Public Board of Directors

Schedule	Thursday, 6 Sep 2018 9:00 — 12:00 BST
Venue	CRH - Large Training Room, Learning Centre
Organiser	Amber Fox

Agenda

9:00	1. Welcome and Introductions To Note - Presented by Philip Lewer
9:01	2. Apologies for absence: Helen Barker (Bev Walker representing) Karen Heaton Mandy Griffin To Note
9:02	3. Declaration of Interests To Note
9:03	4. Minutes of the previous meeting held on 5 July 2018 To Approve DRAFT - PUBLIC BOD MINS - 5.7.18 v2.docx
9:08	5. Action log and matters arising For Review APP B - ACTION LOG - BOD - PUBLIC - as at 5 July 2018.docx
9:13	6. Chairman's Report a. Annual General Meeting Minutes – 19.7.18 b.Council of Governors Election Results To Note - Presented by Philip Lewer AGM Minutes - 19.7.18 v2.docx
9:18	7. Chief Executive's Report a.Response to the Secretary of State To Note - Presented by Owen Williams

9:28	8.	Patient/Staff Story: Flu Campaign Patient Story (Video) - Katie Berry To Note
9:38	9.	High Level Risk Register To Approve - Presented by Jackie Murphy High Level Risk Register .pdf High Level Risk Register - Appendix - FINAL High Level Risk Register summary- August 2018 - board summary.pdf
9:43	10.	Winter Plan 2018 Presentation To Approve
9:53	11.	Resilience & Security Management Final Report To Approve Resilience & Security Management Report June17 - April18.pdf Resilience & Security Management Report June17 - April18 - Appendix - CHFT SRM Final Report Draft 2018.pdf
10:03	12.	Local Health Resilience Partnership (LHRP) Core Standards To Approve NHS England Emergency Preparedness, Resilience And Response (Eprr) National Standards Annual Submission.pdf NHS England Emergency Preparedness, Resilience And Response (Eprr) National Standards Annual Submission - Appendix - Local Health Resiliance Partnership (.pdf
10:13	13.	Director of Infection, Prevention and Control Annual Report To Approve - Presented by David Birkenhead Quarterly DIPC Report.pdf Quarterly DIPC Report - Appendix - Quarterly DIPC Report 31st July 2018.pdf

10:23	14.	West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding To Approve - Presented by Victoria Pickles West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding.pdf West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding - Appendix - Combined - WY and Harrogate Health and Care Partnership .pdf
10:33	15.	Governance Report a. Constitutional Changes b. Deputy Chair / SINED Appointment c. Use of Trust Seal d. Board Workplan To Approve - Presented by Victoria Pickles Governance Report .pdf Governance Report - Appendix - Governance Report.pdf
10:43	16.	Quality & Performance Report – July 2018 QUALITY & PERFORMANCE REPORT .pdf QUALITY & PERFORMANCE REPORT - Appendix - Integrated Performance Report - July 18.pdf
10:53	17.	Data Quality Assessment To Note DATA QUALITY ASSESSMENT .pdf DATA QUALITY ASSESSMENT - Appendix - Data Quality Assessment.pdf
11:03	18.	Annual Fire Report To Approve - Presented by Lesley Hill CHFT Annual Fire Report 2018.pdf CHFT Annual Fire Report 2018 - Appendix - CHFT Annual Fire Report 2018Final.pdf
11:13	19.	Month 4 Financial Summary To Approve - Presented by Gary Boothby Finance Headline Message - Month 4 .pdf Finance Headline Message - Month 4 - Appendix - Board of Directors Financial summary Month 4.pdf

11:28	20.	Calderdale and Huddersfield Solutions Update To Note - Presented by Gary Boothby
11:38	21.	Revalidation and Appraisal of Non Training Grade Medical Staff To Approve - Presented by David Birkenhead Revalidation and Appraisal of Non Training Grade Medical Staff .pdf Revalidation and Appraisal of Non Training Grade Medical Staff - Appendix - Revalidation - Board of Directors - September 2018 Final.pdf
11:48	22.	Workforce Race Equality Standard (WRES) Report To Note - Presented by Suzanne Dunkley Workforce Race Equality Standard (WRES) Report.pdf Workforce Race Equality Standard (WRES) Report - Appendix - BoD 6 September 2018 - WRES Report.pdf
11:58	23.	Quality of Appraisals To Note - Presented by Suzanne Dunkley Quality of Appraisals.pdf Quality of Appraisals - Appendix - BoD 6 September 2018 - Quality of Appraisals.pdf

12:08 24. Update from sub-committees and receipt of minutes & papers

•Audit & Risk Committee – minutes from meeting 11.7.18
•Quality Committee – minutes from meeting 2.7.18 & 30.7.18
•Finance and Performance Committee – minutes from the meeting 29.6.18, 31.7.18 and verbal update from meeting 31.8.18
•Charitable Funds Committee – minutes from meeting 28.8.18
•Council of Governors – minutes from meeting 4.7.18 & 19.7.18
•Workforce Committee - minutes from meeting 10.07.18

To Note

CHFT Draft ARC Minutes July 18 v2.docx

FINAL Quality Committee Minutes (2 July 2018) (Approved by QC on 30 July 2018).docx

App A - DRAFT Quality Committee Minutes (30 July 2018).docx

APP A - Draft Minutes of the FP Committee held 290618.docx

APP A - Draft Minutes of the FP Committee held 310718 v2.docx

Charitable Funds - Minutes of previous meeting - DRAFT - Appendix - Minutes 28 August 2018.pdf

A. DRAFT MINS - CHFT Council of Governors Meeting - 4.7.18 v2.docx

A. DRAFT MINS - CHFT Council of Governors Meeting - 19.7.18 v2.docx

10 July 2018 draft WC minutes.pdf

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25. Date and time of next meeting

Thursday 1 November 2018, 9:00 am (Public)
Venue: Large Training Room, Calderdale Royal Hospital

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1. Welcome and Introductions

To Note

Presented by Philip Lewer

2. Apologies for absence:

Helen Barker (Bev Walker representing)

Karen Heaton

Mandy Griffin

To Note

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 5 July 2018

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 5 July 2018 at 9am in the Large Training Room, Calderdale Royal Hospital

PRESENT

Philip Lewer	Chairman
Owen Williams	Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance and Procurement
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Richard Hopkin	Non-Executive Director
Jackie Murphy	Chief Nurse
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director

IN ATTENDANCE

Amber Fox	Corporate Governance Manager
Mandy Griffin	Managing Director Digital Health
Victoria Pickles	Company Secretary
Cornelle Parker	Deputy Medical Director
Lindsay Rudge	Deputy Chief Nurse (for item 112/18)
Gavin Boyd	Consultant Microbiologist (for item 112/18)
Anu Rajgopal	Consultant Microbiologist and Guardian of Safe Working (for item XX)
Elaine Brotherton	Patient Safety Quality Lead, Families and Specialist Services Division
Anne-Marie Henshaw	Assistant Director of Nursing, Families and Specialist Services Division

OBSERVERS

Brian Moore	Lead Governor
Dr Peter Bamber	Staff Elected Governor
Azizen Khan	Assistant Director of Human Resources

102/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

103/18 APOLOGIES FOR ABSENCE

Apologies were received from:
Anna Basford, Director of Transformation and Partnerships
Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Dr David Birkenhead, Medical Director

104/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

105/18 MINUTES OF THE MEETING HELD 7 JUNE 2018

The minutes of the previous meeting were approved as a correct record subject to the following amendment on page 7;

'The visit by Deloitte was on **20** February 2018 to assess the Trust's self-assessment on digital maturity.'

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

106/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

97/18 – The action around the Health and Safety annual report is deferred and will be part of the Board workshop on 17 July.

The minutes from the meeting held 23 May will be approved at the meeting in September.

13/18 Guardian of Safe Working – Additional administrative support has been identified with a team now assisting the Guardian of Safe Working.

107/18 CHAIR'S REPORT

a. Council of Governors Meeting – 4.7.18
The Chair provided feedback from the Public Council of Governors' meeting held 4 July 18. The meeting was lengthy and a decision has been made to hold a further brief meeting before the Annual General Meeting on 19 July 2018 to discuss staff membership relating to the Wholly Owned Subsidiary.

b. Council of Governors Election Results
The Company Secretary advised the results from the election have been received and all seats up for election have been filled. The results will be shared at the Annual General Meeting taking place on 19 July 2018.

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

108/18 CHIEF EXECUTIVE'S REPORT

a. NHS Confederation - Health and Social Care to the 2030
The Chief Executive declared he is a Trustee and Vice Chair of the NHS Confederation and has circulated the Executive Summary from the Confederation. This executive summary was produced to help stimulate the 10 year forward view.

It was noted that the report is focused in particular on improvements in productivity in the NHS, showing an annual growth around 4%. At the moment annual growth is 3.6% in year 1 and 3.4% in year 2. The report also suggests a funding challenge for the NHS going forward with no declaration around Social Care funding.

The Chief Executive made reference to the comparison of 2015 to 1997 data around inpatient admissions which relates to the response from Independent Reconfiguration Panel.

The Chief Executive highlighted capital spending is moving towards more of a Digital agenda in the next few years and where the capital opportunities are in the future as the Trust describe themselves digitally.

It was noted the Government will receive pressure from Higher Education over the next 5-10 years.

OUTCOME: The Board **NOTED** the Health and Social Care to the 2030s Executive Summary.

b. CQC Report
The Chief Executive highlighted the CQC rating of the Trust as 'Good' overall following the inspection earlier this year. The Chief Executive thanked staff, colleagues, partners, the public, the role of the Governors and the Board for the outstanding continued effort.

The CQC prepared for 10-50% of those Trusts that were already designated as 'Good' or

'Outstanding' to go backwards under the new regime.

The Chief Executive highlighted the importance of celebrating this great moment of the CQC 'Good' rating and the real achievement it reflects.

The Chief Nurse described the next steps regarding the action planning process on the back of the CQC report where there are a number of 'must do' and 'should do' actions. A number of CQC briefing events have taken place and those who have attended are very proud of their contribution.

There will be a lessons learned paper on the back of feedback from everyone who contributed in the visit from being prepared for the visit or providing data.

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

109/18 PATIENT/STAFF STORY

The Chair welcomed Elaine Brotherton and Anne-Marie Henshaw to the meeting. Elaine provided a presentation on a comparison of complex investigations pre and post the implementation of the maternity EPR. She described how the system enables records to be clearly tracked and that some of the benefits are:

- Reduction in number of records to review when investigating an incident/complaint
- Legible and easy to assign to a clinician
- Multiple access for users – more than one professional reviewing records at any one time e.g. statement writing
- Investigations can be carried out within recommended timescales
- Ease of review with families – look professional, records are legible
- Mitigated risk relating to potential falsification of records e.g. accusations of falsifying records after the event – different pens used

Linda Patterson asked if patients are able to access their maternity records. Anne-Marie Henshaw explained that the maternity services had won a national NHS Digital bid to fund the module for patients to access their notes. This module will go live mid-September and patients will be able to access their notes via smartphone or tablet.

Alastair Graham asked if there were any plans to link the maternity record into Cerner EPR. Anne-Marie Henshaw explained lots of work has taken place over the previous 12 months looking at the functionality in Cerner in comparison to the current K2 Athena system. A decision had been made to continue with the current system for a further two years. This will be reviewed again at the end of the contract however there are currently no risks of running the two systems. Anne-Marie Henshaw highlighted the ambition between West Yorkshire and Harrogate to have one Maternity EPR.

Andy Nelson asked if there is any difference to patient outcomes. Anne-Marie explained that the previous paper based audits were time consuming. Records can now be collated within a day patterns in data more easily identified. Maternity can now audit in much more detail on a weekly and monthly basis. The Managing Director for Digital Health mentioned the benefits realised from K2 Athena were realised in the Digital Maturity Assessment. Anne-Marie added the service receives an additional income benefit as a result of improved care and this has been evidenced. Outcome measures can be provided for individual practices.

The Chief Executive highlighted the opportunities of improving sharing with Practices with K2 working with SystemOne. The Chief Executive asked the Board to recognise the significant benefits of the K2 Athena and improvement for staff knowing there is real audit trail and story of care provided.

Anne-Marie Henshaw invited Board members to contact Anne-Marie.Henshaw@cht.nhs.uk if they are interested in viewing the K2 Athena system.

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

110/18 HIGH LEVEL RISK REGISTER

The Chief Nurse reported the risks scoring 15 or above within the organisation. The following risks are scoring 15 or more on the risk register:

7278 (25) Longer term financial sustainability risk **(NEW)** – This risk is now more forward looking than the previous risk on the risk register.
6903 (20): Estates/Resus risk, HRI
7271 (20) HRI ICU collective infrastructure risk **(NEW)** – This risk has separated the resus and ICU risk. The Chief Operating Officer clarified the resus risk is also a collective infrastructure risk and there are several 12 scores within the risk that equal to 20 and work is underway on this.
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk

The CQC risk of not receiving a rating of 'Good' has now been closed.

Andy Nelson asked that the decision to reduce the EPR financial risk be reviewed and expressed concern on the wording for the longer term financial sustainability risk (7278) as it refers to the control total. It was agreed to discuss this in more detail at the Finance and Performance Committee.

ACTION: Executive Director of Finance / Finance and Performance Committee

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

111/18 LEARNING FROM DEATHS – QUARTERLY REPORT

The Deputy Medical Director presented the quarterly learning from deaths report and highlighted that the Trust's first Learning from Deaths Summit will take place on Thursday 12 July 2018.

A video on End of Life Care was presented to the Board and is available below.

P:\BOARD OF DIRECTORS 2018\7. 5 JULY 2018\PUBLIC PAPERS\End of Life Care - Video.mp4

It was noted the Trust is now a positive outlier for HSMR for the period of March 2017 – February 2018. Linda Patterson highlighted HSMR is discussed at the Quality Committee and that there continues to be a focus on this work linked to the national programme.

The Chief Executive commented on the Trust's positive position in relation to HSMR and agreed to write to thank colleagues who had been involved in the work over the years to support the Trust's achievement.

ACTION: Chief Executive

The Deputy Medical Director noted the issue around initial screening reviews which is at 25-30% with the aim to increase this to 75-80%. An updated figure will be provided at the next Board.

ACTION: Medical Director

The Chief Operating Officer explained a number of videos are being put together by the cancer team with use of charitable funding to support staff in having difficult conversations with patients and their families.

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

112/18 **DIRECTOR OF INFECTION, PREVENTION AND CONTROL ANNUAL REPORT**

The Deputy Chief Nurse presented the annual report. She explained that it has been a challenging year with increased infection rates of MRSA, C.Difficile and E.coli. There had also been an increase in the number of patients diagnosed with influenza compared to in 2016/17. As a result, the frequency of the Infection, Prevention and Control Group meetings have increased.

The Deputy Chief Nurse described the team's 'Go See' visit to Wolverhampton to look at the outstanding practice areas in their services and identify learning for the Trust. There had also been positive patient led inspections and the cleaning team had been accredited with Honours. The Lead Governor commented that he had been involved in the patient-led assessments of the care environment (PLACE) inspections, and had identified high levels of cleanliness and hygiene across the organisation.

Gavin Boyd, Consultant Microbiologist reported that the team are looking at MRSA cases in detail to identify learning as well as looking at the work undertaken by Harrogate and Dirstrict Foundation Trust to reduce their incidence of C.Difficile.

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

113/18 **CARE OF THE ACUTELY ILL PATIENT**

The Deputy Medical Director highlighted the six l themes referenced in the report.

A Task and Finish group has been set up to implement NEWS2, a national early warning scores system by March 2019. This system focuses on patients who score 5, which is a level of risk and adverse prognosis. NEWS2 will also pick up consciousness level, not identified in the previous system which will provide significant benefits for the patient.

The Deputy Medical Director highlighted that an audit on End of Life care is available in more detail in the Quarterly Quality report (item 2.3 in report). This is a pilot with relatives of stroke patients who have died, to request feedback on the support they received at the end of their relative's life.

The Director of Digital Health asked if the Trust is considering adopting Nervecentre in the Emergency Department. The Deputy Medical Director responded that adoption of the system is problematic due to the number of attendances that do not result in an admission. This would be discussed further at the Medical Division Performance Review meeting. The Chief Nurse explained a Task and Finish Group is being set up to understand what is technologically enabled and where Nervecentre or EPR is used is being risk assessed. It was noted that the use of the Nervecentre and handheld technology has made a difference to the Trust's HSMR position.

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

114/18 **QUARTERLY QUALITY REPORT**

The Deputy Chief Nurse presented the Quarterly Quality report which is aligned with the Care of the Acutely Ill report.

The main highlights were from 3 priorities:

1. NEWS2 (the Trust's observation and escalation system) – needs to be implemented by end of March 2019.
2. Patient Flow – there is an immense amount of improvement work in terms of patient flow, looking at the Safer Programme to review length of stay, and ensuring patients are discharged to an appropriate safe place. The multi-agency discharge event (MADE) had been held bringing together partners from across the health and social care system to review patients currently in hospital to enable discharge and supportive measures.
3. End of Life – work is underway particularly looking at improving the survey of bereaved families.

There is an ongoing issue with complaints being answered in timely fashion and a deep dive is due to be presented to the Quality Committee to consider how response times can be improved.

The Deputy Chief Nurse also highlighted that the action plan from the most recent CQC Well Led Inspection has been developed and will be monitored through the Quality Committee based on the BRAG (Blue, red, amber, green) rating used in the previous CQC action plan.

Alastair Graham highlighted the very positive story reflected in the quarterly report.

OUTCOME: The Board **RECEIVED** the Quarterly Quality Report.

115/18 GOVERNANCE REPORT

a. Board to Ward Visits Feedback
The Company Secretary explained that the feedback from the last cohort of Board to Ward visits has been circulated. She highlighted that Board to Ward visits are an opportunity for Board members to talk to staff and patients on wards and in departments and to thank staff, celebrating the 'Good'. The visits for the next quarter are currently being arranged.

b. Board meeting dates proposal
The proposal for future Board meeting dates was shared with the Board. It was noted that a meeting in public will be held every other month with a strategy meeting to be held in the alternate month.

A summary report on Non-Executive responsibilities and roles will be brought to a future meeting for discussion.

c. Approval of Terms of Reference:
The following updated terms of reference were approved by the Board:
- Quality Committee
- Workforce Committee
- Finance and Performance Committee

OUTCOME: The Board **RECEIVED** the Board to Ward feedback and **APPROVED** the Board meetings for 2019 / 2020 and the updated Terms of Reference.

INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance. It was noted the Trust is in a positive position in terms of performance and all domains are amber or green and are improving. The main highlights from the report were:

- The SAFE domain is now green following improvements in Harm Free Care including pressure ulcers
- Agency spend has reduced
- Cancelled operations are reducing and it has been the lowest month ever despite reducing the bed base
- Sickness levels continue to fall
- There has been recruitment into the Medical Division
- Complaints closed within timeframe continues to be a challenge and two divisions have been asked to present their position and action plan to the Quality Committee in July
- Paediatrics have received a CHKS accreditation (National Healthcare Intelligence and Quality Improvement Service)
- Emergency care standard – closed June down at 94.7%, both sites have improved, Huddersfield was above 90% in June and Calderdale delivered over 95% every day of the month in June

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

116/18 **MONTH 2 FINANCIAL SUMMARY**

The Executive Director of Finance highlighted the key following points from the report:

- The year to date deficit is £9.24m, in line with the plan submitted to NHS Improvement
- Total clinical income is just above plan by £0.02m.
- In month activity increased slightly so that the Aligned Incentive Contract is now only protecting the income position by £0.01m
- There remains an underlying adverse variance from plan which has had to be mitigated by the release of £0.5m (a quarter) of the Trust's £2m full year reserves of which £1m is earmarked for winter
- Cost improvement plans achieved in the year to date is £1.54m against a plan of £1.67m, a £0.13m shortfall
- Agency expenditure was beneath the agency trajectory set by NHS Improvement
- At this early stage the forecast is to achieve the £43.1m deficit, £19.9m adverse variance from control total as planned

The Executive Director of Finance reported on the System Recovery Scheme, a detailed piece of work with commissioners where an opportunity was identified of around £16M. The System Recovery Group continues to meet monthly however a number of schemes are behind plan. As a result there will be a star chamber process. By the end of July further work on the opportunities and gaps will be completed.

OUTCOME: The Board **RECEIVED** and **APPROVED** the Month 2 Financial Summary

117/18 **CARDIOLOGY RESPIRATORY AND ELDERLY MEDICINE RECONFIGURATION UPDATE**

The Chief Operating Officer presented an update on the outcomes from the reconfiguration of cardiology, respiratory and elderly medical services six months on. The key highlights from the report were:

- It is clear there is improved communication, better access and continuity of care
- More access to senior decision making
- Staff have reported improved access to training provision
- Better than anticipated benefits of reducing cross-site transfer of patients. The agreed pathways with Yorkshire Ambulance Service has resulted in more patients going to the correct hospital site
- The Frailty Service is further enhanced; however, there is an increased number of readmissions to the frailty team which is above what would be expected and is being further investigated
- Patients who attend Calderdale Emergency Department receive a diagnosis much quicker and move to the correct ward
- There have been no DATIX incidents or complaints attributed to the reconfiguration
- Elderly medicine and respiratory are moving to a standalone medical rota, similar to Cardiology, rather than a general medical rota
- Focus work is taking place in Cardiology to move from a 'good' to 'great' service

Richard Hopkin asked about the financial impacts of the reconfiguration. The Chief Operating Officer responded that there had been some financial savings which had been accounted for within the safer programme. She added that as the service is embedded there is further to be achieved in terms of length of stay and beds.

OUTCOME: The Board **RECEIVED** the report and **REQUESTED** a further update in three months.

ACTION: Chief Operating Officer

118/18 **GUARDIAN OF SAFE WORKING HOURS REPORT**

Anu Rajgopal, Consultant Microbiologist gave a presentation setting out the work of the

Guardian of Safe Working over the previous quarter.

There were 19 exception reports in this quarter compared to 26 exception reports in the previous quarter. The main issue is rota gaps and winter months. The escalation process has moved to new system Allocate and there is a plan to train supervisors and target Divisional meetings.

The appointment of physician associates feels to have had a positive impact. The figures will be reviewed to test whether this is a sustained increase.

David Anderson, the Freedom to Speak Up Guardian raised the importance of raising and listening to concerns.

119/18 UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES

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

a. Quality Committee

Linda Patterson, Chair of the Quality Committee provided an update on the sepsis deep dive reviewed at the Quality Committee following a detailed paper submitted in April. The Sepsis Collaboration Group is meeting every month. There is detailed data on sepsis screening available from EPR and it is evident HSMR is reducing. Linda referenced the CHFT position on the sepsis chart ranking 37th out of 131 Trusts.

Linda Patterson gave a verbal report following the meeting on 2 July 2018.

- The Committee received a presentation from the Associate Medical Director provided a presentation on how we achieve and are compliant with NICE Guidelines
- Report from National Clinical Audit Benchmarking to review the Trust position compared to the rest of the national audit
- The Quality Committee have requested that Finance and Performance Committee review and monitor the Use of Resources section and actions of the CQC report

OUTCOME: The Board **RECEIVED** the minutes the meeting held on 4 June 2018 and **NOTED** the update from the meeting held on 2 July 2018.

b. Finance and Performance Committee

Richard Hopkin provided an update from the Finance and Performance Committee.

- Released £0.5M contingency as planned
- Non-Executive Directors have agreed to look at attendance at the Performance Review meetings and agency review meetings
- There is potential for less focus on depth of coding as EPR gives opportunity to increase depth of coding. The Deputy Medical Director added that there are three trainee coders due to start in post which will help improve this
- Depth of Coding KPIs have improved and thanks have been passed onto the coding team for their hard work over the last 12 months

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 5 June 2018 and **NOTED** the update from 29 June 2018 meeting**.**

DATE AND TIME OF NEXT MEETING

The Chair closed the public meeting at 11:27 am.

5. Action log and matters arising

For Review

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 5 July 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
5.7.18 117/18	**RECONFIGURATION UPDATE** Further review of the impact of the recent interim medical services reconfiguration to be brought back to Board in 3 months	HB		November 2018		
5.7.18 111/18	**LEARNING FROM DEATHS – QUARTERLY REPORT** Update to be provided on initial screening reviews (ISR) and increasing this from 25-30% to 75-80%	DB		September 2018		
	LEARNING FROM DEATHS – QUARTERLY REPORT To write a letter/email thanking colleagues who had been involved in the HSMR work over the years to support the Trust's achievement	OW	Action completed.	July 2018		6.7.18
5.7.18 110/18	**HIGH LEVEL RISK REGISTER** Decision to reduce the EPR financial risk be reviewed and the wording for the longer term financial sustainability risk (#7278) as it refers to the control total	GB / F&P Committee		September 2018		
7.6.18 97/18	**HEALTH AND SAFETY ANNUAL REPORT** Clarity on arrangements post wholly owned subsidiary go-live	LH / OW	To be discussed at the Board workshop on 17 July.	July 2018		5.7.18
7.6.18 98/18	**INTEGRATED PERFORMANCE REPORT** Performance forward view to be included in report	HB		July 2018		5.7.18
7.6.18 102/18	**MINUTES FROM SUBCOMMITTEES** Workforce Committee terms of reference to be presented to Board	VP	Included on this agenda	July 2018		5.7.18

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 5 July 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.12.17 183/17	**PATIENT STORY** It was agreed to discuss how EPR can support the serious incident investigation and information capture.	JM	1.2.18 Agreed that EPR/Serious Incident Investigation would be presented at a future meeting.	July 2018		5.7.18
		HB	The COO advised that at the end of the quarter she would bring a paper to Board updating on winter planning arrangements and conversations with partners.	September 2018		
7.12.17 187/17	**CHIEF EXECUTIVE'S REPORT** The Quality Committee will undertake a review of the impact of the recent interim medical services reconfiguration and report back to the Board	Chair of Quality Committee / HB		July 2018 ~~May 2018~~		5.7.18
7.12.17 188/17	**QUARTERLY QUALITY REPORT** The Quality Committee will undertake a deep dive on sepsis and will report back to the Board	Chair of Quality Committee / DB	5.7.18 - Verbal update provided by Linda Patterson at the meeting	July 2018		5.7.18
7.12.17 197/17	**UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES** The Chief Executive advised that a piece of work was underway looking at staff experience of appraisals would be brought to a future BOD meeting	SD		September 2018		
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT** Karen Heaton asked if other Trusts had used alternative	DA	Contacted the National Guardian Office to enquire if they have any information on alternative routes for Raising Concerns. Received information via attendance at the Regional Meeting of Guardians where we have had presentations from different	~~July~~ September 2018		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	routes and Dr Anderson agreed to investigate this further.		approaches in different Trusts. Set up a Raising Concerns, Insight and Analysis group in so much as they recognise that using the FSUG is only one way to raise concerns and Staff members may choose to approach a chaplain, discuss a worry within Occupational Health Team, reflect a concern in staff survey, or indeed raise a concern during a staff grievance investigation. There may be concerns not escalated by Staff but come to light through a patient complaint or included by a patient on a Friend and Family test. The purpose of the above Insight and Analysis group is to triangulate the above different sources of concerns. Barry Mortimer and David Anderson have done a Go see to this Trust. This confirms the approach that the Trust have taken in so much that creating a culture where staff feel safe to raise concerns is paramount and via the route they prefer, while continuing to improve and make the Freedom to Speak Up processes more visible and accessible.			
1.3.18 44/19	**BOARD SKILLS AND COMPETENCIES** Arrangements were being made to prepare a Board Development Programme and utilise some of the intelligence from this exercise, along with strategic issues in its development and would be brought back to the Board in the near future.	OW/PL/ SD/VP	Workshop held with the Board of Directors on Thursday 28 June 2018 – development plan to be brought to Board in September	September 2018		
5.4.18 57/18	**HIGH LEVEL RISK REGISTER** It was agreed Audit and Risk Committee would monitor the risk to business continuity should a power outage or cyber-attack occur.	MG / RH		September 2018		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 5 July 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
5.4.18 62/18	**DATA QUALITY ASSURANCE** Receive the outcome of the NHSI Data Quality Assessment and associated recommendations	HB		September 2018		

6. Chairman’s Report

a. Annual General Meeting Minutes – 19.7.18

b.Council of Governors Election Results

To Note

Presented by Philip Lewer

Minutes of the Calderdale & Huddersfield NHS Trust
Board of Directors and Council of Governors Annual General Meeting held
Thursday 19 July 2018 at 6.00 pm
Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Speakers
Philip Lewer, Chair
Owen Williams, Chief Executive
Gary Boothby, Executive Director of Finance
Lindsay Rudge, Deputy Chief Nurse
Brian Moore, Publicly Elected Governor -- Lead Governor
Clare Partridge, Partner, KPMG External Auditors

Board of Directors
David Birkenhead, Executive Medical Director
Dr David Anderson, Non-Executive Director
Helen Barker, Chief Operating Officer
Anna Basford, Director of Transformation & Partnerships
Rob Birkett, Assistant Director, Information
Karen Heaton, Non-Executive Director
Lesley Hill, Executive Director of Planning, Estates & Facilities
Linda Patterson, Non-Executive Director
Victoria Pickles, Company Secretary
Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Andy Nelson – Non-Executive Director

Governors
Annette Bell
Dianne Hughes
Lynn Moore
Kate Wileman
Nasim Banu Esmail
Stephen Baines
Alison Schofield
Linzi Smith
Salma Yasmeen
Felicity Astin

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS
The Chair opened the meeting by welcoming everyone to Calderdale Royal Hospital during the month where the Trust celebrated the NHS 70th Birthday. He explained that the meeting is an opportunity to reflect on the previous12 months within the Trust and share the Trust's plans and challenges for the coming year. The Chair reported that he joined the Trust in April 2018 as the previous Chair, Andrew Haigh, had stepped down having completed his maximum term. The Chair extended thanks to Andrew on behalf of the Trust for his guidance, support and leadership over the seven years he was in post.

The Chair described the challenging year for the Trust with one of the busiest winters on record, implementation of the new Electronic Patient Record and first of new type of inspection from the Care Quality Commission (CQC), all against a backdrop of a significant financial deficit.

The Char introduced the speakers and noted that members of the Board of Directors and Council of Governors were also present in the audience.

The Chair explained a number of Council of Governors will have completed their tenures, including Kate Wileman and Di Wharmby and he thanked them for their valuable contribution.

The Chair noted special thanks to the Chief Executive, Non-Executive Directors and Council of Governors, in particularly Brian Moore for their patience and understanding during the first few months of him being in post.

Thank you was noted to the League of Friends and the wonderful support from the volunteers throughout the year.

2. APOLOGIES

Apologies were received from:

Board of Directors

Jackie Murphy, Chief Nurse
Mandy Griffin, Managing Director - Digital Health
Phil Oldfield – Non-Executive Director
Alastair Graham – Non-Executive Director
Richard Hopkin – Non-Executive Director

Governors

Rosemary Hedges
Di Wharmby
Veronica Maher
John Richardson
Brian Richardson
Dr Peter Bamber
Sian Grbin
Chris Reeve
Rory Deighton
Jude Goddard

3. ANNUAL ACCOUNTS – APRIL 2017 TO MARCH 2018

Gary Boothby, Executive Director of Finance presented the Annual Accounts, full details of which were available in the Annual Report.

Financial Context

The Executive Director of Finance gave some key facts and figures on the Trust from 2017/18:

- 114,000 inpatients (elective, non-elective and day cases)
- 415,000 outpatients
- 148,000 A&E attendances

- Turnover £361m
- 5,300 full time equivalent staff
- Property and equipment over two hospital sites with a combined value of £220m
- Challenging operational and financial landscape

2017/18 Financial Performance

Compared to 2016/17:

- 9% more non elective inpatients were treated
- 2% less activity was seen in A&E
- 12% decrease across planned day case and elective activity combined
- Most challenging winter to date

Headline performance:

- Composite performance for 18/19 – A&E 4 hour waits, 18 week performance and cancer performance – highest nationally

Planned 2017/2018 Position

- Challenging operational plan of £26m overspend
- Required £20m of efficiency savings (5.5%)
- £10.1m Sustainability and Transformation Funding available contingent upon planned deficit and performance measures
- £8m risk highlighted to regulator at planning stage
- Revised £34m deficit target agreed with regulator in year to reflect risk
- Plan to spend additional £14.4m on capital

Specific Facts – Income

- Total Income £360m
- (£375m 2016/17)
    - 73% of our income continues to come from our 2 main health partners Calderdale CCG and Greater Huddersfield CCG
    - 11% of our income continues to come from Nationally Commissioned bodies

Specific Facts – Expenditure

- Total expenditure £391m*
- (£388m 2016/17)
    - Operating Expenditure £377m
    - £245m of our costs relate to pay
    - Agency staffing costs reduced £23.4m 16/17, £16.9m 17/18
    - Non-pay expenditure £132m
        - Asset financing and interest charges £14m

2017/2018 Financial Performance

	Plan	Actual	
I&E deficit	(£26.00m)	(£34.00m)	🔴
Revised I&E deficit*	(£34.00m)	(£34.00m)	🟢
Agency Expenditure	£16.86m	£16.86m	🟢
Capital *	£14.39m	£15.62m	🔴
Cash	£1.91m	£2.00m	🟢
Loan balance	£87.62m	£103.86m	🔴
CIP	£20.00m	£17.91m	🔴
Use of Resources	3	3	✓
Unqualified External Audit Opinion	✓	✓	✓

* Deficit and capital spend in line with position agreed with NHSI in-year ✓

Use of Resources

- Use of Resources assessment undertaken in March 2018, based on 2017/18 use of resources
- Undertaken by NHS Improvement
- Contributes to overall CQC rating

Overall assessment: Requires Improvement but positive narrative

The Future

- Unprecedented financial challenges - locally and nationally
- No short term solutions to CHFT's financial deficit
- Continued partnerships with other organisations across West Yorkshire
- Modernisation – digital next steps

4. QUALITY REPORT

Lindsay Rudge, Deputy Chief Nurse presented the Quality Report. The presentation highlighted the quality priorities for 2017/18 and their progress:

- CQC inspection March – April 2018 - The Trust's overall rating improved from requires improvement in March 2016, to Good
- Consistently achieving cancer waiting time standards for 2 week from referral to being seen and 31 days from diagnosis to treatment
- Development of psychology services for cancer patients
- Piloting new posts to improve patient experience, e.g. Nurse Consultant, cancer care co-ordinator
- Significant improvement in the Trust's mortality measures – Hospital Standardised Mortality Ratio (HSMR) we are a positive outlier and Summary Hospital-level Mortality Indicator (SHMI) within the 'expected range'
- Improvement in mortality supported by focussed work on the Care of the Acutely Ill Patient and Mortality Surveillance Group
- PRASE study continues to provide in patient anonymised feedback on safety domains, e.g. communication, care, ward environment - excellent results

- The Children's Diabetes team are using a new app to help share key messages with local families of children who have diabetes

Our Strategic Aims are:

- Improve outcomes for acutely ill patients
- Implement our end of life care strategy
- Provide safe care
- Improve community services
- Demonstrate engagement and co-design

5. EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Clare Partridge from KPMG gave a presentation outlining the work undertaken by the external auditors on the Annual Report and Accounts and the Quality Accounts.

Financial Statements and Annual Report

- Unqualified audit opinion issued
- Non-material amendments were made following the audit, including adjusting intangible assets to reflect the reduced impairment on the Electronic Patient Record
- Non-material unadjusted audit differences were identified in the audit
- The audit included a detailed consideration of the accounting impact on the Trust in 2017/18 of the C&H Solutions Ltd company – identified no audit adjustments
- Trust financial position – in-year deficit, cumulative deficit and outstanding borrowing commitments leads to a material uncertainty relating to the Trust's going concern

Use of Resources

- Qualified 'adverse' conclusion on the use of resources
- Reflects the financial position of the Trust through the year and at the year end
- Operating deficit for the new year of £35M
- Planned deficit for 2018/19 of £43M with required savings of £18M
- Borrowing from Department of Health and Social Care of £103M

Review of Annual Report and Annual Governance Statement

- Annual Report and Annual Governance Statement consistent with financial statements and complies with the FT Annual Reporting Manual (ARM)
- Some minor amendments and improvements suggested to the Annual Report

Quality Report

- Consent of the Quality Report complies with the FT Annual Reporting Manual requirements except for one area
- Some minor amendments and improvements suggested to the Quality Report
- Qualified 'except for' opinion on the basis of the results of our indicator testing

6. FORWARD PLAN

Owen Williams, Chief Executive welcomed everyone and thanked staff, volunteers and Governors for their work and commitment in caring for patients. He referenced

the 'Compassionate Care' logo which is a reminder that patients should receive the very best compassionate care. The Chief Executive shared a personal story of a family member who received compassionate care in their end of life by the Trust. The five year strategy on a page was presented, and the Chief Executive explained the purpose of this strategy is to stand in the future and identify what looks 'good' in order to ensure patients are receiving the best care.

The Chief Executive described the changes to the health landscape across West Yorkshire and Harrogate and that the Trust is part of the wider footprint of care. There is an expectation that all organisations will manage finances to work collaboratively. He spoke about the reconfiguration and advised there will be changes in how services are configured in West Yorkshire over the next five years and stressed that the Trust would always put the patient first.

7. ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would concentrate on the Council of Governors Annual General Meeting.

a. Council Members

The Chair shared the results of the elections run by the Electoral Reform Services on behalf of the Trust over the period 20 April to 6 July 2018. This had resulted in six public seats being filled.

CONSTITUENCY	ELECTED MEMBER
8	Brian Moore
2	Sheila Taylor
2	Christine Mills
6	Annette Bell
1	Donald Rogers-Walker
1	Jude Goddard

The Chair extended a welcome to the newly elected and re-elected governors. He thanked Brian Moore for his hard work as Lead Governor and announced that Alison Schofield would take over the role for 2018/19.

8. OVERVIEW OF THE COUNCIL OF GOVERNOR CONTRIBUTION DURING 2017/18

Brian Moore, Lead Governor provided an overview of the work of the Council of Governors 2017/18 and started by saying 'Happy 70th Birthday to the NHS'.

He explained that it has been a busy year for the Council of Governors. Brian extended thanks on behalf of the Governors to the previous Chair Andrew High, and welcomed Philip Lewer to the role.

Brian explained that the Governors had appointed two new non-executive directors during the year - Andy Nelson and Alastair Graham

Brian commented that Winter 2017 saw great pressures, particular in A&E, and that the response by staff was magnificent and was recognised by the Council of Governors.

Brian also set out other areas of focus by the Governors throughout the year including:

- Attendance at Divisional Reference Groups and associated tours round various departments
- Patient Led Assessment of the Care Environment (PLACE) which had shown high levels of cleanliness, hygiene and food standards
- Recruitment of senior medical staff
- Workshops with Non-Executive Directors to develop the future plans of the Trust,.

Brian highlighted that the Governors had discussed the Trust's decision to develop a Wholly Owned Subsidiary in detail and that not all Governors were agreement with this move.

Brian thanked all staff for their hard work over the year and the contribution to the achievement of the CQC rating of Good. He passed on thanks to the Governors who are leaving for their contribution to the council and welcomed the new governors who are joining the Council. He also gave special thanks to Vicky Pickles, Vanessa Henderson and Kathy Bray for all of their support provided to the Council of Governors

9. QUESTIONS AND ANSWERS

The Chair gave opportunity for those present to raise any general questions of the Board or Council of Governors.

Q: In relation to the reconfiguration, in the full business case published last August, it claimed HRI is expired and refurbishment impossible and would require rebuilding of over £379M, this makes the current proposal spending around £300M at Calderdale a more attractive option. Does the Board still support this view or does it agree with the independent survey which showed that the HRI building is not time expired.

A: The Chief Executive responded. He commented that the Trust respected this piece of work but had its own surveys which had shown different results. He explained that this had been assessed by the Trust's regulatory bodies. The Chief Executive added that the Trust is exploring other options following the Secretary of State's review. Over the next few weeks, the next steps will start to come out in the public domain which will see a positive aspect from the previous plans. He explained that the Trust still needs to go through a process with the regulators, Department of Health and new Secretary of State.

Q: Hands of HRI have requested a meeting with the Trust engineer specialists, the Trust have agreed to have this meeting; however, the follow up letter attempting to make arrangements have not been responded to for some time.

A: The Trust welcomes this conversation and will follow up to make the arrangements.

Q: The review of accounts on page 143 of the main accounts, I noticed the percentages of the staff survey score for KF1.

Question/ Indicator	CHFT 2017	CHFT 2016	National Average
KF1 - Staff recommendation of the Trust as a place to work or receive treatment	3.63	3.72	3.76
Q21a Care of patients/service user is my organisations top priority	70	77	76
Q21c I would recommend my organisation as a place to work	54	59	61
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	66	68	71

All of the indicators for 2017 are under national average and 2016 are slightly under national average. There is a recurrent pattern compared to the national average. I'm not saying the Trust are not compassionate; however, are you concerned about the trend, are the staff wrong or not very happy?

A: The Chief Executive responded and explained that at the time of the survey the Trust was undergoing the significant transformational change of implementing the new Electronic Patient Record. At times staff had felt overwhelmed. Despite this, when it came to providing compassionate day the next day, staff still got up and came to work to provide the same compassionate care for patients. The Chief Executive recommended reading both the Trust's CQC report and the Investors in People report which describes the feel in the organisation becoming much more positive. He added that colleagues had been working in extra-ordinary circumstances with not just the EPR but also working across two sites with an ICU with not the level of resources expected. He explained that the Trust is not surprised by the indicators and is doing as much as they can to improve success. There is further clarity needed around how services will be reconfigured in the future.

Q: The percentage of staff feeling unwell due to work related stress has increased by over 5%, it's concerning this might impact on patient care in the future.

A: The Chief Executive referred to the previous answer and explained that the Trust has a number of actions in place to aim to improve this.

Q: In the 2016 accounts, the CNST (Clinical Negligence Scheme for Trusts) figure that CHFT contributed to the authority is £15.78M, in 17/18 there are 2 columns and last year shows £15.493M which is a shortfall of 250k. Is this correct?

A: The Executive Director of Finance agreed to look into this and provide a written response to the individual.

Q: A question was asked about the significant increase in CNST (Clinical Negligence Scheme for Trusts) contributions between 2014/15 (£11M) and 2017/18 (£17M) as over the same period the number of claims had reduced by 25%.

A: The Executive Director of Finance explained that payments can relate to incidents a number of years previously due to the length of time for the legal process. He added that the level of CNST is not necessarily determined by what happens in this Trust. He explained that the Trust recognises the overall national challenge rising significantly for CNST and that the number of claims has been rising nationally with the value. Over the last few years, the Trust has been working closely with partners of the Trust to complete a comparison which has shown that the Trust's premium has gone up the lowest in the last 3 years (8%, whereas other Trusts have increased by 22%).

Q: The Chair of the Diabetes Support Group asked why there is no mention of prevention or an early intervention programme for Diabetes and what progress has been made on the health and social care aspect?

A: The Chief Executive explained that work has been taking place in communities where patients are more susceptible to diabetes including work to raise awareness, particularly in black minority groups. He added that the Trust wants to get more involved in preventative work and that the developments in digital technology are starting to connect GP and Trust information to identify needs and promote self-care. The Chief Executive added that the new Electronic Patient Record has a 'patient portal' which enables patients to see parts of their health record and over 3,000 have signed up for access to the portal. The Trust has recognised they want to do more with social care and are trying to get to a place where patients only need to share information once. He concluded that there are real time opportunities on the way on the 'Digital' agenda.

Q: In relation to EPR, I am a patient who has 'opted out' of the information sharing, has there been an impact assessment in terms of equality to compare and contrast the delivery of a service on an equitable basis. Are you able to offer a service which doesn't discriminate in terms of direct access?

A: The Chief Executive responded that the Trust would need to better understand the definition in relation to 'opting out' of the GP record sharing and the rules under the General Data Protection Regulation (GDPR).

10. DATE AND TIME OF NEXT MEETING

It was noted that a provisional date had been set for the next Annual General Meeting on Wednesday 17 July 2019 in Acre Mills Outpatients (3rd floor).

The Chair thanked everyone for attending and the questions asked and closed the formal meeting at approximately 19:32 pm.

7. Chief Executive’s Report

a.Response to the Secretary of State

To Note

Presented by Owen Williams

8. Patient/Staff Story:

Flu Campaign Patient Story (Video) - Katie Berry

To Note

9. High Level Risk Register

To Approve

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 6th September 2018	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: High Level Risk Register - To present the high level risks on the Trust Risk Register as at 28 August 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The draft high level risk register has been reviewed by members of the Risk and Compliance Group at it's meeting on 21 August 2018.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

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

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

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

The Issue:

The attached paper includes:

i. Identification of the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks. This paper refers to a summary of the Trust risk profile as at 28 August 2018.

