managing upcoming risks. This is achieved by staff and teams identifying pro-actively risks to avoid adverse events or by managing risks as far as reasonably practicable to minimise the consequences of adverse events, for example for patient outcomes or preventing harm and reducing losses for the organisation. A key part of this pro-active approach to risk management is the use of risk assessment which is detailed as a key risk management tool in the organisation (see Appendix 4).

All members of staff have responsibilities and an important role to play in identifying, assessing and managing risk using the risk management strategy policy and supporting policies and procedures to guide them.

This means:

Staff should pro-actively identify and assess risks and manage these to avoid / minimise adverse events. *(We Do The Must Do's)*

To support staff in their role in managing risk the Trust seeks to provide an open, fair and consistent environment, encouraging a culture of openness and a willingness to admit mistakes and learn from them.

This means:

Staff are open about incidents they have been involved in and feel able to talk to their colleagues about any incident *(We Do The Must Do's)*

All staff, and others associated with the Trust, should report any situation where things have or could have gone wrong through the incident reporting process. Balanced with this approach is the need for the Trust to provide information, counselling, support and training for staff in response to such situation.

This means:

The organisation is open with patients, the public and staff when things have gone wrong and appreciates and explains what lessons can be learned (*We Put The Patient First)*

The Trust wants to learn from events and situations in order to constantly improve management processes, take a systems approach to learning, looking at contributory factors, including human factors to make changes to improve quality and safety. Where necessary and/or appropriate, changes will be made to the Trust's systems to enable this to happen.

The Duty of Candour and Being Open policy is a key tool to support this and to engage with families where things have gone wrong. Staff should be informed of feedback on actions taken as a result of an incident being reported.

This means:

Staff and organisations are accountable for their actions and are treated fairly and are supported when an incident happens (We Do the Must Do's)

In the interests of openness and candour, responding to concerns raised and learning from mistakes, formal disciplinary action will not usually be taken as a result of an investigation into an adverse event. However, the Trust's Disciplinary Policy outlines circumstances in which disciplinary action will be

taken, e.g. professional misconduct. Should disciplinary action be appropriate this will be made clear as soon as the possibility emerges from an investigation and advice would be taken from the Workforce and Organisational Development department.

6. Risk appetite

No organisation can achieve its objectives without taking risks. An organisation's risk appetite is the amount and type of risk that the organisation is willing to take in the pursuit of its strategic objectives.

The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved. The organisation will communicate expectations for risk taking to managers. The current risk appetite is included at Appendix 7 of this strategy.

The Trust uses the risk appetite matrix for NHS organisations developed by the Good Governance Institute to express its risk appetite.

There are 5 levels of risk appetite (excluding no risk appetite) which are detailed below.

Risk level	Risk appetite	Key Elements
1.MINIMAL (as little risk as possible)	**LOW**	Preference for ultra-safe delivery options with a low degree of inherent risk and only for limited reward potential
2.CAUTIOUS	**MODERATE**	Preference for-safe delivery options with a low degree of inherent risk and limited potential for reward
3.OPEN	**HIGH**	Willing to deliver all potential delivery options and choose while also providing an acceptable level of reward and value for money
4.SEEK	**SIGNIFICANT**	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk

5.MATURE	**SIGNIFICANT**	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Expressing the Trust's Risk Appetite

In line with best practice in corporate governance and risk management, the Trust will clearly express the extent of its willingness to take a risk in order to meet its strategic objectives through a risk appetite statement.

The risk appetite will be agreed by the Board and reviewed at least annually or as needed, as risk appetite levels may change depending on circumstances.

Risk Categories

Risks need to be considered in terms of both opportunities and threats and are not usually confined to clinical risk or finances – they are much broader and impact on the capability of the Trust, its performance and reputation. The risk appetite is also influenced by the overall objectives set by the Trust.

The Trust will agree categories of risk when defining its risk appetite and will publish these, which will cover the over-arching areas of:

- Quality, innovation and improvement, safety
- Financial
- Commercial
- Regulation
- Reputation
- Workforce
- Partnerships

The risk appetite statement will be communicated to relevant staff and risks throughout the Trust should be managed within the Trust's risk appetite. Where this is exceeded, action should be taken to reduce the risk.

The Risk and Compliance Group will review the significant risks on the high level risk register to ensure that risks are acceptable within the Trust risk appetite.

The Quality Committee (for clinical risk), Audit and Risk Committee (for all clinical and non-clinical risk) and the Board will also review significant risks and ensure that the Trust's overall portfolio of risks is appropriate, balanced and sustainable.

7. Organisational Structure for Risk Management

7.1 Organisational Structure

A full organisational structure, to help manage delegated responsibility for implementing risk management systems within the Trust is given at Appendix 2.

7.2 Roles and responsibilities of Committees responsible for risk

Board of Directors

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

Board members must ensure that the systems, policies and people that are in place to manage risk are operating effectively, focused on key risks and driving the delivery of objectives.

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

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

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

- Set corporate strategy and priorities and monitor progress against these; the Board must decide what opportunities, present or future, it wants to pursue and what risk it is willing to take in developing the opportunities presented. The Board is also responsible for ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and High Level Risk Register

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

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

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

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

- The Company Secretary is responsible for the work of the Board and its Committees and for ensuring integration of their activities, particularly the governance and regulatory responsibilities

Audit and Risk Committee

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

The Risk and Compliance Group, chaired by the Assistant Director of quality and Safety, reports to the Audit and Risk Committee. Its role is to promote effective risk management and to establish and maintain a dynamic Board Assurance Framework and Risk Register through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality.

The Information Governance Group and Data Quality Board also report to the Audit and Risk Committee.

To ensure that Board Committees are effectively managing risks within their remit, each Committee undertakes a self-assessment of performance annually and share these assessments with the Audit and Risk Committee.

Finance and Performance Committee

The Finance and Performance Committee has delegated authority from the Board to oversee, co-ordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases. It is responsible for identifying any financial and performance risks.

Workforce Committee

The Workforce Committee provides assurance to the Board of Directors on the quality of workforce and organisational development strategies and the

effectiveness of workforce management in the Trust and is responsible for identifying any workforce and training risks.

Quality Committee

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

There is a number of groups that support the work of the Quality Committee and directly report to it, including the Health and Safety Committee, as depicted in the governance structure at Appendix 2. The sub–group reporting structure is currently under review and any changes will be reflected in the governance structure.

8. Accountabilities, Roles and Responsibilities for Risk Management

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

The Chief Executive has overall accountability and responsibility for:

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

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

8.3 Non-Executive Directors

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

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

The Senior Independent Non-Executive Director is Richard Hopkin who is also the Deputy Chair.

8.4 Executive Directors

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

Lead Executive Director	Risk Area
Director of Nursing The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director. They ensure organisational requirements are in place which satisfies the legal requirements of the Trust for quality and safety, patients and staff. This includes delivery of processes to enable effective risk management and clinical standards. The Board Assurance Framework lead is the Company Secretary.	• Board lead for clinical risk management: – Risk Management Strategy and Policies – Risk appetite – Monitoring the management of risks across divisions and escalate as needed • Serious Incidents and Incident Reporting • Patient Advice and Complaints Service • Patient Experience • Quality and Quality Improvement • Safeguarding and Deprivation of Liberty • Mental health act compliance • Quality regulatory compliance
Medical Director The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Chief Nurse and leads the quality improvement strategy. Responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation. The Medical Director is supported in this by the Deputy Medical Director and Associate Medical Directors.	• Clinical medical risk • Infection Prevention and Control • Caldicott Guardian information risks – delegated to the Deputy Medical Director • Responsible Officer for GMC • Medicines Management – delegated to Chief Pharmacy Officer • Clinical audit and effectiveness • Compliance with NICE guidance • Quality Improvement • Research & Development – delegated to Deputy Medical Director
Director of Finance The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within the Trust and actions to control these.	• Financial risk • Procurement risk • Counter fraud and reporting to NHS Protect • Financial regulatory compliance • Estates and Facilities risks provided by the Project company (PFI) and wholly owned subsidiary CHS

Chief Operating Officer The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.	• Performance risks • Performance regulatory compliance • Safe and sustainable operational services • Security Management • Trust Resilience • Fire Safety
Director of Workforce and Organisational Development The Director of Workforce and Organisational Development has executive responsibilities which include identification and assessment of risks associated with recruitment, employment, supervision, training, staff development and staff well–being.	• Freedom to Speak Up Guardian • Staffing risks including training, workforce planning, recruitment and retention, • Health and Safety, including external reporting for RIDDOR • Workforce Policies • Professional registration • Staff Well Being

8.5 Board Directors

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

Director of Transformation and Partnerships The Director of Transformation and Partnerships has lead responsibility for service redesign and reconfiguration and working together with our partners across the local health and social care economy.	• Risks in relation to service reconfiguration and transformation • Partnership risks
Managing Director – Digital Health The Managing Director promotes the need to manage information and IT risks, for the security of patient records and IT business continuity arrangements.	• Information governance risks, including general data protection and external reporting to the Information Commissioner • Senior Information Risk Officer – delegated to head of informatics, is responsible for ensuring the Trust manages its information risks, through the development of information asset owners and information asset administrators • Electronic Patient Record

Calderdale and Huddersfield Solutions Limited, a wholly owned subsidiary by CHFT, provides:

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

CHS provides advice and management on the following risks:

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

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

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

8.6 Assistant Director for Quality and Safety

The Assistant Director for Quality and Safety supports the Chief Nurse and Medical Director in their clinical quality and safety and risk management responsibilities as well as quality improvement. This includes overseeing the risk management function, including the risk register and compliance with the requirements of CQC standards.

8.7 Clinical and Divisional Directors

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

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and Director of Operations.

They are responsible for demonstrating and providing leadership of risk management within their division, directorates and teams. They are accountable for:

- Pro-actively identifying, assess, managing and reporting risks in line with Trust processes – this includes ensuring Divisional Digital Boards identify and describe risks relating to the Electronic Patient Record and other information systems on their divisional risk register and escalate these appropriately in line with the risk management framework
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture
- Seeking assurance through governance arrangements of the effectiveness of risk management
- Ensuring clinical risks, health and risks, emergency planning and business continuity risks, project and operational risks are identified and managed
- That general managers, operational managers, matrons, ward managers, departmental team managers are responsible for ensuring effective systems of risk management and risks registers are in place at all levels

8.8 All Staff

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

8.9 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of Contractors' policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFT's health and safety rules

and the staff member responsible is fully aware of the contractor's activity for which they are engaged and, if applicable, are in possession of the contractor's risk assessment and method statement for their activity.

9. SYSTEMS and PROCESSES for MANAGING RISK

9.1 Policies

There are a number of key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. These supporting policies are detailed at Appendix 3.

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

9.2 Incident Reporting

The formal reactive method of identifying risks within the Trust is through the electronic risk management system, Datix where all staff can report incidents accidents and near misses in a timely way, with incidents graded for type and severity. This enables the organisation to investigate and identify learning to make quality improvements in patient safety at all levels of the organisation.

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

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

Staff wishing to raise concerns in accordance with the Freedom to Speak up: Raising Concerns Policy should utilise the reporting facility in that policy.

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

9.3 Board Assurance Framework (BAF)

The Board Assurance Framework provides the Board of Directors with an oversight of the strategic risks to meeting the Trust's objectives together with the controls and methods of providing assurance that controls are effective. Risks on the BAF are owned by Trust Directors.

The BAF maps out the controls already in place and the assurance mechanisms available so that the Board can be confident that they have sufficient assurances about the effectiveness of the controls. The risks are cross-referenced to the risks on the corporate risk register.

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

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

The assessment of risk within the BAF is reviewed at the Risk and Compliance Group. The risks on the BAF are scrutinised a minimum of three times a year in line with the frequency in the Standard Operating Procedure by the Board of Directors with input from the Quality Committee, the Finance and Performance Committee and the Workforce Committee. Oversight of the system of risk management, including the BAF, is provided by the Audit and Risk Committee. The Trust will continue to review and amend both the risk register and the BAF content in line with best practice identified, for example through audit and benchmarking.

The Board Assurance Framework is closely linked with the high level risk register (HLRR), which reflects significant risks identified at both a corporate department and divisional level. The Company Secretary and the Senior Risk Manager ensure that the link between the High Level Risk and the Board Assurance Framework is maintained, and that the Audit and Risk Committee is satisfied that this is occurring.

9.4 Risk Registers

All areas assess record and manage risk within their own remit, reporting on the management of risks through the risk register, using the risk grading system detailed at Appendix 4. All risks are linked to strategic objectives.

A database is used to capture all risks to the organisation including clinical, organisational, health and safety, financial, business and reputational risks. A framework is in place for assessing, rating and managing risks throughout the Trust, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, division, directorate and team. Further detail on the process for populating the risk register is given in the Risk Management Policy.

It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the Corporate Risk Register which is an integral part of the Trust's system of internal control.

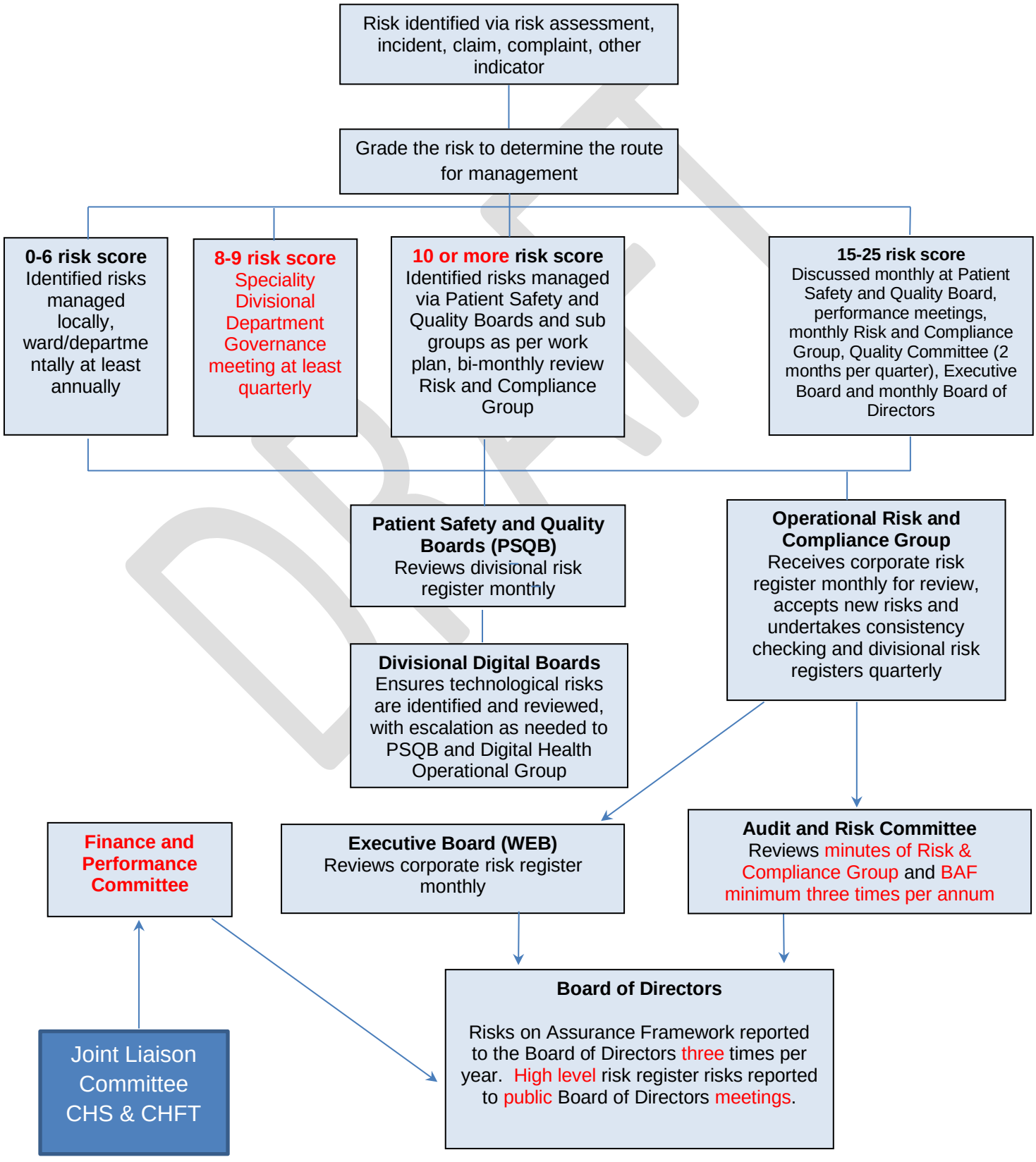
The high-level risk register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk and Compliance Group and presented to the Board of Directors.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions, including risks regarding technology

from divisional Digital Board meetings. The Risk Management Policy details the process for risk register reporting.

The diagram overleaf depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

Structure and flow chart for the management of assurance and risk



9.5 Compliance Register

As part of good governance and being a well-led organisation, to ensure that the Trust manages risks and responds to issues highlighted in external reviews, each division and corporate services maintain a register of compliance. This register provides an overview of compliance with regulatory standards, (financial, performance, estates and quality). Guidance is provided to divisions to ensure consistency of the content of compliance registers.

The register is a systematic approach to recording external assessments of standards through inspections, peer reviews and accreditations, in line with the Trust policy for Managing External Agency Visits, Inspections and Accreditations, ensuring an organisational overview of any aspects of non-compliance, forward planning for future assessments and identification of potential risks.

The register details the date and type of assessment, level of compliance, actions required, consequence of non-compliance and any associated risks. It also includes the date the next assessment is due.

Each division presents their compliance registers to the Risk and Compliance Group for review every two months. Divisional compliance registers are reviewed at divisional Patient Safety Quality Board meetings to provide assurance that appropriate information is recorded and actions are being progressed.

9.6 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review and implement policies, procedures and guidelines for the effective control of risks.

Responsibilities of staff at all levels for risk are given at section 8. Details of Trust risk management specialists are given at Appendix 3.

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager Data Protection Officer	Information Governance Risks, including general data protection (GDPR)
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks Fit and Proper Persons
Chief Nurse	Clinical Risk
Director of Workforce and OD	Health and Safety Risks
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Resilience and Security Manager	Emergency Planning and business continuity risks Security Manager
Fire Safety Manager Health and Safety Advisor	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines Management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Quality Governance leads Assistant Director of Quality and Safety Senior Risk Manager and Risk Manager Head of Complaints and Legal Services	All risks and risk management tools, processes and training.
Head of Safeguarding/Safeguarding Team	Safeguarding Risks

9.7 Risk Management Software

The Trust uses two risk management databases, Datix, for incident reporting, complaints, concerns, claims and inquests to support identification, management and investigation into adverse events and a bespoke database for the risk register. The Datix system allows the Trust to share information and triangulate data on an individual and aggregate basis. This provides an easy way for staff to report and get feedback on incidents, ensure an appropriate level of investigation based on severity, capture actions and learning from adverse events and analyse data to identify themes and trends for the whole organisation.

A bespoke database is used for the management of the risk register, which allows reporting and analysis at directorate, divisional and Trust-wide level.

9.8 Risk Identification and Assessment

Risk assessment is a systematic and effective method of identifying risks and determining the most effective means to minimise or remove them. It is an essential part of risk management within the Trust.

The formal pro-active method of identifying operational risks within the Trust is through the use of risk assessments. Clinical and non-clinical risk assessment is used to populate directorate, divisional and corporate risk registers. The Board of Directors is responsible for identifying strategic risks associated with the strategic direction of the organisation.

All risk assessments in all departments should be regularly updated and formally reviewed on an annual basis.

It is essential to identify the scale and significance of a risk. It is important to distinguish between these elements and to provide a clear and applied assessment; a risk may be extreme in scale without having great significance and vice versa. Equally it is important to assess and manage cumulative risk.

Guidance for staff on risk assessment is given in the Risk Management Policy.

9.9 Risk Grading Matrix

Staff should use the risk grading matrix, adapted from a national model by the National Patient Safety Agency for the NHS, to ensure a consistent approach to assessing risks.

The risk grading matrix provides a description of risk types and defines an impact score from 1 – 5 and a likelihood score from 1 – 5. The impact score multiplied by the likelihood score determines the actual grading of the risk – refer to Appendix 4 for details.

The information produced from the risk assessment is used to populate the risk register.

For assessment of the severity of incidents, the Trust uses the grading scale given at Appendix 9 which grades no harm incidents as green, incidents with minimal harm as yellow, incidents with moderate or short term harm as orange and incidents where there is severe or long term harm or death as red incidents.

Complaints are assessed in line with the grading policy within the complaints policy which is based on patient experience.

9.10 Root Cause Analysis / Learning

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

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

The Trust has a clear framework for undertaking root cause analysis for all moderate harm and severe harm incidents. This ensures that action is taken to prevent the potential for recurrence locally and at a corporate level. Specific root cause analysis processes have been developed for specific incidents, i.e. pressure ulcers, infection related incidents. These are detailed in the Incident Reporting Policy.

10. Risk Management Training

In order to develop a risk aware culture and to ensure successful Implementation of this strategy there needs to be training for staff.

Risk management training and awareness already occurs in a number of different methods, e.g. Board workshops, risk register training, root cause analysis training, complaints investigation training, Datix training as well as ad hoc training.

11. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

12. Monitoring the Effectiveness of this Strategy

The strategy will be reviewed on a three-year basis or sooner as required.

A review process will be developed to assist in evaluating performance and progress in developing and maintaining effective risk management capability within divisions and corporate functions across the organisation and the effectiveness of risk management control processes. This will include leadership for risk management, local ownership of risk, equipping staff to manage risk well, governance arrangements to support the risk management framework, policies and procedures.

13. Associated Documents/Further Reading

The relevant policies and procedures listed in section 9.1 should be read in accordance with this strategy.

APPENDIX 1

Definitions

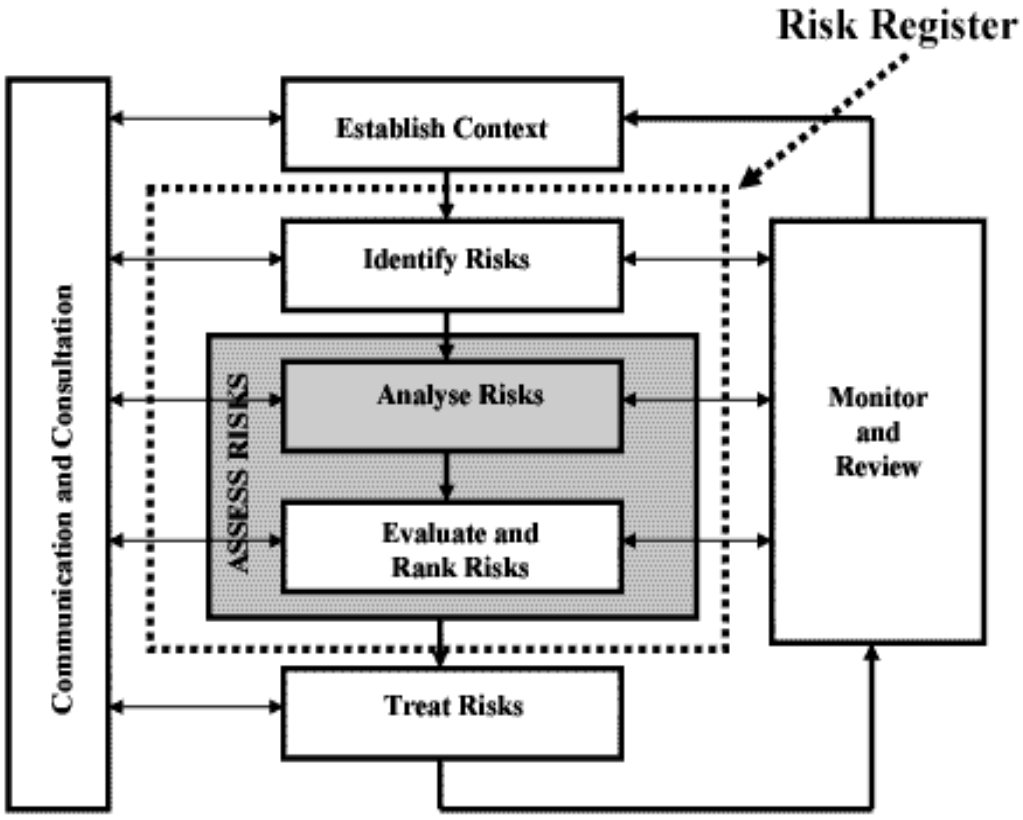
Risk is the chance that something will happen that will have an impact on the achievement of the Trust's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the risk occurring). See section 9.8 and Appendix 4.

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

The **risk management process** is the systematic application of management policies, procedures and practices to the task of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk. It is described in the diagram below.

Significant risks are those which, when measured according to the grading tool at Appendix 4, are assessed to be significant, with a risk score of 15 or more. The Board will take an active interest in the management of significant risks.

Cumulative risks are individual risks from different areas which, when added together, may combine to become a significant risk.



Risk Management Overview from AS/NZS 4360:19

APPENDIX 2

GOVERNANCE STRUCTURE JANUARY 2020

A&E Board (System Resilience Group)

CHFT & BTHFT Transformation Board

Partnership Transformation Board

WYAAT Committee in Common

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Philip Lewer / Frequency: Quarterly

Organ Donation Committee
Chair: Philip Lewer / Frequency: Quarterly

Council of Governors
Chair: Philip Lewer / Frequency: Quarterly

Nominations & Remuneration Committee
Chair: Philip Lewer / Frequency: Ad hoc but at least once annually

Audit and Risk Committee
Chair: Andy Nelson
Frequency: Quarterly

Transformation Programme Board
Chair: Peter Wilkinson
Frequency: Bi-Monthly

Finance & Performance Committee
Chair: Richard Hopkin
Frequency: Monthly

Nominations & Remuneration Committee
Chair: Philip Lewer
Frequency: Ad hoc at least once annually

Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

Quality Committee
Chair: Denise Sterling
Frequency: Monthly

Risk & Compliance Group
Chair: Chief Nurse
Frequency: Monthly

Information Governance & Risk Strategy Committee
Chair: CIO
Frequency: Quarterly

Clinical Records Group

Data Quality Board
Chair: COO
Frequency: Monthly

Health & Safety Committee Chair: ED Workforce & OD / Chief Nurse
Frequency: Monthly

Security & Resilience Group

Capital Planning Group

Commercial Investment & Strategy Committee

The Health Informatics Service Board

Huddersfield Pharmacy Specials Board

Divisional and Corporate Performance Reviews Executive Lead &
Chair: **COO**
Frequency: Monthly

CHS & CHFT Joint Liaison Committee

Medical Devices & Procurement Group

Divisional Management, Patient Safety, Quality Boards
Chair: **DD**
Frequency: Monthly

KPIs

Directorates (Speciality)

Trust Executive Board
Frequency: Weekly

Chair: CEO
Frequency: Weekly
One meeting per month focused on performance

Turnaround Executive
Chair: **CEO**
Frequency: Weekly

Digital Operational Board
Frequency: Monthly

EPR Partners
Frequency: Quarterly

Divisional Digital Boards
Frequency: Monthly

Research and Innovation Group
Chair: Deputy Medical Director
Frequency: Quarterly

Infection Control Prevention Committee
Chair: IPC Doctor
Frequency: Quarterly

Medication Safety and Compliance
Chair: CD Pharmacy
Frequency: Monthly

Infection Control Prevention Board
Chair: Medical Director
Frequency: Monthly

Hospital Transfusion Committee

Falls Improvement Collaborative

Resuscitation Group

Thrombosis / VTE Group

Pressure Ulcers Collaborative

IV Strategy Group

Radiation Protection Board

Safeguarding Committee
Chair: Deputy Chief Nurse
Frequency: Bi-Monthly

Patient Safety Group
Chair: AD Quality & Safety
Frequency: Monthly

Cancer Board
Chair: COO
Frequency: Monthly

Serious Incident Panel
Chair: **CEO**
Frequency: Bi-monthly

Dementia Operational Group

Family and Friends Group

Patient Experience and Caring Group
Chair: Deputy DoN
Frequency: Six Weekly

Deteriorating Patient Collaborative

End of Life Care Group

Clinical Effectiveness and Audit Group

Nutrition Steering Group

Sepsis Improvement Collaborative

Mortality Surveillance Group

CQC Response Group (Task & Finish)
Chair: Chief Nurse
Frequency: Monthly

Clinical Improvement Group
Chair: Medical Director
Frequency: Monthly

V15 January 2020

APPENDIX 3

Supporting Policies

There are a number of key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance:

Risk Management / Corporate

- Being Open / Duty of Candour Policy
- Central Alerting System
- Complaints policy
- Conflicts of Interest and Standards of Business Continuity
- Control of Substances Hazardous to Health (COSHH)
- Claims policy
- Emergency Preparedness, Resilience and Response Policy
- External Visits Policy
- Fire Safety Strategy
- Health and Safety policy
- Incident Reporting, Investigation and Management policy
- Major Incident policy
- Inquest Policy
- Information Governance Strategy and associated policies
- Policy for Developing Policies
- Risk Management Policy
- Safe Management of Contractors
- Security Policy
- Waste Management Policy
- Violence and Aggression in the Workplace

Workforce and Organisational Development

- Capability policy
- Freedom to Speak Up: raising Concerns Policy
- Harrassment and Bullying Policy
- Induction policy
- Mandatory Training Policy
- Mental Wellbeing and Stress Management Policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Promoting Good Health at Work Policy

Clinical

- Blood Transfusion policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Falls Prevention and Management policy
- Infection Control policies
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Policy on the implementation of NICE guidelines
- Point of Care Testing Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Slips, Trips and Falls Policy

- Race Equality Scheme

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

APPENDIX 4

Risk Management Specialists

Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As the Trust Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that the Trust creates and manages its information risks, through the development of a network of Information Asset Owners (IAAs) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that the Trust has a robust Strategy of policies and procedures for the management of the Trust's information, both corporate and clinical/patient.

The Information Governance Manager liaises with the Trust's Caldicott Guardian and Senior Information Risk Owner to ensure that the Trust meets and complies with the standards set out in the Information Governance Toolkit.

Data Protection Officer –the data protection officer is responsible for collection and protection of personal data and ensures the Trust follows the law and appropriate regulations

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee's risk responsibilities system. This role also ensures that the Trust is aware of any compliance issues, i.e. via the Single Oversight Framework from NHS Improvement, and that any risks associated with new business or service change which may impact on the Trust ability to adhere to the Single Oversight Framework are appropriately reported throughout the organisation.

Chief Nurse
The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of the Trust for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation, report directly to the Chief Executive and the Board, challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions; assess the impact of all existing and new policies and plans on infection and make

recommendations for change; be an integral member of the organisation's clinical governance structures.

Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Chief Nurse and leads the quality improvement strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where the Trust is involved.

Other Executive Directors
Director of Workforce and Development has executive responsibility for health and safety

Director of Finance has responsibility for managing the PFI provider and Calderdale Huddersfield Solutions to manage estates risks.

Chief Operating Officer has responsibility for security management, Trust resilience and fire safety.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Safety Manager
This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. They also provide specialist advice to design consultant/architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Health and Safety Advisor
The Health and Safety Advisor is responsible for monitoring all staff related incidents on a regular basis and ensuring this is reported to the Health and Safety Committee. They will organise health and safety training and education of staff to support CHFT's compliance with health and safety requirements. Duties of all employees are detailed in the health and safety policy.

Resilience & Security Manager
The overall objective of the Trust Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency

Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for the Trust (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within the Trust, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
The Trust has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
The Trust has a Radiation Protection Board chaired by the divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian
The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support the Trust to become a more open and transparent place to work.

The Senior Risk Manager has day-to-day responsibility for risk management process, management including:

- the development of risk management strategy and policies
- administration of risk management systems
- oversight of risk exposures facing the business
- provision of risk management training and support to divisions
- the maintenance of the high level risk register
- support the development of local risk registers
- lead in triangulating and sharing lessons for learning from adverse events
- risk management training
- management of legal services

The Risk Manager also provides advice and support on risk management to staff.

Associate Director of Quality and Safety – this role has operational responsibility

for risk management, complaints and legal services and is supported in this by a Head of Complaints and Legal Services and Senior Risk Manager.

Head of Safeguarding has day-to-day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners.

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP – 2020-017
Review Date: March 2021
Review Lead: Company Secretary

APPENDIX 5 - RISK GRADING MATRIX

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2 Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	1	2	3	4	5
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly	Expected to occur daily
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

Table 3 Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risks on the risk register, the scores obtained from the risk matrix are assigned grades as follows

1- 6	Low Risk
8-12	Moderate Risk
15-25	Significant Risk

APPENDIX 6

INCIDENT GRADING MATRIX

Degree of Harm	Description	Level of Investigation
No harm / near miss Impact prevented (near miss)	An incident that might have had the potential to cause harm but was prevented, resulting in no harm	Green (local review)
No harm Impact not prevented	An incident that occurred but no harm resulted	Green (local review)
Low / Minimal harm	An unexpected or unintended incident where patient (s) required extra observation or minor treatment and caused minimal harm to one or more persons	Yellow (Local investigation)
Moderate / Short term harm	An unexpected or unintended incident where patient(s) required further treatment or procedure which caused significant but not permanent harm (e.g. increase in length of hospital stay by 4-15 days)	Orange Divisional level investigation
Severe / permanent or long term harm	An unexpected or unintended incident that appears to have resulted in permanent harm	Red Serious incident investigation
Death caused by the patient incident	An unexpected or unintended incident that directly resulted in death	Red Serious incident investigation

CHFT RISK APPETITE – January 2020 **APPENDIX 7**

Risk Category	This means	Risk Level	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 (4)**	**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 (3)**	**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, equality and patient safety, which will be subject to rigorous impact assessments. The balance of price, value and benefits will be considered. We will allocate resources to capitalise on opportunities.	**CAUTIOUS (2)**	**MODERATE**
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 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 (2)**	**MODERATE**

Legal	We will comply with the law.	**MINIMAL (1)**	**LOW**
Innovation / Technology	The risk appetite for innovation / technology is high 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.	**OPEN (3)**	**HIGH**
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.	**OPEN (3)**	**HIGH**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to staff/patient safety and harm and clinical outcomes for patients.	**MINIMAL (1)**	**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.	**MINIMAL (1)**	**LOW**

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. 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 (4)**	**SIGNIFICANT**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK (4)**	**SIGNIFICANT**

19. Board Assurance Framework

To Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 March 2020
Meeting:	Board of Directors
Title:	Board Assurance Framework
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee 29 January 2020 Finance and Performance Committee 3 February

Actions Requested:
To approve

Purpose of the Report

The Board Assurance Framework (BAF) is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and provides Board members with an understanding of the principal risks to the achievement of the Trust's strategic objectives.

The BAF is presented to the Board for approval.

Key Points to Note

This paper presents the BAF as at 25 February 2020 to the Board following meetings with all risk owners to update and review the content of the Board Assurance Framework during January and February 2020. Each Director has reviewed the risk description, risks core, controls assurances and actions to address gaps in control.

At a risk management Board development workshop in December 2019 the reporting schedule for the Board Assurance Framework was revised to allow for review by the Audit and Risk Committee prior to presentation to the Board, given the role of this Committee in providing asssurance on risk management processes. In 2020/21 the BAF will be presented to the Board on 3 September, 5 November 2020 and March 2021.

The Trust has 16 risks on the BAF and has the following risk profile for the risks on the Board Assurance Framework using the 5x5 risk matrix to assess risk likelihood and impact, an increase of one risk since the last report to the Board in September 2019.:

- 7 risks rated red with a risk score between 15 and 25
- 8 risks rated amber with a risk score between 8 and 12
- 1 risk rated green with a risk score between 1 and 6

The Chief Executive is currently meeting the risk owners of the six red risks on the BAF month focussing on risk mitigation.

The movement on the the BAF since the full BAF report was presented to Board in September 2019 and the Health & Safety risk, ref 16/19 was approved at the Board meeting on 9 January 2020 is given below:

BAF reference 18/19 – Long term financial sustainability – risk score of 25
Following discussion at the Board workshop and at the Finance and Performance Committee on 3 February 2020 it was agreed that risk 7278 on the high level risk register, relating to long term financial sustainability is a longer term strategic risk and is more appropriate for the BAF. Risk 7278 has therefore been closed on the risk register. Risk ref 18/19 has therefore been developed following a review of risk 7278 on the high level risk register and risk 13/19 delivery of the long term financial plan, which was previsouly on the BAF and has now been removed from the BAF. Risk ref 18/19 is the combined and refreshed long term financial risk.

BAF reference 14/19 financial risk regarding capital – risk score increas 12 to 16
The captial BAF risk score has increased from 12 to 16 as whilst the Strategic Outline Case, SOC, for reconfiguration, is expected to receive approval at a national level, internal capital remains constrained due to the Trust overall financial position.

EQIA – Equality Impact Assessment

No impact identified.

Recommendation

The Board is asked to approve the Board Assurance Framework as at 25 February 2020.

Latest update for 5 March Board - 24 February 2020

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2019/20

Contents:

compassionate care

CHFT RISK APPETITE STATEMENT - APPROVED JANUARY 2020

Risk Category	This means	Risk Level	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 (4)**	**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 (3)**	**HIGH**
Financial / 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, eqyuality and patient safety, which will be subject to rigorous impact assessments. The balance of price, value and benefits will be considered. We will allocate resources to capitalise on opportunities.	**CAUTIOUS (2)**	**MODERATE**
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 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 (2)**	**MODERATE**
Legal	We will comply with the law.	**MINIMAL (1)**	**LOW**
Innovation / Technology	The risk appetite for innovation / technology is high 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.	**OPEN (3)**	**HIGH**
Commerical	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.	**OPEN (3)**	**HIGH**
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 for patients.	**MINIMAL (1)**	**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.	**MINIMAL (1)**	**LOW**
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. 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 (4)**	**SIGNIFICANT**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK (4)**	**SIGNIFICANT**

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2020
FULL LIST

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Appetite
Transforming and improving patient care							
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	15 =	**10**	AB	2827, 5806,7413,7414	Seek / Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	**6 =**	**4**	DB	None	Cautious / Moderate
04/19	Risk that the Trust does not listen, involve and engage patients and the public in the delivery and improvement of services and that people from protected characteristic groups receive sub optimal care due to lack of capacity and capability to respond in a a meaningful way to patient and service user feedback resulting in services not designing services using patient receommendations	12	**9 =**	**4**	EA	None	Cautious / Moderate
05/19	Risk that the resource, capacity and capability of full optimisation of the EPR system does not continue to further enhance quality and safety.	15	**9 =**	**4**	MG	6715	Seek / Significant
Keeping the base safe							
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**12 =**	**10**	EA	6345,7078, 5747 7345, 6715, 7396	Minimal / Low
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action	25	**15 =**	**10**	OW	None	Cautious / Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**12 =**	**8**	HB	See sheet	Cautious / Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**20 =**	**8**	GB	5806	Minimal / Low
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	**9**	**9**	**4**	SD	7413, 7414 , 7474	Minimal / Low
A workforce fit for the future							
10a /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	**9**	DB	2827,7078, 5747	Minimal / Low
10b /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	**9**	EA	6345	Minimal / Low
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues	16	**12 =**	**9**	SD	7248	Seek / Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms	**12 =**	**9 =**	**4**	SD	None	Seek / Significant
Financial sustainability							
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	16↑	12	GB		Cautious / Moderate
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution..	**9 =**	9 !	**6**	GB		Open / High
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	**25 =**	**25 !**	**16**	GB		Cautious / Moderate

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)				9. Estate fit for purpose =	13. Financial delivery = 18. Long term financial sustainability !
Likely (4)			14. Capital =		10. Staffing levels =
Possible (3)		3. Seven day services =	12. Staff engagement = 14. Commercial growth 16. Health & Safety ! 17. Integrated Care Service financial!	8. National and local targets = 6. Compliance with quality standards= 11. Clinical leadership =	5. EPR benefits realisation = 1. Approval of hospital reconfiguration strategic outline case 7. Compliance with NHS Improvement =
Unlikely (2)			4. Public involvement =		2. Delivery of WYAAT programme =
Rare (1)					

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
1.19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures have been established within the Trust. The Transformation Programme Board has been established as a formal sub-committee of the Trust Board to oversee service transformation and reconfiguration plans. The Trust has quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). The Trust is procuring the necessary external professional and technical skills and advice required. The Trust is working closely with the Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. The Trust is working closely with the West Yorkshire and Harrogate Health and Care Partnership and commissioners to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and CCGs ability to provide formal letters of support for the business cases. A local system Partnership Transformation Board that has members from CCGs, ICS, YAS, and the Trust meets monthly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and NHSE/NHSI, DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). OBC scheduled for approval in December 2020. Third line ICS and NHSE/NHSI review and approval of business cases prior to submission to DHSC.	• See below	The Trust is working with regulators to secure agreement that the early call down of capital to fund necessary professional and technical fees to produce the OBC will be agreed.	5x5 = 25	3x5 = 15	2x5 = 10

Gaps in Control	**The**	**Lead**
• Insufficient internal capacity to support development of the business case • Unable to procure the necessary expertise and techincial skills to develop the business case	Identified internal resource and are appointing additional capacity, Q4 Procurement of external technical expertise and capacity in progress with timescale to appoint in February 2020.	AB for all actions

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in a & e - workforce standards, A& E and critical care
5806 - urgent estate work not completed
7413 - fire compartmentation risk HRI
7414 - building safety risk, HRI

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
3.19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) • Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology, gastro, stroke, haematology, acute medicine, diabetes with discussions progressing in palliative care • Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR and SHMI within expected range. Audit to assess impact of expanded 7 day working on outcomes: HSMR and weekend vs weekday mortality trends over the last 2 years Second line Integrated Board report Benchmarked against four priority seven day standards - full compliance at most recent audit in May 2018. Bi-annual submission for compliance against the seven day standards to NHS England / Improvement approved at WEB (20/06/19, 12/12/19 confirmed compliance against all four NHSE priority standards Single Oversight Framework. Quality Accounts 2019/20 confirmed compliance against standards 2018/19. Third line Positive feedback from NHSI/E, NHSE-led, WYAAT-wide implementation scheme Benchmarking exercise against remaining 6 non-priority standards to report to WEB	Radiology staffing pressures present risk of continued delivery of standards 5 and 6 - access to diagnostic tests and access to consultant -directed interventions	• Scope for futher implementation limited without service reconfiguration or additional investment	**5x3 = 15**	**3x2= 6**	**2x2 = 4**
Action					**Timescales**			**Lead**		
National survey completed twice a year					June 2020			DB/CP		
Links to risk register: No high level risks with score >15										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
4.19	Quality Committee	Executive Director of Nursing / Deputy Chief Executive	**Risk** Risk that the Trust does not listen, involve and engage patients and the public in the delivery and improvement of services, people from protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Working with HealthWatch on key areas of interest / concern • Patient Experience Group in place • Patient engagement in Outpatient Transformation Programme, including online survey of patients about future O/P service model and work with Healthwatch on protected groups on barriers to communication • Pilots of changes to service models being tested with patients • Engagement champions in place across the Trust • Engagement toolkit being developed • Engagement events re: Strategic Outline Case • N&MW strategy	<u>First line</u> Public involvement and engagement included in Patient Experience Group Areas of good practice identified within the Trust <u>Second line</u> Governor attends Patient Experience Group Patient Experience Group reporting to Quality Committee Project Management information on service change and engagement (PMO workbooks) <u>Third line</u> Annual reporting to CCGs CQC rating of Good - report referenced positive examples of patient engagement Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data Co-ordination role for engagement to be agreed. Lack of consistent approach when seeking patient input to re-designing services with Patient panel being set up with governor engagement, Quality Committee governor Lack of resource to support effective and meaningful engagement Action: Staffing structure review by Director of Nursing by December 2019 Patient and service User Engagement Strategy being reviewed, Director of Nursing December 2019 Patient Experience strategy being developed as integral part of nursing and midwifery strrategy - move to control	Patient Experience reports to Board - further opportunities to provide direct Board oversight of service user stories to Board Well-led developmental review identifies actions to improve patient involvement and E&D	**3x4 = 12**	**3x3 = 9**	**1x4 = 4**
								Lead		
Quality directorate staffing structure review Patient and Service User Launch of nursing and midwifery strategy including patient experience strategy					31/01/20 31/12/19 January 2020			Ellen Armistead Ellen Armistead Ellen Armistead		
Links to risk register: No risks on the risk register >15										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	OWNER Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JANUARY 2020 Initial	Current	Target
5.19	Finance and Performance Committee	Managing Director of Digital Health	**Risk** Risk that the resource, capacity and capability of full optimisation of the EPR system does not continue to further enhance quality and safety. **Impact** - limited opportunity to deliver improvements in clinical outcomes	• Digital Health Forum meets monthly with Executive Directors where any escalations and updates are presented • External funding secured for next 2 years • Managing Director attends Audit and Risk Committee to provide udpate on digital issues • Appointment of Director of Digital Transformation and Innovation January 2020, Non-Executive sponsor for digital including EPR • Operational Delivery Board in place with cross divisional representation • Digital Boards in place at divisional level which discuss the current digital agenda and operational impact and business continuity requirements of any digital change. • EPR BAU team fully resourced, •Business as Usual structure to be aligned with demand and capacity , • Transformation Board reporting • Programme Board in place with cross trust representation • Change prioritisation meetings in place which should complement the needs of this Trust and EPR partner Bradford Teaching Hospitals Trust	First line Digital Health Forum Operational Board reporting Digital open days held Digital 5 year Strategy – first draft presented to Weekly Executive meeting, Second line Audit and Risk Committee focus on digital agenda including EPR (July 2019 meeting) Report to Finance and Performance Committee Financial benefts report to Board confirmed EPR system return on investment was realised June F&P reported to Board in July Third line •Digital 5 year Strategy – first draft presented to CCG clinical leads (Calderdale & Greater Hudersfield . Digital maturity assessment 2017 Trust 13th in country. Clinical digital maturity index - Trust number 1 nationally (NHS England) Reference site for Cerner for EPR	• Number of issues following implementation still to be addressed • Business as usual structure doesn't include development structure •Further work to be done on benefits realisation to ensure embedded across the Trust linked to wider work on benefits realisaton Agree optimise resource to realise the benefits Business as usual structure not aligned to demand and capacity Action: Full review of digital health support infrastructure and identify the gap to inform the investment required Lead: Managing Director THIS Timescale: Plan agreed by end of November 2019. Resource plan developed	Engagement on Digital Strategy - see actions Digital Strategy Board sign off planned for May 2020 • Lack of capital funding for developments. •. Work is ongoing to document all quality and safety benfits. Awaiting results of digital maturity asssessment submitted to NHS England / Improvement July 2019	3x5 = 15	3x4 = 12	2x5 = 10

Action	Timescales	Lead
Work on quality and safety benefits realisation continues within annual planning arrangements Engagement plan developed for Digital Strategy	01/03/2020 February and March 2020	GB / MG Director Digital Transformation

Links to risk register:
EPR related risks 6715 documentation
There are no high level risks relating to benefits realisation.

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
16.19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	• SLA in place for CHS to provde Health and Safety Training for CHFT colleages. • Director and Non-Executive Director Health and Safety Champion identified • Proactive health & safety committee • Annual report on Health and Safety to Board • Health and Safety action plan • Training: 'Leading Safely' IOSH training for Board members February 2019 • Health and Safety mandatory training for staff (3 years) • Health and Safety training on staff induction • COSHH training • Risk assessment training	First line Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health & Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health & safety incidents and learning, medical devices training & monitoring, fire and securitry information . s and shared learning, health and safety incidents / learning. Second line Board joint responsibility for risk understood following the Board IOSH training in February 2019 WEB reports on mandatory training, health and safety training compliance currently at target levels 9 January 2020 external Health and Safety review presented to Board • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 Third line External health and safety review (Quadriga) 2019 (reference also to fire safety)	• Health and Safety Policy to be revised to include statement of intent with supporting policy / procedural guidance and provide clarity on roles and responsibilities - Need for specific policies for Risk Assessment, Noise Policy and others (as detailed in Quadriga report) • Lack of identified and competent resource to recruit to CHFT Head of Health and Safety and secure an appropriate candidate • Explore models of independent and professional external provison of technical health and safety advice (similar to Authorised Engineer role)	• Lack of health and safety input to Audit and Risk Committee - need to review reporting arrangements • As detailed in Quadriga review: update Health & Safety Policy, Review RIDDOR reporting, Develop Risk Assessment Policy & matrix, ensure compliance with fire safety, share and discuss joint CHS & Trust risks & mitigation at Joint Liaison Committee meetings. • 2020/21 Annual Health and Safety action plan to be developed and prsented to H&S Committtee in March 2020, Board, May Board Lead: H&S advisor Day to day H&s activity is lead by CHS with ultimate responsibility through the MAnaging Director, CHS. CHFT needs to assure itself that these activities provide a health & safe environment for staff, pateints and visitors. Lead: S Sugarman / Suzanne Dunkley	**3x3 = 9**	**3x3 = 9**	**2x2 = 4**

Action	**Timescales**	**Lead**
Reframe the current 5 Year Strategy objective on health and safety	April 2020	SD / A Wilson
- Implementation of 2019/20 action plan (including Health and Safety Policy review)	31 March 2020	As per plan
- Review Board/Committee reporting on health and safety	31 March 2020	SD / AM
- Plan 2021 internal audit review of health and safety	2021 internal audit plan	AM / GB

Links to risk register:
7413 fire compartmentation, 7414 building safety, 7474 medical devices

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
KEEPING THE BASE SAFE

TRUST GOAL: 2 KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
6.19	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Partial review of quality governance arrangements • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements at divisional level, including compliance registers • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures via ward assurance tool • Programme of assurance visits in place • Consistent mandatory and essential training compliance • Process in place for reviewing quality metrics at ward and department level	<u>First line</u> Assessment of compliance with NICE guidance Ward accreditation - Performance against saferty must dos reviewed at ward / matron level Improvement in HSMR & SHMI Mandatory tining compliance at August 2019 94.04% <u>Second line</u> Clinical audit plan reviewed Quarterly Quality Report to Quality Committee and Board KPIs in Integrated Performance Report PSQB reports to Quality Committee Infection Prevention and Control report to Board Serious incident report to Quality Committee Safer Staffing Hard Truths report to Board 5.9.19. <u>Third line</u> CQC rating of Good Quality Account reviewed by External Auditors and stakeholder bodies Independent assurance on clinical audit strategy Feedback through ongoing relationship with arms length regulatory bodies Independent Service Reviews (ISR) and accreditations. ISR March 2019 assurance on process for responding to NPSA alerts Health Services Investigation Branch reports	• Standard of serious incident investigations needs further improvement • Estate issues identified - Development of HRI estates strategy • Safety "must do's" to be embedded on wards Quality Governance - quality governance arrangements and structures to be reviewed Lead: Director of Nursing / Medical Director timescale Jan 2020	• CQC assessed the Trust as requires improvement for safe domain • Staff FFT and staff survey (2018) responses show marginal improvement • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements (Allocate) Inconsistent performance around safety must dos Lack of triangulation of impact of staffing gaps on safety and quality - action addressed in future hard truth reports to Board	**3x5 = 15**	**3x4= 12**	**2x5 = 10**

Action	**Timescales**	**Lead**
Implement safety must do action plan	As per business planning timescale	EA
Explore digital solution for safety must dos	Hard Truths report to Board 6 monthly (next report March 2020)	EA
Hard Truths staffing report to include triangulation of staffing gaps with safety and quality		LR/EA

Links to risk register:
Risk 6345 - nurse staffing risk, risk 7078 - Medical staffing risk , risk 7345 - Referrals to district nursing service, risk 5747 interventional radiology staffing, 6715 clinical documentation, risk 7396 inadvertent connection to air flow instead of oxygen.