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

iii. Details of movement during July and August 2018

Two new risks have been added to the high level risk register as detailed below and one risk has reduced in score, removing it from the high level risk register:

Risk 7280 relating to unnecessary repeat blood specimen collection from the Family and Specialist Services risk register was approved as a new high level risk t the July Risk and Compliance Group at a risk score of 15.

Risk 7251, from the Surgery and Anaesthetics division risk register relating to patients with eye disease receiving a poor patient experience and delay due to Optovue OCT machines not functioning was approved as a new high level risk at the August Risk and Compliance Group at a risk score of 15. A business case is being developed.

One risk has reduced in score, risk 6596, from a risk score of 16 to 12, relating to not conducting timely investigations into serious incidents due to improvements in the timeliness of submitting serious incident reports.

Next Steps:

Discussion took place regarding risk 7081 regarding pressure ulcers from the Medical Division risk register at the Risk and Compliance Group. It was agreed that further work would be undertaken to review the risk register content and scoring and this will be re- presented to the Risk and Compliance Group at the meeting

on 18 September.

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed.
ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required.

Appendix

Attachment:

FINAL High Level Risk Register summary- August 2018 - board summary.pdf

High Level Risk Register Board Summary – August 2018

Risks at 28th August 2018

TOP RISKS

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

7278 (25) Longer term financial sustainability risk
6903 (20): Estates/Resus risk, HRI
7271 (20) HRI ICU collective infrastructure risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk

The Trust risk appetite is included below.

NEW RISKS

There are two new risks added to the high level risk register from the July and August meetings of the Risk and Compliance Group:

Risk 7280 (15) Family and Specialist Services
Risk 7280 relates to unnecessary repeat blood specimen collection from the Family and Specialist Services risk register was approved as a new high level risk at the July Risk and Compliance Group at a risk score of 15.

7251 (15) Surgery and Anaesthetics Division
There is a risk of patients with eye disease receiving a poor experience and possible delay due to the Optovue OCT (Ocular Coherence Tomography) machines at both Acre Mills and CRH Eye Clinics not functioning to expected levels. This is resulting in a slower patient flow through clinics due to the increase time taken per scan. The machine can "crash" leading to inability to perform scans and access historical results for progression of eye conditions to determine management plans.

Risk 7081 from the Medical Division risk register regarding pressure ulcers was discussed at the Risk and Compliance Group and it was agreed further discussions about the risk would take place with the Director of Operations from the Medical Division and the Director of Nursing. The risk will be re-presented to the Risk and Compliance Group at its meeting on 28 September.

CLOSED RISKS

7046 (16) EPR clinical risk
Risk closed as agreed by Director of Nursing, Director of Digital Health, EPR Operational Group and Risk and Compliance Group 16 July 2018. A risk relating to encounters, which is captured on risk 7114, is being managed by Julian Bates (score 12)

RISKS WITH REDUCED SCORE

6596 <u>New Score 12</u> (Previous Score 16) Corporate Division
Risk 6596 is the risk of not conducting timely investigations into serious incidents due to not responding quickly enough to the new national SI framework.

The rationale for the reduction in the likelihood score for this risk is that analysis indicates that investigations in June were within a total average of 79 working days, and in July a total of 69 working days. Both these were within the target of an average of no more than 20 working days overdue. Second half day introduction to RCA held. Incident Reporting Policy revised and ready for review. Recommend downgrade to likelihood of 3, reducing the overall risk score to 12 which will be managed on the Corporate Quality Risk Register.

RISKS WITH INCREASED SCORE

None

AUGUST 2018 –SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 28.08.2018

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Mar 18	April 18	May 18	June 18	July 18	Aug 18
10/17	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
06/17	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing (JM)	=16	=16	=16	=16	=16	=16
06/17	7134	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/2019	Medical Director (DB)	=16	=16	=16	=16	=16	=16
09/17	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
09/17	6903	Keeping the base safe	Resuscitation HRI Estates risk	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
05/17	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
10/17	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
06/17	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
10/17	6949	Keeping the base safe	Blood transfusion service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
05/17	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Medical Director (DB)		!16	=16	=16	=16	=16
	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)		!16	=16	=16	=16	=16
11/17	7248	Keeping the base safe	Mandatory Training	Director of Workforce and OD (SD)		!16	!16	=16	=16	=16
09/17	7271	Keeping the base safe	ICU Huddersfield – collective infrastructure risk from 12 individual risks	Director of Estates and Performance (LH)				**!20**	=20	=20
	7280	Keeping the base safe	Unnecessary repeat specimen collection by not following EPR procedures	Director of Operations, FSS (RA)					**!15**	**=15**
	7251	Keeping the base safe	Ophthalmology equipment risk	Divisional Director, SAS (WA)						**!15**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	Mar 18	April 18	May 18	June 18	July 18	Aug 18
FINANCE RISKS										
	6895	Financial Sustainability	Finance IT systems	Director of Finance (GB)	=8	=8	=16	=16	=16	=16
13/17	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)				!25	=25	=25
Performance and Regulation Risks										
10/17	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20
10/17	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20

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

TRUST RISK PROFILE AS AT 28/8/2018

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation ! 7280 Unnecessary repeat specimen collection ! 7251 Ophthalmology risk	= 6345 Nurse Staffing = 7078 Medical Staffing = 7271 ICU infrastructure	=7278 Financial sustainability
Likely (4)				=5862 Risk of falls with harm =7132 Patient scores in ED =7134 Sepsis CQUIN =7223 Digital IT systems risk =7248 Mandatory training =6895 Finance core function	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 HRI Resus estates risk
Possible (3)					= 6011 Blood transfusion process = 5747 Vascular /interventional radiology service = 6949 Blood transfusion service
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

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

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

High Level Risk Register (15 or over)

Risk as of 28th August 2018

NHS
The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Target	Tolerate	RC	Exec Dir	Lead
Very High	7278	Corporate	Finance and Procurement	Jun-2018	Proposed for Acceptance	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £43.1m (£19.9m variance from the 18/19 control total). This includes loss of access to £14.2m Provider Sustainability Funding (PSF). The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raises concerns regarding going concern and value for money. The Trust does not currently have an agreed plan to return to in year balance or surplus.	Working with partner organisations across WYAAT and STP to identify system savings and opportunities Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Development of Business Case for reconfiguration Development of 25 year financial plans in support of Business Case Finance and Performance Committee in place to monitor performance and steer necessary actions Aligned Incentive contract with two main commissioners. On-going dialogue with NHS Improvement	Pressures on capacity planning due to external factors. Competing STP priorities for resources Progression of transformations plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors The Trust does not currently have an agreed plan to return to in year balance or surplus.	25 5 x 5	25 5 x 5	20 5 x 4	August 2018 Long term Financial plan continues to be developed in conjunction with regulators and department of health.	Mar-2019		FPC	Gary Boothby	Philippa Russell
Very High	7271	Estates & Facilities	Estates	Jun-2018	Active	Keeping the base safe	Intensive care unit (ICU) HRI - There is a collective risk in regards to the ICU from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: • Ventilation – Imminent failure of the ventilation system due to end of useful life resulting in potential danger to staff and patients • Electrical Resilience –UPS/IPS power failure resulting in harm to patients from no functioning equipment • Flooring – causing trips/falls and infection control hazards for staff and patients • Electrical Infrastructure - failure of infrastructure • Plumbing infrastructure - failure with resulting infection hazards for staff and patients • Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases • Building Fabric - infections & failure due to moisture ingress within the plaster/concrete within ICU resulting in poor environmental conditions. • Compliance / Statute Law – Compliance / Statute Law – Failure of equipment or infrastructure could result in HSE intervention	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit. Resulting recommendations are actioned following a risk assessment process.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU, currently this is not achievable due to patient flow and Capital budget constraints.	20 5 x 4	20 5 x 4	0 0 x 0	June 18 Update - High-level discussions on funding and operational plans to mitigate the above risks by carrying out Estates work in Financial Year 20/21 Agreed for inclusion on high level risk register 13.6.18 July 18 Update - Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime August 18 Update - Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. New discussions on how to maintain the Ponta Beams are taking place with the maintenance provider Draeger.	Sep-2020		DB	Lesley Hill	Chris Davies
Very High	6903	Estates & Facilities	Estates	Dec-2016	Active	Keeping the base safe	Resus - There is a collective risk in regards to Resus from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: Ventilation - potential danger to staff and patients from nitrous oxide due to the lack of background air changes resulting in harm . (The Trust has been advised by their external independent Authorising Engineer to install mechanical ventilation to the RESUS area to mitigate the risk.) Electrical Resilience – lack of support infrastructure/ Medical IT i.e. UPS/IPS to ensure continuity of power supply in the event of a power outage resulting in harm to patients	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of RESUS, currently this is not achievable due to Capital budget constraints. Refurbishment requires decant for around 6 months, Operational Plans & activity currently do not permit this length of decant.	20 5 x 4	20 5 x 4	0 0 x 0	June 18 Update - Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime July 18 Update - Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime August 18 Update - Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. Estates services have commissioned a feasibility study to develop a modular unit at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Oct-2019		RC	Lesley Hilll	Chris Davies

							Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases Medical Engineering Risk - 4 Dameca Anaesthetic Machines - failure due to end of useful life resulting in unplanned disruptions/ harm to patients Operational Safety – the current space within each bed bay does not meet the minimum required space for operational safety resulting in harm to patients and staff Compliance / Statute Law – All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law resulting in prosecution											
Very High	7078	Corporate	Workforce & Organisational Development	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	August 2018 Over 200 new doctors in training joined the Trust in August. All trainees were cleared and started in post as planned. The Medical Education department provided a junior doctor specific induction on changeover day to ensure that trainees were able to 'hit the ground running' as quickly as possible. The FY1 trainees had their two days of induction and 2 days of shadowing existing Foundation trainees prior to changeover so that they were ready to commence on the Wednesday when the other trainees were in induction. There are more new trainees coming in September and October, and their pre-employment checks are underway to ensure that they too start in post without delay. The GP trainees have been booked to attend the corporate induction on Tuesday 28th August. As employees of the trust rather than the GP Practice this will ensure that even though they will be off-site in their day to day work, they are aware of our values and culture. The GP Practices have undertaken their role specific local inductions. The new HRBPs in Medicine and Surgery and Anaesthetics division have now started in post, August 2018, and will be working closely with Medical HR to support recruitment and retention of our Medical and Dental staff.	Jan-2019		WF	David Birkenhead	Pauline North
Very High	2827	Medical	Emergency Care	Apr-2011	Active	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 Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development 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 gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention Inability of School of EM to allocated trainees.	20 4 x 5	20 5 x 4	12 4 x 3	May 2018 Junior doctor interviews 18.5.18 FY3 posts being interviewed Consultant interviews set for 15.5.18 (2 applicants) Reviewing junior doctor rota alongside the ACP rota June 2018 update Consultant recruitment - appointed one applicant ACP, MG, CESR un-changed July 2018 update No change August 2018 update Continued recruitment drive for Middle Grade doctors - vacancy rate is currently at % CESR applicant being pursued ACP programme developing as planned and 2 ACP's due to join MG junior rota from January 2019 Locum Consultant contract has ended in July 2018	Mar-2019		WEB	David Birkenhead	Dr Mark Davies
Very High	5806	Estates & Facilities	Estates	May-2015	Active	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.	The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. Each of the risks above has an entry on the risk register and details actions for managing the risk.Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	6 3 x 2	June 18 Update - The Capital Plan for 18/19 is now underway, Ward flooring replacement to commence June, Main entrance Infrastructure to commence in July. Work already started on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient. July 18 Update - Ward flooring replacement has commenced on Ward 3, Main entrance Infrastructure to commence in July. Work already started on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient. Current Mechanical & Electrical Systems continue to be	Feb-2019		RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies

							The main risks identified within the Estates Risk Register being: • 7220 Flooring: cracked, torn, blown flooring screed and vinyl resulting in possible slips, trips, falls • 6734 Pipework: Potential of water borne diseases due to the corrosion of services pipe work • 6735 Structural: if more openings are made through the structure it will make the building unstable. • 6736 Air Handling Units: non-compliance, & increased infection risk to both patients and staff • 6737 Windows: all elevations of the Hospital require replacing, prone to leeks and very drafty • 6739 Roofs: water ingress through roofs resulting in decanting services, wards and departments. • 6761 Ward Upgrade Programmes: Compliance with regulatory standards - Health & Social Care Act • 6762 Day Surgery: Non-compliance with relevant HTM standards • 6763 Environmental Condition: failure to bring areas of the Hospital to a condition B level • 6766 Road Surfaces: South Drive and Tennis Court car park in need of repairs potential for injury to public • 6767 Staff Residences: Properties not statutory compliant for accommodation in regard to fire and utilities. • 6769 Electrics: Statutory compliance to reduce the risk of electric shock and damage to equipment • 6770 Plantroom: Statutory and physical condition of the plant room to H & S regulations • 6332 Asbestos: risk of industrial disease to staff, patients and general public • 6771 Emergency Lighting: Statutory compliance in order to provide adequate emergency lighting • 5963 Equality Act: non-compliance with the Equality Act 2010 due to a inadequate physical access • 6764 Fire Detection: aged fire detection could lead to inadequate fire detection. • 6860 Electrical 3rd substation HV supply only 1 meter apart • 5511 Fire Compartmentation: inadequate fire compartmentation in ceilings; risers and ducts. • 6897 BMS heating controls failure will result no control over heating or air condition throughout the hospital • 6997 Structural Cladding - Loose Portland Stone creating a hazard • 5630 Poor condition of the WCs in HRI's public areas • 6848 Water Safety: non-compliance to statutory law across HRI due to the ageing infrastructure	they are made safe again.					monitored through a Planned Preventative Maintenance (PPM) regime. August 18 Update - Ward flooring replacement complete on Ward 3, Ward 11 flooring replacement in progress, Main entrance Infrastructure now in progress. Work progressing on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient.					
Very High	6345	Corporate	Workforce & Organisational Development	Jul-2015	Active	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16	4 x 4	20	4 x 5	9	3 x 3	August 2018 Applicants from the International recruitment trip to the Philippines continue to progress (119 offers were made in country, since March 2017, with on-going training and tests underway), 8 Nurses have started with the Trust in 2018, with a further 5 starting in September and 68 still engaged in the recruitment process. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued and is progressing with offers during July 2018. Application numbers are low and divisions are discussing a new approach advertising by specialty with targeted recruitment support. 53 newly qualified nurses are due to start with the Trust on 19 September. Advertising is continuing to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT. Following great feedback from our Physician Associates, the Trust is advertising for a further 10 posts in various medical and surgical specialties, the advert is due to close on 30 August, interest is high with good numbers of applications received so far.	Dec-2018		WF	Jackie Murphy, Jason Eddleston	Paul Casson/Rachael Pierce

High	7132	Medical	Emergency Care	Nov-2017	Active	Keeping the base safe	The Trust EPR system whilst having the facility to record NEWS and PAWS assessments, it does not have the facility to calculate the score unless all fields are filled. This is not always clinically appropriate. There is a risk to patient safety due to EPR system not automatically calculating and recording the score. This provides the potential for non recording, miscalculation and non detection of deterioration of patients. A number of clinical incidents have identified failure to detect deterioration as a contributing factor	All staff informed to document PAWS and NEWS as a clinical note with PAWS and NEWS in the title and laminated charts put up in the cubicles in the department. All staff have been made aware of the change. SOP and training has been provided. Above audited as part of monthly documentation audit.	Clinical staff not routinely looking at PAWS and NEWS and relying on individual judgement of vital signs recorded.	16 4 x 4	16 4 x 4	2 1 x 2	Immediate mitigation: All staff informed to document PAWS and NEWS as a clinical note with PAWS and NEWS in the title and laminated charts put up in the cubicles in the department. Regular documentation spot checks by lead nurses. Medical staff to evidence use of early warning scores in their clinical decision making. Issue escalated to A Morris and J Murphy to establish if PAWS and NEWS can be on the front page of the ED clinical summary. May 2018 Update: Mitigation still in place. Audits in place re: compliance of staff calculating news. Talks on going with nervecenter to ascertain whether we can filter by area in ED and not have all patients on. June 2018 Update: Still awaiting update from nerve centre. Audits still in place. Staff are complying with mitigation in place. July 2018 NEWS audits have taken place and totals are sometimes being missed. Reminders put in safety huddle. Change request gone into EPR board as they may have a work around. August 2018: Meeting with nerve centre being planned to see re: implementation in the ED. Audits continue monthly	Nov-2018		PSQB	David Birkenhead	Louise Croxall
High	7134	Corporate	Corporate Quality	Nov-2017	Active	Transforming and improving patient care	CQUIN target at risk of not being met for 2018/19 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	Awareness and new controls for ward areas Sepsis nurse in post Divisional plan, leads identified -improvement action plan in place -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues Information on patients not receiving the sepsis bundle in a timely manner. Clarity on use of EPR prompts required	16 4 x 4	16 4 x 4	7	Assess impact of EPR sepsis prompt Improve safety huddles to include sespis Coordinate activity with the Deteriorating Patient Group NB. See high level risk register 6990 operational lead Juliette Cosgrove June 2018 100% of patients now screened for sepsis 95% of patients with sepsis have the sepsis alert completed. Further work on going to look at compliance with BUFALO once sepsis identified – some delays in extracting data from EPR. Work underway to develop sepsis training programme July 2018 The CQUIN risk remains – mainly around the administration of antibiotics. Overall performance is improving and we continue to focus on early administration of antibiotics. August 2018 No changes	Sept-2018		DB	David Birkenhead	Rob Moisey
High	7223	Corporate	THIS	Mar-2018	Active	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 4 x 4	16 4 x 4	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete). April Update: Trend rollout (AV & Encryption) still due to complete at the end of April 18 for CHFT. No further update. May: No further update June: Following the power failure to the HRI Data Centre early June, there is additional work being carried out by Estates to ensure resilliency for power. No further update or change to score. July 2018: No further update or change to score August 2018 No further update or change to score - Awaiting confirmation from E&F around the remedial Power/UPS following the outage in June.	Sep-2018		RC	Mandy Griffin	Rob Birkett
High	7248	Corporate	Organisational	Apr-2018	Active	Developing our	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts.	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action	None	16 4 x 4	16 4 x 4	4 4 x 1	June 2018 Training now falls under the title 'Essential Safety Training' and includes our 9 mandatory subjects alongside the 41 essential skills. This approach strengthens the importance of completing the essential skills designated to specific roles and by combing the two areas into one enhances the Trusts' requirement to reach 96%	Mar-2019		WF	Suzanne Dunkley	Ruth Mason

							Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our 9 mandatory training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 mandatory subjects alongside the 41 essential skills. This approach strengthens the importance of completing the essential skills designated to specific roles and by combing the two areas into one enhances the Trusts' requirement to reach 96% across all the training offerings.	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.					across all the training offerings. July 2018 A paper went to EB on 28 June giving current compliance for the Trust as a whole, by division and by directorate. Work to improve compliance includes HRBP's liaising closely with senior colleagues on a weekly basis, updated compliance on the intranet and a communications plan to include screensavers and a message in CHFT weekly. August 2018 A proforma has been designed to process requests for additional role specific training to be added to the list. Any such requests affecting clinical staff will be reviewed by the nursing & midwifery practice committee and a decision reached. This should help to provide some rigor and consistency around managing the list of role specific essential training.					
High	6895	Corporate	Finance and Procurement	Dec-2016	Active	Keeping the base safe	Risk of Inability to fulfil core functions of the Finance and Procurement department, i.e. Internal and external financial reporting; business partnering with Divisional management teams; transactional functions of paying suppliers, raising invoices and placing orders for goods and services; cash management; adherence to procurement legislation. Due to IT Systems failure of financial ledger, fixed asset register, costing system or procurement systems. Resulting in failure to meet statutory deadlines; ensure good governance of the organisation with regard to the financial position and outlook; maintain cash flow to suppliers and staff; maintain supply of goods and services essential to operational performance and safety; comply with procurement legislation leading to legal challenge.	The majority of the Trust's key Finance and Procurement systems are outsourced to a third party and contractual arrangements exist for continuity of service and resilience. In case of failure, the department would revert to saved records and manual systems supported by generic Office software. Further action is being taken as follows: 1. Address additional short term resource requirements in Accounts Payable - additional resource in place supported off site by systems supplier NEP, local resource being prioritised from within wider finance team and additional temporary local resource to be in place from June. 2. Escalation of outstanding issues with system provider, NEP - including site visit and regular senior communication between parties 3. Systems optimisation project to create action plan including engagement and communications roll out - detailed action plan with sub projects, key milestones and KPIs. Fortnightly meeting to ensure oversight. 4. Continued focus on cash management actions through cash committee and divisional cascade	In December 2017, the Trust's key finance ledger system and procurement ordering system went through an upgrade with the existing supplier, North East Patches (NEP). The system changeover adversely affected functionality in a number of areas. Many of the initial issues have been resolved but the residual system issues cause potential operational risk to the Trust's ability to maintain supply of goods and services essential to operational performance and safety. The key issues are: - the slower speed of processing invoices for payment which has generated a backlog of outstanding invoices, compounded by the additional volume of queries into the department that this is generating - the lack of a system automated reminder to the requisitioners of goods within the Trust meaning that receipting is not being completed in a timely manner to allow for payment to be made - these issues are compounded by the Trust's ongoing challenges of cash availability meaning that payments are having to be prioritised (See Risk ref 6968)	8 4 x 2	16 4 x 4	8 4 x 2	July update: 1. Additional temporary resource is in place in Accounts Payable, with further capacity being sought in addition to off-site processing support to address invoice backlog. A number of material cash receipts have been pursued and will be received in July, this will further ease the Trust's ability to catch up on payment timescales and reduce the additional pressure brought about through creditors chasing payment 2. Regular communication remains in place at a Senior level with the system supplier. A number of residual issues impacting system effectiveness will only be resolved on a further upgrade to the system which is in testing with an expectation of go live in late summer / early autumn. 3. Systems optimisation plan, 'Silver Lining Project' progressed with some improvements now in place and others in train. A key action to close is the implementation of agency pre-approval through the Allocate system which requires wider operational involvement. 4. A 'Go See' knowledge exchange is planned with York Teaching Hospitals who are in a similar position. 4. Raising of cash awareness on-going. August 2018 no update	Aug-2018		FC	Gary Boothby	Kirsty Archer
High	5862	Medical	All Directorates Medical	Aug-2013	Active	Keeping the base safe	We have a risk of harm due to vulnerable patients who are more likely to fall due to the unfamiliar hospital environment. The impact is high levels of fractures, head injuries all causing increased length of stay with associated issues	Falls management policy Safety Huddles Falls bundles Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment Enhanced care team and assessment process Safety rails assessment Falls champions	Insufficient uptake of education and training of nursing staff, particularly in equipment. On occasion staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. Failure to use preventative equipment appropriately. Low levels of staff training. Failure to implement preventative care. Limited amount of falls prevention equipment. Increased acuity and dependency of patients Lack of access to falls prevention training for agency staff.	12 4 x 3	16 4 x 4	9 3 x 3	July 18 trust wide falls action plan to go to Falls collaborative meeting 17th july to be approved Falls awareness week - aiming to reinvigorate falls champions and invite to falls collaborative meeting no change in risk level August 2018 Falls incidents and harm incidents have remained at a similar level in July with one harm fall reported. Falls collaborative work continues with a number of initiatives continuing. Risk rating reviewed and considered unchanged.	Nov-2018		PSQB	Jackie Murphy	Helen Hodgson
High	6949	Family & Specialist Services	Pathology	Mar-2017	Active	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas. 2. Staff rotas changed to a block pattern for night shifts. 3. All substantive vacancies are being advertised and gaps backfilled with locum staffing. 4. Staff development plan in place for training Biomedical Scientists 5. Existing business continuity plan in place	1 & 2. Substantive Biomedical Scientists are working additional shifts on a voluntary basis with no obligation to provide cover and over a sustained period of time with no imminent resolution. 3. Delay in recruiting locums due to impact of Flexible workforce procedures. 4. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments. 5. Business continuity plan has not had a recent test with relevant stakeholders - further work required to establish contingency plan if rota was unfilled at any point in time.	10 5 x 2	15 5 x 3	5 5 x 1	3. Understand blockers to the recruitment process and determine options to expedite the process. 5. Organise a test for Business continuity plan with relevant stakeholders. Update 12/1/2018- BCP test planning meeting arranged for 15th Jan. Planning actual test for last week Feb 2018 June 2018 Test of BCP in department being planned Staff training plan underway The risk is expected to be mitigated or lowered once an additional three staff are on the shift. 1 staff member is now requesting shifts for September another is starting transfusion training Next week for 3 months. Expected to be available for shifts in September, another staff member is expected back from Mat leave Sept. will need re-assessment of competence before back on shift. Expectation October Senior manager are now analysing the training plan to identify any support to expedite. July 2018 - Risk presented at PRM 4/7/18. Department to prepare 3R report and meeting with senior managers to look for options to mitigate risk earlier than 2020 August 2018 - no change	Oct-2018		DB	Rob Aitchison	Hayley Baker

High	7280	Family & Specialist Services	Pathology	Jun-2018	Active	Keeping the base safe	Risk of: unnecessary repeat specimen collections (same EPR order) or rejected Specimens (incorrect EPR order used) Caused by: Failure to follow procedures in EPR at point of specimen collection. (not clicking collected) Resulting in: increased patient harm through repeat specimen collections and subsequent delays in patient care	1.Ward patients- the lab phones and requests new order to be sent down (samples processed) 2.Out patients- if there is a location sticker the lab will phone and find out if bloods required- if so new order with barcodes requested by lab (samples processed)	1. Not all ward staff have been trained correctly to order tests in EPR (see also 3 below) 2.Current lab procedures for allowing the labelling of samples without the need for disclaimer form is outwith the minimum data set policy and is facilitating the problem 3. Staff are not clicking collect once they have ordered and collected specimen- this results in order remaining live in EPR. (see also 1 above) 4.High volumes of outstanding orders in the system 5. Lab do not have an effective system in place for logging rejected specimens in APEX or feeding back to users (Lab IT system)- lack of awareness by service users of the number of specimens being rejected or collected incorrectly 6. Additional tests are being routinely added to phlebotomy lists 7. OP phlebotomy requests are being processed without appropriate requests - use of duplicates of request forms	15 3 x 5	15 3 x 5	3 3 x 1	1. Lab to liaise with EPR trainers 2. comms re use of disclaimer form to be sent out by lab. 4. cerner do not have resolution to outstanding worklists- international problem. Lab to continue to monitor situation 5. Lab to develop system for logging rejected requests in APEX-EPR lab staff to be trained to mark as collected those requests where barcode has been used and results issued 6. Lab IT to liaise with EPR team to restrict addition of requests onto the phlebotomy list 7.Comms to clinicians around end-date for lab accepting inappropriate requests from out patients.(feedback directly to clinicians on each incorrectly requested test in interim) July /2018 meeting of key lab staff with AMF and risk presented at the Midwifery and nursing clinical meeting 4/7/2018. plan for intensive directed training and a targeted improvement week on major wards July 2018 August 2018 Ward visits have taken place and meetings (Matrons, Midwifery and nursing)have taken place with explanations presented by path leads on the risk. The lab have started to record the repeat samples within LIMS where possible- for feedback to wards. Discussions ongoing with senior managers on next steps with this risk	Dec-2018		PSQB	Rob Aitchison	Karen Mitchell
High	6011	Family & Specialist Services	Pathology	May-2014	Active	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust). - Solution identified and purchased - currently for implementation from August 2018. This solution will mitigate the current risk in full.	Lack of electronic system Lack of duplicate sampling Training compliance not at 100%	15 5 x 3	15 5 x 3	3 3 x 1	April 2018 Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB) May 2018 Progress has been made and the Trust has agreed to implement the hand held PDA devices. Training will progress shortly in preparation of a roll out training scheme for the whole Trust At present the project is on target. (HLB) June 2018 Blood track implementation progressing in line with plan. Key operator training will take place in June and full user training to commence in July. Go live scheduled for mid-August. July 2018 Training progressing in line with plan. August 2018 Blood track implementation ongoing in line with plan	Oct-2018		PSQB	Julie O'Riordan	Sarah Ramsden and Alison Milner
High	5747	Family & Specialist Services	Radiology	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant in post Ad-hoc locums supporting the service Continue to try to recruit to vacant posts	Failure to secure long term locum support. Lack of clarity on regional commissioning arrangements relating to vascular services	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response. June 2018 Locum cover remains in place until October 2018. Trust contacting NHS England to clarify process timeline for WY model. July 2018 Locum cover planned in until mid-October. Continuing to pursue possible recruitment of substantive consultant. No update on timescales for regional vascular services and currently no support available from neighbouring Trusts August 2018 Locum in place until 12th October. Continuing to pursue possible recruitment of substantive consultant.	Mar-2019		DB	Rob Aitchison	Sarah Clenton
High	6715	Corporate	Corporate Nursing	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2	Establish clinical documentation group June 2018 The ward assurance process is being tested The training to improve documentation for nurses has been planned and is being encouraged, this will be reported to senior nurse huddle for management Appointment of operational manager to support digital boards Clinical posts being recruited to Training and change team amalgamated to enable focused support July 2018 The gaps remain in the clinical digital posts; recruitment has commenced The training team and change team have amalgamated to become the digital health team and they are prioritising both training and change process in order to reduce variation in documenting There is further roll out planned regarding ward assurance with further work planned for community settings August 2018 Appointment made to Chief Nurse Information Officer (CINO) post. Use of ward assurance tool to review documentation. Chief Clinical Information Officer (CCIO) and CNIO to revisit the Clinical Records Group	Nov-2018		WEB	Jackie Murphy	Jackie Murphy

High	7251	Surgery & Anaiesthetics	Ophthalmology	Apr-2016	Active	Keeping the base safe	There is a risk of patients with eye disease receiving a poor experience and possible delay due to the Optovue OCT (Ocular Coherence Tomography) machines at both Acre Mills and CRH Eye Clinics not functioning to expected levels. This is resulting in a slower patient flow through clinics due to the increase time taken per scan. The machine can "crash" leading to inability to perform scans and access historical results for progression of eye conditions to determine management plans	Increase use of the Heidelberg OCT machine on Floor 2 to spread demand for scans during clinics but requires patients to travel between 2 floors during their visit.	IT System Admin to cover OCT, Medisoft, Optos, Heidleberg and Imagenet systems, the client base, updates and a “go to” person, a silver service engineer dedicated to your department. The OCT server ran out of space last August, linked the server to the Trusts Storage Area Network and backed up and restored the archive so it is kept on the Trusts larger area however this only gave the system 6TB more space, even though we have a lot more available to allocate, the limitation is 16TB per volume. Optovue are unable to use a 2nd Archive to keep us going and the system is obsolete in this regard. There is a very high risk impact as the machines will now allow progression scan s to be reviewed. A recent performance review identifies the need for a new infrastructure otherwise the machines will not function beyond January 2019 due to server storage reached, this will impact on patient care as unable to receive these diagnostic scans to monitor progression of their eye disease.	9 3 x 3	15 3 x 5	0 0 x 0	Consider an IT Lead for Ophthalmology OCT gets a good health check from the suppliers - due 17 July 2018. To consider if Optovue have a newer system to offer - Haag Streit contacted awaiting repsonse method of clearing up space, and needs a good house cleaning from within the department CHFT-OCT servers warranty expires within the next financial year(28/03/2019), backing up the system for 12TB costs the Trust about £10-15k a year in licensing alone, a new server would be at least £10k	Aug-2018	Sep-2018	Aug-2018	Sep-2018	

10. Winter Plan 2018 Presentation

To Approve

11. Resilience & Security Management Final Report

To Approve

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Gorman, PA to Director of Planning, Performance, Estates & Facilities
Date: Thursday, 6th September 2018	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Resilience & Security Management Report June17 - April18 - The contents of this report reflect the complete commitment of the Board to achieving the safest possible environments in which to deliver quality health care services. It details the work of the Resilience and Security Management Specialist for the period 1 June 2017 to 31 March 2018 and reflects the outcomes that have occurred during this reporting period.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Transforming and improving patient care.	
Sustainability Implications: None	

Executive Summary

Summary:

The emergency preparedness, resilience and response alongside safety and security of staff, patients, carers, relatives, visitors and property are a key Trust priority. The delivery of high levels of safety and security is critical to the delivery of the highest possible standards of clinical treatment and care and CHFT is committed to improving the environment and sense of overall personal security for those who access our services and for those who provide those services. CHFT provides specialised services in the Acute approach.

The Trust Board has a designated Security Management Director and Non-executive Director as required to discharge the Secretary of State Directions (2004). The Trust also has a designated, accredited and developed the Resilience and Security Management Specialist (RSM) to provide contracted strategic, tactical and operational support and advice on security risk management matters for all staff groups.

Security affects everyone who works in the National Health Service. All of those working within the Trust have a responsibility to be aware of security issues and to assist in preventing security related incidents and losses. It is the case that we are all accountable all of the time, for the security of ourselves and patients, visitors and colleagues and property around us. Reduction programmes relating to incident intelligence and losses relating to violence and aggression, theft or damage will lead to more resources being freed up for the delivery of clinical care and contribute to engendering and maintaining an environment where everyone feels safe and secure. Security management is about delivering commensurate, realistic and achievable improvements and developing good practice into best practice.

CHFT is a category 1 responder under the Civil Contingencies Action 2004 (CCA 2004) so that it can perform its critical activities in the event of an emergency or business interruption. CCA 2004 states Categorised 1 responders are required to:-

• Assess the risk of emergencies occurring and use this to inform contingency planning.
• Put in place emergency plans.
• Put in place a business continuity management led process to identify and mitigate risks.
• Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency. Share information with other local responders to enhance co-ordination.
• Co-operate with other local responders to enhance co-ordination and efficiency.

The contents of this report reflect the complete commitment of the Board to achieving the safest possible environments in which to deliver quality health care services. It details the work of the Resilience and Security Management Specialist for the period 1 June 2017 to 31 March 2018 and reflects the outcomes that have occurred during this reporting period.

I am pleased to recommend this report for the approval of the Trust Board.

Lesley Hill
Director of Estates, Facilities & Planning
Security Management Director (SMD) & Accountable Emergency Officer (AEO)
Calderdale & Huddersfield NHS Foundation Trust

Main Body

Purpose:

For approval of the Trust Board.

Background/Overview:

CHFT is a category 1 responder under the Civil Contingencies Action 2004 (CCA 2004) so that it can perform its critical activities in the event of an emergency or business interruption. CCA 2004 states

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• Co-operate with other local responders to enhance co-ordination and efficiency.

The Issue:

The contents of this report reflect the complete commitment of the Board to achieving the safest possible environments in which to deliver quality health care services. It details the work of the Resilience and Security Management Specialist for the period 1 June 2017 to 31 March 2018 and reflects the outcomes that have occurred during this reporting period.

Security and Preparedness matters need to be considered by all staff as an integral part of their role and as a major factor in how we deliver specialised services to in a safe and secure manner, for the future.

Next Steps:

Transforming and improving patient care.

Recommendations:

The Board is asked to approve this report.

Appendix

Attachment:

CHFT SRM Final Report Draft 2018.pdf

Resilience & Security Management
Final Report – Phase 1

Calderdale & Huddersfield NHS Foundation Trust (CHFT)

June 2017 – April 2018

FOREWORD AND EXECUTIVE SUMMARY

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I am pleased to recommend this report for the approval of the Trust Board.

Lesley Hill
Director of Estates, Facilities & Planning
Security Management Director (SMD) & Accountable Emergency Officer (AEO)
Calderdale & Huddersfield NHS Foundation Trust

INTRODUCTION

NHS PROTECT - SECURITY RISK MANAGEMENT

Introduction

In December 2003, the Secretary of State and Lord Warner launched the security management strategy, '*A Professional Approach to the Management of Security in the NHS'.* The main objective of this strategy is the delivery of an environment, for those who work in or use the NHS that is properly secure so that the highest standards of clinical care can be made available to patients. The directions on security management measures create the structure required to implement the strategy and define the roles and responsibilities of health bodies and NHS Protect. A key element of the structure was the introduction of the Resilience and Security Management Specialists (RSM) in each health body. The RSM is the focal point for the local delivery of professional and inclusive security management work carried out to a high standard within a national framework, supported by appropriate, relevant guidance and advice from NHS Protect.

NHS Protect

The Security Management Service joined with the Counter Fraud Service and was launched in April 2003 and has policy and operational responsibility for the management of security in the NHS. This work is broadly defined as the protection of people and property in the NHS. Work on protecting people – tackling violence against staff – is already underway supported by a separate set of directions that created a national framework for this work and which introduced a number of key practical measures. During 2012, NHS Protect re-launched its anti-crime strategy.

NHS Protect leads on work to safeguard NHS staff, patients and resources. It will meet the challenges facing the NHS, with the emergence and development of the new NHS delivery framework. We aim to provide increased levels of support, guidance and advice by improving the management of information and the delivery of anti-crime intelligence.

Crime can be prevented and reduced by targeting and co-ordinating work effectively, building in anti-crime measures at all stages of national and local policy development, and reflecting wider government initiatives where appropriate. To enable compliance with the NHS Standard Contract, NHS Protect will provide a Crime Risk Assessment Toolkit, we will set standards for tackling crime across NHS funded services and we will use an evaluation model to assess the effectiveness of prevention activity and improve future proactive work.

NHS Protect Anti-Crime Strategy

Given the backdrop of reform within the NHS, NHS Protect need to continuously improve anti-crime provision to safeguard the NHS for the future. In order to ensure this continuous improvement, NHS Protect has five strategic aims:

- To provide **national leadership** for all NHS anti-crime work by applying an approach that is strategic, co-ordinated, intelligence-led and evidence based.

- To **work in partnership** with the Department of Health, commissioners and providers, as well as our key stakeholders, such as the police, the CPS, local authorities and professional organisations such as the National Fraud Authority and the Cabinet Office Counter Fraud

Task Force, to coordinate the delivery of our work and to take action against those who commit offences against the NHS.

- To **establish a safe and secure environment** that has systems and policies in place to: protect NHS staff from violence, harassment and abuse; safeguard NHS property and assets from theft, misappropriation or criminal damage; and protect resources from fraud, bribery and corruption.

- To lead, within a clear professional and ethical framework, **investigations** into serious, organised and/or complex financial irregularities and losses which give rise to suspicions of theft, fraud, bribery or corruption.

- To **quality assure** the delivery of anti-crime work with stakeholders to ensure the highest standard is consistently applied.

In order to reduce crime, it is necessary to take a multi-faceted approach that is both proactive and reactive. We advocate the adoption of three key principles designed to minimise the incidence of crime, and to deal effectively with those who commit crimes against the NHS. These principles apply across the sector, at national and local and at strategic and operational levels. The three key principles are:

- **Inform and involve** those who work for or use the NHS about crime and how to tackle it. NHS staff and the public should be informed and involved with a view to increasing understanding of the impact of crime against the NHS. This can take place through communications and promotion such as public awareness campaigns and media management. Working relationships with stakeholders will be strengthened and maintained through active engagement. Where necessary, we will all work to change the culture and perceptions of crime so that it is not tolerated at any level. NHS Protect provides the tools to those who tackle crime so that they are equipped to deliver this strategy at the local level. We will also provide local specialists with the information and intelligence they need in order to be able to detect and investigate crime.

- **Prevent and Deter** crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit crime. Successes will be publicised so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing crime by robust systems, which will be put in place in line with policy, standards and guidance developed by NHS Protect.

- **Hold to account** those who have committed crime against the NHS. NHS Protect will professionally train specialists who tackle crime and ensure they continue to meet the required standard. Crimes must be detected and investigated, suspects prosecuted where appropriate, and redress sought where possible. Where necessary and appropriate, this work should be conducted in partnership with the police and other crime prevention agencies. In relation to economic crime, investigation and prosecution should take place locally wherever possible. NHS Protect will deal with cases which are complex or of national significance through the National Investigation Service. Where recovery of monies lost to crime is viable, this should be pursued. In relation to crimes against NHS staff, criminal damage or theft against NHS property, investigation and prosecution should be undertaken in liaison with the police and CPS or where necessary NHS Protect. NHS funded organisations

will need to meet the relevant standards when tackling crime, and will be responsible for ensuring that they do so, supported by NHS Protect's quality assurance process.

NHS ENGLAND – EMERGENCY PREPAREDNESS RESILIENCE & RESPONSE (EPRR)

Introduction

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the CCA 2004 and the NHS Act 2006.

Emergency Preparedness

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

Resilience

Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.

Response

Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders.

Emergency

Under Section 1 of the CCA 2004 an "emergency" means;

> "(a) *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*
> *(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;*
> *(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom*".

Incident categorisation

For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to

internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

Business Continuity Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed).

Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

Major Incident

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency.

Types of incident

The following list provides commonly used classifications of types of incident. This list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate Incident Level.

- **Business continuity/internal incidents** – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime
- **Big bang** – a serious transport accident, explosion, or series of smaller incidents
- **Rising tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action
- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about an impending situation, reputation management issues
- **Chemical, biological, radiological, nuclear and explosives (CBRNE)** – CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials
- **Cyber-attacks** – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
- **Mass casualty** – typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures

Statutory requirements & underpinning principles of EPRR

Under the NHS Constitution the NHS is there to help the public when they need it most, this is especially true during an incident or emergency. Extensive evidence shows that good planning and preparation for any incident saves lives and expedites recovery. All NHS funded services must therefore ensure they have robust and well tested arrangements in place to respond to and recover from these situations.

Statutory requirements under the Civil Contingency Act, 2004 (CCA)

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies). Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- share information with other local responders to enhance co-ordination
- cooperate with other local responders to enhance co-ordination and efficiency

Category 1 responders for health are:

- Department of Health (DH) on behalf of Secretary of State for Health (SofS)
- NHS England
- Acute service providers
- Ambulance service providers
- Public Health England (PHE)
- Local authorities (Inc. Directors of Public Health (DsPH))

Category 2 responders are critical players in EPRR who are expected to work closely with partners. They are required to cooperate with and support other Category 1 and Category 2 responders. They are less likely to be involved in the heart of planning work, but will be heavily involved in incidents that affect their own sector. Category 2 responders have a lesser set of duties - co-operating and sharing relevant information with other Category 1 and 2 responders.

Underpinning principles for NHS England EPRR

a) **Preparedness and Anticipation** – the NHS needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) **Continuity** – the response to incidents should be grounded within organisations' existing functions and their familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

c) **Subsidiarity** – decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local responders should be the building block of response for an incident of any scale.

d) **Communication** – good two way communications are critical to an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

e) **Cooperation and Integration** – positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response. Active mutual aid across organisational, within the UK and international boundaries, as appropriate, is responsive and reactive.

f) **Direction** – clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response. A strong capacity in NHS England to oversee the health service working.

Statutory requirements applicable within the NHS Act 2006 (as amended)

The NHS Act 2006 (as amended) requires NHS England to ensure that the NHS is properly prepared to deal with an emergency. CCGs, as local system leaders, should assure themselves that their commissioned providers are compliant with relevant guidance and standards and they are ready to assist NHS England in coordinating the NHS response.

The key elements are contained in Section 252A of the NHS act 2006 (as amended) and are:

> a) NHS England and each CCG must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency
> b) NHS England must take steps as it considers appropriate for securing that each CCG and each relevant service provider is properly prepared for dealing with a relevant emergency
> c) The steps taken by NHS England must include monitoring compliance by each CCG and service provider; and
> d) NHS England must take such steps as it considers appropriate for facilitating a coordinated response to an emergency by the CCGs and relevant service providers for which it is a relevant emergency.

A "relevant emergency" is defined as:

- In relation to NHS England or a CCG: any emergency which might affect NHS England or the CCG (whether by increasing the need for the services that it may arrange or in any other way);
- In relation to a relevant service provider: any emergency which might affect the provider (whether by increasing the need for the services that it may provide or in any other way).

Designation of the Resilience and Security Management Specialist (RSM)/EPRR)

The Director of Estates, Facilities and Planning is the nominated Security Management Director (SMD) and Accountable Emergency Officer (AEO) Ms L Hill and the nominated executive director (NED) is presently nominated.

Ian Kilroy is presently the designated Trust Resilience & Security Management Specialist.

It is essential that the RSM continues with professional development, in order to keep up to date with developments in security management and attends quarterly regional meetings and training sessions with the NHS Protect, Yorkshire & Humberside Security Management Group, NHS England Core Standards, West Yorkshire Acute Trust Emergency Planning Practitioners Group and National Associated Healthcare Security Forums.

The Trust RSM responsibilities are broad, but nationally dictated priority areas of action have been identified and are outlined within the annual work plan as follows:

- NHS Protect Security Management Standards – Assurance Framework
- NHS Prevent operational lead
- Significant Security Incident Investigations
- Security Management Audits
- Police Liaison
- Anti- crime risk profile
- Security Risk Register
- Security Design advice on Capital Estates Projects
- NHS England Emergency Preparedness, Resilience and Response
- Business Continuity Management System
- Integrated Emergency Management
- Crisis and Disaster Management
- NHS England Core Standards
- Civil Contingency Act 2004

Action Plan & Progress update – GAP Analysis completed Sep 2016

Emergency Preparedness, Resilience and Response (EPRR) & Security Risk Management (SRM)

EPRR Identified topics	***Progression***	***Planned Completion Date***
Strategic Leadership in Crisis (SLiC)	*Developmental Course is developed for Director and Senior OCM Group. Training delivered by Cabinet Office identified lead and RSM. 2 dates agreed. Jun-Jul 2018. Additional event planned for Sep 2018*	*Sep 2018*
E-Learning Dynamic – Developmental Training Courses Major Incident – Flow Management, Business Continuity Management, Loss of Power, IT Disaster Recovery, HAZMAT, Conflict Resolution Training	*Designed and manufactured for high proportions of identified staff to respond to business continuity disruptions, critical incidents and declared major incident catalogues. Draft versions of topics developed. Meeting with WOD determined. Progression with Dynamic*	*Completion aimed at July 2018. Implementation of training events planned. Commence in Aug 2018 in agreed stages before April 2019*
NHS England EPRR Core Standards	*Reviewed and completed. Positions being assessed. Met with Head of EPRR, NHS England to brief*	*Instigated fresh standards in Jul 2018. Completion as required following NHS England requirements*
Joint Emergency Services Interoperability Programme (JESIP) - Commander and All Staff Aide Memoir	*Agreed. Organised and ordered. To be issued to staff at Exec/SMOC levels*	*Completed guidance booklets. To be implemented through different events. Apr 2018*
Specialised Incident Response Plans – Flood, Severe Weather, HAZMAT, Fuel Disruption,	*Re written. Awaiting Pan Flu, OPEL, Mass Casualties. Targeted by next financial phase*	*Majority completed. Require implementation*

EPRR, BCM, Evacuation, Lockdown and Major Incident Plan		*of Mass Casualties, OPEL and Pandemic Flu completion forecasted before Apr 2019*
Chemical, Biological, Radiation, Nuclear Explosives (CBRNE) / Hazardous Material (HAZMAT)	*Working Group set up for 5 Jan 2018. Training identified for PRPS and HAZMAT. Suit training delivered on 17 & 18 Apr 2018. Tent training developed for 30 May 2018. USB shared. Plan drafted. HO Aide Memoire printed and available. ED Staff programme being developed*	*Completion of Tent, Suit, Guidance booklets, Incident Response Plan, DVD, E-Learning completion. Require staff group identified and mandatory training package agreed for ED staff Group. Sep 2018 required*
YAS Audit – HAZMAT Group	*HAZMAT Working Group established. Action plan programmed.*	*HAZMAT Group programme continues*
Security & Resilience Governance Group Terms of Reference	*Security & Resilience Governance Group (SRGG) established. Agreed with H&S Committee. To set up meetings*	*Meeting commenced in May 2018. To commence every 2-3 months throughout*
Non-Executive Director - SRGG	*Identified. Meeting to be confirmed*	*Completed May 2018*
Table Top Exercises completed – THIS, Winter, Medical Gases, FSS, WOD, Pathology, EPR Simulation Based Exercises completed – Emergo Mohawk, Argus	*Ongoing for Radiology, Community, Medical Wards, Surgery, E&F, ISS/Engie*	*Achieved. Further events to follow on an annual basis*

Business Continuity Management – Liaison with Surgery, Medical, ICU, E&F, Radiology, ISS	*Progressing. Internal plans reviewed. Database developed and co-ordinates Trust position*	*To continue*
UC Liaison – On Call Management & HAZMAT	*Training for On Call Management and JESIP prepared. Awaiting update*	*To be agreed*
Loggist Training	*RSM topic identified. PHE qualified staff. Training schedule to be agreed*	*To be developed*
Resilience Support Officer	*Job description written. Role identified. EPC attended for Tactical Command Group, Exercise Emergency Plans. Table Top Exercises supported.*	*To continue and develop*
Strategic Tactical & Operational Guidance Handbooks	*Printed and completed prepared for SLiC*	*Completed 2018*
EPRR Internal web page	*Designed and developed. On site for sharing information and sources of support mechanisms to On Call Management*	*Completed March 2018*
Resilience Direct	*External secure web site to be completed*	*To be developed Apr 2019*
Security Risk Management Update		
Progression	Update	Planned completion date
CRT – Conflict Resolution Training is mandatory package and being reviewed. Other information available	*Dynamic is designing and developing new package for topic of mandatory identified staff*	*Aug 2018*
PI – Physical Intervention Training identified for high risk group of staff	*Training dates have been agreed. Jun 2018- Jul 2019*	*Implemented. To be followed until Jun 2019 for reflection*

Lockdown – Resilience plan developed and connect to security systems. Project Artemis	*Connected E&F, ED and other services to understand portfolios. To be progressed*	*Sep 2018*
Security Management Strategy – S1 on internal website.	*S1 written. Delivered to Exec Board on 17 Jan 2018. Update in upcoming year to concentrate on specialised Security Management procedures*	*Apr 2019*
SRM Web page – Developed Security Risk Management topic	*Developed. For progress*	*Completed implementation*
Security Officers – Raising portfolio on words about restraint, force, secure conditions and support to Trust staff	*Single Points of Contact established. To be continued*	*Completed*
'Pin-Point' – Staff attack alarm systems being reviewed within ED at HRI/CRH	*Contact made with E&F & ED colleagues. To be continued*	*Apr 2019*
CCTV – HRI reviewed and developmental in place for disclosure	*Prior discussions identified areas requiring amendments. Work in progress. Procedure required*	*Apr 2019*
AACS – Automated Access Control Systems being amended to high risk areas	*Reviewed and progress required with E&F colleagues*	*Completed implementation. To be continued*
Lock doors – Joint Clinical/Security audit to be completed at HRI/CRH	*Meeting and surveys scheduled. HRI completed. CRH to be completed*	*Dec 2018*
Project Argus – Counter Terrorism delivered at Exec Board level – See report	*ACT to be developed and introduced on E-Learning package*	*Oct 2018*
Project Griffin – Developed concerning domestic and extremism for NHS Staff to identify	*See above attached*	*Nov 2018*

and community partnership group		
Police Liaison – WY Police	*Workshops delivered. Continual*	*Continues*
PCSO workshops for staff	*As above*	*Continues*
DATIX Security Intelligence – Developed system to capture incident reports and response to situations	*Developed and work in progress. H&S Committee established and Safe Guard Committee figures updated regularly.*	*Completed implementation. To continue development*
JDM – Joint Decision Model aide memoire	*To be designed*	*Apr 2018*
'Respect Us' Posters	*Designed and printed. To be issued to multiple site areas*	*Completed*
Not Part of the Job (NPOJ1)	*Designed and printed available to all groups for information*	*Completed*
Safe room in ED@HRI/CRH – Identified and developed into secure areas	*Work in progress*	*Aug 2018*
Protective Security Intelligence Assessment – Tool to use Centre for the Protection of National Infrastructure	*To be revealed*	*Sep 2018*

PROPOSED PRIORITY AREAS OF ACTION

Violence Reduction Programme

CHFT IS committed to minimising the risk of physical and non-physical assaults against its staff. The RSM will focus efforts on the development of a violence reduction strategy and subsequent work streams that compliments the Health & Safety Committee.

Asset Management & Protection

All those who work in, provide or use services in the NHS have a collective responsibility to ensure that property and assets that support service delivery are properly secure. Reviews have been conducted for the security of property and assets this will be progressed further through the forth coming year.

Security Incident Reporting System (SIRS)

Presently, CHFT is continually piloting the introduction of SIRS through externally exporting the physical assault data only. As the Trust are a DATIX vendor, we are assisting NHS Protect with development of software analysis.

Conflict Management and Physical Intervention Training

Aggression Management is a fundamental learning outcome for all staff operating within the organisation based on a mandatory training needs analysis. There is a variety of specialised programmes based upon associated and reasonably foreseeable risk. All front line staff who undertake the conflict management programme meet and exceed the national requirement for NHS Protect. Additional, disengagement, holding, enhanced interventions is delivered based on training needs analysis and documented risk factors.

Managing Lone Working

There are a small number of staff working out of community services that have been risk assessed as lone working and as such as a control measures are in place and commensurate to the risk faced. Staff had been issued with the lone worker device as part of the national procurement process. This has been subsequently removed as part of a risk based approach and robust assessment criteria.

Specialist Incident Response Plans

Focus upon the identified IRP is relevant with regards to understanding, testing and practicing the plan. Additionally, obvious connections to NHS England EPRR core standards; is crucial to the CCA 2004.

Business Continuity Management

The efforts to improve the position is refreshing with the TTE approaches to service disruption tests alongside identified areas. Work for progression is the identified annual work programme and the identification of high risk areas.

Risk Assessment/Register Process

Plans require documentation and storage of the IRP to the system. Following Register requires update, development and monitoring the situation. Anticipation and assessment are crucial processes for the critical infrastructures.

Training & Exercising Practices

Continuation of the events is engrained and requires embedding into the service within CHFT. All areas require connection but needs communicated effort to raise portfolio.

Professional & Service Development

The RSM has attended regional meetings with other RSM throughout the Yorkshire and Humberside. Other Seminars including ACPO Prevent national conference were attended. Additional, multiple Emergency Planning events involving Local Authorities, WY Fire and Rescue, Public Health England and Clinical Commissioning Group exercises.

The RSM is also an active member in the following professional institutes:

- National Association of HealthCare Security
- Emergency Planning Society
- Institute of Conflict Management
- Emergency Planning College – Strategic Crisis Management
- Emergency Planning College – Exercising Emergency Planner
- International Association of Trainers in Anger Management
- Home Office - Project Griffin/Argus/ACT Trainer Course
- Public Health England – Loggist Instructor/Trainer Course

Priorities moving forward

This reporting period evidences the continuing progress that CHFT has demonstrated. Through the designated RSM provision to support and promote a safe and secure environment for all staff, service users, carers, visitors and contractors, the organisation illustrates its compliance with internal and external frameworks. Significant progress has been made and will continue; in particular the following priorities are identified.

- The RSM to continue the role following the agreed work plan for 2018/2019.

- The RSM to develop to establish and promote measures for crime reduction and effective security risk management in addition to resilience and business continuity management.

- The RSM will continue to conduct crime reduction surveys/security threat assessments on premises and systems of work, as requested.

- The RSM to continue as a priority, supporting staff who are victims of assault and consult and advise on the management of violent and aggressive service users and to continue to support staff who are victims of other crimes.

- The RSM will continue to investigate security risk incidents, in conjunction with organisational management and external agencies.

- The RSM will be responsible for producing the annual report and work plan in compliance with NHS National contract for service provider's directives.

- The RSM will continue to develop and maintain networks, links and training that support the role and the roles of the Trust.

SUMMARY

I am proud to announce that CHFT is continuing to work to mitigate the security management risks and emergency preparedness faced by the organisation. As services are reviewed and develop, along with new ways of working, it will be extremely important that issues surrounding the security of all the Trust assets and contingency approaches, but particularly its staff, are taken into consideration, to ensure that maximum benefit is gained from changes to the organisation, its structure and how services are delivered.

Security and Preparedness matters need to be considered by all staff as an integral part of their role and as a major factor in how we deliver specialised services to in a safe and secure manner, for the future.

Ian Kilroy (Original Signed)

Ian Kilroy
BSc (Hons) Dip.SP&C Dip.HEP ASMS MICM MIATAM
Resilience & Security Management Specialist
Calderdale & Huddersfield NHS Foundation Trust

12. Local Health Resilience Partnership (LHRP) Core Standards

To Approve

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: NHS England Emergency Preparedness, Resilience And Response (Eprr) National Standards Annual Submission - -	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Estates & Facilities Quality Safety Board	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

-

Main Body

Purpose:

The purpose of the supporting papers is to provide the Board with an overview of the Civil Contingencies Act 2004 and provide a current position statement following the self-assessment against NHS England national standards for emergency preparedness, resilience and response (EPRR), additionally relating to business continuity matters. This highlights areas of work and consolidates a resilience footprint across the wider health economy. The supporting information details are:-

- NHS England 2018-2019 - Core Standards self-review document
- Statement of Compliance against the core standards
- Agreed action improvement plan to develop the current profile to agreed standards
- CHFT's EPRR Strategy detailing how CHFT embeds the EPRR process within core business activity

Background/Overview:

EPRR Standards Version 6 have developed progressively to self-review changing aspects of EPRR landscape. CHFT has routinely complied with the direction for submission.

Overview of this year's standards against current EPRR portfolio practice is that there are similar significant pieces of work required following from the previous submission. The compliance level would be proposed Substantial with the caveat of fully implementing the associated improvement/action plan. There has been significant improvements since previously submitted.

The Issue:

Issues relating to refreshed specialised Incident Response Plan requiring development or continuing review. Training needs analysis associated with crisis and emergency management training for management layers in the Trust. Testing and exercising formalised and Trust owned plans to demonstrate compliance with categorised responder status under the statutory guidance of the Civil Contingencies Act 2004 and NHS England Guidance

Next Steps:

To approve:-
Core standards gap analysis
Statement of compliance "Substantial"
Core standards improvement/action plan
CHFT's EPRR strategy approach – Training, Exercises, Plans, Tests, Development

Recommendations:

For the Board of Directors to support the full agenda throughout the Trust on the EPRR Strategy portfolios suggestions as detailed in the next steps.

Appendix 1 – Statement of Compliance
Appendix 2 – Core Standards Improvement/Action Plan

Appendix

Attachment:

Local Health Resiliance Partnership (LHRP) Core Standards.pdf

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

STATEMENT OF COMPLIANCE

Calderdale and Huddersfield NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Calderdale and Huddersfield NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	9	1	4
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	8	1	0
CBRN	14	13	1	0
Total	64	57	3	4

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	0	4	0
Command structures	4	0	4	0
Total	8	0	8	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments (including organisational evidence)
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Fully compliant		Ian Kilroy - Resilience Management	N/A	Director of Performance, Planning & Estates & Facilities is currently AEO. From 1 Sep 2018 that role will transfer to Chief Operating Officer. The Non Executive Director is nominated and involved from May 2018
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should:	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant		Ian Kilroy - Resilience Management	N/A	The EPRR strategy embraces the policy statements.
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Fully compliant		Ian Kilroy - Resilience Management	N/A	The Resilience & Security Final Report had been shared with the appropariate Health & Safety Committee and forwarded to the Executive Directors Board
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant		Ian Kilroy - Resilience Management	N/A	The Annual work programme for EPRR has been agreed. The On Call Management principles have been agreed to embrace training, exercises and plans
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Fully compliant		Ian Kilroy - Resilience Management	N/A	Resilience and Security Manager roles agreed with the Trust. Resilience & Security Support Officer is agreed wi the Trust. Job descriptions included. Organisational structure included. Terms of reference for the Security and Resilience Governance Group included.
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant		Ian Kilroy - Resilience Management	N/A	The Security & Resilience Governance Group will capture, share and change responses to incidents. Additionally, previous exercises that have been completed follow a report that is shared internally with Divisional Boards. The internal web page for EPRR/BCM/Security Risk Management also capture lessons learnt in the final reports that are added to Trust staff.
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Fully compliant		Ian Kilroy - Resilience Management	N/A	The Estates & Facilities Quality Safety Board capture associated risks relevant to EPRR. Seperately, the risk management approacg, which has been designed by THIS colleagues to cover all NHS England EPRR Core Standards and updated by Resilience Management Team
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant		Ian Kilroy - Resilience Management	N/A	The CHFT has a risk management strategy. Risk & Quality Board meet regularly. DATIX is the current incident records system in place. Security & Resilience Governance Group review, investigate and updates DATIX.
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Internal and external partners are engaged with the regards to testing, exercising, reviewing and implementing changes to plans
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Reviewed and written. Exercised within PHE Emergo Mohawk, CTSA Argus
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Reviewed and implemented during Jun-Jul 2018
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Reviewed and connected to Winter plam exewrfcises
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	Reviewed plan in process - Aug 2018	Ian Kilroy - Resilience Manager	N/A	Reviewed
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Reviewed by Infectious Prevention Team

17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented. Additionally, OPEL Plan being reviewed.
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Evacuation Plan written. Estates and Facilities BCM Exercise evidence shelter contexts.
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Lockdown plan written. Exercied through BCM TTE
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage "protected individuals"; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	Major Incident Plan does hold information however, separate incident response plan requires review	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented. Additionally, OPEL Plan being reviewed.
23	Duty to maintain plans	Excess death planning	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Review of current position required	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented. Additionally, OPEL Plan being reviewed.
24	Command and control	On call mechanism	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Fully compliant		Bev Walker - Director in Urgent Care & Resilience Management Team	N/A	Director of Urgent Care developed training strategy. On Call Management approach reviewed. SLIC implemented, Strategic, Tactical & Operational Guidance booklets designed. JESIP aide memoirs available. Internal web site developed.
25	Command and control	Trained on call staff	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant		Bev Walker - Director in Urgent Care & Resilience Management Team	N/A	On Call Management approach reviewed. SLIC implemented, Strategic, Tactical & Operational Guidance booklets designed. JESIP aide memoirs available. Internal web site developed. E-Learning packages of Major/Critical Incidents, BCM and Command/Control structures
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Fully compliant	Training Syllabus Programme to be agreed	Ian Kilroy - Resilience Manager	N/A	Progressed
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Implemented internal Table Top/Simulation Based Exercises including Winter, Argus, FSS, Community, TruMed, E&F, Medical Wards, Surgey, WOD, Patho,ogy, Radiology, THISx2, EPR
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Fully compliant	To be developed. Initial training captured	Ian Kilroy - Resilience Manager	N/A	Stratgic and Tactical Handbooks designed and issued to On Call Management Groups
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Fully compliant	Needs review	Ian Kilroy - Resilience Manager	Jul-19	Current ICC at HRI and CRH available for usage. Both sites require review. Deep dive
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Position present
32	Response	Management of business continuity incidents	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans	Fully compliant		Ian Kilroy - Resilience Manger	N/A	
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records	Fully compliant	Needs review	Ian Kilroy - Resilience Manager	N/A	CHFT have Resilience Management Team PHE Loggist Trainers x2. Training package needs agreement with On Call and Incident Response facilities. WY Audit supports development of roles. Sessions been agreed. Staff to be identified and training agreed in next 12 months.
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Fully compliant		Ian Kilroy - Resilience Manager	N/A	

35	Response	Access to 'Clinical Guidance for Major Incidents'	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Accessible on EPRR internal web site
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Accessible on EPRR internal web site
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Fully compliant		Victoria Pickles - Company Secretary	N/A	Evidence with connection with Kirklees and Calderdale LA Group. Equally connect with Greater Huddersfield and Calderdale CCG. WYAT is additionally presnet.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Fully compliant		Victoria Pickles - Company Secretary	N/A	Communications Stragey agreed.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Fully compliant		Victoria Pickles - Company Secretary	N/A	Communincations Team lead assistance
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings	Fully compliant	To be reviewed	Lesley Hill		Resilience Manager recognised attendance and will priorities attendance. AEO to be changed in Sep 2018. Agreements for attendance at the meetings are identified as essential functions.
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Fully compliant	To be reviewed	Lesley Hill		AEO to be changed in Sep 2018. Agreements for attendance at the meetings are identified as essential functions.
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Fully compliant		Ian Kilroy - Resilience Manager	N/A	
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Fully compliant		Lesley Hill	Jul-19	
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Fully compliant		Ian Kilroy - Resilience Manager	N/A	BCM Policy agreed
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Table Top and Simulation Based Exercises completed.
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Database and Internal web page developed
50	Business Continuity	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Fully compliant		IT Security Manager, THIS	N/A	Information available
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Multiple improvements made. Evidenbace available.
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Fully compliant	To be reviewed and continued	Ian Kilroy - Resilience Manager	N/A	Evalaution reports available
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Fully compliant	To be reviewed and continued	Ian Kilroy - Resilience Manager	N/A	Internal Audits completed
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Improvements evidence available
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Partially compliant	To reviewed and continued	Ian Kilroy - Resilience Manger	N/A	
56	CBRN	Telephony advice for CBRN exposure	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully compliant		Ian Kilroy - Resilience Manager	N/A	

57	CBRN	HAZMAT / CBRN planning arrangement	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Fully compliant		Ian Kilroy - Resilience Manager	N/A	HAZMAT Plan agreed, YAS Audit improved. PRPS developed. Tent improved. YAS Presentation improved. CHFT ED staff scheduled training dates for ED Staff.
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Assessment aligned to core statndards risk profile
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Partially compliant		Ian Kilroy - Resilience Manager	N/A	Trained staff developing
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/epr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Fully compliant		Ian Kilroy - Resilience Manager	N/A	CHFT Medical Engineers confirm equipment, devices and maintenance
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Annual maintennace agreed
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Fully compliant		Ian Kilroy - Resilience Manager	N/A	CHFT Medical Engineers confirm equipment, devices and maintenance
63	CBRN	Equipment PPM	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Fully compliant		Ian Kilroy - Resilience Manager	N/A	
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Fully compliant		Ian Kilroy - Resilience Manager	N/A	
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Y	Maintenance of CPD records	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Resilience Manager and x3 CHFT staff (ED Consultatnt, ED Nurse & ED Training Facilitator) attended PRPS, NARU, YAS training events.
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully compliant		Alexandra Kersink - ED Training	To be reviewed and managed internally	ED Staff training dates agreed Sep-Nov 2018. Improved progression identified. Planned to achieve.
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Fully compliant		Ian Kilroy - Resilience Manager	N/A	Threat assessment. PRPS. Tent. EPRR information shared. HAZMAT Guidance booklet developed. Step 123 videoas available. HAZMAT Incident Response Plan agreed and available on internal web site.
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully compliant		Alexandra Kersink - ED Training	To be reviewed and managed internally	ED Staff training dates agreed Sep-Nov 2018. Improved progression identified. Planned to achieve
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	Y		Fully compliant		Alexandra Kersink - ED Training	To be reviewed and managed internally	

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control										
Domain: Incident Coordination Centres										
1	Incident Coordination Centres	Communication and IT equipment	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y		Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
2	Incident Coordination Centres	Resilience	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Up to date training records of staff able to resource an ICC	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
3	Incident Coordination Centres	Equipment testing	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Post test reports Lessons identified EPRR programme	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
4	Incident Coordination Centres	Functions	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
Domain: Command structures										
5	Command structures	Resilience	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
6	Command structures	Stakeholder interaction	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	EPRR policy statement and response structure	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
7	Command structures	Decision making processes	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
8	Command structures	Recovery planning	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	

Overall assessment:			Substantially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
11	**Duty to maintain**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	
17	**Duty to maintain**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented
18	**Duty to maintain**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented. Additionally, OPEL Plan being reviewed.
19	**Duty to maintain**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Non compliant	Gather information, write plan, implement changes to services effected.	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented
23	**Duty to maintain**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Review of current position required	Ian Kilroy - Resilience Manager	Jul-19	Exercise Mohawk demonstrated engagement. E-Learning Mass Casualty/Counter Twerrorism/ Fatalities implemented. Additionally, OPEL Plan being reviewed.
55	**Business Contin**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Partially compliant	To reviewed and continued	Ian Kilroy - Resilience Manger	N/A	
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 2	Partially compliant		Ian Kilroy - Resilience Manager	N/A	Trained staff developing
1	**Incident Coordin**	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.		Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	

2	**Incident Coordin**	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Up to date training records of staff able to resource an ICC	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
3	**Incident Coordin**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Post test reports Lessons identified EPRR programme	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
4	**Incident Coordin**	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
5	**Command struct**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
6	**Command struct**	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	EPRR policy statement and response structure	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
7	**Command struct**	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	
8	**Command struct**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Partially compliant	To be rewviewed	Bev Walker - Director in Urgent Care, Resilience Management Team	Jul-19	

13. Director of Infection, Prevention and Control Annual Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 6th September 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Quarterly DIPC Report - The Board is asked o receive the report on the position of healthcare associated infections	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked o receive the report on the position of healthcare associated infections

Main Body

Purpose:

none

Background/Overview:

none

The Issue:

none

Next Steps:

none

Recommendations:

The Board is asked o receive the report on the position of healthcare associated infections

Appendix

Attachment:

Quarterly DIPC Report 31st July 2018.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Quarterly DIPC report
1st April 2018 to 31st July 2018

Performance targets

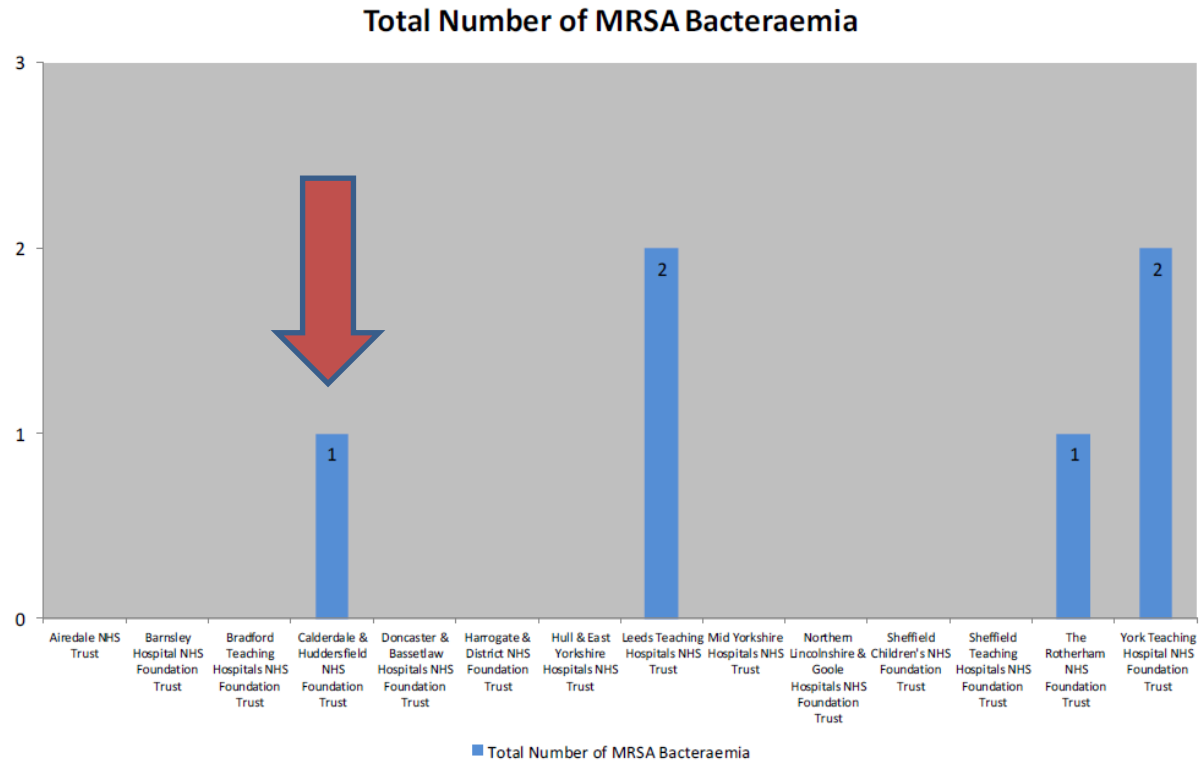
Indicator	End of year ceiling	Year-end performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**1**	This case is a pre case and he had repeatedly positive blood cultures during his hospital admission. It is classified as an ongoing infection but will appear on CHFT figures.
C.difficile (trust assigned)	20	**13**	7 Non Preventable 5 Preventable 1 Pending RCA meeting
MSSA bacteraemia (post admission)	9	**2**	Local ceiling – 15/16 outturn 1 in the Medical division 1 in the Surgical division
E.coli bacteraemia (post admission)	39	**16**	Local ceiling – 15/16 out-turn with a 10% reduction year on year.
MRSA screening (electives)	95%	97.3%	
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.53%	Rolling 12 months
ANTT Competency assessments (doctors)	90%	78.54%	Divisions have been tasked with improving compliance.
ANTT Competency assessments (nursing and AHP)	90%	93.86%	Well done to our nursing colleagues
Hand hygiene	95%	99%	

Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	95.8%	
Isolation breaches	**Non set**	101	This is a slight increase compared to the same time period last year. (97)
Cleanliness	Non set	96.5%	

MRSA bacteraemia:
There has been 1 MRSA cases attributed to the organisation; a gentleman who had previously had 2 pre MRSA bacteraemia since the 1st April. Repeat blood cultures where taken on numerous times during his hospital admission, it is classified as an ongoing infection but will appear on CHFT figures.

The chart below compares total numbers of attributed MRSA bloodstream infections to each organisation in Yorkshire & The Humber.



MSSA bacteraemia:
There have been 2 post-admission MSSA bacteraemia cases from the 1st April to the end of July 2018; compared to 10 for the same time period last year.
No comparative data is available with other Trusts.

Clostridium difficile:
The ceiling for 2018/19 is for no more than 20 post-admission cases. From the 1st April to the end of July there have been 13; compared to 8 for the same time period last year.
There have been no clusters or link cases identified.

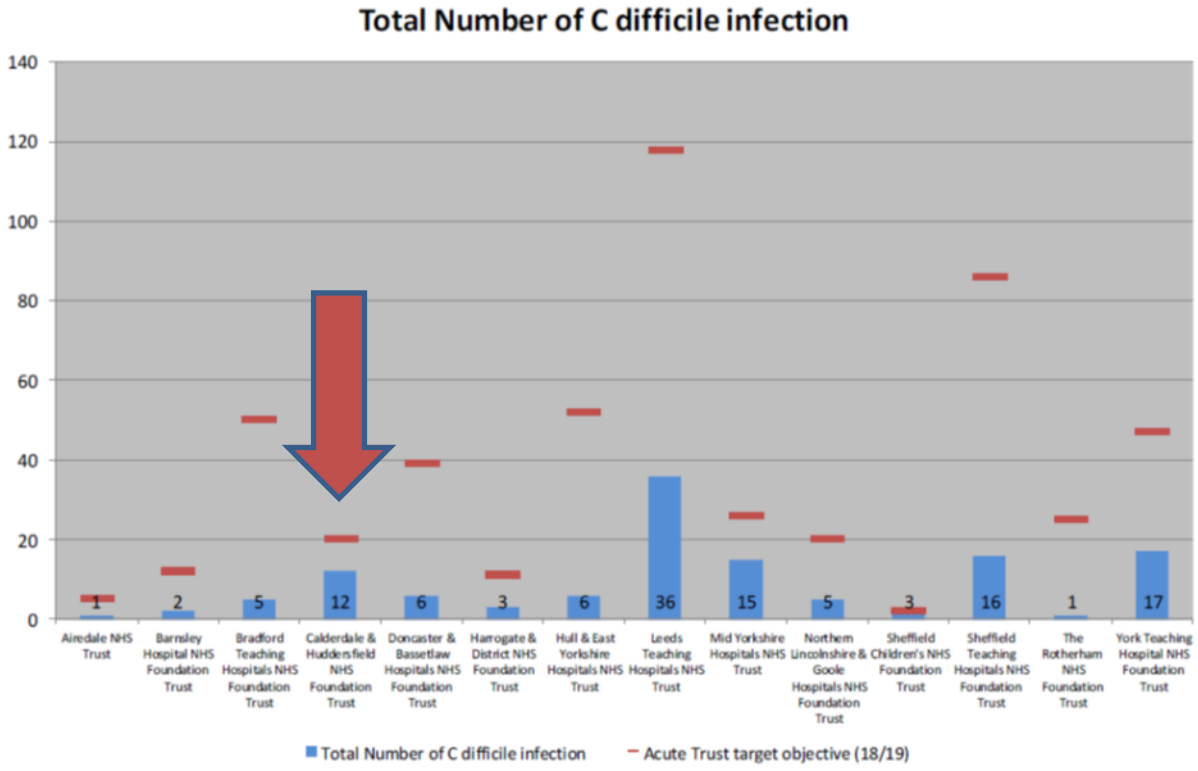
Key themes from the C. difficile cases identified at post-infection review are:

- Completion of the Bristol Stool Chart and assessing patient bowel habits. Compliance with this reduced since the introduction of EPR. Work is ongoing to improve access to, and use, of the Bristol Stool Chart within EPR.

- Delay in isolation – wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling.
- Antibiotic prescribing is generally in line with policy, although inappropriate antibiotic prescribing including extended courses of antibiotics has been highlighted in a couple of cases. Antibiotics guidelines are currently being reviewed.

Work is ongoing to improve compliance with the above issues, and is incorporated within the HCAI Action Plan.

The chart below compares total numbers of attributed C. difficile infections to each organisation in Yorkshire & The Humber.



E. coli bacteraemia:

There have been 16 post-admission E-coli bacteraemia cases against the internal objective of 39; There is both a Trust and health economy wide reduction plan which has been developed and will be monitored through the HAI Performance Board and the HCAI Health Economy Meeting.

Outbreaks & Incidents: There have been a number of Norovirus outbreaks

WARDS CLOSED & BED DAYS LOST FIGURES					
MONTH	**HOSPITAL SITE**	**WARD**	**DAYS CLOSED**	**BAY/S CLOSED**	**BED DAYS LOST**
April	HRI	H1	6	-	60
		H8	6	-	17
		H20B	13	-	21
		H22	4	-	10

There has been a cluster of CPE cases identified on one of the wards, this has been managed as an outbreak.

Influenza:
A planning meeting has been arranged for August to prepare for the next Flu season.
The staff flu immunisation campaign is currently being planned and will commence the first week in October; we aim to achieve a 75% uptake.

Central Vascular Access Device related bacteraemia
The internally set target for CVAD related bacteraemia is 1 per 1000 CVAD line days, the current rate is 0.53%

Isolation Breaches
There have been 101 isolation breaches since 1st April 2018 compared to 97 breaches for the same time period last year. The majority of breaches are patients with a previous history of MRSA colonisation at the time of admission to MAU, or patients being transferred and their infection status not being handed over, although this information is all clearly visible within the EPR; the IPCT will continue to monitor isolation breaches.

Audits:
23 Quality improvement environmental audits have been carried out since the beginning 1st April 2018 to 31st July.
Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating.

- 12 of the areas achieved a green rating.
- 11 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.

Other:
The IPC surveillance system is currently undergoing an upgrade which will hopefully assist us in the management of outbreaks and much improved SSI reporting, the anticipated 'go live' date is December 2018.
The IPCT continue to work both proactively and reactively and developing more collaborative working with the divisions.

14. West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding

To Approve

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding - A Memorandum of Understanding (MOU) for the West Yorkshire and Harrogate Health and Care Partnership	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

-

Main Body

Purpose:

The purpose of this paper is to seek the Board's approval for:
• the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership; and
• Calderdale & Huddersfield NHS Foundation Trust to commit to working in partnership by authorising the Chief Executive to sign the MoU.

Background/Overview:

1. West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the NHS Five Year Forward View. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, including Calderdale & Huddersfield NHS Foundation Trust.
2. In November 2016 the STP published high level proposals to improve health, reduce care variation and manage our finances. Since then the partnership has made significant progress to build capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our collective aims.
3. The partnership has already begun to make an impact in other important areas. Our Cancer Alliance Board is a national exemplar, and has attracted £12.6m in funding to transform cancer diagnostics. We have developed a strategic case for change for stroke from prevention to after care. We have streamlined management of CCGs and established a Joint Committee of CCGs and Committee in Common for acute trusts; these will strengthen collaborative working and facilitate joint decision making. We have secured £31m in transformation funding for A&E, cancer, mental health, learning disabilities and diabetes, and £38m capital from the Autumn budget for CAMHS, pathology, telemedicine, and digital imaging.
4. In October 2017 the System Leadership Executive Group agreed that a new MoU should be developed to formalise working arrangements and support the next stage of development of the WY&H HCP. The MoU builds on the existing partnership arrangements to establish more robust mutual accountability.
5. The final draft of the MoU is attached as an Appendix to this paper for approval.

Purpose of the MoU
1. The MoU is an agreement between the WY&H health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.
2. The MoU does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework to underpin collective ownership of delivery. It also provides the basis for a refreshed relationship between local NHS organisations and national oversight bodies.
3. The MoU is not a legal contract, but is a formal agreement between all of the partners. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.
4. The draft MoU should be read in conjunction with the STP Plan, published in November 2016, the Next Steps (February 2018) and the local plan for Calderdale & Huddersfield NHS Foundation Trust.

5. The MoU provides a platform for:
a) a refresh of the governance arrangements for the partnership, including across WY&H, and the relationship with individual Places and statutory bodies;
b) the delivery of a mutual accountability framework that ensures we have collective ownership of delivery,

rather than a hierarchical approach
c) a new approach to commissioning, and maturing provider networks that collaborate to deliver services in place and at WY&H level;
d) clinical and managerial leadership of change in major transformation programmes;
e) a transparent and inclusive approach to citizen engagement in development, delivery and assurance;
f) better political ownership of, and engagement in the agenda, underpinned by regular opportunities for challenge and scrutiny; and
g) a new assurance and accountability relationship with the NHS regulatory and oversight bodies that provides new flexibilities for WY&H to assert greater control over system performance and delivery and the use of transformation and capital funds; and
h) the agreement an effective system of risk management and reward for NHS bodies.

6. The text of the MoU sets out details of:
• The context for our partnership;
• The partner organisations;
• How we work together in WY&H, including our principles, values and behaviours;
• The objectives of the partnership, and how our joint priority programmes and enabling workstreams will improve service delivery and outcomes across WY&H;
• Our mutual accountability and governance arrangements, including how we will move towards a new approach to assurance, regulation and accountability with the NHS national bodies;
• Our joint financial framework;
• The support that will be provided to the Partnership by the national and regional teams of NHSE and NHSI;
• Which aspects of the agreement apply to particular types of organisation.

Becoming and Integrated Care System
1. In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way our WY&H partnership works and for the progress we have made. It means we can join the leading edge of health and care systems, gaining more influence and more control over the way we deliver services and support for the 2.6 million people living in our area.

2. The importance of joining up services for people at a local level in Bradford District and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield is at the heart of our local plans and our WY&H programmes. All decisions on services are made as locally and as close to people as possible. Our move to becoming an ICS is predicated on this continuing to be the case.

3. This integrated approach to health and care will continue to support much closer working between our organisations. The MoU will provide a firm foundation for this. It reflects and builds on the current ways of working and agreed principles for the partnership and maintains an ethos of the primacy of local Place.

The Issue:

Progress to Date
1. Over recent months drafts of the MoU have been discussed in development sessions by members of the Boards and Governing Bodies of partner organisations and by members of Health and Wellbeing Boards and the WY&H Joint Overview and Scrutiny Committee. We discussed the MOU at the Board meeting in May and sent feedback to the HCP.

2. Feedback from these discussions has directly influenced the development of the final draft, which has now been agreed by the WY&H HCP System Leadership Executive Group.

3. The HCP core team has sought a legal opinion on the text of the MoU, on behalf of all Partner organisations. The lawyers were able to provide helpful suggestions to improve clarity and remove elements of ambiguity. They also confirmed that the MoU was sound, and was not inconsistent with statutory or regulatory frameworks, or with the powers and duties of individual partners.

What it means for Calderdale and Huddersfield NHS Foundation Trust
By signing the MoU we will commit to play our full role as a member of WY&H HCP and to work within the

frameworks described. Accepting our share of collective responsibility will give us and our partners the opportunity to achieve greater autonomy and control over how we develop and transform our health and care services. The partnership will be an overall collaborative framework for local Accountable Care Partnerships.

Next Steps:

Each Partner organisation is being asked to approve and sign the MoU. It is expected that this process will be completed over the summer.

Recommendations:

It is recommended that the Board
a) Approve the MoU; and
b) Authorise the Chief Executive to sign the MoU.

Appendix

Attachment:

Combined - WY and Harrogate Health and Care Partnership Memo of Understanding.pdf

West Yorkshire and Harrogate
Health and Care Partnership

Memorandum of Understanding

D R A F T

August 2018

Contents

Foreword

Since the creation of West Yorkshire and Harrogate Health and Care Partnership in March 2016, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 2.6 million people living in our area.

Our commitment remains the same and our goal is simple: we want everyone in West Yorkshire and Harrogate to have a great start in life, and the support they need to stay healthy and live longer. We are committed to tackling health inequalities and to improving the lives of the poorest fastest. Our commitment to an NHS free at the point of delivery remains steadfast, and our response to the challenges we face is to strengthen our partnerships.

The proposals set out in our plan are firming up into specific actions, backed by investments. This is being done with the help of our staff and communities, alongside their representatives, including voluntary, community organisations and local councillors. Our bottom-up approach means that this is happening at both a local and WY&H level which puts people, not organisations, at the heart of everything we do.

We have agreed to develop this Memorandum of Understanding to strengthen our joint working arrangements and to support the next stage of development of our Partnership. It builds on our existing collaborative work to establish more robust mutual accountability and break down barriers between our separate organisations.

Our partnership is already making a difference. We have attracted additional funding for people with a learning disability, and for cancer diagnostics, diabetes and a new child and adolescent mental health unit.

However, we know there is a lot more to do. The health and care system is under significant pressure, and we also need to address some significant health challenges. For example we have higher than average obesity levels, and over 200,000 people are at risk of diabetes. There are 3,600 stroke incidents across our area and we have developed a strategic case for change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions. This Memorandum demonstrates our clear commitment to do this.

Rob Webster
West Yorkshire and Harrogate Health and Care Partnership Lead
CEO South West Yorkshire Partnership NHS FT

1. Parties to the Memorandum

1.1. The members of the West Yorkshire and Harrogate Health and Care Partnership (the **Partnership**) , and parties to this Memorandum, are:

Local Authorities

- City of Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council[1]
- Wakefield Council

NHS Commissioners

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG
- NHS England

NHS Service Providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- The Leeds Teaching Hospitals NHS Trust
- The Mid Yorkshire Hospitals NHS Trust

- South West Yorkshire Partnership NHS Foundation Trust[1]
- Tees, Esk, and Wear Valleys NHS Foundation Trust[1]
- Yorkshire Ambulance Service NHS Trust[1]

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission [TBC]

Other Partners

- Locala Community Partnerships CIC
- Healthwatch Bradford and District
- Healthwatch Calderdale
- Healthwatch Kirklees
- Healthwatch Leeds
- Healthwatch North Yorkshire
- Healthwatch Wakefield
- Yorkshire and Humber Academic Health Science Network[1].

1.2. As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this Memorandum.

1.3. Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

Definitions and Interpretation

1.4. This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5. This Memorandum shall commence on the date of signature of the Partners, and shall continue for an initial period of three (3) years and thereafter subject to an annual review of the arrangements by the [Partnership Board].

[1] These organisations are also part of neighbouring STPs.

Local Government role within the partnership

1.6. The West Yorkshire and Harrogate Health and Care Partnership includes eight local government partners. The five Metropolitan Councils in West Yorkshire and North Yorkshire County Council lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and the local Health and Wellbeing Boards. The Metropolitan Councils, Harrogate Borough Council and Craven District Council lead on housing. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions.

1.7. Within the WY&H partnership the NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

1.8. Local government's regulatory and statutory arrangements are separate from those of the NHS. Councils are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime certain aspects of these arrangements will not apply. Most significantly, Councils would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

Partners in Local Places

1.9. The NHS and the Councils within the partnership have broadly similar definitions of place. (The rural Craven district is aligned with Bradford for NHS purposes, but is seen as a distinct local government entity in its own right within North Yorkshire.)