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
7.19	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement (NHS E/I) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Quarterly review meeting with NHS E/I • Control total for 2019/20 accepted • Standing Financial Instructions and budget managent • Corporate compliance register in place • Review of monthly NHS E/I bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Well Led CQC review 2018, rating of "good" • Use of Resources inspection completed and action plan being implemented • Board approved 5 Year Strategic Plan	First line Clear PMO and Performace Review (PRM) reporting from Divisions provides assurance performance is on track with close monitoring of emergency care standard Second line Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee which shows cip delivery on track at month 4, 2019/20 Review by Quality Committee and Board of progress with CQC action plan and use of resources action plan. July 2019 Board report on CQC shows 49 actions completed and embedded. Third line Further autonomy granted from NHS E/I as result of performance and acceptance of the 2019/20 control total from NHSE/I. Quarterly PRM with NHS E/I 8 July, 14 October, 19 December 2019 Round table meetings being held with CCGs, NHS England / Improvement	• Challenging financial position - refer to BAF risk 18/19 Action: Progression of reconfiguration of hospital services to move to a more sustainable financial position in the future, with close management of in-year financial plan and delivery. Awaiting confirmation of PLACE based NHSE/I arrangements to replace QRM meetings. (Awaiting confirmation of PLACE based NHSE/I arrangements to replace QRM meetings).	• Performance against key targets • Use of Resources rating of requires improvement - review to be arranged Feedback on external Governance well-led development review to Board 6 February 2020. Trust eligibility for Provider Sustainability Fund and Financial Recovery Fund is contingent on delivery of 2019/20 control total on a quarterly basis. Q1 , 2 and 3 acheived and monitoring of delivery for Q2,3 and 4 by Finance and Performance Committee.	5x5 = 25	3x5 = 15	2x5 = 10
Action					**Timescales**			**Lead**		
Use of resources and CQC action plan (2 actions) being implemented					Ongoing - reported to Quality Committee and Finance and Performance Committee			EA / GB		
Links to risk register:										

TRUST GOAL: 2. KEEPING THE BASE SAFE									
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**	
8.19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Impact** - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders	• **General** performance controls include weekly performance monitoring and management arrangements, CQUINs, leadership masterclasses held weekly, monthly Quality & Performance Executive Board meeting, IPR presented to relevant Board Committees - e.g. F&P Performance Review Meeting (PRM), bronze, silver and gold command arrangements and escalation process **Specific** performance controls established for key metrics: • A&E delivery board with partners which oversees overall emerency care performance • System wide urgent and emergency care programme established focused on transforming urgent care • Dedicated lead roles in planned care, urgent care, cancer and performance • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Urgent Care Board, Cancer Board and Diagnostics Board estabished with Clinical Director attendance to ensure robust medical leadership	<u>First line</u> Weekly performance review with divisions. Divisional board and PRM reviews of performance with executive attendance Regular clincial director (CD) attendance at specialty boards and CD sign off of urgent care innovation plans. Weekly escalation at WEB Integrated Performance report focus of one WEB each month for detailed scrutiny with wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Improving IPR score as at June 2019 <u>Second line</u> Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff <u>Third line</u> Urgent Care and Planned Care Boards and System Resilience group Quarterly review meeting with NHS E/I on performance	• System responsiveness dependent on formal escalation by CHFT when agreed tiggers reached. Action: System Full Capacity protocol in development with increased out of hospital focus. Lead: A& E Delivery Board Timescale: Q4 • Achievement of 4 hour emergency care standard requires micro-management. Action: Establishment of system wide urgent and emergency care programme. • Continued incorrect use of RTT codes increasing validation dependancy Action - established RTT diagnostic programme Lead: Head of Planned Care Timescale: November 2019 for all diagnostics, March 2021 for full assurance	Inconsistant tracking of performance recovery actions. Action: weekly 1:1 performance reviews with each Director of Operations. Comprehensive review of previous IPRs and presentations of finding to Divisional Boards. +A1 Lack of triangulation across the IPR to ensure cause and effect clear and actions target root cause. Action: Established process for sub board tier to review IPR and produce a report triagnulating the IPR bi-monthly	**Initial** 4x4 = 16	**Current** 3x4 = 12	**Target** 4 x 2 = 8
Action					**Timescales**			**Lead**	
Dashboard to be developed to support system escalation RTT Diagnostic Programme					December 2019 March 2021 (full assurance)			Bev Walker Katharine Fletcher	
Links to risk register: None									

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING NOVEMBER 2019**		
								Initial	**Current**	**Target**
9.19	Quality Committee	Executive Director of Finance	**Risk** Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care **Impact** - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Medical device and maintenance policies &procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts • Estates in 5 Year Strategic plan • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Audit of medical devices by independent assessor • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire • Concordat in place with West Yorkshire fire authority	First line • Close management of service contracts to ensure planned maintenance activity has been performed Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS Review of CHS SLAs (Quantitive KPIs & Qualitative Performance) carried out Q4 2020 Audits of routine checks, estates Second line Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via service performance reports Assurance provided by Authroised Engineerss following audits against Estates statutory requirements WEB reports on medical devices July 2019 H&S Training 95% target achieved, 98% as at 22.1.20,. 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line PLACE assessments CQC Compliance report Progress made on DoH Premises Assurance Model (PAMs) to illustrate to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe. HSE review of water management Familiarisation visits by local operational Fire and Rescue teams External assurance from authorising engineers for high voltage/ low voltage systems, reviewed at CHS Contracts and Performance Committee 21.8.19.	**Deep Dive into Joint Risks** - Detailed review of controls Vs joint CHS/CHFT risks to form part of JLC Agenda (as per Quadriga recommendation) * **Opportunity to Enhance Strategic PFI Governance Arrangements** - quarterly meeting with CHS/Albany/Engie & ISS to ensure more rigour * **Develop Audit Programme** carried out by Service Performance for CHS/PFI services * **Validate Appointment Letters** for HTM Compliance Matrix (CHS & PFI) • Investment strategy in response to 6 Facet Survey for HRI agreed by Board - November 2019, lead Anna Basford. Funding available for prioritised work but does not cover ALL backlog maintenance £85m • Capital funding awarded, confirmation of capital funding from NHS Improvement. Exxternal review of estates to priorities expenditure in financial plan 2019/20 • **H&S Review Annual Plan** reported to Board of Directors Jan 2020; workplan being progressed. Recommendations to take forward and report back at 4 monthly intervals.	• Issues identified with estate requiring urgent work	4x4 = 16	5x4= 20	2x4 = 8

Action	**Timescales**	**Lead**
Deep dive into joint risks with CHFT and CHS and assurance re: collection of risks on risk 5806 on risk register Audit Programme to be develeoped	Mar-20	HB / AWilson AB SD

Links to risk register:
Risk 5806 - Urgent estate schemes not undertaken -A3
Risk 7414 - Building safety risk, HRI
Risk 7413 - Fire compartmentation risk, HRI
Risk 7474 - Medical Devices

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JANUARY 2020 Initial	Current	Target
16.19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	• SLA in place for CHS to provde Health and Safety Training for CHFT colleages. • Director and Non-Executive Director Health and Safety Champion identified • Proactive health & safety committee • Annual report on Health and Safety to Board • Health and Safety action plan • Training: 'Leading Safely' IOSH training for Board members February 2019 • Health and Safety mandatory training for staff (3 years) • Health and Safety training on staff induction • COSHH training • Risk assessment training	First line Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and securitry information . s and shared learning, health and safety incidents / learning. Second line Board joint responsibility for risk understood following the Board IOSH training in February 2019 WEB reports on mandatory training, health and safety training compliance currently at target levels 9 January 2020 external Health and Safety review presented to Board • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 Third line External health and safety review (Quadriga) 2019 (reference also to fire safety)	• Health and Safety Policy to be revised to include statement of intent with supporting policy / procedural guidance and provide clarity on roles and responsibilities - Need for specific policies for Risk Assessment, Noise Policy and others (as detailed in Quadriga report) • Lack of identified and competent resource to recruit to CHFT Head of Health and Safety and secure an appropriate candidate • Explore models of independent and professional external provison of technical health and safety advice (similar to Authorised Engineer role)	• Lack of health and safety input to Audit and Risk Committee - need to review reporting arrangements • As detailed in Quadriga review: update Health & Safety Policy, Review RIDDOR reporting, Develop Risk Assessment Policy & matrix, ensure compliance with fire safety, share and discuss joint CHS & Trust risks & mitigation at Joint Liaison Committee meetings. • 2020/21 Annual Health and Safety action plan to be developed and prsented to H&S Committtee in March 2020, Board, May Board Lead: H&S advisor Day to day h&s activity is lead by CHS with ultimate responsibility through the MAnaging Director, CHS. CHFT needs to assure itself that these activities provide a health & safe environment for staff, pateints and visitors. SS / SD	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
Reframe the current 5 Year Strategy objective on health and safety	April 2020	SD / A Wilson
- Implementation of 2019/20 action plan (including Health and Safety Policy review)	31 March 2020	As per plan
- Review Board/Committee reporting on health and safety	31 March 2020	SD / AM
- Plan 2021 internal audit review of health and safety	2021 internal audit plan	AM / GB

Links to risk register:
7413 fire compartmentation, 7414 building safety, 7474 medical devices

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE (Where are we failing to gain evidence about our system/ controls?)	RATING JANUARY 2020 Initial	Current	Target
10a /19	Workforce Committee and Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Guardian of Safe Working in place which ensures safe working hours for junior doctors. • E -job planning ensures efficient use of medical staff workforce and visibility of Consultant workforce activity • Use of CESR programme to increase Consultant workforce in appropriate specialties supports recruitment and retention • Medical workforce team portfolio includes recrutiment and retention workstream, recruitment and retention strategy in place • Agency and bank use of medical staff • Service improvement in cardiology, respiratory and frailty, with developmnent of acute floor and frailty service at HRI to aid recruitment • Medical workforce steering group meets bi-monthly, focus on using current staff effectvely, retention and recuitment. •Workforce Committee • WYAAT networking approach to pressured specialties, eg Vascular Surgery, Interventional Radiology and programme of work • ED business continuity plan in place; • Ongoing recruitment programme in place, including international recruitment; • Medical Workforce Programme Steering Group meets bimonthly Segmentation approach and vacancy tracker in place to focus medical recruitment resource on clinically high risk and likelihood of appointment. Vacancy tracker maps medical workforce to medical establishment, tracks vacancies, pipeline and retention. Electronic job planning in place for all consultants Junior doctor awards Adopted SAS doctor charter	First line Staffing levels, training & education compliance and development reported to WEB, Divisional business meetings and PSQBs consider staffing levels as part of standard agenda, IPR with key KPIs shows slight decrease in sickness levels, and reduction in agency spend Weekly meeting on agency spend and report to Turnaround Executive 6 additional PA posts recruited to Improvements in mortality (HSMR / SHMI). Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend - 78% reduction in medical agency spend based on forecast. Vacancy tracker broadly shows improvement in some medical specialties. Second line Monthly performance meetings (PRM) review workforce reports Workforce Committtee - eg report on retention 5.11.19. shows positive progress with recruitment to Consultant posts but hard to fill specialty vacancies remain (net gain of 12.6 wte as at 25.10.19.) Medical Appraisal and revalidation report to Board, demonstrates high quality workforce. Guardian of Safe Working Board report (4.7.19., 9.1.20.) on working hours - no safety concerns, investing in improved facilities for trainees PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship with arms-length bodies, GMC Report on Junior Doctor Experience	Recruitment and retention strategy for medical and therapy staffing required (PN) Medical E-rostering only partially implemented for doctors - to roll out from May 2019 for sub-consultant doctors and from October 2019 for consultants - dependent in part on support from Allocate Pensions rules reduce willingness of medical staff to deliver additional work (national issue). Business case for Activity Manager to support e-rostering and increase visibility of range of activities of medical workforce	• Need to embed workforce plan			

Action	Timescales	Lead
E-rostering being rolled out to medics- timescale exteded from September 2020 to March 2021 to allow more information on Consultant activity to be populated on the system	09/03/2021	Associate Medical Director
Activity Manager Business Case to Capital Investment Strategy Group	January 2020	Associate Medical Director
Trust part of WYAAT bid to NHS I for funding for electronic workforce solutions for medical staffing		

Links to risk register:
Risk 6345 - nurse staffing risk
Risk 2827 - Over reliance on middle grade doctors in A&E
Risk 7078 - medical staffing risk
Risk 5747 - Vascular / interventional radiology staffing

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JANUARY 2019 Initial	Current	Target
10b.19	Workforce Committee and Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	Nursing and Midwifery Strategy- implementation of "Time to Care" Daily and weekly nurse staffing escalation reports • Ongoing recruitment programme in place, including international recruitment • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes • Risk assessments in place • Nursing and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance	<u>First line</u> Staffing levels, training & education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IPR shows slight decrease in sickness levels, and reduction in agency spend Bi-annual review of ward nursing levels 6 additional PA posts and nursing associate posts recruited to Medical : Improvements in mortality (HSMR / SHMI).Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend Agency spend reported weekly to Turnaround Executive Reduction in average hourly rate for nursing staff has not impacted on fill rate. <u>Second line</u> Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues., Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board Septemner 2019 KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee <u>Third Line</u> Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Nursing Despite controls in place there will still be occasions where capacity does not meet demand, eg increasing staffing sickness Nursing and Midwifery Strategy not yet embedded.	1	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
Launch of Nursing and Midwifery Strategy	Jan-20	EA

Links to risk register:
Risk 6345 - nurse staffing risk

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JANUARY 2020 Initial	Current	Target
11.19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. -	• Organisational Development Strategy, The Cupboard recipe cards for Working Together to Improve (leadership and engagement), equality, diversity and inclusion and talent management recipe cards which set out key actions in these areas and measures for monitoring success. • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Performance appraisal based around behaviours with temperature check guide introduced to help colleagues to think about the four pillars and their contribution to one culture of care • Development of new roles across professional groups, eg physicians associates., development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Development of Managers Essentials programme and compassionate leadership orgramme, CLIP, being designed collaboratively with colleagues New Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. Development of specific behavipours to support 4 pillars by BAME network	First line Clinicians leading of transformation programmes e.g. cardio /respiratory Recruitment to key Consultant roles across the Trust - report to Workforce Committee 5.11.19. Second line Integrated Performance Report and Workforce Committee reports show a rolling absence rate of 3.69%% (as at December 2019) and rolling turnover score of 8% (lowest recorded) as at November 2019 Revalidation report to board Board approval of OD strategy - March 2019 Board update on delivery of OD strategy - Jan 2020 Wokforce Committee approved Management Essentials & Leadership (Clip) Programme in December 2020, Board noted January 2020 Third line Investors in People (IIP)Silver Accreditation to 2021 based on assessment of the IIP principles of leading, improving and supporting. Very positive feedback from interim IIP annual review from October 2019. BMA referring to CHFT as an employer of choice for junior doctors due to level of support for trainees Feedback from Royal Colleges Junior doctor GMC questionnaire feedback Positive feedback from Junior doctors on medical training - Health Education England survey, July 2019, showed improved scores in Anaethesia, Paediatrics, Urology, Obstetrics and Gynaecology, Trust moved from 8th in region to 5th, with 100% response rate OFSTED Interim report has given reasonable progress on all actions relating to the clinical assessment team for Apprentices (August 2019)	Launch Management Essentials and CLIP development programmes in April 2020 Action - see below		4x4 = 16	3x4 =12	3x3 = 9

Gaps in Controls	Action, Lead, Timescales	Lead
Nursing development programme in line with year of Nurse and Midwife	April 2020 Ellen Armistead,Suzanne Dunkley, Lindsay Rudge, Ruth Mason	EA
Nursing development programme in line with year of the nurse and midwife	April 2020 Ruth Mason	RM
Launch Management Essentials and Compassionate Leadership in Practice development programme		

Links to risk register:
Risk 7248 - mandatory training

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JANUARY 2020 Initial	Current	Target
12.19	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Colleague engagment is a key recipe card in The Cupboard which set out key actions in these areas over the next 3 - 5 years and measures for moniroing success. Hot house events to ensure all strateguc colleague policies and practices are developed collaboratively across the Trust Leadership visibility increasing through tea trolley rounds and a series of events in the engegament calendar Assurance visits ensure senior clinical and non clinical visibility and engagement based on themes • Quarterly staff FFT in place provides interim feedback on whether colleagues would like to receive treatment by the Trust • 'Ask Owen' being responded to and a similar mehcanism to allow colleagues to say thank you to each other is being developed CHuFT portal for colleagues to congratulate and thank each other for a job well done • Celebrating success year long programme of events, annual awards ceremony booked for July 2020 celebrating the positives and other events will ensure improved engagement in colleague and Trust wide improvement and success. • Staff survey action plan implemented to improve take up of staff survey • Health and wellbeing strategy refreshed and includes modules for both mental and physical good health. "New Year New Me" capmaoign launched January 2020, part of Health & Well Being recipe card in The Cupboard • Ways of engaging colleagues include CDAG, Colleague Disability Action Group, LGBTQ network, BAME network in place and well attended	First line CQC preparation for self assessment shows some areas reporting GOOD in well led domain Improving absence position (see 11/19) Freedom to Speak Up concerns increased from 2 in September 2018 to over 50 in July 2019, reflecting better communication and engagement with the process Successful launch of CHuFT portal in October 2019 Second line Integrated Board report shows sickness absence improved, July 2019 Freedom to Speak Up annual report to Board July 2019 Hot House events held for Healthe & Well Being, Equality & Diversity, Apprenticeships, Staff Survey - demonstrateg engagement and collaboration informing people management policices and processes Third line Staff FFT / staff survey provides some positive feedback, 2018 survey had highest respose rate of 51% Investors in People accrediation - Silver award to 2021, which shows a more qualitiative review of Trust culture than the annual NHS staff survey CQC rating of Good	Plans to coordinate all celebrating succcess activities across the Trust, - ongoing discussion wth Communications team to agree process and branding activity March 2020 Action to address gap in control: see below	Awaiting 2019 staff survey results - expected mid March 2020	3x4 = 12	3x3 = 9	1x4 = 4

Action to address gap in control	Action and timescale	Lead
Ongoing discussion with Communications team to agree celebrating success activities across the Trust	Discussion with Workforce and Organisational Development and Communications team.	Ruth Mason

Links to risk register:
No high level risk register related risks scoring over 15.

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
14.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Small contingency remains in place to cover any further changes. Transformation Programme Board established with oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience	<u>First line</u> Reporting through WEB on capital prioritisation 2018/19 Capital Plan delivered Sale of Acre House Avenue properties in 2019/20 in support of capital expenditure <u>Second line</u> Turnaround Executive Reports Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Third line</u> Monthly return to NHS E/ I Quarterly meeting with NHS E/I Business case for reconfiguration continues to progress through NHS E/I approval process	The long term capital spend required for HRI is in excess of internally generated capital funds. The 2019/20 Capital plan is reliant on land sales (Acre House and Glenacre House) plus a combination of both emergency capital bids and business case drawdown to fund a replacement MRI and meet essential health and safety requirments at HRI in relation to both fire safety and cladding.	Land sales of Glen Acre / Acre House not yet agreed - progressing as per plan Emergency capital approval from NHS England / Improvement to be confirmed Backlog maintenance costs will remain in excess of planned capital spend.	4x5 = 20	4x4 = 16	3x4=12

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through F&P and Board	Ongoing	GB

Links to risk register:

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
15.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Pharmacy Manufacturing Unit (PMU), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place Managing Director for Calderdale Health Solutions Limited inplace (September 2019) Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings THIS Executive Board meeting with Non-Executive attendance Escalation process if THIS targets not met via Turanround Executive and Finance and Performance Committee CHS and PMU Board chaired by Non-Executive Director	**First line** Individual boards (THIS, PMU, CHS) and report on performance against targets into Finance and Performance Committee	PMU requires further capital investment to continue to grow. Exploring future commercial options - lead: Director of Finance THIS continue to bid for aditional external work but at present this is not sufficient to close the financial gap THIS continue to maximise commercial opportunities. Contract with Bradford and Craven district due to commence 1.4.20.	PMU requires capital investment to meet its ambitious growth plan for 2020/21	3x3 = 9	3x3 = 9	2x3= 6
Action					**February 2020**			**Lead**		
Ongoing monitoring of financial position through F&P and Board					Ongoing			GB		
Links to high level risk register:										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JANUARY 2020**		
								Initial	**Current**	**Target**
18/19	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit and reliance on cash suppport. Whilst the Trust is developing a business case that will bring it back to unsupported financial balance in the medium term. this plan is subject to approval and the release of capital funds **Impact** - financial sustainability - loss of financial recovery funding (FRF) - increased regulatory scrutiny - Impact - financial sustainability - insufficient cash to meet revenue obligation - inability to invest in patient care or estate - adverse impact on Use of Resources rating	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Project Management Office in place to support the identification and delivery of CIP Escalation forum to support CIP schemes off track Budgetary control process with increased profile and ownership Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Development of: - 25 year financial plans in support of Business Case - 5 year Long Term Financial Plan forms part of ICS financial plan Standing Financial Instructions set authorisation limits	First line Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly Capital Management Group meeting receives capital plan update reports Second line Turnaround Executive Reports Scrutiny at Finance and Performance Committee and Board Reports on progress with strategic capital to Transformation Programme Board (monthly) Board Finance reporting Third line 2019/20 financial plan accepted. Monthly return to NHS E/ I Quarterly meeting with NHS E/I Strategic Outline Business Case submitted April 2019 and 5 year plan submitted October 2019.	Divisional business planning to confirm scale of efficiency requirement (CIP) for 2020/21 and development of cip plans Pressures on capacity planning due to external factors. Competing ICS priorities for resources Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Limited additional revenue costs have been included for the development of the Reconfiguration Business Case	Developing 2020/21 financial plan and balanced position expected based on allocated financial trajectory for next 3 years, access to non-recurrent Financial Recovery Funding (FRF) - draft 5 March 2020, with final plan submitted to NHS I by end of April 2020 Reliance on overall ICS achievement of Financial improvement Trajectory to secure full FRF allocation. Use of resources review to be undertaken	5x5 = 25	5x5 = 25	4x4 = 16

Action	**Timescales**	**Lead**
2020/21 Financial Plan	31/03/2020	GB
Divisional business planning for 2020/21	31/03/2020	GB/HB
Development of financial modelling for reconfiguration Outline Businss Case	31/12/2020	GB

First line
Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly
Capital Management Group meeting receives capital plan update reports

BOARD ASSURANCE FRAMEWORK
JANUARY 2020
KEY

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CSU	Commisisoning Support Unit
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
WYSTP	West Yorkshire Sustainability and Transformation Plan
ICS	Integrated Care System
DH	Department of Health

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
HB	Helen Barker, Chief Operating Officer
AMH	Anne-Marie Hensahw, Assistant Director of Quality and Safety
MG	Mandy Griffin, Managing Director of Digital Health
RM	Ruth Mason, Associate Director of Engagement and Inclusion
AM	Andrea McCourt, Company Secretary
CP	Cornelle Parker, Deputy Medical Director
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
OW	Owen Williams, Chief Executive
EA	Ellen Armistead, Director of Nursing / Deputy Chief Executive
ALL	All board members

20. High Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 March 2020
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing, Deputy Chief Executive
Previous Forums:	Risk and Compliance Group – 13 January, 17 February 2020 Weekly Executive Board – 28 February 2020

Actions Requested:
To approve

Purpose of the Report

A key element of risk management is to clearly understand the risks pertinent to the Trust and ensure effective governance is in place to support a consistent and integrated approach to risk management.

The purpose of this report is to present an update of the risks on the high level risk register and to assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks as at 18 February 2020.

Key Points to Note

The Trust has 24 risks on the high level risk register as at 18 February 2020, an increase of 3 since the report to Board on 6 January 2020.

In terms of movement on the high level risk register six new risks have been added since this was last reported to the Board on 6 January 2020, three risks have been removed from the high level risk register of which one remains on the local risk register and two have been closed as detailed in the paper.

New Risks

Family and Specialist Services Division

7389 (risk score 15) Blood Transfusion compliance
7279 (risk score 15) Point of Care testing

Corporate Division

Quality and Safety: 6596 (risk score 12) compliance with national serious incident framework.
THIS: 7617 (risk score 16) Data Security Protection Toolkit

Community Healthcare Division

7599 (risk score 15) Community IT risk

Medical Division

7395 (risk score 16) Acute Floor staffing risk

Risks with Reduced Score

Risk 6493, complaints management,has been removed from the high level risk register following a reduction in risk score to 12 as detailed in the paper and will be managed on the divisional risk register.

Closed Risks

The risks below have been closed as detailed in the paper:

- *Risk 7278 long term financial risk* - following discussion at the Finance and Performance Committee this risk is deemed a strategic risk not appropriate for the high level risk register. A review and consolidation of financial risks on the Board Assurance Framework has taken place and will be presented to the Board separately.

- *Risk 5806 urgent estates risk* – as noted in January a review of this long standing risk with multiple estates issues has been undertaken by Calderdale and Huddersfield Solutions Ltd (CHS) who have revised the risk on the CHS risk register. This revised risk will be monitored via the Joint Liaison Committee meetings with CHS and therefore the former CHFT risk 5806 is now closed. The strategic estates risk for HRI continues to be an item reviewed and updated on the Board Assurance Framework.

To Note

- Risk 6715, poor documentation, has been reviewed together with the Medical Director and it has been confirmed that this risk should remain. A broader digital risk will be developed following approval of the Trust Digital Strategy on whoich engagement is currently taking place.

EQIA – Equality Impact Assessment

The purpose of this document is to take all reasonable steps to ensure that risks are identified and recorded on the appropriate agreed database as per the Risk Management Policy and to minimise risk and maximise quality of service to patients and stakeholders.

The risk owner is accountable to determine any proposed actions to mitigate any equality impact arising from a risk.

Recommendation

The Board is asked 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

Calderdale and Huddersfield NHS Foundation Trust

High Level Risk Register – Board 5 March 2020

Risks at 18th February 2020

TOP RISKS

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

7454 (20): Radiology Staffing Risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk *

*Risk 7078 – the risk description has been updated following discussion with the Medical Director to refer to current pressured specialties and the following have been removed as they are no longer pressured specialties: Urology, Care of the Elderly and A&E consultants.

The Trust risk appetite is included below.

NEW RISKS (Date agreed by Risk and Compliance Group stated)

7617 Score 16 Corporate (4 Impact x 4 Likelihood) THIS Agreed 17.2.20. Cyber Breach Risk

Risk of being in breach of contractual obligations, reputational damage to the Trust and becoming an NHS England/Improvement (the Cyber Risks and Operations group) trust of concern due to non- compliance with the Data Security protection toolkit resulting in inability to trade due to contractual obligations not being met, loss of income and reputational damage.

7279 Score 15 (3 Impact x 5 Likelihood) Family and Specialist Services (FSS) Agreed 17.2.20. Point of Care Testing (POCT) Risk

Risk of Point of Care Testing (POCT) results not being available in EPR caused by lack of interfacing between POCT devices and EPR resulting in patient harm through lack of availability of Point of Care results or mismanagement due to transcription errors

7395 Score 16 (4 Impact x 4 Likelihood) Medical Division Agreed 17.2.20. Acute Floor Staffing Risk

There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to significant shortfalls in staffing as vacancies remain unfilled (currently 9.8 WTE B5 & 2 WTE B6 vacancies) and not achieving safe staffing levels on the acute floor at HRI, WFM 8:7 long day 8:6 night.

This will result in reduced patient safety and experience and impact on staff wellbeing and morale.
Inability to staff flexible capacity ward areas.

7599 (15) – Community Healthcare (Impact 3 X Likelihood 5) Agreed 13.1.20. Community IT Risk

There is a risk of community staff not being able to complete contemporaneous patient records due to existing IT equipment is at/or reaching end of life resulting in incomplete patient information across all community services which could lead to essential information being missed.

The impact is on clinical and non-clinical teams are not able to work in an efficient/effective and agile way which is reflective of the digital strategy within CHFT.

6596 16 (↑12) – Corporate (Impact 4 x Likelihood 4): Quality and Safety Agreed 13.1.20. Serious Incident (SI) Framework Compliance Risk

There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share the findings with those affected.

7389 15 – FSS (Impact 3 x Likelihood 5) Agreed 13.1.20. Blood Transfusion Compliance Risk

Risk of inability to maintain adequate control over the QMS and Technical expertise within the transfusion department due to loss of critical team members within the Transfusion Department and national shortage of suitable replacement resulting in potential Inability to conform with MHRA regulations and loss of UKAS accreditation.

REDUCED RISKS

6493 ↓12 (15) – Corporate

Complaints Management
There is a risk that the Trust does not respond in a timely way to complaints and breaches NHS Complaints Regulations 2009 Due to complaints responses not being investigated within agreed timescales, staff not recording all complaints investigations on Datix Resulting in dissatisfaction for complainants due to poor communication, poor performance on complaints responsiveness, reputational damage, increasing Ombudsman referrals

Rationale for Reduction

Assistant PALS and Complaints Manager in post. Medicine Division remains a concern. All Divisions have processes in place. Tracking and monitoring established with escalation via Quality and Safety Senior Management team to Director of Nursing. Assistant Director of Quality and Safety meets regularly with Assistant Directors of Nursing. Reduced likehood to 4 (from 5)

CLOSED RISKS

7278 (25) (Impact 5 x Likelihood 5) Longer term financial sustainability

Risk Description

Longer term financial sustainability:
The Trust has a planned deficit of £37.99m (as per the NHS Improvement 19/20 control total). Acceptance of this control total gives the Trust access to £6.15m MRET funding, £7.33m Provider Sustainability Funding (PSF) and £14.81m Financial Recovery Funding (FRF), reducing the planned deficit to £9.71m. The receipt of PSF and FRF are dependant on achievement of the control total. 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 2018/19 external audit opinion raised concerns regarding going concern and value for money. Whilst the Trust is developing a business case that will bring it

back to balance within the next 8 years, this plan is subject to approval and the release of capital funds.

Rationale for Closure

Following discussion of the Board Assurance Framework at the Audit and Risk Committee on 29 January 2020 and the Finance and Performance Committee on 3 February 2020 it was agreed that risk 7278 should be removed from the risk register.

The rationale for this decision is that risk 7278 is a long term risk to our strategic objectives relating to finance and therefore as a strategic risk, sits more appropriately on the Board Assurance Framework.

The revised Board Assurance Framework will be presented to the Board on 5 March 2020.

5806 (20) – CORPORATE: Estates (Impact 5 x Likelihood 4)

Urgent estate work not completed

This risk related to a collection of HRI estates risks, each with their own risk entry on the CHS risk register.

Rationale for Closure

CHS has reviewed and revised risk 5806 and the revised risk has been reviewed by the Director of Finance as well as the Risk and Compliance Group. The risk will be managed by CHS and the Trust will continue to monitor this risk via Joint Liaison Committee meetings.

The Board Assurance Framework risk 09/19 describes the strategic risk relating to maintenance of current estate and equipment and mitigation of this risk will continue to be monitored by the Board via the Board Assurance Framework

RISKS UNDER REVIEW

3793 (16) - SAS - Opthalmology follow up appointment capacity risk

This risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments has a risk score of 16. There has been a reduction in holding list numbers. The risk score will be reviewed at a work together get results session with ophthalmologists in March 2020, this session was postponded from January 2020.

February 2020 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 18th February 2020

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead/ Divisional Director						
•					Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20
QUALITY AND SAFETY RISKS										
10a/19	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
10a/19	7454	Keeping the base safe	Radiology service provision staffing risk	Divisional Director of FSS (JO'R)	=20	=20	=20	=20	=20	=20
08/19	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)	=16	=16	=16	=16	=16	=16
11/19	7248	Keeping the base safe	Essential Safety Training	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
06/19	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
06/19	3793	Keeping the base safe	Opthalmology follow up appointment capacity risk	Divisional Director of SAS (WA)	=16	=16	=16	=16	=16	=16
06/19	2830	Keeping the base safe	ED Mental Health Breach	Associate Director of Nursing (MM)			!15	=15	=15	=15
06/19	7315	Keeping the base safe	Out patient appointments capacity risk	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15
05/19	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (EA)	=15	=15	=15	=15	=15	=15
10a/19	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
06/19	7474	Keeping the base safe	Medical Devices Risk	Director of Finance (GB)	=15	=15	=15	=15	=15	=15
08/19	7430	Keeping the base safe	Radiology Requests risk	Divisional Director of FSS (JO'R)		!15	=15	=15	=15	=15
05/19	7527	Keeping the base safe	Maxillofacial follow up appointment	Divisional Director of SAS (WA)		!15	=15	=15	=15	=15
06/19	7615	Keeping the base safe	Emergency Care Standard	Chief Operating Officer(HB) / Director of Nursing (EA)					!15	=15
08/19	**7389**	**Keeping the base safe**	**Blood Transfusion Compliance Risk**	**Divisional Director of FSS (JO'R)**					**!15**	**=15**
06/19	**6596**	**Keeping the base safe**	**Serious Incident Framework Compliance Risk**	**Director of Nursing (EA)**					**!16**	**=16**
06/19	**7599**	**Keeping the base safe**	**Community IT Risk**	**Associate Director of Nursing Community Health Services (AD)**					**!15**	**=15**
06/19	**7617**	**Keeping the base safe**	**Cyber Breach Risk**	**Managing Director – Digital Health (MG)**						**!16**
06/19	**7279**	**Keeping the base safe**	**Point of Care Testing (POCT) Risk**	**Divisional Director of FSS (JO'R)**						**!15**
10b/19	**7395**	**Keeping the base safe**	**Acute Floor Staffing Risk**	**Director of Nursing (EA)**						**!16**

WORKKFORCE RISKS										
10b/19	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 (EA), Director of Workforce	=20	=20	=20	=20	=20	=20
10a/19	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 (EA), Director of Workforce	=20	=20	=20	=20	=20	=20

ESTATES / SAFETY RISKS										
09/19	7414	Keeping the base safe	Buidling safety risk	Director of Finance (GB)	=15	=15	=15	=15	=15	=15
09/19	7413	Keeping the base safe	Fire safety risk HRI	Director of Finance (GB)	=15	=15	=15	=15	=15	=15

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

- **Board Assurance Framework risks referenced above**

05/19	Risk that the resource, capacity and capability of full optimisation of the EPR system due to lack of optimisation of the system does not continue to further enhance quality and safety
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and inclusive leadership to colleagues.

Feb 2020

TRUST RISK PROFILE AS AT 18/02/2020

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 =7315 Appointment Risk =7430 Radiology Requests Risk !7615 Emergency Care Standard !7599 Community IT Risk !7389 Blood Transfusion Complaince Risk !7279 Point of Care Testing	= 6345 Nurse Staffing = 7078 Medical Staffing =7454 Radiology staffing	
Likely (4)				=7223 Digital IT systems risk =7248 Essential Safety Training =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity =2830 ED Mental Health Breach !6596 SI Framework Complaince Risk !7395 Acute Floor Staffing Risk !7617 Cyber Breach Risk	= 2827 Over reliance on locum middle grade doctors in A&E
Possible (3)					= 5747 Vascular /interventional radiology service =7413 Fire compartmentation HRI =7414 Building safety risk =7474 Medical Devices Risk =7527 Maxillofacial follow up appointment
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE January 2020

Risk Category	This means	Risk Level	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to delvier high quality patient care (despite greater inherent risk)	**SEEK (4)**	**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 (3)**	**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, equality and patient safety, which will be subject to rigorous ~~quality~~ impact assessments. The balance of price, value and benefits will be considered. We will ~~aim to~~ allocate resources to capitalise on opportunities.	**CAUTIOUS (2)**	**MODERATE**
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 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 (2)**	**MODERATE**
Legal	We will comply with the law.	**MINIMAL (1)**	**LOW**
Innovation / Technology	The risk appetite for innovation / technology is high 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.	**OPEN (3)**	**HIGH**
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.	**OPEN (3)**	**HIGH**

Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to staff/patient safety and harm and clinical outcomes for patients.	**MINIMAL (1)**	**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. .	**MINIMAL (1)**	**LOW**
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. 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 (4)**	**SIGNIFICANT**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK (4)**	**SIGNIFICANT**

Board 5 March 2020
High Level Risk Register as at 18 February 2020

NHS
The Health Informatics Service
Informing Healthcare

Risk No	Div	Dir	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
2827	Medical	Emergency Care	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to 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 risk 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 Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rotas requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development 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 Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 years from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	20 5 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	**February 2020** No further progress to update Nov 2019 New rotas working well. To date there has been a reduced requirement for ad hoc locums	Mar-2020	Aug-2020		WEB	David Birkenhead	Dr Mark Davies
7078	Corporate	Medical Director's Office	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) 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 Gastroenterology, Radiology, Dermatology and Ophthalmology, (TBC) and dual site working which impacts 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	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties 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 Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - 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	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	**February 2020** Preparation and pre-employment checks for new trainees that will join the Trust in February is almost complete, with no delays anticipated. Given the volume of new starters to CHFT the Medical Education department have planned a Medic specific induction for Wednesday 5 February 2020. A large number of trainee vacancies are a cause for concern within Paediatrics and Emergency Medicine. The Medical Director has highlighted the concerns to Health Education England with regards to Paediatrics which has been caused by vacant posts, maternity leave and a number of less than full time trainees. The national shortage of paediatric doctors is compounding the problem. The number of gaps is creating pressure within the department as consultants are often required to 'act down' into registrar level roles to ensure safe patient care. Whilst post offers have been made for Paediatric Trust doctors, there will be a	Mar-2020	Mar-2020		WF	David Birkenhead	Pauline North

				- delay in implementation of key strategic objectives							period of time before they are ready to commence in post as these are overseas candidates who will need to relocate to the UK. Two offers have been made for Trust doctor roles at ST3+ level in Emergency Medicine and whilst a large number of vacancies remain, these new appointments offer an opportunity for the trust to develop a skilled team that is not overly reliant on Agency workers. They are both very keen to progress through the CESR route to enhance skills and expand their experience. A number of overseas doctors attended the GMC Welcome to UK Practice session on 20 January 2020. This is a training session delivered by the GMC which gives a useful insight into the communication differences between different healthcare economies. All attendees felt it was useful and opportunities have been identified to improve the induction experience of Medical staff when joining the Trust from overseas. These suggestions will form part of the action plan for Medical HR to improve the recruitment experience.						
6345	Corporate	Workforce & Organisational Development	Keeping the base safe	There is a 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 Establishment reviews/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 Nurse Staffing Risk (see also medical staffing risk 7078 and	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - 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 - Introduction of new roles eg Nurse associate	Low numbers of applications to nursing posts across grades and specialities National shortage of RGN's	16 4 x 4	20 4 x 5	9 3 x 3	• Local/domestic recruitment - monthly assessment centres • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit (See attached milestone plan/tracker in documents)	**February 2020:** Local and domestic recruitment activity continues. International recruitment on-going Plans continue to deploy the next cohort of nursing associate graduates into the workforce Work progressing to embed safe care live. January 2020: Full review of the risk compleated New graduates now in shift fill Planning for the deployment of the first NA cohort in June 2020 International recruitment continues Planning for the next cohort of TNA's Hosting increased numbers of undergraduate students Risk 5937 merged to this risk (6345)	Mar-2020	Jun-2020		WF	Ellen Armistead, Suzanne Dunkley	Michelle Bamforth

				therapy staffing risk 7077). Risk was also referenced in Risk 5937 - this has now been merged to Risk 6345.													
7454	Family & Specialist Services	Radiology	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets.	- Agency Sonographer cover. - NHS Locum cover. - Lung and chest: Additional reporting support from external providers and temporary change to job plan. Ad hoc support from WYAAT Trusts. - IR: Support from neighbouring organisation (1 day per week); Support, 1 day per week, through private agreement with private provider; working with WYVAS to plan cover until vascular service reconfiguration complete. - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in all areas, including: - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave.	15 3 x 5	20 4 x 5	1 1 x 1	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Actively seeking a second overseas fellow. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed a NHS Locum Chest Radiologist, due to commence August 2020.	**February 2020 Update:** Risk reviewed and description and other fields updated to reflect the current position. December 2019 Update: Introduction of a named Consultant each morning/afternoon who is assisting with prioritisation and validation of requests	Mar-2020	Aug-2020		PSQB	Stephen Shepley	Sarah Clenton
6596	Corporate	Corporate Quality	Keeping the base safe	There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share 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 - Investigator Training - 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	1. Operational pressures and impact on capacity to undertake investigations in a timely way 2. Sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors. 4. Lack of access to documents on EPR to non clinical investigators. 5. Operational pressures impacting on time for conducting investigations 6. Requirement to undertake SI investigations is not in Consultant job plans	16 4 x 4	16 4 x 4	4 4 x 1	Increase number of trained investigators Be clear in delivering training there is a requirement to participate in SI investigations as part of the investigation team To add EPR document access for non clinical SI investigators Learning Group to develop approach on learning and a learning event Paper with options for pool of trained investigators to WEB	**February 2020** Discussion with Director of Nursing regarding written communication to line managers of investigators regarding their involvement in serious incident investigation to reduce withdrawal rates. Business case for pool of trained investigators in development. Dec 2019 - challenges with operational pressures and time for investigation teams to progress investigations. Risk Team supporting by requesting statements, collating information. Escalated status of SIs to SI panel. Consideration to be given to options for pool of trained investigators.	Mar-2020	Sep-2020		QC	Ellen Armistead	Maxine Travis

					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												
7223	Corporate	THIS	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 4 x 4	16 4 x 4	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).	**February 2020** There are a number of associated Cyber/DSPT/Reliance risks relating to the reliance of CHFT on its digital platforms. Work has been ongoing in Jan/Feb 2020 towards DSPT however not to the extent that would change the scoring of this risk at this point. No further update. Nov 19 - As per Octobers update, the DSP Toolkit Plan is still being pulled together with resource being identified for a Jan 2020 start. There is a separate risk logged for potential non-compliance of the toolkit (7617)however the overlap with this risk is significant enough to maintain (and potentially increase) the score.	Mar-2020	Mar-2020		RC	Mandy Griffin	Rob Birkett

7248	Corporate	Workforce & Organisational Development	Developing our workforce	The risk: Not all colleagues will complete their designated core 'Essential Safety Training' (EST) subjects. In addition not all colleagues will complete their role specific training. Resulting in: Colleagues practicing without the recorded required knowledge or understanding of core EST subjects. This could lead to unsafe practice, potentially leading to incidents involving colleagues and/or patients. EST consists of 10 'core' subjects which all colleagues must be consistently 100% compliant in. There are a further 35 subjects which are 'role specific' – subjects which are dependent on the role the colleague has. The Trust has a compliance target of 90%. Our core subjects have been consistently above this target since April 2019, with an average of 95.22%. The focus therefore is on the compliance of the 35 role specific subjects. Compliance for these subjects range from 97.60% to 50.04%. We expect all role specific training to be on target by August 2020.	All electronic e-learning 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	16	4	January 2019 Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support. Additional training dates have been added for safeguarding and MCA/DoLS level 3.There are sufficient places to train ALL staff who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.	**February 2020** - The core 9 subjects remain at over 90% compliance. A full deep-dive into the role specific subjects below 90% has taken place and the findings presented to Executive Board. For these subjects, details of non-compliant colleagues is being emailed to managers in February. An EST Line Manager Bulletin special is being sent to managers which explains where we are at and what we need to do to improve compliance. January 2020 - The core 9 subjects remain at over 90% compliance. Of the 34 role specific subjects, 18 are now below 85% compliance. An action plan is in development to address these and this will be shared with the Executive board this month.	Mar-2020	Mar-2020		WF	Suzanne Dunkley	Charlotte North
2830	Medical	Emergency Care	Keeping the base safe	There is a risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department. Due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability. Resulting in a lack of supervision and care provided in the wrong place	Appropriate assessment from nursing team to identify high risk patients. (ReACT self-harm risk assessment at triage.) Nurse in visible areas use 1-1 nursing if deemed appropriate. Referral to Mental Heath Liaison Team, service available over 24 hours. Use of security service as necessary. Referral to CAMHS for children and adolescents. Missing Persons Policy for escalation if patients abscond	Delays in timely assessment from the CAMHS service. Mental health inpatient capacity limited locally and nationally. Absence of departmental guideline for rapid tranquilisation of mentally disturbed patients No clear pathway between SWYFT and the Local Authority in terms of the timeliness of Mental Health Assessments, Gatekeeping assessments and securing a bed in a MH facility Lack of additional resource availability to provide 1:1 when required.	3	16	9	Develop clear escalation process to support nurse staffing in the ED when demand exceeds capacity.	**January/February 2020**: Work ongoing in the department SOP produced to standardise care in the ED for this patient group. Awaiting results from recent serious incidents. December 2019: Continuing to review all mental health long waits within the department and evaluate care in the department and appropriate escalation.	Mar-2020	Jun-2020		NA	Maggie Metcalfe	Louise Croxall

3793	Surgery & Anaesthetics	Head and Neck	Keeping the base safe	Risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum and agency staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 3 x 2	16 4 x 4	3 1 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) Appointment made, anticipated start date July 2019 - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	**January/February Update** Holding list currently 1249, 500 are diagnostic visual fields due to EPR scheduling error rather than genuinely overdue, Orthoptic team validating and identifying those to book. Failsafe co-ordinators proving effective in identifying capacity and monitoring overdue requests. Requested for a weekly report of % no. of patients seen 'on time', seen within '25% of the scheduled request', within 25-50% overdue request and over 50% their scheduled request. Continue to work on recruitment to full vacancies with substantive, locum, agency and transformational work utilising non-medical workforce. 9/12/19 - discussed at risk and compliance - agreed reduction, which will be confirmed at SAS PSQB on 16th December 2019 To remain at 16 until a work together session with ophthalmologists in Jan 2020	Mar-2020	Mar-2020		DB	Will Ainslie	Pnt Laloe
6829	Family & Specialist Services	Pharmacy	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 and January 19 EL (97) 52 external audit which reported 3 major deficiencies limiting its capacity to make parenteral products. Resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 and July 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be implemented before October 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include:	Until the strategies outlined above to improve capacity have been implemented we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm . Potentially when CRH closes, will open HRI unit earlier at 7.30am to prepare those doses required at CRH and ensure timely transport. Delay in project- new unit not now due to open until Aug 20	15 3 x 5	16 4 x 4	3 3 x 1	Agreed Action Plan October 18 to reduce capacity at HRI ADU i - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit. Delays in project have delayed the temporary closing of the CRH unit to November 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in .. Phasing in of ready to use chemo batches also underway.	**February 19 update**- as Dec update- further delays in lease sign off / step in rights/ defect liability contract and therefore start of enabling work is further delayed. New unit at CRH unlikely to be open before Sept 2020. December 19 update. Delay due to Project Echo/ lease agreements with lenders solicitors being reviewed. CRH unit now due to close Jan 20 and enabling work start mid- Jan but awaiting confirmation from Associate Director of Finance re outcome of lease sign off debate. This is likely to delay opening of new unit to Aug 20 and reliance on HRI aseptic unit until that point.	Mar-2020	Sep-2020		DB	Ellen Armistead	Elisabeth Street

					syringe drivers, adult parenteral nutrition), update the product catalogue, and from June 2020 - outsource radiopharmacy (buy in MDVs of radioisotopes from Bradford)												
7617	Corporate	THIS	Keeping the base safe	Risk of: being in breach of contractual obligations, reputational damage to the Trust and becoming an NHS England/Improvement (the Cyber Risks and Operations group) trust of concern. Due to: non- compliance with the Data Security protection toolkit Resulting in: inability to trade due to contractual obligations not being met, loss of income and reputational damage. In addition, as a HSCN consumer, we are responsible for maintaining compliance with relevant NHS Digital Information Governance and data security standards and accreditation including the Data Security and Protection Toolkit (DSPT) which is one of our obligations under the HSCN Connection Agreement. It is not necessary to complete a Data Security and Protection Toolkit (DSPT) assessment in order to gain access to HSCN. However, all organisations that have or require access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Our current Trust status stands as 'Standards Not Met', If we are to publish a further DSPT with 'Standards Not Met', our Organisation may become a Trust of concern to NHS England/Improvement.	Control Group established – Governance Risk and Compliance (GRC) IT Workstreams in place to address areas of non-compliance Operational control by THIS Director Project management in place to steer progress Data Protection Officer oversight	Agreed resource to deliver the required work Agreed funding (capital) to improve the infrastructure Clear plan with timescales and deliverables (in process)	16 4 x 4	16 4 x 4	4 4 x 1	3 workshops have taken place to understand the resource and capital investment needed to close the gaps and meet the required level of compliance. The output from these workshops is the compilation of a plan with timescales and deliverables. This plan will be complete in Dec 19 with the first actions commencing in January 2020 where funding allows for resource and infrastructure investment.	Weekly meetings are being held to track progress and highlight any areas of concern. 3 initial workshops to understand the scale of the changes required have taken place during Nov/Dec 19 Raised at Divisional Board in both November and December 2019 with senior management engagement February 2020: There is a plan in place following the workshops however requests for supplementary funding (both capital and revenue pressures) has been rejected therefore THIS are working through the work plans that have been agreed over the next 6 months in order to complete a further DSPT self assessment in October 2020. No change in risk score.	Mar-2020	Oct-2020		DB	Mandy Griffin	Rob Birkett

7395	Medical	Acute Medicine	Developing our workforce	There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients. Due to significant shortfalls in staffing as vacancies remain unfilled (currently 9.8 WTE B5 & 2 WTE B6 vacancies) and not achieving safe staffing levels on the acute floor at HRI, WFM 8:7 long day 8:6 night. This will result in reduced patient safety and experience and impact on staff wellbeing and morale. Inability to staff flexible capacity ward areas.	The ward managers will review the upcoming week for any possible shift changes to even out staffing levels and shortfalls. Send all shifts to bank and agency as soon as the roster is signed off. Continuous job advertising specifically for the acute floor HRI. Nurse in charge will review the staffing for the next 72hours each day. Send representatives to the recruitment fayres from the acute floor. Block booking lower tier nursing agencies. Matron lead discussions at 10:30AM staffing meeting to discuss support from different areas. Nursing associates are now within our numbers of qualified on the unit therefore we have to achieve our WFM when they are on duty.	Ongoing attendance at the recruitment fayre. Recruitment team advertising continuous acute floor positions to roll over. Nurse in charge checklist adapted to reflect the 72hour staffing review. After roster sign off, ward manager/sister in charge will send all shifts to bank/agency to adhere to the KPI deadlines. Gaps in control Nurse bank and nurse agency don't always cover the shift shortfalls. Failure to recruitment in current vacancy posts. There is an added pressure in that the amalgamation of two wards into the Acute floor has meant that annual leave booked has been above the 15% target for 2019/2020 financial year.	12 3 x 4	16 4 x 4	1 1 x 1	Ongoing attendance at the recruitment fayre. Recruitment team advertising continuous acute floor positions to roll over. Nurse in charge checklist adapted to reflect the 72hour staffing review. After roster sign off, ward manager/sister in charge will send all shifts to bank/agency to adhere to the KPI deadlines. Further open evening to arrange.	**February 2020** Current vacancies: B6 – 0.08WTE B5 – 11.8. Rolling advert with interviews every 2 weeks 3 newly qualified in the pipe line with no confirmed start date potential March/ April. 2 nursing associates due to start June. Band 6 on maternity leave and 1 due for maternity leave in June 2020 30th December Update Current vacancies B5 - 9.8 WTE - rolling advert out at present, shortlist and interview every 2 weeks B6 - 2.08 WTE - out to advert at present, closing date 2nd Jan Block booking of Tier 1 agency staff until end of January 2x B5 awaiting start dates 2x newly qualified awaiting confirmation of pass	Mar-2020	Mar-2020		PSQB	Maggie Metcalfe	Lauren Rainey
7279	Family & Specialist Services	Pathology	Keeping the base safe	Risk of: Point of Care Testing (POCT) results are not available in EPR Caused by: Lack of interfacing between POCT devices and EPR Resulting in: Patient harm through lack of availability of Point of Care results or mismanagement due to transcription errors	Manual transcription of POCT results into EPR as clinical notes by clinical teams Manual transcription of POCT results into the LIMS by laboratory staff for transmission into EPR (Full blood count results only) Most devices with the ability to connect are linked to Middleware (Cobas 1000 or POCcelerator) which archives patient results with limited user access.	1. Failure to transcribe results into EPR once tests are completed. 1a. Audit of flu testing Nov19-Jan20 showed 46% of flu tests were NOT recorded in patient notes. 2. Failure to record all available results produced by the device e.g missed calcium, missed potassium results when focus is on pO2 or lactate result. 3. Transcription errors not checked by person or machine. 4. Alerts not triggered by abnormal results as data not entered in designated fields e.g. Sepsis pathway 5. Clinicians not acting on abnormal results as no reference range available e.g. Low calcium 6. Lack of monitoring and trend review for patient conditions due to results not entered in tabular format.	15 3 x 5	15 3 x 5	3 3 x 1	1. Create/identify test server for Cobas 1000 to develop interface with EPR test environment (THIS) 2. Test interface connections between Cobas and EPR (THIS/EPR) 3. Create Event Set Hierarchy for reporting all possible results into EPR (POC team/EPR) 4. Review data quality for patient testing on middleware 5. Identified as a risk as part of GIRFT and added to action plan for 2020. Previous actions up to Jan 2020 1. Develop interface (Path IT and THIS)- Ongoing discussions with CSC alongside other potential routes for connecting to APEX. 2. EPR training- lab to liaise with EPR trainers to embed training- Completed 07/08/2018 3. Encourage incident reporting- Completed July 2018 4. Revise current POCT training delivered by lab team to POCT users (include tests available from POCT and actioning of incidental findings) Completed July 2018	**February Update** 1) Recent review and updating of risk description and rating 2)Project now prioritised as part of GIRFT 3) THIS have identified a test server - waiting for Roche to respond to progress 4)a POCT specimen label containing the MRN number in barcode format is being actively worked on by the EPR team Update 06/01/2020-Waiting for THIS to identify a test server to enable progress. Request with Neil Staniforth. Asfeen Malik has informed us this has now been put back due another Trust workstream	Mar-2020	Jun-2020		PSQB	Stephen Shepley	Emma James

										5.Lab to place guidance laminates above POCT machines and also issue to ward managers- Completed July 2018							
7599	Community Healthcare	Divisional	Not Stated	There is a risk of community staff not being able to complete contemporaneous patient records due to existing IT equipment is at/or reaching end of life; resulting in incomplete patient information across all community services which could lead to essential information being missed. The impact is on clinical and non-clinical teams are not able to work in an efficient/effective and agile way which is reflective of the digital strategy withn CHFT.	Planned upgrade to commence Jan 2020. (based upon 28 laptops/week, and a planned programme to 587 laptops = 5 months). This will provided 12-18 months of extra life in the eqiupment. Capital bid to replace existing IT equipment has been submitted as part of annual planning process. The bid covers a 3 year period. Divisional business case being drawn together which describes requirement for equipment replacement and aspirations to support truey live access into all systems when working in primary care settings.	THIS resouce to support planned upgrade is only available for 3 months The upgrade programme is already identfied as taking 5 months. In equitable access to equipment as a result of 5 month upgrade programme	15 3 x 5	15 3 x 5	4 2 x 2		**February 2020** Upgrade plan underway with 18 laptops per week being upgraded. Community Midwives (FSS Division) are also included in the upgrade, so completion timescale will need to be extended.	Mar-2020	Mar-2020		DB	Andrea Dauris	Helen Webster-Mare
7615	Medical	All Directorates Medical	Keeping the base safe	There is a risk of not meeting the four hour emergency care standard Due to increasing demand on Emergency Care (approximately 5% above plan) meaning significant workload above workforce model, inappropriate use of ED. ED team factors including medical and nurse staffing (Risk ID 2827 and 6044), not triaging, patient flow, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community Resulting in poor patient experience, potential risks to delivery of fundamental care standards and potential harm to the patients, increased scrutiny and reputational risk to the organisation	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - eg gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and teams Skill mix- training for newly qualified nurses Streaming from the fron tdoor and admission avoidance services - frailty, streaming,	Partners not being able to deliver YAS - transport - escalation and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams	15 3 x 5	15 3 x 5	1 1 x 1	Patient Flow action plan in place Governance - reported monthly at WEB Patient Flow action plan owner – Deputy COO, Accountability- Directors	**February 2020 Update** Position remains challenging. Mitigation continues	Mar 2020	Mar-2020		WEB	Helen Barker/ Ellen Armistead	Bev Walker