1.10. All of the Councils, CCGs, Healthcare Providers and Healthwatch organisations are part of their respective local place-based partnership arrangements. The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making. Other key members of these partnerships include:

- GP Federations
- Specialist community service providers
- Voluntary and community sector organisations and groups
- Housing associations.
- other primary care providers such as community pharmacy, dentists, optometrist
- independent health and care providers including care homes

2. Introduction and context

2.1. This Memorandum of Understanding (Memorandum) is an understanding between the West Yorkshire and Harrogate health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

2.2. West Yorkshire and Harrogate Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven[2], Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

2.3. Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

2.4. We published our high level proposals to close the health, care and finance gaps that we face in November 2016. Since then we have made significant progress to build our capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our aims.

Purpose

2.5. The purpose of this Memorandum is to formalise and build on these partnership arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.6. The Memorandum is not a legal contract and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. It is a formal understanding between all of the Partners who have each entered into this Memorandum intending to honour all their obligations under it. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

2.7. Nothing in this Memorandum is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the

[2] Whilst Craven is organisationally aligned with the NHS in Bradford, it is a distinctive place in its own right, forming part of North Yorkshire.

Memorandum, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

2.8. The Memorandum should be read in conjunction with the Partnership Plan, published in November 2016, the Next Steps (February 2018) and the six local Place plans across West Yorkshire and Harrogate.

Developing new collaborative relationships

2.9. Our approach to collaboration begins in each of the 50-60 neighbourhoods which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

2.10. Neighbourhood services sit within each of our six local places (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These places are the primary units for partnerships between NHS services, local authorities, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services.

2.11. The focus for these partnerships is moving increasing away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

2.12. These place-based partnerships, overseen by Health and Wellbeing Boards, are key to achieving the ambitious improvements we want to see. However, we have recognised that there also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for West Yorkshire and Harrogate as a whole. We apply three tests to determine when to work at this level:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (ie, complex, intractable problems).

2.13. The arrangements described in this Memorandum describe how we will organise ourselves, at West Yorkshire & Harrogate level, to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

Promoting Integration and Collaboration

2.14. The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

2.15. The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHS Improvement Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and Monitor/NHS Improvement and will keep this position under review accordingly.

2.16. The Partners understand that no decision shall be made to make changes to services in West Yorkshire and Harrogate or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

3. How we work together in West Yorkshire and Harrogate

Our vision

3.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer and stroke
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Overarching leadership principles for our partnership

3.2. We have agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking

place at the appropriate level and as near to local as possible

Our shared values and behaviours

3.3. We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

Partnership objectives

3.4. Our ambitions for improving health outcomes, joining up care locally, and living within our financial means were set out in our STP plan (November 2016, available at: https://wyhpartnership.co.uk/meetings-and-publications/publications). This Memorandum reaffirms our shared commitment to achieving these ambitions and to the further commitments made in *Next Steps for the West Yorkshire and Harrogate Health and Care Partnership*, published in February 2018.

3.5. In order to achieve these ambitions we have agreed the following broad objectives for our Partnership:

i. To make fast and tangible progress in:
   - enhancing urgent and emergency care,
   - strengthening general practice and community services,
   - improving mental health services,
   - improving cancer care,
   - prevention at scale of ill-health,
   - collaboration between acute service providers,
   - improving stroke services, and
   - improving elective care, including standardisation of commissioning policies.

ii. To enable these transformations by working together to:
   - Secure the right workforce, in the right place, with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff ,

- Engage our communities meaningfully in co-producing services,
- Use digital technology to drive change, ensure systems are inter-operable, and create a 21st Century NHS,
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the strategic capital and estates plans across West Yorkshire and Harrogate, maximising all possible funding sources and ensuring our plans support the delivery of our clinical strategy, and
- Ensure that we have the best information, data, and intelligence to inform the decisions that we take.

iii. To manage our financial resources within a shared financial framework for health across the constituent CCGs and NHS provider organisations; and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

iv. To operate as an integrated health and care system, and progressively to build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services;

v. To act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

Delivery improvement

3.6. Delivery and transformation programmes have been established to enable us to achieve the key objectives set out above. Programme Mandates have been developed for each programme and enabling workstream. These confirm:

- The vision for a transformed service
- The specific ambitions for improvement and transformation
- The component projects and workstreams
- The leadership arrangements.

3.7. Each programme has undergone a peer review 'check and confirm' process to confirm that it has appropriate rigour and delivery focus.

3.8. As programme arrangements and deliverables evolve over time the mandates will be revised and updated as necessary.

4. Partnership Governance

4.1. The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

4.2. The Partnership provides a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale.

4.3. A schematic of our governance and accountability relationships is provided at **Annex 2** and terms of reference of the Partnership Board, System Leadership Executive and System Oversight and Assurance Group are provided at **Annex 3**.

Partnership Board

4.4. A Partnership Board will be established to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

4.5. The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils and senior representatives of other relevant Partner organisations. The Partnership Board will have an independent chair and will meet at least four times each year in public.

4.6. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive

4.7. The System Leadership Executive (SLE) Group includes each statutory organisation and representation from other Partner organisations. The group is responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives.

4.8. Each organisation will be represented by its chief executive or accountable officer. Members of the SLE will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

4.9. A new system oversight and assurance group (SOAG) will be established in 2018/19 to provide a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It will:

- be chaired by the Partnership Lead;
- include representation covering each sector / type of organisation;
- regularly review a dashboard of key performance and transformation metrics; and
- receive updates from WY&H programme boards.

4.10. The SOAG will be supported by the partnership core team.

West Yorkshire and Harrogate programme governance

4.11. Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate priority and enabling programmes (the **Programmes**). Each programme has a Senior Responsible Owner, typically a Chief Executive, accountable officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each relevant service sector.

4.12. Programmes will provide regular updates to the System Leadership Executive and System Oversight and Assurance Group. These updates will be published on the partnership website.

Other governance arrangements between Partners

4.13. The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, acute providers, mental health providers, Councils) that support the way it works. These are described in paragraphs 4.14 to 4.29 below.

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

4.14. The nine CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six Places that make up our Partnership.

4.15. The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

4.16. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs.

West Yorkshire Association of Acute Trusts Committee in Common

4.17. The six acute hospital trusts in West Yorkshire and Harrogate have come together as the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone; they require the hospitals to work together to achieve solutions for the whole of West Yorkshire and Harrogate that improve the quality of care, increase the health of people and deliver more efficient services.

4.18. WYAAT is governed by a memorandum of understanding which defines the objectives and principles for collaboration, together with governance, decision making and dispute resolution processes. The memorandum of understanding establishes the WYAAT Committee in Common, which is made up of the Chairs and Chief Executives of the six trusts, and provides the forum for working together and making decisions in a common forum. Decisions taken by the Committee in Common are then formally approved by each Trust Board individually in accordance with their own internal procedures.

West Yorkshire Mental Health Services Collaborative

4.19. The four trusts providing mental health services in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust and South West Yorkshire Partnership Foundation Trust) have come together to form the West Yorkshire Mental Health Services Collaborative (WYMHSC). The trusts will work together to share best practice and develop standard operating models and pathways to achieve better outcomes for people in West Yorkshire and ensure sustainable services into the future.

4.20. The WYMHSC is underpinned by a memorandum of understanding and shared governance in the form of 'committees in common'.

4.21. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services to the Harrogate area.

Local council leadership

4.22. Relationships between local councils and NHS organisations are well established in each of the six places and continue to be strengthened. Complementary arrangements for the whole of West Yorkshire and Harrogate have also been established:

- Local authority chief executives meet and mandate one of them to lead on

health and care partnership;

- Health and Wellbeing Board chairs meet;
- A Joint Health Overview and Scrutiny Committee
- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

Clinical Forum

4.23. Clinical leadership is central to all of the work we do. Clinical leadership is built into each of our work programmes, and our Clinical Forum provides formal clinical advice to all of our programmes.

4.24. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

4.25. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

4.26. The Clinical Forum has agreed Terms of Reference which describe its scope, function and ways of working.

Local Place Based Partnerships

4.27. Local partnerships arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population. Each of the six Places in West Yorkshire and Harrogate has developed its own arrangements to deliver the ambitions set out in its own Place Plan.

4.28. These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

4.29. There are seven local health and care partnerships (two in Bradford District and Craven and one in each other place) which will develop horizontally integrated networks to support seamless care for patients.

5. Mutual accountability framework

5.1. A single consistent approach for assurance and accountability between Partners on West Yorkshire and Harrogate system wide matters will be applied through the governance structures and processes outlined in Paragraphs 4.1 to 4.12 above.

Current statutory requirements

5.2. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

5.3. NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

A new model of mutual accountability

5.4. Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health. The partners will:

- Agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across WY&H; and
- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

5.5. The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

5.6. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

5.7. System oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a clinically and publically-led process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

5.8. The Programmes will, where appropriate, take on increasing responsibility for managing this process. The extent of this responsibility will be agreed between each Programme and the SLE.

5.9. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a co-ordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking action

5.10. The SOAG will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal action and interventions. Actions allocated to the SOAG are to make recommendations on:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- the appointment of a turnaround Director / team; and
- restrictions on access to discretionary funding and financial incentives.

5.11. For Places where financial performance is not consistent with plan, the Partnership Directors of Finance Group will make recommendations to the SOAG on a range of interventions, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- the appointment of a turnaround Director / team;

- enhanced controls around deployment of transformation funding held at place; and
- reduced priority for place-based capital bids.

The role of Places in accountability

5.12. This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

5.13. Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

5.14. In each Place the statutory bodies come together in local health and care partnerships to agree and implement plans across the Place to:

- Integrate mental health, physical health and care services around the individual
- Manage population health
- Develop increasingly integrated approaches to joint planning and budgeting

Implementation of agreed strategic actions

5.15. Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies oversight and escalation

5.16. As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in West Yorkshire and Harrogate in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership to seek a resolution prior to making an intervention with the Partner.

6. Decision-Making and Resolving Disagreements

6.1. Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

Collective Decisions

6.2. There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- **Decisions delegated to collaborative forums** - some partners have delegated specific decisions to a collaborative forum, for example the CCGs have delegated certain commissioning decisions to the Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the respective Joint Committee and not this Memorandum. There are also a specific dispute resolution mechanisms for WYATT and the WYMHC.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in Paragraphs 6.3 below.

6.3. Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating decisions relating to regulatory and oversight functions currently exercised from outside the WY&H system and will look to reach recommendations and any decisions on a Best for WY&H basis. The terms of reference for the Partnership Board will set out clearly the types of decision which it will have responsibility to discuss and how conflicts of interest will be managed. The Partnership Board will initially have responsibility for decisions relating to:

- The objectives of priority HCP work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

6.4. SLE will make recommendations to the Partnership Board on these matters. Where appropriate, the Partnership Board will make decisions of the Partners by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may

be referred to the dispute resolution procedure under Paragraph 6.6 below by any of the affected Partners for resolution.

6.5. In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

Dispute resolution

6.6. Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

6.7. Where necessary, Place or sector-based arrangements (the Joint Committee of CCGs, WYAAT, and WYMHSC as appropriate) will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

6.8. The Partnership will apply a dispute resolution framework to resolve any issues which cannot otherwise be agreed through these arrangements.

6.9. As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

6.10. The key stages of the dispute resolution process are

i. The SOAG will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If SOAG cannot resolve the dispute within 30 days, the dispute should be referred to SLE.

ii. SLE will come to a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. SLE will advise the Partners of its decision in writing.

iii. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the dispute in accordance with the terms of this Memorandum.

iv. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

7. Financial Framework

7.1. All NHS body Partners, in West Yorkshire and Harrogate are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

7.2. A set of financial principles have been agreed, within the context of the broader guiding Principles for our Partnership. They confirm that we will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a West Yorkshire and Harrogate system response to the financial challenges we face; and
- develop payment and risk share models that support a system response rather than work against it.

7.3. We will collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

Living within our means and management of risk

7.4. Through this Memorandum the collective NHS Partner leaders in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective NHS body Partners involved.

7.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks in each Place leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

7.6. The NHS Partners are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

7.7. The Partners intend that any transformation funds made available to the Partnership will all be used within the Places. Funds will be allocated through collective decision-making by the Partnership in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the Partners have agreed that they will deliver the maximum leverage for change and address financial risk.

7.8. The funding provided to Places (based on weighted population) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all Partners that the resource has been deployed to deliver maximum transformational impact, to address financial risk, and to meet the efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and SOAG and be subject to on-going monitoring and assurance from the Partnership.

7.9. Funding provided to the Programmes (all of which will also be deployed in Place) will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant Partners.

Allocation of ICS capital

7.10. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this Memorandum.

Allocation of Provider and Commissioner Incentive Funding

7.11. The approach to managing performance-related incentive funds set by NHS planning guidance and business rules (e.g. the 2018/19 Provider Sustainability Fund and Commissioner Sustainability Fund) is not part of this Memorandum. A common approach to this will be agreed by the Partnership as part of annual financial planning.

8. National and regional support

8.1. To support Partnership development as an Integrated Care System there will be a process of aligning resources from ALBs to support delivery and establish an integrated single assurance and regulation approach.

8.2. National capability and capacity will be available to support WY&H from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9. Variations

9.1. This Memorandum, including the Schedules, may only be varied by written agreement of all the Partners.

10. Charges and liabilities

10.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

10.2. By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a “Contributions Schedule” to be developed by the Partnership and approved by the Partnership Board.

10.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

11. Information Sharing

11.1. The Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best for WY&H basis.

11.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

12. Confidential Information

12.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised

disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

12.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

12.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

12.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

13. Additional Partners

13.1. If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

13.2. The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

14. Signatures

14.1. This Memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Memorandum, but all the counterparts shall together constitute the same document.

14.2. The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

14.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

[INSERT SIGNATURE PAGES AFTER THIS]

Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

ALB	Arm's Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, eg NHSE, NHSI, HEE, PHE
Aligned Incentive Contract	A contracting and payment method which can be used as an alternative to the Payment by Results system in the NHS
Best for WY&H	A focus in each case on making a decision based on the best interests and outcomes for service users and the population of West Yorkshire and Harrogate
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
Committee in Common	
Confidential Information	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
CQC	Care Quality Commission, the independent regulator of all health and social care services in England

GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Paragraph 1.1
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better.
HWB	Health and Wellbeing Board
ICP	Integrated Care Partnership The health and care partnerships formed in each of the
ICS	Integrated Care System
JCCCG	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and "Laws" shall be construed accordingly
LWAB	Local Workforce Action Board sub regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	One of c.50 geographical areas which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people.
NHS	National Health Service
NHSE	NHS England Formally the NHS Commissioning Board
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS

NHSI	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
Objectives	The Objectives set out in Paragraph 3.5
Partners	The members of the Partnership under this Memorandum as set out in Paragraph 1.1 who shall not be legally in partnership with each other in accordance with Paragraph 2.7.
Partnership	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
Partnership Board	The senior governance group for the Partnership set up in accordance with Paragraphs 4.4 to 4.6
Partnership Core Team	The team of officers, led by the Partnership Director, which manages and co-ordinates the business and functions of the Partnership
PHE	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
Places	One of the six geographical districts that make up West Yorkshire and Harrogate, being Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, and "Place" shall be construed accordingly
Principles	The principles for the Partnership as set out in Paragraph 3.2
Programmes	The WY&H programme of work established to achieve each of the objectives set out in paras 4.2,i and 4.2,ii of this memorandum
SOAG	System Oversight and Assurance Group
STP	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
System Leadership Executive or SLE	The governance group for the Partnership set out in Paragraphs 4.7 and 4.8

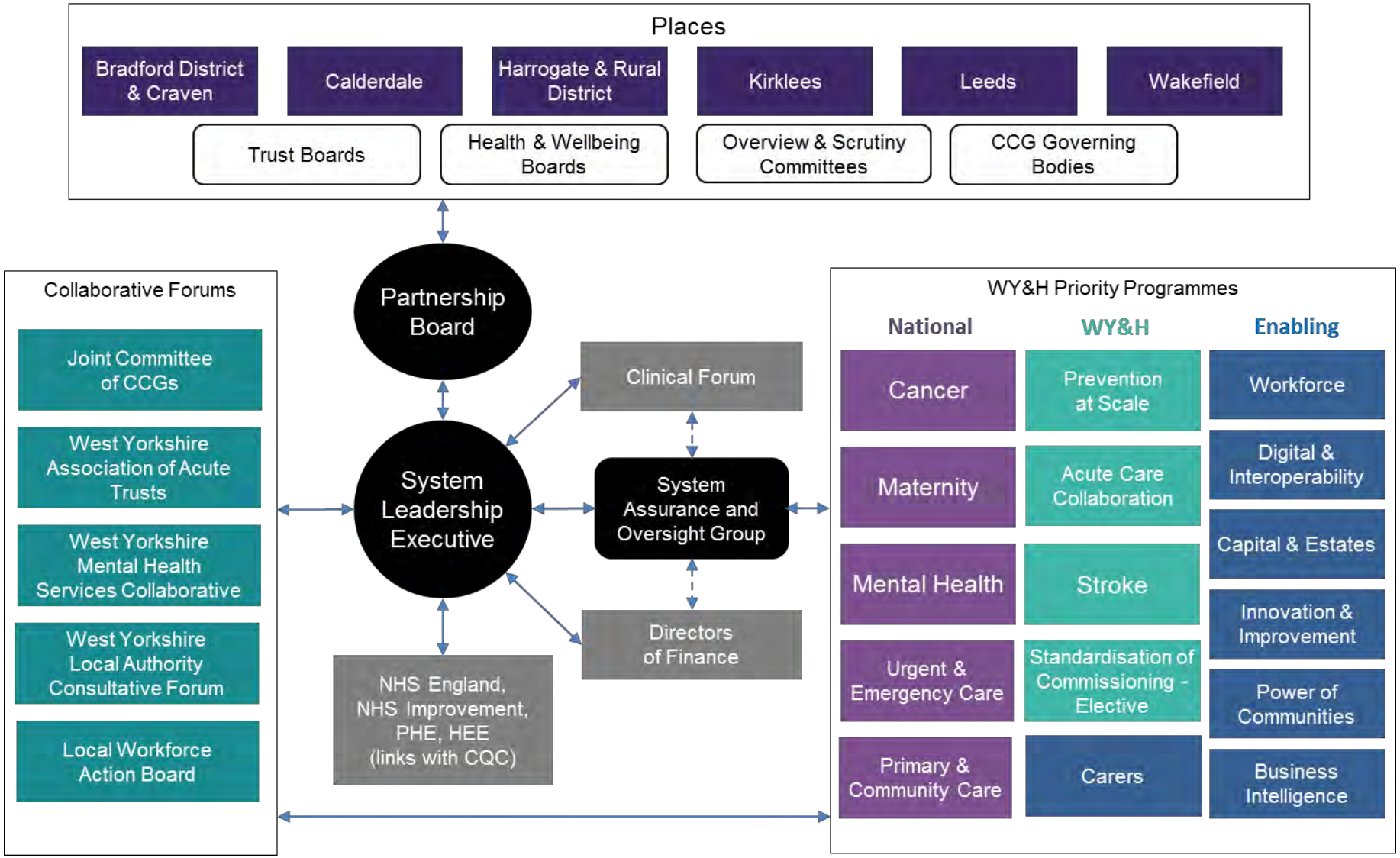
Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association of Acute Trusts
WYMHC	West Yorkshire Mental Health Collaborative

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers[3]	Councils	NHSE and NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financial framework – financial risk management	✓	✓		✓		
Financial framework – Allocation of capital and transformation funds	✓	✓	✓	✓		
National and regional support	✓	✓	✓	✓		

[3] All elements of the financial framework for WY&H, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs.
Locala Community Partnerships CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Schematic of Governance and Accountability Arrangements



Annex 3 - Terms of Reference

Part 1: Partnership Board

Part 2: System Leadership Executive

Part 3: System Oversight and Assurance Group

West Yorkshire and Harrogate
Health and Care Partnership

Partnership Board

Terms of Reference

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June 2018

Contents

1. Introduction and context

1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3. The Partnership Board is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

1.4. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

1.5. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.

1.6. The Partnership Board will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

1.7. These Terms of Reference describe the scope, function and ways of working for the Partnership Board. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our Partnership

2.2. The Partnership Board operates within an agreed set of guiding principles that shape everything we do through our Partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate Partnership belongs to its citizens and to commissioners and providers, councils and NHS
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

Our shared values and behaviour

2.3. Members of the Partnership Board commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honestly and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction and providing strategic oversight for all Partnership business. It will make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

i. agree the broad objectives for the Partnership;

ii. consider recommendations from the System Leadership Executive Group and make decisions on :

- The objectives of priority Partnership work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership
- Operation of the single NHS financial control total (for NHS bodies)
- Common actions when systems become distressed

iii. act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;

iv. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;

v. oversee financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

vi. support the development of local partnership arrangements which bring

together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;

vii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;

viii. oversee a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;

ix. reach agreement in relation to recommendations made by other governance groups within the Partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;

x. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

4. Membership

4.1. The membership will comprise:

- An independent, non-executive Chair
- the Partnership lead CEO
- CCG Clinical Chairs
- CCG Accountable Officers
- Council leaders
- Council chief executives
- Chairs of Health and Wellbeing Boards of each Place
- Chairs of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum
- [Non-executive/Lay members – TBC]

4.2. A deputy Chair will be agreed from among the non-executive members.

4.3. A list of members is set out at **Annex 1**.

Deputies

4.4. If a member is unable to attend a meeting of the Partnership Board, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their organisation, place or group effectively. Deputies will be eligible to vote.

Additional attendees

4.5. Additional attendees will routinely include:

- The WY&H Partnership Director
- The WY&H Partnership Finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The Partnership Board will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The Partnership Board will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.2. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding set out at 5.3 below) it may be referred to the dispute resolution procedure under Paragraph 6.6 of the Partnership Memorandum of Understanding by any of the affected Partners for resolution.

5.3. In respect of priorities for capital investment or apportionment of transformation funding from the Partnership, then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members present at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

6. Accountability and reporting

6.1. The Partnership Board has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.

6.2. The Partnership Board has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements). The minutes, and a summary of key messages will be submitted to all Partner organisations after each meeting.

7. Conduct and Operation

7.1. The Partnership Board will meet in public, at least four times each year. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees and made available to the public no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any Partnership Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

7.8. The secretariat function for the Partnership Board will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

8.1. These terms of reference and the membership of the Partnership Board will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

Annex 1 – Members

Health and Wellbeing Boards

Bradford , Airedale and Wharfedale	✓
Calderdale	✓
Kirklees	✓
Leeds	✓
North Yorkshire	✓
Wakefield Council	✓

Local Authorities

	Leader	Chief Executive
City of Bradford Metropolitan District Council	✓	✓
Calderdale Council	✓	✓
Craven District Council	✓	✓
Harrogate Borough Council	✓	✓
Kirklees Council	✓	✓
Leeds City Council	✓	✓
North Yorkshire County Council	✓	✓
Wakefield Council	✓	✓

CCGs Clinical Chairs

	Chair	Accountable Officer
NHS Airedale, Wharfedale and Craven CCG	✓	✓
NHS Bradford City CCG	✓	✓
NHS Bradford Districts CCG	✓	✓
NHS Calderdale CCG	✓	✓
NHS Greater Huddersfield CCG	✓	✓
NHS Harrogate and Rural District CCG	✓	✓
NHS Leeds CCG	✓	✓
NHS North Kirklees CCG	✓	✓
NHS Wakefield CCG	✓	✓

NHS Service Providers

	Chair	Chief Executive
Airedale NHS Foundation Trust	✓	✓
Bradford District Care NHS Foundation Trust	✓	✓
Bradford Teaching Hospitals NHS Foundation Trust	✓	✓
Calderdale and Huddersfield NHS Foundation Trust	✓	✓
Harrogate and District NHS Foundation Trust	✓	✓
Leeds and York Partnership NHS Foundation Trust	✓	✓
Leeds Community Healthcare NHS Trust	✓	✓
The Leeds Teaching Hospitals NHS Trust	✓	✓
Locala Community Partnerships CIC	✓	✓
The Mid Yorkshire Hospitals NHS Trust	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓
Tees, Esk, and Wear Valleys NHS Foundation Trust	✓	✓
Yorkshire Ambulance Service NHS Trust	✓	✓

Heath Regulator and Oversight Bodies

NHS England	✓
NHS Improvement	✓

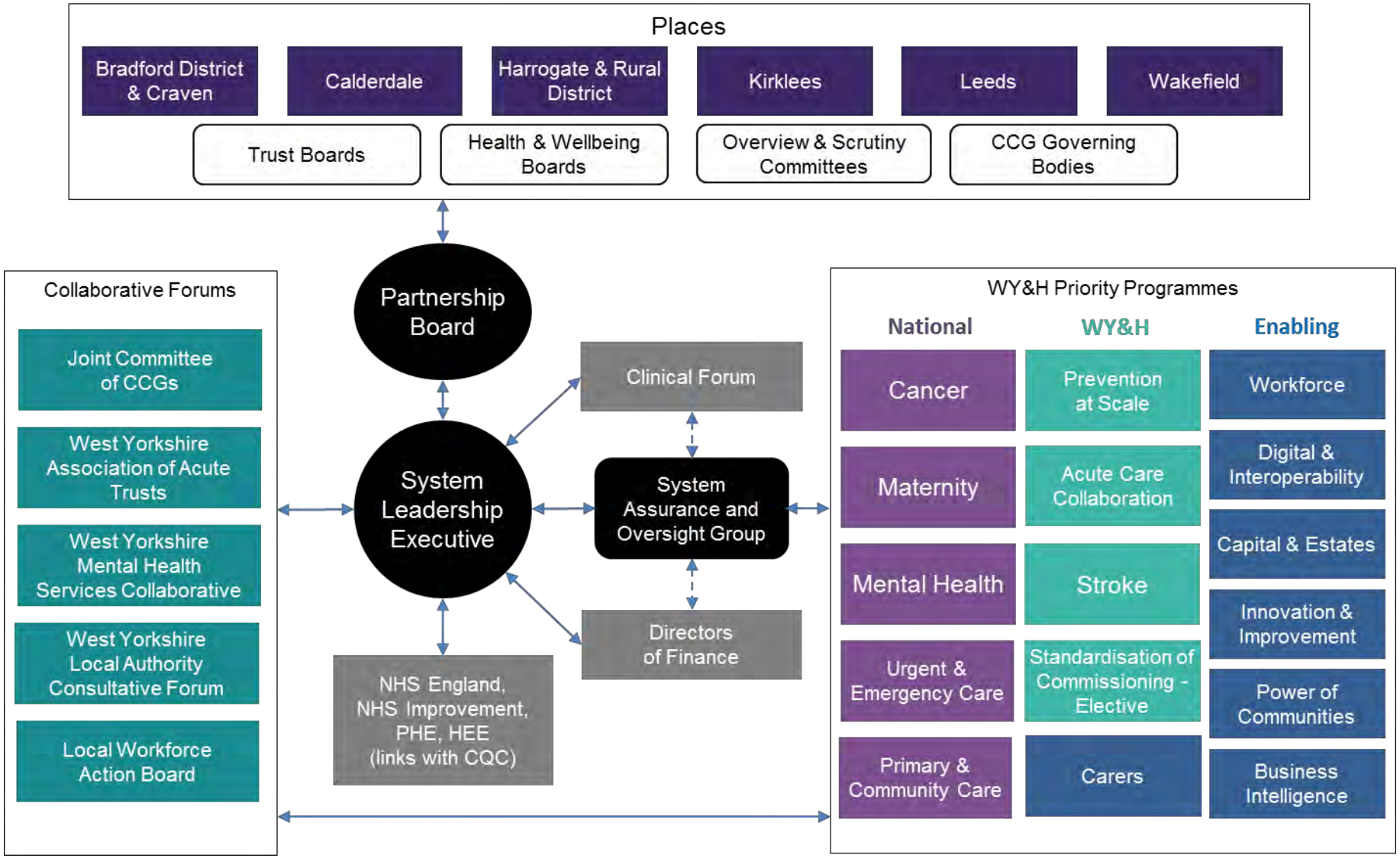
Other National Bodies

Health Education England	✓
Public Health England	✓
Care Quality Commission [TBC]	✓

Other Partners

Healthwatch representative	✓
Yorkshire and Humber Academic Health Science Network	✓

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

System Leadership Executive Group

Terms of Reference

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June 2018

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1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3. The System Leadership Executive Group ('SLE') is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

1.4. The SLE will support the Partnership Board to lead and direct the Partnership and will have overall executive responsibility for delivery of the Partnership plan.

1.5. The SLE will make decisions and recommendations to the Partnership Board on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

1.6. The SLE has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.

1.7. The SLE will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

1.8. These Terms of Reference describe the scope, function and ways of working for the SLE. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

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- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our Partnership

2.2. The SLE operates within an agreed set of guiding principles that shape everything we do through our Partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

Our shared values and behaviour

2.3. Members of the SLE commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honestly and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The SLE will take overall executive responsibility for delivery of the Partnership plan. It will make recommendations to the Partnership Board and make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

i. make recommendations to the Partnership Board on:

- The objectives of priority Partnerhsip work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS bodies)
- Agreeing common action when systems become distressed

ii. progressively build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for healthcare services;

iii. act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;

iv. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;

v. manage financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

vi. support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;

vii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;

viii. oversee the development and implementation of a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;

ix. reach agreement in relation to recommendations made by other governance groups within the partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;

x. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

4. Membership

4.1. The membership will comprise:

- A Chair – the Partnership lead CEO
- CCG Accountable Officers
- Council chief executives
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum

4.2. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

Deputies

4.3. If a member is unable to attend a meeting of the SLE, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to

represent their organisation, place or group effectively. Deputies will be eligible to vote.

Additional attendees

4.4. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.5. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The SLE will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The SLE will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.1. Members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus cannot be reached, then decisions will be made by 75% majority of the Group present and voting at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

6. Accountability and reporting

6.1. The SLE will be accountable to the Partnership Board, which provides the formal leadership of the WY&H Partnership. The SLE has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.

6.2. The SLE has a key role within the wider governance and accountability arrangements for the WY&H Partnership (see **Annex 2** for a description of these arrangements). The minutes will be submitted to each meeting of the Partnership Board. The minutes, and a summary of key messages will also be submitted to all Partner organisations after each meeting.

7. Conduct and Operation

7.1. The SLE will normally meet monthly. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any SLE member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

7.8. The secretariat function for the SLE will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

8.1. These terms of reference and the membership of the SLE will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

Annex 1 – Members

Local Authorities

City of Bradford Metropolitan District Council	
Calderdale Council	
Craven District Council	
Harrogate Borough Council	
Kirklees Council	
Leeds City Council	
North Yorkshire County Council	
Wakefield Council	

NHS Commissioners

NHS Airedale, Wharfedale and Craven CCG	
NHS Bradford City CCG	
NHS Bradford Districts CCG	
NHS Calderdale CCG	
NHS Greater Huddersfield CCG	
NHS Harrogate and Rural District CCG	
NHS Leeds CCG	
NHS North Kirklees CCG	
NHS Wakefield CCG	
NHS England	

Healthcare Providers

Airedale NHS Foundation Trust	
Bradford District Care NHS Foundation Trust	
Bradford Teaching Hospitals NHS Foundation Trust	
Calderdale and Huddersfield NHS Foundation Trust	
Harrogate and District NHS Foundation Trust	
Leeds and York Partnership NHS Foundation Trust	
Leeds Community Healthcare NHS Trust	
The Leeds Teaching Hospitals NHS Trust	
Locala Community Partnerships CIC	
The Mid Yorkshire Hospitals NHS Trust	

South West Yorkshire Partnership NHS Foundation Trust	
Tees, Esk, and Wear Valleys NHS Foundation Trust	
Yorkshire Ambulance Service NHS Trust	

Heath Regulator and Oversight Bodies

NHS England	
NHS Improvement	

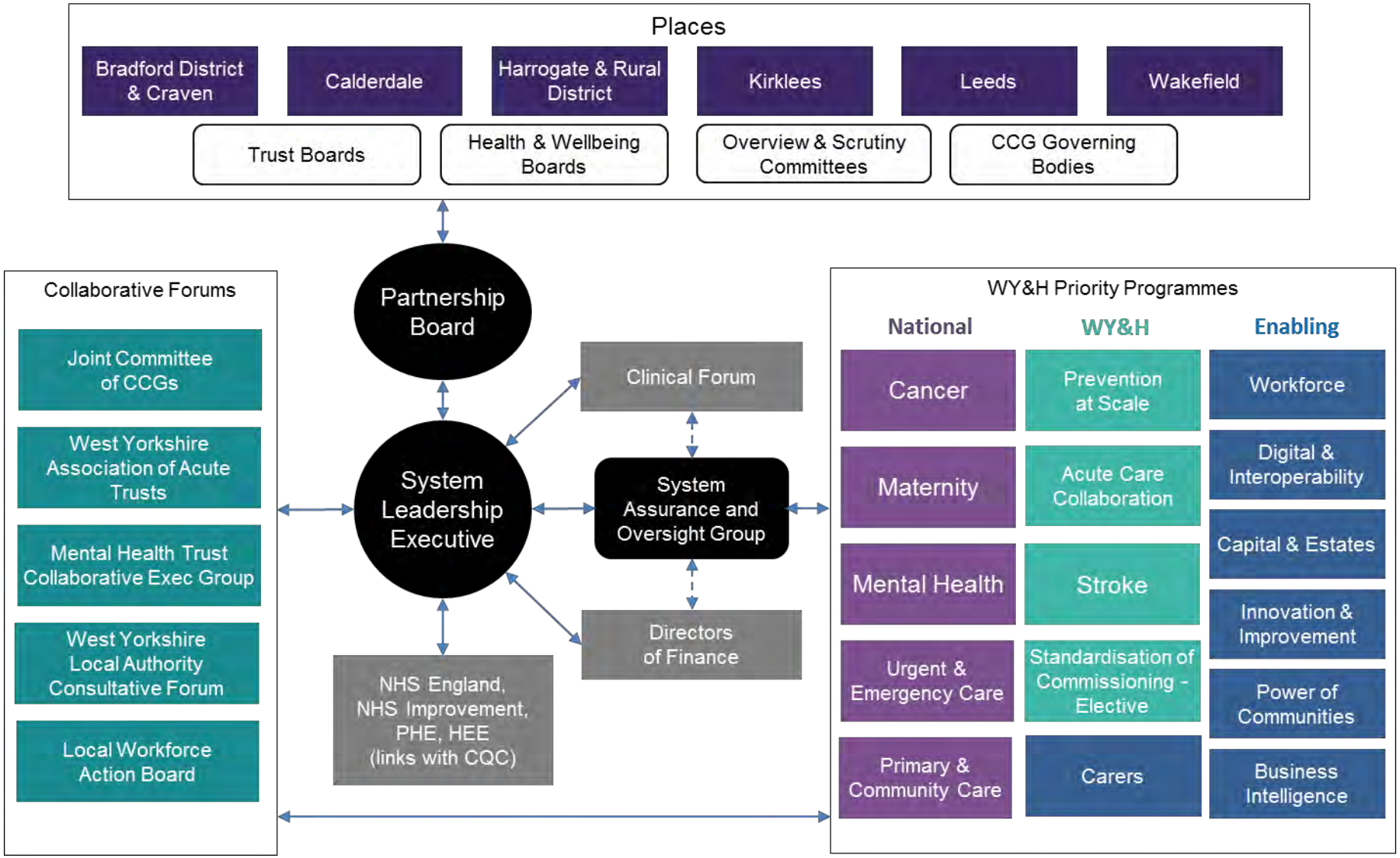
Other National Bodies

Health Education England	
Public Health England	
Care Quality Commission [TBC]	

Other Partners

Clinical Forum Chair	
Healthwatch representative	
Yorkshire and Humber Academic Health Science Network	

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

System Oversight and Assurance Group

Terms of Reference

D R A F T

June 2018

Contents

1. Introduction and context

1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3. The System Oversight and Assurance Group is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

1.4. The Partnership has agreed to adopt a new integrated approach to leading performance development and culture change, encompassing operational performance, quality and outcomes, service transformation, and finance.

1.5. This new approach will feature:

- a single framework, covering individual places, and West Yorkshire and Harrogate as a whole;
- an increasing focus on making judgements about a whole place, while understanding the positions of individual organisations;
- a strong element of peer review and mutual accountability;
- a clear approach to improvement-focused intervention, support and capacity building.

1.6. The purpose of the System Oversight and Assurance Group is to be the primary governance forum to oversee the Partnership's mutual accountability arrangements. It will take an overview of system performance and progress with delivery of the Partnership's plan

1.7. These Terms of Reference describe the scope, function and ways of working for the System Oversight and Assurance Group. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our partnership

2.2. The System Oversight and Assurance Group operates within an agreed set of guiding principles that shape everything we do through our Partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

Our shared values and behaviour

2.3. Members of the System Oversight and Assurance Group commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honestly and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The System Oversight and Assurance Group will provide oversight, and challenge to the delivery of the aims and priorities of the Partnership. In support of this, its responsibilities are to:

i. lead the development of a dashboard of key performance, quality and transformation metrics for the Partnership;

ii. take an overview of performance and transformation at whole system, place and organisation levels in relation to Partnership objectives and wider national requirements;

iii. take an overview of programme delivery;

iv. receive reports from WY&H programmes and enabling workstreams on issues which require escalation;

v. develop and maintain connections with other key groups and organisations which have a role in performance development and improvement, including:

- Care Quality Commission
- Quality Surveillance Groups
- Place-based transformation boards
- A&E Delivery Boards
- WY&H Directors of Finance Group
- WY&H Clinical Forum;

vi. lead the development of a framework for peer review and support for the Partnership and oversee its application;

vii. make recommendations to the System Leadership Executive, in consultation with WY&H programme boards, and national NHS bodies, on the deployment of improvement support across the Partnership, and on the need for more formal action and interventions. Actions will include the requirement for:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- the appointment of a turnaround Director / team;
- agreement of restrictions on access to discretionary funding and financial incentives.

4. Membership

4.1. The membership of the System Oversight and Assurance Group will include representation from each sector of the partnership, ie providers, commissioners, Councils, national bodies, Healthwatch.

4.2. The membership will comprise:

- A Chair – the Partnership lead CEO
- Acute sector – chair of WYAAT
- Mental health sector – chair of Mental Health Services Collaborative
- CCGs – nominated lead accountable officer
- A representative of community / primary care providers
- Local authorities – lead CEO for health
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Healthwatch

4.3. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

Deputies

4.4. If a member is unable to attend a meeting of the System Oversight and Assurance Group, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

Additional attendees

4.5. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The System Oversight and Assurance Group will not be a formal decision making body. The Group will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. The Group will not take votes and will not require a quorum of members to be present to consider any business.

5.2. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.3. Under exceptional circumstances any substantive difference of views among members will be reported to the System Leadership Executive Group.

6. Accountability and reporting

6.1. The Group does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations. However, NHS England and NHS Improvement will, where appropriate, enact certain regulatory and system oversight functions through the Group.

6.2. The Group has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

6.3. The System Oversight and Assurance Group will formally report, through the Chair, to the System Leadership Executive Group. It will make recommendations, where appropriate to the System Leadership Executive Group.

7. Conduct and Operation

7.1. The Group will normally meet monthly. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

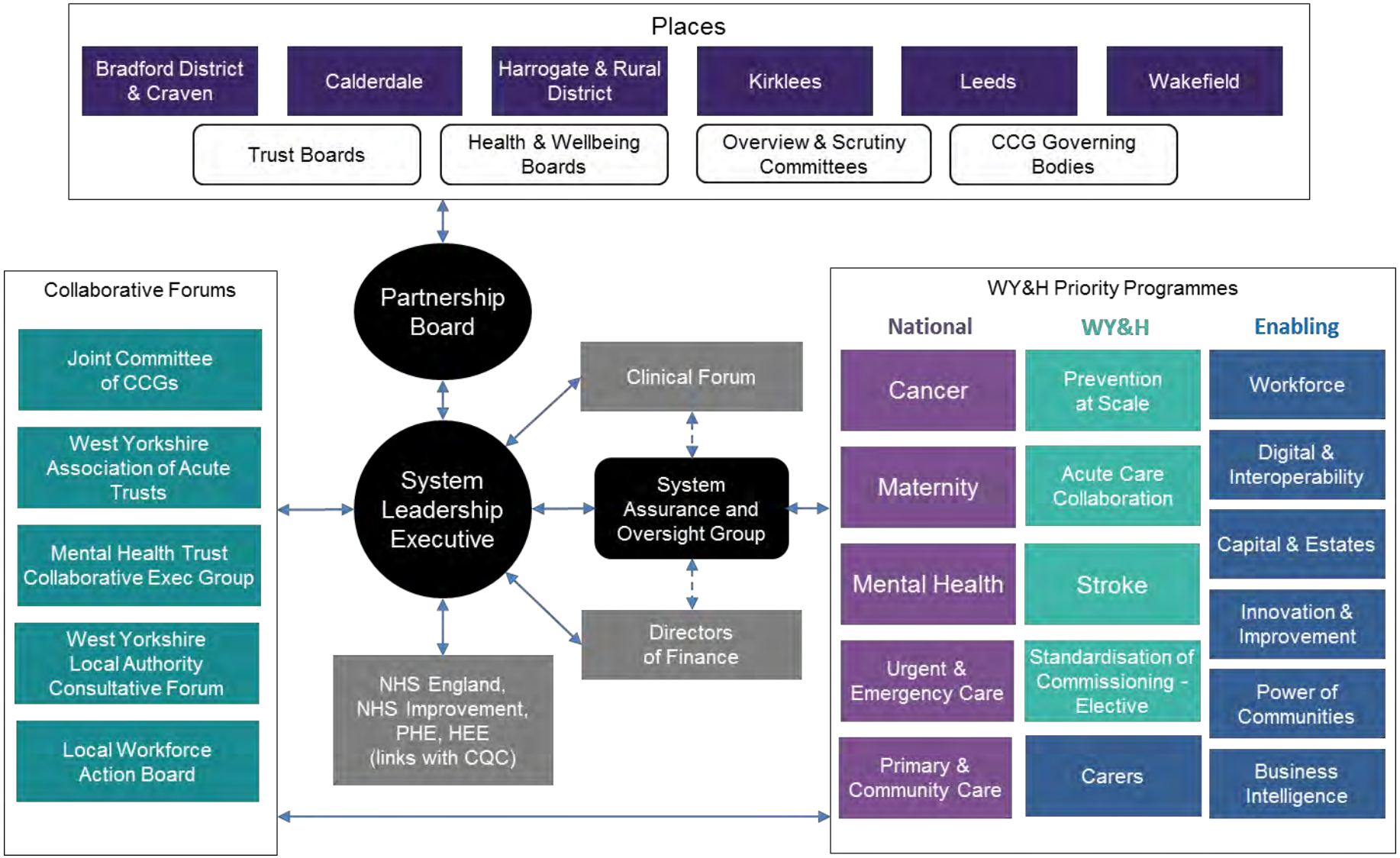
7.8. The secretariat function for the System Oversight and Assurance Group will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

8.1. These terms of reference and the membership of the Group will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

Annex 1 – Members

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

Clinical Forum
Terms of Reference

April 2018

Contents

1. Introduction and context

1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

1.2. The partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3. The Clinical Forum is a key element of leadership and governance arrangements for the West Yorkshire and Harrogate health and care partnership.

Purpose

1.4. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

1.5. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

1.6. These Terms of Reference describe the scope, function and ways of working for the Clinical Forum. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership [**forthcoming],** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your

physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.

- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our partnership

2.2. The Clinical Forum operates within an agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

Our shared values and behaviour

2.3. Members of the Clinical Forum commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honestly and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.

- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The Clinical Forum will provide clinical leadership, oversight, and challenge to the development and delivery of the aims and priorities of the partnership. In support of this, its responsibilities are to:

i. lead the development of a clinical strategy and narrative for West Yorkshire and Harrogate

ii. ensure that all plans within the West Yorkshire and Harrogate health and care partnership are clinically led, evidence based, and configured to improve patient outcomes;

iii. ensure the voice of the patients, service users and citizens is heard and reflected in all plans;

iv. maintain and embed clinical co-production as a core principle of the partnership;

v. support collaboration and strengthen partnerships between clinical colleagues;

vi. exhibit clinical leadership and galvanise professional colleagues and partner organisation to agree models of care which support delivery to close the three gaps (health, care and finance) in West Yorkshire and Harrogate

vii. champion change and evidence-based innovation within their own organisations and Place, with peers, professional colleagues and networks;

viii. support transition to new models of care, where appropriate.

ix. make recommendations to the System Leadership Executive Group on proposals developed by priority workstreams and local place-based partnerships;

x. provide oversight and alignment of all clinical initiatives across West Yorkshire and Harrogate;

xi. support regular communication and engagement with all stakeholders;

xii. support through review the evaluation and impact of all workstreams and plans

xiii. provide innovative solutions to system-wide challenges, particularly where there are dependencies between workstreams (including enablers) and local plans;

xiv. provide input and assurance to the clinical representation on each of the workstreams;

xv. ensure a robust framework for quality impact assessment of change is established and implemented;

xvi. review system performance on the quality of health and care services and provide a mechanism for partner organisations to hold each other to account on quality, making appropriate links with the Quality Surveillance Forum.