5747	Family & Specialist Services	Radiology	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant interventional radiologist posts resulting in an inability to deliver hot week vascular cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1 NHS Locum in post (on 12 month contract, due to be renewed in the Summer). - 1 NHS (Bank) Locum supporting thee service in tandem with the above. - 1 day per week support from a neighbouring organisation. - 1 day per week support under private agreement from a private provider. - Working closely with WYVAS to plan and secure adequate cover.	- Uncertainty over date vascular reconfiguration will be complete. - Difficulty in securing cover long term whilst reconfiguration discussions are ongoing.	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post, advertising for joint post with Bradford Teaching HT. 2. Working with WYVAS to progress a regional approach.	**February 2020 Update**: Full review of risk and update to all section to reflect the current position. December 2019 Update: We now have a Vascular Radiologist from MYT/LTHT working at HRI one day per week. This will assist with stabilisation of the service and support for our new NHS Locum, in particular in relation to EVAR (Endo Vascular Aneurism Repair) provision. We continue to work with WYVAS. Actions underway from regional Chief Operating Officers meeting held in early October 2019 regarding Radiology. Looking to create regional contingency.	Mar-2020	Mar-2020		DB	Stephen Shepley	Sarah Clenton
7315	Trustwide	All Divisions	Keeping the base safe	There is a risk of delay to patient care, diagnosis and treatment Due to insufficient outpatient appointment capacity to meet current demands Resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and possible claims. Please refer to following individual risks: 4050 6078 6079 7199 7202	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3	Monitoring of appointment backlog at Performance Meetings Validation of Holding List and Appointment Slot Issues List SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level	**February 2020** FSS Update 1. Paediatrics perspective – ASI managed on a weekly basis additional clinics put in specialties where we have long waits eg Allergy and enuresis. Follow ups longest waiters cardiology working to find solution – increased local offer reviewing visiting consultant offer from Leeds 2. Gynaecology – management of ASI – managed on a weekly basis. Adding additional clinics to support from registrar level - Further work to be undertaken with follow ups to look for other solutions. Medicine Update: Medicine ASI's are currently at 378 which is a significant reduction in the last month, as at the 13th January the number was 696. The number for Medicine in February 2019 was 1587 (12 months ago) and in August 2019 was 1227 (6 months ago). The specialities with the biggest reductions are Gastro, Cardiology due to implementation of the CAS service and Neurology due to Nurse Led Services. The division is on trajectory to further reduce ASIs by March 2020 as requested as part of the RTT 4 point plan. Surgery Update:ASI position improved, currently best position for 5 years, Opthalmoloyg remains a challenge due to Orthopaedic workforce, 2 fail safe pathways and triage of follow -ups. Specialty specific ASI risks to be developed.	Mar-2020	Mar-2020		PSQB	Helen Barker	Mel Addy, Asif Ameen and Stephen Shepley

7389	Family & Specialist Services	Pathology	Keeping the base safe	Risk of: Inability to maintain adequate control over the QMS and Technical expertise within the transfusion department Due to: Loss of critical team members within the Transfusion Department and national shortage of suitable replacements. Resulting in: Potential Inability to conform with MHRA regulations and loss of UKAS accreditation. Refer to QP (RP-008) for full detail of risk	System Admin Role – DS and AF are supporting the system admin role on a part time basis QMS Slippage- Non-transfusion band 7 support staff for blood sciences can providing limited help with specific non-technical audits Loss of band 3 – Highly qualified staff members will be de-skilling to cover this role. Loss of band 7 – Other band 7 is learning some of the responsibilities that other solely performs, other band 6 staff are being developed in preparation for a Band 7 role. Loss of other staff – Other band 6 staffs are being developed in preparation for a Band 7 role, and where appropriate the quality role is being disseminated down to other Band 5/6 staff.	1 No recent review of the structure within the Transfusion Department for long term resilience and capacity planning 2 KPI/QMS needs to be controlled over longer term 3 Band 3 position needs filling 4 Continuity planning for critical staff retiring is not robust 5 Inadequate support for SPOT	15 3 x 5	15 3 x 5	1 1 x 1	1 No recent review of the structure within the Transfusion Department for long term resilience and capacity planning 1(a) Meeting between the management team to confirm a long term sustainable structure for the department. (HB)- Completed May 2019 2 KPI/QMS needs to be controlled over longer term - actions to mitigate still being investigated. - Re-addressed action s in may 2019 3 Band 3 position needed 3(a) Recruit into Band 3 and potential Band 7 vacancies within the transfusion department (HB by 4/1/2019) JD/VCF all completed nov 2011- recruitment process due Jan 2019- Ongoing May 2019 4 Continuity planning for critical staff retiring is not robust 4(a)-Define a continuity plan for the critical role planning retirement April 2019 with the team and start to implement (to include options for recruiting at risk and any shadowing that can be started prior to formal notification of retirement) (HB - Jan 2019) 4(b) Prepare provisional JDs for posts where staff have expressed interest in moving (HB -Jan 2019) 5 Inadequate support for SPOT - Needs to be written up as a separate risk - to discuss in PGB May 2019 5(a) Plan to reduce the gaps within the SPOT workload – gain financial support & complete recruitment process (HB December 2019)- see above	**February Update** 05/02/2020 1) 2 x vacant band 6 post has been shortlisted - only two suitable applicants to interview. Interview date set. 2) 1 x Band 6 post has been approved and currently out to advert. 3)Capacity planning fr long term stability. a)Capacity spreadsheet still underway - meeting arranged for 7/2/20 to review progress 4) KPI's continuing to improve 5)Seconded Band 7 now in post and off the 24/7 shifts. Update 09/01/2020 1) 2 x vacant Band 6 posts have been approved, advertised and awaiting shortlisting which will stabilise the rota and provide additional support into the quality management resources. 2) 1 x band 6 vcf awaiting approval 3) Capacity planning for long term stability- Tool developed and planning underway. 4) Free up capacity of current experts staff to concentrate on higher priority activities- devolving other tasks to staff in wider team. - Underway and being monitored. Progress being made KPI's are all reducing. 5) Band 7 post has been filled on a 12 month secondment.	Mar-2020	Mar-2020		PSQB	Julie O'Riordan	Hayley Baker

7413	Corporate	Finance and Procurement	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 x 3	15 x 3	1 x 1	Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks.	**February 2020** Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 26th Feb to review and submit the risks which will likely remove this risk. Nov/Dec 2019 CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trust's reconfiguration plans.	Mar-2020	Mar-2020		NA	Helen Barker	C Davies
7414	Corporate	Finance and Procurement	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors and staff. CHS RISK = 7318	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 x 3	15 x 3	1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	**February 2020** CHS continue to monitor cladding following works completed on high risk areas. Option appraisal provided to CHS which will be considered as part of capital works. Dec 2019 - CHS carrying out re-inspection 12 months on, any remedial works will be carried out from the re-inspection. CHS awaiting finalisation of the SDP but continue to explore over cladding option following an option appraisal.	Mar-2020	Mar-2020		FC	Gary Boothby	C Davies / A Wilson

7430	Family & Specialist Services	Radiology	Keeping the base safe	There is a risk of being in breach of IRMER regulations due to the way roles are set up within EPR, as this allows non medical staff who are not permitted to request Radiology exams as part of their role. Under IRMER 17 regulations a non medical health care professional can refer for radiological examinations but only under a clearly defined agreed protocol and only after receiving the appropriate irmer training. therefore access to radiology requesting should be restricted to these groups only.	There is an approval process within radiology to allow access to non medical referring that require access to this for their role. A register of all non-medical referrers is accessible to all staff. It is fully up to date and updated daily. Radiology staff can check unknown referrers against this list. When requests from inappropriate staff are noticed they are taken up with the staff in question. All radiology requests are vetted for appropriateness and justified in accordance with IRMER 2017. Please note this also includes requests that do not involve ionising radiation e.g. ultrasound and MRI. A quarterly audit is done of request made, and any prolific requestors are contacted.	Despite this gatekeeping the volume of requests that come into radiology mean this manual checking is ineffective. These requests will come through into the Radiology systems and although the name of the referrer is present with the request unless each one is individually checked staff would be unsure if an unrecognised name is a new FY1 or non medical referrer, thus there is a good chance the exam will be done. The numbers of requests received mean the controls in place can never be 100% effective There is no way to stop the problem at source without the creation of extra EPR requesting groups which would add to an admin burden to the system or potentially affect other systems within EPR.	15 3 x 5	15 3 x 5	9 3 x 3	- To audit quarterly and contact referrers concerned - To continue to raise issue via digital board - To ensure Radiology record of approved requesters continues to be up to date - At last audit some 6707 (12% of total) requests were made by inappropriate referrers.	**February 20** A freeze is now in place on any EPR development work until the end of May. We will be unable to advance the pilot of this project till the EPR upgrade is completed.	Mar-2020	Mar-2020		PSQB	Stephen Shepley	Mark Williams
6715	Corporate	Corporate Nursing	Keeping the base safe	There is a risk to patient safety, outcome and experience Due to inconsistently completed documentation on EPR Resulting in a potential 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	Establishment of clinical documentation group	**February 2020** Digital Champions - received the go ahead from Chief Nurse and Chief Medical Officer to progress Digital Champions. Business case to be submitted detailing what this would look like and the associated benefits. Go See at Leeds carried out in December regarding proof of concept. - Re-education being scoped through Outpatients Department. Plan to re-educate all members of staff who deliver care in this area and to then move to inpatient services. December 2019 visit to Leeds - 17th December with engagement from ED, Acute Floor and Training. E Cras Audit Tool being audited on Ward 6 CRH. Engagement nationally with counterparts who use the same electronic system looking at alternatives to improving digital clinical record. Continue to support the Discharge Quality Group factoring in digital clinical record.	Mar-2020	Jun-2020		WEB	Ellen Armistead	Carol Gregson/Graham Walsh

7474	Trustwide	All Divisions	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and use across CHFT due to the lack of assurance of the Trust Asset Register being up to date including equipment which has been gifted or bought without CHS involvement resulting in potential patient harm. CHS Risk 7438 –(Rating 20) - There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, resulting in potential patient harm CHS Risk 7438 –(Rating 20)	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.	Failure to manage, maintain and service medical devices.	5 5 x 1	15 5 x 3	1 1 x 1	2019/05/21-Update Contract meeting held with SLA provider Mid York's now in agreement with them to complete outstanding work, problem identified individuals within CHFT retaining un-serviceable medical devices within community(this will be stopping have instructed Mid York's to remove devices), a forecast of dates for servicing will be pushed out to community. Feedback on good progress has reduced the likelihood from 4 to 3. (28th May 2019) As agreed by DoN (J Murphy) and DoF.	**February 2020 update** 2020/02/04-High Risk numbers fell High risk (408 to 393), Medium fell (1722 to 1714), Low fell (1325 to 1283), a total of (3455 to 3390). Continuing efforts to reduce the number of devices at risk. 2019/12/02-Update-High Risk numbers fell High risk (524 to 408), Medium fell (2184 to 1722), Low fell (1860 to 1325), a total of (4568 to 3455). The audit carried out with community has greatly reduced the number of devices we are looking for this in conjunction with contracts management and training has had a positive impact on compliance	Mar-2020	Mar-2020		RC	Ellen Armistead	Robert Ross
7527	Surgery & Anaesthetics	Head and Neck	Keeping the base safe	There is a risk that patients will not receive appropriate follow up care for their clinical pathway which can cause delays for diagnosis and treatment in Maxfax and ENT	A failsafe process has been implemented for the post cancer patients , ? recurrent cancer / Surveillance through the cancer head and neck services. The validation team are prioritising the maxillofacial validation of 591 patients. Checks that all orders at placed following outpatients attendance Added onto careplans of review of follow ups dates required for all cancer diagnosed patients	EPR system (Lists) Lists of patients Failsafe Escalation process to implemented within appointment centre, secretaries. Appropriate training within the department	15 5 x 3	15 5 x 3	4 2 x 2	Review outstanding validations- Completed Develop process with appointment centre (Validation team) Completed Develop escalation process with appointment centre , secretaries for cashing up of clinics, and process to add further requests if appointments are cancelled. Completed Communication plan within the head and neck services. Completed High level process to roll out within the division. - Ongoing , process map developed, awaiting sign off by division.	**January/February 2020** Update clinical validation process to be sent to DMT for sign off and circulate wider through the trust. ENT Validations - Being monitored through customer contact awaiting latest update following 2018 validations 12 December update - All validation for Maxfax completed and monitored weekly . Development of surveillance patients portal digitally is being worked by information management. Progressing well for all patients identified no commencing date as yet. To be sent to DMT to reduce risk	Mar-2020	Mar-2020		PSQB	Mel Addy	Laura Cooper

21. Integrated Performance Report – January 2020

To Note

Presented by Helen Barker

Date of Meeting:	**5th March 2020**
Meeting:	**BOARD OF DIRECTORS**
Title of report:	**QUALITY & PERFORMANCE REPORT**
Author:	**Peter Keogh, Assistant Director of Performance**
Sponsor:	**Helen Barker, Chief Operating Officer**
Previous Forums:	**Finance & Performance Committee, Quality Committee**

Actions Requested:

- To note

Purpose of the Report

To provide the Board of Directors with the performance position for the month of January 2020.

Key Points to Note

January's Performance Score has peaked at 76% with 4 green domains continuing the Trust's excellent performance for 2019/20. Both the SAFE and EFFECTIVE domains maintained their green performance. The CARING domain remains amber with a slight deterioration in a couple of FFT areas. The RESPONSIVE domain remains amber although all key cancer targets have been achieved. 2 of the 4 stroke indicators are still missing target alongside 6 weeks Diagnostics. WORKFORCE remains green with sickness levels and EST continuing their strong performance which is a great achievement. Efficiency & FINANCE is now green.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

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

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

January 2020

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.

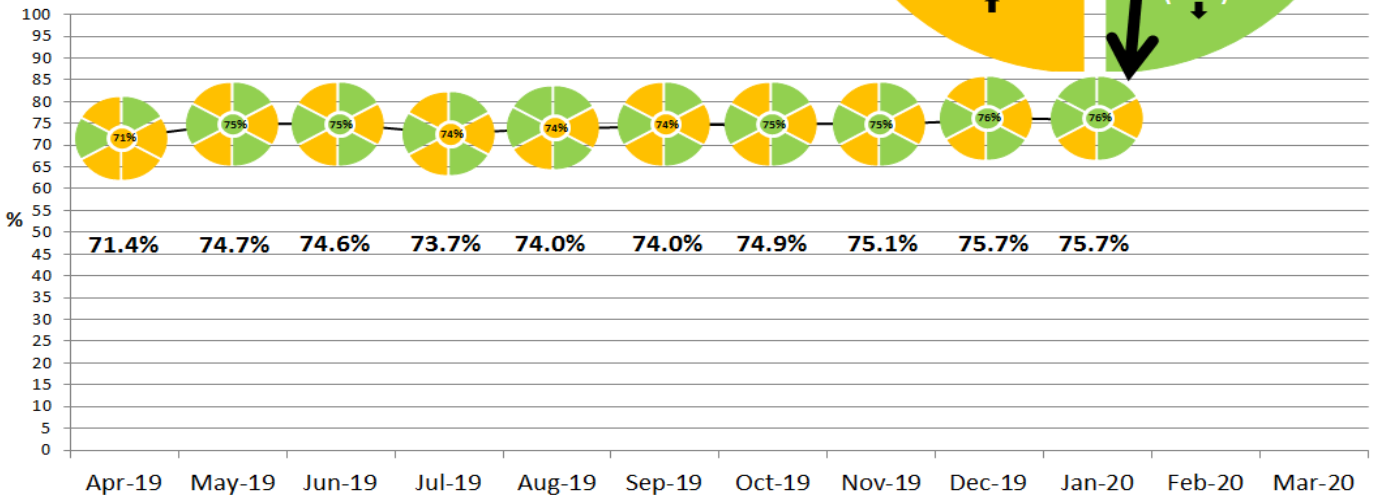
Nationally published data shows CHFT did achieve the 62 day Cancer Screening target for December which was showing as missed last month.

Performance Summary

January

RAG Movement

January's Performance Score has peaked at 76% with 4 green domains continuing the Trust's excellent performance for 2019/20. Both the SAFE and EFFECTIVE domains maintained their green performance. The CARING domain remains amber with a slight deterioration in a couple of FFT areas. The RESPONSIVE domain remains amber although all key cancer targets have been achieved. 2 of the 4 stroke indicators are still missing target alongside 6 weeks Diagnostics. WORKFORCE remains green with sickness levels and EST continuing their strong performance which is a great achievement. Efficiency & FINANCE is now green.



OVERSIGHT FRAMEWORK

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

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

Key Indicators

	18/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD	Performance Range		
SAFE													Green	Amber	Red
Never Events	4	0	0	0	0	0	0	0	0	1	**0**	**1**	0		>=1
CARING													Green	Amber	Red
% Complaints closed within target timeframe	42.00%	29.0%	38.0%	58.0%	37.0%	22.0%	47.0%	40.0%	41.0%	50.0%	**51.0%**	**41.0%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - Response Rate	36.39%	34.35%	36.50%	32.61%	33.58%	26.59%	30.68%	31.51%	29.82%	28.33%	**29.80%**	**31.59%**	>=24.5%		<24.5%
Friends & Family Test (IP Survey) - % would recommend the Service	97.46%	97.29%	97.56%	96.91%	97.40%	96.40%	97.31%	97.63%	96.78%	97.06%	**95.79%**	**96.92%**	>=96.7%	93.8% - 96.6%	<93.8%
Friends and Family Test Outpatient - Response Rate	10.75%	7.93%	9.25%	9.93%	10.11%	7.71%	5.62%	6.25%	6.52%	5.29%	**6.49%**	**7.21%**	>= 4.7%	2.3% - 4.6%	<2.3%
Friends and Family Test Outpatients Survey - % would recommend the Service	90.92%	91.13%	90.36%	91.81%	92.11%	92.31%	91.92%	91.70%	92.80%	92.68%	**92.68%**	**91.96%**	>= 96.2%	93.4% - 62.1%	<93.4%
Friends and Family Test A & E Survey - Response Rate	13.03%	11.56%	11.48%	14.46%	11.37%	11.10%	9.03%	10.28%	11.12%	10.29%	**10.74%**	**11.09%**	>= 11.7%	4.2% - 11.6%	<4.2%
Friends and Family Test A & E Survey - % would recommend the Service	83.80%	83.88%	84.79%	85.60%	82.29%	86.82%	80.28%	85.86%	81.84%	85.78%	**86.49%**	**84.38%**	>=87.2%	82.8% - 87.1%	<82.8%
Friends & Family Test (Maternity Survey) - Response Rate	36.51%	30.84%	41.78%	52.54%	38.29%	34.61%	32.27%	33.65%	37.10%	38.42%	**38.50%**	**33.80%**	>=20.8%	10.4% - 20.7%	<10.4%
Friends & Family Test (Maternity) - % would recommend the Service	98.64%	100.00%	99.19%	99.43%	99.53%	98.61%	98.66%	99.60%	98.70%	98.73%	**99.30%**	**99.20%**	>=97.3%	94.3% - 97.2%	<94.3%
Friends and Family Test Community - Response Rate	4.91%	3.38%	5.74%	2.15%	2.48%	2.46%	4.31%	6.10%	9.11%	3.40%	**2.48%**	**4.32%**	>=3.2%	1.7% - 3.1%	<1.7%
Friends and Family Test Community Survey - % would recommend the Service	94.64%	96.69%	95.48%	97.96%	98.15%	98.21%	97.07%	96.20%	94.66%	96.70%	**97.46%**	**96.32%**	>=96.7%	94.4% - 96.6%	<94.4%
EFFECTIVE													Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	2	1	0	0	0	0	0	0	0	0	**0**	**1**	0		>=0
Preventable number of Clostridium Difficile Cases	5	0	0	0	3	1	0	0	0	0	**1**	**5**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.25											**98.63**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	84.51											**88.6**	<=100	101 - 109	>=111
RESPONSIVE													Green	Amber	Red
Emergency Care Standard 4 hours	91.29%	90.19%	92.30%	89.32%	91.44%	91.37%	86.82%	84.19%	82.68%	81.97%	**85.88%**	**87.62%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	64.00%	46.55%	50.88%	63.41%	55.36%	58.21%	62.50%	41.82%	47.37%	40.40%	**49.06%**	**51.21%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.46%	96.56%	96.92%	98.00%	98.75%	98.24%	99.09%	99.15%	99.40%	99.21%	**99.15%**	**98.46%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.56%	98.34%	94.01%	93.56%	97.87%	100.00%	99.27%	96.77%	97.92%	98.38%	**99.41%**	**97.46%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.63%	100.00%	99.40%	100.00%	99.40%	100.00%	100.00%	98.51%	100.00%	100.00%	**99.40%**	**99.63%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	99.04%	100.00%	100.00%	100.00%	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	**100.00%**	**99.57%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	52.42%	31.58%	31.58%	55.56%	84.21%	41.67%	40.91%	59.09%	54.55%	52.17%	**53.33%**	**50.47%**	>=85%		<=84%
62 Day GP Referral to Treatment	88.37%	88.51%	91.76%	89.16%	89.58%	93.69%	91.76%	87.56%	91.85%	91.49%	**87.76%**	**90.32%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	94.42%	91.30%	96.30%	100.00%	88.46%	86.67%	88.89%	77.50%	100.00%	92.86%	**95.24%**	**91.78%**	>=90%		<=89%
WORKFORCE													Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.69%	3.67%	3.64%	3.61%	3.61%	3.63%	3.66%	3.71%	3.74%	3.84%	*	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.39%	2.37%	2.36%	2.33%	2.33%	2.35%	2.39%	2.41%	2.42%	2.47%	*	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.30%	1.29%	1.28%	1.28%	1.28%	1.28%	1.27%	1.30%	1.33%	1.37%	*	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.45%	93.18%	93.40%	93.36%	94.68%	94.58%	95.22%	95.30%	95.32%	95.13%	94.79%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff		16.52%	50.88%	96.43%	97.63%	96.97%	96.11%	95.21%	94.65%	93.65%	92.75%	-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	92.85%	87.23%	86.89%	85.28%	86.21%	85.27%	86.71%	83.81%	88.42%	83.23%	82.21%	-	>=95%	>=90%	<90%
FINANCE													Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	0.01	**0.01**	**0.01**	**0.01**	**0.01**	0.00	**0.00**	**0.00**	**0.23**	**0.00**	**0.00**	**0.25**			

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Appointment Slot Issues on Choose & Book achieved below 20% target for the first time in over 12 months continuing the great improvement in ASI performance.	% non-elective #NoF patients with admission to procedure < 36 hours - Performance fell to 68.57% compared to 85% target. Trauma surges continue to be the biggest challenge to this KPI.	The surge protocol is enacted appropriately when required. RCAs continue for all clinical and non-clinical breaches.
All key Cancer targets hit in 10 out of the last 13 months.	RTT Waits over 52 weeks - there were 7 at month end.	As part of the RTT Diagnostic project and agreed trajectory with NHSI/E we have been reviewing 3,000 patients on a Non-Planned Waiting list that were not on a current RTT Pathway. At month end, 7 of these were found to have been waiting over 52 weeks for treatment, 5 of which have now been treated with plans for remaining 2 patients.
Turnover rate (%) - Rolling 12m - at 7.36% lowest in over 12 months.		

Executive Summary

The report covers the period from January 2019 to allow comparison with historic performance. However the key messages and targets relate to January 2020 for the financial year 2019/20.

Domain	Area
Safe (86%)	• **Health & Safety Incidents (RIDDOR) -** 1 in January. Incident under investigation.
Caring (63%)	• **Complaints closed within timeframe** - Complaints performance improved again to 51% in January. Divisional Senior Management Teams and Corporate Complaints Team colleagues continue to work together to improve the quality and timeliness of complaint responses, and training and supervision of colleagues responding to complaints. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 93% against the 96.2% target. Changes are expected as the Trust continues to work through its ratified outpatient transformation plan. Divisions have reviewed the FFT comments and there are no new trends emerging. • **Friends and Family Test A & E Survey - Would Recommend**. Performance has improved to 86.5%, just below 87.2% target. An initiative to improve patient experience whilst waiting has been acknowledged with patients indicating the very positive impact. • **% Dementia patients screened following emergency admission aged 75 and over** - performance is at 40.7% and is a long way from the 90% target. There is active ongoing discussions to address the performance with the clinical lead and the Deputy Medical Director.
Effective (89%)	• **% non-elective #NoF patients with admission to procedure < 36 hours** - Performance fell to 68.57% compared to 85% target. Trauma surges continue to be the biggest challenge to this KPI. The surge protocol is enacted appropriately when required. RCAs continue for all clinical and non-clinical breaches.

Background Context

January saw an increase in non-elective activity impacting on capacity and flow over and above plan. The pressures around discharge into the Calderdale system continued to put pressure onto bed capacity with a resultant requirement to open additional beds early in the month.

In the Medicine division there has been an increase in short term sickness affecting ward staffing as well as relatively high levels of sickness in senior management cover particularly at matron level which have both contributed to the challenging operational situation.

Acute Floor consultants have continued with cross-site working and the team are meeting regularly to discuss progress and share learning.

The Same Day Emergency Care (SDEC) Unit continues to work well with some very positive feedback received. During January 289 patients were seen on the unit all of which had a comprehensive geriatric assessment and as a result we are seeing a 10% reduction in frailty breaches compared to last winter.

Nurse staffing has been challenging with less take up of bank and agency due to the holiday period compounded by the additional bed requirement.

OPD transformation work in Ophthalmology continues with improvements in triaging, extended non-medical roles and Failsafe pathway co-ordinators. The launch of the Ophthalmology Referral Portal occurred in January to enable High Street Optometrists to refer electronically via the portal.

Executive Summary

The report covers the period from January 2019 to allow comparison with historic performance. However the key messages and targets relate to January 2020 for the financial year 2019/20.

Domain	Area
Responsive (70%)	• **Emergency Care Standard 4 hours** - Improvement in performance to 85.88%. Although we have continued to see high activity and acuity in department during January, flow out of the department has improved due to improved bed availability elsewhere in the hospital. The numbers of patients who were streamed also increased in month which will have contributed to this increased ECS performance. We continue to escalate where appropriate and having the matron and operational manager on each site continues to help ensure patients are moved through as quickly as possible. The senior nursing team continue to link with the central operational team to highlight those patients with long waits and attending silver command meetings to support flow. • **Stroke targets** - % Stroke patients spending 90% of their stay on a stroke unit increased to 83% against the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival improved to 49% against the 90% target. We are continuing with the action plan put in place following the latest SSNAP score which was outlined in last month's response. A group job planning session was held on 6th February which looked at how an ACP model could support the stretched consultant workforce within the current workforce model. We have had agreement from commissioners to support funding a trial of community beds. We are currently working up a detailed proposal for this with the aim for the CCGs to begin funding something from June. This should enable the team to develop a flexible bed base to ensure capacity for acute beds meets demand. From September 2020 we should be able to remodel the bed base which will reduce the pressure on the limited consultant capacity. We have worked closely with Locala to develop a bid for an enhanced early supported discharge model, replicating the service currently on offer in Calderdale and meeting national gold standard. This will reduce the length of stay for Huddersfield residents, supporting us to further reduce our bed base. The bid has been submitted to NHSE and we are waiting to hear whether it has been approved. • **RTT Waits over 52 weeks** - As part of the RTT Diagnostic project and agreed trajectory with NHSI/E we have been reviewing 3,000 patients on a Non-Planned Waiting list that were not on a current RTT Pathway. At month end, 7 of these were found to have been waiting over 52 weeks for treatment, 5 of which have now been treated with plans for remaining 2 patients. • **% Diagnostic Waiting List Within 6 Weeks** - Echo is now achieving target. A new trajectory has been agreed to clear the diagnostic backlog by 31st March 2020.
Workforce (86%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total continues to achieve target although both short and long-term sickness did not achieve target in month. RTWI performance is still performing well at 76% and turnover rate continues to decrease. • **Essential Safety Training -** overall just below 95% with only Safeguarding below 90%.
Finance (76%)	• **Year to Date Summary** The year to date deficit is £9.77m, a £0.25m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding. • There is some pressure year to date due to higher than planned non-pay expenditure including utilities, outsourced services and maintenance contracts. • These pressures have been offset year to date by lower than planned pay expenditure, delivered in the face of pressure from Medical pay awards and the opening of additional capacity. • Clinical income performance (contract and other) is below plan by £0.39m. The Aligned Incentive Contract (AIC) protects the income position by £1.00m resulting overall in a favourable variance of £0.61m, an improvement compared to the position in Month 9. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services. • CIP achieved year to date is £8.34m, £0.13m more than planned. • Agency expenditure year to date is £6.17m, £3.28m below the planned level. **Key Variances** • Clinical income is above plan overall, but only as a result of the £1.00m protection offered by the Aligned Incentive Contract (AIC), with lower than planned activity levels across all points of delivery with the exception of A&E. However, AIC protection has continued to reduce with an in month movement of £0.69m. • Surgical Division continue to show a favourable variance to plan, reflective of lower expenditure linked to lower activity levels. However, the Medicine position has worsened further in month primarily due to the opening of additional capacity and a pressure on High Cost Drugs which is being jointly reviewed by colleagues in Finance and Pharmacy. • Some non-clinical areas are experiencing pressure with unplanned costs in Corporate Division due to medico-legal fees and higher than planned cross-charge for services from CHS due to pressure on the cost of utilities. • There is an adverse variance on Medical staffing expenditure of £0.42m, although this includes £0.70m pressure due to pay awards. Some additional funding has been allocated by DH, but this is insufficient to fully cover the planning gap (a net pressure of £0.46m year to date). • Nursing pay expenditure is lower than planned year to date by £0.71m, despite the opening of additional capacity, supported by planned winter reserves and a reduction in both agency usage and average hourly rate. **Forecast** The Trust continues to forecast achievement of Control Total, although this position is at risk now that NHSI and DHSC have advised that Project Echo will not be able to complete in year despite the Trust having completed the necessary steps. The Trust is liaising with regulators and the Integrated Care System on how this pressure can be handled. There remains some uncommitted winter reserve available to manage any winter pressures that continue into the final two months, but all other contingencies are now fully committed.

Background Context

Gaps in nursing staff across Community continue to be a concern due to vacancies and sickness.

Children's Community Therapy waits continue to be a risk and the Associate Director of Therapy is putting mitigation in place to ensure safety or quality of care for children is not compromised.

Middle grade cover in Paediatrics continues to be a challenge with the February rotation rota showing more gaps. The Deanery have recognised our position and will seek to improve it in the August rotation. The service is looking to attract overseas doctors with variable success. A new 2 year Specialty Doctor post has also been created.

The Radiology team are continuing to actively recruit to Radiology Consultant post's BMJ advert and the Clinical Director has been a key panelist in the national recruitment of Global Fellows from India with positive outcomes for CHFT.

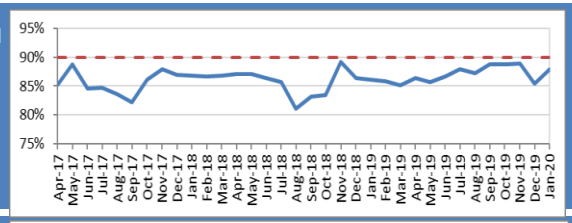
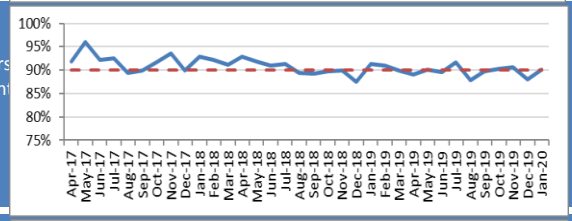
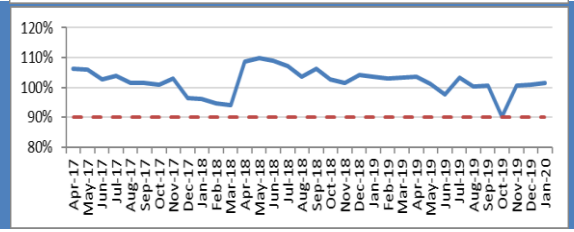
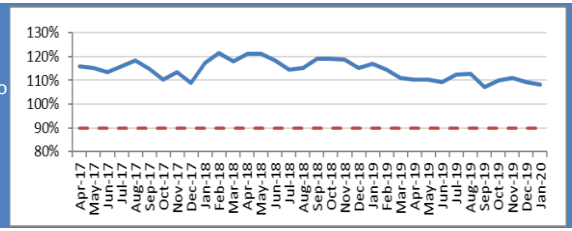
Pathology attended WEB to discuss the service reconfiguration across WYAAT. Meetings have been arranged with potential partners within the next couple of months with the aim of having a clear recommendation by September to inform the Trust reconfiguration plan.

There has been significant progress made with the mobilisation of the Outpatient Action Plan. The more challenging areas of delivery have been put into supported escalation.

Work continues to progress major capital schemes. The upgrade of the CRH aseptic unit will commence in the next few weeks and is due to complete in August. CRH's replacement MRI scanner will be handed over for use at the start of the 2020/21 financial year. The Gamma camera at HRI will be in use in April.

The Outpatient Pharmacy Dispensing Service tender has closed and the contract awarded to Rowlands Pharmacy. The Pharmacy and Procurement teams are working together to ensure the new dispensaries open with no disruption despite the tight turnaround.

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.	87.98% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 5 74.7% - Ward 8a 70.8%	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 are attributed to a level of vacancy . CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	90.12% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - Ward 8A 71.0%	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. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	101.43% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 64.9% - 6c 72.8% - NICU 47%	The low HCA fill rates in January 2020 are attributed to a level of HCA sickness and vacancy within the FSS division This is managed on a daily basis against the acuity of the work load. 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.	108.26% of expected Care Support Worker hours were achieved fo night shifts.		Staffing levels at night <75% - NICU 56.5%	The low fill rate of unqualified staff on night shift on NICU is due to some current vacancy however this has not impacted on care as these staff provide care for lower intensity babies alongside a registered B5 nurse. Intensive and High dependency care is provided specifically by qualified in neonatal speciality registered nurses.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT						Care Hours Per Patient Day		MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Ward Assurance	Total RN vacancies	Total HCA vacancies
		Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD						
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual										
CRH ACUTE FLOOR	GENERAL MEDICINE	2,874.92	2,864.33	2,336.50	2,224.00	99.6%	95.2%	2,519.00	2,430.08	2,046.00	1,831.50	96.5%	89.5%	7.6	7.3		2	24	65.6%	5.11	
HRI ACUTE FLOOR	GENERAL MEDICINE	3,129.00	2,810.98	2,693.50	2,615.17	89.8%	97.1%	2,728.00	2,420.17	2,046.00	2,010.00	88.7%	98.2%	8.1	7.6			6	73.0%	11.73	
WARD 5	GERIATRIC MEDICINE	1,556.03	1,162.30	1,347.33	1,841.00	74.7%	136.6%	1,001.00	1,023.00	1,023.00	1,212.50	102.2%	118.5%	6.4	6.8			6	60.8%		
WARD 15	GENERAL SURGERY	1,790.33	1,344.50	1,539.33	1,884.67	75.1%	122.4%	1,353.00	1,078.00	1,375.00	1,788.00	79.7%	130.0%	7.4	7.4		1	9	57.8%		
RESPIRATORY FLOOR	GENERAL MEDICINE	3,541.50	2,970.73	2,472.00	2,337.83	83.9%	94.6%	2,728.00	2,411.67	1,023.00	1,052.50	88.4%	102.9%	6.5	5.9				75.7%	7.31	
WARD 6	GENERAL MEDICINE	1,572.08	1,242.00	1,218.00	1,601.75	79.0%	131.5%	1,023.00	1,003.50	1,023.00	1,320.50	98.1%	129.1%	6.8	7.3			1	55.7%		
WARD 6C	GENERAL MEDICINE	1,004.73	781.17	749.60	545.67	77.7%	72.8%	671.00	682.00	341.00	330.00	101.6%	96.8%	5.6	4.8			9	52.5%		
WARD 6AB	GENERAL MEDICINE	1,743.10	1,538.42	1,489.80	1,526.63	88.3%	102.5%	1,359.50	1,233.83	1,364.00	1,359.50	90.8%	99.7%	6.4	6.0		1		71.2%		
WARD CCU	GENERAL MEDICINE	1,412.00	1,226.92	373.00	368.00	86.9%	98.7%	1,023.00	1,012.00	0.00	0.00	98.9%	-	8.5	7.9			6	63.5%		
WARD 7AD	STROKE MEDICINE	212.17	197.17	197.00	197.00	92.9%	100.0%	165.00	132.00	110.00	110.00	80.0%	100.0%	1.2	1.1			1	71.0%		
WARD 7BC	STROKE MEDICINE	395.33	324.83	274.33	261.33	82.2%	95.3%	330.00	321.00	110.00	99.00	97.3%	90.0%	1.5	1.4			3	70.5%		
WARD 12	MEDICAL ONCOLOGY	1,539.50	1,341.00	781.00	940.00	87.1%	120.4%	1,023.00	957.00	341.00	418.00	93.5%	122.6%	5.8	5.7			1	55.8%		
WARD 17	GASTROENTEROLOGY	1,957.98	1,531.33	1,157.17	1,287.83	78.2%	111.3%	1,353.00	1,078.00	693.00	675.00	79.7%	97.4%	7.0	6.2		1	8	72.7%		
WARD 20	GERIATRIC MEDICINE	1,656.75	1,442.40	1,604.67	1,996.83	87.1%	124.4%	1,364.00	1,179.00	1,364.00	1,809.75	86.4%	132.7%	6.8	7.3			9	63.1%		
WARD 21	TRAUMA & ORTHOPAEDICS	1,614.00	1,361.33	1,298.33	1,466.17	84.3%	112.9%	1,069.50	997.00	945.50	1,255.50	93.2%	132.8%	8.0	8.2		6		65.8%		
ICU	CRITICAL CARE MEDICINE	3,960.00	3,892.08	776.00	503.50	98.3%	64.9%	4,266.50	3,799.73	0.00	0.00	89.1%	-	67.2	61.2			10	49.9%		
WARD 3	GENERAL SURGERY	949.00	918.83	582.25	573.75	96.8%	98.5%	713.00	701.50	529.00	504.67	98.4%	95.4%	6.2	6.0				67.2%		
WARD 8A	TRAUMA & ORTHOPAEDICS	900.00	637.08	586.67	546.42	70.8%	93.1%	713.00	506.00	356.50	368.00	71.0%	103.2%	9.5	7.6		1		48.6%		
WARD 8D	ENT	803.50	806.25	577.75	562.42	100.3%	97.3%	713.00	713.00	172.50	195.50	100.0%	113.3%	6.4	6.5			2	56.7%		
WARD 10	GENERAL SURGERY	1,318.75	1,285.75	814.50	843.05	97.5%	103.5%	1,293.00	1,067.00	713.00	861.00	82.5%	120.8%	6.9	6.7			1	65.7%		
WARD 11	CARDIOLOGY	1,723.17	1,594.20	1,123.83	1,035.67	92.5%	92.2%	1,242.00	1,121.75	713.00	794.50	90.3%	111.4%	5.8	5.5		2	5	65.9%		
WARD 19	TRAUMA & ORTHOPAEDICS	1,622.00	1,536.42	1,399.33	1,345.67	94.7%	96.2%	1,069.50	1,058.00	1,069.50	1,345.00	98.9%	125.8%	7.7	7.9		1	3	45.9%		
WARD 22	UROLOGY	1,185.83	1,174.00	1,116.00	1,172.20	99.0%	105.0%	713.00	713.00	713.00	871.50	100.0%	122.2%	5.4	5.7		1	2	60.8%		
SAU HRI	GENERAL SURGERY	1,465.67	1,311.92	732.17	734.00	89.5%	100.3%	1,658.50	1,570.50	356.50	427.00	94.7%	119.8%	9.3	8.9				15.2%		
WARD LDRP	OBSTETRICS	3,950.50	3,582.83	945.50	736.50	90.7%	77.9%	3,894.75	3,532.42	708.25	639.25	90.7%	90.3%	22.2	19.8				16.2%		
WARD NICU	PAEDIATRICS	2,690.50	2,182.33	814.50	382.50	81.1%	47.0%	2,081.50	1,761.00	713.00	402.50	84.6%	56.5%	14.3	10.7				17.5%		
WARD 3ABCD	PAEDIATRICS	3,962.33	3,352.08	707.83	679.33	84.6%	96.0%	4,056.00	3,241.75	529.50	500.00	79.9%	94.4%	9.8	8.2						
WARD 4ABD	OBSTETRICS	2,500.00	2,257.00	712.00	632.33	90.3%	88.8%	1,782.50	1,746.00	713.00	683.50	98.0%	95.9%	5.0	4.7		1	3	71.7%		
WARD 4C	GYNAECOLOGY	1,262.67	1,099.67	355.25	374.25	87.1%	105.3%	713.00	721.50	356.50	355.75	101.2%	99.8%	7.5	7.1						
TRUST		**54,293.35**	**47769.87**	**30775.15**	**31215.5**	**87.98%**	**101.43%**	**44619.25**	**40211.4**	**21447.75**	**23219.9**	**90.12%**	**108.26%**	**7.5**	**7.1**						

Hard Truths: Safe Staffing Levels (3)

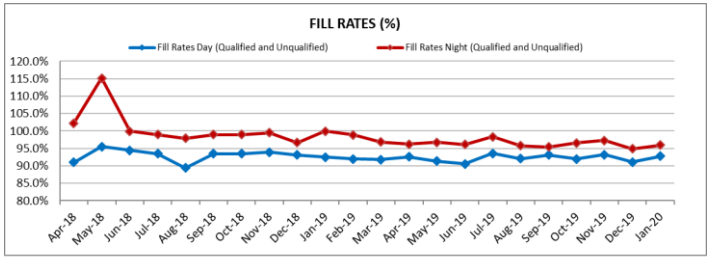
Care Hours per Patient Day

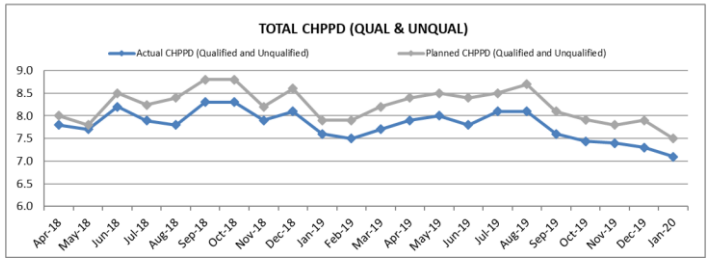
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Nov-19	Dec-19	Jan-20
Fill Rates Day (Qualified and Unqualified)	93.2%	91.1%	92.8%
Fill Rates Night (Qualified and Unqualified)	97.3%	94.9%	96.0%

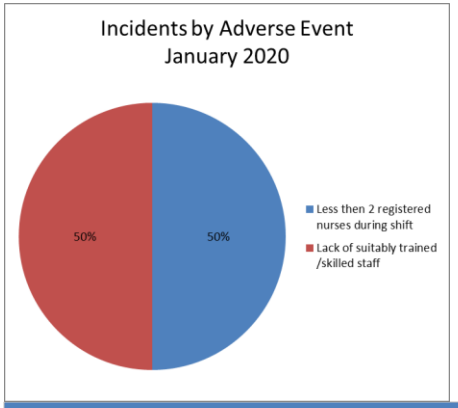
Planned CHPPD (Qualified and Unqualified)	7.8	7.9	7.5
Actual CHPPD (Qualified and Unqualified)	7.4	7.3	7.1

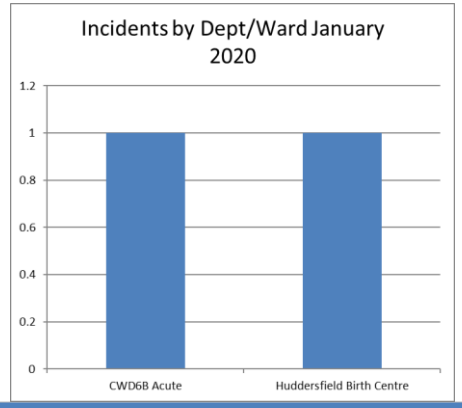
A review of January data indicates that the combined (RN and care staff metrics) resulted in 2l clinical areas or the 28 reviewed having CHPPD less than planned. 6 departments reported CHPPD slightly in excess of those planned and 1 has CHPPD at planned levels. Areas with CHPPD greater than planned is attributed to 1-1 enhanced care requirements or support of additional capacity beds.

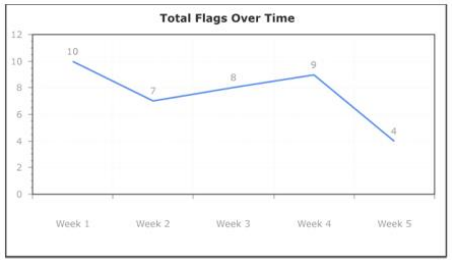


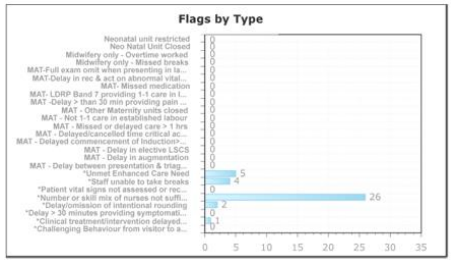


RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correc t but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the e scalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There has been a significant rise in reported incidents sine the Trust has moved to using safe care live. This is thought to be more reflective of the current situation. Each time an incident is reported an escalation cascade is initiated informing the senior, responsible nurse. The mitigation and outcome is then recorded live of the system. The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required. No reported incidents reported in January 2020 e resulted in harm

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

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. Monthly recruitment initiatives continue
3. Applications from international recruitment projects are progressing well and the first 35 nurses have arrived in Trust, with a further 4 planned for deployment in the New Year
4. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 6 NA who started in post in April 2017. A further 69 trainees are on programme and will graduate in 2020. The programme will next run in March 2020 with 17 recruits
6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment & retention of the graduate workforce
7. A new module of E roster called safe care has been introduced across the clinical divisions. Benefits will include, better reporting of red flag event and, real-time data of staffing position against acuity

CQUINS - Key messages

Area	Reality	Response	Result
CCG1a: Antimicrobial resistance - Lower urinary tract infections in older people	CCG1a: Q3 performance was 56% compared to 43% in Q2.	Nitrofurantoin 100mg MR caps have now been added to formulary. New dipsticks (which don't test for markers of infection) to be added to elderly wards.	Reinvigorate educational programme for ward teams – work towards 90% compliance in Q4 Accountable: Clinical Director of Pharmacy
CCG3a: Alcohol and Tobacco - Screening **CCG3b: Alcohol and Tobacco - Tobacco Brief Advice** **CCG3c: Alcohol and Tobacco - Alcohol Brief Advice**	CCG3a - Q3 performance was 58.7% compared to 58.3% in Q2. CCG3b - Q3 performance was 23.1% compared to 21.2% in Q2. CCG3c: Q3 performance was 37.0% compared to 28.8% in Q2.	Changes have been made in EPR to allow easier documentation. Very brief advice training is now available on ESR for staff to access. Working with the Smoke free CHFT group to provide a brief advice handout signposting patients to the relevant services to support in reducing/stopping alcohol and smoking usage.	Month on month improvement is expected. Accountable: Associate Director of Nursing - Community
CCG7: Three high impact actions to prevent Hospital Falls	Overall performance for Q3 was 18%, a slight improvement from previous quarters. Lying and standing BP, there was some improvement from 20% in Q2 to 25% in Q3. Mobility assessment within 24 hours has dropped to 65% compared to 69% in Q2.	To improve compliance the clinical team are reviewing their engagement processes.	Month on month improvement is expected in Q4. Accountable: Consultant lead for Falls.
CCG11: Same Day Emergency Care	This data was not submitted as the audits were not completed on time due to internal pressures and sickness.	The CCG have been alerted and the performance will be submitted in May when the submission reopens.	Month on month improvement is expected in Q4. Accountable: Head Nurse and Clinical Lead for ED.

CQUIN - Key Measures

		Indicator Name	Target	Q1	Q2	Q3	Q4
Prevention of Ill Health	CCG1: Antimicrobial Resistance	CCG1a: Antimicrobial resistance - Lower urinary tract infections in older people	90%	**8.0%**	**43.0%**	**75.0%**	Submission Deadline May 20
		CCG1b: Antimicrobial resistance - Antibiotic prophylaxis in colorectal surgery	90%	**85.40%**	**86.0%**	**95.0%**	
	CCG2: Staff Flu Vaccinations	CCG2: Staff Flu Vaccinations	80%	Data collection in Q3	Data collection in Q3	**72.3%**	
	CCG3: Alcohol and Tobacco	CCG3a: Alcohol and Tobacco - Screening ACUTE	80%	64.5%	**65.7%**	**65.1%**	
		CCG3a: Alcohol and Tobacco - Screening COMMUNITY		25.3%	**19.3%**	**24.0%**	
		CCG3a: Alcohol and Tobacco - Screening TRUST (combined)		**57.8%**	**58.30%**	**58.70%**	
		CCG3b: Alcohol and Tobacco - Tobacco Brief Advice ACUTE	90%	13.8%	**10.8%**	**11.5%**	
		CCG3b: Alcohol and Tobacco - Tobacco Brief Advice COMMUNITY		92.0%	**91.1%**	**93.2%**	
		CCG3b: Alcohol and Tobacco - Tobacco Brief Advice TRUST (combined)		**25.1%**	**21.2%**	**23.1%**	
		CCG3c: Alcohol and Tobacco - Alcohol Brief Advice ACUTE	90%	29.0%	**29.7%**	**34.3%**	
		CCG3c: Alcohol and Tobacco - Alcohol Brief Advice COMMUNITY		22.2%	**7.7%**	**52.1%**	
		CCG3c: Alcohol and Tobacco - Alcohol Brief Advice TRUST (Combined)		**28.7%**	**28.8%**	**37.0%**	
Patient Safety	CCG7: Three high impact actions to	CCG7: Three high impact actions to prevent Hospital Falls	80%	**12%**	**13%**	**18%**	
Best Practice Pathways	CCG11: Same Day Emergency Care	CCG11a: SDEC - Pulmonary Embolus	75%	**100.0%**	**98.3%**	**Not Submitted**	
		CCG11b: SDEC - Tachycardia with Atrial Fibrillation	75%	**91.4%**	**94.6%**		
		CCG11c: SDEC - Community Acquired Pneumonia	75%	**97.7%**	**92.0%**		

22. CHS Managing Director Report for January 2020 and February 2020

To Note

Presented by Stuart Sugarman

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

FEBRUARY 2020

Calderdale and Huddersfield Solutions Ltd
Huddersfield Royal Infirmary · Trust Headquarters ·
Acre Street · Huddersfield · HD3 3EA
Web: www.chs-limited.co.uk
Company registration number 11258001 · VAT number 293 0609 00

1.0 Company Update

- OCS formerly managed Cleaning and Security Services at Acre Mill Outpatients on behalf of the Pennine Property services. On the 31st December this service transferred to CHS from OCS as a result of our successful bid to run these services. At the beginning of January, Debbie (HR Business Partner) and I were pleased to welcome the staff who transferred to CHS and wish them well. In total 9 members of staff transferred to CHS.

Back Row – Andrew Holdsworth, Susanna Goodall. Front Row – Louise Knight, Ben Meggat, Paul Walker and Chantelle Hare.

- I am also pleased to announce that we have signed an agreement to lease for a property in Elland. This which means we can relocate our equipment loan service from Salterhebble and the Health Informatics Service (who are currently spread out in numerous locations) to the new property in Elland. This move will generate annual rental savings of around £50k per annum over and above the operational efficiency of co-locating these two services. I would like to thank Tom Donaghey our Property Manager who found this property before it came on to the open market. The move is planned to take place by 31 March 2020.

- CHS staff responded amazingly well to Storm Ciara on the 9th February which brought heavy rainfall and up to 80mph gusts to Calderdale & Huddersfield. Many parts of our estate were affected by the storm. All staff members from our Estates, Porters, janitors, cleaning services, front desk and Security staff really helped out with the urgent work needed to keep the site functioning, I would like to particularly thank:
- Cleaning Services Team Leaders, Sarah McNamara and Jean Cane
- Janitors, Dave Hemmingway, Tina Jennings and Josh Griffin
- Charge Hand Porter, Jamie Bussey Thornton
- Estates Maintenance, Elwyn Lawrence, Dean Nugent, Robert Szoradi
- Front Desk, Linda Hartley
- Our Security team
- Fran Brocklehurst- our CHS manager on call over the storm weekend

2.0 Service updates

2.1. Estates

CHS will receive £1,038K to address back-log maintenance for HRI. Discussions around the wider procurement for CRH/HRI has commenced with a view to appointing a design team in March to commence master planning HRI in line with recommendations from Mott Macdonalds. This will run in parallel with the CRH design and engagement workshops bringing both projects under one team.

Work continues to rationalise the estate footprint, CHS on behalf of the Trust have instructed local estates agents to dispose of Glen Acre House, Acre House and Acre House Avenue. Need to find alternative space for Glen Acre Staff. Approx 40 staff in total. Acre House - issues with planning resolved and expecting approval by 17/01. Marketed for offers in excess of £1m.

The LED scheme continues to progress on both sites albeit with challenges around delivery. The HRI programme has commenced with manufacturing of the light fittings, completing the programme in August 2020. CRH will commence their programme of works in FY20/21 starting the first week in April for approx. 12 months.

Fire safety remains an area of focus particularly at HRI, CHFT has commissioned a Trust wide survey with agreement from CHS on an holistic review brief of fire safety across the Trust with focus on fire strategy at HRI. External consultancy Mott MacDonalds have been commissioned to carry out this review. Initial document/data sharing has commenced with planned visits TBC.
The Capital scheme to verify / remediate 60 min compartmentation continues, last few remaining areas to replace doors with a view to completing the scheme this Financial Year. A subsequent maintenance programme using (FDIS) qualified inspectors will annually verify the 60 min doors with visual inspections conducted on the remaining doors.
Fire Risk Mitigation comes in the form of staff training, weekly / annual Fire Alarm testing, Fire Risk Assessments and subsequent actions monitored by the Trust Fire Safety Committee.

The Portland stone cladding panels and windows remain a short and long-term risk at HRI, on-going maintenance and remediation continues to address the immediate risk, CHS estates are undertaking a process of due diligence to resolve the longer-term solution / replacement. This option includes over cladding the existing façade. Precedence has been set at Bristol Royal Infirmary while Aintree Hospital is currently completing the design stage and about to begin construction. Several “Go See” visits are being organised for members of the Trust to attend.
To mitigate the risk of falling stone panels a 12 month survey is conducted by structural engineers BWB to assess the condition and movement. Of the original 1515 Portland stone cladding panels inspected and scoring a condition C or above on the scoring matrix it was recorded that a further 24 panels now require imminent attention due to concerns regarding indications of potential movement and their general poor state of condition. Immediate remediation was carried out using resin anchors effectively bolting the stones to the building. BWB structural engineers now suggest a 6-month inspection to mitigate the risk. This will now need planning into the Capital Plan.

2.2. Medical Engineering

The Trust has spent the £100k identified to mitigate the risk surrounding end of life medical devices, correspondingly the risk score of 15 has reduced to a 6, most of this equipment is

now onsite or is planned to be within the near future. The task of equipment installation, training delivery and reaching the required compliance of 70% within areas is ongoing, prior to Devices being released.

Appointment of new Medical Device Training/Support Coordinator, bringing the team back up to strength.

Medical Engineering team have completed a number of Medical Device training courses, increasing our own compliance with the added benefit of future maintenance cost savings as Medical Devices come off of warranty.

Statutory training has been identified as a significant risk, to that end the Medical device training team have been escalating the issue where possible, key areas are:

- Clinical Staff not being given the time to train during work, some have come in on time off, this needs to be addressed by divisions.
- Certain departments not fully engaging with the task and placing enough priority to training.
- Operational risk of insufficient trained staff to safely operate Medical Devices in clinical areas.
- Risk of untrained staff operating Medical Devices for which they have no training, putting the Patient, Staff member and Trust at risk.

Decontamination contract has now been novated to CHS. A meeting has been set up to explore and resolve the operational management of this as the SLA has not yet been produced.

Equipment has been identified and rejected as unsuitable for use in a clinical environment due to non-conformity with regulations, any new purchases of medical equipment need to be done via the correct process to ensure that no losses are incurred by the Trust.

A business case was produced to further invest in the service, which has been placed on hold. This is a strain on the department which had been given the role of managing the Trust's Medical Device maintenance portfolio, avenues are being explored to mitigate this.

"Go see" to Dewsbury was conducted to explore the benefits of asset tracking and temperature monitoring, this was instigated on the back of the "WYAAT Scan 4 Safety" agenda for FY 20/21, which is to include asset tracking and active temperature monitoring, this will lead to efficiencies for clinical staff freeing up valuable time for patient care, both with the management of Medical Devices and the monitoring of temperature controlled Pharmaceuticals, with added benefit of increasing CQC compliance, stock management and patient safety.

2.3. Facilities

Plans are in place for the community equipment team, to move into the new building at Elland (as above) during the weekend of 21/22 March. Communications have started to go out to relevant parties.

Transport tender out to framework and includes 7 x fully electric vehicles.

BICS training has been scheduled in for 2020 with the intention that all domestic assistants will be trained by the end of the financial year. CHS are to provide schedule/costs to train housekeepers.

Electronic meal collation going well and is providing a lot more information for the department.

WYAAT tender for main meals is ongoing, with food tasting taking place in April, with a view to award contract at the end of April.

2.4. Procurement

In January we confirmed a start date with Alexandra, the new Deputy Head of Procurement for 6th May 2020 and have welcomed Dan, Procurement Apprentice and Emma, Assistant Buyer (six-month fixed term contract).

The National 'Unsung Heroes' awards are taking place on 28th February 2020 with our Materials Management team up for an award.

In both January and February, the Procurement and Materials Management Teams claimed both of the CHS 'Gold Star Awards' with Tom Redfearn winning in January and Tony Farrand in February which is fantastic news.

The 20/21 CIP pipeline is in development with approximately £400k of identified schemes to date. Further workshops are being held and we are progressing positively.

The 19/20 CIP plan is currently tracking at £663k to month 12 in delivery. An £85k gap is identified and the team are working to close this gap.

The Reconfiguration Design Team procurement process is ongoing and will look to conclude in March 2020. The Pharmacy Outpatient Dispensing Procurement has also concluded with the Trust awarding to Rowlands without issue. Mobilisation is now beginning.

Other key projects the team are working on are as follows; Orthotics, Orthopaedic Implants, among others.

3.0 CHS

3.1. Spotlight Award Our Spotlight Award winner for December is Tom Redfearn

Tom was nominated by Kate Roberts for his dedicated work on the Outsourced Pharmacy Dispensing Procurement Process, which has been and is continuing to be, highly complex. His co-ordinated work with the stakeholder team has allowed for a seamless evaluation so far, which will no doubt reflect on the end result.

Our Spotlight Award winner for January is Anthony Farrand.

Tony, who is a receipt and distribution officer, was nominated by Daniel Hawtin, supply chain lead in Purchasing & Supplies Department. Tony was nominated for his contribution and input into assessing risks in the stores and loading bay area at Huddersfield Royal Infirmary. Many of the suggestions from Tony following recent risk assessments in the department have now been implemented. 'Keeping the base safe' ensures colleagues and anyone else accessing the stores are safe.

3.2. Finance

Year to Date
The completion of month 10 has resulted in a year to date (YTD) £0.41m surplus.

Pay is underspent year to date with a favourable variance of £0.67m due to vacancies and new staff being appointed on CHS terms and conditions with a lower pension contribution rate. This is consistent with prior months. Non pay is in line with plan and income showing as under £0.68m which represents the income required to cover the pay underspend. With regards to the contract variations between CHS and the Trust, actual variances on the service elements have been transacted, but we continue to work on the goods and services transacted through CHS.

Forecast
Based on the performance in month 10 and assuming any risks can be mitigated in year with appropriate recovery plans, CHS are forecasting to achieve plan. Risks which continue to be assessed are; delivery of high-risk CIP schemes, retaining the pay expenditure within plan after the recruitment to vacancies and lines of non-pay which have resulted in overspends in previous years (such as utilities and clinical waste).

3.3. Workforce

Attendance
CHS absence for January is 5.9 % comprising LTS 4.40 % and STS 1.5%. This is a decrease on December figures however remains above the 4% threshold with long term sickness cases being a particular concern. Each long-term case has a management plan and we are currently supporting a number of chronic illness cases to conclusion. A deep dive is underway with managers to examine both long term and short-term absence to look at each stage of the process to ensure understanding and adherence to the policy framework. This month's figures show a further rise in reported anxiety, stress and depression related absence and this will be looked at as part of the deep dive process.

Appraisal and Essential Skills Training (EST)
Appraisal (97.4 %) and Essential Skills Training (EST) are all over 95%, with the exception of manual handling at 94.4%. This is due to Estates staff being trained together (on 6 February 2020) to level 2. The EST figures will reflect this additional training next month.

Vacancies
Vacancies within the Company stand at 13.4 wte and are currently being recruited to.

Acre Mill
2 Security Guards and 6 Domestic Assistant staff transferred to CHS on 31 December 2019 following a successful tender for the services. Local inductions have taken place and the staff will also participate in the wider Trust induction. A welcome meeting took place on 13 January 2020 to introduce the staff to Stuart Sugarman our managing director and the domestic services manager is in regular contact to make sure our new colleagues are kept up to date and feel part of the team.

Staff Survey
The survey closed on 29 November 2019. Our response rate is 46% which is higher than the previous survey of 41%. An initial report has been received which is currently being analysed and shared with the senior team. Picker, the current service provider, is producing an additional summary report which will be circulated when received.

Flu Campaign
The uptake of vaccination in CHS is at 84%. The campaign is open ended at this stage however statistics are submitted to the DoH at the end of February. Additional sessions have been provided by immunisers. Heads of Service continue to reinforce the importance of the vaccine and encourage attendance.

4.0 KPI's

We continue to deliver the vast majority of KPI's as 'green', meeting SLA with the exception of:
Portering Services – Immediate continues to be a challenge. The practice of all portering requests from the Emergency Department with the majority of requests as immediate continues to be an issue.
Waste – Engagement with CHFT to increase recycling rates is currently unachievable, in month of January 12.00% against a target of over 25%. This was a slight increase from December at 10.84%

5.0 Risks

An overview of CHS risk register is included within Appendix 1.

The high risks that CHS seek to manage and mitigate are:

- HRI Estates failing to meet minimum condition due to age and condition of the building (20)
- Resus – Collective risk to maintain compliance / upgrade (20)
- ICU – Collective risk to maintain compliance / upgrade (20)
- Medical Engineering - There is a risk of equipment failure from Medical Devices on the current trust asset list (15)
- Fire safety due to breaches in compartmentation, and a lack of compartmentation in some areas, and enough staff trained in fire safety awareness and as fire wardens (in CHFT) (15)
- The façade of HRI (15)
- Incorrect chemical balance in feed water supply to steam boilers (15).

6.0 Recommendation

Shareholders are asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – February 2020

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	3	0
Red Risks High	4	0
Amber Risks Moderate	27	-1
Green Risks Low	15	+1
Total	49	0

Risk ref + score	Strategic Objective	Risk	Executive Lead	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20
CHS Risk 5806 (Joint)	Keeping the Base Safe	HRI Estates failing to meet minimum condition due to age and condition of the building	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 6903 (CHFT 7444 (12)	Keeping the base safe	Resus – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7271 (CHFT 7442 (12)	Keeping the base safe	ICU – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7438 (CHFT 7474 (15)	Keeping the base safe	There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5369) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care , resulting in potential patient harm	Manager Director (SS) Head of Medical Engineering (RR)	=20	=20	=20	=15	=15	=15
CHS Risk 7318 (CHFT 7414 (15)	Keeping the base safe	There is a risk to life and building due to the failed / heavily corroded metal ties that hold back the Portland Stone cladding at HRI, particularly Ward Black 1 South Elevation potentially resulting in falling Stone debris.	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15
CHS Risk 5511 (CHFT 7413 (15)	Keeping the base safe	Collective Fire Risk – There is a risk of increased fire spread and delayed evacuation at HRI	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15
CHS Risk 7481 (Not CHFT)	Keeping the base safe	Incorrect chemical balance in feed water supply to steam boilers	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15

23. Governance Report

• Fit and Proper Persons Self Declaration Register

• Declarations of Interests Register

• Board Terms of Reference

• Nomination and Remuneration Committee (Board of Directors) Terms of Reference

• Quality Committee Terms of Reference

• Guidance for reserving matters to a private session of the Board of Directors

• Board Workplan 2020

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	5 March 2020
Meeting:	Board
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Previous Forums:	See relevant section

Actions Requested:
To note

Purpose of the Report

This report brings together a number of governance items for review by the Board as at March 2020 which include:

Items to note:

a. Fit and Proper Persons Self Declarations Register
b. Board of Directors Declarations of Interest Register

Items to approve:

c. Board of Directors Terms of Reference
d. Nominations and Remunerations Committee (Board of Directors) Terms of Reference
e. Quality Committee Terms of Reference
f. Guidance on Matters Reserved for the private session of the Board
g. Board workplan 2020/21

Key Points to Note

a. Fit and Proper Persons

The Board of Directors Declarations of Interests register as at 25 February 2020 is attached at Appendix 1 (to follow).

The fit and proper persons regulation (FPRR) requirements came into effect for all NHS Trusts and Foundation Trusts in November 2014 to ensure greater regulation of NHS Board level Directors. Regulation 5 of the Health and Social Care Act 2008 provides for the CQC to monitor and assess how well Trusts discharge their responsibility to comply with the fit and proper persons requirements for Directors.

The regulation requires NHS Trusts to seek the necessary assurance that all Executive and Non-Executive Directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. The CQC holds Trusts to account in relation to FPPR through their well-led domain assessments and inspections.

In 2019 the Kark review of the fit and proper persons test (FPPT) was published and made five key recommendations including that all directors should meet specified standards of competence to sit on the board of any health providing organisation.

The Trust process for ensuring that Directors and Non-Executive Directors are suitable and fit to undertake their role includes:

- At recruitment the suitability of candidates for Director and Non-Executive Directors is checked by declaring their fitness to be a Director prior to interview and appointment as a Trust Executive Director, Director or Non-Executive Director. Mandatory employment processes are completed that secure proof of identity and right to work in the UK, employment references, qualifications and professional registration details, Disclosure and Barring Service (DBS) certification, bankruptcy and insolvency and disqualified directors register information and occupational health clearance.

- Discussions and recommendations regarding appointments by the relevant Nominations and Remuneration Committee

- Annual checks relating to skills and competencies and a check against the Companies House disqualified directors register. In addition, for this year, checks against the Insolvency Service bankruptcy and insolvency register and an internet search have been conducted.

- Annual self-declaration that the requirements of FPP have been met are requested and recorded

- Fit and Proper Persons register presented to the Board at a public meeting on an annual basis

The Trust also needs to ensure that there is an assessment process in place to regularly monitor and review the ongoing fitness of Directors, for example through appraisal or other processes. The Trust has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role through the application of contractual terms and employment policies and procedures in relation to conduct and capability.

Proposed Changes

A review of previous FPP declarations has identified that there is a range of staff beyond Director level who have in the past been required to declare they are a fit and proper person.

A review of this has taken place with the Deputy Chief Executive/Director of Nursing and it has been agreed that the following groups of staff are required to complete a Fit and Proper Persons declaration:

- Executive Directors (including the Chief Executive)
- Directors
- Non-Executive Directors (including the Chair)
- Deputy Directors (Finance, Medical, Nursing, Operations and Workforce and organisational Development)
- Company Secretary

The declarations for 2020 have therefore been sought and are presented for the individuals occupying the roles set out above.

Disclosure and Barring Service (DBS)

There are 3 types of disclosure, basic, standard and enhanced. Disclosures are secured on appointment.

The basic disclosure only show convictions that are not 'spent'. The standard disclosure identifies spent/unspent convictions, cautions, reprimands and final cautions. The enhanced disclosure provides the same information as standard plus any additional information deemed relevant held by local police and a check of adult and children barred lists.

It is unlawful to obtain a disclosure on individuals who are not in an eligible position or undertake regulated activities. An eligible position is a post working with children, young people or vulnerable adults. Regulated activities include providing healthcare, providing personal care and the transportation of people.

NHS Employers advises that under current legislation:

- There is no legal basis to undertake an enhanced with barred list check on all directors. A check is only mandated if a director is in regulated activity themselves i.e. they are a registered healthcare professional, or, they have direct accountability for managing/supervising registered healthcare professionals who are in a regulated activity on a day to day basis.
- For director level positions that are not in regulated activity, employers will need to determine whether there is any eligibility, because of their duties and interaction with patients, for a standard check.
- While there is no legal requirement to obtain a basic disclosure, it strongly recommends that employers as a minimum should seek a basic disclosure for director level positions which are not eligible for an enhanced or standard check but where there is a high level of accountability/responsibility and trust.

The practice of the Trust has been to require enhanced disclosures for Board members. It is proposed to move to a mix of basic, standard and enhanced disclosures secured on appointment as follows:-

<u>Enhanced</u>
Medical Director
Director of Nursing
(and their respective Deputy Director)

<u>Standard</u>
Chief Executive
Chief Operating Officer
Director of Finance
Director of Workforce and OD

(and their respective Deputy Director)

<u>Basic</u>
Chair
Non-Executive Directors
Director of Transformation and Partnerships
Director of The Health Informatics Service

There is no requirement for an annual disclosure to be secured. However, the Trust requires that individuals covered by FPPR register for the DBS Update service which allows for regular and routine access to information held by the DBS.

RECOMMENDATION: The Board is asked to **NOTE** the Fit and Proper Persons declarations and the process that has been followed to undertake checks on suitability.

b. **Board of Directors Declarations of Interest**
The Board of Directors Declarations of Interests register as at 25 February 2020 is attached at Appendix 2 (to follow). Any further amendments are to be advised to the

Corporate Governance Manager. The Board declarations of interest are available to the public on the Trust website.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors Declarations of Interests register.

c. Board of Directors Terms of Reference

The Board of Directors terms of reference describe the role and work of the Board. An annual review of the terms of reference has been undertaken and additions are highlighted to strengthen existing responsibilities. Additional details have been added on Board meeting procedures and a cross reference to the Constitution has been added. The section on reviewing effectiveness of the Board has been refreshed to reflect current practice. All changes are highlighted in the paper at Appendix 3.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors Terms of Reference.

d. Nominations and Remuneration Committee (Board of Directors) Terms of Reference

A meeting of the Nominations and Remuneration Committee of the Board of Directors took place on 11 February 2020. The terms of reference were reviewed at the meeting and the revised terms of reference are attached at Appendix 4 for approval by the Board, with the changes highlighted in the document; these principally relate to clarity on the Committee's remit in terms of senior roles within the wholly owned subsidiary, Calderdale Huddersfield Solutions Limited.

RECOMMENDATION: The Board is asked to **APPROVE** the Nominations and Remuneration Committee (Board of Directors) Terms of Reference**.**

e. Quality Committee Terms of Reference

The terms of reference of the Quality Committee were reviewed at the meeting on 6 January 2020 and the revised terms of reference are attached at Appendix 5 for approval by the Board. The changes made are:

- Organ Donation Committee removed from sub-groups at appendix 2 of the terms of reference
- Addition of named NED at appendix 2
- Frequency of Medication Safety and Compliance Group changed from quarterly to monthly at appendix 2 and 3

RECOMMENDATION: The Board is asked to **APPROVE** the Quality Committee Terms of Reference

f. **Guidance on Matters Reserved for a private session of the Board of Directors** In March 2019 the Trust Board agreed guidance on matters reserved for a private session of the Board of Directors, noting it is the Trust's intention for all matters to be discussed in public, unless there are special reasons which are outlined in the attached guidance document (Appendix 6).

The guidance has recently been reviewed by Company Secretaries across the WYAAT area and through WYAAT Chairs and Chief Executives. The Board is asked to approve two additions to the guidance which are given below. The full guidance is attached at Appendix 6.

FOI section	**Reason for exemption**
Section 14 14(1) Vexatious Requests	The Act does not oblige the Trust to comply with a request for information if the request is vexatious.

	Section 14(1) may be used in a variety of circumstances where a request, or its impact on a public authority, cannot be justified.
Section 22* Information intended for future publication	Drafts of documents not in final form that have firm plans for future publication that can be advised to the requestor e.g. - The Annual Report and accounts which can only be made public once has been laid before parliament - Draft consultation documents

Recommendation: The Board is asked to **APPROVE** the additions to the guidance on matters reserved to a formal private session of the Board.

g. Board of Directors workplan

The Trust Board workplan has been updated for 2020/21 and is presented to the Board for review at Appendix 7. The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and approve the workplan.

RECOMMENDATION: The Board is asked to **APPROVE** the Board workplan for 2020/21

EQIA – Equality Impact Assessment

There is no differential impact as a result of this report on people with protected characteristics.

Recommendation

The Board is asked to **APPROVE** the following:

- Board of Directors Terms of Reference
- Nominations and Remunerations Committee (Board of Directors) Terms of Reference
- Quality Committee Terms of Reference
- Guidance on Matters Reserved for the private session of the Board
- Board workplan 2020/21

The Board is asked to **NOTE** the following:

- Fit and Proper Persons Self Declarations Register
- Board of Directors Declarations of Interest Register

FIT AND PROPER PERSON SELF-DECLARATION REGISTER FEBRUARY 2020

Calderdale and Huddersfield NHS Foundation Trust

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
EXECUTIVE DIRECTORS										
25.2.20	**ARMISTEAD**	Ellen	Executive Director of Nursing/Deput y CEO	NMC registration number: 83G1353E	1.5.19	17.10.19	Owen Williams	1.7.19	Clean 3.3.20.	Clean 3.3.20.
6.2.20	**BARKER**	Helen	Chief Operating Officer	-	13.1.16	11.6.2019	Owen Williams	1.1.16	Clean 3.3.20	Clean 3.3.20.
5.2.20	**BIRKENHEAD (Dr)**	David	Executive Medical Director	MB.ChB, MD, FRCPath	30.11.15 & 29.1.18 001511499967	5.6.20	Owen Williams	01.12.99	Clean 3.3.20	Clean 3.3.20.
10.2.20	**BOOTHBY**	Gary	Executive Director of Finance	Assoc CMA 8659790 CIPFA 41612-CIP	December 2019	25.6.19	Owen Williams	07.03.16	Clean 3.3.20	Clean 3.3.20.
18..2.20	**DUNKLEY**	Suzanne	Executive Director of Workforce & OD	FCIP 31049644	December 2019	April 2019	Owen Williams	01.02.18	Clean 3.3.20	Clean 3.3.20.
13.2.20	**WILLIAMS**	Owen	Chief Executive	-	08.07.16	12.2.20	Philip Lewer	14.05.12	Clean 2.3.20	Clean 2.3.20
DIRECTORS & COMPANY SECRETARY										
6.2.20	**BASFORD**	Anna	Director of Transformation & Partnerships	-	28.06.2016	June 2019	Owen Williams	15.7.13	Clean 3.3.20	Clean 3.3.20.
13.2.20	**GRIFFIN**	Mandy	Managing Director – Digital Health	-	No check completed. Basic disclosure to be made.	4.7.19	Owen Williams	19.01.09	Clean 3.3.20	Clean 3.3.20.

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
10.2.20	**SUGARMAN**	Stuart	Managing Director - CHS	Solicitor and member of the Law Society	September 2019	-	-	30.9.19	Clean 3.3.20	Clean 3.3.20.
24.2.20	**MCCOURT**	Andrea	Company Secretary	-	April 2015	8.5.19	Owen Williams	18.5.15	Clean 3.3.20	Clean 3.3.20.
NON-EXECUTIVE DIRECTORS										
5.2.20	**GRAHAM**	Alastair	Non- Executive Director	N/A	December 2017	5.12.19	Philip Lewer	01.12.17	Clean 3.3.20	Clean 3.3.20.
7.2.20	**HEATON**	Karen	Non- Executive Director	Member of CIPD	May 2016	March 2019	Philip Lewer	01.03.16	Clean 3.3.20	Clean 3.3.20.
11.2.20	**HOPKIN**	Richard	Non- Executive Director	FCA (membership number 7311370)	14.12.17	14.2.19	Philip Lewer	01.03.16	Clean 3.3.20	Clean 3.3.20.
4.2.20	**LEWER**	Philip	Chair	-	April 2018	July 2019	Board	01.04.18	Clean 3.3.20	Clean 3.3.20.
5.2.20	**NELSON**	Andy	Non- Executive Director	-	09.10.17	14.01.19	Philip Lewer	01.10.17	Clean 3.3.20	Clean 3.3.20.
13.2.20	**STERLING**	Denise	Non- Executive Director	Health and Care Professionals Council OT10114	October 2019	Objectives Agreed for 2020	Philip Lewer	01.10.19	Clean 3.3.20	Clean 3.3.20.
13.2.20	**WILKINSON**	Peter	Non- Executive Director	Member of the Royal Institution of Chartered Surveyors (MRICS),Ref No 0085230	September 2019	Objectives Agreed for 2020	Philip Lewer	01.10.19	Clean 3.3.20	Clean 3.3.20.

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
DEPUTY DIRECTORS										
5.2.20	**ARCHER**	Kirsty	Deputy Director of Finance	Chartered Management Accountant, ACMA (CIMA)	March 2018	7.5.19	Gary Boothby	1.8.08	Clean 3.3.20	Clean 3.3.20
6.2.20	**WALKER**	Bev	Deputy Chief Operating Officer/Director of Operations for the Community	NMC 83E0282E	DBS being undertaken currently	2.4.19	Helen Barker	7.11.88	Clean 3.3.20	Clean 3.3.20
14.2.20	**EDDLESTON**	Jason	Deputy Director of Workforce and OD	CIPD 10327459	No check completed. Basic disclosure to be made.	30.4.19	Suzanne Dunkley	08.02.1999	Clean 3.3.20	Clean 3.3.20
6.2.20	**PARKER**	Cornelle	Deputy Medical Director	GMC 3286582	May 2017	4.2.20	Dr Rajprasad Karadi	08.05.2017	Clean 3.3.20	Clean 3.3.20
13.2.20	**RUDGE**	Lindsay	Deputy Chief Nurse	RGN 90E0076E	27 June 2019	4.6.2019	Jackie Murphy	12.7.93	Clean 3.3.20	Clean 3.3.20

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT 3 MARCH 2020

Calderdale and Huddersfield NHS Foundation Trust

Date of Declar-ation	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies.	Ownership/ Part Ownership of private companies and businesses	Controlling Share holding	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Any connection with a voluntary or other organisation contracting for NHS services	Other Employment (paid or non-paid) with a third party
EXECUTIVE DIRECTORS								
13.2.20	Owen Williams	Chief Executive	Nil	Nil	Nil	Member of West Yorkshire Association of Acute Trusts – Committee in Common Chair of the West Yorkshire and Harrogate Capital & Estates Board	Vice Chair of NHS Confederation Chair of the Local School Committee for Beckfoot Thornton School, Leaventhorpe Lane, Bradford, BD13 3BH	Nil
5.2.20	Dr David Birkenhead	Consultant Microbiologist / Executive Medical Director	Chair Woodlands Meltham Ltd. Benson Medical Services	Nil	Nil	Vice-Chair of the WYAAT Pathology Network. Member of the WYAAT Medical Directors Group. Chair of the WYAAT LIMS Procurement Group. Medical Director Local Workforce Action Board Representative		Infection control advice to the BMI Huddersfield

25.2.20	Ellen Armistead	Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil
6.2.20	Helen Barker	Chief Operating Officer	Nil	Company Secretary to husband's lighting business which has previously sold to the NHS. No sales to CHFT and not NHS sales in last 24 months. Expert Lighting Direct Ltd.	Nil	Nil	Company Secretary of husband's business.	Nil
10.2.20	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships	Nil	Nil	Member of the West Yorkshire Association of Acute Trusts Finance Group Member of Integrated Care System Directors of Finance Forum Member of the Partnership Transformation Board	Nil	Nil
18.2.20	Suzanne Dunkley	Executive Director of Workforce & OD	Nil	Nil	Nil	Nil	Nil	Nil
CHAIR AND NON-EXECUTIVE DIRECTORS								
4.2.20	Philip Lewer	Chair	Nil	Nil	Nil	Member of: West Yorkshire Association of Acute Trusts (WYAAT) – Committee in Common	Nil	Nil

						West Yorkshire NHS Chairs meeting Pennine GP and CHFT Board to Board meetings Partnership Transformation Board		
28.2.20	Richard Hopkin	Non-Executive Director	Capri Finance Ltd – own consultancy company.	Nil	Nil	Treasurer (Hon) Community Foundation for Calderdale Finance Consultant Age UK Calderdale and Kirklees and also for Age UK Wakefield and District	Age UK – The Onside Foundation	Other project work through consultancy company Capri Finance Limited
7.2.20	Karen Heaton	Non-Executive Director	Nil	Nil	Nil	Nil	University of Manchester – Director of Human Resources Member of Confederation of British Industry (Employment & Skills Board) From 09/19	Nil
5.2.20	Andy Nelson	Non-Executive Director	Non-Executive Director & Strategic Advisor to the Board of The Law Society	Nil	Nil	Nil	Nil	1 or 2 lectures per year for Lancaster University
13.2.20	Peter Wilkinson	Non-Executive Director	Leeds Grand Theatre and Opera House Ltd – independent member of the Board and Trustee. A company limited by guarantee and a registered charity. Non-Executive Director Decipher Consulting UK Ltd.	PW Advisory Ltd – own consultancy company based in Holmfirth	Nil	Nil	Nil	Nil

			Consultancy business based in Manchester/Macclesfield					
13.2.20	Denise Sterling	Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Non paid Trustee, Board of Bradford Diocesan Academies Trust
5.2.20	Alastair Graham	Non-Executive Director	Director and Chair of Calderdale and Huddersfield Solutions Limited	Nil	Nil	Nil	Nil	Nil
ATTENDEES AT BOARD OF DIRECTORS								
6.2.20	Anna Basford	Director of Transformation & Partnerships	Nil	Nil	Nil	Nil	Nil	Nil
19.2.20	Mandy Griffin	Managing Director – Digital Health	Nil	Nil	Nil	Nil	Nil	Nil
10.2.20	Stuart Sugarman	Managing Director – CHS	Nil	Nil	Nil	Nil	Nil	Nil

All the above Board of Directors have confirmed that they continue to comply with the Fit and Proper Person Requirement.

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTITUTION

In accordance with its Constitution, the Trust has a Board of Directors, which comprises both Executive Directors, one of whom is the Chief Executive and Non-Executive Directors, one of whom is the Chair.

As set out in Annex 8 of the Constitution the Trust has Standing Orders for the Board of Directors which describe the practice and procedures for the business of the Trust. Those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, information for the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

2. PURPOSE

The principal purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients, [service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision , strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets, maintains and oversees the implementation of the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:

- Is responsible for setting values, ensuring they are widely communicated and

that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS England/ NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to foundation Trusts;
- Ensures that the Trust operates in accordance with its Constitution
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures the the Trust protects the health and safety of Trust employees and all others to whom it has a duty of care
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Review and approve the Trust's Annual Report and Accounts, including the Quality Report
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures that all required returns and disclosures are made to the regulators and complies with all relevant regulatory, legal and code of conduct requirements, including Care Quality Commission fundamental standards for all regulated activities ;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business.
- Agrees the schedule of matters reserved for decision by the Board of directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for

senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community.
- Meets its engagement obligations in respect of the Council of Governors and members and ensures that governors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically
- Agree the Trust's financial objectives and approve the financial plan
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and Council of Governors and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chairman and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

7. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS'

The Non-Executive Directors are accountable to the Council of Governors' for the performance of the Board of Directors. To execute this accountability effectively, the Non-Executive Directors will need the support of their Executive Director colleagues. A well-functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship. The Non-Executives also should ensure that the Board as a whole allows Council of Governors' time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS AND PROCEDURES

The Board of Directors will meet at least 6 times a calendar year in public on dates agreed with the Chair. Dates of forthcoming meetings held in public shall be posted on the Trust's website.

Agendas and papers for forthcoming meetings of the Board to be held in public,and minutes of previous meetings held in public, shall be posted on the Trust's website.

Additional meetings of the Board may be held in private for consideration of confidential business.

Further details on the practice and procedure of the Board of Directors can be found in Annex 8 of the Constitution.

9. QUORUM

Seven directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

If an Executive Director is unable to attend a meeting of the Board, an alternative may be appointed to attend that meeting or part of it, if so requested by the Chair. Any such alternative shall not be counted as part of the required quorum unless they have been formally been appointed by the Board as an Acting Director.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Company Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive

- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the Council of Governors and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the chair and chief executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

The Board will review its effectiveness in the following ways:

Review of attendance records
Annual reports from Board Committees
Board of Director Development Workshops
Outputs from any Well-Led Governance Reviews
Board Effectiveness Review

Date approved: Drafted: 25 FEBRUARY 2020

Review Date: February 2021

Calderdale and Huddersfield NHS Foundation Trust

NOMINATIONS AND REMUNERATION COMMITTEE (BOARD OF DIRECTORS)

TERMS OF REFERENCE

Version:	1 Board approved 30.6.16. 2 Draft submitted to Board for approval 5.3.20. following approval by Nominations and Remuneration Committee
Approved by:	Board of Directors
Date approved:	30.6.16 5.3.20.Tbc
Date issued:	30.6.16
Review date:	March 2021

NOMINATIONS AND REMUNERATION COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Nominations and Remuneration Committee. The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

2.1 The Nominations and Remuneration Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

2.2 The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nominations and Remuneration Committee.

2.3 The Nominations and Remuneration Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from both within and outside the Trust with relevant experience and expertise if it considers this necessary to the exercise its functions.

3. Purpose

3.1 To be responsible for identifying and appointing candidates to fill all NHS Foundations Trust Executive Director positions on the Board and non-Board Director roles, including Director roles within wholly owned subsidiaries of the Trust and for determining their remuneration and other conditions of service. When appointing the Chief Executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006. When appointing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

3.2 To be responsible for identifying and appointing candidates to fill Calderdale and Huddersfield Solutions (CHS) Ltd Chair, Non-Exeuctive Director and Director roles and for determinging their remuneration and other conditions of service.

4. Nominations role

The Committee will:

4.1 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations to the Board with regard to any changes.

4.2 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors, taking into account the challenges and opportunities facing the Foundation Trust and the skills and expertise needed, in particular on the Board in the future.

Give full consideration to and make plans for review and succession planning for the non-Board Director roles and Director roles for wholly owned subsidiaries established by the Board, taking into account the skills and expertise needed.

4.3 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.4 Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

4.5 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.6 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise.

4.7 Be responsible for identifying and nominating a candidate for approval by the Council of Governors in accordance with the Constitution to fill the position of Chief Executive.

4.8 Ensure that proposed appointees comply with the Fit and Proper Persons Requirements and disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.9 Consider any matter in line with Trust procedures relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Foundation Trust.

5. Remuneration role

5.1 Establish and keep under review a remuneration policy in respect of Executive Board Directors (and senior managers on locally determined pay).

5.2 Consult with the Chief Executive about proposals relating to the remuneration of other Executive Directors and non-Board Directors.

5.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors and non-Board Directors including Director roles within wholly owned subsidiaries of the Trust , including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses; and compensation payments.

5.4 In adhering to all relevant laws, regulations and Trust policies:-

- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors and non-Board Directors while ensuring that increases are not made where trust or individual performance do not justify them.
- Be sensitive to pay and employment pay and conditions elsewhere in the trust.

5.5 Monitor and assess the output of the evaluation of the performance of individual directors, and consider this output when reviewing changes to remuneration levels.

5.6 Advise upon and oversee contractual arrangements for Executive Directors and non-Board Directors, including but not limited to termination payments (including redundancy), taking account of national guidance where appropriate, always ensuring that poor performance is not rewarded.

5.7 Delegate responsibility to the Chief Executive and Director of Workforce and Organisational Development for the determination of the Trust's pay and reward strategy as it affects all other staff,working within national frameworks where required.

6. Membership and attendance

6.1 The membership of the committee shall consist of:

- The Trust Chair
- The other Non-Executive Directors on the Board (excluding the Chair of the Audit and Risk Committee for remuneration business)
- The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his/term terms of condition and remuneration.

6.2 The Trust Chair shall chair the committee.

6.3 A quorum shall be three members which must include either the Trust Chair or Trust Deputy Chair/Senior Independent Non-Executive Director. In the absence of the Trust Chair, the Trust Deputy Chair/Senior Independent non-Executive Director will chair the meeting.

6.4 The Executive Director of Workforce and Organisational Development shall normally be invited to attend meetings in an advisory capacity.

6.5 Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

6.6 Members unable to attend should inform the Committee Secretary at least 7 days in advance of the meeting.

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

7. Administration

7.1 The Company Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the Company Secretary in this regard include but are not limited to:

- Agreement of the agenda with the chair of the committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

8. Frequency of meetings

8.1 Meetings shall be held as required but at least twice in each financial year,

9. Reporting

9.1 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 unless it would be inappropriate to do so.

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

9.3 The Committee shall receive and agree a description of the work of the Committee, its policies and all Executive Director emoluments in order that these are accurately reported in the Trust's Annual Report.

10. Review

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

Date Approved:

Review Date: February 2021

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.

4.24. To receive internal audit reports (with a quality element) and seek assurance on recommendations

5. Membership and attendance

5.1. The Committee shall consist of the following members:

- Two 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
- Medical Director
- 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:

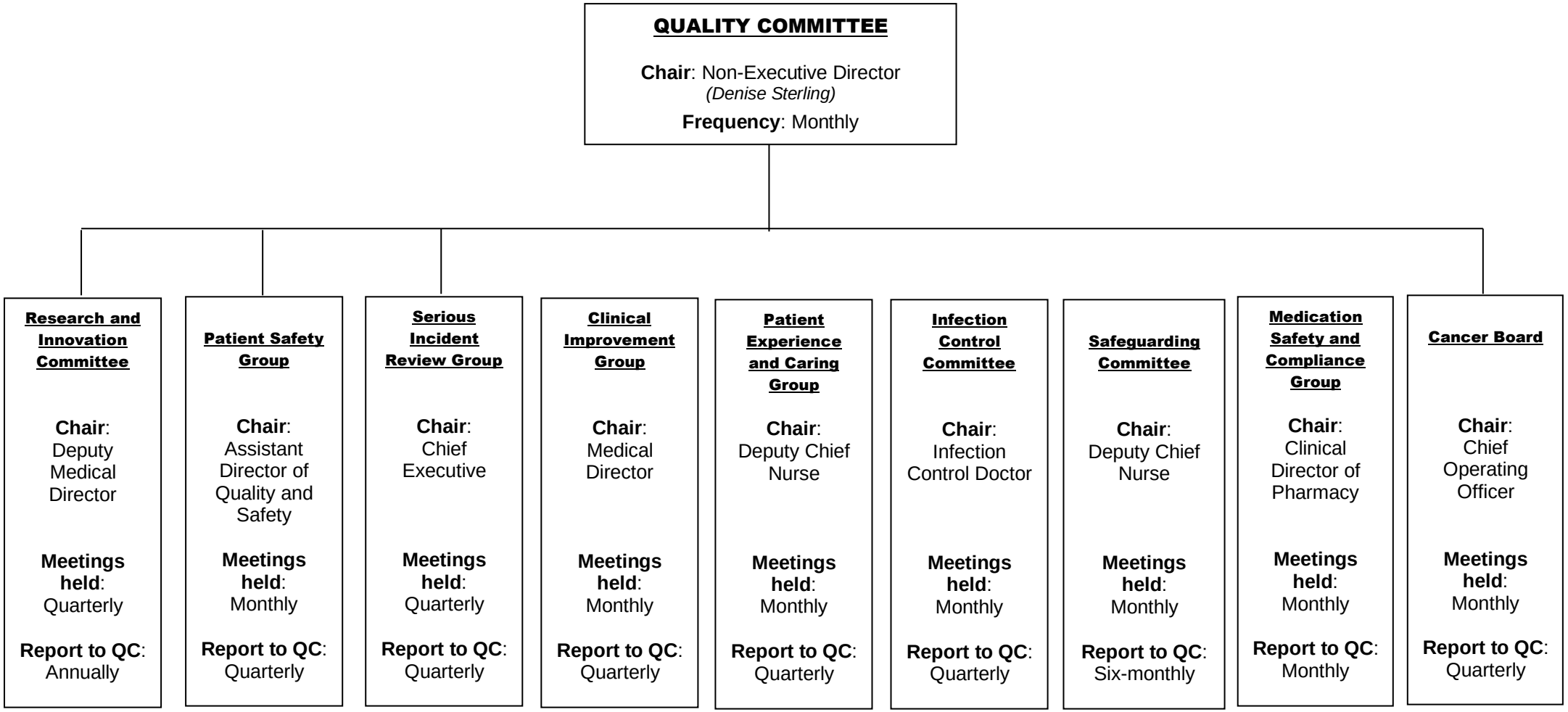
- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 5 working days prior to the meetings;
- The action point from each meeting are circulated within two working days, on 80% of occasions

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
Executive Director of Nursing	All meetings
Medical Director	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 (Quarterly) ▪ High Level risk register (Bi-monthly) ▪ Medication Safety and Compliance Group (Monthly) ▪ Serious Incident Report (Monthly) As required: ▪ Prevention of future death reports, ▪ Incident reports / action plans.
Effective	▪ NICE guidance compliance (Annual) ▪ Clinical Improvement Group (Quarterly) ▪ Cancer Board Report (Quarterly) As required: ▪ Service specific reports / invited service reviews as required – detailed in workplan
Experience	▪ Patient Experience and Caring Group (Quarterly)
Responsive	▪ Quarterly report (Quarterly) ▪ Quality Account (Quarterly) ▪ Quality Annual report
Well-Led	▪ CQC report (Six monthly) ▪ Research and Innovation (Annual) ▪ 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)

Versions:	**1.1** first draft circulated for review to Chair / Director of Nursing **1.2** Amendments prior to Trust Board **1.3** Amendments after submission to Quality Committee **1.4** Further amendments **1.5** Further amendments **2** Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3 **3** Amendments made: ▪ Chief Operating Officer removed from membership ▪ Executive Director of Planning, Estates and Facilities removed from membership ▪ Two non-executive directors instead of three ▪ Purpose added in relation to internal audits **3.1** Amendments made (with Chair) (June 2019) ▪ Organ Donation Committee and Cancer Board added to sub-groups at appendix 2 ▪ Frequency of sub-group meetings amended at appendix 2 ▪ Frequency of meetings amended at appendix 3 **4** Amendments made: ▪ Organ Donation Committee removed from sub-groups at appendix 2 ▪ Addition of named NED at appendix 2 ▪ Frequency of Medication Safety and Compliance Group changed from quarterly to monthly at appendix 2 and 3
Appendices	**1.** List of members **2.** Sub groups **3.** Reports aligned to CQC domains
Date issued by Quality Committee:	January 2020
Date approved by Board of Directors:	TBC
Review date:	January 2021

APPENDIX 6

Calderdale and Huddersfield NHS Foundation Trust

GUIDANCE FOR RESERVING MATTERS TO A PRIVATE SESSION OF THE BOARD OF DIRECTORS

It is the Trust's intention for all matters to be discussed in public, unless there are special reasons as outlined in this guidance document.

Background

The Trust's Constitution states that meetings of the Board of Directors shall be open to members of the public. However, members of the public may be excluded from a meeting for reasons of commercial confidentiality or on other proper grounds.

Within the Constitution's Standing Orders for the practice and procedure of the Board of Directors, it outlines that special reasons shall include, but not be limited to, the following:

- Discussion of any matter which contains confidential, personally identifiable information relating to a member of staff or a service user or carer.
- Discussion of any matter which contains commercially sensitive information relating to the Trust or a third party.

having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

Determination

Within the NHS Providers' guidance *The Foundations of Good Governance: A Compendium of Best Practice 2011* and NHS Leadership Academy's *The Healthy NHS Board 2013 - Principles for Good Governance,* it recommends that when determining which matters should be reserved for private consideration, the Trust should consider whether the information to be discussed would be exempt from disclosure under the Freedom of Information Act (FOI) 2000.

FOI section	Reason for exemption
Section 14 14(1) Vexatious Requests	The Act does not oblige the Trust to comply with a request for information if the request is vexatious. Section 14(1) may be used in a variety of circumstances where a request, or its impact on a public authority, cannot be justified.
Section 22* Information intended for future publication	Drafts of documents not in final form that have firm plans for future publication that can be advised to the requestor e.g. - The Annual Report and accounts which can only be made public once has been laid before parliament - Draft consultation documents

Section 24 Safeguarding National Security	The information is exempt if it is required for the purposes of safeguarding national security e.g. Cyber
Section 31 31(1)(a), (b), (c) and (f) 31(1)(g)*, 31(2)(b) * or (j) Law enforcement	- Disciplinary or legal investigations of members of staff or the Trust. - Processes for identifying any improper conduct. - Serious incident reports.

FOI Section	**Reasons for exemption**
Section 32 Information contained in court records	Information that we hold that was created explicitly for or was used in any court proceedings.
Section 36 36(2)(b)(i)*, (b)(ii)* and (c)(*) Free and frank discussion and the effective conduct of public affairs	Exemption may only be considered if the Trust's qualified person (Chief Executive) has provided a written opinion that disclosing the information would prejudice the Trust's affairs. Information discussed could include: - Matters in the initial stages of enquiry. - Early stages of strategic thinking. - Sensitive 'live' issues. - Draft minutes of meetings. - Recommendations from external organisations. - Professional advice obtained. - Options papers. - Discussions about future public consultations.
Section 38 Health & Safety	Matters in relation to the health and safety of staff members, service users, carers or other members of the public.
Section 40 40(2) Personal data	Information containing the personal data of including staff members, service users, carers or other members of the public where the disclosure would not be fair to that person. This exemption only applies to the living, and consent to the disclosure being considered will not have been given and that the other legal bases for disclosure, as set out in the Data Protection Act, will need to be considered.
Section 41 Information provided in confidence	Information provided in confidence from another person or organisation, if releasing that information would lead to a claim for breach of confidence.
Section 42* Legal professional privilege	Legal advice including communications with law firms.

Section 43* 43(2)* Commercial interests	Disclosure of the information would be likely to damage the Trust's commercial interests or those of a third party. The Trust must be able to demonstrate exactly how the requested information would prejudice the Trust's or another party's interests.
Section 44 Prohibitions on disclosure	Information which is prohibited to be disclosed by law, stating which law prohibits the release of the information and why.

AM
February 2020

DRAFT BOARD WORK PLAN 2020-2021 - WORKING DOCUMENT – UPDATED 25.2.20

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Date of agenda setting/Feedback to Execs	2 April 2020	4 June 2020	5 August 2020	5 October 2020	7 December 2020	1 February 2021
Date final reports required	28 April 2020	23 June 2020	25 August 2020	27 October 2020	5 January 2021	23 February 2021
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
REGULAR ITEMS						
Board Assurance Framework (Quarterly)	✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓
Care Quality Commission Update (CQC)	✓	✓	✓	✓	✓	✓
Climate change Sustainability Report		✓				
Director of Infection Prevention Control (DIPC) report (See annual items)	✓				✓	
High Level Risk Register	✓	✓	✓	✓	✓	✓
Learning from Deaths – Quarterly Report		✓ Q2		✓Q3		✓ Q1
Guardian of Safe Working Quarterly Report		✓Q1		✓Q2	✓Q3	
Quarterly Quality Slide Report + Presentation focused on one topic (NB – Quality Account in Annual Report)	Quality A/cs		✓ Q1	✓Q2		Q3✓
Staff Survey Results		✓		✓		✓
Nursing and Midwifery Staffing Hard Truths Requirement			✓ (Bi-annual)			✓ (Bi-annual)

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Safeguarding update – Adults & Children			✓ (Annual report)			✓
Financial Update	✓	✓	✓	✓	✓	✓
Plan on a Page Strategy	✓ (2020/21)					✓ (Annual report)
Health and Safety Update	✓		✓	✓		
MINUTES FROM SUB-COMMITTEES						
Quality Committee update & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & Minutes	✓	✓	✓	✓	✓	✓
F&P Committee update & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee update & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
A&E Delivery Board Minutes	✓	✓	✓	✓	✓	✓
GOVERNANCE REPORT						
Standing Orders/SFIs/SOD review	✓					
Non-Executive appointments			✓	✓		✓
Board workplan		✓		✓		✓
Board skills / competencies					✓	
Board meeting dates		✓			✓	
Committee review and annual reports		✓				
Annual review of NED roles			✓			
Use of Trust Seal		✓		✓		
Declaration of Interests - BOD (annually)						✓
Attendance Register – (annually)	✓					
BOD Terms of Reference						✓
Sub Committees Report & Terms of Reference	✓					✓

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Constitutional changes (+as required)	✓					
Compliance with Licence Conditions	✓					
Assurance (Quality) Visits Feedback		✓		✓		✓
ANNUAL ITEMS						
Annual Plan						✓
Capital Plan					✓	
Council of Governors Elections		✓ (results)	✓			✓ (timetable)
Digital Health Strategy	✓	✓		✓		
Emergency Planning Annual Report			✓			
Fit and Proper Person Self-Declaration Register						✓
Guardian of Safe Working Hours Annual Report	✓		✓		✓	✓
HPS Annual Report	✓					
Health and Safety Annual Report		✓		✓ (update)		
Public Sector Equality Duty (PSED) Annual Report						✓ (Annual Report)
DIPC Annual Report (ALSO SEE REGULAR ITEMS)		✓ (Annual Report)				
Fire Safety Annual Report	✓ (Annual Report)					
Medical revalidation & appraisal			✓ (Annual Report)			
Freedom to Speak Up Annual Report	✓					✓ (Annual Report)
Review of Board Sub Committee TOR	✓					
Risk Appetite Statement				✓		
Risk Management Strategy					✓	
Winter Plan			✓	✓		
Workforce OD Strategy						✓

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Local Health Resilience Partnership (LHRP) Core Standards			✓			✓
Performance management update				✓		

24. Update from sub-committees and receipt of minutes & papers

• Finance and Performance Committee – minutes from meetings held on 29.11.19, 31.12.19 and 3.2.20 - R Hopkin

• Audit and Risk Committee – minutes of meeting held on 29.1.20 - A Nelson

• Quality Committee – minutes of meetings held on 2.12.19, 6.1.20 and 5.2.20 - D Sterling

• Charitable Funds Committee – verbal update on meeting held on 26.2.20 - P Lewer

• A&E Delivery Board – minutes from 10.12.19 and 7.1.20 - H Barker

• Organ Donation Committee – minutes of meeting held on 15.1.20 - P Lewer

• Workforce Committee - minutes of meeting held on 18.2.20 - K Heaton

• Council of Governors - minutes of meeting held on 23 January 2020

To Note

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 29 November 2019, 9.30am – 12.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Chief Operating Officer (In part)
Kirsty Archer	Acting Director of Finance
Owen Williams	Chief Executive
Peter Wilkinson	Non-Executive Director
Richard Hopkin	Non-Executive Director (CHAIR)

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Philip Lewer	Trust Chair (In part)
Will Ainslie	Clinical Director, Surgical Division (for Item 184/19 only)

ITEM

179/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

180/19 APOLOGIES FOR ABSENCE

Apologies from Phil Oldfield, Gary Boothby, Stuart Baron and Sian Grbin were noted.

181/19 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

182/19 MINUTES OF THE MEETING HELD 1 NOVEMBER 2019

The Draft Minutes of the meeting held 1 November 2019 were approved subject to including a Declaration of Interest from Richard Hopkin with his interests in Age UK and their involvement in the Discharge Lounges.

183/19 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as follows: -

010/19: ED Workforce Staffing – The Chief Operating Officer confirmed that a paper is now available, and this will be on the Agenda for the **3 February 2020**.

009/19: Use of Resources – The Acting Director of Finance confirmed that she had approached NHSI for their advice for their suggestions as to who we could engage with regarding a peer review and we are awaiting their response. However, it was suggested that we should re-visit approaching external organisations to expedite the request – **KA/AMcC – To find an alternative for the peer review.**

In terms of increasing the profile of UoR within the Trust, a workshop will be taking place 29 January to include a wider group of colleagues who may be involved in evidence gathering for the CQC and it was agreed that Non-Executives should also be invited – **KA to extend the invite to the Workshop to Non-Executives.**

141/19: Income position – cost out, it was agreed that this would be picked up under Item 188/19 on today's agenda – **item closed**.

170/19: Month 6 Finance Report – actions will be picked up under the Month 7 Finance Report **– item closed**.

056/19: Patient Flow & EC Improvement Plan – As part of these discussions it was suggested that 'Winter' would be a specific agenda item for the meeting on the 3rd February 2020.

ACTION: To include 'Winter' as an Agenda item – **HB, 3/2/2020**

184/19 THEATRE UTILISATION UPDATE

Will Ainslie, Clinical Director, Surgical Division presented an update following the original presentation received by the Committee in May. It was noted that Theatre Utilisation has been benchmarked nationally and is not just a local issue. Following a review of the internal data, it became obvious that it was time for a fresh approach and a new Theatre Utilisation Knowledge Portal App was developed. With the development of the App the Surgical Division started to look for opportunities and it was found that in some Specialties there was some under-utilisation. The presentation detailed the opportunities along with the issues which have been identified through this process.

Discussions took place regarding the buy-in to the GIRFT initiatives, it was noted that this varies from specialty to specialty and attendance is mixed. It was also noted, however, that we are working with our own data and colleagues should start taking ownership and we could engage more with clinicians.

In terms of benchmarking it was confirmed that in general this is being monitored by KPIs. It was acknowledged that late starts is an area which needs focus, however, due to many issues including administration and availability of rooms to interview the patient this is quite complex.

The Committee thanked WA for the update noting that there had been quite a lot of progress over the last 6 months with work still to do, however, there is a plan to have identified all opportunities across all areas of the matrix by 24 December 2019. The opportunities will feed into CIP next year however, a recurrent solution is required to fill the gap and there is confidence that we can achieve this.

ACTION: To receive a further update at TE and then to come back to this Committee next year **– AB/WA 2/3/2020**

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

FINANCE & PERFORMANCE

185/19 AGED DEBT REPORT AND MONTH 7 FINANCE REPORT

Aged Debt - The Acting Director of Finance presented a specific report to update the Committee on the latest position regarding aged debt. The report also outlined the actions being taken to deal with aged debt and future opportunities to be considered. The key point to note is that the aged debt at the end of October 2019 was £3.994m

(less than 1% of Turnover) and the level of risk posed is mitigated by the bad debt provision. A number of actions have been put in place to address the aged debt position and to improve cash management and reduce risk. It was noted that a routine Agreement of Balances exercise takes place twice a year, this ensures NHS organisations and other Government bodies' balances are aligned and any issues are discussed and agreement reached.

It was also noted, that there is further opportunity to address the high-volume low value invoices which were highlighted within the report and it was acknowledged that a dedicated resource should improve the position.