3.2. Members of the group should ensure that all groups of clinicians within their organisations are engaged with the work of the Clinical Forum as appropriate.

4. Membership

4.1. The membership of the Clinical Forum will reflect the engagement of all Places and partner organisations.

4.2. Members will be senior clinicians (normally clinical commissioners, provider GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.

4.3. The membership will comprise:

- A Chair
- One clinical commissioner representative from each of the six places
- One representative from each mental health and community trust
- One representative from each acute Trust
- One representative from Yorkshire Ambulance Service
- One medical representative from NHS England and NHS Improvement
- One Nursing and Quality Lead
- One Allied Health Professional representative
- One Community Pharmacist representative
- Two representatives of primary care federations
- One Director of Adult Social Services
- One Director of Public Health
- The Clinical Director for the West Yorkshire Association of Acute Trusts
- One representative from Yorkshire Academic Health Science Network

4.4. A deputy Chair will be agreed from among nominated members.

4.5. A list of current members is set out at **Annex 1**. (Arrangements for future changes to the role of Chair and nominated members will be confirmed with the Forum).

4.6. Additional representatives may be requested to attend meetings of the Clinical Forum from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- clinical leads for each of the West Yorkshire and Harrogate priority programmes and enabling workstreams
- Local Medical Committee representatives.

Additional attendees

4.7. A representative of Healthwatch, members of the WY&H partnership core team, external advisers, and other individuals may be invited to attend for all or part of any meeting as and when appropriate, at the discretion of the Chair.

Deputies

4.8. If a member is unable to attend a meeting of the Clinical Forum, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

5. Accountability and reporting

5.1. The Clinical Forum will not be a formal decision making body. It does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations.

5.2. The Clinical Forum has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

5.3. The Clinical Forum will formally report, through the Chair, to the System Leadership Executive Group. The Chair will be a core member of this group.

5.4. The Forum will make recommendations, where appropriate to the System Leadership Executive Group.

6. Conduct and Operation of the Clinical Forum

6.1. The Forum will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members.

6.2. The Forum will not take votes and will not require a quorum of members to be present to consider any business.

6.3. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

6.4. Under exceptional circumstances any substantive difference of views among members will be reported by the Chair to the System Leadership Executive Group.

Secretariat

6.5. The secretariat function for the Clinical Forum will be provided by the WY&H partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

6.6. The secretariat will collate papers and circulate them to members and attendees no less than five days before the meeting. Late papers will be permitted in exceptional circumstances at the discretion of the Chair.

7. Frequency of meetings

7.1. The Clinical Forum will usually meet each month. An annual schedule of meetings will be confirmed by the secretariat.

7.2. Additional or extraordinary meetings may be called for a specific purpose at the discretion of the Chair.

7.3. Members will normally be given a minimum of six weeks' notice of any meeting of the Forum.

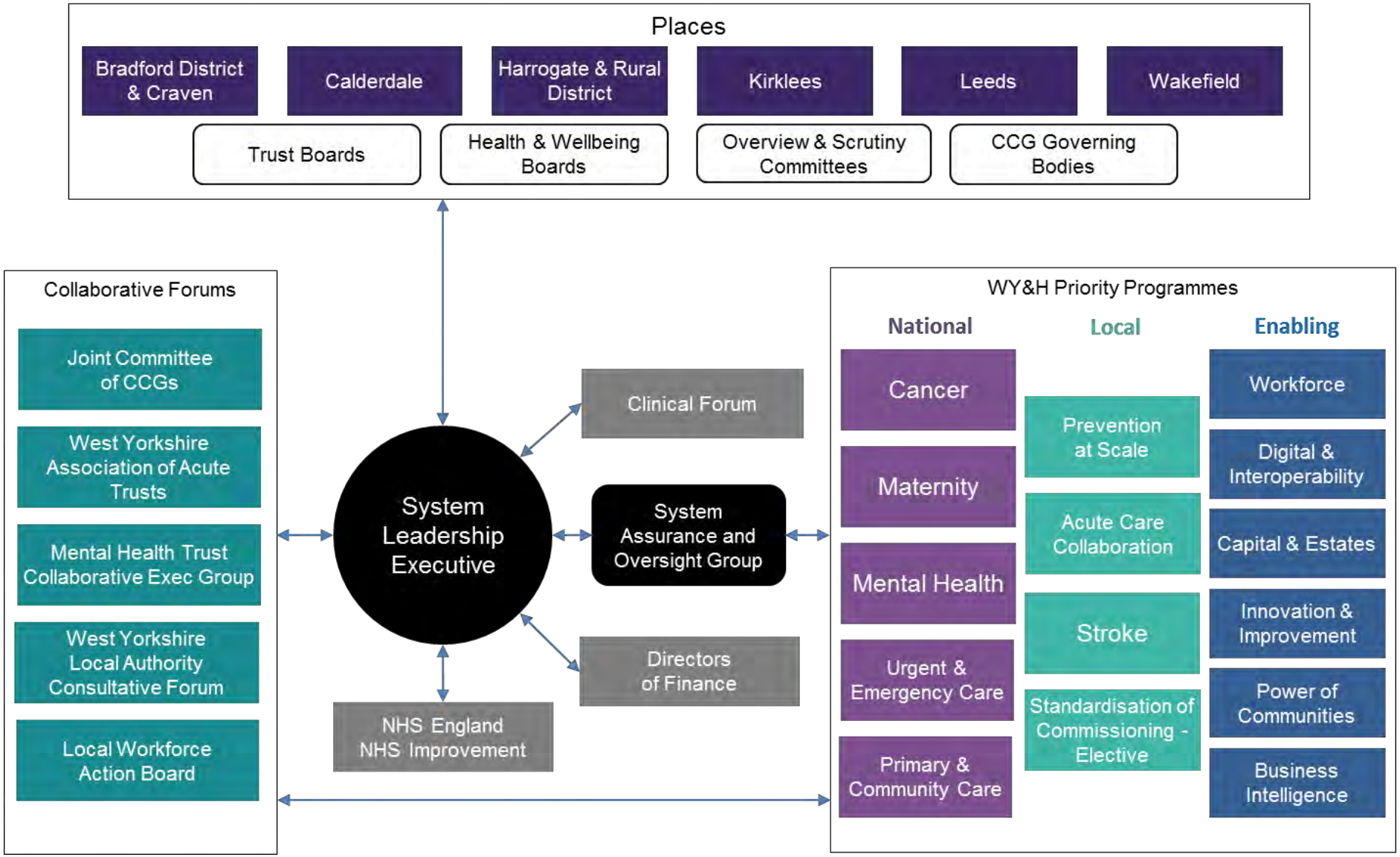
8. Review

8.1. These terms of reference and the membership of the Forum will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Annex 1 – Nominated members of the Clinical Forum

	Nominee
Chair	Dr Andy Withers
CCGs / Places	
Bradford District and Craven	Dr James Thomas
Calderdale	Dr Steven Cleasby
Harrogate and Rural District	Dr Bruce Willoughby
Leeds	Dr Gordon Sinclair
North Kirklees and Greater Huddersfield	Dr David Kelly
Wakefield	Dr Phil Earnshaw
Acute Trusts	
Airedale NHS Foundation Trust	Jill Asbury
Bradford Teaching Hospitals NHS Foundation Trust	Dr Bryan Gill (Deputy Chair)
Calderdale and Huddersfield NHS Foundation Trust	Brendan Brown
Harrogate and District NHS Foundation Trust	David Scullion
The Leeds Teaching Hospitals NHS Foundation Trust	Dr Yvette Oade
The Mid Yorkshire Hospitals NHS Foundation Trust	David Melia
Mental Health and Community Providers	
Bradford District Care NHS Foundation Trust	Dr Andy McElligott
Leeds and York Partnership NHS Foundation Trust	TBC
South West Yorkshire Partnership NHS Foundation Trust	Tim Breedon
Leeds Community Healthcare NHS Trust	Marcia Perry
Others	
NHS England	Dr Yasmin Khan
Allied Health Professional	TBC
Community Pharmacist	Ruth Buchan
GP Providers x 2	TBC
Social Care	TBC
Public Health representative	Andrew O'Shaughnessy
WYAAT Clinical Lead	Robin Jeffrey
Yorkshire Ambulance Service	Julian Mark
Nursing & Quality Lead (and QSG link)	Jo Harding
AHSN	Mike Potts (interim)

Annex 2 – Schematic of Governance and Accountability Arrangements



15. Governance Report

a. Constitutional Changes

b. Deputy Chair / SINED Appointment

c. Use of Trust Seal

d. Board Workplan

To Approve

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: Governance Report - September 2018 - This report brings together a number of governance items for review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
a. Constitutional Changes
b. Deputy Chair / SINED Appointment
c. Use of Trust Seal
d. Board Workplan

Main Body

Purpose:

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

Background/Overview:

-

The Issue:

a. Constitutional Changes
As part of the governance work to set up the wholly owned subsidiary, the Council of Governors were asked to consider an amendment to the Trust's Constitution to enable employees of Calderdale and Huddersfield Solutions to either remain, or become, staff 'members' of the Trust. There is already provision in the Constitution for people who are employed by another organisation (e.g. a charity) and who regularly work with or in the Trust to become staff 'members'.
The Council of Governors recommended that existing members of staff who transfer into the Company be allowed to remain as staff members of the Trust. They also asked that we regularly publicise to new staff of the Company that they are able to register as a public member.

b. Deputy Chair / SINED Appointment
NHS Foundation Trusts are strongly encouraged to take full account of the best practice provision in the Code of Governance. NHS Foundation Trusts have to either comply with the Code or explain non compliance.
The Code states that:
"The Board of Directors should appoint one of the Non-Executive Directors to be the Senior Independent Director, in consultation with the Members' Council. The Senior Independent Director should be available to members and Council members if they have concerns which contact through the normal channels of Chairman, Chief Executive or Director of Finance, has failed to resolve or for which such contact is inappropriate. The Senior Independent Director could be the Deputy Chairman".

David Anderson's tenure as a Non-Executive Director ends this month. David has done an excellent job of being the Senior Independent Director. It is recommended that in addition to continuing his role as Deputy Chair, Phil Oldfield takes on the role of Senior Independent Director.

c, Use of Trust Seal
There have been four documents sealed since the last report to the Board in April 2018. All four documents relate to the transfer of the lease within the Bestway group of companies.

d. Board work plan
The Board work plan has been updated to reflect the new meeting schedule and is presented to the Board for review The Board is asked to consider whether there are any other items they would like to add for forthcoming meetings.

Next Steps:

- The appointment of the SINED will go to the Council of Governors for approval in October.

Recommendations:

The Board is asked to:
- APPROVE the Constitutional Changes
- APPROVE the Deputy Chair / SINED Appointment
- NOTE the use of the Trust Seal
- COMMENT on the Board work plan

Appendix

Attachment:

Governance Report.pdf

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
4-18	14.06.18	14.06.18	Lease assignment from the current tenants Bestway Panacea Healthcare Limited to the proposed assignee, Bestway National Chemists Limited. This is in relation to the Well Pharmacy at Calderdale Royal Hospital.	NAME: Jackie Murphy  TITLE: Director of Nursing
				NAME: Vicky Pickles  TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
5-18	14.06.18	14.06.18	Lease assignment from the current tenants Bestway Panacea Healthcare Limited to the proposed assignee, Bestway National Chemists Limited. This is in relation to the Well Pharmacy at Huddersfield Royal Infirmary.	NAME: Jackie Murphy  TITLE: Director of Nursing
				NAME: Vicky Pickles  TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
6-18	14.06.18	14.06.18	Lease assignment from the current tenants Bestway Panacea Healthcare Limited to the proposed assignee, Bestway National Chemists Limited. This is in relation to the Well Pharmacy at Acre Mill, Huddersfield.	NAME: Jackie Murphy  TITLE: Director of Nursing NAME: Vicky Pickles  TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
7-18	14.06.18	14.06.18	Bestway Lease Assignments Deed of Novation which will transfer the Service Contract in relation to Well Pharmacy at HRI, CRH and Acre Mill	NAME: Jackie Murphy  TITLE: Director of Nursing
				NAME: Victoria Pickles  TITLE: Company Secretary

DRAFT BOARD WORK PLAN 2018-2019 - WORKING DOCUMENT – UPDATED 20.8.18

			Public	Public	Private	Public	Private	Public	Private	Public	Private	Public
Date of meeting	**5 April 2018**	**3 May 2018**	**7 June 2018**	**5 July 2018**	**2 Aug 2018**	**6 Sept 2018**	**4 Oct 2018**	**1 Nov 2018**	**6 Dec 2018**	**3 Jan 2019**	**7 Feb 2019**	**7 Mar 2019**
Date of agenda setting/Feedback to Execs	20.3.18	16.4.18	21.5.18	18.6.18	16.7.18	13.8.18	17.9.18	15.10.18	19.11.18	17.12.18	21.1.18	18.2.18
Date final reports required	28.3.18	25.4.18	30.5.18	27.6.18	25.7.18	29.8.18	26.9.19	24.10.18	28.11.18	26.12.18	30.1.18	27.2.18
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓		✓		✓		✓		✓
Chairman's report	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-		-	-	✓	-	-	-	✓
DIPC report	-	✓	-	-		✓	-	-	-	✓	-	-
High Level Risk Register	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Care of the acutely ill patient report				✓				✓		✓		
Learning from Deaths – Quarterly Report			✓					✓Q3				✓
Patient Survey				✓								✓
Quarterly Quality Slide Report + Presentation focussed on one topic (may be used as patient/staff story) (NB – Quality Account in Annual Report)		Quality A/cs		✓		✓		✓ Q2				✓
Colleague Engagement/Staff Survey (NB - Gold Standard by 2018 and Platinum	✓			✓				✓				✓

			Public	Public	Private	Public	Private	Public	Private	Public	Private	Public
Date of meeting	**5 April 2018**	**3 May 2018**	**7 June 2018**	**5 July 2018**	**2 Aug 2018**	**6 Sept 2018**	**4 Oct 2018**	**1 Nov 2018**	**6 Dec 2018**	**3 Jan 2019**	**7 Feb 2019**	**7 Mar 2019**
Standard by 2020 agreed at 25.2.16 BOD)												
Nursing and Midwifery Staffing – Hard Truths Requirement		✓						✓				
Safeguarding update – Adults & Children		✓ Annual report						✓				
Review of progress against strategy (Qly)						✓				✓		
Plan on a Page Strategy Update			✓									
Quality Committee update & mins	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & mins		✓	✓			✓	✓	✓		✓	✓	✓
F&P Committee update & mins	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes				✓		✓			✓			✓
Performance Management Framework – update on work from sub-committee workplans		✓										
Guardian of Safe Working Quarterly Report (Anu Rajgopal to attend if available)	✓			✓				✓				✓
Governance Report: to include such items as:												
Standing Orders/SFIs/SOD review								✓				
Non-Executive appointments (+ Nov - SINED & Deputy)						✓						
Board workplan			✓			✓						✓
Board skills / competency										✓		
Board meeting dates				✓						✓		
Committee review and annual report												✓
Annual review of NED roles								✓				

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

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

DRAFT BOARD WORK PLAN 2018-2019 - WORKING DOCUMENT – UPDATED 20.8.18

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

16. Quality & Performance Report – July 2018

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: QUALITY & PERFORMANCE REPORT - -	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board, Finance & Performance Committee, Quality Committee	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

July's Performance Score has achieved 70%. The SAFE domain has slipped to amber due to a Category 4 pressure ulcer and EDS below target. The CARING domain is almost green with both Community FFT targets being achieved. EFFECTIVE is green although #NoF and E-coli missed target. The RESPONSIVE domain remains amber although Stroke missed 3 out of 4 targets – all key cancer targets have been achieved for 7 out of the last 9 months. In WORKFORCE there was a small dip in Essential Safety Training hence overall reduction for the domain. Within EFFICIENCY & FINANCE Agency usage and CIP deteriorated in-month alongside Theatre utilisation.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

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

Appendix

Attachment:

Integrated Performance Report - July 18.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

July 2018

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

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

There were a few changes in July that have affected previous months.

There was an MRSA in June, not previously reported and a preventable C-diff in April not previously reported.

In Workforce Appraisal (1 Year Refresher) - Non-Medical Staff has now been corrected to a KEY target and carries a higher weighting. In-month sickness absence has also been removed from the Performance Score to avoid double counting in the 12 month rolling total.

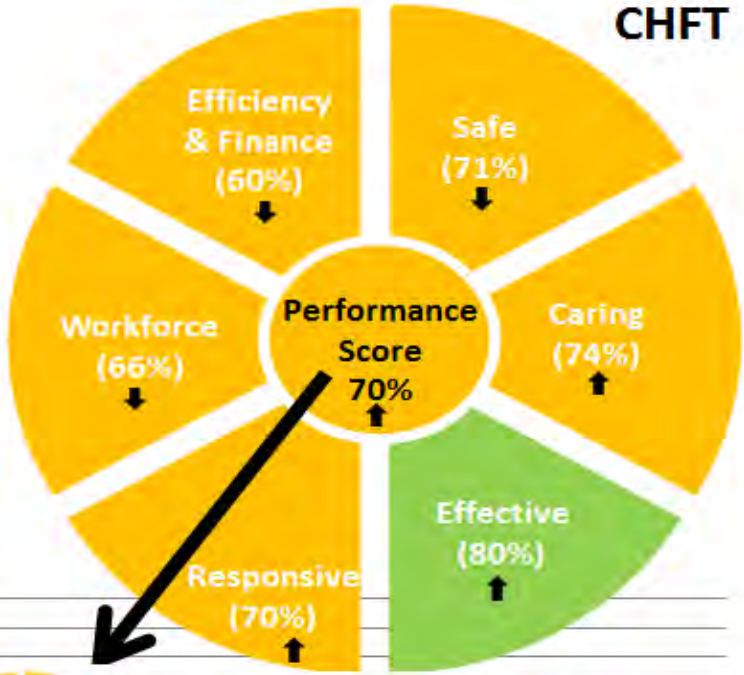
Activity has been removed from the Performance Score until scoring can be devised which reflects the Aligned Incentive Contract.

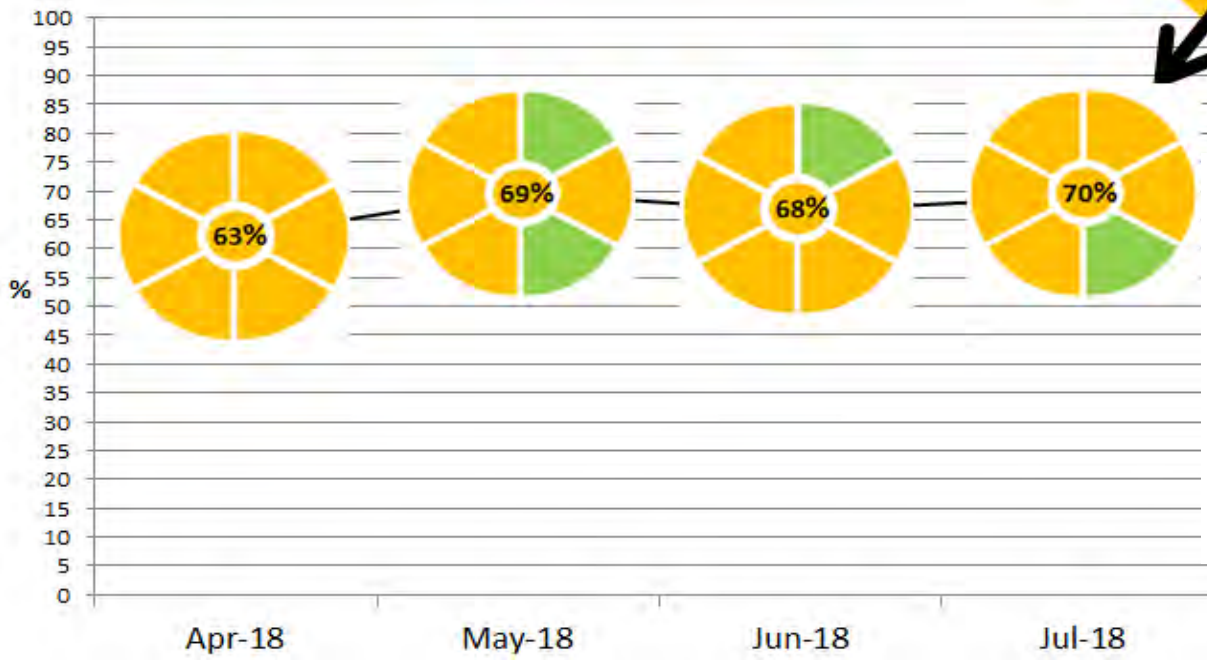
Performance Summary

July

RAG Movement

July's Performance Score has achieved 70%. The SAFE domain has slipped to amber due to a Category 4 pressure ulcer and EDS below target. The CARING domain is almost green with both Community FFT targets being achieved. EFFECTIVE is green although #NoF and E-coli missed target. The RESPONSIVE domain remains amber although Stroke missed 3 out of 4 targets – all key cancer targets have been achieved for 7 out of the last 9 months. In WORKFORCE there was a small dip in Essential Safety Training hence overall reduction for the domain. Within EFFICIENCY & FINANCE Agency usage and CIP deteriorated in-month alongside Theatre utilisation.





SINGLE OVERSIGHT FRAMEWORK

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

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

Key Indicators

	17/18	Apr-18	May-18	Jun-18	Jul-18	YTD	Annual Target	Monthly Target
SAFE								
Never Events	1	0	0	0	**0**	**0**	0	0
CARING								
% Complaints closed within target timeframe	48.70%	37.00%	44.00%	30.00%	**31.00%**	**35.00%**	95%	95%
Friends & Family Test (IP Survey) - Response Rate	31.40%	40.00%	39.00%	38.80%	**36.50%**	**38.70%**	>=25.9% /24.5% from June 18	
Friends & Family Test (IP Survey) - % would recommend the Service	96.90%	96.70%	98.00%	97.40%	**97.40%**	**97.40%**	>=96.3% / 96.7% from June 18	
Friends and Family Test Outpatient - Response Rate	10.10%	11.30%	10.50%	11.40%	**11.40%**	**11.10%**	>=5.3% / 4.7% from June 18	
Friends and Family Test Outpatients Survey - % would recommend the Service	89.70%	90.70%	91.00%	90.40%	**90.80%**	**90.70%**	>=95.7% / 96.2% from June 18	
Friends and Family Test A & E Survey - Response Rate	10.20%	10.70%	9.60%	12.80%	**15.30%**	**12.10%**	>=13.3% / 11.7% from June 18	
Friends and Family Test A & E Survey - % would recommend the Service	85.00%	84.70%	86.30%	84.30%	**84.30%**	**84.80%**	>=86.5% / 87.2% from June 18	
Friends & Family Test (Maternity Survey) - Response Rate	41.00%	33.20%	34.80%	34.80%	**33.70%**	**34.10%**	>=22.0% / >=20.8% from June 18	
Friends & Family Test (Maternity) - % would recommend the Service	97.60%	98.00%	98.90%	98.20%	**98.40%**	**98.40%**	>=97% / 97.3% from June 18	
Friends and Family Test Community - Response Rate	6.50%	3.60%	6.30%	4.20%	**4.40%**	**4.70%**	>=3.4% / >=3.5% from June 18	
Friends and Family Test Community Survey - % would recommend the Service	90.00%	93.90%	92.60%	92.00%	**97.40%**	**93.90%**	>=96.2% / >=96.6% from June 18	
EFFECTIVE								
Number of MRSA Bacteraemias – Trust assigned	5	0	0	1	**0**	**1**	0	0
Preventable number of Clostridium Difficile Cases	8	3	1	1	**0**	**5**	<=20	< = 2
Local SHMI - Relative Risk (1 Yr Rolling Data)	909.96					100.64	<=100	100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	82.47					82.9	<=100	100
RESPONSIVE								
Emergency Care Standard 4 hours	90.61%	91.52%	93.23%	94.78%	**92.37%**	**93.00%**	>=95%	95%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	60.36%	58.00%	53.49%	68.63%	**54.00%**	**58.76%**	>=90%	90%
% Incomplete Pathways <18 Weeks	93.75%	93.77%	93.32%	94.05%	**93.99%**	**93.99%**	>=92%	92%
Two Week Wait From Referral to Date First Seen	94.09%	95.63%	98.78%	98.61%	**98.82%**	**98.03%**	>=93%	93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.88%	95.48%	95.28%	98.94%	**95.74%**	**96.29%**	>=93%	93%
31 Days From Diagnosis to First Treatment	99.83%	100.00%	99.37%	99.40%	**100.00%**	**99.69%**	>=96%	96%
31 Day Subsequent Surgery Treatment	99.26%	100.00%	100.00%	100.00%	**96.77%**	**98.92%**	>=94%	94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%	98%
38 Day Referral to Tertiary	45.49%	47.62%	41.38%	48.15%	**54.55%**	**47.47%**	>=85%	85%
62 Day GP Referral to Treatment	88.67%	90.66%	92.35%	83.98%	**88.39%**	**88.62%**	>=85%	85%
62 Day Referral From Screening to Treatment	94.87%	81.82%	91.67%	100.00%	**100.00%**	**93.18%**	>=90%	90%
WORKFORCE								
Sickness Absence rate (%) - Rolling 12m	4.10%	4.10%	4.07%	4.04%	*	-	4%	4%
Long Term Sickness Absence rate (%) -Rolling 12m	2.55%	2.54%	2.53%	2.51%	*	-	2.7%	2.7%
Short Term Sickness Absence rate (%) -Rolling 12m	1.55%	1.56%	1.53%	1.53%	*	-	1.3%	1.3%
Overall Essential Safety Compliance		95.00%	94.40%	93.96%	93.84%	-	95%	95%
Appraisal (1 Year Refresher) - Non-Medical Staff - Rolling 12m	93.50%	15.43%	62.67%	96.65%	96.74%	-	95%	95%
Appraisal (1 Year Refresher) - Medical Staff - Rolling 12m	69.88%	99.75%	99.70%	98.65%	96.59%	-	95%	95%
FINANCE								
I&E: Surplus / (Deficit) Var £m	-7.97	0.01	0.00	0.00	0.01	**0.01**		

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Friends and Family Test Community Survey - % would recommend the Service - at 97.4% best performance since March and is now achieving both FFT targets.		
38 Day Referral to Tertiary - starting to see marked improvement at 55% which is best performance since November against 85% target.	% Complaints closed within target timeframe - at 31% little performance improvement seen.	The Executive team are commissioning a review by an expert external to the Medicine Division to undertake a formal review of its position, current processes and internal management, actions taken over the past 12 months and proposed recovery plans.
All key cancer targets achieved for 7 out of the last 9 months.		

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance is below the 95% target at 92.67%. The Medicine division has focused work on auditing standards and ensuring senior nursing staff are involved in safety thermometer audits - this is beginning to show signs of a positive step change towards an average of 93% from a previous running level of less than 90%. The surgical division experienced a lower than usual in-month position due to a higher number of Catheter related UTI infections on ICU. These are being examined but performance is expected to be above target next month. • **Category 4 Pressure Ulcers Acquired at CHFT** - there was 1 category 4 pressure ulcer in the division of Surgery in June.
Caring	• **Complaints closed within timeframe** - Of the 78 complaints closed in July, 31% were closed within target timeframe. The backlog of breaching complaints was still 14 at the end of July. The Executive team are commissioning a review by an expert external to the Medicine Division to undertake a formal review of its position, current processes and internal management, actions taken over the past 12 months and proposed recovery plans. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 90.8% still below 95.7% target. GM and Ops manager to review clinic start and end times, and clinician presence to ensure understanding of which patients experience delay and agree mitigating actions (to be completed by August). • **Friends and Family Test A & E Survey - % would recommend the service**. Performance remained at 84.3% in month. The Quality Lead (new in post) is pulling together a plan to ensure that mitigations/solutions are put in place following the learning. • **% Dementia patients following emergency admission aged 75 and over** - current performance at 34.36% has improved but is still some distance from 90% target.
Effective	• **Infection Control - MRSA/E.Coli** - there was one MRSA reported for June. There were 5 cases of E.Coli in July. • **Mortality Reviews** - 16.4% is lowest performance since August. Mortality reviews continue to be allocated albeit on a monthly basis for an ISR (Initial Screening Review). The ISR online tool has been shortened and revised to reflect questions relating to quality of care. Face to face training support remains on offer. Senior nurses are also being asked to contribute to these. SJRs are up to date with bi-monthly discussion at the LfD panel. • **% Sign and Symptom as a Primary Diagnosis** - Performance remains just below target. The audit work continues within specialties and S&S cohorts. 2 of the coding team have achieved the ACC qualification. A Clinical Coding Action plan has been drafted for 2018/19 which looks to address some of the key issues affecting the quality of the coding. This will be finalised by the end of July and progress monitored via Clinical Coding Improvement Steering Group. • **#Neck of Femur** - performance dropped to 78.57% in July against 85% target. CD and GM working with #NoF MDT to explore ways of responding to increased requirement for Total Hip Replacement.

Background Context

July was a busy month with surgical demand higher than usual, a picture seen across West Yorkshire. AED attendances and the weather resulted in higher admission rates for frail patients suffering heat related illness.

Wards were supported with increased access to iced water and fans and staff were further supported with the introduction of lightweight uniforms funded from charitables.

Divisions, led by Clinical Directors and the COO have been finalising plans for Winter, learning from 2017/18. These have been agreed with AED delivery Board and implementation has commenced to ensure they are in place without the use of agency staffing.

Within Medicine & Surgery vacancies/gaps in the management teams have continued in July and this has stretched capacity.

There continues to be issues with vacancies in several key specialties that require capacity to deliver on-call which is driving continued use of agency consultants. Both Paediatric and Womens services continued to experience staffing pressures within junior doctor rotas due to unfilled allocations and sickness. Both services are making efforts to ensure agency costs can be avoided where possible. The Medical workforce programme is working well and costs are reducing but further scrutiny has been applied by NHSI around the number of cap breaches. Nursing agency portfolio continues to make step changes with Thornbury eliminated and use of HCA agency has ceased. The Trust is actively engaging with current WYAAT work on sustainable services.

July was the first full month where Cardiology and Respiratory had a Consultant of the Week (CoW) model fully embedded and going forward we expect to see LOS and flow benefits from these models. It was also the first month that we have seen fasttrack only patients in Dermatology, this is the first stage along with discussions with commissioners in sourcing a sustainable solution in Dermatology.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** 92.37% in July, (93.5% all types) - first dip in performance since March. The team continues to work with the acute directorate to review how admission avoidance is implemented on the HRI site and work continues with the frailty team to review current pathway and impact on CDU and ED. The ED team continues to turn around the patients that can be seen in a GP setting. The focus is still on embedding the action cards into the co-ordinator's role. Co-ordinator study days have been well received and the Directorate will monitor the role and improvements going forward. • **Stroke** - 3 out of 4 targets missed in-month. The stroke team have not had any patients on a waiting list so the patients who did not spend 90% of their stay on the stroke unit must have been either incidental findings or had other clinical needs that meant their stay needed to be in another specialty. The importance of stroke patients spending at least 90% of their time on the stroke unit has been emphasised to the acute teams. Patient flow have been asked to ensure that when a patient presents to HRI or has a stroke at HRI to blue light the patients over to the stroke unit. The solution to current performance will be the stroke assessment bed, pilot was proposed to start in july however has been delayed due to an A&E cubicle refurbishment. The Stroke team is resourced and on stand-by waiting for the go-ahead from ED team. • **38 Day Referral to Tertiary** - 55% for July which is best position since November. Further discussions are planned with colleagues at Bradford and Airedale around the Urology pathway. • **Appointment Slot Issues on Choose & Book** - improved slightly to 42% in-month. Some additional resource usually used for ASI clinics in Upper and Lower GI and Urology has been diverted to undertaking Endoscopy sessions to deal with increase in demand there and to ensure 99% diagnostic performance is maintained. In Ophthalmology the team have been directing additional resources to reducing the holding/pending list. In ENT we lost a large amount of capacity due to Mr Smelt's sickness absence.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Sickness is achieving target in-month and RTWI performance has improved to 68.5%. There is a focus at PRMs to improve this area. • **Essential Safety Training** compliance has fallen in-month particularly in Fire Safety and Equality and Diversity training. A paper will be presented at Executive Board on 6th September exploring the impact of re-distributing the 9 core essential safety training learning requirements currently in quarter 4 across quarters 2 and 3 instead.
Finance	• **Finance**: **Year to Date Summary** The year to date deficit is £16.51m, in line with the plan submitted to NHSI. • Clinical contract income is below plan by £0.68m. The Aligned Incentive Contract is now protecting the income position by £0.56m in the year to date (£0.51m at Month 3), leaving an unmitigated income variance of £0.12m. • There remains an underlying adverse variance from plan which has had to be mitigated by the release of the maximum available contingency reserves in the year to date £0.67m, whilst preserving the earmarked reserve required for the winter plan. Unless run rate improves, a financial pressure will emerge in months 6-12 once contingencies are exhausted. • The underlying operational position excluding reserves release and AIC protection is £1.23m overspent in the year to date. • CIP achieved in the year to date is £3.54m against a plan of £3.78m, a £0.24m shortfall. • Agency expenditure remains £0.13m beneath the agency trajectory set by NHSI. **Key Variances** • The required £18m CIP for the full year has now been identified in full. However, the monthly profile of CIP delivery differs from the fixed original plan, driving a £0.24m pressure in the year to date. • The AIC protection remains at Trust level but has not extended significantly in-month. • In spite of the lower activity than plan Medical pay expenditure continues above plan with a year to date adverse variance to plan of £0.80m. The run rate has improved from prior months but spend remains above plan in-month. • Nursing pay expenditure has reduced over the last 3 months, but remains above plan with a year to date adverse variance of £0.32m (excluding the impact of pay awards which is funded as income). However, nursing agency costs are £0.67m lower than plan year to date with a significant reduction in the use of the very highest cost agencies. • Aside from the ongoing run-rate pressure, one-off non-recurrent items have adversely impacted the divisional position by c.£0.2m in-month relating to the prior year. A pro-active review is being undertaken to gain assurance that these items have now been fully flushed out. • These adverse variances have been offset by the release of the maximum available contingency reserve in the year to date. **Forecast** • The forecast is to achieve the planned £43.1m deficit; this relies upon full delivery of the £18m CIP plan including high risk schemes. • The forecast will also require an improvement in the underlying run rate to contain expenditure within budgeted levels.

Background Context

CHFT is now providing cover for Locala Community Dental Service to maintain activity. A meeting is to be held with Locala management team about future requirements and service resilience in August.

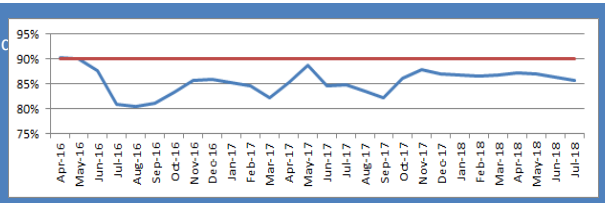
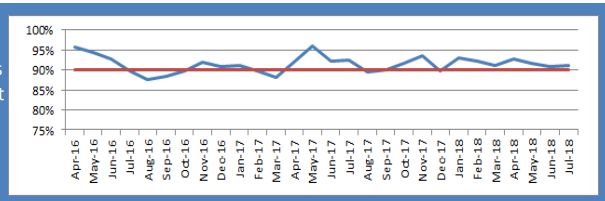
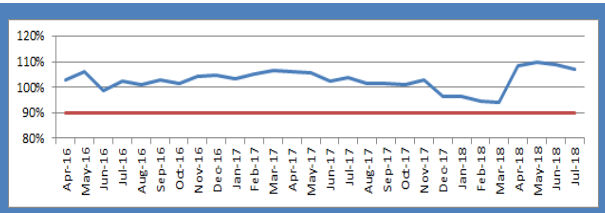
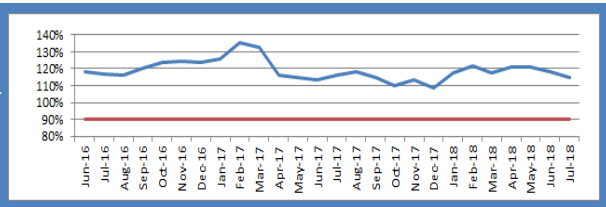
During July the Community division has worked on National Intermediate Care Benchmarking alongside divisional priorities following the SMT time-out in June. These are:
- Admin review
- Scheduling tool for nursing
- Calderdale Framework
- Estates rationalisation
- Nursing strategy
- Therapy strategy.

Intense training continues to secure the safe deployment of the BloodTrack project which will go-live at the end of August.

An Executive/Consultant event was held with Cardiology celebrating the work that has been developed in the specialty and agreeing how this service can further improve. A follow-up event is scheduled for November.

In addition A GP:Consultant engagement event was held with the Calderdale GPs that evaluated very positively, a similar event is being planned for Greater Huddersfield before bringing this into a joint forum.

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.	85.67% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 5 74.6% - Ward 7a/b 74.5% - Ward 12 74.9% - Ward 17 69.8% - Ward 21 69.6%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy. This is managed on a daily basis against the acuity of the patients
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.24% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - ward 10 65.6%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates on ward 10 and 5b, are due to a level of vacancy. This is managed on a daily basis and CHPPD is maintained.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	107.18% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - Ward NICU 66.5% - Ward 3 CRH 56.8%	The low HCA fill rates in July are attributed to a level of HCA sickness 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.	114.53% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	No HCA shifts in July had fill rates less than 75%

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	DAY						NIGHT						Care Hours Per Patient Day							
	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies	Ward Assurance
	Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual											
CRH ACUTE FLOOR	3,106.43	2,860.17	1,926.00	1,973.50	92.1%	102.5%	2,717.00	2,532.75	1,705.00	1,780.50	93.2%	104.4%	10.2	9.8			3	17	13.66	1.37	81.2%
HRI MAU	1,896.67	1,859.87	1,988.00	1,886.67	98.1%	94.9%	1,705.00	1,553.75	1,364.00	1,378.75	91.1%	101.1%	7.6	7.3			2	16	3.84	3.23	85.0%
HRI Ward 5 (previously ward 4)	1,681.50	1,254.38	1,144.50	1,761.25	74.6%	153.9%	1012	968.00	1023	1,396.00	95.7%	136.5%	5.9	6.5			1	12	5.35	0	89.1%
WARD 15	1,827.15	1,481.98	1,540.83	1,856.00	81.1%	120.5%	1,353.00	1,189.00	1,364.00	1,479.00	87.9%	108.4%	6.4	6.3				7	5.94	0	97.0%
WARD 5C	1,052.17	935	818.5	866.50	88.9%	105.9%	682	681.00	341	407	99.9%	119.4%	5.6	5.6			1	2	0	0	99.1%
WARD 6	1,688.97	1,599.58	976	1,048.33	94.7%	107.4%	1023	1009.5	682	803	98.7%	117.7%	7.9	8.1			3	6	4.13	0.72	93.9%
WARD 6BC	1,592.13	1,548.05	1,557.00	1,394.00	97.2%	89.5%	1,364.00	1,319.87	671	712.5	96.8%	106.2%	10.3	9.9				8	0	3.91	100.0%
WARD 5B	1,685.00	1,372.50	814.33	980.5	81.5%	120.4%	1,364.00	992.00	341	715	72.7%	209.7%	8.2	7.9				2	16.19	0	93.8%
WARD 6A	1,031.83	865.17	744	878	83.8%	118.0%	682	671.00	682	804.50	98.4%	118.0%	5.7	5.8				4	4.2	0	91.4%
WARD CCU	1,628.50	1,332.00	372	366	81.8%	98.4%	1023	1012	0	11.5	98.9%	-	11.2	10.1				1	2.01	0	94.7%
WARD 7AD	1,751.50	1,305.70	1,593.33	2,298.33	74.5%	144.2%	1023	1014.8	1023	1,529.00	99.2%	149.5%	6.9	7.9				2	3.58	1.99	92.2%
WARD 7BC	2,528.25	1,914.82	1,630.83	1,717.90	75.7%	105.3%	2,046.00	1673.5	682	1076.5	81.8%	157.8%	9.9	9.1				1	0	0	90.5%
WARD 8	1,483.08	1,250.92	1,212.33	1,554.33	84.3%	128.2%	1012	896.33	1023	1,211.25	88.6%	118.4%	6.2	6.5				7	3.71	0	95.9%
WARD 12	1,723.25	1,290.75	789.50	1,126.75	74.9%	142.7%	682	682	682	682	100.0%	100.0%	5.3	5.2				4	2.24	0.36	93.3%
WARD 17	2,085.00	1,455.17	1,131.00	1,225.50	69.8%	108.4%	1023	1,001.00	682	715.00	97.8%	104.8%	5.5	5.0	1		1	3	5.55	0	98.2%
WARD 5D	804.98	739.23	843.00	780.67	91.8%	92.6%	682	638.00	385	428.50	93.5%	111.3%	6.5	6.2					8.56	6.41	97.3%
WARD 20	1,879.92	1,572.17	1,763.25	2,002.83	83.6%	113.6%	1,364.00	1,248.50	1,364.00	1,485.50	91.5%	108.9%	6.1	6.1			3	8	10.27	0.28	93.8%
WARD 21	1,558.67	1,089.08	1,459.33	1,411.17	69.9%	96.7%	931.50	804.5	1,035.00	1,046.50	86.4%	101.1%	8.1	7.1			5		4.63	0	90.5%
ICU	4,486.45	4,000.75	753	621	89.2%	82.5%	4,136.50	3,657.50	0	31.5	88.4%	-	39.7	35.2			4		0	0	90.6%
WARD 3	1,005.00	1013.33	714	762	100.8%	106.7%	688.5	688	345	368	99.9%	106.7%	12.0	12.4			6		0.94	0.37	
WARD 8AB	993.53	731.87	676.5	778.67	73.7%	115.1%	678.5	575	345	391	84.7%	113.3%	8.1	7.4				8	2.52	0	100.0%
WARD 8D	906.30	858.55	784.98	693.65	94.7%	88.4%	667	597.33	0	333	89.6%	-	7.1	7.5				1	2.67	0.23	93.2%
WARD 10	1,436.00	1,222.00	816.33	893.58	85.1%	109.5%	1,035.00	679.00	690	1,046.50	65.6%	151.7%	7.3	7.1			1	7	7.07	1.5	87.0%
WARD 11	1,704.33	1,591.00	1,090.50	1,234.83	93.4%	113.2%	1,000.00	1,000.00	690	759	100.0%	110.0%	7.9	8.1					1.15	1.17	92.6%
WARD 19	1,642.50	1,277.33	1,131.83	1,456.83	77.8%	128.7%	1,035.00	1,023.00	1,035.00	1,104.00	98.8%	106.7%	7.4	7.5			2	8	1.62	0	96.8%
WARD 22	1,164.67	1,148.17	1,125.17	1,148.67	98.6%	102.1%	690	690.42	690	690	100.1%	100.0%	5.5	5.5				2	0.01	0	92.3%
SAU HRI	1,870.25	1,740.42	937.5	970.83	93.1%	103.6%	1,377.50	1,318.00	345	353	95.7%	102.3%	9.5	9.1				1	0	0	83.8%
WARD LDRP	4,441.55	3,645.38	948.5	829.5	82.1%	87.5%	4,255.83	3,558.50	713	694.75	83.6%	97.4%	15.5	13.1						4.58	94.2%
WARD NICU	2,721.50	2,159.60	770.5	512.5	79.4%	66.5%	2,139.00	1,839.25	713	540.5	86.0%	75.8%	12.7	10.1					2.42	1.92	100.0%
WARD 1D	1,311.33	1,132.92	353.83	342.33	86.4%	96.7%	709	710.5	356.5	346	100.2%	97.1%	4.7	4.4					4.73	0.19	88.5%
WARD 3ABCD	3,068.17	3,103.00	1,196.50	679.5	101.1%	56.8%	2,845.50	2,820.50	356.5	276	99.1%	77.4%	13.6	12.5					0	2.33	83.1%
WARD 4C	1,389.83	1,218.75	352	372.67	87.7%	105.9%	701.5	714.75	355.33	324.42	101.9%	91.3%	10.0	9.4				1	0.36	0.9	88.3%
WARD 9	878	856.3	356.5	351	97.5%	98.5%	713	713	356.5	322	100.0%	90.3%	5.0	4.9					4.52	3.53	98.9%
Trust	**60024.42**	**51425.9**	**34311.4**	**36775.8**	**85.67%**	**107.18%**	**44,360.3**	**40,472.3**	**22,039.8**	**25,241.7**	**91.24%**	**114.53%**	**8.24**	**7.89**							

Hard Truths: Safe Staffing Levels (3)

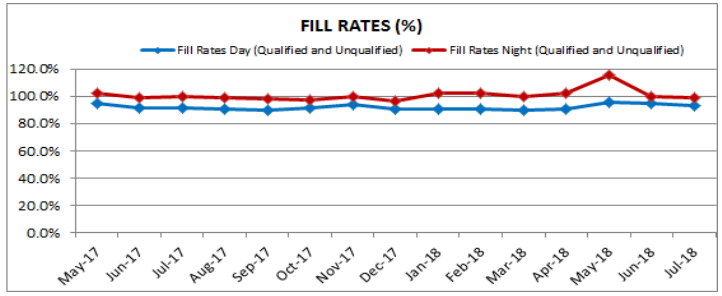
Care Hours per Patient Day

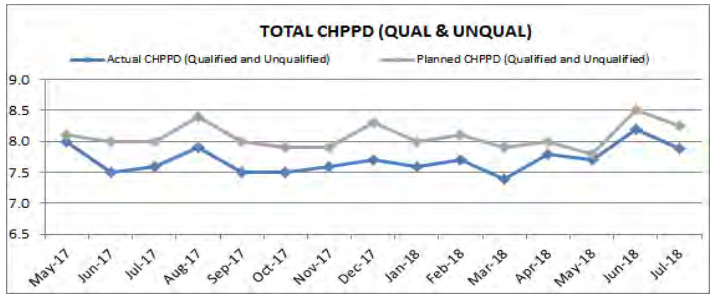
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	May-18	Jun-18	Jul-18
Fill Rates Day (Qualified and Unqualified)	95.49%	94.44%	93.50%
Fill Rates Night (Qualified and Unqualified)	115.19%	99.93%	98.97%

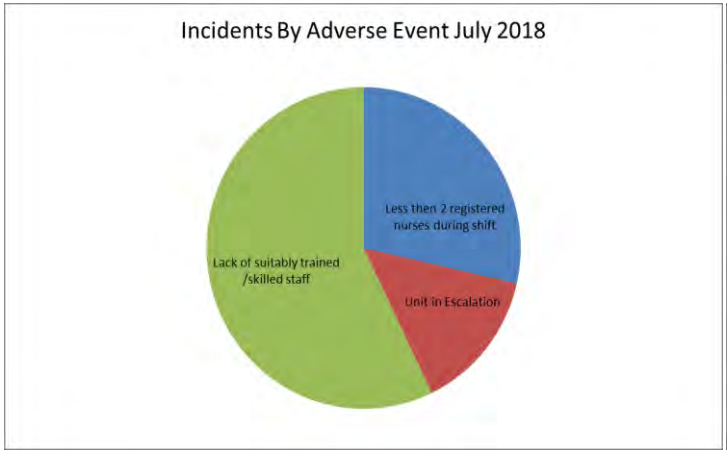
Planned CHPPD (Qualified and Unqualified)	7.8	8.5	8.2
Actual CHPPD (Qualified and Unqualified)	7.7	8.2	7.9

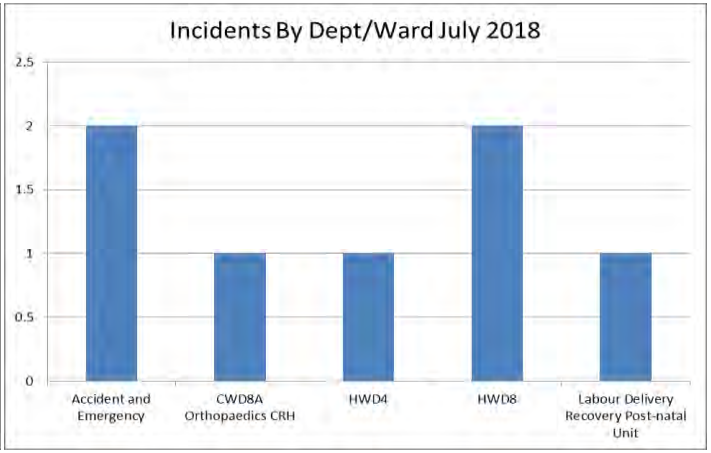
A review of July CHPPD data indicates that the combined (RN and carer staff) metric resulted in 21 clinical areas of the 32 reviewed having CHPPD less than planned. 8 areas reported CHPPD slightly in excess of those planned and 3 areas having CHPPD as planned. Areas with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix.These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There were 7 **Trust-Wide Red shifts** declared in **July.**
As illustrated above the most frequently recorded red flagged incident is related to "lack of suitably trained staff".
No datix's reported in July have resulted in patient harm

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

Ongoing activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.The Trust is expecting 53 new graduate nurses between September and November 2018.
2. Further recruitment event planned for Octoberr 2018.
3. Applications from international recruitment projects are progressing well and the first 12 nurses have arrived in the Trust, with a further 10 planned for deployment between early September and December 2018
4. A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. 57 candidates have now been transferred onto the OET programme.
5. The Trust is working with the recruitment agent to appraise its potential to recruit ILETS/OET compliant nurses. This workstream is progressing well with x2 nurses now deployed
6. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017. A proposal has being developed to up-scale the project in line with the national and regional workforce plans. A second cohort of 20 trainees commenced training on the 4th of June 2018. A further cohort are planned for training in December 2018
7. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce
8. 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

17. Data Quality Assessment

To Note

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: DATA QUALITY ASSESSMENT	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board, Finance & Performance Committee, Quality Committee	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The Intensive Support Team (IST) has reviewed the assessment tool populated by CHFT and subsequently met with Trust senior managers to discuss this in more detail; this report provides a summary of key areas requiring further action. It was noted that CHFT has a clear focus and good understanding of its Data quality issues. A PAS upgrade in May 2017 and associated actions has required additional resource which has been supported by CHFT, providing evidence of our hard work to ensure the transition was as smooth as possible, reflecting a positive and proactive approach. We have assured NHSI that we have the capability and capacity to take forward the recommendations in this report. This is being done through the attached action plan. We have also agreed to run the tool every 6 months internally and have an NHSI assessment of this annually.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note the final Data Quality Assessment report and the Trust's response via an action plan. Also to note the Terms of Reference for the Data Quality Board.