The Committee asked for assurance that the Trust is doing all it can regarding the overseas debt and salary overpayments. It was noted that in the case of the overseas patient who had been admitted to ICU and whose debt was over £100k this was picked up immediately. A debt collection agency has been assigned to the debt which enabled a payment plan to be put in place based on the assessment of affordability. It was also noted that we have received advice from the regional lead of NHSI/E regarding a process for up-front payments which is now in place. With regard to salary overpayments a paper has been submitted to the Audit & Risk Committee (ARC) for discussion following a benchmarking exercise carried out by Internal Audit this showed the Trust as being a slight adverse outlier and will continue to be on the agenda for ARC.

The Committee **NOTED** the contents of the report and Aged Debt will continue to be monitored through the Finance Report.

MONTH 7 FINANCE REPORT

The Acting Director of Finance reported the following headlines at Month 7:-

- The year to date deficit is £8.34m which is in line with plan.
- Agency expenditure is lower than planned and lower than the NHS trajectory, however, we have seen a switch to Bank expenditure with some payments at a premium rate compared to substantive.
- Capital is underspent year to date due to the re-profiling of the externally funded emergency capital bids.
- Cash, we had more cash than planned and borrowing is below plan which is also linked to the reprofiling of capital spend.

In terms of the forecast, the Committee were reminded that at Month 5 recovery plans were identified in order to secure the year end position. In month this position has stabilised, and the recovery stands at £1.7m, circa £1.3m has been identified and work to identify the gap continues, the main area of focus is the Medicine Division. It was noted that the Division attended Turnaround Executive to present their plans, this was not concluded, and a review of their recovery plan will continue at their Performance Review Meeting (PRM) this afternoon. It was noted that Divisions need to hold and deliver their recovery requirements.

Medical Pay Profiling – Pay expenditure is forecast to be higher in the second half of the year in part due to the Medical Staffing pay awards paid in September which will continue to the end of the year. In addition to the pay awards, expenditure in the final 6 months of the year will be higher due to reduced vacancies in both Community and FSS Division, reconfiguration project staffing costs and winter and

growth costs. This will be offset to some extent by an increased monthly CIP target.

Medical Staff Pay Award – following feedback it was felt that we have a lesson to learn regarding the interpretation of guidance and that we should look outside the WYAAT area to canvass understanding of future guidance.

In terms of the Forecast Recovery and the THIS Division it was confirmed that conversations have taken place with Mandy Griffin, Managing Director, Digital Health and agreement has been reached to revise the target this year which will leave them with a greater challenge for next year. It was also noted that it had been stressed to THIS that Finance should have a higher profile at their Monthly Executive Meeting, and this has been acknowledged by the Chair of that forum.

CIP – whilst the Trust is forecasting to fully deliver the £11m target this year it was noted that there has been some slippage of the recurrent/non-recurrent split which creates a greater challenge for the next financial year. It was also noted that CIP is slightly ahead year to date, and we are currently working on scoping schemes. We continue to work towards identifying schemes to the value of £14m for next year with a dedicated TE session in the next few weeks.

Risk – it was agreed by the Committee to keep the 'Risk of not achieving the 2019/20 Financial Plan' at 12.

The Committee **NOTED** the report for Month 7.

186/19 2020/21 CAPITAL PLAN OVERVIEW

The Chief Operating Officer presented slides which updated the Committee regarding the Capital Plan for 20/21. The presentation summarised the Capital Programme for the Divisions, including Corporate, following the annual 'Dragons Den' type pitch held on the 27 November 2019. It was noted that there had been £27.0m worth of bids for a total resource available of £4.0m, including a contingency reserve of £0.5m which will be challenging. It was also noted that all schemes with a risk above 15 and some 12 rated schemes were supported.

The individual list of schemes were reviewed and the following headlines noted:-

- IM&T will be the biggest challenge as their request was for £3.9m of investment, the majority being investment to be able to maintain core infrastructure. The Division had not prioritised the end-user devices, however, the panel took the decision to invest in this area. It was also noted that further conversations will take place with THIS regarding the risk. In an effort to try to bridge the gap discussions regarding alternative funding will take place within the Digital Health Forum.

- CHS/Estates schemes - the panel excluded the Fire scheme from the bids as this is part of the Emergency Capital Bid, however, this will be revisited if necessary.

- FSS had the largest value of requests at £10.9m with most of the kit required being high cost, however, £645k of schemes were prioritised.

It was noted that for the next financial year it is the intention to tighten governance around Capital spend and that schemes which have been supported will require business cases to be approved at the start of the financial year to enable spend as soon as possible without slippage.

OW suggested that a review of the panel may need to take place in future to include colleagues who have the technical expertise to assist with the decision making.

ACTION: It was suggested by the Chief Executive that the investments relating to medical devices should be shared with Staff Governors – **HB/KA**

The Committee **RECEIVED** and **NOTED** the presentation.

187/19 INTEGRATED PERFORMANCE REPORT - OCTOBER

The Chief Operating Officer reported the following key headlines:-

- The October performance is the best it has been all year.
- There are specific concerns within the RESPONSIVE domain which stands at 59%
- Complaints - is a mixed picture, in terms of responses, the quality appears to be better. However, consequently, there is an increase in the severity which requires the intervention of the Chief Executive who will personally be meeting with complainants.
- #NoF sits at 77% a #NoF focused deep-dive has taken place with Trauma & Orthopaedics. It was noted that patients who are not being seen within 36 hours are being seen within 48 hours, just missing the target. Depth of coding still requires more work to do within FSS and Surgery.

In terms of RESPONSIVE, the following headlines were noted:-

- Emergency Care Standard (ECS) continues to be challenging it continues to be below our trajectory and our expectations.
- The challenge is to implement our Improvement Plan at pace, this was discussed at WEB in terms of making sure actions are being followed up. Specifically, within A&E there are inexperienced new starters working in a difficult working environment, therefore, a senior experienced Head Nurse and an additional Matron (one at each site) have been drafted into ED to provide support. Co-ordinator training and triage has also been introduced.
- To impact further on our performance this week, 3 wards have closed and 2 restricted due Gastroenteritis and the Norovirus across both sites. Alternative plans have been implemented to ensure there is safe capacity which is safely staffed.
- Stroke – SSNAP ‘A’ is being retained, but there is an element of challenge relating to admitting stroke patients directly to a stroke bed. There is a suggestion that our reporting may be incorrect as we are including patients who have been discharged from stroke care but are not in a stroke bed, this is being reviewed.
- Diagnostics – Echocardiography will be compliant this month. In terms of Neurophysiology this may not be fully compliant until February, an external review has taken place and actions will be put in place with a further review in 3 months’ time.

- ASI – remains a challenge, capacity is always restricted around peak holiday periods. This will be picked up as part of the Outpatient Improvement Plan.
- Cancer – Day 62 continues its amazing progress and Day 38 is slightly better.

The Non-Executive Directors were asked to take a balanced view regarding our positive performance as there are also examples of under-performance.

The Committee **NOTED** the IPR for October and appreciated the current operational challenges.

188/19 ALIGNED INCENTIVE CONTRACT (AIC) – DRIVERS TO MONTH 7

The Acting Director of Finance and Chief Operating Officer worked together to provide a presentation outlining the current position regarding the AIC. For the benefit of the Non-Executives KA explained the background for moving to the AIC from a Payment by Results (PbR) contract.

The proposed outcomes from the presentation were noted:-

- To develop a shared understanding of the benefits being driven by the AIC.
- To bring together the operational and financial picture
- Preparation for 2020/21 contract negotiations with Commissioners
- To enlist Finance & Performance as critical friends to strengthen the future discussions.

HB gave the Committee an in-depth review of the areas which have seen investment by doing something differently supported by the AIC, particularly the Frailty Service, Admission Avoidance the Enhanced Discharge and Reduced Length of Stay.

It was noted that we should try to build into the contracting conversations with our Commissioners funding for research which would give us an understanding of the access to services particularly frailty for the BAME community. Also, the percentage of respiratory patients with learning difficulties was also called out as an area for discussion.

It was also noted that we should include sustainability, digital working and transformation into contract discussions, and it was recognised that colleagues involved in Quality should be invited to take part in those discussions

The Committee **NOTED** the presentation

STRATEGIC ITEMS

189/19 CIP UPDATE

The Committee discussed CIP as part of the Finance Report.

GOVERNANCE

190/19 DRAFT MINUTES FROM SUB-COMMITTEES

The draft Commercial Investment & Strategy Committee held 4 October 2019 were not available for the Committee, however, the Acting Director of Finance reported the approval at that meeting of an additional £200k for Cerner Licencing Costs relating to the increased volume of licences we are using at the contractual level.

The following Minutes were received:

- Draft THIS Executive Meeting held 2 October 2019
- Draft Capital Management Group held 13 November2019
- Draft HPS Board Meeting held 25 November 2019 with the following headlines:
    - Finance – ahead of plan at Month 7
    - Staff Survey – more work has taken place and a document will be fed back. This has largely been closed due to the timing of the next survey. Workshops have taken place and communication is something which needs continual work and initiatives will keep going.

The Minutes were **RECEIVED** and **NOTED** by the Committee.

191/19 WORK PLAN

The Committee **NOTED** the Work Plan which will be updated to reflect the actions from this meeting.

192/19 MATTERS TO CASCADE TO THE BOARD

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

- Theatre Utilisation Update – the process of identifying further opportunities will be complete by the end of the year and that this Committee will re-visit in 2020.
- UoR – an alternative to the peer review is on-going and clarification will be received shortly.
- IPR – Positive October performance.
    - Cancer targets positive
    - Complaints still getting focus
    - Further investigation into #NoF
    - Depth of coding highlighted for more focus within FSS and Surgery
    - Reference to the challenges in November to date in ED and the ward closures
- Capital - plan in place for 20/21 subject to confirmation of the Emergency Capital Bids particularly around 'Fire'.
- AIC re-negotiation summarised
- Aged Debt – the position and the actions which are being taken discussed
- Month 7 – on plan and the Risk profile will remain at 12

193/19 REVIEW OF MEETING

The Committee agreed that there had been good discussions.

194 /19 ANY OTHER BUSINESS

In terms of the next meeting it was agreed that an informal session should take place on the 31 December either face to face or via conference call.

DATE AND TIME OF NEXT MEETING:
TUESDAY 31 December 2019, 9.30am – 10.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE. Dial in details are also available as follows:-

Please Dial: **3310 (internal)** OR **01484 343310 (external or mobile)**
When prompted, enter the Conference number – **2761#**
Then, when prompted, enter the Security PIN – **2761#**

Calderdale and Huddersfield NHS Foundation Trust

APP A1

Notes of the INFORMAL Finance & Performance Committee held on Tuesday 31 December 2019, 9.30am – 10.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer – via conference call
Kirsty Archer	Acting Director of Finance
Richard Hopkin	Non-Executive Director (CHAIR)

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Notes)
Philip Lewer	Trust Chair

ITEM

195/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

196/19 APOLOGIES FOR ABSENCE

Apologies from Anna Basford, Gary Boothby, Owen Williams, Peter Wilkinson and Sian Grbin were noted.

197/19 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

198/19 MINUTES OF THE MEETING HELD 29 NOVEMBER 2019

The Draft Minutes of the meeting held 29 November 2019 to be carried forward to the next formal meeting of the Finance & Performance Committee to be held 3 February 2020 for approval.

199/19 ACTION LOG AND MATTERS ARISING

The Action Log and Matters Arising to be carried forward to the next meeting on the 3 February 2020.

FINANCE & PERFORMANCE

200/19 MONTH 8 FINANCE REPORT

The Acting Director of Finance reported the following headlines at Month 8:-

- The year to date deficit is £8.67m, a £0.24m favourable variance from plan. However, the favourable position is due to a gain on the disposal of property and is excluded for the purposes of allocation of Provider Sustainability Funding and Financial Recovery Funding. On a Control Total basis, we are on plan.
- CIP delivered slightly ahead of plan year to date at £6.34m.
- Agency expenditure remains lower than the planned level and lower than the NHSI agency trajectory.

Within the position there has been continued pressure year to date due to higher than planned non-pay expenditure including utilities, maintenance contracts and

outsourced services, and additional pressure within the Medical Division has been seen due to capacity pressures. These pressures have been contained in month with the improvement by other Divisions and the release of winter funding. We have also been awarded an additional £0.5m of central ICS Winter funding to support winter pressures.

In terms of the forecast we continue to forecast delivery of the £9.7m planned deficit on a Control Total basis. The key operational focus in the final four months is to contain the overall winter expenditure with the earmarked funding as well as the additional central funding. In addition to this the completion of Project Echo in year is an emerging risk. It was noted that this was flagged at the last Quarterly Review Meeting (QRM) with NHSI, at that meeting it was clearly stated that the Trust is very well advanced with the project to complete, however, we are relying heavily on NHSI and the DHSC for their approval which is posing the risk. It was also noted that we will continue to progress conversations up to year-end with NHSI and the appropriate colleagues centrally.

In terms of winter pressures, it was noted that it will be challenging for various reasons, such as availability of nursing staff and bed capacity which is likely to have an effect on performance rather than finance. There will be a joint meeting in the New Year to discuss the management of the Winter budget both from an operational and financial point of view.

The Committee noted the potential risks and opportunities highlighted within the Finance Report which are being managed month on month.

201/19 2020/21 FINANCIAL PLAN UPDATE

The Acting Director of Finance explained that a more comprehensive update of the Financial Plan would be presented to the next meeting, however, to keep the Committee updated the following points were highlighted:-

- The context of our Financial Plan for 20/21 is in line with the submission of our 5 Year Plan to ICS and NHSI which was submitted in line with our Financial Improvement Trajectory (FIT) for the next four years. Therefore, our FIT for the next financial year is to achieve a deficit of £26.1m bringing us to breakeven with external support.
- Planning Guidance has not been received as yet from NHSI.
- National Tariff prices have been issued and these are being worked through.
- Meetings have taken place with each of the main clinical Divisions with further meetings to go through plans to take place during January. Additional meetings with Corporate and non-Clinical areas will also take place.
- At this early stage the scale of the challenge is large, but we are working to pare back the requests to contain the CIP target to an achievable level. However, there is a risk that this will exceed the £14m CIP described in the 5 Year Plan based on the level of pressures put forward.
- Any developments will need to be considered through the Commercial Investment & Strategy Committee process.

The Chief Operating Officer added that it has been made clear to all Divisions, both clinical and non-clinical, that this is a collective process which requires ownership of the decisions and the associated risks.

It was noted that Contract Negotiations with Commissioners are not well advanced, however, work with the Divisions to help develop a Demand Plan which will be the basis of conversations with Commissioners has been undertaken and will proceed in the New Year.

It was also noted that the deadline for the Financial Plan Draft submission is early-February and will be available for sign-off at the next Finance & Performance Committee on the 3 February 2020.

202/19 INTEGRATED PERFORMANCE REPORT - NOVEMBER

The Chief Operating Officer reported that the November performance score was 75% with 3 Green and 3 Amber domains.

The following areas of concern were noted:-

- Stroke – with the publication of the latest quarter we have dipped to a SSNAP 'B'. Work has been undertaken with SSNAP and there could be an element of over-reporting of breaches and this requires a focussed action plan which will be picked up with the Division at their next performance review.
- RTT – NHSI have accepted our stretch proposal, however, as we continue with the diagnostic validation and until we are 'clean' we still have a continuous risk.
- Outpatient Action Plan – there is concern from the clinical divisions regarding their capacity, meetings with each specialty to carry out risk assessments are taking place and assistance from Ellen Armistead and David Birkenhead is being sought. The Outpatient Action Plan will go through Quality Committee but there will be a further update to this Committee at the next meeting.
- Diagnostics – Echocardiography will be challenging through December but this is a much better position.
- Emergency Care Standard (ECS) – remains the biggest challenge. The final report following the external investigation of the 9 x 12 hour breaches is yet to be received, however, none of the patients involved came to harm but lessons will be learnt from a process perspective.
- Radiology – Another WTGR session took place prior to Christmas with good progress in relation to the actions but this comes at a cost. The number of Radiologists still remains problematic with NHS locums in place.

The following positives were noted:-

- Cancer – is looking very positive against all the indicators.
- #NoF – good performance in Month but December may be challenging.
- Appointment Slot Issues – the best position since the implementation of EPR.

It was noted that a piece of work to triangulate the transfer of care delays regarding the number of beds open and the financial impact will take place to enable system-wide discussions.

A question was raised regarding the 'Accountable Person' listed within the report on Page 9. It was clarified that the Accountable Person for the Percentage of Serious Incidents sits with Andrea McCourt and that the Reporting of Injuries Diseases and

Dangerous Occurrences Regulations (RIDDOR) sits with Suzanne Dunkley, the report will be amended accordingly.

In terms of the overall picture, the Chair commented that he was pleasantly surprised with the performance score and that we are currently 9th out of 123 Trusts in relation to our A&E 4 hour performance and the best in West Yorkshire which is also very positive.

FLOW DASHBOARD
The Dashboard monitoring Flow was tabled for the first time, it was noted that Helen Barker would review this report with the Operations Team with a view to including a narrative and the statistics for the Discharge Lounge into the format which was felt would be a more helpful report for the Committee.

GOVERNANCE

203/19 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were received:

- Draft Commercial Investment & Strategy Committee held 14 November 2019
    - The tender is due to close for the new provider for the outpatient dispensing service and the assessment process will progress. The aim is to have the new supplier engaged from the end of May beginning of June 2020.
- Draft Capital Management Group (CMG) held 12 December 2019
    - A later draft version of these Minutes had been published with an added point, it was noted that THIS are intending to commit to a lease for a property in Elland which will relocate THIS teams and the equipment loan store. It was raised at CMG as this will require £258k of capital to develop the premises for the use of the building. It was also noted that the generated savings and benefits from this move will be pulled together in a paper for Executive Board.
    - It was also requested that point '7.2 HTM Fire' within the Minutes requires a more detailed note in terms of what was committed, what has been done and how this changed the risk profile.

The Minutes were **RECEIVED** and **NOTED** by the Committee.

204/19 WORK PLAN

The Chair confirmed that the Work Plan would be updated to reflect 2020/21 business and that the date of the Board Assurance Framework should be aligned with the Board and Audit & Risk Committee meeting dates.

205/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the key points discussed:-

- Month 8 – slightly better than plan due to property disposal.
- Forecast – to deliver our £9.7m deficit but there are challenges around the containment of Winter spend, the delivery of Project Echo, recovery within the Medicine Division and technical issues around the Pennine Property Partnership (PPP) which we are seeking to manage.

- Financial Plan Update – working within the parameters of the 5 Year Plan already submitted, no formal guidance has been received to date, additional pressures have been identified which could potentially increase our CIP requirement.
- Performance – 75% in November better than anticipated, however, there are areas of concern which were discussed. The escalation procedures of our local system partners relating to the transfer of care were also discussed.

206/19 REVIEW OF MEETING
Nothing to note.

207/19 ANY OTHER BUSINESS
Nothing to note.

DATE AND TIME OF NEXT MEETING:
Monday 3rd February, 11.00am to 2.00pm – BOARD ROOM, HRI

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Monday 3 February 2020, 11.00am – 2.00pm Board Room, Huddersfield Royal Infirmary

PRESENT

Gary Boothby	Director of Finance
Helen Barker	Chief Operating Officer
Owen Williams	Chief Executive
Richard Hopkin	Non-Executive Director (CHAIR)

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Philip Lewer	Trust Chair
Rosemary Hogartt	Deputy Governor

ITEM

001/20 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting and introductions were made to Rosemary Hogartt.

002/20 APOLOGIES FOR ABSENCE

Apologies from Anna Basford, Peter Wilkinson and Sian Grbin were noted.

003/20 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

004/20 MINUTES OF THE MEETING HELD 29 NOVEMBER 2019

The Draft Minutes of the meeting held 29 November 2019 were approved subject to an amendment on Page 4 under Minute 186/19. The Private Minutes from the same meeting were also approved and will be presented to the Board under the Private Session only.

The notes of the Informal session held 31 December, 2019 were also approved as an accurate record.

005/20 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as follows: -

088/19: RTT – The Chief Operating Officer confirmed that the Field Test site reporting would continue for a further 12 months. The report giving an indication of where we are will be reviewed as a 'Private' item at the next F&P Committee – **HB, 2/3/20**

009/19: Use of Resources (UOR) Update – The Deputy Director of Finance informed the Committee that we are liaising with Mersey Audit who link with Aqua the organisation involved in the Well-Led Review to pick up the external review. A Workshop took place at the end of January involving colleagues including Non-

Executives, the workshop looked at how UOR sits within the overall CQC Framework and specifically into the five areas covered. From this session groups worked on the information gathering of these five areas to formulate an action plan which will be used as part of the external review. It was acknowledged that we need to increase the engagement of colleagues who are likely to be approached. OW suggested that to get everyone to the same level of understanding regarding UOR it should be a specific topic for WEB and should be a high priority as there is every possibility that there could be a UOR inspection any time.

ACTION: To circulate the presentation used at the Workshop to the forum and the Non-Executive Directors for information – **KA**

ACTION: To place this on the Agenda for WEB and any other relevant forum to increase the engagement of all colleagues who may be involved in the UOR inspection – **KA/AMcC**

ACTION: To provide an update at the next meeting giving 4 or 5 issues and our collective understanding of those issues - **KA**

130/19: HPS Action Plan re Staff Survey – The Director of Finance provided an extract from the Managing Director's Report from the last HPS Board Meeting which highlights some of the actions following the 2018 Staff Survey. It was noted that the 2019 Staff Survey results are still embargoed but it seems that the results have not improved, and questions are being worked through. It was thought that the timing of the 2019 Survey could have been an issue as Workshops were still taking place as the survey was being completed, however, it was recognised that there are clearly issues. On the Trust report PMU is one of the areas which requires a higher priority to do something differently and support from Workforce and Organisational Development to formulate an action plan will be sought. It was also noted that the staff survey will continue to be monitored as a standard item on the HPS Board agenda.

ACTION: To discuss with the Chair of the Workforce Committee to include on their Agenda and to continue to monitor this situation through HPS Board – **RH**

124/19: Procurement – Process & Opportunities – The Deputy Director of Finance provided a paper in response to the questions raised following the presentation which was made to this forum in July 2019 addressing some of the business and structural opportunities raised at that point. It was noted that interviews for the Deputy Head of Procurement have taken place and an offer for the role has been made. It was also noted that the Head of Procurement has expressed frustrations regarding the workstreams within WYAAT and ICS seeing little progress. It was noted this has been escalated through the Director of Finance (DoF) forums. The lack of pace of the national roll-out of Category Towers has also been flagged at WYAAT DoF forums who have written collectively to Supply Chain flagging the risks, and as a consequence, the Director of Supply Chain will be attending the next DoF meeting.

FINANCE & PERFORMANCE

006/20 MONTH 9 FINANCE REPORT

The Deputy Director of Finance reported the following headlines at Month 9:

- The year to date deficit is £10.27m, a £0.24m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial Recovery Funding.
- CIP achieved year to date is £7.37m, £0.21m more than planned.
- Agency expenditure year to date is £5.72m, £2.65m below the planned level, however, we have seen a switch to Bank expenditure.
- Non-pay expenditure is seeing an adverse variance which is being managed.

In terms of the Forecast, the plan assumed delivery of Project Echo by the end of the financial year. NHSI and DHSC are now advising that this will not now be the case, driving a pressure in year of circa £2m. The Trust is exploring options to mitigate the financial impact of this delay in this financial year, including ongoing discussions with regulators. The Trust remains on track to deliver the recovery and restraint requirement reported last month of £1.7m. There remains some uncommitted winter reserve available to manage any winter pressures that continue into Quarter 4.

- Capital is in line with our revised plan submitted to NHSI in the summer which includes a significant amount of expenditure in the final quarter and this is being monitored and tracked.
- Cash balance is higher than planned due to a timing issue on the repayment of loans, however, we are forecasting to be at plan by the end of the year.

RH asked about the lower than planned VAT recovery, KA explained that this is more to do with how we budgeted for this benefit following the new structure of CHS. The VAT assessment was at a point in time and has shown a natural fluctuation. Following learning, going forward, we will hopefully have a clearer picture of where the VAT sits.

In terms of Aged Debt RH was encouraged with the Minutes from the Cash Committee and the progress we are making. KA assured the Committee that there are no concerns and that the increase relates predominantly within PMU and the non-payment of invoices during the Christmas period, these invoices have since been paid within January 2020. With regard to additional Credit Control resource, it was confirmed that the HPS Account Managers are to take a more pro-active approach in terms of debt management.

The Committee **NOTED** the report for Month 9.

007/20 MONTH 9, FINANCE FORECAST

The Director of Finance presented a paper which sets out the current forecast financial position across NHS organisations in the Integrated Care System (ICS) in 2019/20 based on the Month 9 financial position. It also outlines the approaches that are being deployed to manage the overall position, as well as other potential risks and how they could be mitigated. The overall challenge was highlighted however, it was noted that this is not thought to be a risk.

The Committee **NOTED** the risk in the system and the mitigating actions.

008/20 2020/21 FINANCIAL PLAN

The Deputy Director of Finance gave a presentation which provided a re-cap of the 5 Year Plan submitted in October 2019. It was noted that the allocation of Financial Recovery Funding (FRF) would take our position to breakeven in each year. However, a greater proportion of the FRF allocations will be linked to achievement of system Financial Improvement Trajectories (FIT). The presentation also reminded the forum that the final submission assumed a £14m CIP. Planning Guidance for the Operational Plan for 20/21 has just been received and is in-line with expectations. The draft Operational Plan is due early March 2020 and the final submission due by late April, however, this will not be our internal deadline which will hopefully be by the end of March before the start of the next financial year.

In terms of the headlines within the guidance most were around the FRF, however, the following changes will have an impact to the FIT:

- Clinical Negligence Scheme for Trusts (CNST) payment which is above the inflationary uplift that is allowed in the tariff so expect that the FIT will move in accordance making it a neutral cost
- International Financial Reporting Standard 16 (IFRS16) which changes the way we account for leases, will have impact on our I&E position and our balance sheet.
- A switch to Public Dividend Capital (PDC) from interest upon debt restructure

The Financial Bridge was described in detail and the pressures and developments were highlighted, however, taking into account all the assumptions it leaves a gap or CIP of £18.4m, before we have completed the final Planning process. The opportunities to close the gap were noted as follows;

- Further contribution from activity growth
- Further review of pressures and developments
- Potential CCG support through contract negotiation

The CIP development and Capital Plan for 20/21 were described and detailed within the presentation and the summary was noted as follows:

- Current challenge of £18.4m.
- £10.5m CIP at GW1 / scoping leaves residual challenge of c. £8m.
- Opportunities remain to reduce the gap will be progressed throughout February
- Internally funded capital plan prioritised.
- Further changes to overall capital plan based on IFRS 16 and new externally funded projects.
- Cash borrowing position very much dependant on new financial regime on debt structure.
- Short term working capital requirements will remain re: timing of FRF.
- Proposal is to confirm acceptance of 20/21 FIT, with a £14m CIP target and emphasis on containing the challenge at this level.

The presentation will be uploaded to Convene following this meeting.
Further discussions took place regarding the level of CIP and the challenge to get the target down to no more than £14m. It was noted that one of the biggest challenge will be to get cost out with activity down whilst keeping our patients safe.

ACTION: To share the' Pressures' in more detail off-line with the Chair – **GB/KA**

It was noted that we will continue to work with our Commissioners over the next month regarding the AIC and to conclude the work regarding 'Pressures' with a proposal to come to the next F&P before going to the Board for approval in March. It was also noted that EQIAs will be carried out, including EQIAs on those pressures which we are not funding, to ensure a clear audit trail and understanding.

The Committee **NOTED** the 2020/21 Financial Plan and acknowledged the process and the assumptions.

009/20 REVIEW OF THE FINANCE ELEMENT OF THE BOARD ASSURANCE FRAMEWORK (BAF)

The Deputy Director of Finance took the forum through the Finance elements on the BAF. The Committee discussed the following Risks:

13.19 – Risk that the Trust will not deliver the long-term financial plan.
14.19 – Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term.
15.19 – Risk that the Trust will not delivery external growth for commercial ventures within the Trust.
17.19 – ICS risk of reputation damage or failure to capitalise on system wide opportunities.
18.19 – Risk of failure to secure the longer-term financial sustainability of the Trust

Following in depth discussions regarding what should appear on the BAF and on the Risk Register it was agreed that **13.19** should be incorporated with **18.19** to become a combined risk on the BAF rather than the Risk Register. It was agreed that the proposed revised wording and the mitigation should be presented to the next F&P Committee in addition to the proposed target and current score.

ACTION: To propose a set of revised wording for the BAF and review the widely different targets which range from 4 – 25 prior to Board in March – **OW/AMcC and GB/KA, 2/3/20**

Regarding **14.19,** the current score of a 12 was discussed and it was agreed that this would also be reviewed off-line to be presented at the next meeting.

With regard to risk **17.19,** it was noted that this is mainly outside our individual control and would be a risk of circa £13m (50% of the FRF) if the ICS failed every quarter. To make the BAF meaningful risks need to be addressed and not be static. It was agreed that this risk should be referenced as an element of the combined Longer-Term Financial Sustainability risk rather than a separate item on the BAF. It was also agreed that should the position change significantly it could be added to the BAF at a later date.

The Committee also reviewed the 19/20 Financial Risks included in the Finance Report, the following was agreed:

- LTFS – to be taken off
- Risk of not achieving 19/20 Financial Plan – Risk Score 12. It was agreed to keep the Risk Score the same, however, a full review of Risks will be carried out at the next meeting.

010/20 INTEGRATED PERFORMANCE REPORT - DECEMBER

The Chief Operating Officer reported that we have generally continued to have a good month of progress, following key headlines were noted:

- A Never-Event within December was recorded, which was disappointing.
- % No. of Complaints closed is at 50% which is a better position, the challenge is sustainability. OW reported that he had had interaction with 3 families recently and the theme within the last three scenarios has been the communication with families. It was also recognised that we should aim to be better in explaining and sharing with relatives how we have applied the learning from their loss and this is still work in progress. It is important to note that there has been improvement, however, we should not get to the position where families have to meet with the Chief Executive.
- Emergency Care Standard (ECS) continues to be a challenge with transfer of care being one of the key drivers.
- Cancer – good position, however, January is tight due to deferral of treatment over the Christmas period.
- RTT – continue with the field test
- Diagnostics – administration validation should be complete by the end of March, however, there is still a pressure around a cohort of patients who then need to be clinically validated.
- Diagnostics – Neurophysiology, WTGR work has taken place with the team and they are being supported by deferring completion to the end of March.
- ASIs – continues to improve being the best position within the last 2 years.
- Outpatient Improvement Plan – going to Quality Committee, validation ongoing but there has been a technical improvement
- #NoF overall compliance with the best practice guidance – positive position, and will be presenting at a Board Workshop
- Workforce – continues to be positive in terms of sickness and turnover, however, this may be masking 'hotspots' and this is being explored.

An observation from the Chief Executive is that our position is quite remarkable as our performance includes December. However, we should continue to ensure there are no underlying quality issues and that communication of our good performance and key messages should filter down to a wider audience.

The Committee **NOTED** the IPR for December and the continued good performance.

011/20 WINTER UPDATE

The Chief Operating Officer explained that the Flow Dashboard had been included in the papers for information only. It was recognised that there had been different pressure points and that Paediatrics and Adults are now being looked at separately. In addition, our conversation rate still appears to be quite high from A&E through to admission. It was agreed that with the refresh of the IPR inclusion of information relating to Winter could be added rather than provide a separate report.

As an overview, it was acknowledged that Emergency Care had been a challenge. In terms of the Frailty Team this has been a success and the challenge for both ourselves and the system would be to extend this service to both sites and to increase

the hours. In addition, there is a challenge to look at the system we are currently running to ask if it is appropriate for the needs of the BAME population.

The Committee **NOTED** the Winter Update.

STRATEGIC ITEMS

012/20 CIP UPDATE

The Committee discussed CIP as part of the Finance Plan discussions.

GOVERNANCE

013/20 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were received:

- Draft Capital Management Group held 15 January 2020.
    - The previous F&P Committee Minutes highlighted the lack of content in relation to the 'HTM Fire' action within the CMG held in December. HB confirmed that the Fire Committee had received verbal assurance, but nothing had been documented.

ACTION: This will be picked up at the March Fire Committee and F&P will be updated - **HB**

- Draft HPS Board Meeting held 20 January 2020.
- Cash Committee held 16 January 2020
    - A question regarding the attendance and are the right colleagues attending. It was noted that it could be seen as being finance heavy, however, there are representatives from Pharmacy, W&OD and a Divisional representative. It was also noted that we have made good progress since the establishment of the Committee and we continue to pro-actively implement additional actions. It was also noted that since the establishment of CHS there has been added complexity and there is specific focus on the Cash Committee Work plan.

ACTION: To review the fiscal arrangements with CHS and whether there is an embedded way of working – **KA, 28/9/20**

The Minutes were **RECEIVED** and **NOTED** by the Committee.

014/20 WORK PLAN FINANCIAL YEAR 2019/20

The Committee **NOTED** the Work Plan for the remainder of 2019/20 and the deadline of **24 February 2020** for the submission of responses for the F&P Committee Self-Assessment in time for a response at the next meeting.

DRAFT WORKPLAN FINANCIAL YEAR 2020/21

Discussions took place regarding the F&P Committee Annual Report, it was agreed and that a date would be scheduled onto the Workplan for 20/21. In terms of presentations to schedule a GIRFT update which should be scheduled for **June 2020** and Model Hospital and UOR to be linked and to be scheduled later in the year.

The Workplan will be updated accordingly.

015/20 MATTERS TO CASCADE TO THE BOARD

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

- UoR – there is still a need to develop a shared understanding with the Exec and Non-Exec teams in anticipation of a Well-led Review and more discussions to take place.
- Month 9 - on plan with agency still below plan with a switch to bank. Adverse variances with non-pay offset by favourable variances on pay.
- Forecast – on plan to hit the full year deficit target subject to potential slippage on Project Echo.
- Capital – spend down on plan due to timing
- 20/21 Plan – following recent receipt of the planning guidelines the scale of the challenge to achieve the projected deficit of our 5 Year Plan will be £18.4m with a need to bridge to £14m
- BAF – agreed to combine the risks relating to Long Term Financial Performance & Sustainability and the ICS risk combined into one risk and cover on the BAF not on the risk register. The wording and current and target scores will also be reviewed. The Capital current and target scores on the BAF will also be revisited.
- IPR – strong performance generally in December at 74%. Excellent metrics relating to Cancer, ASIs and #NoF, however, a Never Event was also discussed.
- Complaints – improvement in the admin performance, still work to do with the dealing of Complaints and the Chief Executive is involved in that process.
- Challenges around Emergency Care particularly the Transfer of Care issues and discussions with the respective Councils are on-going to address. The Stroke SSNAP rating is 'B'.
- The positive position carried through winter with partnership co-operation was recognised.

016/20 REVIEW OF MEETING

The Committee agreed that once again there had been good points of discussion.

ANY OTHER BUSINESS

The following items were raised and noted:

- A point regarding Divisional and Corporate spending was raised on behalf of Sian Grbin, RH acknowledged that he had responded to this point at the Governors Meeting, however, he would be happy to pick up with Sian again. KA also was happy to meet with Sian to explain the information.
- GB confirmed that the Finance Department had come runners up for the 'Team of the Year' Award at the HFMA Yorkshire & Humber Annual Conference and that the 20:20 Outpatients Transformation project had won an award.

DATE AND TIME OF NEXT MEETING:
MONDAY 2 March 2020, 11am – 2pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE.

Draft Minutes of the Audit and Risk Committee Meeting held on:
Wednesday 29 January 2020 in Room 3, Acre Mills Outpatients commencing at 11:00 am

PRESENT

Andy Nelson (AN)	Chair, Non-Executive Director
Denise Sterling (DS)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director

IN ATTENDANCE

Andrea McCourt (AMcC)	Company Secretary
Adele Jowett (AJ)	Assistant Anti-Crime Manager (Audit Yorkshire)
Betty Sewell (BS)	PA to Director of Finance (Minutes)
Gary Boothby (GB)	Director of Finance
Kirsty Archer (KA)	Deputy Director of Finance
Leanne Sobratee (LS)	Internal Audit Manager, Audit Yorkshire
Mandy Griffin (MG)	Managing Director, Digital Health
Clare Partridge (CP)	External Audit Partner, KPMG
Salma Younis (SY)	Senior Manager, KPMG
Peter Keogh (PK)	Assistant Director of Performance (for Item 07/20 only)

OBSERVERS

Philip Lewer (PL)	Trust Chair
Olivia Townsend (OT)	Local Counter Fraud Specialist

01/20 APOLOGIES FOR ABSENCE

Apologies were received from: John Richardson, Keith Redmond, Helen Kemp-Taylor, Helen Barker (for Item 07/20)

02/20 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

03/20 MINUTES OF THE MEETING HELD 30 OCTOBER 2019

The minutes of the meeting held on 30 October 2019 were approved as a correct record subject to the amendment of the job title for Kirsty Archer to 'Acting Director of Finance' as at the time she was covering for the Director of Finance.

OUTCOME: The Committee **APPROVED** the minutes of the meeting held 30 October 2019.

04/20 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updated accordingly.

Update on ICODD – The Managing Director, Digital Health confirmed that the ICODD module is ready for deployment, however, clinical negotiations are still on-going. It is likely that the module will be deployed with a caveat that it may change once EPR has been up-graded – **action closed.**

i) Health & Safety Attendance at Audit & Risk Committee (ARC)

Following the arrangement for the Health & Safety Committee to report into ARC concern was raised that there was no Health & Safety representation at this forum. The Company Secretary advised that it had been agreed at the January Board, to provide assurance, the Board would receive a Health & Safety Report three times a year.

ii) Sub-Committee Reporting

Discussions took place regarding the length of the papers which are received by this Committee from its Sub-Committees. It was suggested that going forward each Sub-Committee should agree their key themes which have been discussed, and the key issues raised, this would then be turned into a

one-page summary report for ARC. As part of the discussions it was agreed that the minutes from the Sub-Committees would be uploaded to the Reading Room on Convene to enable further scrutiny. In addition to this each Sub-Committee will be scheduled to attend ARC individually throughout the year to give a detailed report with Information Governance scheduled to attend the April meeting.

A deep-dive would be requested from each reporting group, noting Data Quality had presented to this meeting with Information Governance to be scheduled for April, Health & Safety for July and Risk and compliance for October 2020.

ACTION: To ensure the Minutes from Sub-Committees are uploaded to the Reading Room on Convene - **AMcC**
ACTION: Information Governance to be scheduled as an Agenda item for the April Committee – **MG/AMcC**

OUTCOME: The Committee **APPROVED** the trial of a one-page summary from its Sub-Committees in an effort to address the length of papers received by the forum – **Action: AMcC**

Theatre Stock Management and Stock Take Audit

iii) The Deputy Director of Finance reported that in response to the Year-End Audit Report a Task & Finish Group had taken place with the various disciplines involved in the audit. This exercise has proved useful in understanding the whole process. As an outcome to this exercise a number of actions have been agreed to improve the quality of the stock take for next year-end:

- Improved communications between ourselves and external audit regarding the reality of a live running theatre environment and our mitigations for those issues.
- Refresh of the Standard Operating Procedures with better communication for the team.
- Improvement of the stock sheets.
- Reinstatement of a process which had lapsed relating to a rolling validation of items recorded on the Bluespier stock management system, the number of items will also be reviewed.

It was noted that KPMG are happy with the actions and are now in the process of agreeing a date for a stock count.

The Managing Director, Digital Health raised a point that as part of the Scan 4 Safety project there is a theatre work-stream which includes stock which is part of the WYAAT collaborative inventory system currently being procured and in future years theatre stock could be streamlined further.

OUTCOME: The Committee **NOTED** the report and acknowledged the robust set of actions.

06/20 CYBER SECURITY DEEP DIVE

The Managing Director, Digital Health presented an overview and assurance of the work being carried out in relation to Cyber Security. The presentation covered the background to vulnerable areas, accreditations and the must dos. It was noted that to invest in our infrastructure and to keep the Trust safe and cyber-free there is also a commercial opportunity which provides income. The statutory requirements are ever increasing and NHS Digital are responsible for alerting colleagues within Trusts that they are vulnerable to cyber-attack. The Data Security Protection Toolkit (DSPT) for 2019/20 has new standards for technical safety as well as information governance; this has become a challenge for the Trust which will require investment.

In terms of the recent Audit Report, Audit Yorkshire had carried out an internal audit and as a consequence had awarded 'Significant Assurance'. However, MG suggested that we should not be too complacent with this assurance. It was noted that within the Audit Report there were positive comments on things that we were doing well, however, this is to be balanced with regard to the number of 'reds' relating to patching and the supported software. It was noted that the internal audit report was based on the older Information Governance toolkit not DSPT.

With regard to the next steps the actions from the audit report will be completed with a focus on full compliance of the DSPT which will require an investment plan. A capital bid was submitted to the capital panel for around £9m of which £1m was secured. The possibility of securing external funding for our key risks is being progressed and we are awaiting confirmation regarding this. A Cyber Team is being established to enhance our skill base and capacity.

It was acknowledged that there is always more to do regarding staff awareness and along with Information Governance mandatory training there are regular communications circulated asking colleagues to remain vigilant for phishing e-mails which should be reported immediately.

OUTCOME: The Committee **RECEIVED** and **NOTED** the Cyber Security Deep Dive recognising the ever-evolving threat of a cyber-attack and the on-going agenda item for the Trust.

07/20 DATA QUALITY UPDATE REPORT

The Assistant Director of Performance presented to the Committee a report following its request to provide assurance regarding the Trust's data quality processes which had been commissioned from an external organisation in September 2019. Key metrics across the domains of workforce, in patients, theatres and outpatients were reviewed. The conclusion of the report was that the metrics examined gave significant assurance about data quality across the variety of indicators, however, the internal work on referral to treatment (RTT) and the wider planned access data quality continues to highlight areas for improvement. It was noted that in light of the continued validation work on RTT the Data Quality Board had agreed to focus on continuing to improve the RTT/Access elements of data quality and that the recommendations from the report should be put on hold until the RTT field test is complete.

MG commented that having gone through the implementation of EPR we were the only Trust who continued the reporting of RTT from go-live, this has been a challenge for most Trusts and shows the strength of the team.

PK assured the Committee that there is an on-going programme in place and the recommendations will re-visited at an appropriate time.

OUTCOME: The Committee **NOTED** the Data Quality Update Report and the encouraging outcomes and also the challenges.

08/20 BOARD ASSURANCE FRAMEWORK (BAF)

The Company Secretary reported that the Trust Board held a BAF and Risk Management Workshop in early December 2019. At this workshop it was decided to re-align the BAF review dates at Board and Committee meetings to allow for prior review of the BAF by the Audit & Risk Committee before the Board meeting. The paper detailed the revised Committee and Board dates agreed for 2020 / 2021. This will ensure the Audit & Risk Committee and Board review the BAF three times a year in line with the frequency of the BAF Standard Operating Procedure.

In terms of the risk profile for strategic risks, it was noted that there are 18 risks in total with 7 red. There are three new risks, one being a Health & Safety risk which was discussed and agreed at the Board in January 2020. The two added more recently, namely Integrated Care Systems (ICS) financial risk, ref. 17/19 with a score of 9 and the Long Term Financial Sustainability (LTFS) risk, ref 18/19 which has a score of 25. At the Board workshop it was proposed that the LTFS, which is currently on the high level risk register should sit on the BAF and that discussions should take place at Finance & Performance Committee on the 3rd February 2020 to confirm this. Committee suggested reviewing whether the two long term financial risks should be merged.

The External Audit Partner clarified that in her view the role of the Audit Committee was to make sure that there is proper challenge and that the BAF process is fit for purpose, however, there are more deep-dives into risk with the Audit & Risk Committee testing the process.

AN recognised that most risks are well aligned but felt that there was more work to do matching risk appetite to target risk. The Company Secretary explained that some of the scores are higher due to the pressing operational nature of the risk compared to the longer term strategic risk. It was noted that with regard to the EPR risk this should be reduced to a 9. Discussions then took place as to whether the EPR risk was too narrow and it was suggested that EPR should be replaced by a risk relating to digital experience as a whole. It was also noted that this change may be difficult to monitor, however, with the development of a Digital Strategy describing our ambitions this could be the measurement and could be translated into the BAF.

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ACTION: To provide a revised description of the EPR risk following discussion of the Digital Strategy at the May Board meeting – **MG/AMcC**

ACTION: To discuss and review within Finance & Performance Committee with the possibility of amalgamating both financial risks as one – **KA**

OUTCOME: The Committee **RCOMMENDED** the updated Board Assurance Framework (BAF) to the Board noting that amends to EPR/Digital and Finance Risks will be received.

09/20 COMPANY SECRETARY'S BUSINESS

i. Risk Management Strategy

The Company Secretary reported that the Risk Management Strategy had been refreshed as detailed in the paper. The revised strategy will also be presented to the Quality Committee on 5 February 2020 prior to consideration for approval at the Weekly Executive Board meeting on 20 February 2020 and by the Board on 5 March 2020. The Committee were also advised that the Quality Committee reporting groups are being actively reviewed and this part of the structure is likely to change. For clarification the reference to the Senior Risk Manager relates to Maxine Travis who has been in post since April 2019.

The External Audit Partner referenced the 'Three Lines of Defence' which was felt could relate to a wider group of external parties. AN also commented that the 'risk level /appetite' in section 6 be clarified as the BAF has both a risk appetite level and risk appetite - this will be picked up outside the meeting.

OUTCOME: The Committee **RECOMMENDED** to the Board the revised Risk Management Strategy subject to the comments noted.

ii. Annual Report Timetable 2019/20

The Company Secretary presented the Annual Report & Accounts Timetable highlighting that guidance is still to be received for Quality Account and this delay could cause a backlog. External Audit highlighted that if RTT was a mandatory indicator an alternative indicator would need to be agreed. It was noted that the Committee and Board meetings would take place on the 20 May 2020 for the 2019/20 Annual Accounts and Annual Report sign-off.

OUTCOME: The Committee **NOTED** and **APPROVED** the Annual Report Timetable.

iii. Review Standing Orders / Standing Financial Instructions (SFIs) / Scheme of Delegation

The Company Secretary reported that to take account of the further work required on the SFIs an extension of 3 months to complete this work has been requested and the Standing Orders, Standing Financial Instructions and Scheme of Delegation will, therefore, come back to the April meeting.

ACTION: To ensure this is an Agenda Item for the April meeting – **KA/AMcC**

OUTCOME: The Committee **APPROVED** the extension to enable further work to be carried out.

iv. Internal Audit Monthly Insight Report (TIAN)

The Company Secretary reported that Internal Audit now share the NHS monthly Insight Report. This had been discussed at Quality Committee, however, following their discussions it was felt that ARC was the more appropriate Committee to receive this report. The Internal Audit Manager shared with the Committee that three other Trusts take the report to their ARC. The Company Secretary explained that there is an issue to ensure relevant colleagues within the Trust are seeing the report. The Committee agreed that all three Chairs of the Sub-Committees (Finance & Performance, Quality Committee and Audit and Risk Committee) should receive the report and the Company Secretary should highlight the salient points for each Committee to be followed through. It was also agreed that the monthly meports would be collated by Internal Audit and uploaded to the Reading Room on Convene.

ACTION: To arrange for the monthly Internal Audit monthly Insight report to be combined and uploaded to the Reading Room on Convene with the salient points highlighted – **LS/AMcC**

OUTCOME: The Committee **AGREED** a process for the dissemination of the Internal Audit Monthly Insight Report.

v. Self-Assessment of Committee Effectiveness

The Company Secretary informed the Committee that the annual Self-Assessment of Committee Effectiveness would be circulated for completion by the **14 February 2020**, the outcome of this assessment will inform an action plan for the Committee.

OUTCOME: The Committee **NOTED** the request to complete the Self-Assessment of Committee Effectiveness by the due date.

10/20 THIRD PARTY ASSURANCE MAPPING

The Company Secretary reported that the third-party assurance mapping links into the Trust's Code of Governance. The paper listed the third-party bodies with which the Trust needs to co-operate, some statutory and some non-statutory. It was noted that research into what other Trusts are doing in this area had been hard to find and any intelligence would be appreciated.

The External Audit Partner suggested that Leeds Community had been very active in this area and could be approached to consider how they had developed their mapping. The Managing Director of Digital Health informed the Committee that there had been a robust joint governance structure with Bradford Teaching Hospital in relation to EPR, it was agreed to share the collaborative and joint governance structure with the Company Secretary. Discussions took place regarding the organisations to be added to the lists, the relationships that we practically have with the relevant bodies,the 'owner' of that relationship and whether more work should be done to document the key relationships and how they are managed.

ACTION: To share the EPR collaborative and joint governance structure with the Company Secretary - **MG**

OUTCOME: The Committee **APPROVED** the Third-Party Assurance schedule subject to addition of other partners.

11/20 THE EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

i. Review of Losses and Special Payments

The Deputy Director of Finance reported the losses and special payments over Quarter 3, 2019/20, which was relatively higher than previous quarters. The combination of the following items had driven the increase:

- historical bad debt write-offs

- a higher than normal level of payments through NHS Resolution which also relate to historic items.
- a specific item relating to the write-off of stock in Angiology, the issue of stock management has been picked up directly with this service.
- the routine write-off of stock within PMU has been recognised within this report, the impact quarter by quarter has been backdated for this year.

OUTCOME: The Committee **APPROVED** the content of the losses and special payments report.

ii. Review Waiving of Standing Orders

The Deputy Director of Finance reported over the quarter, a total of £161k standing orders have been waived. There had been a total spend of £12m through the Procurement department within the quarter.

OUTCOME: The Committee **APPROVED** the Q3 waiving of standing orders report.

12/20 INTERNAL AUDIT

i. Review Internal Audit Progress Report

The Internal Audit Manager confirmed that against the plan there are 10 audit reports:

- 8 significant assurance
- 1 high assurance
- 1 limited assurance

9 of these been finalised since the October 2019 meeting.

The Internal Audit Manager explained that there is a further report regarding GP Communications which will be 'limited', the recommendations have recently been agreed and will be presented to the Digital Health Forum before being finalised and presented to ARC. In addition, the report relating to Patient Access has now been finalised and issued, this is reflected in the KPIs which have improved in terms of the percentage of final reports issued within target time, which now stands at 90%. In terms of changes to the plan it was reported that two changes related to straight swaps, however, there was a concern that the 30 days would not be used for the Medical Directorate Audit due to staff sickness. Since the publication of the report it had been confirmed that the days would be used for a Delegated Consent audit which is in the planning stage. The deferral of the HPS audit was also highlighted and noted by the Committee.

RH referred to the audit regarding Estates Management Expenditure and the concerns raised within the report. LS suggested that the recommendations now in place along with the likely move from a manual to an electronic process should tighten up the system. With regard to the question relating to the potential issue of obtaining value for money, it was noted the scale of the issue needs to be understood, however, it relates to items less than £10k.

RH also referred to the Financial Systems audit report which makes reference to the sign-off of control account reconciliations and journals and that the recommendations dating back several years. KA commented that we are constantly trying to improve and KPIs are being monitored for each divisional finance team. There has been an improved position and proactively we are reviewing the content of some of the control requisitions and questions are being asked of the divisions regarding their coding. In addition, there are plans to meet with each of the divisional teams for them to be challenged face to face regarding their KPIs.

ACTION: To share KPIs relating to financial systems with Internal Audit – **KA**

AN referred to the End of Life Care audit and the follow up on elements of the Gosport Enquiry Review. It was noted that the field work is now complete, and the report should be ready over the next few weeks. AN asked that there should not be a disconnect between Quality Committee and ARC and that we should look to share the report so that any issues can be raised early.

ACTION: To share the report regarding the Gosport Enquiry Review with Quality Committee - **LS**

OUTCOME: The Committee **APROVED** the internal audit Q3 progress report.

ii. Internal Audit Follow Up Report – Summary for Q3, 2019/20

The Internal Audit Manager reported that not all outstanding recommendations have been closed, however, the narrative details the work which has been undertaken and that by quarter 4 quite a few should be cleared. It was noted that there are two overdue 'major' recommendations, however, things going well with more realistic deadlines which should achieved.

AN highlighted the graphs which shows that we seem to have drifted in relation to overdue recommendations and Internal Audit will follow up.

OUTCOME: The Committee **APPROVED** the Internal Audit Follow Up Report for quarter 3, 2019/20

13/20 LOCAL COUNTER FRAUD

Local Counter Fraud Progress Report

The Assistant Anti-Crime Manager (Audit Yorkshire) highlighted the mandatory introduction of a Counter Fraud Champion for every health body. The Fraud Champion should be a senior manager within the health body but should not have managerial responsibility for Counter Fraud work. The report included the Frequently Asked Questions (FAQs) with regard to this role for information.

It was noted that there has been a new referral relating to allegations of staff working whilst claiming sick pay. This investigation is still in the early stages and a further update will be given at the next ARC meeting. It was also noted that as part of the NHSCFA's plans to support and assist organisations in improving counter fraud outcomes they will soon be providing health bodies with benchmarking information for review. During 2020 Audit Committee Chairs, Chief Finance Officers and LCFSs will receive notification of when the benchmarking data will become available and how it can be accessed.

A draft counter fraud plan will be discussed in Quarter 4 with the Director of Finance and the Head of Anti-Crime Services (Audit Yorkshire), and will then be presented for approval at the ARC to be held on the 15th April 2020.

OUTCOME: The Committee **NOTED** the Local Counter Fraud Progress Report

14/20 EXTERNAL AUDIT

Sector Update

The External Audit Partner from KPMG presented the sector update for January 2020. The key point highlighted refers to NHS Pensions Tax which remains an operational issue.

External Audit Plan 2019/20

The Senior Manager, KPMG, highlighted the risks on the audit plan which have been identified and will be the focus of the audit, noting these are part of the standard audit approach. It was noted that the Quality Account guidance has not yet been published, however, meetings are in the diary with the Company Secretary to discuss the process. It was also noted that the conversations have taken place regarding the timings of the IFRS 16 accounting standards change relating to Project Echo.