Appendix

Attachment:

Data Quality Assessment.pdf

NHS Improvement

Data Quality Assessment

Calderdale and Huddersfield NHS Foundation Trust

Report on the outputs of the self-assessment tool

1 Contents

1. Executive Summary

The IST has reviewed the assessment tool populated by the trust and subsequently met with the trust to discuss this in more detail; this report provides a summary of key areas requiring further action. The trust has a clear focus and good understanding of their Data quality issues. A PAS upgrade in May 2017 and associated actions has required additional resource which has been supported by the trust, providing evidence of the trust's hard work to ensure the transition was as smooth as possible, reflecting a positive and proactive approach. The trust has the capability and capacity to take forward the recommendations in this report.

2. Findings

A. Business Rules Exclusions

Only two of the national exclusions have been quantified, those excluded from reporting through the scripting to extract RTT reportable pathways should be identifiable and visible to enable audit checks on the correct application of the exclusion. The trust has noted that most national exclusions are not regularly reviewed.

Recommendation: The trust to provide clarification as to why pathway volumes have not been provided. Excluded pathways should be visible and quantifiable to enable audit checks on the correct application of the exclusion.

Referrals to a non-consultant led service

The trust has identified a large number of referrals to non-consultant led services, but that there is no review process in place for the application of this exclusion.

Recommendation: The trust should ensure that there are regular checks in place to ensure that any pathways that may be referred to a non-Consultant clinician working as part of a Consultant led service, and pathways referred on to Consultant-led services following an original referral to a non-Consultant service are included in RTT reporting.

Local rules

The trust has set out several local business rules and exclusions applied to RTT reporting, including quantification of pathways and the criteria applied.

Recommendation: It is recommended that criteria used for locally applied business rules excluding pathways from RTT reporting are included in the trust's rolling audit programme to ensure that pathways are being reported and managed appropriately.

The application of software solutions would qualify as local rules and should be subject to audit as noted above.

Following the site visit, the trust agreed to review their governance paperwork supporting their systems and processes (specifically documenting RTT exclusions). In addition, they will carry out a deep dive review of their trauma and orthopaedic and gynaecology pathways to

fully understand the illogical data currently showing on Unify II (and add appropriate actions to their local data quality action plan) as this cannot be explained at this stage.

B. Data Checks Input Sheet

The IST notes there are a number of data entries missing for the months of 'May 2017 – November 2017' for two entries pertaining to "Total Admitted Incomplete Pathways" ; "Over 18 Weeks Admitted Incomplete Pathways" and for a further six data entries; namely, "Total Elective Active Admitted Waiting List on a RTT pathway (Admission Method 11 & 12)", "Pathways with clock start date = decision to admit date", "Planned waiting list entries with no 'due date' or 'admit by date'", "Planned waiting list entries beyond their due date", "Number of patients awaiting a post clock stop/non- RTT follow up" & "Number of patients awaiting a post clock stop/non- RTT follow up without a due date". The trust board took a decision to stop reporting admitted and non-admitted clock stops for a number of months whilst focussing resources on maintaining the reporting of incomplete pathways (hence some of the missing data in this assessment). This decision was shared with and agreed by the regulators. The trust is currently reporting against all parts of the RTT monthly data return.

N**ote:** The IST has taken the decision to remove the data entry for April 2017 as the data for this month is significantly different due to the initial impact of the PAS upgrade. In cases where April data was previously included, the average calculations are now different from those submitted however more representative.

C. Further Questions

PAS Outlook

The IST notes that regular day attendee patients e.g. day case oncology and haematology activity continues to be manually entered onto the old PAS system as the solution within Cerner was deemed unsuitable.

Recommendation: The trust to ensure the progression with the identified alternate system is on track and those outcomes and progress against recommended areas for improvement are monitored on a rolling basis.

Note: The trust reported that amendments to Cerner should be in place by December 2018, making use of the former PAS system redundant.

Data Quality Governance

Responding to the question "Does the trust have a current published Data Quality Policy and what is the timescale for review?", the trust has stated; "No Data Quality Policy … was discontinued in 2014. There is a data quality protocol that was last updated in November 2016 that went to Information Governance and Records Strategy Group for sign off, and fed into IG toolkit submission. Review date is unknown as awaiting guidance on updates to Information Governance Toolkit replacement. It will be no later than November 2018."

Recommendation: The trust ensure the progression with the IT Governance toolkit is on track and that outcomes and progress against recommended areas for improvement are monitored on a rolling basis.

Note: The trust confirmed the board receive weekly reports and the COO and CIO sign off the RTT data submissions. There are several good practice examples shared by the trust

around data quality governance procedures described within the report. It would be beneficial to discuss these with a view to sharing on a wider footprint as possible examples of good practice.

D. Data Check Results

Please find below a summary of indictors where the IST have some queries or recommendations for further discussion with the Trust:

Indicator	Performance	Risk	Risk Explanation	Recommendations / Queries
% size of planned waiting list versus active waiting list	78.1%	Medium	(>5%,< 60%)= L, (>60%, <80%) = M, (<5%,>80%)= H	The planned waiting list is high in comparison to the active waiting list. The trust should ensure that the planned waiting list is regularly validated to ensure that only appropriate procedures are recorded on the planned waiting list.
% of pathways where clock start date = DTA date	6.9%	Low	< 20%= L, (>20%, <50%)= M, > 50%= H	
% of elective admissions on an RTT pathway	53.7%	High	>97%- L, 80-97%- M, Less than 80%- H	The percentage of elective admissions on an RTT pathway is low in comparison to the active waiting list. The trust to understand why the proportion is low. Potential scenarios include a high number of diagnostic admissions and or unusually high numbers of planned patients.
% of elective admissions versus admitted completed pathways	72.3%	High	>97%- L, 80-97%- M, Less than 80%- H	This indicates that a relatively low proportion of elective admissions result in a clock stop, and the data above indicates that a relatively small number of patients on an elective waiting list are not on an RTT pathway. It is recommended that the trust explore this further to assure itself that admissions for treatment including those diagnostic procedures that convert to therapeutic procedures are recorded correctly.
% of elective referrals versus clock starts	143.6%	High	(>90%, <110%) = L, ((>80%, <90%) OR >(110%, <120%)) = M, (<80%, > 120%) = H	This indicator reflects a significant proportion of new clock starts without an elective referral, including where there is a new decision to treat following previous clock stop, which can be an area that warrants further investigation

Indicator	Performance	Risk	Risk Explanation	Recommendations / Queries
% of unknown clock starts monthly	0.00	Low	<5%= L, (>5%, <10%) = M, >10%= H	This shows that all pathways have a clock start date recorded. Where patients are referred from another organisation (IPT), the trust must ensure that the appropriate clock start is used and audited regularly.
% of patients removed due to data validation	16.8%	Medium	<10%- L, (>10%, <20%) = M, >20%= H	Please note the calculation for this indicator has been updated. The trust should aim to validate pathways as close to real time as possible to provide ongoing assurance of pathway data. The additional commentary provided by the trust explains that treatment does not automatically stop an RTT clock but this is triggered by admission date. This will result in a delay in the recording of clock stops for patients who remain an inpatient beyond completion of month end reporting data.
% average additions versus removals (comparison of clock starts to completed pathways plus DQ removals)	73.5%	High	(>90%, <110%) = L, ((>80%, <90%) OR >(110%, <120%)) = M, (<80%, > 120%) = H	In the region of 25% of pathways are not accounted for when comparing average clock starts with stops/removals/validation. The Trust should audit a sample of this group to determine appropriate RTT status - the rationale and criteria for these patients should be visible and the criteria understood.
% of planned waiting list entries with an admit by date	79.5%	High	100%= L, (>80%, <100%) = M, <80%= H	The percentage of patients without an 'admit by' date is rated as high. The trust should ensure that all patients on the planned waiting list have an admit by date recorded as appropriate for patients added to the planned waiting list; to ensure patients are booked for procedures at an appropriate time.
% of planned waiting list entries who have passed their admit by date	8.1%	Medium	<5%= L, (>5%, <15%) = M, >15%= H	The number of patients who have passed their 'admit by' date should be managed and reported as active pathways. There may be a risk of clinical harm where treatment or surveillance checks have been delayed.

Indicator	Performance	Risk	Risk Explanation	Recommendations / Queries
% of follow up outpatient waiting lists with a clinical review date	100.0%	Low	100%= L, (>80%, <100%) = M, <80%= H	The trust has recorded that all follow up out patients have a clinical review date.
% of follow up outpatient waiting patients who have passed their clinical review date	21.7%	High	<5%= L, (>5%, <15%) = M, >15%= H	It is recommended that the trust assure itself that there is appropriate management non-active follow up patients should be visible on a non-admitted PTL.

E. Risk Score Summary Sheet

The Risk Score Summary is based entirely on the data that has been inputted into the model, it calculates an aggregated risk score based on section followed by a total risk score and assigns a risk rating to the Trust position.

	Low Risk	Medium Risk	High Risk
Business Rules Exclusions	0	0	0
Data Checks- Results	3	3	6
Further Questions	0	0	0
Total	3	3	6

Six areas of high risk are identified, which require investigation as a matter of urgency. Additionally, three areas of medium risk have been identified.

The overall number of high and medium risk indicators does not indicate the level of risk in itself – each represents an area of potential concern if an adequate explanation cannot be identified.

Recommendation: All areas of high and medium risk, and other issues highlighted in this report need to be investigated further to understand any underlying issues.

The trust was advised to complete the data quality assessment proforma following a review of the nationally submitted Unify II return. The trust has been highlighted as one that has submitted illogical data. This is apparent where a given specialty reports a clearance time of over 18 weeks with a related performance of over 92%. In the most recently published data (April 2018) the trust has nine reported specialties that meet the above criteria.

Recommendation: Trust to investigate reasons behind illogical data.

3. Next steps

The trust is advised to review the recommendations set out in this report, investigate the issues highlighted and develop plans to address areas of concerns.

This report to be shared with NHSE and NHSI regional colleagues, where further follow up to this report will be agreed.

Nikki Waddie

Improvement Manager

Elective Care Intensive Support Team

Referral to Treatment : Data Quality Self Assessment - Calderdale and Huddersfield NHS Foundation Trust **Reporting Period : August 2018**

Date for Overall Compliance	Mar-19	Overall RAG Status	On Track and due to be completed by planned due date

Key Risks for Escalation this Reporting Period

Capacity available to complete validation required to timescale. Analytical capacity to deliver monitoring.

	Key Implementation Activities	Due Date	Progress since last month	Actions planned for next month	RAG Status
1	**Business Rules Exclusions**				
1.1	The trust to provide clarification as to why pathway volumes have not been provided. Excluded pathways should be visible and quantifiable to enable audit checks on the correct application of the exclusion.	Jul-18	Report received	Plan to respond / document end July 18	Behind track, no clear recovery plan in place
1.2	Ensure regular checks in place to ensure that any pathways that may be referred to a non-Consultant clinician working as part of a Consultant led service, and pathways referred on to Consultant-led services following an original referral to a non-Consultant service are included in RTT reporting.	Aug-18	Report received	Plan to document end Aug 18 and ensure an ongoing process	On Track and due to be completed by planned due date
1.3	It is recommended that criteria used for locally applied business rules excluding pathways from RTT reporting are included in the trust's rolling audit programme to ensure that pathways are being reported and managed appropriately.	Sep-18	Report received	Understand timetable for agreement of rolling audit programme and build this requirement into said audit programme	On Track and due to be completed by planned due date
2	**Further Questions**				
2.1	Regular Day Attenders : The trust to ensure the progression with the identified alternate system is on track and those outcomes and progress against recommended areas for improvement are monitored on a rolling basis.	Dec-18	Report received - Regular Day Attenders Launch even planned for 19/7/2018	Attend launch event and ensure service coverage and reporting requirement for regular day attenders fully understood. Medical Oncology, Rheumatology, Haematology now all sorted as of 21/8/18. Still to sort Lithotripsy and ensure Urology Chemo checked to be capturing ok on EPR.	On Track and due to be completed by planned due date
2.2	Data Quality Governance : The trust ensure the progression with the IT Governance toolkit is on track and that outcomes and progress against recommended areas for improvement are monitored on a rolling basis.	Mar-19	Report received.	Understand requirements of IG Toolkit, implement and monitor accordingly.	On Track and due to be completed by planned due date
2.3	Data Quality Policy	Dec-18	Just establishing Data Quality Board, aim to have Data Quality Policy completed by Dec 2018	Continue DQ Board set up and work towards DQ policy being created. Received data quality policies from Bradford and Harrogate - other local trusts asked w/c 9/8/18. Need to be worked through.	On Track and due to be completed by planned due date
3	**Data Check Results**				
3.1	% size of planned waiting list versus active waiting list : The planned waiting list is high in comparison to the active waiting list. The trust should ensure that the planned waiting list is regularly validated to ensure that only appropriate procedures are recorded on the planned waiting list.	Aug-18	Report received - Planned Waiting list should be assessed weekly in Weekly Performance meeting - detailed clean up plan regards "To Be Seen By" date is required and is to be completed by end August 2018, then weekly monitoring validation will be actioned	Current planned waiting list sizes to be shared with services via weekly performance meeting for sign off / agreement of where further validation required. Analysis needs doing urgently (update 21/8/18)	Behind track, but with recovery plan in place
3.2	% of elective admissions on an RTT pathway : The percentage of elective admissions on an RTT pathway is low in comparison to the active waiting list. The trust to understand why the proportion is low. Potential scenarios include a high number of diagnostic admissions and or unusually high numbers of planned patients.	Nov-18	Already understanding that a good proportion of this is due to patients that have been treated electively were not removed from waiting list - either because there were 2 waiting list entries and only one closed or admitted through incorrect workflow. It was not appreciated that cancelling an "order" did not close the associated waiting list record and validation on this has been in progress for two months now. Numbers have reduced markedly with a reduction of over 500, Urology a specialty of particular note	Ensure learning from Urology secretaries is shared throughout service. Information and Surgical management to understand next big category area (likely to be Endoscopy). Further analysis required if the requirement is to be met.	Behind track, no clear recovery plan in place
3.3	% of elective admissions versus admitted completed pathways : It is recommended that the trust explore this further to assure itself that admissions for treatment including those diagnostic procedures that convert to therapeutic procedures are recorded correctly.	Dec-18	Report received in addition to Internal Audit report, Issue identified with Urology Chemotherapy patients not being captured as planned electives.	Learning from Internal Audit report to be shared with service and work plan agreed to increase numbers of patients captured as planned electives where required. Further analysis to take place identifying other inconsistency issues i.e. captured on MAR but not captured in RTT Admitted completed reporting	On Track and due to be completed by planned due date
3.4	% of elective referrals versus clock starts : This indicator reflects a significant proportion of new clock starts without an elective referral, including where there is a new decision to treat following previous clock stop, which can be an area that warrants further investigation	Dec-18	Report received, RTT Validation team have highlighted numerous common patterns of pathways being started following long term follow up appointments indicating issues with RTT terminology understanding out in the service.	Areas incorrectly starting new pathways commonly to be targeted and further RTT training to be supplied including simple help guide crib sheets detailing correct RTT Status capture for common pathway flows. These to be specific to specialties where relevant.	On Track and due to be completed by planned due date
3.5	% of patients removed due to data validation : The trust should aim to validate pathways as close to real time as possible to provide ongoing assurance of pathway data. The additional commentary provided by the trust also explains that admission for treatment does not automatically stop an RTT clock but that this is triggered by the completion of clinical coding following discharge. This will result in a delay in the recording of clock stops for patients who remain an inpatient beyond completion of month end reporting data.	Mar-19	Report received. Need to understand this further - not sure this is clinical coding related but more to do with when patient is actually discharged	Pick up at meeting with NHS I on 18/07/2018. Review current validation timetable process. Close examination of Gynaecology and Trauma and Orthopaedics. Understand now the issue of false looking clearance times showing that so many pathways need to be validated - particular problem in medical specialties	On Track and due to be completed by planned due date
3.6	% average additions versus removals (comparison of clock starts to completed pathways plus DQ removals) : In the region of 25% of pathways are not accounted for when comparing average clock starts with stops/removals/validation. The Trust should audit a sample of this group to determine appropriate RTT status - the rationale and criteria for these patients should be visible and the criteria understood.	Dec-18	Report received	Break down analysis at specialty level and choose first specialty to audit	On Track and due to be completed by planned due date
3.7	% of planned waiting list entries with an admit by date : The percentage of patients without an admit by date is rated as high. The trust should ensure that all patients on the planned waiting list have an admit by date recorded as appropriate for patients added to the planned waiting list; to ensure patients are booked for procedures at an appropriate time.	Aug-18	Report received - well documented already within weekly performance meeting. Understanding of why different ways of capturing "admit by date" is in the current build has started with back office team.	Pain Management Waiting List Planned patients to be validated including entry of "To Be Seen By" dates. Progress being made now with Pain Management- w/c 20/8/18 - need plan for other specialties and ensure Endoscopy are clear of responsibilities. Also have been issues with reporting accuracy.	Behind track, but with recovery plan in place
3.8	% of planned waiting list entries who have passed their admit by date : The number of patients who have passed their admit by date should be managed and reported as active pathways. There may be a risk of clinical harm where treatment or surveillance checks have been delayed.	Aug-18	Report received - this monitoring takes place within Weekly performance report - will be available as complete picture from Sept 1st onwards providing 3.7 completed. Monitoring available for all daily via Knowledge Portal waiting list model	Make staff aware of facility in Knowledge Portal	On Track and due to be completed by planned due date
3.9	% of follow up outpatient waiting patients who have passed their clinical review date : It is recommended that the trust assure itself that there is appropriate management non active follow up patients should be visible on a non-admitted PTL.	Jul-18	Report received : understood that detailed assurance process is already available via weekly performance report and Knowledge Portal Holding List model	Confirmation that current process is robust to be signed off by Appointments / COO. Need paper to sign off	Complete
4	**Risk Score Summary Sheet**				
4.1	All areas of high and medium risk, and other issues highlighted in this report need to be investigated further to understand any underlying issues. The trust was advised to complete the data quality assessment proforma following a review of the nationally submitted Unify II return. The trust has been highlighted as one that has submitted illogical data. This is apparent where a given specialty reports a clearance time of over 18 weeks with a related performance of over 92%. In the most recently published data (April 2018) the trust has nine reported specialties that meet the above criteria.	Dec-18	Report received - many of areas that are high / medium risk already have plans against them (as per this implementation template) - those that have not to be confirmed and appropriate action plan to be agreed	Pick up at NHS feedback meeting 18/7/18 to understand better and pull together a plan to tackle the specialties currently seen as illogical. Issue with clearance times understood, Medical specialties, Gynaecology and Orthopaedics biggest problem areas. Basically need to keep working on getting the total open pathways in these areas cleaner by i) validation and ii) not adding further data quality problems in at source.	On Track and due to be completed by planned due date
5	**Other actions**				
5.1	Repeat data self-assessment on a regular basis to provide assurance in relation to progress. To be submitted to NHSI annually. Next external submission due March 2019, then annually.	Mar-19	Not due	Not due	On Track and due to be completed by planned due date

Data Quality Board (DQB) – Terms of Reference

Purpose: To Provide Assurance that data used within CHFT and reported by CHFT is of a high standard

Accountable for providing assurance that

- the Trust is compliant with statutory and regulatory requirements in respect of data quality
- data used for reporting is accurate and timely
- prior to submission, external reported data is accurate

Agenda

- To improve and maintain the quality of data within the Trust;
- To agree Data Quality Dashboard Indicators;
- To ensure that all data quality issues relating to EPR, including Administrative EPR SOPs, have all the appropriate information recorded against them in order for them to be effectively managed;
- To introduce standardised procedures Trust-wide for the collection and validation of data and agree error reports;
- To raise awareness of, identify and manage work in progress and review the data quality standards within the Information Governance toolkit e.g. mandatory datasets;
- To agree the annual audit programme then review and action audit reports in relation to data quality;
- To agree performance deep-dives;
- To ensure key data quality issues impacting on clinical coding teams are understood and resolutions prioritised accordingly;
- To commission reports in relation to highlighted concerns or adhoc issues as required;
- To agree any requests for changes to data collection/data definitions;
- To ensure regular data quality reports are made available including the financial impact of data quality issues and an understanding of the impact for each Commissioner;
- To ensure all externally reported data is accurate, meets deadlines and is appropriately signed off internally;
- To identify escalation processes for data quality issues and criteria for reporting these to WEB, EPR Programme Board, Finance & Performance Committee, Information Governance and Records Strategy Committee (IGRSC) and others as appropriate;
- To ensure that there is communication of the data quality issues throughout the organisation;
- To ensure the Trust has an up to date Data Quality Policy and Data Dictionary;
- To regularly evaluate Trust's Data Quality Maturity Index (DQMI) and direct improvement requirements as necessary.

People

- Chief Operating Officer
- Chief Information Officer
- Assistant Director of Performance
- Director of Operations - FSS
- Director of Operations - S&A
- Chief Clinical Information Officer
- Chief Nursing Information Officer
- Associate Director of Quality
- Head of Contracting
- Deputy Director of Workforce and OD
- Clinical Coding Lead
- Data Protection Officer

Chair – Chief Operating Officer
Vice Chair - Director of Operations - FSS

Other colleagues may be co-opted onto the group as agenda requires

Quorum

- Minimum of 5 members, including 1 Operational, 1 corporate and 1 information/performance representative
- Attendees must be present at a minimum of 75% of meetings
- Nominated Deputies, with delegated authority for decision-making will be accepted on a meeting by meeting basis.

Design

Frequency

- Monthly

Decision-making

- External Reporting sign-off
- DQ audit programme
- Data Quality Policy
- Items for escalation

Authority

- Sign-off arrangements for external reporting
- Prioritisation of audit programme
- Sign-off of self-assessments
- Sign-off of data definitions
- Agreement on escalations

Reporting Strategy

- Reports into Finance & Performance Committee
- Escalation into Weekly Executive Board

Support from

- THIS for minutes, agenda setting etc.

Decisions – recommend approval of

- Data Quality Strategy
- Audit reports and recommendations
- Self-Assessments
- Proposed variations from national guidance.

18. Annual Fire Report

To Approve

Presented by Lesley Hill

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Gorman, PA to Director of Planning, Performance, Estates & Facilities
Date: Thursday, 6th September 2018	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: CHFT Annual Fire Report 2018 - This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2017/2018 in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.	
Action required: Approve	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: None	
Governance Requirements: Transforming patient care. The report includes a Fire Safety Work plan for 2018/19.	
Sustainability Implications: None	

Executive Summary

Summary:

This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2017/2018 (1st April 2016 to 31st March 2017) in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

Main Body

Purpose:

The Executive Board is requested to receive and note the contents of the annual Fire Safety report and agree the draft work plan for 2018 / 2019

Background/Overview:

The Trust has made progress over the last 12 months in terms of fire safety and continues to progress year-on-year.

The Issue:

Transforming patient care

Next Steps:

A further annual report will be provided in 12 months time.

Recommendations:

The Executive Board is requested to receive and note the contents of the annual Fire Safety report and agree the draft work plan for 2018 / 2019

Appendix

Attachment:

CHFT Annual Fire Report 2018Final.pdf

CHFT Annual Fire Safety Report
1st April 2017 – 31st March 2018

1. Introduction

This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2017/2018 (1st April 2017 to 31st March 2018) in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

The Trust has made progress over the last 12 months in terms of fire safety however there is further work to implement to ensure compliance.

2. Executive Summary

The RRO provides the legal framework for the implementation of fire safety in organisations and the HTM provides guidance on how to manage fire safety in healthcare premises detailing the responsibilities placed on the Trust and its employees.

Fire safety advice, support and training is provided by the Fire Officer who resides within the Estates and Facilities Division. The Trust is provided with independent advice from the formally appointed authorising fire engineer AE(Fire) as required by HTM 05.

Following the fire at Grenfell Tower the Trust will continue to monitor and apply lessons-learnt from the post-incident inquiry process. It is also important for the Trust to assess proposed building design and work to standards in the light of inquiry findings.

The current financial constraints faced by CHFT and reduced capital will impact on the journey towards safer and compliant buildings. Whilst the future of HRI is to be decided; CHFT must ensure standards are achieved and capital funds are made available to ensure we keep the HRI base safe.

Improvements with the building compartmentation at HRI were reduced due limited funding. What must be remembered is that the Enforcement notice issued under the Regulatory Reform (Fire Safety) Order was only lifted if we as a Trust worked towards year on year improvements.

Compartmentation concerns in PFI buildings across the UK have shown how vulnerable buildings are if compartmentation issues are not managed appropriately and, once installed, must be maintained. Fortunately Calderdale Royal Hospital does not fall within the poor state some PFI hospital buildings find themselves in. However, HRI continues to have major weaknesses in compartmentation which will require sustained investment over many years to achieve our legal duties. The change of use of areas from clinical to office based functions (eg: such as in the old OPD area) requires major compartmentation work and should not be underestimated, as a fire in this area would have significant implications for the whole block (eg: ED, CDU, Pathology, etc).

HRI fire detection upgrade programme has resulted in an improved detection system making good progress towards a compliant system and has significantly improved from the previous year. Approximately 1400 additional devices (mainly smoke detectors) have been installed.

CRH fire alarm system is being upgraded via the life cycle programme and a floor per year is being achieved. Work commenced at the top of the building and has now reached the ground floor.

Fire training this year utilised the ESR system, so staff training registers reduced the administration burden. This was achieved by uploading the booklet so printing costs were also saved. Face to face training will be needed in 2018/19.

Space utilisation continues to be a challenge with the requirements to move departments rapidly resulting in missed opportunities to check adequate fire precautions / compartmentation / fire alarms are in place for the change of use. Often fire risk assessments are not considered before the move has taken place.

The Trust must also ensure departments change their working practices and refrain from placing combustible materials (i.e. beds and chairs) in corridors which is dangerous due to the impact this can have on evacuation and also increases the fire load; unfortunately, this continues to be common practice which has increased due to the use of the new mobile work stations (EPR).

3. REPORT

3.1 Fire Risk Assessments

Fire Risk assessments are a legal requirement and have been carried out for all CHFT premises. A total of 100 plus fire risk assessments have been provided to areas for review at Quality and Safety Boards. The responsibility of implementing action plans resides with local areas and it is challenging to provide assurance that all actions have been implemented and completed. To address this, an audit of the Fire Risk Assessments is being carried out to ensure we have a clear view of the current position.

The main areas for improvement are fire compartmentation (HRI) and fire door maintenance (HRI). Other common findings include poor housekeeping and storage with particular storage issues across both sites resulting in beds being located on corridors.

The continual movement of departments and staff to different locations does not always necessitate the need for a review of the fire risk assessment. More thought and planning is needed in the use of space so it is appropriate both in terms of location and appropriate from a fire safety perspective.

3.2 Fires and Fire Alarms

Fires

There have been no fires during the last 12 months at CRH and HRI, however there have been in the Dales which is operated by SWYMHT.

False Alarms

There remains a high number of false alarms especially at HRI which has significantly increased, mainly due to the misuse of toasters and also because better detection is being introduced within the premises. Efforts are being made to reduce these False Alarms through adjustments to the sensitivity of the detectors, but it is down to staff training that is lacking on the wards. Life cycle upgrades on the fire alarm system at CRH is helping to reduce the activations.
The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation and actions to prevent a reoccurrence.

Table 1 – Fire Alarm Statistics HRI

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2017/18	HRI	76	0	76	0
2016/17	HRI	35	0	35	0
2015/16	HRI	36	2	34	0
2014/15	HRI	53	4	49	4
2013/14	HRI	67	5	40	6

Table 2 Fire Alarm Statistics CRH & Dales

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2017/18	CRH	37	0	37	1
2016/17	CRH	33	2	31	1
2015/16	CRH	62	2	60	3
2014/15	CRH	100	0	100	5
2013/14	CRH	95	2	93	6

An unwanted fire signal (UFS) is a fire alarm where the fire service attend site and there is no fire. West Yorkshire Fire and Rescue Authority charge organisations £450 for each UFS. Their objective is to reduce the number of UFS thus ensuring fire tenders are available for actual fire calls. CHFT's Fire Officer and AE continue to work closely with the Authority, Estates and Facilities, Engie and ISS to ensure, where possible, we manage UFS internally and are not charged.

3.3 Fire Safety Training

Fire training has been by the reading of a booklet on line, and where possible, in the trainee's workplace or an area which simulates their place of work, which has been well received by staff. There has been a marked improvement from 74% of Trust staff the previous year to 92%. The staff requirement to have their training up to date for their appraisals has had a major influence. Table 3 illustrates fire safety training statistics.

Table 3 Fire Training Statistics

Year	Fire Safety Training	Fire Warden Training
2017/18	5630	270
2016/17	4452	151
2015/16	4171	1089

2014/15	4976	1042
2013/14	2460	826

This coming year's fire training will revert back to face to face training which is manageable with there being limited capital schemes being proposed and funded.

Fire Warden Training
There was a marked drop in numbers of staff being trained as fire wardens, this was caused by changes in working locations of staff, senior staff retiring, plus other demands being placed on staff. Steps have been taken to increase the number of wardens, but the reality is that managers of their departments need to ensure this happens.

Fire Response Team Training
Additional training, including using fire extinguishers, has been provided to CHFT's fire response teams which include Site Coordinators/Night Matrons, Porters, Estates and Security.

3.3.1 Fire Evacuation Training
Due to the risk to patients there are limited options to undertake live fire evacuation training on wards. However in numerous areas some staff evacuations with staff actually practicing "hands on" training for the event has occurred. Further evacuation training is planned for 2018 but these exercises depend on the availability of suitable facilities and staff being available. The health centres where we have control have all completed an evacuation drill, (Allan House, Brighouse and St John's).

4. GOVERNANCE

4.1 Audits
CHFT's AE(Fire) has commenced auditing the CHFT's premises in 2017 to measure compliance against the Fire Safety (Regulatory Reform) Order and HTM 05. An in depth compliance report will be produced by the AE (Fire) detailing both strengths and areas for improvement.

Health & Safety Committee
Monthly performance reports are provided to the Health and Safety Committee with quarterly updates detailing progress against the annual action plan.

Fire Safety Meetings
Monthly/Quarterly meetings take place which involve the Fire Manager, Fire Safety Officer, AE (Fire) and other key stakeholders ensuring any new and emerging risks are captured and managed accordingly.

A Fire Safety Committee
A specific committee has been established to look at CRH fire issues and help resolve and monitor issues, it was covered by the JSLT (joint safety leadership team) meeting, but became too onerous.

1. CAPITAL WORKS

5.1 Fire Compartmentation
The Trusts buildings are made up of a number of fire resisting compartments to reduce the spread of fire from one location to another. This fire compartmentation allows the Trust to use progressive horizontal evacuation as its primary evacuation method.

The fire compartmentation at HRI has deteriorated over a large number of years due to intrusive work carried out by contractors when installing new services. An Estates lead fire survey identified areas where remediation was necessary to reinstate the compartmentation back to its original design. A subsequent action plan was developed to ensure all high risk areas are reinstated and risks mitigated.

Over the period there have been a number of capital schemes that have improved the fire precautions within the Trust these are:

- HRI Service ducts which run at various levels throughout the Trust

Capital funding allocation remains low, estates & finance prioritise schemes in terms of the risk they pose to the Trust. This resulted in additional fire safety schemes dropping from the annual plan, reduced funding on schemes that were highlighted in the West Yorkshire Fire & rescue enforcement notice continue to progress but at a much slower pace.

CRH does not have major capital works due to an annual life cycle programme which keeps the areas to a good standard and the premises are newer.

5.2 Fire Detection

Improved fire detection has been installed in nearly all the areas where old detection was present at HRI. There has been some major work carried out to update and improve coverage at HRI bringing the system up to the required standard with approximately 1400 new detectors being fitted. The better detection should see a reduction in fire alarm calls, despite there being more detectors installed.

CRH fire detection is also being upgraded with the lifecycle programme that is in place and so a further reduction of calls is anticipated.

Fire Door Maintenance

The lack of resources and facilities to repair fire doors has created a backlog of work; however a new workshop has been built and a revised workforce model should see staff allocated to fire door maintenance.

6. West Yorkshire Fire & Rescue

There is a sustained open dialogue between West Yorkshire Fire & Rescue Service, the Trust Fire Officer and AFE. This happens when fires occur and whenever upgrade work is planned through building control. The regular contact also gives them reassurance the Trust is progressing and hence they have not made a formal visit during the last 5 years however, this could change. We have recently closed dialogue regarding the cladding risk highlighted by the Grenfell Tower disaster.

Operational Visits

There have been a steady number of both operational and familiarisation visits by local Fire Crews. These ensure that fire crews have a better understanding of the problems they will face in the event of a fire or evacuation which will enable them to manage and deal with the situation better. Some of the unoccupied buildings are being used to facilitate fire service training, at both Acre House Avenue and the old nurses accommodation block, mainly in an evening and at weekends.

7. FIRE SAFETY WORKPLAN FOR 2018/2019

	WHAT	WHO	WHEN
1.	Provide fire safety data Trust and DoH following Grenfell fire incident.	Fire Officer / Head of Estates	As and when required
2	**Fire Risk Assessments** Embed fire risk assessments as part of Divisions local governance structure (eg: Div. Quality & Safety Boards). These should be cascaded upon review.	Fire Officer / Director of Estates, Facilities Planning & Performance	On going
2.1	**Audit** Complete HRI / CRH audit of fire safety Vs HTM (including Fire Risk Assessments).	Authorising Engineer AE (Fire)	On going
2.2	Complete Community audit of fire safety Vs HTM (including Fire Risk Assessments).	AE (Fire)	On going
3.1	**Training** Fire warden training (Refresher & New)	Fire Officer	On-going
3.2	Training Monitor staff to ensure understanding of Fire safety awareness training	Fire Officer	31.3.19
3.3	Training Fire extinguishers training for key staff (practical)	Fire Officer	31.3.19
3.4	Training Develop training for 2019/20	Fire Officer	31.12.19
3.5	Training Plan and deliver practical evacuation training including off site office areas	Fire Officer	31.3.19
4.1	Capital Works Ensure any works carried out comply with Fire Regulations	Fire officer / Head of Estates	31.3.19
4.2	Capital Works Progress installation of fire detection at HRI	Deputy Fire Manager / Head of Estates	31.3.19
4.3	Capital Works Continue to provide overview of CRH new Fire detection system	Deputy Fire Manager / Head of Engie Estates	31.3.19
5.	Fire Alarm Activation Continue to reduce the number of fire alarm activations across CHFT	Fire Officer / CHFT Colleagues	31.3.19

1. RECOMMENDATION

The Executive Board is requested to receive and note the contents of the annual report and agree the draft work plan for 2018 / 2019

26th May 2018
Keith Rawnsley
Fire Officer

19. Month 4 Financial Summary

To Approve

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Finance Headline Message - Month 4 - See attached	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

See attached.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

-

Appendix

Attachment:

Board of Directors Financial summary Month 4.pdf

FINANCE HEADLINE MESSAGE – MONTH 4
BOARD OF DIRECTORS
6 SEPTEMBER 2018

Year to Date Summary

- The year to date deficit is £16.51m, in line with the plan submitted to NHSI.
- Clinical income is below plan by £0.68m. The Aligned Incentive Contract (AIC) is now protecting the income position by £0.56m in the year to date (£0.51m at Month 3), see Appendix 1 for detail.
- There remains an underlying adverse variance from plan which has had to be mitigated by the release the maximum available contingency reserves in the year to date £0.67m, whilst preserving the earmarked reserve required for the winter plan. Unless run rate improves, a financial pressure will emerge in Months 6-12 once contingencies are exhausted.
- The underlying divisional position excluding reserves release and AIC protection is £1.23m overspent in the year to date.
- CIP achieved in the year to date is £3.54m against a plan of £3.78m, a £0.24m shortfall.
- Agency expenditure remains £0.13m beneath the agency trajectory set by NHSI.
- The working capital position at the end of Month 4 is much improved following cash receipt of £2.9m STF bonus funding and £4.2m for the settlement of the PFI facilities management agreement from 17/18. This cash has enabled the backlog of outstanding approved invoices to be paid.

Key Variances

The table below outlines the Month 4 financial position adjusted to show underlying operational variance from plan by Division.

	Reported Position YTD (M4)			Adjustments		Underlying Variance from Plan (YTD)	
	Plan	Actual	Variance	Remove Impact of Aligned Incentive Contract	Remove impact of pay award		
	£'000	£'000	£'000	£'000	£'000	£'000	
Corporate Services	(10,651)	(10,727)	(76)	(0)	28	(48)	
Families & Specialist Services	(1,174)	(1,343)	(169)	(156)	61	(263)	
Estates & Facilities	(9,158)	(9,308)	(150)	(0)	35	(116)	
Health Informatics	18	(155)	(172)	0	6	(167)	
Medical Division	8,761	8,829	68	(598)	71	(459)	
Surgery & Anaesthetics	3,832	3,490	(342)	113	81	(148)	
Community Division	1,093	1,079	(13)	81	40	108	
Pmu	928	939	12	0	3	14	
Divisional Operating Position	**(6,351)**	**(7,195)**	**(844)**	**(559)**	**325**	**(1,079)**	
Technical Accounting & Reserves*	(10,168)	(9,312)	857	0	(325)	532	
Total Trust Surplus / (Deficit)	**(16,519)**	**(16,506)**	**13**	**(559)**	**0**	**(547)**	

* Note: Includes Contingency Reserves released of £670k and (£370k) unallocated CIP

- The required £18m CIP for the full year £18m has now been identified in full. However, it should be noted that the monthly profile of CIP delivery differs from the fixed original plan.

This drives a £0.24m pressure in the year to date and whilst this is a timing difference, it will make it more difficult to achieve plan in Months 5 and 6.

- The AIC protection remains at Trust level but has not extended significantly in-month, however the differential position by division has moved considerably. Surgery division is now being adversely impacted by the AIC whilst Medical division position includes £0.60m additional income under the AIC than the operational position would justify.
- In spite of the lower activity than plan Medical pay expenditure continues above plan with a year to date adverse variance to plan of £0.80m. The run rate has improved from prior months but spend remains above plan in-month by £0.12m.
- Nursing pay expenditure has reduced over the last 3 months, but remains above plan with a year to date adverse variance of £0.32m (excluding the impact of pay awards which is funded as income). However, nursing agency costs are £0.67m lower than plan year to date with a significant reduction in the use of the very highest cost agencies.
- Aside from the ongoing run-rate pressure, one-off non recurrent items have adversely impacted divisional positions by c.£0.2m in-month relating to the prior year. A pro-active review is being undertaken to gain assurance that these items have now been fully flushed out.
- These adverse variances have been offset by the release of the maximum available contingency reserve in the year to date.

Forecast

- The forecast is to achieve the planned £43.1m deficit; this relies upon full delivery of the £18m CIP plan including high risk schemes.
- The forecast will also require an improvement in the underlying run rate to contain expenditure within budgeted levels

Action Required

- **Full delivery of £18m CIP**
- **Containment of expenditure within budgeted levels, particularly clinical pay**
- **Identify cost out opportunities enabled by the AIC**
- **Maximise cash availability, focus on collecting outstanding debt**

CLINICAL CONTRACT UPDATE – MONTH 4

Summary

The in-month and year-to-date clinical contract across all Commissioners is summarised below:

Point of Delivery	In-month						Year-to-Date					
	Activity			Income			Activity			Income		
	Plan	Actual	Variance	Plan (£'m)	Actual (£'m)	Variance (£'m)	Plan	Actual	Variance	Plan (£'m)	Actual (£'m)	Variance (£'m)
Daycase	3,194	3,203	9	2.30	2.29	-0.01	12,202	12,080	-122	8.79	8.78	0.00
Elective	562	502	-60	1.77	1.55	-0.22	2,111	1,929	-182	6.66	6.04	-0.63
Non-Elective	4,783	4,918	135	8.62	8.40	-0.22	18,828	19,285	457	33.76	33.67	-0.09
A&E	13,325	13,463	138	1.61	1.70	0.08	52,258	51,668	-590	6.33	6.49	0.16
Outpatient	31,982	32,528	546	3.79	3.73	-0.06	122,311	125,305	2,994	14.52	14.48	-0.04
Other NHS Tariff	10,881	10,781	-101	1.69	1.67	-0.02	42,840	43,234	393	6.85	6.86	0.00
Other NHS Non-Tariff	145,012	145,123	110	6.16	6.25	0.09	574,839	573,937	-903	23.96	23.89	-0.07
CQUIN	0	0	0	0.59	0.58	-0.01	0	0	0	2.29	2.28	-0.01
Sub-total - pre AIC adjustment	**209,739**	**210,517**	**778**	**26.54**	**26.17**	**-0.37**	**825,390**	**827,437**	**2,047**	**103.17**	**102.49**	**-0.68**
AIC Adjustment	-	-	-	-	0.14	0.14	-	-	-	-	0.56	0.56
Net Reported Position	**209,739**	**210,517**	**778**	**26.54**	**26.31**	**-0.23**	**825,390**	**827,437**	**2,047**	**103.17**	**103.05**	**-0.12**

- The AIC contract positions for GHCCG and CCCG are £0.14m below plan in-month and £0.56m below plan year-to-date. Income is therefore protected by the AIC adjustment to this level. Activity is below plan in month across all points of delivery with the exception of Other Non-Tariff and A&E attendances.

- The net reported income position, relating to all other CCGs and NHS England, is £0.16m below plan in-month and £0.12m below plan year-to-date.

Greater Huddersfield CCG and Calderdale CCG AIC Positions

The year-to-date under-performance against the AIC of £0.56m can be summarised by CCG as:

Point of Delivery	GHCCG		CCCG		TOTAL	
	Activity Variance	Income Variance (£'m)	Activity Variance	Income Variance (£'m)	Activity Variance	Income Variance (£'m)
Daycase	152	0.04	-88	0.02	64	0.07
Elective	-86	-0.30	-71	-0.23	-157	-0.53
Non-Elective	-43	-0.30	369	0.02	326	-0.28
A&E	-570	0.00	-248	0.10	-819	0.10
Outpatient	1,193	-0.02	2,583	0.15	3,776	0.13
Other NHS Tariff	756	0.01	469	-0.02	1,225	0.00
Other NHS Non-Tariff	3,688	-0.03	-5,102	0.00	-1,413	-0.03
CQUIN	0	-0.01	0	0.00	0	-0.01
Total	**5,089**	**-0.61**	**-2,088**	**0.05**	**3,001**	**-0.56**

- The main areas of under-performance are elective inpatients, non-elective and high cost drugs. These are off-set by over-performances within outpatient attendance activity.

- Greater Huddersfield CCG has seen lower performance in month 4 compared to Calderdale CCG and this is reflected in the year-to-date positions. The main areas driving this difference in Greater Huddersfield are a reduction in elective and non-elective admissions, lower levels of outpatient attendances and adult critical care. These are partially offset by higher levels of maternity pathway and pass through devices than seen in Calderdale.

20. Calderdale and Huddersfield Solutions Update

To Note

Presented by Gary Boothby

21. Revalidation and Appraisal of Non Training Grade Medical Staff

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 6th September 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Revalidation and Appraisal of Non Training Grade Medical Staff - The paper updates the Board on the position regarding revalidation and appraisal of non-training grade medical staff as at the end of the revalidation and appraisal year (31st March 2018).	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

See attached

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

-

Appendix

Attachment:

Revalidation - Board of Directors - September 2018 Final.pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS - THURSDAY 6th SEPTEMBER 2018

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation. The report will also discuss the 2017/18 appraisal and revalidation year (1st April 2017 – 31st March 2018).

Summary of key points:

- As at 31st March 2018, 338 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 331 on 31st March 2017)
- In the 2017/18 revalidation year (1st April 2017 – 31st March 2018) 49 non-training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 20 non-training grade medical staff in 2016/2017.
- Based on headcount, 94.7% of non-training grade appraisals were completed and submitted in the appraisal year (93.5% in 2015/2016). 5.2% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust, maternity leave, recent return from secondment etc). This compares to 5.5% in 2015/2016.

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

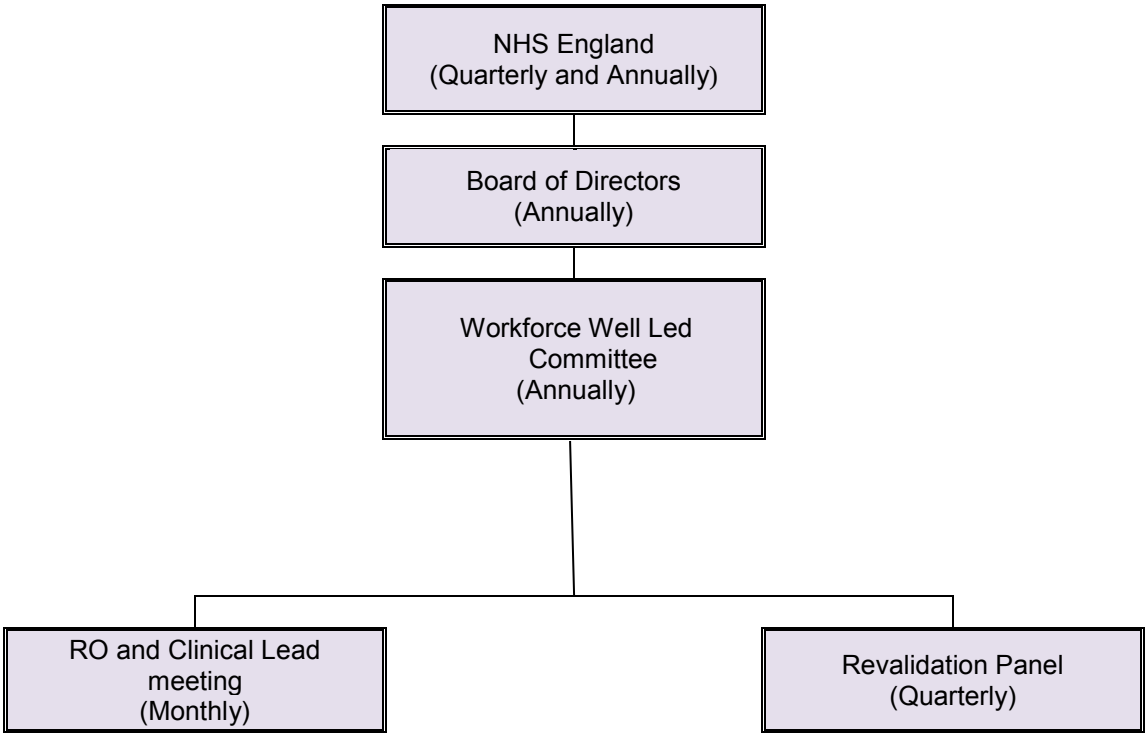
2.2 The Trust has a statutory duty to support the Responsible Officer (Executive Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



3.2 **GMC Connect**

GMC Connect is the General Medical Councils database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

The database is managed by the Revalidation Office on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

4. Medical Appraisal and Revalidation Performance Data

Revalidation Cycles

4.1 The first revalidation cycle started in January 2013. The majority of doctors (with the exception of new starters and those whose revalidation has been put on hold by the GMC) competed their first revalidation cycle by 31st March 2017 and will have had a recommendation made about their fitness to practise by a Responsible Officer (for this Trust this is the Medical Director).

4.2 In the 2017/2018 revalidation year (Year 5) the Responsible Officer has made recommendations for doctors as follows: (see also Appendix A - Audit of Revalidation Recommendations)

Revalidation Cycle (Year 5)	Positive Recommendations	Recommendation Deferred **
Year 5, Quarter 1 (April 2017 – June 2017)	2	0
Year 5, Quarter 2 (July 2017 – September 2017)	0	1
Year 5, Quarter 3 (October 2017 – December 2017)	1	1
Year 5, Quarter 4 (January 2018 – March 2018)	41	3
Total:	**44**	**5**

** The reasons for the deferrals were insufficient evidence being presented for a revalidation recommendation to be made. This was usually due to the fact the doctors were relatively new to the organisation and did not provide sufficient or relevant evidence from previous employers for a recommendation to be made.

4.3 The number of non-training grade medical staff with a revalidation date in the Year 5 Quarter 1 – 3 was low. This trend was replicated across England. When revalidation was introduced in 2012 designated bodies, whilst not able to select revalidation dates were asked to submit cohorts of doctors for revalidation until Year 4 which means the majority of existing medical staff were allocated a revalidation date by the GMC prior to Year 4. Consequently at the start of Year 5 the doctors for revalidation were more recently registered to the GMC so fewer in number. Year 5, Quarter 4 was the first cohort of doctors to be revalidated for the second time, hence the increase in numbers.

Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle.

4.4 The appraisal year runs from 1st April – 31st March. The table below shows the compliance rate at the end of the 2017/2018 appraisal year on 31st March 2018 (see also Appendix B – Audit of all missed or incomplete appraisals).

Grade	Number of doctors with prescribed connection to CHFT	Completed Appraisals (1a)	Completed Appraisals (1b)	Approved incomplete or missed appraisal (1b)	Unapproved incomplete or missed appraisal
Consultants (permanent)	241	99	137	4	1
Staff Grade, Associate Specialist, Specialty Doctor (permanent)	67	28	36	3	0
Temporary or short term contract holders (all grades)	30	5	15	10	0
Total	**338**	**132**	**188**	**17**	**1**

(Doctors with a GMC prescribed connection to CHFT as at 31st March2018)

1a: Completed appraisals: appraisal meeting between 1st April 2017 and 31st March 2018 for which the appraisal outputs have been agreed between appraiser and appraisee.
1b: Approved or incomplete or missed appraisals: accepted reason for appraisal not taking place (eg joined the Trust within the last 6 months, prolonged leave, maternity leave, sabbatical etc).
Unapproved incomplete or missed appraisal: appraisal expected to be submitted. No agreement for the appraisal to be postponed/delayed.

4.5 **Appraisal Completion Comparator Report**

Every year the Trust is required by NHSE to complete an Annual Organisational Audit. The table below shows our appraisal rate submission as compared with other designated bodies across England for 2017/2018.

Grade	CHFT completed appraisal rate %	All Designated Bodies completed appraisal rate %	CHFT approved missed appraisals %	All Designated Bodies approved missed appraisals %	CHFT unapproved incomplete or missed appraisals %	All Designated Bodies unapproved incomplete or missed appraisals %
Consultants (permanent)	97.9	92.7	1.7	4.3	0.4	3.0
Staff Grade, Associate Specialist, Specialty Doctor (permanent)	95.5	88.9	4.5	7.5	0	3.6
Temporary or short term contract holders (all grades)	66.7	82.8	33.3	11.2	0	6.0

(NHSE Medical Revalidation Annual Organisational Audit Comparator Report 2017/2018)

5. Allocation of Appraisers

5.1 The 2017/2018 appraisal year was the first time the Trust allocated appraisers to appraisees. The minimum number of appraisees a trained appraiser is required to appraise each year is 5 (the maximum is 10). A previous audit of appraisers in December 2016 showed that only 19% of trained appraisers were meeting this minimum standard. This revised process has resulted in a more equitable allocation and ensures our appraisers are undertaking sufficient appraisals to retain their skills. The revised process worked well with only 5 appraisees requesting that the appraiser they had been allocated be changed.

6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal;

- The appraiser;
- The appraisal discussion

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Revalidation Panel Quality Assurance Group. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information). (see Appendix C - Quality assurance audit of appraisal inputs and outputs (1st April 2017 - 31st March 2018)

6.2 The Clinical Appraisal and Revalidation lead also routinely quality assures sample of appraisals submitted.

6.3 Access, security and confidentiality

Historical appraisal folders, supporting information and all correspondence relating to the appraisal and revalidation processes are stored on the Trust network drive. Access to the network drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation and the Revalidation Office administrative support. Since 1st April 2017 all new appraisals and supporting information are stored on the PReP system which is ISO27001 accredited, GDPR compliant, 100% IG Toolkit compliant. Earlier appraisals are in the process of being uploaded onto PReP. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.5 Clinical Governance

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data (Dr Foster) and attendance at audit.

7. Update

a) PReP – Appraisal and Revalidation E-Portfolio

From 1st April 2017 the PReP self-service electronic appraisal system was introduced for all non-training grade medical staff. The system is still bedding down into the organisation but benefits have already been realised:

- Automatic reminders to users of appraisal dates;
- A portfolio for users to store evidence of appraisal and CPD;
- Feedback reports generated for all appraisers.

b) Month of Appraisal

In addition to allocating appraisers to appraisees the Revalidation Office also allocate the month the appraisal needs to be completed (with no appraisals being allocated in March). There is still work to do in ensuring that appraisals are completed in the correct month. There is tendency for there to be a rush in February and March to ensure appraisals are completed by the NHSE deadline of 31st March.

c) Appraiser Recruitment

Nine appraisers were recruited and trained in 2017.2018. The Trust currently has 63 active appraisers for non-training grade medical staff.

8 Action Required of the Board

The Board of Directors is asked to:

(i) approve this report.

Dr David Birkenhead
Medical Director/Responsible Officer
September 2018

Appendix A

Audit of Revalidation Recommendations (1st April 2017 - 31st March 2018)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Revalidation Recommendations made between 1st April 2017 and 31st March 2018

	Number
Recommendations completed on time (within the GMC recommendation window)	48
Late recommendations (completed but after GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**48**
Primary reason for late/missed recommendations For late or missed recommendations only one primary reason may be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctors revalidation due date	0
Administrative error	1
Responsible officer error	0
Inadequate resources or support for responsible officer role	0
Other	
TOTAL SUM OF LATE AND MISSED RECOMMENDATIONS	**1**

Appendix B

Audit of all missed or incomplete appraisals audit (1st April 2017 - 31st March 2018)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Doctors Factors (Total)	Number
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due' window'	2
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 months of appraisal due date	0
New starter more than 3 months from the appraisal due date	14
Postponed due to incomplete portfolio/insufficient reporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	1
Other doctors factors (describe)	
	18
Appraiser Factors (Total)	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by the appraiser within 28 days **	188
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational Factors (Total)	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

** NHS England request that we report on the numbers of appraisals not signed by the appraiser within 28 days of the appraisal being completed. However, these appraisals were still recorded as completed since they were submitted within the appraisal year.

There has been a significant increase in this number since the introduction of the PReP system. This is because appraisals are not necessarily being signed off at the time of the appraisal meeting. The forms are completed on line and the appraiser is returning to the system post appraisal to complete outputs etc. These are then returned to the appraisee who approves and the appraiser then signs the appraisal off. We do not believe the delay is negative to the process.

Appendix C

Quality assurance audit of appraisal inputs and outputs (1st April 2015 - 31st March 2016)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Below is a breakdown of the appraisals audited via the Revalidation process. In addition 10% of all appraisals are audited by the Clinical Lead for Appraisal and revalidation.

Total number of appraisals completed		
320	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed acceptable against standards
Appraisal Inputs	**Number audited**	**Number acceptable**
Scope of work: Has a full scope of practice been described?	49	49
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	49	45
Quality Improvement Activity: Is quality improvement activity compliant with GMC requirements?	49	48
Patient feedback exercise: Has a patient feedback exercise been completed?	49	48
Colleague feedback exercise: Has a colleague feedback exercise been completed?	49	48
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	49	48
Is there sufficient supporting information from all the doctors roles and places of work?	49	49
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)	49	48
Appraisal Outputs		
Appraisal Summary	49	49
Appraiser statements	49	49
Personal Development Plan	49	49

22. Workforce Race Equality Standard (WRES) Report

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Tracy Rushworth, PA to Director of Workforce and OD
Date: Thursday, 6th September 2018	**Sponsoring Director:** Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Title and brief summary: Workforce Race Equality Standard (WRES) Report - The report sets out the Trust's position against the Workforce Race Equality Standard (WRES) for 2018. The Trust is required to publish its position before 28 September 2018	
Action required: Note	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: The Workforce Committee approved the WRES report for publication at its meeting on 10 July 2018. The report was also received for information at the Executive Board meeting on 26 July 2018.	
Governance Requirements: A Workforce for the Future	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to note the Report.

Appendix

Attachment:

BoD 6 September 2018 - WRES Report.pdf

Workforce Race Equality Standard

Name of organisation	**Date of report:**
Calderdale and Huddersfield NHS Foundation Trust	July 2018
Name and title of Board lead for the Workforce Race Equality Standard	
Suzanne Dunkley, Director of Workforce and OD	
Name and contact details of lead manager compiling this report	
Azizen Khan, Assistant Director of Human Resources	
Names of commissioners this report has been sent to	
Carol McKenna, Director of Commissioning, Greater Huddersfield CCG and Matt Walsh, Chief Officer, Calderdale CCG	
Name and contact details of co-ordinating commissioner this report has been sent to	
Carol McKenna, Director of Commissioning, Greater Huddersfield CCG	
Unique URL link on which this report will be found (to be added after submission)	
http://www.cht.nhs.uk/about-us/equality-and-diversity-at-chft/	
This report has been signed off by on behalf of the Board on (insert name and date)	
Workforce Committee – 10th July 2018	

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

None identified

b. Any matters relating to reliability of comparisons with previous years

None identified

2. Total numbers of staff

a. Employed within this organisation at the date of the report

6024 (as at 31 March 2018)

b. Proportion of BME staff employed within this organisation at the date of the report

15.2%

3. Self-reporting

a. The proportion of total staff who have self–reported their ethnicity

97.4% (5869)

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

Yes

c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity

The Trust has implemented ESR Employee Self Service which allows staff to update their own record via the ESR Portal. This and further functionality will continue to be promoted.

4. Workforce data

a. What period does the organisation's workforce data refer to?

1 April 2017 - 31 March 2018

5. Workforce Race Equality Indicators

For ease of analysis, as a guide we suggest a maximum of 150 words per indicator.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 1a	Please see appendix 1a	Overall the Trust has 15.2% of its workforce from a BME background compared to 14.6% in the previous year. The report for this year shows that there have been small decreases in non-clinical BME staff in AfC Bands 3,5,8a/b/c,9, and VSM. In the category classed as `under Band 1' (mainly apprentices) a significant decrease of BME staff, moving from 50% in March 2017 to 22.2% in March 2018. Band 2 BME staff has shown an increase changing from 11.6% in March 2017 to 13.6% in March 2018. Further increases are seen in Band 6 (+2.6%),7	Links to the Trust's action plan - to improve recruitment processes and look to include a BME person as a panel member for Band 7 and senior management appointments.

				(+6.4%), and 8d (+5.3%). Clinical BME staff in the category classed as `under Band 1' and AfC Band 3 have seen reductions, with Under Band 1 decreasing by 2.2% and Band 3 by 3.8%. Substantial increases have been seen in Band 1 (+19.4%) and Band 8d (+25%). All other AfC bands have remained constant or increased marginally. Medical BME staff within Consultant and Trainee grades have seen reductions of -0.7% and -3.1% respectively, while Career Grades have shown a small increase moving from 71.1% in March 2017 to 72.9% in March 2018.	
2	Relative likelihood of staff being appointed from shortlisting across all posts.	BME = 0.135 White = 0.233 White 1.73 times as likely to be appointed.	BME = 0.114 White = 0.171 White 1.50 times as likely to be appointed.	The data shows that in a 12 month period (April 2017 to March 2018) the likelihood of BME staff being appointed after being shortlisted has increased. Overall however White staff are now even more likely to be appointed than BME staff.	Please see Indicator 1

3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	BME = 0.0142 White = 0.0059 BME 2.42 times as likely to enter the formal process.	BME = 0.0124 White = 0.0065 BME 1.89 times as likely to enter the formal process.	The information shows that the possibility of a BME colleague entering the disciplinary process is over twice as likely as a White colleague. An increase from the previous year.	Links to the Trust's action plan - Set out clear and helpful guidelines and standards of behaviour deemed to be acceptable/unacceptable
4	Relative likelihood of staff accessing non-mandatory training and CPD.	BME = 0.988 White = 0.978 White 0.99 times as likely to access non-mandatory training.	BME = 0.851 White = 0.823 White 0.97 times as likely to access non-mandatory training.	The data shows that the uptake of non-mandatory training is consistent across the workforce.	Links to the Trust's action plan - to provide mentoring and coaching. The Inclusive Mentoring programme concluded on 11 July 2018 and the Trust has trained 6 individuals to roll this out moving forward. Develop a comprehensive development programme for Agenda for Change pay bands 2 – 7 (clinical and non-clinical) to support them in career progression / promotion.
	National NHS Staff Survey indicators (or equivalent) **For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.**				
5	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White = 27.81% BME = 21.25%	White = 27.74% BME = 14.00%	The average (median) for BME staff within acute Trusts is 28%**.** In comparison the Trusts ranking is below (better than) the average. The latest survey shows that the percentage of BME staff experiencing harassment,	Links to the Trust's action plan – to deliver training to line managers on harassment, bullying and discrimination in the workplace.

				bullying or abuse from patients, relatives or the public in last 12 months has seen a significant increase (+7.25%) when compared to the previous year. White staff have remained largely consistent, with only a minor increase compared to the previous year.	
6	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White = 23.17% BME = 25.00%	White = 23.97% BME = 23.08%	The average (median) for BME staff within acute Trusts is 27%. In comparison the Trusts ranking is below (better than) the average. White staff have reported a slight reduction when compared to the previous year, while BME staff have shown an increase from 23.08% to 25%.	Please see Indicator 5
7	KF21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White = 88.30% BME = 68.48%	White = 87.95% BME = 76.47%	The average (median) for BME staff within acute Trusts is 75%. In comparison the Trusts ranking is below (worse than) the average. White staff have seen a small increase when compared to the previous year. BME staff have seen a significant drop from 76.47% to 68.48%.	Please see Indicator 4
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of	White = 5.17% BME = 20.33%	White = 4.75% BME = 14.29%	The average (median) for BME staff within acute Trusts is 15%. In comparison the Trusts	Please see Indicator 5

	the following? b) Manager/team leader or other colleagues			ranking is above (worse than) the average. White staff have seen a marginal increase. While BME staff report a significant increase in discrimination.	
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	Board BME 5.6% Overall Workforce BME 15.2% Difference -9.7%	Board BME 5.6% Overall Workforce BME 14.6% Difference -9.1%	There is no change in the BME composition of the Board from 2016/2017 to 2017/2018.	Please see Indicator 1

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress?
The Trust has a well-established a BAME Network for the past two years and this has been successfully embedded and is well attended. The BAME Network has been critical in the delivery of the 2017/18 action plan and therefore the same approach will be adopted for the 2018/19 action plan. The BAME Network introduced a new initiative called `Talk in Confidence' and this has been promoted via posters and the intranet and encourages BAME colleagues to talk to a member of the Network in confidence on any work related matters.
7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.
The Trust has developed an action plan for 2018/19 which was approved by the Workforce (Well-Led) Committee on 10 July 2017 – Appendix 1b available at the following link: http://www.cht.nhs.uk/about-us/equality-and-diversity-at-chft/

5.Workforce Race Equality Indicators

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

31 March 2018

	Pay Scale	White %	BME %	Not Stated %
Non-Clinical	Under Band 1	77.8%	22.2%	0.0%
	Band 1	81.8%	14.7%	3.6%
	Band 2	84.7%	13.6%	1.8%
	Band 3	89.8%	7.6%	2.7%
	Band 4	89.2%	8.3%	2.4%
	Band 5	84.2%	13.2%	2.6%
	Band 6	87.0%	8.7%	4.3%
	Band 7	83.1%	13.8%	3.1%
	Band 8a	90.0%	7.5%	2.5%
	Band 8b	97.1%	2.9%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	94.7%	5.3%	0.0%
	Band 9	93.8%	6.3%	0.0%
	VSM*	85.7%	14.3%	0.0%
Clinical	Under Band 1	85.9%	10.3%	3.8%
	Band 1	70.6%	29.4%	0.0%
	Band 2	81.4%	16.1%	2.4%
	Band 3	91.1%	7.3%	1.5%
	Band 4	84.1%	13.6%	2.3%
	Band 5	82.8%	15.0%	2.1%
	Band 6	91.3%	7.3%	1.3%
	Band 7	89.0%	8.4%	2.6%
	Band 8a	92.9%	5.4%	1.8%
	Band 8b	100.0%	0.0%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	75.0%	25.0%	0.0%
	Band 9	100.0%	0.0%	0.0%
	VSM*	100.0%	0.0%	0.0%
Medical	Consultant	50.2%	46.5%	3.3%
	Career Grade	21.2%	72.9%	5.9%
	Trainee Grade	46.6%	43.0%	10.3%
	Other	0.0%	0.0%	0.0%
	Overall Workforce	**82.2%**	**15.2%**	**2.6%**

31 March 2017

	Pay Scale	White %	BME %	Not Stated %
Non-Clinical	Under Band 1	42.9%	50.0%	7.1%
	Band 1	82.4%	14.3%	3.3%
	Band 2	85.8%	11.6%	2.6%
	Band 3	88.3%	8.2%	3.5%
	Band 4	90.3%	8.3%	1.4%
	Band 5	84.2%	15.0%	0.8%
	Band 6	90.9%	6.1%	3.0%
	Band 7	89.6%	7.5%	3.0%
	Band 8a	91.7%	8.3%	0.0%
	Band 8b	96.7%	3.3%	0.0%
	Band 8c	93.8%	6.3%	0.0%
	Band 8d	100.0%	0.0%	0.0%
	Band 9	92.9%	7.1%	0.0%
	VSM*	66.7%	16.7%	16.7%
Clinical	Under Band 1	87.5%	12.5%	0.0%
	Band 1	90.0%	10.0%	0.0%
	Band 2	83.4%	14.5%	2.1%
	Band 3	87.6%	11.2%	1.2%
	Band 4	87.3%	9.8%	2.9%
	Band 5	84.0%	13.5%	2.4%
	Band 6	91.1%	7.3%	1.6%
	Band 7	92.0%	6.4%	1.6%
	Band 8a	95.2%	2.9%	1.9%
	Band 8b	100.0%	0.0%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	0.0%	0.0%	0.0%
	Band 9	100.0%	0.0%	0.0%
	VSM*	100.0%	0.0%	0.0%
Medical	Consultant	50.2%	47.2%	2.6%
	Career Grade	20.0%	71.1%	8.9%
	Trainee Grade	48.9%	46.2%	4.9%
	Other	0.0%	100.0%	0.0%
	Overall Workforce	**83.0%**	**14.6%**	**2.3%**

*VSM = Very Senior Manager. Contains staff in the roles; Chair, Chief Executive, Finance Director, Other Executive Director, Board Level Director, Non Executive Director, Clinical Director - Medical, Medical Director, Director of Nursing, Director of Public Health.

Note - Staff on Local/Senior Manager pay scales have been categorised into AfC bandings based on their full time salary.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

WORKFORCE RACE EQUALITY STANDARD – ACTION PLAN 2018/19

WORKFORCE RACE EQUALITY SCHEME (WRES) ACTION PLAN PROGRESS REPORTING TEMPLATE	
Start date:	**30 June 2016**
Latest update:	**6 July 2018**
Lead Manager:	**Azizen Khan, Assistant Director of HR**
Lead Director:	**Suzanne Dunkley, Director of Workforce and OD**
Monitoring Committee:	**Executive Board / Workforce Committee**
Date signed off as complete	

1. delivered
2. on track
3. off track

ACTION	MEASURE	LEAD/ GROUP MEMBERS	TIMESCALE	RAG	PROGRESS
Trust to lead on delivering the Inclusive Mentoring programme during 2018/19 following a train the trainer programme	Increase in number of BAME colleagues accessing mentoring and coaching. BAME colleagues feel that they can progress in their career regardless of race and culture, age, gender or sexuality.	Azizen Khan Ruth Mason	March 2019	2	The Leadership Academy delivered the Inclusive Mentoring programme in the Trust which was a one year programme. In order for the Trust to become self-sufficient in delivering future programmes a cohort of individuals have been trained as trainers to deliver the programme in future.
Develop a comprehensive development programme for Agenda for Change pay bands 2 – 7 (clinical and non-clinical)	A clear career pathway for BAME colleagues to progress through whilst remaining in employment with the Trust.	Ruth Mason	June 2019	2	Leadership and management development programme being delivered by Health Skills – Compassionate Leadership in Practice during 2017/18. This includes two programmes; one for leaders and the

ACTION	MEASURE	LEAD/ GROUP MEMBERS	TIMESCALE	RAG	PROGRESS
	BAME colleagues feeling they are invested in and valued by the Trust.				second for aspiring leaders. The Trust will explore BAME specific development programmes with WYAAT organisations and the Yorkshire and Humber Leadership Academy. Five colleagues supported to undertake the Change Maker Programme funded by the Leadership Academy. The Programme will support the diversity and inclusion agenda and the individuals will receive training to help them become adept facilitators of inclusive conversations and upskilling in the ability to influence for change.
Set out clear and helpful guidelines and standards of behaviours deemed to be acceptable and un-acceptable as well as offering colleagues a safe space to talk in confidence.	Fewer incidents of discrimination and racism reported through formal processes, improved staff survey results.	Vicky Pickles Azizen Khan	December 2018	2	A CHFT leaflet to be produced with a draft proposal for CHFT behaviours and will be shared with the BAME Network for feedback. Continue to promote the Talk in Confidence colleagues initiative – to provide another source of support BAME colleagues to discuss issues freely and in a safe space.
Training for line managers in how to deal with bullying/harassment and discrimination	BAME colleagues having confidence that the Trust holds a zero tolerance approach to discrimination and	Azizen Khan	October 2018		Development of a bite size training package that is targeted at line managers to be rolled out Trust wide. This requires dedicated focus due to the staff survey results showing an

ACTION	MEASURE	LEAD/ GROUP MEMBERS	TIMESCALE	RAG	PROGRESS
	racism				increase in the number of colleagues feeling discriminated at work from their manager/team leader or colleagues.
Improve recruitment and selection processes by including a BAME person as a panel member for all Band 6, 7 and 8a interviews	Increase in number of BAME colleagues being appointed in Band 6, 7 and 8a posts to support career progression Recruitment and retention of BAME colleagues	Azizen Khan	November 2018		Develop a list of BAME colleagues who will be trained to participate as a panel member

23. Quality of Appraisals

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Tracy Rushworth, PA to Director of Workforce and OD
Date: Thursday, 6th September 2018	**Sponsoring Director:** Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Title and brief summary: Quality of Appraisals - This paper details the findings of a piece of research into the quality of appraisals and outlines future action required to continue the delivery of high quality appraisals.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: This paper was received for information at the 21 June 2018 Executive Board.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to note the content of the Paper.

Appendix

Attachment:

BoD 6 September 2018 - Quality of Appraisals.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

6 SEPTEMBER 2018

QUALITY OF APPRAISALS

1. INTRODUCTION

The Trust introduced an appraisal season in 2017 to allow for a focused period of activity when appraisals could be completed. This year the appraisal season takes place from 1 April 2018 until 30 June 2018. In 2017, the season ran from July to October with an agreed target of 100% compliance. At the end of the season, the compliance result was 96.26%. Whilst this was a successful outcome in terms of quantity completed, it is no indication of the quality of the appraisals conducted.

2. RESULT

All colleagues receive an effective, high quality appraisal. Everyone has agreed objectives which are linked to the Trust's vision, goals and behaviours and have an agreed resourced personal development plan. This is measured by colleagues reporting a positive conversation during their appraisals during which their contribution is recognised with 'no surprises'.

3. REALITY

The 2017 NHS staff survey results showed a score of 2.99 out of 5 for the quality of appraisals. This is lower than the national average for acute trusts which is 3.11.

This score was ascertained by the composite score of the following questions:

20a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

1 ☐ Yes 2 ☐ No 3 ☐ Can't remember

If YES, please answer parts b to f below; if NO, go to Question 21

	Yes, definitely	Yes, to some extent	No
b. It helped me to improve how I do my job.	☐ 1	☐ 2	☐ 3
c. It helped me agree clear objectives for my work.	☐ 1	☐ 2	☐ 3
d. It left me feeling that my work is valued by my organisation.	☐ 1	☐ 2	☐ 3
e. The values of my organisation were discussed as part of the appraisal process.	☐ 1	☐ 2	☐ 3

f. Were any training, learning or development needs identified?

1 ☐ Yes 2 ☐ No

If YES, please answer part g below; if NO, go to Question 21

	Yes, definitely	Yes, to some extent	No
g. My manager supported me to receive this training, learning or development.	☐ 1	☐ 2	☐ 3

In December 2017 and January 2018 a piece of research was conducted about the quality of appraisals and this was presented to the Executive Board on 8 February 2018. A follow up piece of research was conducted during the appraisal season in April and May 2018. The research involved telephoning colleagues who had recently had their appraisal and asking them what it was like, what was good about it or what could be improved. The findings can be found in Appendix 1.

4. RESPONSE

i. Appraisal workshops have been taking place and are offered to appraisers throughout the organisation. Six took place in 2017 and fifteen in 2018 with a further workshop booked in June 2018. The sessions last approximately one hour and cover planning the appraisal; preparing for the conversation; the conversation; setting objectives and completing the paperwork. A total of 139 managers have attended the workshops. An evaluation of the workshops took place in April 2018. Appendix 2 sets out the results.

ii. A dedicated appraisal section of the intranet is available which has a range of tools and guidance available to help managers deliver a high quality appraisal. In the height of appraisal season in 2017 these pages recorded over 4,000 page views per month. During this year's appraisal season the portal has been viewed 22,959 times to date. A communications campaign is under way which includes information about the tools and guides available to appraisers.

iii. A further piece of research will take place at the end of appraisal season, 30 June 2018, to capture additional data about the quality of appraisals. This will involve contacting colleagues who have been appraised and asking them what it was like, what was good about it or what could be improved. A total of 70 colleagues from across all divisions will be contacted and the results combined with the most recent findings to give a broader picture of the quality of appraisals.

iv. In September 2018 a sample of appraisal paperwork will be requested and checked to see if colleagues are still working towards agreed 'live' objectives. Colleagues will be contacted and asked if they are happy to share their appraisal paperwork and have a discussion about their objectives and personal development. A review of the paperwork will take place and it will be identified if objectives are still relevant and if personal development opportunities have been supported where agreed and available. This will give assurance that part of the purpose of appraisals, to look towards the next 12 months, is sustained and that colleagues are engaged in development activity.

5. CONCLUSION

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

Ruth Mason
Associate Director of Organisational Development
August 2018

Appendix 1

Divison	Appraisal Received	Comments
Community	06/04/2018	He did feel they were beneficial and used it as a forum to off load issues and problems, good opportunity to discuss issues. Also liked that he could request training and dveleopment and that it would then be documented. He did say it would have been more beneficial if the Appraiser looked at last years document to see what was discussed as he felt that he could bring in the document he used last year and no one would know.
Community	05/04/2018	She felt that the issues from last year had been resolved and that the appraiser was good. She did feel that her appraisal had come round to quickly and then they should be 12 months between each as she only had one 8 months ago. Felt like a tick box exercise.
Community	11/04/2018	Said her appraisal was fine. She knows her manager quite well so she felt she could be honest with her. It was a relaxed process and said that the documents she was given prior were really helpful. Didn't really feel there was anything that could be improved and they spent enough time together.
Community	08/07/2018	It was fine, I'm nearing the end of my time here so there's nothing exciting I want to do. The appraisal was fine.
Corporate	03/05/2018	Useful chat - time to reflect. Short and clear. Different for me because I work for the CCG so the paperwork isn't relevant - not the same objectives. Was personal and good though.
Corporate	03/05/2018	I've had same manager for 10 years, appraisals have always been the same, I don't know any different. Felt like a tick box exercise - like the manager is just trying to get through everyone. I suppose it depends on what you want out of it - I didn't feel valued at the end. I don't know if any personal development is followed through after. Feels like the managers are just doing what they've always done.
Corporate	08/05/2018	Went well, could tell he'd prepared for it so that was good. He'd remembered things I'd done last year which had gone well so it was good to be thanked for those. Spent a fair bit of time talking really, about work you know but it was good.
Corporate	15/05/2018	Was over fairly quickly but got through everything. Same as usual really. It was okay.
E&F	08/05/2018	Passable - it was alright. Had 2 managers with me, which was explained why and I was okay with that. They had something to tell everyone and wanted to use that time for that as well. I know if I'd have asked the other manager to leave then she would have done - she's very fair like that. It was alright - I get on with my manager really well. I asked questions, they listened - I was happy with it.
E&F		It was fine, the right length. All upto date. Set a few objectives. Always alright here.
E&F	02/05/2018	It was alright - standard really. Asked questions about what good things I've done, how things have been. Given the chance to say what I wanted to. They're always good.
E&F	14/05/2018	It was alright. Managed to talk about issues I wanted to. I was listened too and they took notes. It was alright, fine, okay.
E&F	08/05/2018	Enjoyed it to be honest, wasn't expecting to but it was a really good chat with my manager. Talked over the last year, what's been good and that. Hope the next one is the same!
FSS	01/05/2018	All okay - felt valued. Nothing bad about it. All good - objectives set.
FSS	02/05/2018	New manager, only been in post 2 weeks. Absolutely fine - I got to explain what I'd been doing over the last 12 months. Helped her to understand what we do in clinic. Appraisals used to be the same old thing every time but this was the first time it was of great benefit.

FSS	03/05/2018	Gives you options - wants to hear your opinion. Was a happy experience, I felt listened to. Give you time to get things off your chest - let it all out if you want to. She always gives me time to express myself.
FSS	01/05/2018	Okay, fine - talked through the questions on the paperwork. Talked about last years targets, how things have changed since as I've got a new tole. Went over any training needs. Any improvements in the lab. They're good here - we all follow the procedures. Can bring anything up.
FSS	08/05/2018	It was fine, went well. Overall it was really good.
FSS	01/05/2018	It was fine, that's normal - it's always fine.
FSS	02/05/2018	It was good - she listened to everything I had to say. I was able to chat about when I needed to.
FSS	08/05/2018	It was good. Went over achievements from what was set at my previous appraisal. Asked if I needed help with anything else. Started the appraisal with a 'well done' on a course I've done so that was a nice start. Discussed things not happy with and she gave advice on how to make changes. Looked at projects for this year, research/trials we're part of. What is expected of me. It was productive. Nice informal sit down.
FSS	09/05/2018	Good - making sure everything is okay, what I've found challenging, what I need to learn.
FSS	09/05/2018	Fine, wasn't much to talk about for the next 12 months as I've just told them I'm pregnant! Was a positive experience though, able to talk and get my points across.
FSS	14/05/2018	Good experience - nice to talk about things, air things - talk about anything you need to. Manager listened. We're a new set up and this was the first appraisal in new role - it was very encouraging.
FSS	08/05/2018	Went well. Was good. Could speak, was listened to 100%.
Medical	02/05/2018	Very, very helpful. She listened to everthing I had to say. Very good, very informative.
Medical	27/04/2018	Alright - was a good conversation. Good support for new development opportunity. Helped to clarify what new tasks are going to be.
Medical	09/05/2018	It was fine, I think so. Been doing this job for a while, tend to discuss the same things. It was fine - I'm happy with how it went.
Medical	08/05/2018	Manager was engaging - interested in what I had to say/talk about. We came up with some good ideas about the next 12 months, looking forward to it to be honest.
Medical	09/05/2018	Went okay thanks. Talked about developing and where the role could take me. Didn't learn anything new but was good to have the time to chat with my manager and go over how things have been.
S&A	02/05/2018	Fairly good, went okay. Went through objectives, targets, improvements. Very good overall.
S&A	08/05/2018	Went very well. A few positive things came out of it. A few negatives things were sorted out. Lasted about 3/4 hour. On the whole a good experience.
S&A	03/05/2018	Was about an hour, did a lot of talking. Useful time, don't get the chance that often do you? Looked at goals/visions - that kind of thing. Went well.

S&A	14/05/2018	I've retired and returned - I think it's different for me. Was a ward manager, now a staff nurse. I think I've done a lot of things. I'm a firm believe in appraisals for everyone, they should be encouraging people to move up. If was difficult to say what I want to achieve. I enjoy coming to work, my time is limited only working 15 hours. Did my mandatory training at home. I'm happy coming in, giving 100% and supporting the B7's. That's what I said during my appraisal, that I want to continue doing that. Was happy with how it went.
S&A	16/05/2018	It was alright. Went fine. Not much development for medical secretaries any more. Was more like 'anything to moan about, moan about it'. Had a general chat. It was alright.
THIS	03/05/2018	Good, big chat for over an hour. Talked about training. Felt valued. Set objectives - to do audits.
THIS	02/05/2018	There was direction, I felt valued. Objectives linked to the Trust goals/four pillars which was useful and meaningful. Manager delivers good appraisals, takes time out and has good discussions.
THIS	09/05/2018	Manager did a good job, felt good when we'd finished - like she'd put some effort into it. A few years back it wasn't like that, you'd be sheep-dipped through just to get one on the system but these last few are more personal you know? Means more this way, more personal.
THIS	15/05/2018	My manager did it fine. Couldn’t complain about it. No problems whatsoever. It's different now though - it's not about me anymore. Not about good things over the last 12 months, what training is available. I know there's no budget for training anyway I get that. Seems a 'corporate' thing - not really a PDR. Much more corporate these days. More of a 'you have to have one' rather than there's anything I can do. Manager very understanding. Training doesn't have to cost, it could be shadowing. PDR's are missing the opportunity to inspire people. Trust too focused on doom and gloom - we should be trying to be more positive. The message is about 'war' - we're in a battle. Should be more about geeing people up. Feels like a tick-box exercise.

Appendix 2

Appraisal Workshop - Survey Results

Responses: 32

Was the workshop the right length?	
Yes	100%

Did the workshop meet your expectations?	
Yes	78%
Somewhat	15%
No	7%

Did the workshop help you to deliver high quality appraisals?	
Yes	70%
Somewhat	23%
No	7%

Would you recommend the workshop to your colleages?	
Yes	93%
No	7%

Could you suggest anything to improve the workshop?

"no I have been doing appraisals for many years. with changes in the trust intranet this session was really useful as it signposted you to where all the info was on the trust as it signposted you to where all the info was on the trust intranet and talked over the other useful forms for both managers and staff which I never knew existed"
"no"
"No. It was quite clear."
"I felt that this was a bit of a waste of time and that the only message I took away from the session was 'Look on the intranet'"
"how to fill in the paperwork which is complicated or needs updating there are things on there which don't understand"
"Break into pairs and have scenarios to work through. Talk as a group about experiences.""
"Have some at CRH"
"no"
"nothing at all."
"Nothing it was very helpful."
"No"
"overall the content was fine ."