The Company Secretary confirmed the 15th July 2020 for the presentation to Governors (AGM) to be included in the timetable.

OUTCOME: The Committee **NOTED** the Sector Update and the External Audit Plan for 2019/20.

15/20 ITEMS TO RECEIVE

The minutes of the previous meetings of sub-committees were received:

- Risk & Compliance Group Minutes – 7/10/19, 11/11/19 and 9/12/19
- Information Governance & Records Strategy Committee Minutes – 10/10/19, 6/11/19 and 9/1/20
- Health & Safety Committee – 20/8/19, 23/10/19 and 19/12/19 (action log)
- Data Quality Board Minutes – 11/9/19, 23/10/19, /3/12/19 and 14/1/20

It was noted that following discussions at the start of the meeting agreement had been reached for a more efficient method of receiving feedback from the various forums for future ARC meetings.

OUTCOME: The Committee **NOTED** the minutes received of the various meetings.

16/20 AUDIT AND RISK COMMITTEE WORKPLAN

The Chair and Company Secretary have reviewed the Workplan which now reflects the changes agre

OUTCOME: The Committee **NOTED** the Workplan.

17/20 ANY OTHER BUSINESS

There was no other business.

18/20 MATTERS TO CASCADE TO BOARD OF DIRECTORS

It was agreed to bring the following items to the attention of the Board:

- Cyber Update – Significant assurance from an independent review but we need to stay on top of this ever-evolving threat.
- Data Quality Update – external review was positive, however, there are still areas of focus.
- BAF recommended to the Board but recognised that the EPR and Finance risks need more work.
- Third Party Assurance Mapping – initial look with further work to do to formulate a practical process.
- Internal Audit – mixed story with fewer 'Limited Assurance' reports but need to be sharper in chasing down overdue actions.
- Year End Annual Accounts timetable and Audit Plan approved.

19/20 DATE AND TIME OF THE NEXT MEETING

The next meeting is scheduled on **Tuesday 7 April 2020, 1.00pm - 3.00pm in Room 4**, Acre Mills Outpatients.

20/20 REVIEW OF MEETING

Feedback from the meeting was positive with good content, discussion and coverage within the timeframe.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 2 December 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

206/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Karen Heaton **(KH)**	Non-Executive Director
Dr Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public Governor
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Andrea Dauris **(AD)**	Associate Director of Nursing – Community **(item 221/19)**
Dr Nicola Hardman **(NHard)**	Consultant Microbiologist **(for item 211/19)**
Nicky Hill **(NHill)**	Macmillan Prehabilitation Project Manager **(for CButton /214/19)**
Philip Lewer **(PL)**	Chairman **(Observing)**
Maggie Metcalfe **(MM)**	Associate Director of Nursing – Medical **(item 219/19)**
Joanne Middleton **(JMidd)**	Associate Director of Nursing – Surgery **(item 220/19)**
Dr Julie O'Riordan **(JOR)**	Divisional Director - FSS **(item 222/19)**
Elisabeth Street **(ES)**	Clinical Director of Pharmacy **(item 218/19)**

207/19 APOLOGIES

Christopher Button	Charge Nurse, Cancer Support
Jason Eddleston	Deputy Director of Workforce & Organisational Development
Lindsay Rudge	Deputy Chief Nurse
Denise Sterling	Non-Executive Director
Maxine Travis	Senior Risk Manager

208/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

209/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 4 November 2019 were approved as a correct record.

210/19 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

211/19 ANTIBIOTIC AWARENESS

Dr Nicola Hardman (Consultant Microbiologist) was in attendance to present appendix C, a summary of activity from the antimicrobial management team from the last quarter.

- *NHS Standard Contract* - Trusts are required to reduce their total antibiotic consumption by 1% from their calendar year. The CHFT rolling total consumption data was provided, and currently CHFT is down by 2%.
- *Antimicrobial resistance CQUIN 2019/20: Part CCG1a: Improving the management of lower urinary tract infections in older people* - Performance against this improved

significantly in Q2 from 8% to 43% compliance, and last month's audit compliance was 73%, showing a sustained improvement. The 'ditch the dipstick' campaign has involved bite-sized learning in emergency department, education at Elderly grand round and junior doctor teaching, a screensaver, posters and tea trolley event (including quiz "to dip or not to dip"). Trust guidelines have been updated and feedback is being delivered to individuals not compliant with the CQUIN. Partial compliance will be achieved at 60% and full at 90%, however it is clear that this is proving to be a significant challenge on a regional and national level. It cannot be predicted at this stage if full compliance will be achieved.

- *Antimicrobial resistance CQUIN 2019/20: Part CCG1b: Improving surgical prophylaxis in elective colorectal surgery* – performance against this was consistent at 85% for Q1 and 86% at Q2. Full compliance will occur at 90%. The largest challenge to achieving this is statistical, as the number of cases eligible to be included in the audit sample is very low (average 49 per quarter). Cases which are not compliant are being flagged with the surgical directorate.
- *Gentamicin* - work is ongoing to promote high standards of prescribing for gentamicin within the Trust following a number of incidents. The last audit in June 2019 showed a decline in prescribing and monitoring practice. Further interventions in the form of education, improvements to gentamicin level requesting and the gentamicin video followed, and a gentamicin re-audit is planned for week beginning 2 December 2019.
- *Fluoroquinolones* – an audit was undertaken in April 2019 to determine the compliance of fluoroquinolone prescribing with trust guidelines. There was 65% compliance, which was re-audited in September 2019, with an improvement to 82% compliance.
- *Antibiotic allergy documentation* – a benchmark audit to review the quality of allergy records against NICE guidance is currently underway, for patients identified as having antibiotic allergies who presented to the Trust week beginning 18 November 2019.
- *Antibiotic awareness week* – a week of antibiotic awareness initiatives have taken place this week, with around 900 people completing a pledge at our 'pledge hedge' to promote and maintain good practice in infection control and antimicrobial use.
- *Science Museum, London* - the Antimicrobial Management Team (AMT) were delighted to have their proposal to deliver an event at the Science Museum, London accepted. External funding has been secured to deliver "House of Horrors" in January 2020. The event is aimed at the general public and will focus on modes of infection transmission in the household, causative organisms, treatment and resistance plus household infection control measures.
- *Key risks* -
  - *Lack of engagement from directorates* - representatives from directorates continue to be absent from AMT meetings despite attempts to engage them. This reduces the ability to successfully and rapidly instigate change
  - *Pharmacists* – recent significant low staffing has resulted in an impaired contribution from the department as they have necessarily focussed on the essential activities of medicines reconciliation and supply. As staffing improves, the AMT will need to work carefully with pharmacy to ensure that new staff are fully aware of their responsibilities and can contribute fully, returning the work of the department to previous levels. This is particularly pertinent in view of the upcoming anticipated work on allergy de-labelling, which may require a large culture change within the Trust with significant leadership from pharmacists.

Discussion ensued on the 'ditch the dipstick' campaign, which will be very good to change culture and a good step in progress. Dr Hardman and team were thanked for her their fresh approach to antimicrobial management and for raising its profile in the Trust. Congratulations were also conveyed in relation to the funding for the science museum event.

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

Dr Hardman left the meeting at this point.

212/19 INTERNAL AUDIT UPDATE ON DEATH CERTIFICATION AND UPDATE ON MEDICAL EXAMINER ROLE

Dr Cornelle Parker (Deputy Medical Director) presented appendix D1, advising on the findings of the internal audit report on death certification from January 2019, and an update on the implementation of the medical examiner role.

- *Death certification* – the objective of the audit was to provide assurance that the Trust has robust processes in place to ensure death certificates are completed appropriately. The overall grading was limited assurance and the key finding was that the Trust has adequate guidance in place to support doctors when completing death certificates. There were however, some gaps in assurance, including:

  - no formal policy in place that outlines the Trust's expectations in ensuring that death certificates are completed accurately and appropriately in line with national guidance.
  - Instances whereby death certificates are being returned by the General Registry Office due to inappropriate completion. The reasons for the returns, as confirmed by audit testing included the use of abbreviations and the certificates being illegible and as a result, an unacceptable cause of death.
  - No formal reporting in place recording the volume and reasons for the return of death certificates
  - No Trust monitoring of the completion of death certificates e.g. number of death certificates to sign, how many were signed and when, and whether or not they were signed within the five day target.

  A copy of the internal audit report was available at appendix D2.

- *Medical examiner (ME) role* - Following recent discussion with The Bradford Coroner and Regional Medical Examiner, CHFT will look to appoint a Lead Medical Examiner in January 2020, who will undergo role-specific training and develop a cross-site CHFT Medical Examiner Office, to include recruitment of additional Medical Examiners and Medical Examiner Officers. The latter will support the administrative function of the ME office. Detailed descriptions of the functions of the ME Office are available in the paper and the scope of the Medical Examiner Office will include addressing the shortfalls identified through the Internal Audit Report on Death Certification described above. The role will also link with the learning from deaths (LfD) work and help communication of learning across the organisation.

Discussion ensued on the need for regular reporting on this into either the Workforce Committee or the Quality Committee, and it was also asked whether feedback from the report has been forwarded to the auditors. It was confirmed that this is yet to be done and will be carried out.

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

213/19 MENTAL HEALTH STRATEGY

Lindsay Rudge (Deputy Chief Nurse) gave a verbal update and reported that the mental health strategy is still currently in draft, and will come to this meeting in January 2020 for sign-off. The delay has been a result of the significant amount of work and activity which is ongoing with various work streams.

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

214/19 CANCER BOARD REPORT

Nicky Hill (Macmillan Prehabilitation Project Manager) was in attendance to present appendix E, summarising key points from the last Cancer Board meeting which took place on Wednesday, 9 October 2019.

- *Quality and Safety issue identified – serious incident* – there was one serious incident to review, which revealed a lack of a standardised system and process for ordering follow-

up appointments. The investigation has resulted in a set of standard operating procedures being devised and fail-safe officers working through the lists on the Electronic Patient Record.

- *Performance* - During July – Sept 2019 CHFT achieved five out of the seven national operational standards for cancer waiting times.
- *Trust Multi-Disciplinary Team development event* – 35 individuals attended the event highlighting positive outcomes of several pilot projects within the trust that have improved the efficiency of cancer Multi-Disciplinary Teams. Each MDT was tasked with identifying a pledge to take forward and the cancer management team will work with local teams to achieve their pledges.
- *Funding* – three quality improvement posts have been funded by West Yorkshire and Harrogate (WY&H) Cancer Alliance and Macmillan to focus on Personalised Care Support; a quality improvement project manager post has been funded by WY&H Cancer Alliance to help support improvements in the four key cancer areas; a £16,000 bid was secured from a Patient Education Bursary application to help support patient experience and patient information, and the Cancer Management Team submitted an expression of interest to host the Cancer Optimal Pathway Groups. The Trust has been chosen to host the team that will manage this programme.

Discussion ensued on whether the Cancer Board or the Board of Directors is held to account for national operational standards for cancer waiting times. NH agreed to confirm this with Maureen Overton (General Manager for Operations) and Christopher Button (Lead Cancer Nurse).

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

Nicky Hill left the meeting at this point.

215/19 PATIENT SAFETY GROUP REPORT

Dr Anne-Marie Henshaw (Associate Director of Quality and Safety) presented appendix F, summarising work undertaken by the Patient Safety Group during quarter 2.

The following sub-group reports were received:

- *Medical Devices and Procurement Group* - the six-monthly report was provided highlighting the management and the recording of maintenance events for medical devices.
- *Venous Thromboembolism* – the quarterly report was provided highlighting compliance with risk assessments, hospital associated thrombosis data and clinical engagement from divisions at the Thrombosis Committee.
- *Pressure Ulcer Collaborative* – the quarterly report was provided highlighting an increase in pressure ulcer incidents, all vacant posts within the team now being filled and improvement work on a pressure ulcer reduction action plan and implementation of a decision support tool.

Other updates provided to the Patient Safety Group include:

- *Sharing learning from patient safety incidents*:
  - An increase in '*discharged with cannula in-situ'* incidents was reported during 2017 and 2019 and a deep dive was commissioned to understand why the incidents had occurred and what changes need to be done to improve this aspect of patient care. Learning has been shared and the incidents will be re-audited in quarter 4 (January to March 2020)
  - Learning from three serious incidents (detailed in the report) was also shared
  - During quarter 2, three safety alerts which were not actioned within the required timeframe in quarter 1 were signed off and the Clinical Commissioning Group briefed. There are currently no safety alerts outstanding.

- The medical division presented the Elderly Care Strategy which focus on key safety actions and were commended on this approach to improving safe care for elderly patients. Discussions are being held with other divisions on how to use this as a similar approach.

Discussion ensued on monitoring compliance with safety alerts and whether this is on the audit programme. This was confirmed.

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

216/19 OUTSTANDING SERIOUS INCIDENT ACTIONS

Andrea McCourt (Company Secretary) presented appendix G, updating on the outstanding actions from completed Serious Incidents up to 24 November 2019.

In September 2019, there were 106 open actions and at the time of producing this report, there were 87 open actions associated with serious incident investigations. Of these, 66 had passed the target completion date. The majority of these have an update indicating progress towards delivery. Information on outstanding / overdue actions and actions completed from serious incidents by division were provided. The data was from a point in time, and do not reflect the movement during the two months since last reporting from closure of actions and adding of new actions.

The report demonstrates that continued focus on delivery of actions is having a positive impact in terms of evidencing and completion. The volume and complexity of work required to complete action plans to mitigate risk presents a continuous challenge to divisions and is being proactively supported by the Risk Team and the Quality Governance Leads.

Work is ongoing with the Clinical Audit Team to assess the evidence of assurance available from the Trusts clinical audit programme of local and national audits.

It was reported that the next stage of the process is to review and check actions. The quarterly Serious Incident Review Group (SIRG) offers divisions the opportunity to present assurance of the embedding of actions, lessons learned and for peer review.

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

217/19 HEALTHCARE SAFETY INVESTIGATION BRANCH UPDATES

Dr Julie O'Riordan (Divisional Director for FSS) was in attendance to present appendix H, summarising the five Healthcare Safety Investigation Branch incidents from December 2018 to February 2019.

The background and recommendations for all five cases was provided and immediate action has been taken following two of the incidents, action plans are being developed for two of the incidents and the final report is being awaited for one case. Following the five incidents, a deep dive into orange and red incidents from March 2017 to March 2019 also took place with the themes from the investigations detailed in the report.

Overall findings include engaging colleagues in a 'year of maternity patient safety' themes of the month, continuing quality improvement work and pulling together one overarching action plan themes from red and orange incidents into an overarching action plan.

Discussion ensued on where CHFT benchmark against other organisations. It was stated that units of the same size have around eight incidents; therefore we are not outlying with regard to incidents. It was also stated that an update on the audit to check whether learning is embedded is needed at this Committee, as well as the themes from the year of maternity patient safety once rolled out in January 2020.

OUTCOME: The Quality Committee received and noted the content of the report and an update on the overarching action plan has been added to the work plan schedule for March 2020

218/19 MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

Elisabeth Street (Clinical Director of Pharmacy) presented appendix I1, summarising the September and October 2019 meetings medication safety and compliance group meetings, as well as an update on improving standards of safe and secure handling of medicines.

- *October 2019 medication incident reports* - a total of 114 medication incidents were reported in October 2019. 101 of these resulted in no harm, 12 caused minor harm and one incident resulted in moderate harm. The main themes were provided in the report, and the issue regarding inaccurate drug histories by pharmacy is being reviewed by the Medication Safety Officer who is working closely with the chief technician to develop an action plan to minimise further inaccuracies.
- *Compliance with safe storage and handling requirements* - a summary of recommendations to improve medicines standard 'must do's' was received at the last quality committee meeting, and an action plan is being monitored at the medication safety and compliance group. An update on the action plan was provided in the report.
- *Annual ward manager's medication audit* – This was due for completion by 18 October 2019, with eight weeks given for completion. Unfortunately, only 50% of completed reports were received and the medication safety and compliance group agreed to an extension of a further four weeks, but if any outstanding reports have not been received by 18 November 2019, that area / ward will be classed as non-compliant. The five areas which failed to return completed audits were the ophthalmology outpatient departments at both CRH and HRI; the day case procedures unit; ward 5 HRI and the women's health unit antenatal.
- *Medication key security / storage of medication waste* - Estates have been provided with the cost code to purchase the required digilocks and keysafes and installation work is due to be finished by the end of December 2019.
- *WiFi temperature monitoring trial* – The trial of the sensors and wifi monitoring solution is going well. Medical Engineering are producing a business case for the purchase of a temperature monitoring solution that includes both fridges, fluid warmers and ambient temperature monitoring in areas where medications are stored. The business case will be submitted for funding from 2020/2021 capital funds.
- *Calibration of fridge thermometers* - 95% of fridges have now been recalibrated / replaced. All of HRI and Acre Mills have been calibrated and 90% of the CRH ones are now completed.
- *Discharge medication issues* – the results of the discharge error audit were provided in the report. Further detail is required regarding an action plan and recommendations following this audit, which will be discussed and reviewed at the December MSCG meeting.
- *Oxygen incidents* – there was an increase in reported oxygen incidents in September 2019 and the themes were included in the report. The recommendations and actions are being monitored via the medical gas group. Further issues from porters' concerns for appropriate transfer of patients requiring oxygen have been discussed and actions from those are also included in the report.
- *Controlled drug update* - a review of the controlled drug registers highlighted non-compliance with recording of identification checks when drugs are collected from pharmacy. As of 18 November 2019, pharmacy staff have been informed that they must record this data in the controlled drug register.
- *NICE guidance* – a recent review of the baseline assessment for Trust compliance with *clinical guideline 46 – safe use and management of controlled drugs* has shown an increase in compliance to 99%. This is an increase from 88% compliance in May 2019.
- *Staffing* - Pharmacy staffing levels continue to be a concern, which is recorded on the Pharmacy risk register. The situation is due to improve over the next eight weeks as new pharmacists are recruited and complete their inductions.

- *Terms of reference* - the terms of reference were reviewed and attached for ratification at this Committee.
- *IV Strategy Group* – an issue was highlighted at the November meeting that it appears that no further IV strategy group meetings are planned. Whilst that group reports to the Infection Control board, they are also responsible for advice and guidance for intravenous drug administration and determining best practice standards including responsibilities for training and audit. Potential risk is no evidence or assurance that appropriate IV administration is happening across the Trust.

Discussion ensued on discharge medication and concerns that 73% of errors require pharmacy intervention / correction. ES reported that the results from the audit are being collated and communicated with Cerner. It was stated that it would be useful to see how CHFT results compare with other organisations that use Cerner. It was asked whether the Electronic Patient Record system is being used to its full extent to help reconcile some of the issues, and the need to understand what the root causes of the errors are. ES also reported that a cross-audit with Bradford took place, however, the actions from this are yet to be received. ES agreed to liaise with Damon Horn (Pharmacist) regarding comparing the results with other organisations that use Cerner, and hopes that he would be able to attend a future Quality Committee meeting to explain the results.

The chair stated that CHFT are trying to tackle an issue which is endemic across the NHS, and that the Trust have made this a priority and will continue to monitor and continue to report at this Committee on a monthly basis.

OUTCOME: The Quality Committee received and noted the content of the report and approved the terms of reference from the Medication Safety and Compliance Group.

219/19 MEDICAL DIVISION Q2 PATIENT SAFETY AND QUALITY BOARD REPORT

Maggie Metcalfe (Associate Director of Nursing) briefly summarised the quality and safety issues identified in the quarter. A full copy of the report is available at appendix J.

- *Nurse staffing* - new starters are due to start in the emergency department this month, and active recruitment continues. A new escalation process is in the process of being formulated to ensure that nursing cover is provided to the emergency department when needed. The division has five risks relating to staffing levels on the risk register
- *Complaints* – there was a peak in July 2019 in the emergency network, and the directorate have asked the medical complaints department to provide a list of key themes in order to address these and improve on patient experience. Work is also ongoing in the division to ensure timely responses. There are currently 41 outstanding actions from complaints that colleagues from other divisions are responsible for. It was agreed for some of these to be reviewed through the orange panel meetings.
- *Assessment times* – these are still a concern in both emergency departments and a dashboard has been produced which will be reviewed on a monthly basis.
- *Respiratory floor* – three incidents were datixed in four days during August 2019 due to unskilled workforce. Focused work is being carried out with band 7 colleagues on leadership and management.
- *Discharge incidents* - at Quality Committee in June 2019, a request was made for an explanation into the increase in incident discharges between quarters 3 and 4 2018/19. It was at this time that significant changes were being made to the coding on the Datix incident reporting system. These changes included simplifying the choice of categories that reporters chose when reporting incidents. Absconded/missing patients was previously not under the discharge category which is why there appeared to be an increase in discharge incidents.
- *Vacancies* – in July 2017 there were 14 vacancies for Band 6 ED staff, however, in July 2019, it was over-established by two Band 6 nurses, and therefore there are more senior ED nurses in the emergency department.
- *Positive feedback* - an article in the Huddersfield Examiner raised concerns about a long wait for a child, subsequently resulted in a huge amount of positive feedback from the

public, with lots of great comments about our colleagues and the service provided. These comments will be displayed on a poster in emergency department.

- *Regulation 28* - the Trust was issued with a regulation 28 from a coroner's review, which led to a review of the ED waiting rooms and reception at HRI. There were several recommendations which will require a significant amount of estates work. The link to the risk assessment with recommendations was included in the report.

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

220/19 SURGERY AND ANAESTHETICS DIVISION Q2 PATIENT SAFETY AND QUALITY BOARD REPORT

Joanne Middleton (Associate Director of Nursing) briefly summarised the quality and safety issues identified in the quarter. A full copy of the report is available at appendix K.

- *Infection control* – The division had two key infection prevention and control issues in Quarter 2:
  - There were three Clostridium difficile infections in the division. One on ward 11 and two on Ward 3 in short succession. Issues identified with cleaning services, clutter and antibiotic use. Leadership response and quality of root causes noted to be excellent, with all actions identified completed. The team have also influenced wider learning across the organisation to input learning into the 'beyond the basics' infection control training and this has been actioned.
  - Issues identified with Endoscopy clean rooms caused potential risk to compliance. An interim decontamination manager was appointed from Airedale and a deep clean carried out and processes have been reviewed.

- *Incident* – a serious incident was investigated regarding a maxillofacial patient who should have received six-monthly appointments as part of cancer surveillance. The impact for the patient was that they required extensive treatment and surgery. The root cause was found to be a user error resulting in the patient being lost to follow up. The issues identified have also been highlighted as part of the Trust's deep dive into outpatient activity. A robust action plan is in place and being monitored. Learning has been shared across the division and the development of Standard Operating Procedures to manage clinical validation and response to patients on the incomplete orders list.
- *Appointments* – a matron has been appointed in operating services and a clinical educator is being piloted for six months to provide support for new starters and develop speciality-specific competency frameworks that support succession planning.
- *CQC action* – a 'must-do' action remains outstanding for critical care regarding medical staffing at CRH. The Clinical Director presented a paper to the Weekly Executive Board and it was agreed that a presentation is made at the capital investment group.
- *Complaints* - the division continues to be challenged regarding the sustainability of complaint performance. Some directorates continue to perform well, notably orthopaedics and head and neck. An improvement plan and approach have been developed to try and affect a step-change in performance, and this was included in this report.

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

221/19 COMMUNITY HEALTHCARE DIVISION Q2 PATIENT SAFETY AND QUALITY BOARD REPORT

Andrea Dauris (Associate Director of Nursing) briefly summarised the quality and safety issues identified in the quarter. A full copy of the report is available at appendix L.

- *Equipment* – An issue around both pressure-relieving equipment availability and authorisation was highlighted, which resulted in delays in equipment delivery, putting patients at risk of developing pressure sores. There is now a new system in place with pressure reliving equipment and no further issues have been raised.
- *Cardiac rehabilitation waiting times* – there is currently an 8-week wait for assessment

clinic, the standard being two weeks for elective patients, four weeks for post myocardial infarction, and six weeks for cardiac surgery patients. In order to address this, the Todmorden exercise programme has been cancelled to allow extra clinics which has brought the wait time down to six weeks for all patients, but this is outside the key performance indicator for certification. The team have highlighted that although they are on track to regain the national audit of cardiac rehabilitation (NACR) accreditation this year, it is a retrospective accreditation; therefore the current position may impact on future accreditation.

- *Insulin administration* - Increase in referrals to District Nursing for insulin administration is increasing pressure on capacity for visits. The Community nursing matron will be exploring further to ensure that all options are considered on discharge.
- *Staff safeguarding issues* - Community therapy teams have reported several incidents around social media, where patients have been contacting members of staff via Facebook. This matter has been taken to the health and safety group
- *Pressure ulcer* - through the orange panel meetings, the division have identified a theme that staffing issues have led to some community nursing colleagues becoming task-orientated. This has meant that patients have not always been treated holistically and opportunities to act sooner have been missed.
- *Dietetics* – the team are looking at *Airlogic* which Leeds Community have had great success with. Patients with IBS fill in an online symptom diary prior to their appointment, meaning it can be more focused rather than information gathering. The team plan to find out more from the company and do a 'go see' at Leeds to see if worth considering.
- *GIRFT programme* – at the August Patient Safety and Quality Board meeting, Nicola Bailey (Reconfiguration transformation manager) attended to discuss the Getting It Right First Time (GIRFT) programme. The division agreed that Community Healthcare Services should be involved in any relevant GIRFT projects. There was an upcoming Respiratory project which the respiratory nurses will be involved in.
- *Safety thermometer* – during the quarter, the division was an outlier for harm-free care and has to undertake data validation every month to ensure submissions are correct. During quarter 2 it was identified that the national safety thermometer definitions of NEW and OLD harm are not easily applied to community-based care. There is a need to develop definitions and guidance for community colleagues that meets the requirements of the national data collection but also fit the model of community based care. A meeting has been scheduled for quarter 3 to develop the definitions.
- *CQC* - the division were informed that community services will come under the mental health inspection teams, and will host a welcome event on 18 December 2019 to meet the new relationship manager and help orientate them to the divisional services.

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

222/19 FAMILIES AND SPECIALIST SERVICES DIVISION Q2 PATIENT SAFETY AND QUALITY BOARD REPORT

Dr Julie O'Riordan (Divisional Director) briefly summarised the quality and safety issues identified in the quarter. A full copy of the report is available at appendix M.

- *Fridge temperatures* – current fridge thermometers are being recalibrated. There was some slippage due to various factors; however, this is now improving.
- *Gentamicin* - recent audit demonstrated there were some prescribing issues of incorrect dosing and recording on the Electronic Patient Record. All incidents are being reported on Datix.
- *Mental health* – there are an increasing number and complexities of young people with mental health needs. Nationally there is a lack of tier 4 beds and therapeutic social housing placements for young people. An action plan is in place and work ongoing with social care and other agencies to improve situation.
- *Vacancies* - due to a number of nursing vacancies and maternity leave on the children inpatient nursing roster, there will be a 10.96 whole time equivalent shortfall. Work ongoing within the directorate and finance as part of the hard truths review to consider different nursing models which could accommodate the seasonal workload without resorting to

short term fixed contracts. The impact of this could result in a poor patient experience and delays in care which could have the potential to cause harm. This is on the division's risk register - 7539 scoring 12.

- *Outpatient issues* – a number of issues related to technical faults causing patients to incorrectly receive multiple letters when appointments are cancelled and rebooked, not receive correct SMS text messages relating to their appointment, user errors and capacity and demand issues impacting on patient experience and clinical safety. Work is ongoing to understand the potential impact of the missed appointments and all issues are currently reflected on the risk register.
- *Medication shortages* – the pharmacy team are reporting ongoing national issues with medication shortages with a potential risk to patients if stock cannot be obtained. The pharmacy procurement team are liaising with regional procurement to source alternative products to maintain patient safety.
- *Radiology* – issues are being reported on the stand-alone Xero Viewer programme. If a search is performed by patient name, the full results for the patient are not always shown. There is the potential that using this option may miss some results. If the search is carried out by hospital number via EPR, then there is no issue. A communication has been sent out advising of the issue and stating that a search should be carried out by hospital number not by patient name.
- *Pathology* – working in collaboration to ensure efficient pathways for patients:
  - *Dip stick testing* – Dr Hardman is leading on a Trust wide reduction in the usage of urine dipsticks
  - *Plastic waste* – excellent progress with our Clinical Commissioning Group colleagues around urine containers and the reduction of our plastics footprint

Dr O'Riordan also reported on an issue which did not take place in quarter 2, however, there was an outbreak of serratia which was identified in Leeds, and as a result, all babies were screened and identified that some that had the infection (although this was a different strain to the infection identified in Leeds). Work is ongoing and identified that infection control training was not where it needed to be. Aseptic non-touch technique (ANTT) training changed in September to become three-yearly and some colleagues had dropped out of compliance. There has been a big focus on this which has improved dramatically.

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

223/19 EXTERNAL INSPECTIONS / ACCREDITATIONS REPORT

Dr Anne-Marie Henshaw (Associate Director of Quality and Safety) presented appendix N, the second bi-annual report which sets out the external visits that have taken place and highlights any risks of incomplete actions.

The outcomes of the external visits during quarters one and two were detailed in the report with regular monitoring taking place. During quarters one and two, focused work also continued to improve the quality of the divisional compliance registers and the Trust wide external agency visits, inspections and accreditation data base.

Seven visits are planned during quarters three and four, details of which will be provided in the next report.

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

224/19 INTEGRATED PERFORMANCE REPORT

October's performance score is 75% with four green domains continuing the Trust's excellent performance for 2019/20 where overall the Trust has been green on four out of seven months. The safe and effective domains have both maintained their green performance. The caring domain remains amber, however, further focus on both of the Friends and Family Test Accident and Emergency metrics could see this improve. The responsive domain remains amber with cancer 62-day screening missing target for the fourth month. Two of the four stroke

indicators have missed target again and the 6 weeks diagnostics target remains a challenge. Workforce remains green with sickness levels and essential safety training continuing their strong performance which is a great achievement. Efficiency and finance is now green with an improvement in borrowing.

Complaints – another Work Together Get Results session generated new ideas and will continue to progress.
Emergency care standard 4 hours – whilst this is still in a relatively good position, there has been a downturn in performance. An action plan is in place following a detailed review.
Additional assurance – It was stated that discussions on performance have taken place and the need to ensure that 'green' indicators are still 'green', and that indicators which are continually red to undertake a deep dive.

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

225/19 INFECTION CONTROL COMMITTEE MINUTES

Dr David Birkenhead (Medical Director) presented the minutes of the last infection control committee meeting on 24 October 2019 (appendix P) for information.

226/19 ANY OTHER BUSINESS

Dr Patterson's last meeting

Philip Lewer (Chairman) thanked Dr Patterson on behalf of the Trust for all the work done she has done not only for this meeting, but also in other areas of the Trust.

Dr Patterson stated that it has been a pleasure working with the Quality Committee team and her role as Chair, which has been challenging, but enjoyable.

227/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- That it was a very comprehensive meeting with a number of reports

228/19 EVALUATION OF MEETING

What went well……
- Good attendance
- Very good discussion on certain aspects
- Helpful to have specific focus on Healthcare Safety Investigation Branch investigations

Even better if……..
- Size of agenda could be re-evaluated

229/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The annual work plan for 2020 was available at appendix Q

230/19 QUALITY COMMITTEE 2020 MEETING DATES

The meeting dates for 2020 were available at appendix R.

NEXT MEETING

Monday, 6 January 2020
3:00 – 5:30 pm
Discussion Room 1, **HRI**

QUALITY COMMITTEE

Monday, 6 January 2020
Acre Mill Room 3, Huddersfield Royal Infirmary

1/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr Sarina Beacher **(SB)**	Interim Assistant Director for Quality and Safety
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public-elected Governor
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Maxine Travis **(MT)**	Senior Risk Manager
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

2/20 APOLOGIES

Lindsay Rudge	Deputy Chief Nurse
Elisabeth Street	Clinical Director of Pharmacy

3/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

4/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 2 December 2019 were approved as a correct record with the exception that the date on the front sheet of the minutes is changed from 4 November 2019 to 2 December 2019.

5/20 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

Mental Health Strategy

Action: To be deferred to the next meeting.

6/20 SERIOUS INCIDENT REPORT

Maxine Travis (Senior Risk Manager) presented appendix C, summarising the nine new serious incidents declared and learning from four reports for the period of October and November 2019. Full details of the new incidents were available in the report. No themes were established from the incidents.

The learning and actions from the four completed serious incident reports were discussed. Learning summaries continue to be produced to share across the Trust and regionally, the West Yorkshire Association of Acute Trusts (WYAAT) learning lessons group meets on a quarterly basis to share learning.

Further discussion ensued on how learning is disseminated internally. MT reported that one-page learning summaries are produced for all internal cases which are circulated to divisional Patient Safety and Quality Board meetings. There is also an internal Serious Incident Review

Group where each division has an opportunity to present learning to other divisions. It was also proposed that sharing learning is a quality priority for this year.

It was also noted that the next serious incident report will include a never event which took place in December relating to a wrong site block.

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

7/20 HIGH LEVEL RISK REGISTER

Andrea McCourt (Company Secretary) presented Appendix D summarising risks as at 20 December 2019 which included:

- Six top risks:
  - **7278**: *longer-term financial sustainability risk*
  - **7454**: *radiology staffing risk*
  - **2827**: *over-reliance on locum middle-grade doctors in the emergency department*
  - **6345**: *nurse staffing risk*
  - **7078**: *medical staffing risk*
  - **5806**: *urgent estates schemes not undertaken*

- Two new risks:
  - **7615**: *ED four hour standard risk*
  - **2830**: *ED mental health risk*

- Two reduced risks:
  - **7345**: *Referral to district nurse service on Electronic Patient Record risk*
  - **7251**: *Optovue OCT machine risk*

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

8/20 INTEGRATED PERFORMANCE REPORT

November's performance score is 75% with three green domains continuing the Trust's excellent performance for 2019/20. The safe and effective domains have both maintained their green performance. The caring domain remains amber although Friends and Family Test for A&E, Community and Outpatients 'would recommend' need improvement. The responsive domain remains amber with all key cancer metrics achieving target. Two of the four stroke indicators are still missing target and the 6 weeks diagnostics only just missed target. Workforce remains green with sickness levels and Essential Safety Training continuing their strong performance which is a great achievement. Finance remains green, although deterioration in efficiency metrics means that the domain is now amber.

There have been nine 12-hour breaches in the emergency department which are being investigated externally. The main priority is ensuring patients are safe, and letters are written to patients who have had a wait longer than 4 hours. No complaints have resulted from those.

A Work Together to Get Results session has been undertaken in relation to staffing levels. Results will be taken through the Nursing and Midwifery Committee and will be working in line with the hard truths model.

A complaints deep dive is to take place in March, and it was noted that the outpatients' improvement plan will also begin to be reported at this Committee. Indicators which have been in the red for some time will be placed on an audit programme in the new financial year and included on a rolling assurance report.

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

9/20 TERMS OF REFERENCE

The amendments made to the Quality Committee terms of reference at Appendix F were discussed. Amendments included the Organ Donation Committee being removed from sub-groups at appendix 2, as this is now directly reported to the Board of Directors; the addition of named Non-Executive Director at appendix 2, and the frequency of the Medication Safety and Compliance Group, which has changed from quarterly to monthly at appendix 2 and 3.

Work is ongoing on reviewing the governance structure, which will be in place by 1 April 2020 and may affect the sub-group reporting.

OUTCOME: The Quality Committee received and noted the report, and on the basis of discussion, ratified the terms of reference.

10/20 SUB-GROUP TERMS OF REFERENCE

Dr David Birkenhead (Medical Director) presented the Clinical Improvement Group's terms of reference at Appendix G, which were approved at the Clinical Improvement Group in July 2019.

OUTCOME: The Quality Committee received and noted the report, and pending any review of the Clinical Improvement Group, ratified the terms of reference.

11/20 THE INTERNAL AUDIT NETWORK INSIGHT REPORT

The November 2019 audit Yorkshire insight report at Appendix H was discussed.

Andrea McCourt (Company Secretary) stated that this report, which is a compilation of national audit reports, will now be submitted to the Audit and Risk Committee. Discussion ensued on whether there was any learning from a national position in the reports, and it was agreed that the Audit and Risk Committee will need to provide any specific instruction to the Quality Committee if needed for any reports.

OUTCOME: The Quality Committee agreed that the report will now be monitored by the Audit and Risk Committee, who will request any information from the Quality Committee if needed.

Action: Send report to Quality Governance Leads for information.

12/20 ANY OTHER BUSINESS

Committee priorities

Discussion ensued on the Committee creating time during the meeting to agree on priorities for the Committee, expectations of the Committee and considering the reduction of items on the agenda each month. It was stated that the complaints report should be kept as a regular report and triangulation is needed with near misses, serious incidents and claims, as well as being sighted on any litigation and learning issues. It was also stated that there is a lack of formal reporting of compliments.

13/20 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- Outpatient improvement plan due to be presented next month
- The terms of reference may be subject to change, depending on the governance structure review
- Internal Audit network report will now be monitored at the Audit and Risk Committee.

14/20 EVALUATION OF MEETING

What went well……

- Due to this month's brief agenda, it was really useful to have the time to discuss future Quality Committee agendas and the annual work plan and have an open discussion on what the Committee needs to focus on.

15/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The annual work plan for 2020 was available at appendix I.

The Board Assurance Framework will be added to the work plan.

NEXT MEETING

Wednesday, 5 February 2020
3:00 – 5:30 pm
Acre Mill Room 4, **HRI**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 5 February 2020
Acre Mill Room 4, Huddersfield Royal Infirmary

16/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr Sarina Beacher **(SB)**	Interim Assistant Director for Quality and Safety
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public-elected Governor
Lindsay Rudge **(LR)**	Deputy Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Asifa Ali **(AA)**	Research Lead **(item 23/20)**
Helen Barker **(HB)**	Chief Operating Officer **(item 21/20)**
Katharine Fletcher **(KF)**	Head of Planned Access **(item 21/20)**
Damon Horn **(DH)**	Electronic Patient Record Lead Pharmacist **(item 24/20)**
Elisabeth Street **(ES)**	Clinical Director of Pharmacy **(item 24/20)**
Lucy Walker **(LW)**	Quality Manager, Calderdale & Huddersfield CCG **(Observing)**

17/20 APOLOGIES

Karen Heaton **(KH)**	Non-Executive Director
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Maxine Travis **(MT)**	Senior Risk Manager

18/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

19/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 6 January 2020 were approved as a correct record.

20/20 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

At the end of the last meeting, there was a brief conversation regarding Committee priorities. Further discussions are yet to take place with likely changes to priorities. A position update will be available next month.

21/20 OUTPATIENTS IMPROVEMENT PLAN

Katharine Fletcher (Head of Planned Access) and Helen Barker (Chief Operating Officer) were in attendance to present appendix C and provide an update on progress of delivery against the outpatient improvement plan.

During quarter 2 of 2019/2020, there were concerns around the access to outpatients, the booking processes and overall capacity. In response, a comprehensive deep-dive took place which resulted in the development of a detailed improvement plan, of which the Quality Committee has oversight. The plan includes 48 items which are broken down into three cohorts:

- *Digital / Technology* - This area saw most progress with errors relating to accurate appointment letters and multiple appointments resolved. A new booking system and a scheduling of follow-ups for open appointments have been implemented.

- *User Issues* - The Electronic Patient Record training team are working with colleagues to improve training available, and done some work around induction for medical staff.

- *Capacity* - This area is the most challenging for improvement, as there continues to be a mismatch between capacity and demand in several specialties. Whilst improvements are being noted in Appointment Slot Issues (ASIs), this is being reviewed closer in the 2020 / 2021 planning process.

Each item on the plan has been BRAG rated, with the current status of:

- 15 Blue actions completed with evidence of change
- 12 Red actions with work progressing
- 20 Amber actions with work progressing
- 3 Green actions completed where evidence needed

Details of evidence against each action was summarised and the full action plan was available with the report.

As part of the deep dive, a number of Electronic Patient Record system and process issues were highlighted and shared with Bradford in order to understand if these issues were EPR-wide or limited to CHFT. Overall, there was assurance that the deep dive captured the salient issues, and where there was a difference in approach, this was further reviewed and learning applied. A summary of the review was also made available in the report.

Further work is yet to be done to clearly identify complaints and incidents specifically around the outpatient booking processes, however, as improvement work has only recently been implemented and too early to evidence a direct impact, it was agreed that a further update will be provided to the Quality Committee once there is more evidence.

Several work streams have been escalated due to concerns on progress.
Action: Update on escalated work streams to return to the Quality Committee in April 2020.

Discussion ensued on the timescales for clinical validation and the target date to end the backlog. It was asked if there have been any incidents of harm as a result, and any assurance that data is being captured. It was stated that harm incidents have not yet been noted, however, they are expected to be reported via Datix.

Discussion also took place on education, and it was recommended that all staff undertake Electronic Patient Record refresher training and mandated as part of appraisals. It was stated that this may be a challenge; however, staff groups that are linked to outpatients are undertaking refresher training. It was suggested that refresher training could be part of Essential Safety Training, which may help reduce data quality issues.

Recommendations from the report included that further work to improve the visibility of the outpatient process related complaints and incidents will be added to the improvement plan and that a series of walk rounds commence to further evidence improvement or highlight gaps in assurance.

OUTCOME: The Quality Committee received and noted the progress made to date.

22/20 RISK MANAGEMENT STRATEGY

Andrea McCourt (Company Secretary) presented appendix D highlighting revised changes made to the risk management strategy, which is reviewed on an annual basis. Consultation

has taken place via the members of the Risk and Compliance Group and Quality Committee, and the revised strategy will be considered for approval by the Board on 5 March 2020.

Changes made to the strategy include the revised four pillars table; the addition of text to Board of Directors; the Chief Operating Officer confirmed as being responsible for fire safety; an updated flow chart for the management of risk to align with the Risk Management Policy and updated appendices (Governance Structure; Risk Management Specialists; Incident Grading Matrix and Risk Appetite).

It was reported that the governance structure is due to have further amendments, with the caveat that the sub-groups which report under Quality Committee may change.

Further changes to the strategy were made: the removal of the Non-executive Director's name in section 8.3; the amendment of 'Chief Nurse' to 'Executive Director of Nursing', and the removal of 'well-led' after Workforce Committee in section 7.

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

23/20 RESEARCH AND INNOVATION REPORT

Asifa Ali (Research and Innovation Lead) was in attendance to present appendix E, an annual summary (January 2019 to January 2020) on the Trust's research delivery.

At the end of the 2018/2019 financial year, the Trust superseded its research recruitment target of 1473 by achieving 1,731 (the number of patients and participants recruited into research studies). This also exceeded the recruitment number on the previous year which was 1,649 (2017/2018). The Yorkshire and Humber Clinical Research Network (YH CRN) funding for 2018/2019 was £736,040 and the Trust achieved a balanced position at year end (March 2019). It is important to note that due to a regional funding cut, no increase to CHFT funding was made, despite exceeding its recruitment targets in 2017/2018 and 2018/2019.

Performance summary headlines at the end of quarter 3 (December 2019) was:

- Recruitment activity - 939 against a target of 1,473 (64%). Figures as of today are 1,209 (82%)
- Recruitment to Time and Target (by study measure) - 82% *(Benchmark is 80%)*. This is reported in the Integrated Board Report and has improved.
- The number of studies currently recruiting are 84
- The number of principal investigators at CHFT are 51
- The number of commercial studies is 14 (7 open and in 7 follow-up)

Current studies remain static and the Medical division have the largest activity area and accounts for 52% of all activity as it is heavily cancer-driven. There has been a decrease by 10% from 2018/2019; however, there has been an increase in studies from the Surgical division. Outside of Leeds, CHFT have the highest in surgical studies.

The Trust has an excellent record for achieving research activity success and in the last 12 months there have been several, including being the first site to declare being open for a UK commercial lung cancer study. Other developments include hosting a research event in November 2019 – '#BePartOfResearchEvent' and taking part in the Patient Research Experience Survey.

The research and skills programme did not receive confirmation of its YH Health Education England funding until August 2019. This meant that it has not been possible to deliver the full suite of planned courses for 2019/2020. At the end of quarter 3, 42 NHS staff had accessed the programme. It was stated that the course may become a fee-paying programme, as CHFT hold the copyright.

The Trusts Research Strategy is now one year into its implementation phase. The priority focus has been on commercial research growth, getting new areas 'research ready', promoting research across the Trust and increasing performance activity.

The Research team were congratulated on their successes.

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

24/20 MEDICATION SAFETY AND COMPLIANCE REPORT

Elisabeth Street (Clinical Director of Pharmacy) and Damon Horn (Pharmacist) were in attendance to present appendix F, summarising issues and completed actions from the Medication Safety and Compliance Group held in November 2019.

- *Medication incidents* – In November 2019, a total of 85 were reported and in December 2019, a total of 83 were reported. The learning from these incidents will be included in the Medication Safety newsletter and also shared by the pharmacists with ward staff.
- *Medication Safety and Compliance Group actions* – actions completed in November and December 2019 were listed
- *Medication error policy* - A separate piece of work to produce an overarching policy relevant to all healthcare professional including allied health professionals, doctors and pharmacists, is being undertaken by the Lead nurse for medicines management. The first draft is currently being reviewed by professional leads.
- *Ambient temperature monitoring* – alternative funding being sought due to bid for capital funds being unsuccessful
- *Discharge medication issues* – a 7-day audit was undertaken from 14 to 20 October 2019 on the quality of discharge prescriptions. The total amount of discharges audited at CHFT = 225 and the total number of medications prescribed at discharge = 2055. 6.7% of medication prescribed at discharge had a clinical error, and 31.4% of discharges were affected with a clinical error. The number of discharges with Electronic Patient Record user errors was 45%.
- *Midazolam* – there is limited assurance that some recommendations from older National Patient Safety Alerts (NPSA) have been actioned / embedded. This is a particular concern where the NPSA is directly linked to one of the Never Event categories, as is this case regarding midazolam and Never Event: mis-selection of high strength midazolam during conscious sedation. A gap analysis has been completed, and pharmacy are working on processes to ensure that areas required to keep both high and low strength of midazolam, a risk assessment has been carried out and appropriate mitigations are in place to avoid wrong selection. There are however significant gaps in our compliance with the alert, with no nominated Trust lead. A request has been made to nominate a lead and ensure remaining gaps in recommendations are actioned.
- *Medical gas pipeline systems (part B*) – gaps in compliance with Health Technical Memorandum (HTM) are a nominated Executive Manager and compliance with the recommended training requirements for nursing staff. A request has been sent to the new Managing Director of Calderdale and Huddersfield Solutions for a nominated Executive Manager, and the recommended medical gas training for nursing staff is currently not being achieved. A leaflet has been developed which can be used for cascade training by ward managers to discuss with their teams.

Detailed discussion took place in relation to a re-audit of the discharge medication, which was proposed for October 2020. Due to the number of issues raised, it was stated that October would be too late to re-audit. Discussion also took place on the Electronic Patient Record software upgrade in April 2020 which may have an effect.

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

25/20 SERIOUS INCIDENT REPORT

Andrea McCourt (Company Secretary) presented appendix G, summarising three new serious incidents and learning from one unavoidable fall for the period of December 2019. Full details of all incidents were available in the report.

A key point to note was the declaration of one never event in December 2019 regarding wrong site surgery, which is being investigated.

AMcC stated that this report would be the last in this format, as the reporting of serious incidents will now form part of the quarterly report.

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

26/20 SERIOUS INCIDENT REVIEW GROUP REPORT

Andrea McCourt (Company Secretary) presented appendix H, summarising work done in the Serious Incident Review Group (SIRG) during quarters 1 to 3 of 2019-2020.

- *Learning* – each division shares learning and actions from a serious incident (SI) root cause analysis report. During quarters 1 to 3, learning from eleven serious incidents and complaints were presented and shared.
- *Complaints* - The SIRG will now consider actions and learning from both incident investigations and complaints.
- *Sharing learning* - opportunities for sharing learning through national and regional forums are taking place with the learning summaries now being shared with the West Yorkshire Association of Acute Trusts (WYAAT). Processes to increase the reach of learning to frontline staff to be strengthened and tested for robustness.
- *Terms of reference* - the Group reviewed the terms of reference as scheduled in August 2019, with amendments made to the membership and objectives of the meeting. The Quality Committee are asked to ratify the terms of reference, which were circulated as a separate paper.

Discussion ensued on the purpose of the Group and whether claims should also be referenced. It was asked whether learning from litigations should be included at the Serious Incident Review Group.

Suggested changes to the terms of reference were provided:

- objective (g) Monitor organisational learning, culture and change
- Additional membership to the Group from legal team
- Change 'Committee' to 'Group' in section 7
- 'Governance and Risk' should now be Quality and Safety Team in section 7
- That the name of the Group is changed to 'Adverse Events Review Group'

The suggested name change will be forwarded to the Chair of the Group and the above changes to the terms of reference will be made.

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

27/20 CLINICAL IMPROVEMENT GROUP REPORT

Dr David Birkenhead (Medical Director) presented appendix I, summarising the key points from the Clinical Improvement Group meeting held on 8 January 2020.

It was reported that the Group is currently in a transition period; however reports are still being received from sub-groups.

- *NICE compliance* – an update was provided from the Clinical Effectiveness and Audit Group regarding a new process for compliance within divisions. The Clinical Improvement Group supported this process.
- *Electronic Discharge Summary* - A task and finish group has been commissioned by the Clinical Records Group as there are currently no Key Performance Indicators (KPIs) for discharge summaries. An action has been set for these to be developed.

Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) remain under control and some focussed work on sepsis is being carried out.

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

28/20 PATIENT EXPERIENCE AND CARING GROUP REPORT

Lindsay Rudge (Deputy Chief Nurse) presented appendix J, informing the Quality Committee of outputs from the Patient Experience and Caring Group with assurance that the Trust is supporting the delivery of the strategic goal of 'Transforming and Improving Patient Care'. A summary of the key notes included:

- *Interpreting policy* – this was reviewed and a potential issue identified is a reliance on family members for interpreting, which is not in line with the Trust policy. This has been included on the risk register and may lead to an increase in interpreting costs.
- *Patients leaving the emergency department* - The Group requested assurance regarding patients leaving the emergency department before being seen due to lengthy waiting times. Clarification was given regarding the process, along with confirming that an escalation plan is in place.
- *Dementia awareness* – a draft training strategy has been developed which will impact on essential training requirements for dementia awareness.
- *NHSI transition collaborative* – two videos have been developed to support work and ongoing work on how young people are managed through the transition service.
- *Equality, diversity and inclusion (EDI)* – the Group are supporting and accessing different groups to understand EDI from a patient experience perspective.
- *End of life care* – the Trust's Individualised Care of the Dying Document (ICODD) is being built into the Electronic Patient Record and will be going live in coming months.
- *PLACE inspection* – the annual Patient-Led Assessments of the Care Environment inspection was held in October 2019 with overall positive feedback.
- *Divisional reports* – there is a lot of work around patient experience ongoing across divisions

The terms of reference for the Group were also submitted for ratification at appendix J2. It was asked that the reporting frequency to the Quality Committee in section four of the terms of reference are changed from monthly to quarterly.

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

29/20 QUARTERLY (Q3) QUALITY REPORT

Sarina Beacher (Interim Associate Director of Quality and Safety) presented appendix K, summarising progress against the Trust quality priorities for quarter 3.

The reporting structure has been changed from the previous quarter's report to clearly articulate where the Trust has achieved its quarter 2 objectives, the lessons learnt where possible, and if there is further work to be completed in quarter 4 alongside the priorities. The report provides a RAG review of the following assurance statements:

- Red - Limited Assurance
- Amber - Reasonable Assurance
- Green - Substantial Assurance

The key messages from the quarter 3 report are:

1. CQC remains a high item on the quality agenda with MD8 (medical staffing), SD9 (Emergency Consultant cover) and the learning portal providing limited assurance;
2. Pressure ulcer education requires innovating as this action is providing limited assurance to the Trust's wider pressure ulcer work;
3. The Falls agenda (workshops) must be commenced as planned in March 2020 to ensure best practice is met;
4. The dementia assessment, screening and training requires input to realise the Dementia Strategy;
5. Legal services must commence an audit of files in Quarter 4 and review the Electronic Patient Record ;
6. Nutrition and hydration remain a serious concern in relation to compliance of Malnutrition Universal Screening Tool (MUST) and the overall patient experience;
7. Calderdale and Huddersfield Solutions (CHS) and the Corporate Division have limited assurance in relation to medical device training;
8. We have limited assurance in relation to the development of a database to provide an overview of colleagues with skills in more complex complaints and less experienced complaint handlers as well as limited assurance in relation to the Trust learning from Parliamentary and Health Service Ombudsman (PHSO) cases.

The report also provides an overview of the Trust CQC position along with an update on progress with the three Quality Account priorities and the five CQUINs for 2019-2020.

Discussion ensued on the reporting format and the assurance statements provided. It was agreed that this style of reporting should continue for future reports.

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

30/20 QUALITY ACCOUNT

Dr Sarina Beacher (Interim Associate Director of Quality and Safety) presented appendix L, summarising the timeline for the production of the Trust Quality Account 2019-2020.

Some of the key points to note are that the Quality Account is being drafted by the interim Associate Director for Quality and Safety, who is due to leave the Trust at the end of March 2020, and there is a risk that there may be a delay to the completion if a lead is not appointed. Following the initial draft, support will be required from the Executive / Senior Management team for completion and distribution.

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

31/20 INTEGRATED PERFORMANCE REPORT

Ellen Armistead (Executive Director of Nursing) provided a summary of appendix M, highlighting the key quality issues:

- The safe domain remains green despite one never event declared in December 2019, as previously reported at item 25/20.
- Complaints – total received in month was 32, the lowest in over 12 months. A Work Together Get Results session
- Friends and Family Test system changes in April 2020
- Dementia screening – performance remains below the 90% national target
- CQUINS – it was stated that another CQUIN on screening processes may be introduced. It was agreed that a separate item on CQUINS is added to next month's agenda.

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

32/20 ANY OTHER BUSINESS

There was no other business.

33/20 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- The declaration of once never event in December 2019.
- The outpatient action plan was presented for the first time, and due to return in the future

34/20 EVALUATION OF MEETING

What went well……

- It was a positive meeting
- The Clinical Commissioning Group representative stated that the meeting was very productive, well-chaired and the reports provided assurance and succinct information.

35/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The annual work plan for 2020 was available at appendix N

It was stated that due to next month's meeting being dedicated to the divisional Patient Safety and Quality Board reports, the Patient Safety Group report, the Cancer Board report and the Board Assurance Framework will be deferred to April.

A request was made for the Safeguarding report to be submitted to the Quality Committee in August rather than September, due to the report needing to go to the Board of Directors in September.

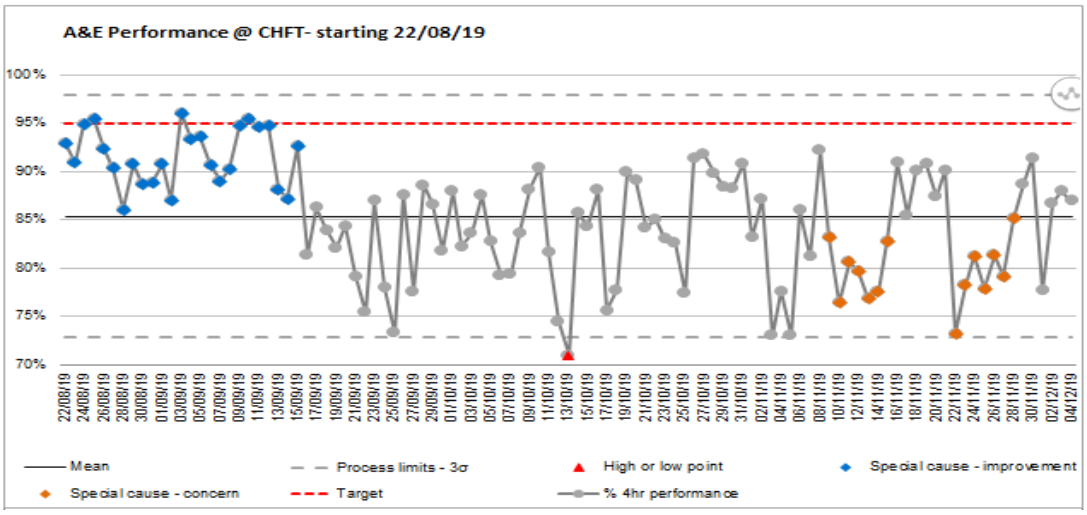
NEXT MEETING

Monday, 2 March 2020
3:00 – 5:30 pm
Acre Mill Room 4, **HRI**

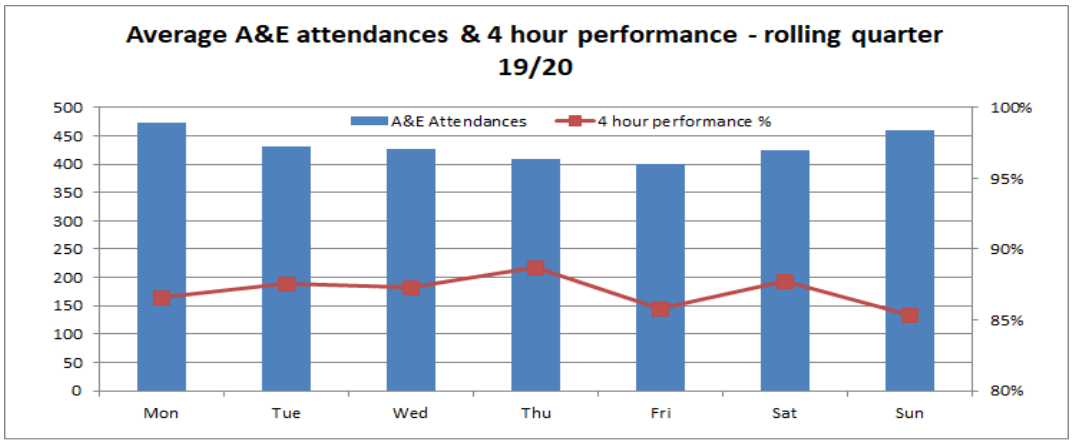
Q3 PSQB Reporting

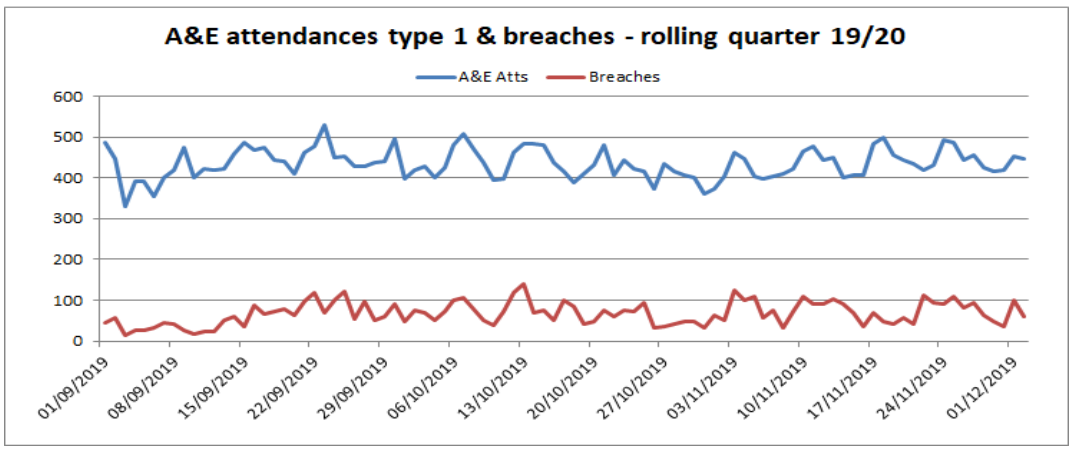
Calderdale and Greater Huddersfield A&E Delivery Board (A&EDB) Highlight Report		
10 December 2019	**12:30 – 14.00**	**Shibden Room Dean Clough**

Chair	Matt Walsh (MW) – CCCG
Attendees	Amanda Evans (AE) – KMC Debbie Graham (DG) – CCCG Farrukh Javid (FJ)- CCCG Iain Baines (IB) - CMBC Mark Davies (MB) – CHFT Rachel Foster (RF) – Locala John Keaveny (JK) – SWYPFT Jordan Wall (JW)- YAS Louise Metcalfe (LM)– NHSE Matthew Bleach (MB) – CCCG Vicky Dutchburn (VD) – GH CCG Andrew Nutter (AN) – LCD
Note Taker	Emily Kennedy – Calderdale CCG
1. Welcome and Apologies	
Lead	**MW**
Apologies and Focus of Meeting	Members were welcomed to the meeting and a round of introductions made. The following apologies were noted; Carol McKenna, Catherine Bange, Keith Wilson, Ruth Buchan, Caroline Smith, Helen Carr, Andrew Simpson, Bev Walker, Kate Gatherer
2. Sign off Highlight Report and Action log	
Lead	**DG**
	The board reviewed the notes from 12th November 2019 and agreed they were an accurate record of the meeting. DG reviewed the action log: Actions closed; 384 , 389, 395, 398, 399, 401, 402, 403, 404, 405,406, 408, 410, 413, 414, 415
3. Performance	
Lead	**MB**
	(a) Overview of performance; MN provided and overview. There was a significant reduction in performance from mid-September 2019 which has not recovered. Of concern, there has been a sustained period of 2 weeks in November where performance points have been below the mean. There was an improvement up until the beginning of December but as of yesterday performance has dropped. It was noted that this mirrors national performance. The board discussed the step change since mid-September; there has been an increase in demand over the last 3 months; there has been a 5% increase in A&E attendances which is 25 patients per day. Of the 5% increase when broken down into age profile, over 65s have increased by 9% and are 3 times more likely to be admitted.

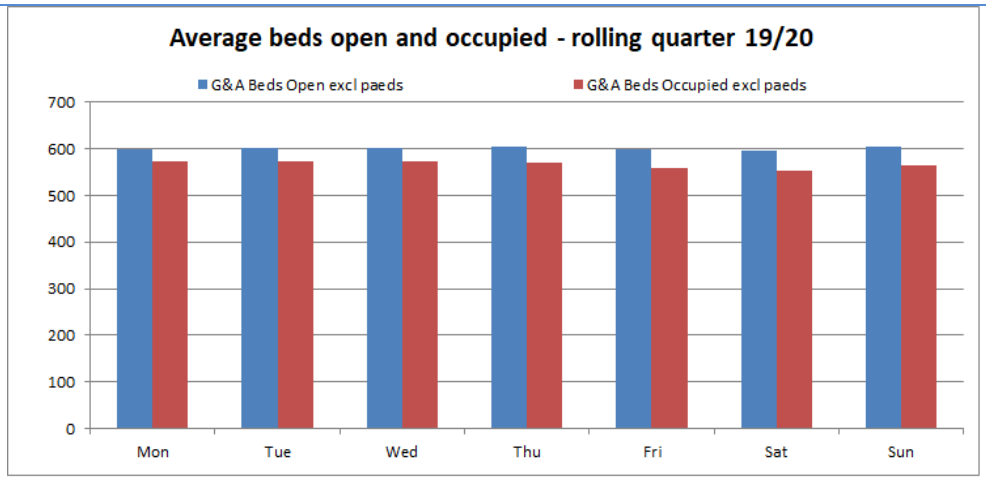


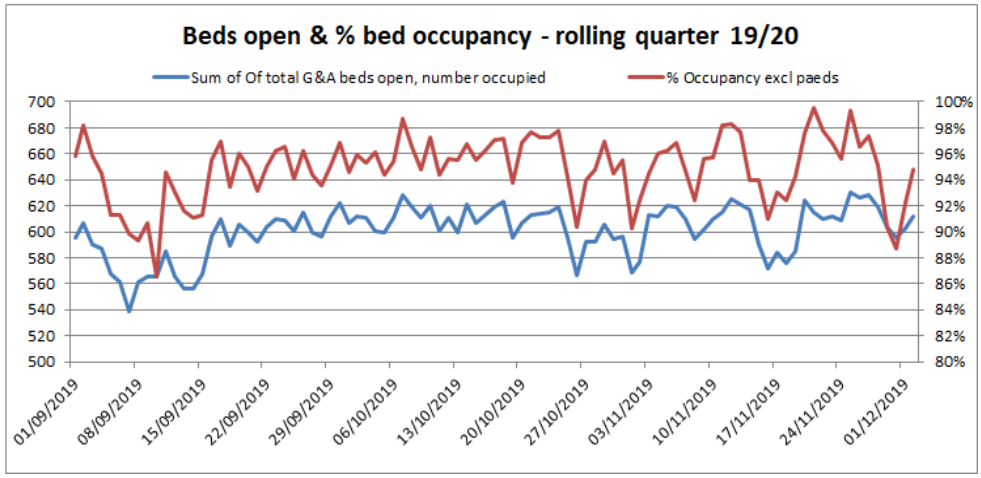
A&E attendances are highest on Sunday and Monday. The system is also experiencing days where there are over 100 breaches.



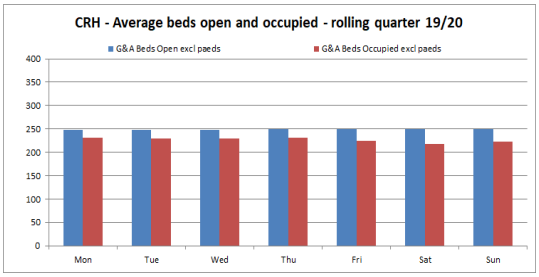


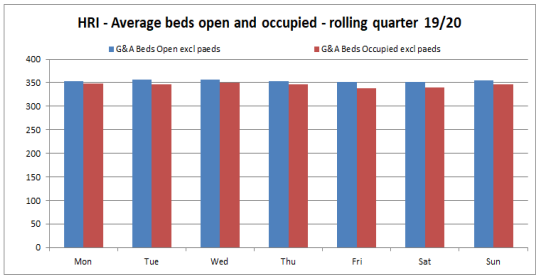
In September bed occupancy was around 90%. This has changed recently due to closure of 3 wards and restrictions on 2 wards with occupancy near 100%

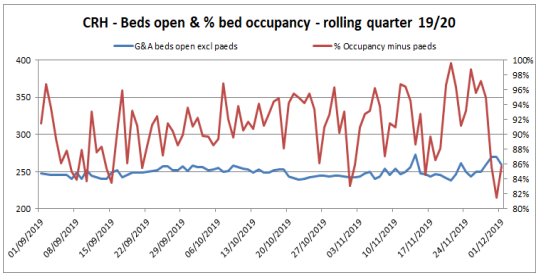


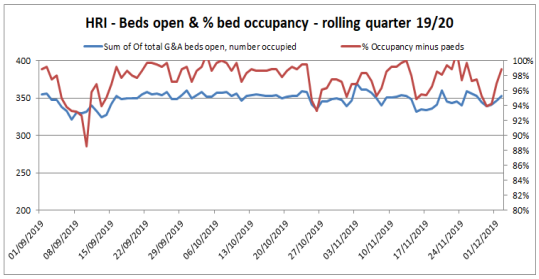


Bed occupancy levels split by site; HRI has significantly higher bed occupancy than CRH.

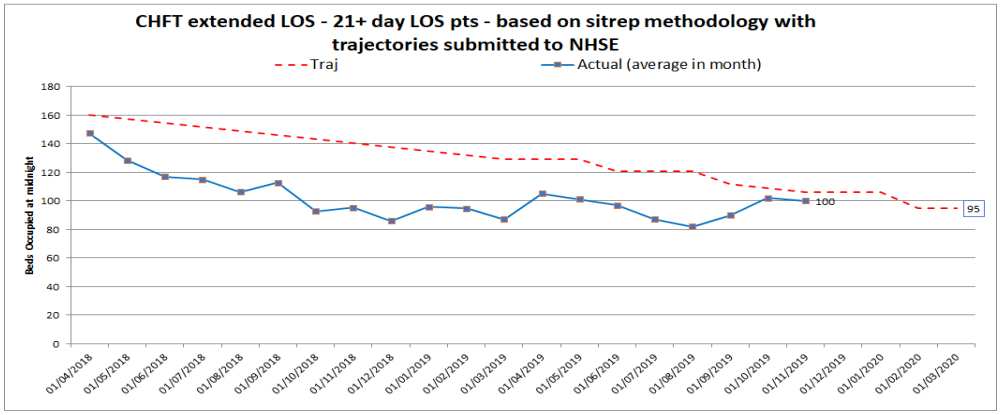




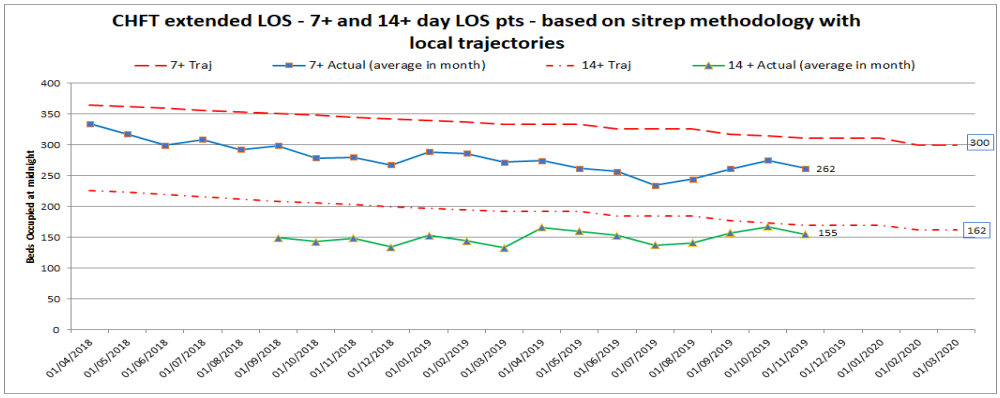




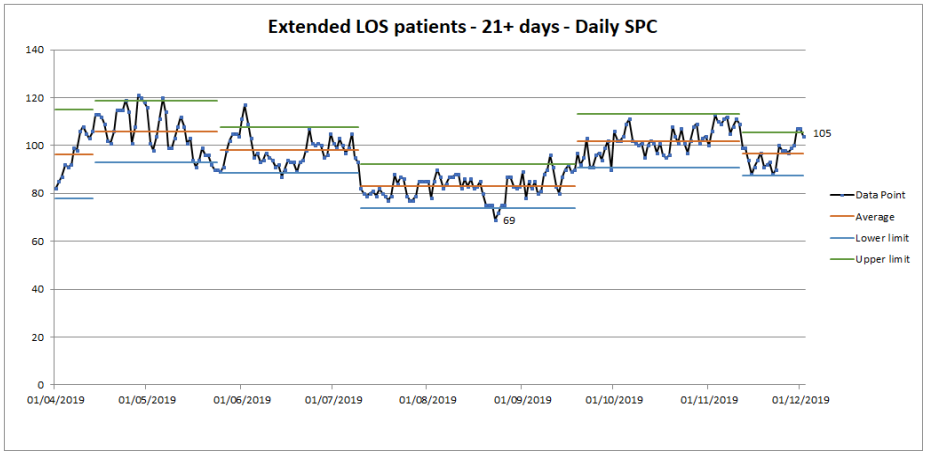
Extended LOS 21+ day. For past 3 months there has been an increase of extended LOS 21+ days but this is below trajectory. However, if this was measured today it would be above the trajectory.



Extended LOS 7+ and 14+ is below the trajectory.



Extended LOS patients 21+ daily position; there was a statistically significant reduction in mid-November. However more recently there has been an increase.



MB provided an update on flu GP consultation rates across the region. Flu rates are higher than this time last year. Calderdale and Kirklees have relatively small levels of flu. The highest rates are North and East Yorkshire.

Organisational flu uptake levels were provided;

Organisation

	December
CHFT	57.4%
SWYFT	61%
YAS	53%
LCD	26%
Locala	74.1%

Calderdale CCG	62%
GH CCG	49%

Action: VD to enquire about any issues with GH CCG staff flu uptake in order to maximise uptake.

IB updated the Board that some CMBC staff have had the flu jab independently - claiming the cost of the jab through expenses. There is therefore not an accurate way of collecting staff flu uptake levels at present. IB assured the Board that flu uptake is on the agenda for CMBC and providers.

AE updated the Board that KMC have been running clinics and staff can attend certain pharmacies. All team managers have been asked to collect flu uptake data within teams; the results of this have been varied.

Action: IB and AE to consider what message of support is needed from the Board to maximise staff flu uptake.

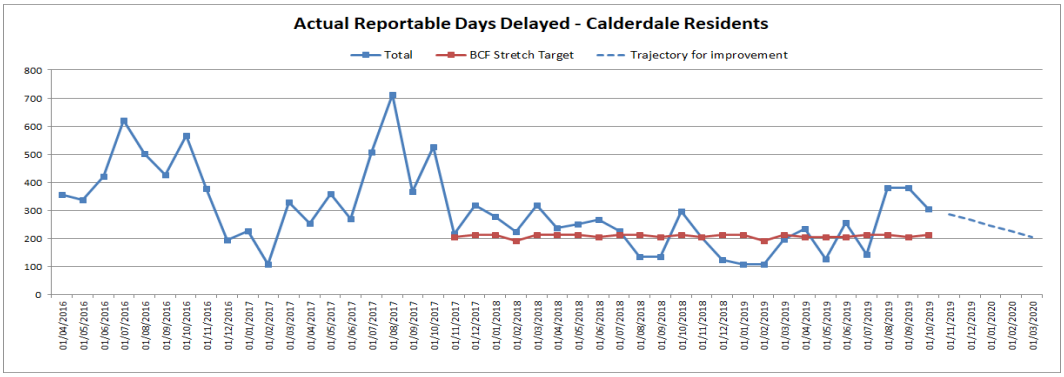
Regarding non-admitted patients, MD provided an update on year-to-date data which shows there has been a 7.7% increase since September in the number of patients attending A&E, but not admitted. This is broken down to the two sites with; 9.6% HRI and 8% CRH.

Action: MD to provide a breakdown of the characteristics of year-to-date non admitted patients.

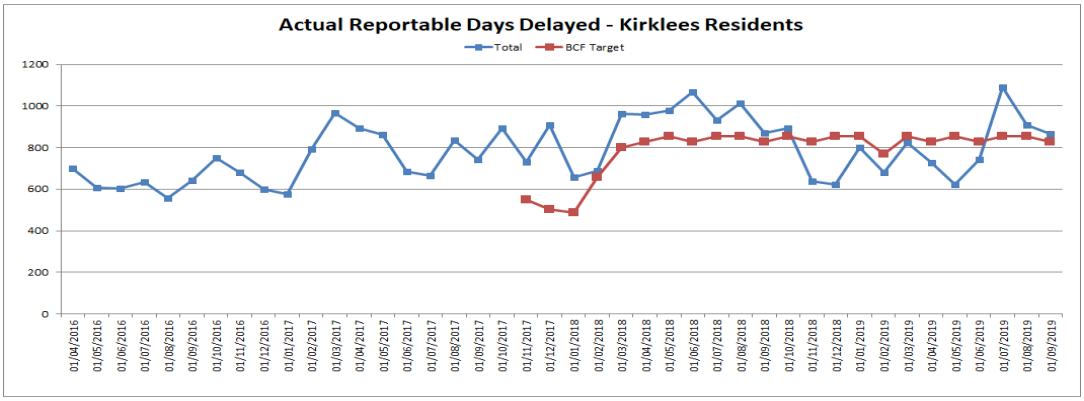
The Board discussed issues and risks associated with focusing the majority of effort on discharge from hospital rather than admission diversion and members agreed to continue this conversation as part of the SRG Urgent Care Board update in January

Action: Board to continue to discuss the need to maximise admission and attendance avoidance as part of the SRG Urgent Care Board update in January; HB/DG

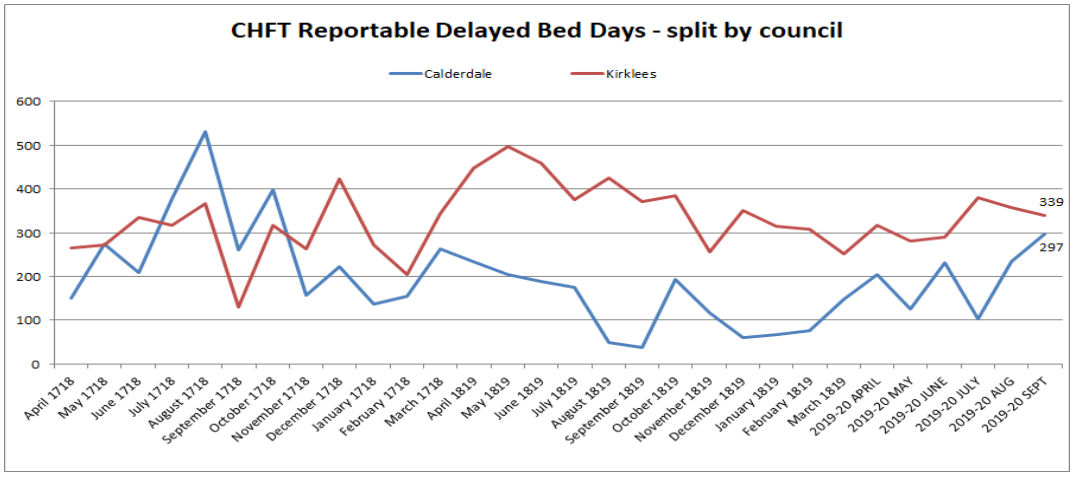
MB provided an update for DTOC; Calderdale's reportable position shows a long-term trend of improvement, but over recent months performance has been over the BCF target. An improvement trajectory was agreed at the SAFER meeting to ensure the trajectory is below the target by March 2020.



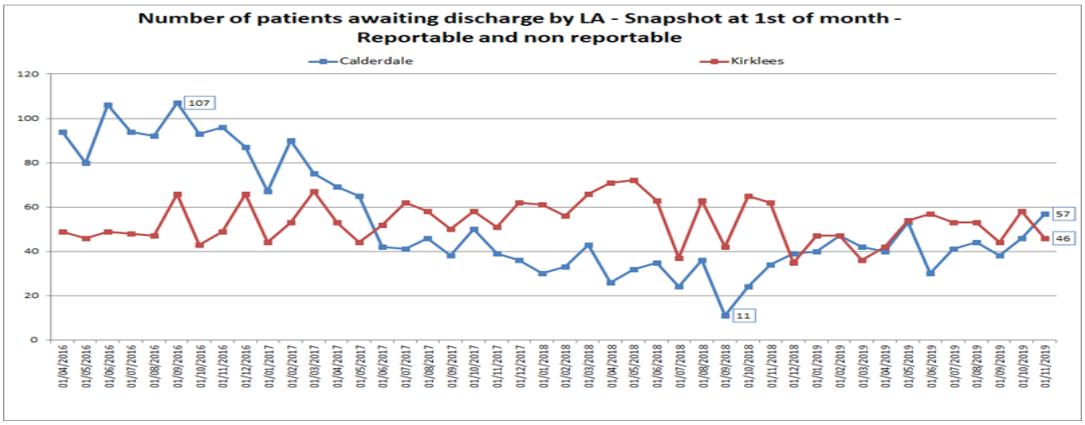
The Kirklees reportable position, includes all providers across this footprint and shows a strong improvement.



CHFT reportable delayed bed-days, split by local authority, shows in recent months there has been a similar level of performance across Calderdale and Kirklees. If this was extended to October and November then Kirklees delayed bed days would be lower than Calderdale.



CHFT over all DTOC position (including reportable and non-reportable)



(b) System Status

DG provided an overview of status and activities over the last 4 weeks:

- YAS have gone to REAP 3 from REAP 2. It is likely the timings of ambulances for low risk patient's (this includes hospital transfers) increases as critical patients are prioritised.

	• CMBC are at OPEL 3 and focusing on hospital flow. Issues were raised regarding the relationship with place and IBCF/BCF funding, especially relating to non-recurrent funding. • CHFT are at OPEL 3 and are experiencing high levels of attendances. In particular pressures in paediatric respiratory. • 111 escalated to OPEL 4 over the weekend due to exceptional demand. LCD are taking un-triaged calls from 111 to help with demand • KMC are currently at OPEL 3 • Locala are at OPEL 2. Moorlands Grange is currently closed due to infection control IB highlighted that not all system leaders have been present on the weekly system calls. It was discussed if all partners are required to be on the call. It was agreed that each local authority, CHFT, SWYPFT and Locala need to be on every call. **Action: DG to send a reminder out for the call tomorrow (11th December). DG to recirculate the dates and times of further calls.** AE highlighted that patients moved into interim placements receive two social care assessments. This impacts on over all social care capacity. The Board discussed how to capture data to reflect increased pressures on community or elective work due to the current focus on the acute. **Action: DG/MB to consider data sets already received to understand community pressures – to be brought back to February 2020 meeting** FJ confirmed that general practice business continuity plans are not focused on system pressures and we might want to consider how we better align system indicators. The Board discussed the lack of knowledge of baseline demand for primary care and the potential for the new APEX system to resolve this. **Action: FJ bring an update on what a OPEL based approach look like in general practices to February 2020 meeting**
4. Winter Planning	
Lead	**DG**
	(a) Review of surge and escalation plans All local surge and escalation plans have been received. They are being reviewed to ensure triggers are consistent and an update will be provided at January's meeting. **(b) Aligning winter communications plans** AH and SR provided an update of the national, regional and the local campaigns and alignment of activities. It was agreed to think about how best to communicate with communication teams during periods of escalating demand within the hospital. **Action: DG to consider when reviewing surge and escalation plans the process of escalate to comms teams** **(c) Additional winter pressures funding letter** CHFT have been allocated £500,000 from NHSE. The funding has been sent directly from the centre to acute trusts. CHFT have already identified priorities the funding will be spent on to recover performance. MW confirmed the use of the funding which has been shared by HB.

	It was discussed that winter funding is usually subjected to scrutiny and rigour through the Board to ensure that all partners are aware of where the funding will be allocated and priorities. In particular, priorities relating to hospital flow and the subsequent impact on local authority and community services. **Action: EK to share clarification email of the 4 priorities that CHFT have identified for winter pressures funding. Any further clarification to be sought by individual organisations as needed and any remaining areas for clarification raised at the January meeting.**
5. Transformation Updates	
Lead	**DG**
	Due to time pressures the Board was not able to consider the SRG Urgent Care Board update. DG confirmed that all 7 SRG UEC work streams have been established. **Action: DG to present a full update regarding SRG and UC Board January meeting and development of the Urgent Treatment Centres at the February meeting.**
6. **WY&H UEC Programme**	
Lead	**DG**
	DG provided an update of the refresh of the WY&H UEC Programme Board. The Board is aiming to strengthen its leadership, membership and clarity of mission. A full review is ongoing of the TOR and this will be shared with the Board in due course. **Action: UEC Work-stream updates to remain a standing item on the A&EDB agenda – EK**
10. For information and AOB	
Lead	**MW**
	(a) Mutual Aid Document The current version of the document has been included in the papers. The aim of item was to seek assurance from representative organisations that they were happy with the current document and processes. BW had confirmed to DG that the HR leads at CHFT have checked the Mutual Aid Document to ensure still relevant. The Board restated its agreement the Mutual Aid Document. (b) Retirement of John Keaveny The chair thanked JK for his participation and commitment as this is JKs last A&E Delivery Board. Members wished him a long and happy retirement and thanked him for all the work he had done to support the Board and the system.
Next Meetings	7th January 2020, Shibden Room, Dean Clough, 12.30-14.00 11th February 2020, Shibden Room, Dean Clough, 12.30-14.00 11th March 2020, Shibden Room Dean Clough, 12.30-14.00

Calderdale & Greater Huddersfield Health Economy
A&E Delivery Board (A&EDB) Action log

No	Minute Ref	Action	Who	Date Due	Update	Status
354	YAS 999	YAS Urgent Care and Communications leads meeting to discuss joint response to members at scrutiny and H&WBB	CB	September 2019	10.12.19 – MB to liaise with JW to complete. Meeting arranged for 8.1.20	Open
356	Board Governance	Update on next steps from the May workshop and governance arrangements to the A&EDB to review our position and decide future actions	DG	January 2020	To be included in January update on SRG UCB	Closed
363	UEC	Workforce planning piece to come back to the A&E DB based on the CLEAR system – EK to put on the workplan	MD	Feb 2020	On the work-plan for Feb 2020 meeting.	Closed
385	YAS IFT/HCP Framework	To agree a date when the new IFT/HCP Framework to be brought back in three months for an update. With feedback from GPs and A&Es	YAS rep	TBC on Jan 2020	To be brought back as needed	Open
393	Winter planning	Clarity required surrounding winter/ EU calls in Calderdale and Kirklees, JP and RG to pull together when clarity available	JP/ RG		To be agended again as needed	Closed
394	Winter Planning	Share reporting template when available for on call managers when available	DG	November 2019	To be agended again as needed	Closed
397	Performance	IB and AE to consider how it might be possible to collect staff flu uptake data from care homes and home care providers.	IB/AE	December 2019		Open
407	Performance	AE to present Home First proposal and admission avoidance once it has gone through local governance processes, date to be confirmed	AE	TBC		Open
409	Adoption of Surge and Escalation plan	DG and JP to review all organisations surge and escalation plans to ensure consistency. To also consider trigger numbers on the TOC list as part of this.	DG/JP	January 2020		Closed

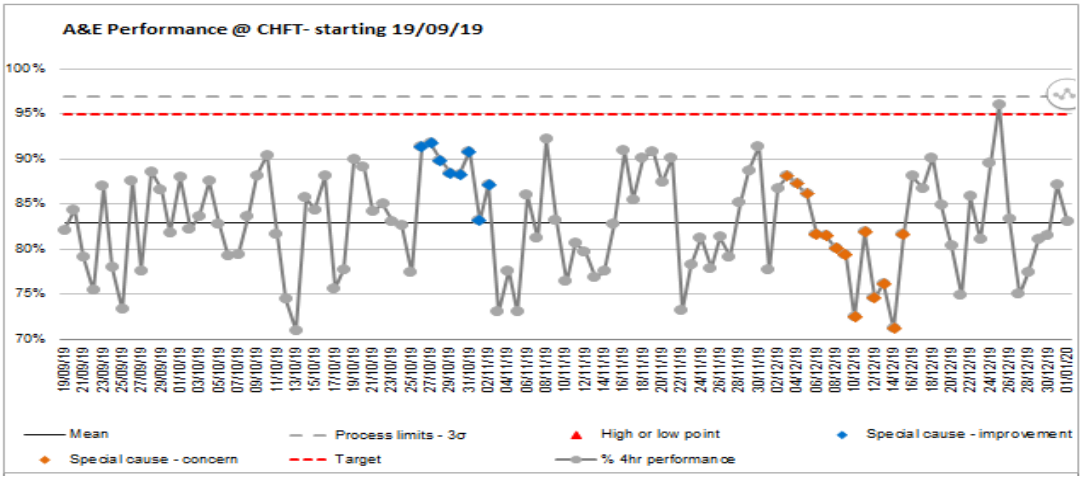
Enclosure A

No	Minute Ref	Action	Who	Date Due	Update	Status
411	Description on winter schemes in General practice	HC to confirm within LCD if they can book into overflow hubs and if not help facilitate this	HC	December 2019		Closed
412	Description on winter schemes in General practice	FJ to confirm if LCD can book into the overflow hub appointments	FJ	December 2019		Open
413	Performance	VD to enquire about any issues with GH CCG staff flu uptake in order to maximise uptake.	VD	January 2020		Open
414	Performance	MD to provide a breakdown of the characteristics of year-to-date non admitted patients	MD	January 2020		Open
415	Performance	IB and AE to consider what message of support is needed from the Board to maximise staff flu uptake.	IB/AE	TBC		Open
416	Performance	Board to continue to discuss the need to maximise admission and attendance avoidance as part of the SRG Urgent Care Board update in January; HB/DG	HB/DG	January 2020	On agenda for January meeting	Complete
417	System Status	DG to send a reminder out for the call tomorrow (11th December). DG to recirculate the dates and times of further calls.	DG	January 2020		Complete
418	System Status	DG/MB to consider data sets already received to understand community pressures – to be brought back to February 2020 meeting	DG/MB	February 2020		Open
419	System Status	FJ bring an update on what a OPEL based approach look like in general practices to February 2020 meeting	FJ	February 2020		Open
420	Winter communications	DG to consider when reviewing surge and escalation plans the process of escalate to comms teams	DG	January 2020		Complete

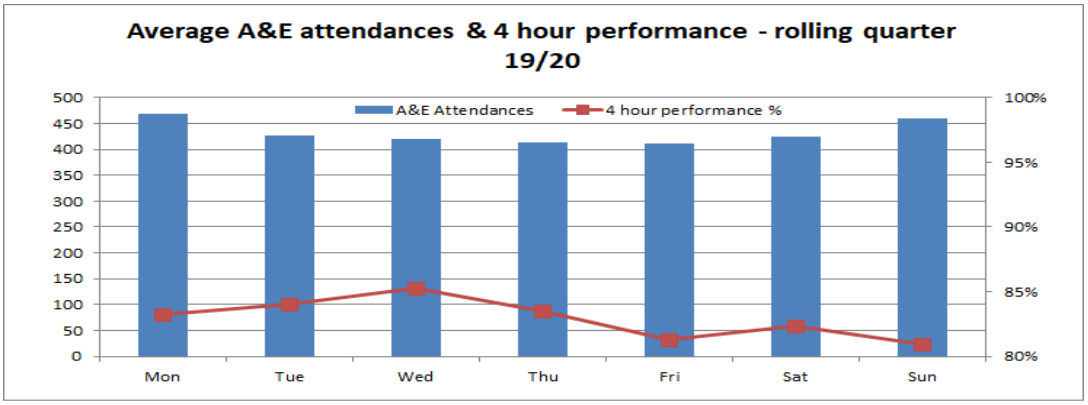
Calderdale and Greater Huddersfield A&E Delivery Board (A&EDB) Highlight Report		
7 January 2020	**12:30 – 14.00**	**Shibden Room Dean Clough**
Chair	Carol McKenna (CMcK) – CCCG	
Attendees	Aimee Haggas (AH) – GH CCG Amanda Evans (AE) – KMC Andrew Simpson (AS) – YAS Debbie Graham (DG) – CCCG Gary Auckland (GA) – SWYPFT Helen Barker (HB) - CHFT Helen Carr (HC) – LCD Iain Baines (IB) - CMBC Mark Davies (MB) – CHFT Matthew Bleach (MB) – CCCG Rachel Foster (RF) – Locala Steven Reed (SR) – C CCG Vicky Dutchburn (VD) – GH CCG Caron Walker (CW) – PH Calderdale (via phone) Jane O'Donnell (JO) – PH Kirklees (via phone)	
Note Taker	Emily Kennedy – Calderdale CCG	
1. Welcome and Apologies		
Lead	**CM**	
Apologies and Focus of Meeting	Members were welcomed to the meeting and a round of introductions made. The following apologies were noted; Matt Walsh, Catherine Bange, Keith Wilson, Ruth Buchan, Caroline Smith, Helen Carr, Andrew Simpson, Bev Walker, Kate Gatherer	
2. Sign off Highlight Report and Action log		
Lead	**DG**	
	The board reviewed the notes from December 2019 and agreed they were an accurate record of the meeting. DG reviewed the action log: Actions closed; 356, 363, 385, 393, 394, 409, 411, 413, 414, 415, 420	
3. Performance		
Lead	**MB**	

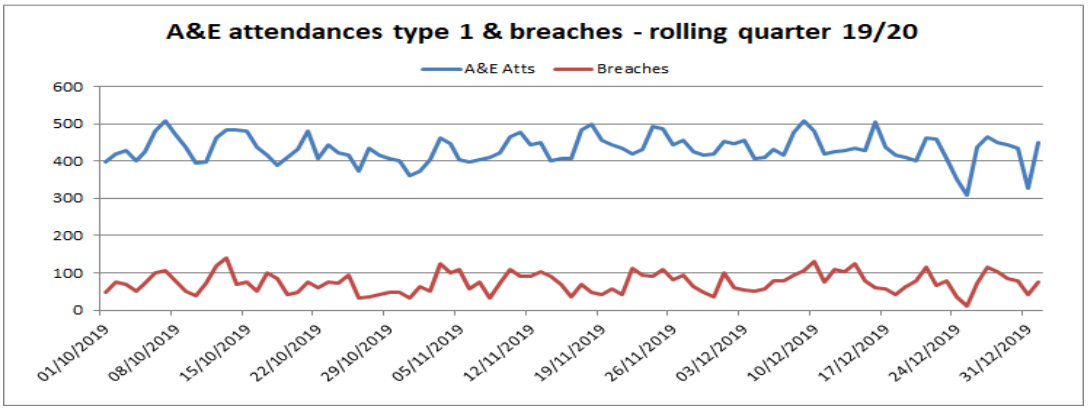
(a) <u>Overview of performance;</u>

MB provided an update of A&E performance; in mid-September 2019 there was an average of 90% which has reduced to 83%. Pressures in early December have seen a sustained period of decreased performance.. There has been a 5% growth in attendances from the same period last year. CHFT benchmarked regionally and nationally are in the lower quartile.

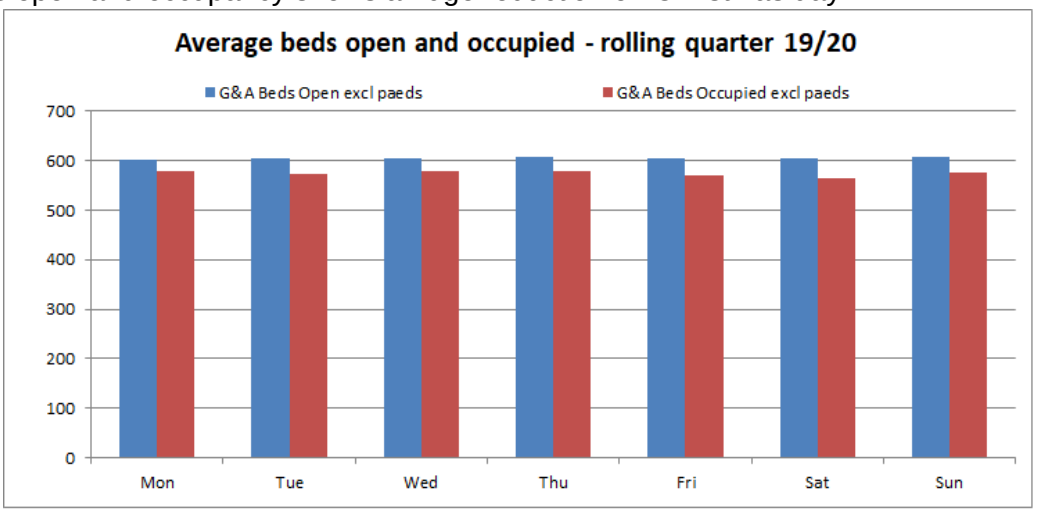


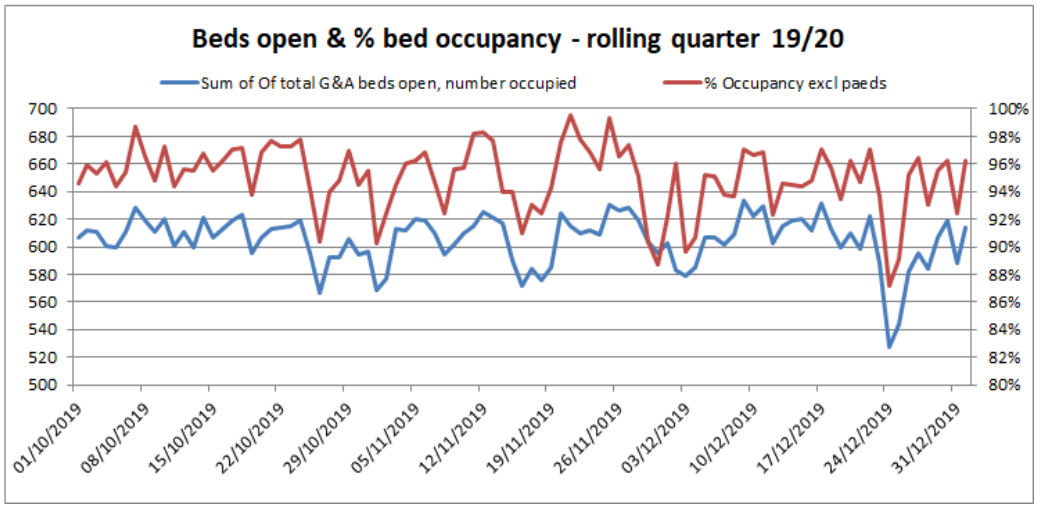
The daily A&E variation shows that on Christmas day there were 200 less attendances than on an average day over the period.



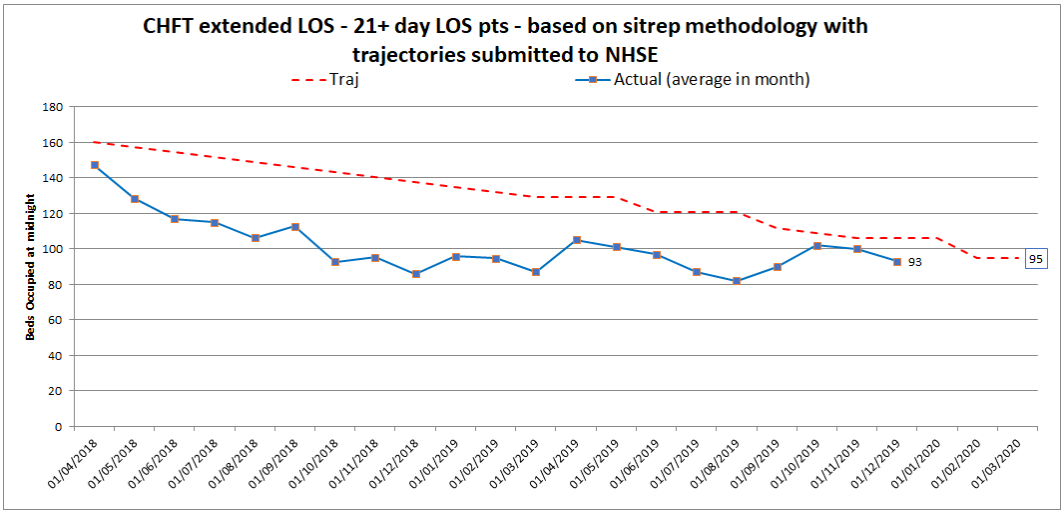


Beds open and occupancy shows a huge reduction on Christmas day.

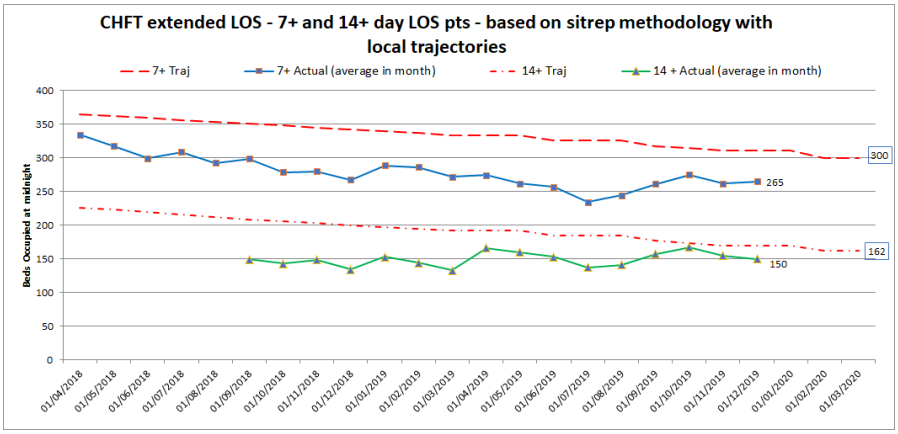




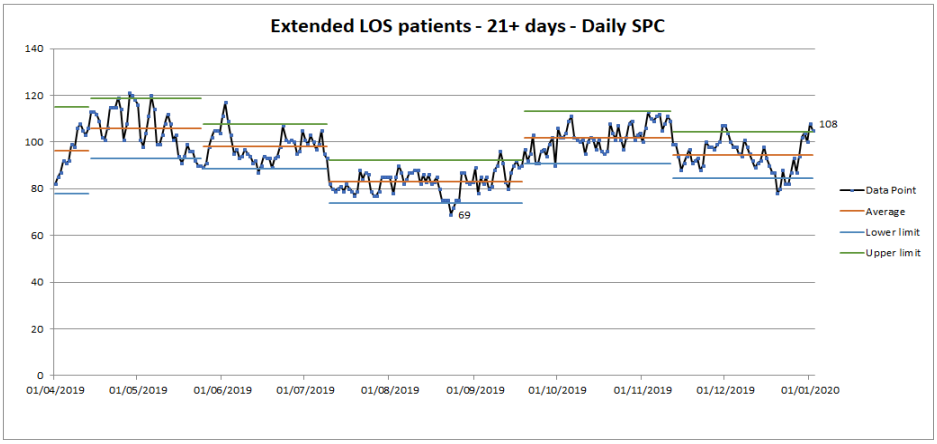
Extended LOS 21+ is below the trajectory at 92 patients;



Extended LOS patients 7+ and 14+ position is below final trajectory position. The challenge in the coming months will be to maintain this performance.

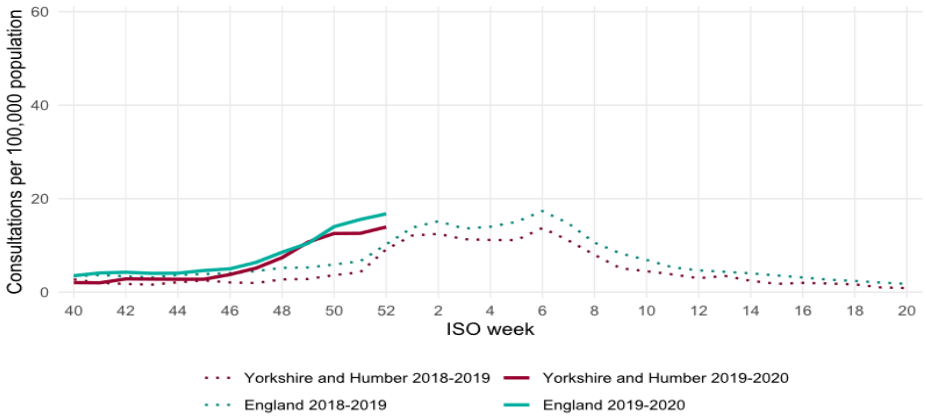


The daily LOS shows in the run up to Christmas there was a reduction due to efforts to get patients home for Christmas day however since then there has been a significant rise.



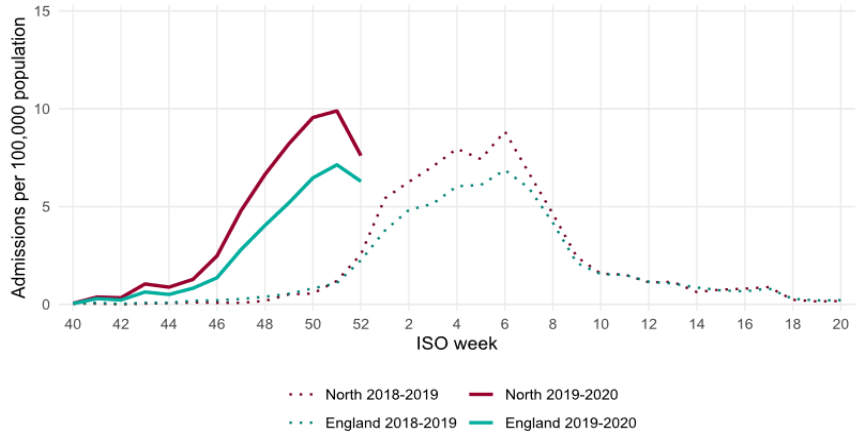
Flu update presented from week 52. GP consults from flu like symptoms is above last years position however still low numbers over all;

Figure 1. ILI consultation rate – GP in-hours syndromic surveillance system

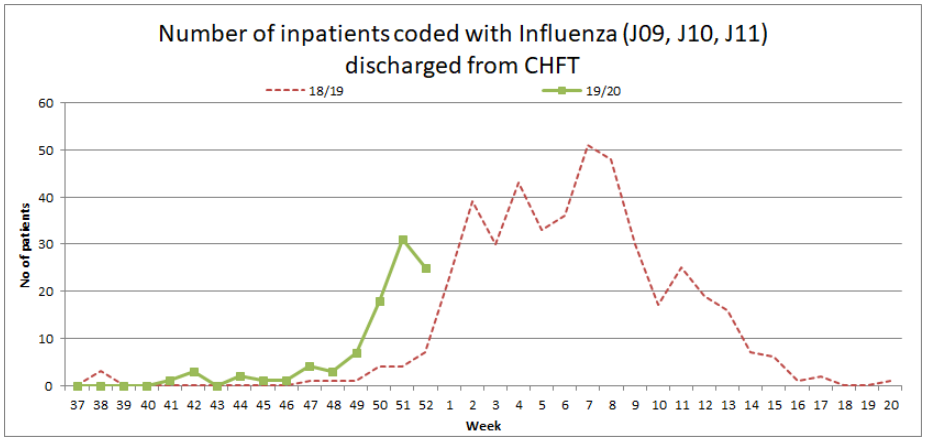


Hospital admissions of confirmed influenza shows flu period has begun 4 weeks earlier and already higher peak than the previous year.

Figure 3. Hospital admissions with confirmed influenza – USISS sentinel scheme



Local flu position shows patients at CHFT who have been discharged with confirmed influenza codes. This shows that flu rates have started to increase 4 weeks prior than last year. Early signs show peak will be higher than last year which is in line with Australia data. As of week 52 there were 95 cases as opposed to 21 last year.



It was discussed that last year flu rates were lower than previous years. It was agreed it would be helpful to compare flu data over the last 5 years to understand longer term trends.

Action: MB to compare flu data from the last 5 years

Organisational position

Organisation

	December	January
CHFT	57.4%	59.6%
SWYFT	61%	77.6%
YAS	53%	56%
LCD	26%	63.8%
Locala	74.1%	75.7%

Calderdale CCG	62%	65%
GH CCG	49%	51%

There was a view that some clinical staff within organisations had been the most resistant to having the flu vaccination. CHFT use the 'good medical practice' approach to encourage clinical staff to be vaccinated.

b) <u>Update from Public Health on Flu Planning</u>

JO'D provided an update from Kirklees Public Health. Just before Christmas there was an increase in influenza like illness in schools and communications have gone out. There had been one care home resident admitted to CHFT with confirmed influenza. Public Health has commissioned a flu vaccine scheme to complement the NHSE scheme for independent care homes. Information is currently being collated from care homes who didn't participate in the scheme. IPC have been promoting the flu vaccine.

CW provided an update from Calderdale Public Health. There have been no identified flu cases within community.

PHE nationally have put in place enhanced surveillance of paediatrics due to 11 paediatric deaths in England.

Action: DG, JO'D and CW to identify links with cohort of flu rates and Surge and Escalation to ensure plans are more robust – due back to Board March

MD highlighted that flu consultation rates are based on in-hour services, however significant amount of urgent care is delivered out of hours.

Action: HC to provide data from LCD for out of hours flu like symptoms

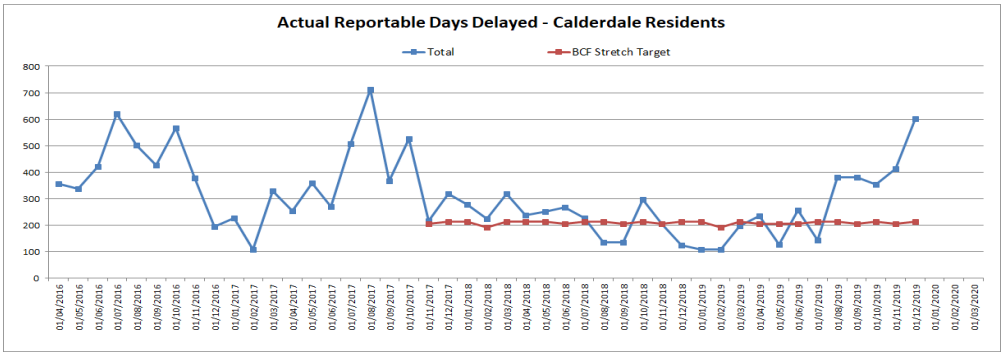
The difference between pandemic and seasonal flu was discussed. PHE and NHSE would lead in a pandemic flu outbreak. Seasonal flu is managed locally and there is no trigger for any escalation actions after rates reach a certain level. PHE have in previous years promoted the vaccine for longer if needed.

HB noted that CHFT have allocated the same funding for point of care testing for flu as last year, however this funding has nearly run out. This means more people are being tested for flu.

Action: MB add flu like symptoms to flu update for CHFT to understand rates of patients tested for flu like symptoms

c) <u>Transfer of Care</u>

Reportable days delayed at Calderdale since August/September has been above the BCF target. December's non-validated figures show 600 days delayed which is the highest for 2 years.



	IB updated that agency staff employed by CMBC before Christmas had now resigned. The 'shop at number 42' service was closed and capacity transferred to the hospital. Due to ongoing staffing issues, the shop will remain closed ensuring additional assessment capacity. Additional rapid hours have been agreed, staff are reviewing this daily to ensure it is flexed as necessary. The Board discussed an improvement trajectory to recover Calderdale's performance. The Board agreed that; DG, HB and IB will meet to decide an improvement trajectory which will be reported and agreed at ICE on the 17th January, this will be shared at the next Board. The trajectory will take into consideration the development of proposals of BCF funding to ensure sustainability. **Action: Calderdale improvement trajectory to be agreed by DG, HB, IB to be reported and agreed at ICE on the 17th January and this will be shared at February Board** HB highlighted that alongside the impact on performance, there is also a significant safety risk at CHFT due to insufficient staffing for the number of beds open. This risk has been escalated to the Quality & Safety Board. There is also a related financial risk for CHFT. HB asked the Board for support regarding regulatory conversations. IB highlighted pressures due to closure of transitional IMC beds at Ferny Lea whereby a community based intervention was meant to take their place. This has not happened as planned. **Action: A&EDB to be sighted on plans for step up and step down capacity (Independent Living Models), in both places (both bed and home based solutions) in March** The Board discussed the MADE calls that are taking place twice weekly in Calderdale. It was discussed that challenges need to be made on the calls regarding shared risk across the system to ensure it does not sit solely with CHFT. It was agreed that IB, HB and DG need to be sighted on emerging themes from the calls. **Action: HC, HB, MD to discuss issues around LCD rotas** **d) <u>System update and de-brief</u>** DG provided an overview of activities since the last Board meeting, including the fantastic effort by staff in all organisations to ensure that as many patients as possible were able to discharged, enabling them to spend Christmas with their families.
4. Winter Planning	
Lead	**DG**
	a) <u>Review of Surge and Escalation plans</u> DG gave an overview of the output of a review of our current S&E Plan. The current Surge and Escalation plan needs to be strengthened. No weightings are associated with the different OPEL levels triggers. The thresholds are potentially too high especially when considering TOC. Different organisations have different triggers which hinders organisations being able to provide mutual aid and effective problem solving. Instead, there needs to be one way of understanding the system status at any point. **b) <u>Full Capacity Planning</u>** DG described the content of a paper shared with the Board. Full capacity plans are generally used by acute trusts to identify critical issues. Nuffield and NHSI have developed and described this approach to use for a system; it should be indicator driven, rules based approach and have a live dashboard that moves the system automatically through OPEL

	levels. 2 examples of the dashboard were shared with the Board from THIS for CHFT and NHSI. The Board agreed to start to develop a full capacity plan for Calderdale and Huddersfield. Concerns were raised about CHFT data being the principle data for the dashboard as would not ensure system response. **Action: DG to bring proposal of full capacity plan to the Board after initial fact finding; due March** **c) <u>Assurance letter from DOH&SC</u>** The Board was assured that both local authorities responded to the letter and confirm that the capacity they have commissioned for home care and care home was the same or greater than last year.
5. Transformation Updates	
Lead	**DG**
	a) <u>Update from SRG UC Board</u> The SRG UEC Board will focus on transformation of the next 1-3 years. Confirm and challenge has taken place and the programme agreed. HB is the SRO. Seven work stream leads and membership have been identified. The next board meeting is scheduled for February. DG confirmed relationship between A&EDB and UEC SRG will not be direct reporting, but updates will be provided as needed. JP updated on the emerging model for UEC hub which will be looking at different way of triaging at the front door. **Action: UEC hubs to be on agenda at next board with possible start date – JP/MD**
6. WY&H UEC Programme	
Lead	**DG**
	The WY&H UEC programme has been refreshed to provide clarity about purpose and leadership. There are 3 initial work streams WYH UEC; intelligence; integrated models and communication and patient education. There are plans to look at high intensity users and the alignment of board and mental health WYH. DG and VD are representatives for the Board at the WY&H UEC programme and will ensure regular feedback to the Board
7. For information and AOB	
Lead	**CM**
	<u>Additional ICS funding</u> JP confirmed £177,000 has been devolved to A&E Delivery Boards. Agreement that this funding will be allocated to community providers (CHFT and Locala). **Action: JP arrange meeting with relevant partners to discuss allocation of ICS funding** <u>Magpie – behaviour change campaign</u> DG has met with Magpie to discuss campaign to reduce patients attending wrong service.

	Action: Magpie behaviour change campaign to be on agenda for February 2020 meeting
Next Meetings	11th February 2020, Shibden Room, Dean Clough, 12.30-14.00 11th March 2020, Shibden Room Dean Clough, 12.30-14.00

Calderdale & Greater Huddersfield Health Economy
A&E Delivery Board (A&EDB) Action log

No	Minute Ref	Action	Who	Date Due	Update	Status
354	YAS 999	YAS Urgent Care and Communications leads meeting to discuss joint response to members at scrutiny and H&WBB	CB	September 2019	10.12.19 – MB to liaise with JW to complete. Meeting arranged for 8.1.20	Complete
363	UEC	Workforce planning piece to come back to the A&E DB based on the CLEAR system – EK to put on the workplan	MD	Feb 2020	On the work-plan for Feb 2020 meeting.	Complete
397	Performance	IB and AE to consider how it might be possible to collect staff flu uptake data from care homes and home care providers.	IB/AE	December 2019	To remain open to test progress	Open
407	Performance	AE to present Home First proposal and admission avoidance once it has gone through local governance processes, date to be confirmed	AE	February 2020	AE to present proposal at February Board – on agenda	Complete
409	Adoption of Surge and Escalation plan	DG and JP to review all organisations surge and escalation plans to ensure consistency. To also consider trigger numbers on the TOC list as part of this.	DG/JP	January 2020		Complete
411	Description on winter schemes in General practice	HC to confirm within LCD if they can book into overflow hubs and if not help facilitate this	HC	December 2019		Complete
412	Description on winter schemes in General practice	FJ to confirm if LCD can book into the overflow hub appointments	FJ	December 2019		Open
413	Performance	VD to enquire about any issues with GH CCG staff flu uptake in order to maximise uptake.	VD	January 2020	Staff are being offered the flu vaccine at pharmacy below Norwich House.	Complete
414	Performance	MD to provide a breakdown of the characteristics of year-to-date non admitted patients	MD	January 2020	MD and MB have met to discuss	Complete

Enclosure A

No	Minute Ref	Action	Who	Date Due	Update	Status
415	Performance	IB and AE to consider what message of support is needed from the Board to maximise staff flu uptake.	IB/AE	TBC		Complete
417	System Status	DG to send a reminder out for the call tomorrow (11th December). DG to recirculate the dates and times of further calls.	DG	January 2020		Complete
418	System Status	DG/MB to consider data sets already received to understand community pressures – to be brought back to February 2020 meeting as part of development of a Full Capacity Plan	DG/MB	March 2020		Open
419	System Status	FJ bring an update on what a OPEL based approach look like in general practices to February 2020 meeting	FJ	February 2020	On agenda for February meeting	Complete
420	Winter communications	DG to consider when reviewing surge and escalation plans the process of escalate to comms teams	DG	January 2020		Complete
421	Performance	MB to compare flu data from the last 5 years	MB	February 2020		Open
422	Public Health flu update	DG, JO'D and CW to identify links with cohort of flu rates and Surge and Escalation to ensure plans are more robust – due back to Board March	DG/JO'D/CW	March 2020		Open
423	Public Health flu update	HC to provide data from LCD for out of hours flu like symptoms	HC	February 2020		Open
424	Public Health flu update	MB add flu like symptoms to flu update for CHFT to understand rates of patients tested for flu like symptoms	MB	February 2020		Open
425	Transfer Of Care	Calderdale improvement trajectory to be agreed by DG, HB, IB to be reported and agreed at ICE	DG/HB/IB	February 2020	On agenda for February meeting	Complete

No	Minute Ref	Action	Who	Date Due	Update	Status
		on the 17th January and this will be shared at February Board				
426	Transfer Of Care	A&EDB to be sighted on plans for step up and step down capacity (Independent Living Models), in both places (both bed and home based solutions) in March		March 2020		Open
427	Transfer Of Care	HC, HB, MD to discuss issues around LCD rotas	HC, HB, MD	February 2020		Open
428	Full Capacity Planning	DG to bring proposal of full capacity plan to the Board after initial fact finding; due March	DG	March 2020		Open
429	Transformation update	UEC hubs to be on agenda at next board with possible start date – JP/MD	JP/MD	February 2020	This will be agended March 2020	Open
430	A.O.B	JP arrange meeting with relevant partners to discuss allocation of ICS funding	JP	February 2020	Monies and schemes have been allocated	Complete

ORGAN DONATION ENGAGEMENT GROUP MEETING
WEDNESDAY 15 JANUARY, 2020
ICU SEMINAR ROOM, CALDERDALE ROYAL HOSPITAL

MINUTES

Present: Philip Lewer (Chair)
Paul Knight, Clinical Lead, Organ Donation
Jayne Greenhalgh, Specialist Nurse, Organ Donation
Caroline Winkley, Sister, ICU
Cara O'Leary, ST7, Anaesthetics
Malcolm Rogers, Donor Family Representative
Karen Piotr, Ambassador
Kim Maloney, ODP, CHFT
Caroline Wright, Communications Team
Rebecca Johnstone, Admin Team Leader, Operating Services and Critical Care

Apologies: Sarah Whittingham, Nursing Line Manager, Organ Donation
Annette Bell, Governor
Jenny Taylor, Finance

Minutes of the Last Meeting

Any Other Business – A theatre debrief after five organ donations had taken place and went well.

The Trust Board is now aware of the ambassador programme.

Donation Activity

Jayne reported that the group are very proud of everyone who has worked so hard, resulting in us receiving such a good report from NHSBT (see attachment.) We now have a Trust consent rate of 75% and 5 donors enabled 16 transplants. Our Trust is held in quite high esteem with NHSBT. Paul reported that the expectation to have no missed opportunities is quite difficult to maintain and it takes a lot of work to make this the norm. Hopefully the next report will also be a good one. Year to date we have had 13 donors.

Missed Opportunities and Action Taken

Jayne reported that since our last meeting in July, 2019 we had just one area of sub-optimal practice. The case was a young man whose family was approached by an ICU doctor before we were at the stage where we would suggest organ donation and without the SNOD present. Despite this, an approach was made by the Organ Donation Team and the patient became a donor. Paul had a conversation with the colleague concerned to remind them of the need to follow guidelines.

Legislation Change

Jayne reported that the law regarding organ donation is changing in Spring 2020. The government are asking the population to now decide whether to opt in or out of organ donation and doing neither will be seen as deeming consent. The changes are not expected to make a huge difference to donation figures and the SNOD team is currently having training on how to speak to families to

help them make a decision. We are expecting quite a lot of opt outs and there is a worry about the backlash this may cause as the public may see this as the government trying to tell us what to do. Malcolm suggested the Communications Team puts something in the staff newsletter and Karen suggested social media is a good way to contact younger people.

Donor Recognition Funding and Finance

Jenny Taylor from Finance sent an e-mail to Paul (copy attached.) Paul explained that the funds are split three ways. Last year the Organ Donation Committee received £1,550 as a result of the donors we had last year. £3,300 is available at the moment for spending by the Organ Donation Committee.

A patient who died on ICU last year was a sculptor by profession and his family would like to donate one of his sculptures to CHFT, to celebrate the gift of life he gave by organ donation. It has been decided that this will be situated in the main entrance at HRI and Caroline Wright has spoken to the patient's brother, who has said he would like to invite the media to the unveiling of the sculpture. Philip offered the use of his office for lunch on the day of the unveiling.

Caroline Winkley, whose daughter Ava is a recipient, spoke about our funding for Ava to take part in the World Transplant Games last year. Ava won all five events and the family were very grateful for the support they received from our group. The British Transplant Games will be held in Leeds next year and the next World Transplant Games will be held in Texas in 2021.

Jayne reported that Laura did a story about her dad being a donor, which featured in our Trust News. Also, a Trust employee from Estates donated a kidney and has just come back to work this week.

Introduction to Ambassador Programme – Karen Piotr

Karen explained what the ambassador programme is. In Summer 2019 there was a big drive across the Yorkshire region and this recruited 68 ambassadors. These ambassadors have given 173 volunteer hours so far. The volunteers have a Watsapp group and Karen said that if we would ever like an ambassador to help with activities, please let them know. Philip stated that this programme has been very well put together.

Promotional Activity/Organ Donation Week

Organ Donation Week this year is 14 to 19 September. Malcolm suggested that it would be good to try and get more ambassadors – we have two at the moment in our area. Although they are not recruiting at the moment, if we know of anyone who may be interested, please give their details to Malcolm or Karen and they will make direct contact with the people before the next run of recruitment. Communications will publicise this in the Trust newsletter at the time.

It was suggested that we could have a stand in the local park on the day of the Caribbean Carnival. Caroline will speak to communications teams in Kirklees, Calderdale and Bradford. Jayne suggested that we could do this as a joint venture with Bradford.

Operational Matters Escalated from Clinical Areas: ED, ICU, Theatres

Paul asked the link people how organ donation is working. Kim said they always move as much medical equipment out of the room as possible to make it less 'clinical.' This gives the family a little bit longer with their loved one in a more dignified setting. Jayne reported that there is always a

moment's silence in theatres before the process of organ donation begins in our Trust and other hospitals have done a few different things. If circumstances allow, in some hospitals staff line the corridor along the patient's journey to theatre. It is not routinely offered as a service, but it is a nice gesture for the family if we can pay respects to the patient. Malcolm suggested that this could be offered to families so they can take part if they so wish.

Paul reported that one colleague is less than happy about withdrawal in the anaesthetic room, due to a bad experience where the ICU nurse was not in the anaesthetic room at the time. He/she had some concerns as to the approach to maintain comfort and dignity for the patient. Paul stated that if any colleagues are not happy to participate in the anaesthetic room, that is fine and someone else may come to take over whenever possible.

Feedback to Trust Board

Philip reported that he feeds back to the Trust Board after every meeting.

Malcolm reported that he gave a presentation to the Board in Bradford and this was well received.

Policies and Guidelines

Paul reported that, as a group, we can put things in place, whilst not always expecting everyone with views against something to take part. Included in the new guidance is guidance on how colleagues with conscientious objection to aspects of organ donation can be supported without detriment to the donation process. Any staff member who has concerns from an ethical perspective about donation can arrange to talk with the SNOD or CLOD and adjustments can be put in place, if necessary, to make sure that other arrangements can be made to facilitate donation.

Paul apologised for the length of time it is taking to put together the guidelines. Jayne thanked Paul for putting a lot of work into this.

Cara asked whether the ODP needs to stay in the anaesthetic room whilst withdrawal is taking place. Paul replied that they should and that there should also be an ICU nurse present to maintain comfort and dignity for the patient. He said that once death is certified, the patient will go straight into theatre and there must be a senior enough anaesthetist who can confirm death and communicate that with theatre staff, so that donation can commence. The SNOD will also be present.

Review of Governance Structure/ Terms of Reference

Nothing to report.

YODELS

The next course is in Bradford, the next one after that in Mid-Yorks. Paul said that the course serves this Trust enormously well and everyone enjoys it. We need to consider whether two courses a year in West Yorkshire is enough, or whether we need to run more.

Any Other Business

Philip would like to record the thanks of the governors for Paul's attendance at their meeting.

Malcolm stated that there are two meetings taking place which will discuss BAME Outreach. These will take place in Bradford and Leeds on 1 February and 1 March. He said that the Muslim community have requested a big push to opt out. Malcolm asked whether Paul and Jayne would like to be involved in the meetings. He reported that Mansoor Ali has moved to Bradford. Jayne will speak to the SNOD in Bradford.

Malcolm reported that the next Collaborative will be held on 30 April. This meeting is based on opt out and legislation changes.

Date and Time of Next Meeting

The next meeting will take place on Wednesday 15 July, 2020 at 10.30 am in the ICU Seminar Room at Huddersfield Royal Infirmary.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE
Held on Tuesday 18 February 2020, 3.00pm – 5.00pm
Room 4, Acre Mill Outpatients

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Jude Goddard	(JG)	Public Governor
Karen Heaton	(JH)	Non-Executive Director (Chair)
Sharon Senior	(SS)	Staff Side Representative
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Nikki Hosty	(NH)	Freedom to Speak Up/Equality, Diversity & Inclusion Manager (for items 08/20 and 09/20)

01/20 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

02/20 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
Gary Boothby, Director of Finance
Andrea McCourt, Company Secretary

03/20 **DECLARATION OF INTERESTS:**

JG declared her own consultancy business stating there is no conflict of interest.

04/20 **MINUTES OF MEETING HELD ON 10 DECEMBER 2019:**

The minutes of the Workforce Committee meeting held on 10 December 2019 were approved as a correct record.

05/20 **MATTERS ARISING**

- Education Committee

SD advised the first meeting of the Education Committee had taken place on 21 January 2020. Membership comprises of senior colleagues from a range workforce areas across the Trust to ensure a consistent approach to identifying the Trust's learning and development needs. The first draft of the Education Committee Terms of Reference (ToR) had been discussed at the meeting , amendments had been made and the revised ToR were shared with the Workforce Committee for review and approval. The Workforce Committee supported the ToR. The Education Committee will meet on a bi-monthly basis and it was agreed the notes of the Education Committee would be shared with the Workforce Committee along with detailed progress.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the report the Education Committee Terms of Reference.

ACTION: Notes of Education Committee to be provided to Workforce Committee Secretary (LR/SD).

- Improving People Practices

JE provided a verbal update to confirm progress against steps being taken to incorporate the recommendations to enhance practices so that we provide 'one culture of care'. A detailed report will be brought to the next Workforce Committee meeting. In addition a 6-month progress evaluation will be undertaken and shared with the Committee to demonstrate delivery of expected outcomes.

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

ACTION: Progress report to be provided to the next Workforce Committee and 6-month evaluation to be provided late summer (JE).

06/20 **ACTION LOG**

The action log was reviewed and updated accordingly.

07/20 **EQUALITY, DIVERISTY & INCLUSION 5 YEAR PLAN**

NH presented a summary of engagement and activities to date. The Committee noted the steady increase in membership of equality groups and growth in the involvement of colleagues in the development and refreshing of Trust policies and papers. Various means of reaching out to colleagues have been established including a 'CHuFT about Inclusion Facebook Group'. The 'Step in their Shoes' workshops commence in April. NH outlined the joint working with Yorkshire Ambulance Service and West Yorkshire Police to look at best practice. The Talk in Confidence group has merged with Freedom to Speak Up Ambassador group in order to work more cohesively.

JG asked about the approach/response to those speaking in confidence. NH advised that colleagues are made aware from the beginning that talking in confidence would only be to a point when patient care, quality or safety, or safety of a colleague is a concern which is embedded in our one culture of care. Colleagues are encouraged to talk internally and are also made aware of other agencies available.

DS enquired about links with other NHS organisations and sharing best practice in terms of policies, process and initiatives. NH confirmed that she is involved in the regional network groups. KH asked how managers are made aware of their responsibilities. NH advised that she works closely with HRBPs, attends senior team leadership meetings, engages managers in roadshows and encourages involvement in the Step in Their Shoes workshops. SD stated this overlaps with the approach and response to the staff survey results with Divisional management teams taking ownership of plans and activity.

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

08/20 **FREEDOM TO SPEAK UP 2019**

NH gave a detailed presentation which outlined activity in 2019. The data showed an increase in reported concerns from 9 in 2018 to 66 in 2019. The top themes for concern were policies, practices and procedures and attitudes and behaviours. There are 36 Freedom to Speak Up Ambassadors/Talk in Confidence colleagues. Visibility has increased by way of stalls, social media, screensavers, intranet, induction. An online portal supports 24/7, 365 access. NH contacts colleagues within 48 hours or if anonymous, activates an appropriate investigation within 7 days. The presentation illustrated improvements made in 2019 as a result of colleagues raising concerns together with

further recommendations for 2020. JE confirmed that the Trust has the National Guardian's Office endorsement of its approach and response to a speaking up culture.

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

09/20 **WORKFORCE DATA DEEP DIVE: VACANCIES**

MB presented the Trust's vacancy position, updates on hotspot areas and actions taken.

As at 31 January 2020 the Trust had 198.33 FTE budgeted vacancies. The planned position submitted to NHSi in April 2019 showed the Trust would be at 194.55 FTE vacancies at the end of January 2020. It was noted there had been only one intake of new starters in January 2020 which had affected the planned position.

The Trust turnover has further decreased from 8.97% in December 2018 to 7.43% at the end of December 2019, which is a positive improvement and forms part of the Trust's 2019/20 one-year strategy `achieve a retention rate of 90% and reduce vacancies to 5% to address recruitment and retention of key roles in CHFT'.

Medical & Dental and nursing agency spend continues to reduce, as more bank staff are used. Work has been taking place within divisions to move agency doctors on to the internal bank or locum.

The national challenges in recruiting qualified nursing staff are anticipated to continue. Work continues with Corporate Nursing to recruit and develop alternative options. DS asked about the age profile of nurses. The Committee noted a quarter of Trust colleagues are reaching the 55-age range. EA confirmed a 3-year nursing plan is being developed and will consider all nursing and nursing support roles such as nursing associates. The Trust's positive relationship with Huddersfield University was noted.

There is real challenge in competing with other Trusts in ensuring the Trust is the employer of choice. JE reinforced that engagement is key and referenced the importance of The Cupboard.

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

10/20 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) DECEMBER 2019**

Performance on workforce metrics continues to be high although the Workforce domain increased to 87.9% in December 2019. This is now 9 consecutive months of a 'Green' domain.

Only 2 of the 17 metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Medical Appraisals'.

The Staff in Post decreased by 22.17 FTE, which, due, in part, to 23.95 FTE new starters in December 2019. This led to an increase of 22.57 FTE vacancies.

Turnover improved again to 7.43% for the rolling 12-month period January 2019 to December 2019. This is the lowest turnover on record beating the previous lowest achieved in November 2019.

The in-month sickness absence increased to 4.07% in November 2019. The rolling 12-month rate increased for the fourth consecutive time in 18 months, to 3.74%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 26.69% of sickness absence in November 2019, decreasing from 28.77% in October 2019.

The RTW completion rate decreased to 78.1% in November 2019.

Performance has improved in 2 of the core suite of essential safety training. With 9 remaining above the 90% target with 5 achieving the 95% 'stretch' target. Overall compliance fell to 95.13%, above the stretch target for the fourth consecutive month.

Agency spend fell by £0.2M, whilst bank spend increased by £0.09M.

2 of the 5 recruitment metrics reported deteriorated in December 2019. The time to hire for colleagues starting in December 2019 decreased and was just under 13 weeks.

KH asked to see more target detail regarding recruitment time-lines.

Due to the time restrictions in the meeting JE offered to meet with DS and JG to take them through the workforce domain data.

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

ACTION: Provide breakdown of recruitment targets (CN).

11/20 **2019 NHS STAFF SURVEY**

SD presented the headline results. We have maintained our overall position – engagement score of 6.9. The 'one culture of care' approach has received positive comments in the free text area but there is also evidence that this is not being displayed at grass roots.

Key themes are IT/equipment, staffing, management, morale, health & wellbeing, progression, training, patient feedback used to improve services and car parking.

It was noted that 9 questions determine our overall engagement score. A draft corporate activity plan had been drawn up to address the low scoring questions.

SD outlined next steps include divisional plans and a detailed Trust wide action plan and associated communication plan. March onwards to concentrate efforts on focussing improvements, monthly check-in, Performance Review Meetings. Managers to have personal objectives in their appraisal to improve workforce health indicators. Divisional management teams will present progress against activity to the April Board Workshop. A formal presentation will be made to the Board of Directors in May.

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

12/20 **RISK REGISTER – WORKFORCE RISKS**

EST – SD reported that Essential Skills Training is constantly above target at 95%. An action plan is being developed to improve rates in terms of role specific compliance.

The Committee agreed the nursing risk should remain at 20.

DB advised conversations are taking place with regard to the positioning of the medical risk. It is anticipated this overarching medical risk will be closed down with separate risks developed around specific recruitment challenges.

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

13/20 **ANY OTHER BUSINESS**

No other business was raised.

14/20 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Position on ED&I and FTSU
Vacancy Deep Dive
Quality & Performance Report (workforce) – improved performance
NHS Staff Survey

15/20 **EVALUATION OF MEETING**

What went well: Helpful to be quizzed and questioned about workforce matters.

16/20 **DATE AND TIME OF NEXT MEETING:**

20 April 2020:
Hot House: Staff Survey & Quality of Appraisals, 1pm – 3pm, DR1&3, Learning Centre, HRI
Review Quality & Performance Report – Workforce, 3pm – 4pm DR2, Learning Centre, HRI

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Wednesday 26 February 2020

Present: Philip Lewer (Chair), Gary Boothby, Richard Hopkin, Peter Wilkinson, John Gledhill

In attendance: Emma Kovaleski, Carol Harrison, Lyn Walsh (minutes)

Apologies: David Birkenhead, Ellen Armistead, Sheila Taylor, Asif Ameen

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence. R Hopkin declared an interest as treasurer of Calderdale Community Foundation.

2. Minutes of the last meeting
The minutes of the last meeting held on 6 November 2019 were agreed as a true and correct record.

3. Actions and Matters arising
Brand Launch: E Kovaleski updated that work was continuing to raise the profile of the charity, promotional resources have now been delivered, items such as pens, mugs, running vests, donation envelopes and a large cheque for photo opportunities.
Good news stories are being shared and social media platforms are now in place and are actively being used. G Boothby commented that the Exec team had been involved in trying to identify accommodation for the charity in the front corridor of the hospital building. **Action Closed.**

Risk register and strategy update: E Kovaleski presented a paper with updates to the risk register. Questions were raised around risk scores and target risk scores. **Action** R Hopkin to review risk register before it is sent to the Trusts risk committee for sign off. **Action Closed.**

E Kovaleski presented a two year strategy paper showing five key areas. This had been previously shared and discussed; this was presented for the committee to formally approve. This has been an outstanding action on audit recommendations; R Hopkin is to update that this is now complete at the next audit committee. He asked that the audit recommendations were shared outside of the meeting. **Action Approved.**
Action E Kovaleski to circulate Audit Recommendations outside meeting.

Review re consolidation of smaller funds: E Kovaleski reported that funds are continually reviewed. C Harrison explained to the new members the number of funds currently in use and how these had been reduced over the years. G Boothby asked if special purpose new funds could be set up. It was agreed that this could be done with R Hopkin suggesting a level of over £5k to be raised before a new fund was opened. P Wilkinson asked if we get cash handed into departments this was confirmed that we do. There are processes in place but an audit trail and capture of donor details are challenging. Operational updates are being looked at. **Action Closed.**

Healthy minds feedback and bid update: P Lewer updated that he had written to the CCG to get their opinion. The CCG provided positive feedback. There was discussion that the CCG may be able to support in the future instead of further grants being given. **Action: £37.5k grant to be released. Action Closed.**

Business case for bespoke fundraising CRM: A fundraising CRM was discussed, to capture donation data to be used to thank and contact donors. There are costs with this option and it will be reviewed in the future. **Action Ongoing.**

Draft Expenditure policy (Inc. allowable/ non allowable): This is still in draft. E Kovaleski presented the paper. G Boothby asked if the format would be made public. Emma confirmed it will be on the intranet and a page will be added to the cupboard. **Action Supported subject to review by P Lewer.**

4. Quarter 3 2019/20 SOFA and Balance Sheet
C Harrison updated on the quarter 3 position Action noted.
Action: Circulate Report & Accounts 1819 to BOD.

5. Quarter 3 2019/20 Income & Expenditure Summary
E Kovaleski presented the new style paper which put some context behind the numbers. A breakdown of where donations come in has been done which will help with focus in the future. Q4 focus was discussed with digital developments, 3 peaks, and great north run in the pipeline.

6. KPI's 2020/2021
KPI's were discussed, how do we measure success and if fundraising is working. E Kovaleski would like some suggestions on where fundraising can be focused. G Boothby is waiting for feedback from other committee members. **Action:** Process G Boothby, Ellen Armistead, D Birkenhead, E Kovaleski to get together to discuss and circulate ideas in the next 2-3 weeks.

7. A Ormerod sub- committee minutes and bids
G Boothby and C Harrison explained the fund to the new members. The bids from Cllrs Carrigan & Potter were considered. Support was given for Walsden St Peter's Primary School therapeutic room £5.7k and support for an extra day per week from the disability support team £3k. **Action C Harrison to make contact.**

8. Organ Donor Memorials at CRH and HRI
Funding for memorials is approved at £300 value at present. This runs out quite quickly and new approvals have to be sort often. P Lewer agreed that a yearly update to the committee was sufficient.

9. General Purpose funds- bidding process
There was discussion about how bids are made and that we need a proper process in place to evaluate and agree on which are successful. **Action**: G Boothby & E Kovaleski to make suggestions and discuss with E Armistead and D Birkenhead.
G Boothby reported that there are possible bids for staff costs in certain areas that would be worth consideration for 12 month periods. **Action** G Boothby to try to get agreement and share outside of the meeting.

10. General Surgical fund - proposal
E Kovaleski presented the paper on behalf of general surgery for feedback from the committee. After discussion it was decided that this didn't meet charitable funds criteria. **Action:** E Kovaleski to feed back to general surgery.

11. Minutes from the staff lottery committee held on 3 December 2019.
For information only action noted.

12. Any Other Business
C Harrison updated that the second payment to Age Concern Todmorden had been made.

E Kovaleski updated that she was involved in other commercial sponsorship (CHuFT).

J Gledhill and the other new members said they liked the function of the committee and were surprised at how much was involved.

15. Date and time of next meeting
27th May 2020 at 14.00 – 15.30 Room Group Therapy Room Acre Mills

CHARITABLE FUNDS COMMITTEE MEETING
26 February 2020
Action Log - 2019/20

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	26.02.20	Audit recommendations to be circulated outside meeting.	**EK**	Mar-20	
Budget Proposal	26.02.20	Business case for fundraising CRM. Update Feb 20 review in future	**EK**	Jan-21	ongoing
Q3 SOFA & BAL SHEET	26.02.20	Circulate Final Accounts 1819 to Board.	**CH**	Mar-20	
KPI's	26.02.20	Process & Measures review	**GB/EK/ EA/DB**	Mar-20	
A Ormerod sub- committee minutes and bids	26.02.20	Confirm approval of bids.	**CH**	Mar-20	
General Purpose funds - bidding process	26.02.20	Bidding process to be discussed and agreed outside of the meeting.	**GB/EK/ EA/DB**	Mar-20	
General Purpose funds - bidding process	26.02.20	Bids re salaries to be discussed outside meeting.	**GB**	Mar-20	
General Surgery Charity proposal	26.02.20	General Surgery proposal declined. Feedback to be given to Division	**EK**	Mar-20	

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 3:30 PM ON THURSDAY 23 JANUARY 2020 IN DISCUSSION ROOM 1, LEARNING CENTRE, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Philip Lewer	Chair

Public Elected Governors

Lynn Moore	Public Elected - North and Central Halifax
Paul Butterworth	Public Elected - East Halifax and Bradford
John Gledhill	Public Elected – Lindley and the Valleys
Sheila Taylor	Public Elected - Huddersfield Central
Christine Mills	Public Elected - Huddersfield Central

Staff Elected Governors

Linzi Smith	Staff Elected – Management / Admin / Clerical
Dr Peter Bamber	Staff Elected – Drs / Dentists
Sally Robertshaw	Staff Elected – Allied Healthcare Professionals (AHPs)

Appointed Governors

Prof Felicity Astin	University of Huddersfield
Cllr Lesley Warner	Kirklees Metropolitan Council

IN ATTENDANCE:

Helen Barker	Chief Operating Officer
Kirsty Archer	Deputy Director of Finance
Ellen Armistead	Director of Nursing
Karen Heaton	Non Executive Director
Peter Wilkinson	Non Executive Director
Alastair Graham	Non Executive Director
Andrea McCourt	Company Secretary
Jackie Ryden	Corporate Governance Manager (minutes)
Vanessa Henderson	Membership and Engagement Manager

01/20 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Veronica Woollin	Public Elected - North Kirklees
Helen Hunter	Healthwatch Kirklees and Calderdale
Owen Williams	Chief Executive
Alison Schofield	Public Elected - North and Central Halifax
Stephen Baines	Public Elected - Skircoat and Lower Calder Valley
Annette Bell	Public Elected – East Halifax and Bradford
Brian Richardson	Public Elected - Calder and Ryburn Valleys
Chris Owen	Public Elected – South Kirklees
Dianne Hughes	Public Elected - North Kirklees (Reserve Register)
Jude Goddard	Public Elected – Calder and Ryburn Valleys
Sian Grbin	Staff Elected – Nurses/ Midwives

Rosie Hoggart	Staff Elected – Nurses/ Midwives
Chris Reeve	Locala
Jayne Taylor	Calderdale and Huddersfield Solutions Ltd (CHS)
Cllr Megan Swift	Calderdale Metropolitan Council

02/20 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors and staff colleagues to the meeting. The Chair thanked Vanessa Henderson for attending.

03/20 DECLARATIONS OF INTEREST

The Chair reminded the Council of Governors and staff colleagues to declare their interest at any point in the agenda.

04/20 MINUTES OF THE LAST MEETINGS HELD 17 OCTOBER 2019 AND EXTRAORDINARY MEETING HELD 22 NOVEMBER 2019

The minutes of the previous minutes held 17 October 2019 and 22 November 2019 were approved as a correct record.

OUTCOME: The minutes of the previous meeting held 17 October 2019 and 22 November 2019 were **APPROVED** as a correct record.

05/20 MATTERS ARISING / ACTION LOG

The action log was reviewed and updated and the following updates were noted.

Membership and Engagement Strategy – The Company Secretary confirmed that the £2,000 in the budget to support the Membership Engagement Strategy will mainly be allocated for promotional material.

Finance report to include a breakdown of figures for agency plus bank by division - following the meeting, the Deputy Director of Finance confirmed that specific divisional detail has been provided directly to Dr Peter Bamber who raised the question.

Paul Butterworth thanked Gerard Curran, the Head of Complaints for meeting with him and for taking the action forward. PB noted that there is still one outstanding issue in relation to the complaints procedure on the internet.
Action: Chair to write letter of thanks to Gerard Curran.
Action: Company Secretary to discuss and clarify with Gerard Curran the link on the internet to the procedure.

06/20 COMPLAINTS AND COMPLIMENTS PRESENTATION

The Director of Nursing gave an update on the handling of complaints following the review of complaints that was undertaken by the Chief Executive in May/June 2019. A number of issues were identified within the process and the way complaints were being handled.

Following the review, work was undertaken to encourage the resolving of complaints at source to reduce the number of complaints and to provide support to the staff who are investigating complex complaints.

A great deal of progress has been made but there is still work to be done. A Work Together Get Results session took place and responses were identified to achieve the desired result. Further work is required to ensure that learning is shared from complaints in exactly the same way as learning from incidents is shared.

Councillor Lesley Warner asked if the weekly drop in session was open to members of the public but EA confirmed it is to support colleagues investigating complaints rather than the public.

Paul Butterworth explained that he had undertaken a cold call exercise and found that members of the public are not always given the same information when they enquire about the complaints process which he believes means that the statistics provided in EA's presentation are not correct.

EA advised that up-dated posters had been distributed the previous week and that all colleagues should now have the same information. EA expressed her gratitude to PB for sharing his concerns and remarked that this has driven some changes in the organisation. Visits to ward areas will check that all colleagues are aware of how to signpost people in the right direction. PB will be undertaking a further cold call exercise and will also be meeting with EA in the next few weeks.

AG asked if an analysis is going to be provided on any themes emerging from the complaints and EA advised this would be addressed in the quality report later in the meeting.

The Chair thanked the Director of Nursing for her update and thanked Paul Butterworth for his tenacity. The Chair added that he has also participated in one of the weekly cold calls to wards when he visited the oncology ward with Ellen Armistead and Denise Sterling.

OUTCOME: The Council of Governors **NOTED** the update on Complaints Handling.

07/20 PERFORMANCE AND STRATEGY

a) Performance Report
The Chief Operating Officer reported a positive position for November 2019.
The main points to note were:

- There are no domains that are red and the overall performance score was 75% which indicates a balanced performance, although this does mask one or two areas of concern, in particular the emergency care standard. This has been a struggle all year, both locally and nationally. CHFT are in the top quartile for performance but HB stated that we still have a firm commitment to improve.
- There has been focus around the exceptionally high number of patients on the transfer of care list and more escalation capacity than planned has been opened.
- A&E attendances since November have been high, with the paediatric service in particular being under pressure.

- The Same Day Emergency Care (SDEC) for Frailty has been opened and is working well, leading to improved performance and helping patients get home more quickly.
- Exceptional performance on cancer continued to be delivered in November and the position is very positive, providing a positive experience for patients. There is a cohort of patients who have not been diagnosed at 62 days which the team are working through. Increasing numbers of cancer referrals are coming in. From 1 April 2020 there will be a new standard for referral to confirmed diagnosis within 28 days. It is believed the target will come in at 70% and the Trust is already exceeding that figure.
- Diagnostic performance was better overall in November and the Trust was just short of achieving 99%. The backlog for Echocardiographs is now clear but the date for Neurophysiology to be clear has been extended to March in order to support the team in that area.
- Stroke performance is going well but there is some pressure on bed availability and there is a cohort of patients with a long length of stay.

The Chair asked about the numbers of patients who are discharged late in the night as this had been raised in the Private Board meeting. HB explained that these are tracked and that the Trust would not knowingly discharge a vulnerable patient at this time without the support of their family, although there are some patients who come through the frailty route who might be discharged in order to avoid having to sit in a cubicle. HB will investigate if she is provided with any specific details.
Action: Christine Mills will raise the issue at the next Quality Committee meeting.

Paul Butterworth asked how many patients are discharged under Continuing Healthcare. HB confirmed that she will aim to provide this information within 10 working days.
Action: HB to provide the number of patients discharged under Continuing Healthcare to Paul Butterworth within 10 working days.

Dr Peter Bamber asked about the statistics under the responsive domain for referral from screening to treatment. HB explained that as the figures are low, averaging 10 patients per month and where one patient chooses to wait longer, this impacts on the target and she is not overly concerned about this.

Professor Felicity Astin asked about the staffing and the average fill rate for care staff compared to registered nurses, with particular reference to Neonatal care and ICU. HB explained that this is in line with the Hard Truths safe staffing level.
Action: EA will investigate and provide clarification back to FA.

OUTCOME: The Council of Governors **NOTED** the performance and strategy report for November 2019.

b) Financial Position and Forecast – Month 8

The Deputy Director of Finance summarised the key points from the Month 8 position:

- The year to date deficit is £8.67m, a 0.24m favourable variance from plan due to gain on the disposal of property. This benefit is excluded for the purposes of

allocation of Provider Sustainability Funding/Financial Recovery funding. The planned deficit for the year end is £9.7m.

- YTD month 8 is in line with the financial plan and noted that gains from property are not counted by regulators
- There is some pressure year to date due to higher than planned non pay expenditure including utilities, maintenance contracts, outsourced services and lower than planned VAT recovery. These pressures have been offset year to date by lower than planned pay expenditure, although for the last three months pay has been slightly overspent due to Medical pay awards and pressure from additional capacity.
- Agency expenditure is lower than plan. This is offset by 'Bank' expenditure.
- Cash balance is higher than planned which is due to a timing issues and will be in line with plan by the year end.
- CIP is in line with plan year to date.
- All metrics are where they need to be.
- Recovery and restraint plans were put in place earlier in the year and have identified the full recovery requirement.

The Chair advised that if any of the Governors would like anything raised at the Finance and Performance Committee meeting they should liaise with their governor representative on the Committee Sian Grbin or contact either Stephen Baines as Lead Governor or the Chair himself.

Following a query from Dr Peter Bamber, the Deputy Director of Finance confirmed that the figures include Calderdale and Huddersfield Solutions Limited.

OUTCOME: The Council of Governors **NOTED** the Month 8 Financial Summary.

c) 2020/2021 Planning Overview Presentation

The Deputy Director of Finance presented the timeline and details for the five year plan. The plan was submitted to the Integrated Care System (ICS) in October 2019 and the Trust is now working on building up the details. KA explained that the expected key national planning guidance has been delayed and has still not been received but is expected during the last week in January 2020. The submission timetable has therefore been moved back to early March, with the operational plan potentially due in April 2020.

In the five year plan the control totals will be removed and replaced with financial improvement trajectories (FIT). The allocation of Financial Recovery Funding (FRF) will then take the position to break even in each year.

A greater proportion of the FRF allocations will be linked to achievement of system FIT. This is the total of individual organisation targets across the Integrated Care System (West Yorkshire). Following a query from Dr Peter Bamber, the Deputy Director of Finance explained that it is hoped this might encourage organisations to work more closely together.

The Trust's FIT for 2020/21 is in line with the financial modelling of the Strategic Outline Case (SOC) for reconfiguration with an expected 0.5% annual improvement thereafter, a less challenging trajectory than the SOC.

KA gave a breakdown of the Financial Improvement Trajectories over the next five years. The efficiency target for the Trust is quite stretching but the Trust had agreed to the target.

KA added that the assumption going forwards is that the aligned incentive contract with the CCGs remains in place, and that the contract level from this year will be used as a baseline for negotiations.

The CIP requirement is likely to be in excess of £14m dependent on the level of pressures and developments funded.

The cash plan assumes FRF will be received from 2020/21, short term borrowing is still required to bridge timing differences on receipt of FRF cash payments.

PB asked if the figures included the cost of the new build and updating of the old buildings. KA explained that these have not been budgeted for, but that reconfiguration will not take place in the period related to the slides. KA added that some of the buildings have already been sold and some are still due to be sold.

Councillor Warner asked about vacancies and whether the money is retained to fill the vacancies. KA confirmed that the money is retained as the model assumes full staffing

PB asked whether finances are more stretched due to changing demographics and KA explained that we receive uplifts for expected pricing changes and growth monies from commissioners which are offset in part by efficiency requirements.

It is planned to hold another capital planning session in 2020 to prioritise plans within the available resource.

Following a question from Dr Bamber, KA confirmed that the figures include planned pay rises. Dr Bamber also asked if there is a budget for replacement of IT equipment, and KA explained that this comes through the capital plan.

The Chief Operating Officer added that a detailed paper had been prepared on the capital plan. This will be circulated to the Governors as soon as possible, and any questions are to be emailed to Stephen Baines or Philip Lewer.
Action: Company Secretary to circulate the detailed paper on the Capital Plan to the Governors.

OUTCOME: The Board **NOTED** the timeline and details for the Five Year Capital Plan.

d) Q3 Update on Quality Priorities and Quality Report Presentation

The Director of Nursing presented an update on the quality priorities. EA asked if Christine Mills could consider what the quality report should include going forwards and she will arrange a meeting to discuss.
Action: EA to meet with Christine Mills to discuss the content of the quality report.

EA explained that the Trust has quite a comprehensive quality governance structure in place but some amendments are to be proposed in order to ensure that no groups are duplicated and there are no gaps. Focus is needed to ensure learning is shared, including the learning from positive events as well as adverse events.

EA gave an update on the Healthcare Safety Investigation Branch (HSIB) who look at designated incidents, including maternity, in order to identify national learning. Four of five maternity investigation reports from HSIB have been received and the final report is awaited.

There have been 13 inquests and 8 of these have been closed.

The Trust is seeing improvement and a downward trend in pressure ulcers. Essential skills training is currently at 96%, which is an excellent performance. The safety thermometer measures are currently around average, and we are seeing a decrease in the number of falls with harm.

Areas for improvement include the recording of dementia screening and issues around the prescribing and storage of medicines.

The current quality account priorities are ED waiting times, the deteriorating patient and mental health in ED, which is a national issue. The mental health strategy is almost ready for approval and EA has also asked for an independent review into this.

The CQC Response Group continues to meet and work on the journey to outstanding. The assessment process has been reviewed and is now more rigorous. The Trust Board is currently going through a well led assessment.

Current quality priorities are focusing on outpatients, patient flow, maternity services, lessons learnt, complaints and medicine safety.

Christine Mills reported that at the last meeting, the Quality Committee had been advised of increase awareness of reducing antibiotics and the amount of plastic used.

OUTCOME: The Council of Governors **NOTED** the update on the quality account priorities.

e) Membership Strategy and Update

The Company Secretary reported that the draft Membership and Engagement Strategy for the next three years was shared with governors at the Council of Governors meeting on 17 October 2019. The current report details the preparatory work that has been undertaken to develop a comprehensive action plan to achieve the goals in the one year Membership and Engagement Strategy for 2020/21.

The Chair will be writing to partners to request their help in increasing membership in among younger people and in the areas which are hard to reach. The development of a patient panel is also being considered. Vanessa Henderson is working with Jude Goddard on further engaging with the public and a pilot training session is being held soon on skills to help governors engage with the public and members.

AG asked if the public engagement sessions for the design brief were being used for engagement with the public regarding membership. Vanessa Henderson advised that the first tranche of meetings had very specific agendas but that she will liaise with the Communications team to use the opportunity going forwards.

OUTCOME: The Council of Governors **APPROVED** the Membership and Engagement Strategy and **NOTED** preparatory work that has been undertaken to develop a comprehensive action plan to achieve the goals in the one year Membership and Engagement Strategy for 2020/21.

f) Risk Register

The Council of Governors received the current high level risk register for the Trust.

OUTCOME: The Council of Governors **NOTED** the current high level risk register for the Trust.

UPDATE FROM COUNCIL OF GOVERNORS SUB-COMMITTEE

08/20 Nominations and Remuneration meeting held on 13.1.2020

The Chair reported that a meeting was held on 13 January 2020 where the Deputy Director of Workforce and Organisational Development presented a paper setting out a new pay structure for Chairs and Non-Executive Director for NHS Trusts and NHS Foundations Trusts, as detailed in NHS Improvement (NHSI) implementation guidance issued in September 2019 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts'. The Chair advised that he had left the meeting while this item was discussed. There will be minor implications for the Trust as a result of the new pay structure.

OUTCOME: The Council of Governors **APPROVED** the minutes of the Nominations and Remuneration Committee meeting held on 13.1.20.

09/20 CHAIR'S UPDATE

The Chair congratulated the Chief Executive on his recent award of an OBE in the New Year's Honours List for services to healthcare in West Yorkshire.
The Chair also advised that Amber Fox had recently given birth to a baby girl and that mother and daughter were doing well.

The Chair reported that he continues to meet with Chairs from other Trusts. He has also spent half a day in the Appointments Centre at HRI and will shortly be attending the CHFT induction day for new starters.

OUTCOME: The Council of Governors **NOTED** the Chair's Update.

GOVERNANCE

10/20 Update from Lead Governor

he Chair gave a brief summary of discussions held with the Lead Governor and actions they have agreed. PL will incorporate this into an email and send out to

governors. In summary, they have agreed that for the Board of Directors meetings priority will be given to the invited governors but any governor is welcome to attend, and that two hard copies of the papers will be printed for use at the meeting. It was also agreed that any questions posed during meetings by the governors will be noted and a response sent out in a timescale agreed at the time. PL has agreed to share confidential information with the Lead Governors in advance of the meetings.
Action: The Chair to email the governors with an update on the actions agreed between himself and the Lead Governor.

OUTCOME: The Council of Governors **NOTED** the Update from the Lead Governors presented by the Chair.

11/20 COMPANY SECRETARY'S REPORT

a. Proposal for 2020 Governor Elections

The Company Secretary reported that we do not yet have a timetable for the Governor elections in 2020 as we are currently evaluating which provider to procure to undertake the election process on the Trust's behalf, as it is a requirement to use an external company. It was confirmed that there are 12 governor vacancies for election during 2020: 8 public governors and 4 staff governors which is a high number of vacancies and therefore engagement with members and the public is key to generate interest in the vacancies.

The elections timetable will be presented to the April Council of Governors meeting for approval.
Action: Elections timetable for 2020 to be presented to the April Council of Governors Meeting.

OUTCOME: The Council of Governors **NOTED** the12 vacancies for election during 2020, **APPROVED** the support and involvement of governors in activities to generate interest in the governor role during the run-up to the elections, **NOTED** that there may be a change to the provider of our election services in 2020 and **NOTED** that the elections timetable will be presented to the April Council of Governors meeting for approval

b. Selection of 2020/2021 Quality Priorities

The Company Secretary confirmed the six quality priorities for 2020/21 that governors agreed for further consideration and the process for selection of the final three quality priorities.

OUTCOME: The Council of Governors **NOTED** the proposed quality priorities for 2020/21 and the process for selecting the final three priorities from the six shortlisted at the Governors workshop in December 2019.

12/20 NON EXECUTIVE DIRECTORS

Peter Wilkinson, Karen Heaton and Alastair Graham gave a brief introduction including their background and their current focus in their role as a Non Executive Director.

Peter Wilkinson joined the Trust in November 2019 and has been working on the following:

- Chair of the Transformation Programme Board; there have been two meetings held so far with another meeting scheduled for 27 January 2020.
- Member of Finance and Performance Committee chaired by Richard Hopkin.
- Member of Charitable Funds Committee and Joint Liaison Committee.

Karen Heaton updated the governors on the recent hothouse sessions on the staff survey and well-being. Both were well attended by a range of staff. A warm welcome would be given to any governor who would like to attend and support the sessions. The Workforce Committee meetings have recently been spending time on performance measures, sickness, slippage on return to work and the need to understand the reasons behind the data on staff turnover. Recruitment of consultants is going well and KH explained that many of the newly recruited consultants are attracted to the Trust based on our values. Work is on-going on diversity and inclusion.

There was a discussion about the difficulties of interviewing when only one applicant is selected. Linzi Smith asked if there was an on-going trend emerging from the exit interviews. KH advised that this had been investigated the previous year but it is possible to re-visit to identify if there are any further trends.
Action: Karen Heaton will arrange for the information from exit interviews to be re-visited at a future Workforce Committee meeting.

KH confirmed that any all governors are welcome to attend the Workforce Committee meetings if they wish.

Councillor Warner enquired if the high turnover of HCAs could be related to pay. KH advised that there could be a multitude of reasons rather than solely due to the pay. Linzi Smith also wondered if the paediatric staffing issues could also be pay related.

Dr Bamber explained that staff considering such ancillary posts have e many work options outside of the NHS, unlike doctors. The fact that the NHS is considered to be a stressful place to work may also put people off applying for posts. KH stated that more work is still required to ensure CHFT is considered a good place to work.

FA pointed out that information could be gleaned from asking colleagues what would make them stay rather than asking why they are leaving.

Alastair Graham chairs a number of interview panels and advised that user panel feedback is extremely valuable in making a decision. There is not always just one candidate and even when that is the case there is still a robust interview process for a candidate.

AG advised he is the Chair of Calderdale and Huddersfield Solutions Limited, which provides estates and facilities mainly on the HRI site but some procurement services also for the CRH site. AG also sits on the Research and Innovation Committee and the Transformation Programme Board.

13/20 UPDATES FROM SUB-COMMITTEES

Time constraints precluded discussion of this agenda item.

14/20 INFORMATION TO RECEIVE

a. Council of Governors Calendar 2020

The Council of Governor's calendar of meetings for 2020 was circulated for information. This includes all governor meetings, workshops and Divisional Reference Groups.

OUTCOME: The Council of Governors **RECEIVED** the updated Council of Governors Register and Calendar for 2020.

15/20 ANY OTHER BUSINESS

AM advised that the Trust is currently undertaking engagement regarding the Digital Strategy and was keen to involve governors. Options to discuss the draft Digital Strategy were discussed with several 90 minute sessions being held that governors could attend or a shorter presentation at the Council of Governors workshop on 13 February 2020. It was agreed that the invites to the 90 minute sessions would be sent to all governors as well as a shorter slot to be added to the 13 February 2020 workshop agenda.

Christine queried whether old laptops could be made available for governors and it was advised that we will look into this.

DATE AND TIME OF NEXT MEETING

The Chair thanked the Council of Governors, Non-Executive Directors and Executive Directors for attending the meeting. The Chair formally closed the meeting at 17:42pm and invited members to the next meeting.

Council of Governors Meeting
Date: Thursday 23 April 2020
Time: 3:30 – 5:30 pm (private meeting 2:00 – 3:15 pm)
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

25. Any other business

26. Date and time of next meeting

Thursday 7 May 2020, 9:00 am

Venue: Boardroom, Huddersfield royal Infirmary

27. Close