Any other comments?

"Really enjoyed the session, it was engaging and gave us the ability to ask questions and discuss scenarios which occur in our every day practice - thank you"
"well delivered workshop"
"Found it extremely helpful and gave me the confidence to deliver appraisals to my team."
"Great workshop delivered by Laurie. Feel confident in conducting a positive appraisal."
"was a very helpful session. always good to have some insight to these things, as opposed to going in blind. just the right length of time. and easther eggs were lovely!!! many thanks"
"This session was good as an update and reinforced what I think we do in community. I liked the information around the new paperwork on the intranet, and in particular the temperature checker, which some of my teams have started to use. Perhaps some time in the future, when we are only going to use the electronic version, it would be good to go through the ESR appraisal electronic record, as I think we are all inputting different data, and some of us just state that it has been done and submit, but the staff keep their paper copy in revalidation folders. Not sure if this is specifically for the ESR team to instruct us or yourselves."
"I found the workshop really helpful just to refresh my approach to appraisals."
"Very clear and well explained. Many thanks."
"The course provided me with the information I needed."
"The speaker broke the session into parts allowing audience participation and offered practical advice and demonstrating where to find supportive written information on the intranet. Well worth attending Thank you!"
"The present paperwork is very poor"
"I have been on previous appraisal workshops but it is always good to attend and it refreshed things for me"

24. Update from sub-committees and receipt of minutes & papers

•Audit & Risk Committee – minutes from meeting 11.7.18

•Quality Committee – minutes from meeting 2.7.18 & 30.7.18

•Finance and Performance Committee – minutes from the meeting 29.6.18, 31.7.18 and verbal update from meeting 31.8.18

•Charitable Funds Committee – minutes from meeting 28.8.18

•Council of Governors – minutes from meeting 4.7.18 & 19.7.18

•Workforce Committee - minutes from meeting 10.07.18

To Note

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 11 July 2018 in the Boardroom, Calderdale Royal Hospital commencing at 11:00 am

PRESENT

Richard Hopkin	Chair, Non-Executive
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director

IN ATTENDANCE

Gary Boothby	Executive Director of Finance
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Kirsty Archer	Deputy Director of Finance
Peter Bamber	Staff Governor
Victoria Pickles	Company Secretary
Clare Partridge	Engagement Partner, KPMG
Adele Jowett	Local Counter Fraud Specialist
Amber Fox	Corporate Governance Manager (minutes)

OBSERVERS

Philip Lewer	Chairman

40/18 APOLOGIES FOR ABSENCE

Apologies were received from Andrea McCourt.

41/18 DECLARATIONS OF INTEREST

There were no declarations of interest declared at the meeting.

42/18 MINUTES OF THE MEETING HELD ON 23 MAY 2018

The minutes of the meeting held on 23 May 2018 were approved as a correct record subject to the following amendments:

1. Remove 'i' from Clare Partridge's name
2. Page 5 – Minor grammar change on the second paragraph

43/18 ACTION LOG AND MATTERS ARISING

The actions arising from the meeting in May were discussed and the action log was updated.

- 19/18 Board Workshop on Risk Management – the Risk Management Programme will be received at Board in September
- 19/18 EPR stabilisation presentation was received from Mandy Griffin at the last Council of Governors meeting on 4.7.18
- 19/18 - the Company Secretary is looking at good practice elsewhere on the BAF with Internal Audit; Internal Audit received an Audit Assurance Framework and are incorporating the recommendations
- 20/18 – a handout was tabled on Sepsis with 3 additional indicators and there was assurance screening takes place when sepsis might be likely. The percentage screened for April and May was 100% and the figures are calculated on a monthly basis and reviewed by the Quality Committee. The Quality Committee will escalate back to the Audit & Risk Committee if further action is required.

- 20/18 GDPR Audit – Engagement has taken place with Leeds since the last meeting an a draft plan has been send to the Executive Director of Finance and is due to go to Executive Board. Adjustments for GDPR and mandatory training will be reviewed at the next Audit and Risk Committee and the finalised version will be circulated.

44/18 COMPANY SECRETARY'S BUSINESS

1. **Board Assurance Framework**
   The Company Secretary presented the revised Board Assurance Framework update.

   A workshop on the BAF, risk management and risk appetite will take place and the timetable will be reviewed. The BAF will be circulated prior to Board in September as part of the development.

2. **Review ARC Annual Workplan**
   The proposed dates for the next 12 month of meetings were circulated and attendees were asked to respond to the invites confirming their availability. There will be a pre-meeting with KPMG and Audit Yorkshire at the July 2019 meeting. The meetings for next year will be scheduled for 2 hours. It has been agreed a special meeting will be arranged each year with the Chairs of all the Sub-Committees.

   The Annual Accounts Process meeting will be arranged in May 2019. The clinical audit work will be picked up in the Internal Audit Programme scheduled for next year.

3. **Review ARC Terms of Reference**
   The Company Secretary shared the reviewed terms of reference with no major changes.

   Andy Nelson highlighted it would be helpful to highlight the changes that have been made. The Company Secretary is working on the Governance Structure to review how the terms of reference are affected by the Wholly Owned Subsidiary.

   Richard Hopkin highlighted 2.2 which reference the Quality Committee in relation to the clinical risks and clinical audit. Richard also raised 4.3 which references inviting the Chief Executive and asked the CEO can be invited to a future meeting. The suggested date was when the review of financial statements takes place.

   ACTION: Corporate Governance Manager

4. **Changes to governance documents required for setting up Calderdale and Huddersfield Solutions**
   The Company Secretary explained all Governance documents are being reviewed to identify which need to be set up for the Wholly Owned Subsidiary. Julie Dawes and Kirsty Archer have been working together on changes to the standing financial instructions.

   The Company Secretary advised this is part of the engagement process before being reviewed at the Board on 23 August.

   Andy Nelson questioned why the Executive Board has lower limits than the Chief Executive in Appendix 1 and asked who is responsible for authorising items at £3M. It was suggested the Executive Board should have more authority as it is a wider group.

   The Director of Finance explained the revenue expenditure for Directors will go through a Business Case process irrespective of delegation limit.

   The Audit and Risk Committee asked that the process is correctly articulated in the documents.

   ACTION : Executive Director of Finance

The Director of Finance highlighted the changes to the standing financial instructions, which were:

- Pay expenditure – simplified jargon
- Pension changes according to National rules
- Temporary staffing and workforce plans have balanced out and now match with regulatory expectations

The above changes will be tracked for review at the Board on 23 August.

OUTCOME: The Board **NOTED** and provided comments on the Standing Financial Instructions and Scheme of Delegation and **APPROVED** the updated terms of reference for Audit and Risk Committee and Audit and Compliance Group

45/18 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

The Executive Director of Finance described the work that has taken place to include additional comments.

1. Review Waiving of Standing Orders

The Executive Director of Finance reported there were 13 standing orders waived during the course of the quarter. Andy Nelson felt this is a higher level than previous months.

It was noted for the month of May, two individuals for consultancy were employed who were recommended by NHSI and the Trust has seen an impact of their work as a result. It was noted nursing agency spend is coming down. The Trust is within the overall agency trajectory.

There was discussion regarding there being only one supplier for the ultrasound scans in June. The Executive Director of Finance explained the maintenance is built in as part of tender process and ultrasound is on a framework supplier and the value has already been tested. The Deputy Director of Finance further explained that this particular supplier is able to integrate with Trust IT systems, this is unique.

Phil Oldfield asked if decisions being made involve procurement which was a question raised at the F&P Committee. The Deputy Director of Finance confirmed procurement are involved in the process for the tender to be awarded and procurement are guided by the service who have a balance of challenge and local knowledge. The Executive Director of Finance acknowledged there is an opportunity to involve procurement earlier on.

Richard Hopkin suggested 'subject to tender' and 'subject to framework agreement' should be included in the report.

ACTION: Executive Director of Finance

There was discussion around whether a formal approval procedure is required for consultancy costs. The Executive Director of Finance explained NHSI have a process which was used once as part of the FBC preparation and Project Echo. This has been discussed at every QRM and there has been no response. The Executive Director of Finance raised this with the Chief Executive who suggested challenging NHSI to clarify why they are not following correct process.

ACTION: Executive Director of Finance

2. Review of Losses and Special Payments

The Deputy Director of Finance presented the report for the quarter ending 30 June 2018. The total summary of losses equals £7.5k which takes into account the rebate from NHS resolution. This is a relatively low quarter compared to previous quarters. There was

assurance the pharmacy stock processes are managing the level of pharmacy losses.

3. CHFT Capital Plan 2018-23 Draft

The Executive Director of Finance presented the Capital Plan. There was discussion at F&P Committee to adjust the risk register in relation to capital to make the Committee more aware of financial challenges to capital over the next few years. The largest increase for capital next year is within Digital, subject to business cases. Andy Nelson suggested Voice Recognition would be a good investment as part of the Digital capital. The capital plan will go to the Capital Management Group and weekly Executive Board and will feed into the strategic capital plan.

The longer term capital risk has been suggested as no longer a finance risk but an estates sustainability risk. Peter Bamber asked what the advantage of this change was; Phil Oldfield explained there will be additional sources of capital if there is sufficient money to keep the organisation safe; however, there will be focus on the safety element. The Executive Director of Finance provided re-assurance making this an estates risk doesn't change the problem or challenge; this is about evaluating external spending. There was a suggestion to reprioritise into the following categories; 'Maintenance Capital' and 'Development Capital'. It was also noted there is a bid for emergency capital funding from an operational point of view.

OUTCOME: The Audit and Risk Committee **NOTED** the report

4. Reference Cost Sign Off

Annually the Trust is required to submit reference costs. Historically submission has been approved by the Director of Finance who confirms that the submission has been prepared ir line with approved costing guidance. For the 2017/18 submission which is due in July 2018, there is now a requirement that the Board or its Audit & Risk Committee confirm a number c criteria have been met. The required criteria were documented in the attached summary. The Executive Director of Finance reported that he receives assurance regarding a number of these criteria through various internal and external reviews during the year.

Phil Oldfield requested the various external and internal audit reviews are documented and shared in order for ARC to sign off the reference cost before submission.

ACTION: Executive Director of Finance

OUTCOME: The Audit and Risk Committee **NOTED** the report and sign-off will be sought outside of the meeting with feedback from internal audit

46/18 Internal Audit

1. Review Internal Audit Follow-up Report

The Internal Audit Manager reported improvement in number of overdue recommendations, which has reduced by 8%. The profile is being raised through Weekly Executive Boards.

There are currently 9 overdue recommendations with the majority from 2017/18.

Feedback from Andy Nelson was it is positive to see the improvement. Complaints handling element has been outstanding for a while and the Executive Director of Finance has been involved and those with no responses will be chased.

The Executive Director of Finance explained progress should have closed a number of responses with only 1 outstanding.

The process in terms of revising the review date would need to have a good rationale with agreement between internal audit and owner/responsibility for the recommendation.

The Company Secretary highlighted the Executive Leads need to be updated.

ACTION: Internal Audit Manager

2. Review Internal Audit Progress Report

Ten audit reports have been agreed with management since the last Audit and Risk Committee. A further two reports have been issued in draft.

The Company Secretary reported the request for funding of the new 'declaration of interests' system is going to the Commercial Investment and Strategy Committee on 19 July for approval.

There are two systems running at the moment for payroll, ESR and paper based system tha will be phased out by September. This will result in the governance process within payroll b much tighter.

Phil Oldfield raised there is concern agency do not have adequate checks before starting. The Internal Audit Manager explained this is mainly related to one particular agency which w be phased out and re-assured there are tighter controls in place from January 2019.

Phil Oldfield asked how often do the Trust receive assurance agencies meet all of our professional standards. The Executive Director of Finance responded those on the framewo submit
annually and are subject to audit, the challenge is around off-framework agencies.

The number of off-framework agencies has significantly reduced. The agencies off-framewo are booked through the flexible workforce team are still subject to checks and registrations.

ACTION: Internal Audit Manager

In May there were 33 outside the framework out of 400 and 33 out of 486 in June.

3. Internal Audit Annual Report 2017/18

No significant changes were highlighted. The KPIs were discussed and the reporting deadli will be revised by the internal Audit Manager to see improvements moving forward.

OUTCOME:

47/18 Local Counter Fraud

1. LCFS Progress report

The Local Counter Fraud Specialist provided an update on current investigations.

2. Counter Fraud Annual Report

The Local Counter Fraud Specialist referenced the self-assessment tool which measures staff's understanding of fraud and explained this is difficult to evidence. The Trust benchmark very well in relation to other organisations.

OUTCOME: The Committee **RECEIVED** the progress and annual report

48/18 External Audit

1. Technical Update

The technical update was received and it was noted the Accounting Manual will be reviewed by the Finance team.

OUTCOME: The Board **NOTED** the technical update for information

49/18 ITEMS TO RECEIVE AND NOTE:

1. **Information Governance & Records Strategy Committee Minutes – 25.6.18**
2. **Risk & Compliance Group Minutes – 21.5.18, 18.6.18**
   Peter Bamber raised the fact that the risks in the minutes are only referenced by number and it is difficult to understand the meaning. There was a suggestion that the risks are described or attached as an appendix with a summary of key points; otherwise, the minutes can't be used effectively looking back.

OUTCOME: The Committee **RECEIVED** the minutes

50/18 ANY OTHER BUSINESS

IT Business Continuity Risks (in the event of system outage/cyber-attack)
This is being picked up through internal audit.

New Finance / Procurement System
The internal Audit Manager responded an audit was originally in the plan for Q1 and has been deferred to Q2 Silver Cloud Project which will pick up a lot of the learning. York is completing a very similar audit for Q1 which was deferred to Q2 for similar reasons. This will be discussed at the next Audit and Risk Committee.

51/18 MATTERS TO CASCADE TO BOARD

- Update on Board Assurance Framework review including benchmarking exercise
- ARC Terms of Reference
- Governance documentation changes relating to the WOS
- Reference Cost Sign-Off
- Update on Internal Audit
- Good news on Payroll
- 3 limited assurance reports
- Waiving of standing orders report

DATE AND TIME OF NEXT MEETING
Wednesday 17 October 2018 at 10.30 am – Large Training Room, Learning Centre, CRH

REVIEW OF MEETING
The Chair closed the meeting at 13:03 pm.

QUALITY COMMITTEE

Monday, 2 July 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

102/18 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Helen Barker **(HB)**	Chief Operating Officer
Alistair Graham **(AG)**	Non-Executive Director
Lesley Hill **(LH)**	Director of Planning, Performance, Estates and Facilities
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Lynn Moore **(LyM)**	Governor
Jackie Murphy **(JMy)**	Interim Chief Nurse
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In Attendance

Mr Neeraj Bhasin **(NB)**	Associate Medical Director **(for items 112/18, 113/18 & 114/18)**
Kristina Rutherford **(KR)**	Director of Operations – Corporate **(for items 107/18 & 121/18)**
Dr Cornelle Parker **(CP)**	Deputy Medical Director **(for Dr David Birkenhead)**

103/18 APOLOGIES

Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Medical Director
Paul Butterworth	Governor
Jo Middleton	Interim Assistant Director of Quality and Safety

104/18 DECLARATIONS OF INTEREST

There were no declarations of interest

105/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 4 June 2018 were approved as a correct record.

106/18 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

107/18 CARE QUALITY COMMISSION (CQC) REPORT

Kristina Rutherford (Director of Operations - Corporate) was in attendance to present appendix C and provide a CQC update.

On Wednesday, 20 June 2018, the Trust received the attached published CQC report (appendix C2) following the unannounced inspection (6-8 March 2018) and well led inspection (3-5 April 2018).

The Trust received an overall rating of 'good', with only the safe domain remaining at 'requires improvement'. This is an improvement on the Trust's last inspection where the Trust was rated as 'requires improvement' overall due to the domains of Safe, Effective and Well Led also being rated as 'requires improvement'. All of the Trust's services are now rated by the CQC as 'good', with the exception of community inpatients (Community Place). The Trust received a total of 30 'must do' actions and 52 'should do' actions across all

services, some of which are duplicated and recorded again under a number of services / sites. These 'must' and 'should do' actions have now been complied into a post-inspection action plan which will be monitored through the CQC Response Group.

The report details the Trust's CQC ratings by service area and site, results from the use of resources inspection and also lists the key themes from the report, including:

- Improvements with the access and flow through critical care services, reducing delays for patients and non-clinical transfers.
- The Trust's performance which is better than the England average for the emergency care standard over the preceding 12 months
- Follow-up care for critical care patients following discharge from hospital being implemented through a clinic.
- Specialist midwives now available for pregnant women who might require additional help or support
- Maternity services improvements in stillbirth rates and the proportion of women who experienced a third or fourth degree tear.
- The Trust's appraisal compliance target of 95% being achieved by most services.
- The electronic patient record (EPR) enabled staff to securely access up-to-date, accurate and comprehensive information on patients' care and treatment.
- Strengthened governance systems within critical care, maternity, and children and young people's services and significant improvements made since the last inspection
- Strong, visible and effective leadership across the majority of services inspected.
- Effective governance and quality monitoring processes across most of the services inspected. Key risks identified were escalated effectively.

The 'must' and 'should do' actions and areas for development from the use of resources report are being populated into an action plan that will be submitted back to the CQC on Friday, 20 July 2018. Progress against this action plan will be monitored through the CQC Response Group which will oversee the delivery of the plan, monitor progress, approve the sign-off actions, and agree submission of a sustained position to the Quality Committee. The Quality Committee will then provide assurance to the Board on the action plan and give final sign off for sustained actions.

Discussion ensued on the Community inpatient aspect of the action plan, as the unit is no longer in operation. The recommendations from the report will be used to review other community core services through a peer review process. It was asked if there were any plans to re-open Community Place, and it was stated that there are plans to open beds that will provide a similar service which will utilise nurses in care homes to deliver the service. Engagement has taken place with NHS Improvement and the CQC to ensure that care homes are signed up with the Trust on this.

Discussion also took place on progress with improvement work since the last inspection in 2016. It was stated that daily checks on fridge temperatures, controlled drugs cupboards, etc. are undertaken by the nurse in charge on all wards and departments. A monthly schedule of assurance will also take place.

It was stated that the results from the report were a tremendous achievement and reflects the fantastic work and effort undertaken over the past two years. The results have been relayed through CQC briefing events, and it was also stated that colleagues are immensely proud and delighted with the result. Discussions are now underway on how to achieve a rating of outstanding.

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

108/18 SERIOUS INCIDENT

Andrea McCourt (Head of Governance and Risk) presented appendix D summarising the nine new serious incidents reported to commissioners in March and April 2018:

- March 2018 (2 falls, 1 delay in cancer pathway and 1 assault on the neonatal unit)
- April 2018 (2 neonatal deaths, 1 missed diagnosis (spinal), 1 infection (clostridium difficile (C.Diff) cluster) and 1 category 4 pressure ulcer)

The emerging theme for March and April 2018 were falls. Further details of all cases are included in the accompanying paper.

Discussion ensued on the lessons learned section of the report, which was stated to be really clear and comprehensible. The learning is shared at divisional Patient Safety and Quality Board meetings and also available on the shared learning intranet page. It was also asked if learning is shared with junior doctors, and AMcC stated that Angela Legge (Senior Risk Manager) liaises with Dr Andrew Lockey (Director of Medical Education) on this, but will confirm.

The Chair enquired whether junior doctors, as part of their curriculum, need to demonstrate their learning from incidents. It was stated that they would be able to describe an incident that they have been involved in, and it was also stated that a brilliant bulletin, produced by a junior doctor involved in an investigation, can be circulated to share learning.

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

109/18 HIGH LEVEL RISK REGISTER

Andrea McCourt (Head of Governance and Risk) presented appendix E summarising the changes to the high level risk register as at 25 June 2018:

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

- Three reduced risks, which were discussed in depth at the last Risk and Compliance Group meeting on 18 June 2018
- Two new risks (see list above)
- One closed risk

Further detail of all the above risks is included in the accompanying paper.

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

110/18 PATIENT SAFETY

Michelle Augustine (Governance Administrator) presented appendix F summarising key points from the last three Patient Safety Group meetings held on:

- Thursday, 26 April 2018

  - Update received from the Medication Safety Group including the reporting on a change to the group's governance arrangements which will consist of the disbanding

of the Medication Safety Group and the creation of a new Medication Safety and Compliance Group in May 2018. The new group will report directly to Quality Committee.
- Update received from the falls collaborative including the reporting on a change of clinical lead, continued improvement work and uptake in falls awareness training
- Update received from the Point of Care Testing group including the reporting on an issue with blood gas analyser machines on the Medial Assessment Unit (MAU), which are sited in an unsuitable area. This is currently being taken forward by Dr Karen Mitchell (Consultant Chemical Pathologist)
- Update received from the Hospital Transfusion Committee including the reporting on a risk of insufficient support for clinical staff at the launch of BloodTrack (electronic blood tracking system). Assurance was given that measures are in place to increase compliance with essential skills training.

- Thursday, 17 May 2018

  - Update received from the Radiation Protection Board including the reporting of improvements noted on staff safety reporting, the Trust's compliance with the new Health and Safety Executive legislation pertaining to Radiation Protection and the noted increase in reporting of staffing incidents in March 2018.

- Thursday, 14 June 2018

  - Update received from the Pressure Ulcer Improvement Group including the reporting of an increase in Category 2 pressure ulcers, and divisional support needed for Tissue Viability Link Practitioners (TVLIPS).
  - Update received from the Venous Thromboembolism (VTE) Committee including the reporting of an improving position on VTE performance; however committee attendance remains an issue.
  - Note made that the Quality and Performance Report does not include deep tissue injuries and unstageable pressure ulcers. A request was made for a breakdown of data by divisions; however the data may not have been accurate.

Discussion ensued on the validation of pressure ulcer data and the support for TVLIPS. It was reported that the validation will be monitored by the Patient Safety Group, and the support for TVLIPS to ensure that they are skilled and able to support ongoing learning and leadership.

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

111/18 HEALTH AND SAFETY

Lesley Hill (Director of Planning, Performance, Estates and Facilities) presented appendix G summarising key points from the Health and Safety Committee held on 20 June 2018:

- Staff side health and safety issues - an opportunity for conflict resolution training for Community staff visiting patients' homes due to an incident reported when two members of staff were approached in a threatening manner whilst home visiting.
- Incident – a canister imploded in theatres whilst staff carried out a procedure, and staff concerned required a hearing test due to the blast. Medical Engineering replaced the canister and has contacted the manufacturers requesting information on how often the canisters need replacing. Photographic evidence was also taken and the manufacturers are due to carry out a site audit to check how many of the old canisters are on site.
- Timely closure of incidents – attendees will be formally written to with concerns that incidents are not being updated and not being closed in a timely manner.

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

112/18 NICE GUIDANCE REPORT

Mr Neeraj Bhasin (Associate Medical Director) was in attendance to present compliance with the National Institute for Health and Care Excellence (NICE) guidance report (appendix H). The report provides a snapshot position on NICE guidance within the Trust and work being undertaken by the Clinical Effectiveness and Audit Group (CEAG) to confirm compliance with clinical guidelines, interventional procedures and technology appraisals.

There are currently:

- 288 clinical guidelines - 144 (68%) fully compliant, 38 (18%) partially compliant, 14 (7%) partially compliant and not working towards full compliance due to commissioning issues or deviations from NICE recommendations and 14 (7%) awaiting assessment. 78 of the guidelines were not relevant to the Trust. There has been a significant improvement with fully compliant guidelines, as this previously was around 45%.

- 618 interventional procedure guidelines - 69 (88%) being fully compliant and 9 (12%) awaiting assessment. 540 guidelines are not relevant to the Trust.

- 526 technology appraisals - 325 (97%) fully compliant and 11 (3%) awaiting assessment. 190 technology appraisals are not relevant to the Trust. An action was raised at the Calderdale and Greater Huddersfield Clinical Commissioning Group's (CCG) Clinical Quality Board meeting in January 2018 regarding progress with a significant number of technology appraisals awaiting assessment (42), some of which were over a year old. These issues have now been resolved and assurance has been given that a better process is now in place.

OUTCOME: The Quality Committee received and noted the content of the report and were assured of the Trust's NICE position.

113/18 NATIONAL CLINICAL AUDIT BENCHMARKING (NCAB) REPORT

Mr Neeraj Bhasin (Associate Medical Director) presented appendix I which highlighted results for Calderdale and Huddersfield NHS Foundation Trust (CHFT) compared to other Trusts in national mandatory audits. NCAB is an online portal providing access to national audit performance data.

In 2017 / 2018 CHFT was eligible to participate in 39 national audits; however we did not participate in four of these:

- Inflammatory bowel disease (IBD) Registry – the clinical team wanted a dedicated Electronic Patient Record (EPR) tool designing to directly export parameters into the software, however, it was suggested that the team continue with the current mechanism of manual entry.
- National Bariatric Surgery Registry – this was not participated in due to restricted access until only recently. A local database has been created and data input began in April 2018, and will be monitored.
- British Association of Urological Surgeons (BAUS) Nephrectomy Surgery – this audit was not participated in due to lack of resources, however this has now been resolved. Data collection for 2018 has begun.
- BAUS Percutaneous Nephrolithotomy (PCNL) - this audit was also not participated in due to lack of resources, however this has now been resolved. Data collection for 2018 has begun.

CHFT also participated in 13 other national audits not listed on Quality Accounts, which were below national average. Each audit has an action plan, details of which are in the attached paper:

- National Bowel Cancer Audit

- National Lung Cancer Audit
- National Oesophago-Gastric Cancer Audit
- Intensive Care Audit - HRI
- Hip Fracture Audit - HRI
- National Emergency Laparotomy Audit
- Paediatric Diabetes Audit
- Severe Sepsis and Septic Shock Audit (CRH and HRI)
- Royal College of Emergency Medicine (RCEM) Consultant sign-off Audit - CRH
- RCEM moderate and acute severe asthma audit (adults and paediatrics)
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK

NB also reported that work on Surgical Site Infections (SSI) rates, surgical outcomes and Getting It Right First Time (GIRFT) is being covered to create a resource that gathers and monitors all data as a whole.

Discussion ensued on the work needed to be done to export measurable factors from clinical audits onto the Electronic Patient Record (EPR). It was suggested that this could be raised with the new Chief Clinical Information Officer who is due to be allocated next month.

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

114/18 CLINICAL AUDIT PROGRAMME 2018 / 2019

Mr Neeraj Bhasin (Associate Medical Director) presented appendix J which summarises the 2018 / 2019 Trust clinical audit programme and projects.

There are currently 339 projects for 2018/2019 so far:

- 25 in the corporate division
- 95 in the surgical division
- 97 in Families and Specialist Services division
- 103 in the medical division
- 19 in the community division

In comparison to previous years (293 projects in 2016/17 and 361 projects in 2017/18), the number of projects for 2018/19 will likely increase due to more projects being added during the year. NB also reported on changes that are being made to prioritise national versus local clinical audits, to align clinical audits with Trust priorities and quality improvement, a central allocation of audits with a direct junior doctor, further clinical audit lead engagement, monitoring of clinical audits at Patient Safety and Quality Board meetings and an update of the Trust Clinical Audit intranet page.

Discussion ensued on the importance of quality improvement with clinical audits and junior doctors' awareness of learning from national audits results.

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

115/18 CLINICAL OUTCOMES GROUP AND MORTALITY SURVEILLANCE GROUP REPORTS

The reports from the Clinical Outcomes and the Mortality Surveillance Groups (appendix K) were accepted as read.

Discussion ensued on learning from death, initial screening reviews, structured judgement reviews and the Learning from Death (LfD) summit due to take place on 12 July 2018. It was suggested that Dr Sal Uka (Associate Medical Director) attends the meeting on 1 October 2018 to give an update on progress with structured judgement reviews and to give feedback from the LfD summit.
ACTION: Dr Sal Uka to be invited to meeting on 1 October 2018

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

116/18 PATIENT EXPERIENCE AND CARING GROUP REPORT

Jackie Murphy (Interim Chief Nurse) presented the report (appendix L) highlighting key points from the Patient Experience and Caring Group meetings held in May and June 2018:

- Draft Dementia Strategy – This has been developed following engagement with patients, carers and community groups. There are five key themes and the next steps are to launch the strategy and develop a work plan.
- Annual complaints report – Report received and the focus for 2018 / 2019 is to understand and respond to emerging themes and intervening to prevent complaints.
- Equality Delivery System (EDS2) - Presentation received on progress made against equality objectives by patient representatives and voluntary groups in both Calderdale and Kirklees.
- Mixed sex audit and work with transgender groups – Positive results received from audit of the eliminating mixed sex accommodation policy (staff and patient perspective). The policy also includes accommodation for transgender people and further work is taking place to review current arrangements and requirements.
- Patient experience feedback – Analysis of inpatient feedback identified three main categories for improvement: equipment and amenities, food and general communication. The Estates and Facilities Division agreed to lead some improvement work in these areas.
- Outpatient Healthwatch reports – Positive feedback received from survey of patients' experiences of booking appointments and attending outpatient clinics, following the introduction of the Electronic Patient Record (EPR). An action plan is being progressed to address the concerns raised.
- Divisional reports received on positive activities taking place to improve the experience for patients.
- Learning Disabilities programme of improvements – updates provided on progress with campaigns

Discussion ensued on the accuracy of waiting times in outpatient clinics, and it was reported that a deep-dive is due to be carried out on the Friends and Family Tests (FFT) and will be added to the terms of reference.

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

117/18 QUALITY AND PERFORMANCE REPORT

Helen Barker (Chief Operating Officer) presented appendix M which highlighted May's improved performance score to 69%.

All domains have improved in-month. The safe domain is now green following improvements in harm free care including pressure ulcers. The caring domain has improved in Friends and Family Test (FFT) (Outpatients and Emergency Department). Small improvement in fractured neck of femur means the effective domain is now green. The responsive domain has improved with all key cancer targets back on track, although diagnostics waiting list within six weeks missed target again due to cystoscopy performance. All finance indicators maintained April's performance. Activity is above target for day cases, non-elective and outpatient levels. In Workforce, appraisals for medical staff achieved target and sickness/absence performance has improved.

The model hospital results were also shown, and suggestions were welcomed on how to present the data.

Most improved outcomes (harm free care performance, long-term sickness absence rate and last minute cancellations to elective surgery) and most deteriorated outcomes (Friends and Family Test (FFT) in Community, 38 day referral and post-partum haemorrhage greater than 1500ml) were summarised. Challenges are being faced with the Emergency Care Standard performance at HRI. CRH is delivering a solid level of performance significantly better than the 95% target, but HRI is running up to 10% lower, and actions to improve this are being discussed as a focus for the teams. The improved long-term absence rate performance was noted, and any suggestions on how to sustain this level of performance were welcomed.

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

118/18 QUALITY REPORT

Jackie Murphy (Interim Chief Nurse) presented appendix N1 summarising:

Five reports relating to quality were presented to the Board during April to June 2018 which included an update on mobile technology in maternity, experience of Lesbian, Gay, Bi-sexual and Transgender (LGBT) patient's using Trust services and the Trust "Treat me well" pilot for learning disability patients.

The three quality account priorities 2018 / 2019 (quarter 1) - Care of the acutely ill patient, Patient flow and End of life care. Details of all reports are included in the accompanying paper and presentation (appendix N2).

Discussion ensued on complaints escalation from the medical and surgical divisions. Following a performance review meeting, HB formally requested that both divisions attend the next Quality Committee meeting to give clear assurance on their complaints position.
ACTION: Andrew Mooraby (Associate Director of Nursing – Medical) and Margaret Metcalfe (Deputy Associate Director of Nursing – Surgical) to be invited to the next Quality Committee meeting to report on their complaints position.

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

119/18 QUALITY COMMITTEE ANNUAL REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix O which describes the activities of the Committee and how it met the duties within the terms of reference during 2017 / 2018. The report includes:

- An overview of the role of the Committee
- Details of membership and attendance during 2017 / 2018
- Information of the work of the Committee in the areas of quality improvement, governance and risk / patient safety, audit and assurance and quality and safety reporting.
- The effectiveness of the Committee – this section summarises the response of the self – assessment by members in March 2018 which reviewed the committee's focus and objectives, committee team working, committee effectiveness, committee engagement and committee leadership. Eight responses were received and findings are summarised within the report.

Discussion ensued on the next steps for the Committee and continued improvement work on areas where improvements in care are required, such as pressure ulcers. It was stated that a request has been made for an update on pressure ulcers at this Committee.

OUTCOME: The Quality Committee received the positive report.

120/18 ANNUAL PATIENT ADVICE AND COMPLAINTS REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix P which analyses the nature and number of complaints and contacts with the Patient Advice and Complaints service at the Trust during 2017 / 2018. A summary of the key points from the report were:

- A decrease of 0.3% in the number of complaints received in 2016 / 2017 compared to 2017 / 2018.
- The majority of complaints (50%) were graded as orange.
- Communications, clinical treatment and patient care (including hydration and nutrition) were the main subjects of complaints and are identical to the previous financial year.
- Appointments (including delays and cancellations) remain the main subject of concerns received.
- Medicine is the division with the highest number of complaints (42%); however, Medicine is also the largest division and the number of complaints reflects its size.

The report also detailed the themes of complaints and concerns received, the severity of complaints and concerns received, the amount of closed complaints and learning from complaints. The feedback received from complaints gives the Trust a wealth of information that can be used to improve services and provides detailed insight into a patient's experience.

Areas for improvement are to:

- Sustain timely responses to complainants;
- Update the complaints training to modular-based training which contains an online module that complaints investigators can complete.
- Continue to focus on quality responses that address all aspects of complaints and introduce the Trust new response template.
- Analyse responses from satisfaction survey to identify further areas for improvement.
- Improve identification of sharing and learning from complaints within the Trust learning from adverse events framework.

Discussion ensued on the constant performance maintained despite the upheaval of Electronic Patient Record (EPR) implementation and the disruption of services during winter. It was stated that a message of thanks should be conveyed to colleagues involved, which HB and Vicky Pickles (Company Secretary) will follow-up on.

OUTCOME: The Quality Committee received the positive report.

121/18 QUALITY STRATEGY

Kristina Rutherford (Director of Operations - Corporate) gave a verbal update on the quality strategy, and work being done to align it with the Trust strategy, quality priorities, what needs to be done to build capacity and capability and how assurance processes can link with quality improvement. A significant amount of work is ongoing, and a full draft report will be presented once all work has been completed.

Discussion ensued on ensuring that the quality strategy ties in with the overall organisation development strategy, and it was reported that support is being provided by the Workforce and Organisational Development team to ensure that this is embedded.

OUTCOME: The Quality Committee received the positive report.

122/18 ANY OTHER BUSINESS

Jackie Murphy (Interim Chief Nurse) delivered a verbal update summarising the findings from the independent inquiry report of hospital deaths at the Gosport War Memorial Hospital between 1988 and 2000.

All Trusts have been asked by NHS Improvement to review a number of areas to assure how effective clinical governance is in relation to:

- Working practices on particular ward areas - is it within agreed norms?
- Response to patient / relative concerns
- Response to staff concerns / whistle-blowers / Freedom to Speak Up guardians
- Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and Maintaining High Professional Standards (MHPS) investigation if indicated
- Medical appraisal; 360 feedback
- Accuracy of death certification / understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding) / learning from deaths - Structured judgement reviews
- Controlled Drug use and scrutiny of high usage areas
- Meaningful audits on the standard of care

Discussion ensued on commissioning Internal Audit to carry out a report on end of life care, as well as the recording of controlled drugs in resuscitation. Responses to the recommendations and an intended plan of oversight will be produced and returned to this Committee on 3 September 2018 in advance of assurance to the Board.
ACTION: Findings to return to meeting on 3 September 2018

123/18 MATTERS TO REPORT TO BOARD OF DIRECTORS

- Review of Gosport report received
- Learning for deaths report to be reported to the Board
- Progress on quality priorities
- Paper received on CQC inspection report and the Quality Committee's monitoring and implementation of the action plan
- Quality Committee annual report approved
- Annual report on Complaints 2017/18 reviewed
- Two divisions escalated to the next meeting to report on assurances on complaints
- Positive position of NICE report noted
- Positive performance shown from the NCAB results

124/18 EVALUATION OF MEETING

- Good meeting with positive content
- The length of the reports was mentioned and it was suggested that a summary on a page from sub-groups could be submitted, with the minutes of the sub-groups appended as a separate set of papers.
- The frequency of sub-group meetings was also mentioned and it was suggested that some may move to bi-monthly or quarterly reporting.

125/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix Q) was accepted.

NEXT MEETING

Monday, 30 July 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

Minutes APPROVED by Quality Committee on 30 July 2018

QUALITY COMMITTEE

Monday, 30 July 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

126/18 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Anderson **(DA)**	Non-Executive Director
Helen Barker **(HB)**	Chief Operating Officer
Dr David Birkenhead **(DB)**	Medical Director
Lesley Hill **(LH)**	Director of Planning, Performance, Estates and Facilities
Lynn Moore **(LyM)**	Public Elected Governor
Jackie Murphy **(JMy)**	Interim Chief Nurse
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Melanie Addy **(MAd)**	Director of Operations – Surgical **(item 134/18)**
Janette Cockroft **(JC)**	Matron - Service Performance / Patient Experience **(item 132/18)**
Angela Legge **(AL)**	Senior Risk Manager **(for item 136/18, 137/18 and 138/18)**
Ayesha Marshall **(AMa)**	Lead Tissue Viability Nurse **(for item 131/18)**
Andrew Mooraby **(AMo)**	Associate Director of Nursing – Medical **(item 134/18)**
Carl Norwood **(CN)**	Observer **(Shadowing Helen Barker)**

127/18 APOLOGIES

Alistair Graham	Non-Executive Director
Andrea McCourt	Head of Governance and Risk
Jo Middleton	Interim Assistant Director of Quality and Safety

128/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

129/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 2 July 2018 were approved as a correct record.

130/18 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

131/18 PRESSURE ULCER UPDATE

Ayesha Marshall (Lead Tissue Viability Nurse) was in attendance to present the pressure ulcer review report (appendix C).

- Pressure ulcer collaborative continues with Janette Cockcroft as Chair.
- Key issues include:
  - Moisture lesions not being recorded correctly on Datix. At the moment they are being under-reported and mis-categorised.
  - Continence, which cause moisture lesions is not managed correctly
  - Category 2 pressure ulcers are increasing and should be managed by TVLIPS (Tissue Viability Link Practitioners) on the wards due to tissue viability nurse reduced resources

- 169 pressure ulcer incidents reported via Datix during the period February, March and April 2018. Tables within the report also show a breakdown of the severity of pressure ulcers as well as the high incidence of pressure ulcers within the medical division.
- 7 medical device related pressure ulcer incidents (3 in the surgical division and 4 in the medical division)
- there has been a significant increase of hospital acquired and community acquired pressure ulcers when comparing quarter 1 2017-2018 with quarter 1 of 2018-2019, (94 in 2017-2018 and 125 in 2018-2019)
- Tissue viability referrals have increased from 215 in December 2017 to 268 in June 2018
- The implementation of new guidance ensures that training adheres with the curriculum

Discussion ensued on the noted increase in some injury from harm of pressure ulcers. Work is being done with divisional teams on improvement work. The continence team are also engaging with the training of a band 6 colleague to review moisture lesions, to recognise the impact and to understand if further investment is required. It was also stated that individual wards are monitoring harm free care, with the medical division hosting a pressure ulcer summit. It was asked whether community teams are included in the work ongoing, and it was stated that work is ongoing with the Quest team, the pressure ulcer prevention team and community practices, both in Huddersfield and Halifax.

AMa was thanked for her report including the extensive work being undertaken. It was summarised that an increase in pressure ulcers has been noted, however, data is currently being validated. It was agreed that a follow-up report would be received in six months' time.
ACTION: Pressure ulcers update report to return in January 2019.

132/18 FALLS UPDATE

Janette Cockroft (Matron for Service Performance / Patient Experience) was in attendance to give an update on the quality improvement initiatives at throughout quarter 1 (April to June 2018) and current performance in relation to falls metrics (appendix D).

The Trust has seen a change in the number of falls being reported month on month, from an average of 173 down to 146 currently, which is being maintained. In more recent months, there were some data points close to the upper limit, which reduced in May 2018; however, the trend needs to be closely monitored.

The Falls Collaborative team meet on a monthly basis to cascade improvement work through a small network of clinically-based falls champions, the primary focus of which continues to be on falls in acute medicine and successful preventative interventions which include safety huddles, increased visibility and supervision from nursing staff and more recently with the enhanced care support workers for the most vulnerable adults.

There have been two top performing wards in relation to days between falls – Wards Surgical Assessment Unit, SAU, at Huddersfield and Ward 6C at Calderdale. The Falls Collaborative team also planned its second annual falls awareness campaign promoting how 'Falls prevention gets attention'. The national falls and fragility audit of inpatient falls was repeated in May 2018 and findings indicate that visual checks, lying and standing blood pressure, availability of mobility aids and medication reviews are areas that need improvement. This has been included in the revised action plan for 2018-2019.

Discussion ensued on whether the Electronic Patient Record (EPR) could be used to prompt some of the areas which need improvement following the audit, and it was stated that there is some functionality to develop with this. It was also stated that the number of harm falls is reducing.

JC was thanked for her report and it was summarised that the number of falls being reported month on month are being maintained and a downward trend in the number of harm falls was noted, with work ongoing to improve further.

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

133/18 LOOKED AFTER CHILDREN (LAC) UPDATE

Lindsay Rudge (Deputy Director of Nursing) gave an update on the looked after children health report (April 2017 to March 2018) (appendix E).

The report covers the reporting period of 1 April 2017 to 31 March 2018 and:

- Reviews work undertaken by the Calderdale Looked after Children's (LAC) health team in fulfilling its contractual responsibilities to support the Calderdale Clinical Commissioning Group (CCG) and Calderdale Council's children's care services when discharging their statutory duty to improve the health and well-being of Calderdale looked after children.
  - All staff are now in post, with the Designated Nurse hours being converted from 1.0 Whole-time Equivalent (WTE) into 2.6 WTE Specialist Nurse posts.

- Identifies challenges and gaps in health provision that exist, and to make recommendations on actions for improvement and priorities for 2018-2019.
  - Service specification and remodel - significant progress has been made against this priority, which is in section 7 of the report.
  - Recommendations made by the CQC following the Children Looked After and Safeguarding (CLAS) inspection are being progressed with no recommendations requiring escalation to the Executive Board level.

LR acknowledged Hannah Smith (Looked After Children Designated Nurse – now retired), who contributed to the service and took the work forward. The Quality Committee thanked LR for the very positive report and the amount of work that has taken place

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

134/18 COMPLAINTS FROM DIVISIONS

Surgery

Melanie Addy (Director of Operations for Surgical Division) was in attendance to give an update on the surgical division's complaints.

- Reality
  - In September 2017, the division had 25 overdue complaints, with 11 of these more than three weeks old, and three of the longest being over three months old.
  - Only 10 colleagues were responsible for writing complaint responses, which contributed to the overdue complaints
  - There has been an increase in the complexity of complaints
  - Cross-divisional complaints continued to be a challenge with limited satisfactory solutions provided in a timely manner

- Response
  - Employment of Patient Experience and Quality Support for the Division in quarter 4.
  - Expansion of the number of colleagues who can investigate and respond to complaints, by including Clinical Operations Managers and Service Managers within the division.
  - Ensuring no one person has more than three complaints to respond to at any one time, with consideration given to complexity, cross-specialty and cross divisional concerns.
  - Agreement within division to complete response outside own directorate if capacity allows.
  - Increased and more proactive Clinical Director involvement.
  - Internal target allocated on completion dates (20 days), which are shorter than the Trust completion dates (25 days), in order to improve performance.

- Result
  - As of 20 July 2018, there were seven overdue complaints in the division, with the oldest being 2-3 weeks over the target date
  - Of the seven overdue complaints, six have gone for closure, and the remaining complaint is a priority within the division.
  - There are currently 30 open complaints in total and six of these have gone for closure without breaching their target dates.

MAd stated that the division have learnt lessons and still have further work to do. The division have now increased the number of colleagues who can investigate, respond to complaints and get responses right the first time, which will make the process more sustainable.

It was also stated that once the overdue complaints have been undertaken, the division will ensure complaints with an upcoming target date does not breach the target time by incorporating the principles described in the report.

Medicine

Andrew Mooraby (Associate Director of Nursing of Medical Division) was in attendance to give an update on the division's complaints.

During quarter 4 of 2017/18 and quarter 1 of 2018/19 the medical division saw a notable rise in the number of open complaints it has had to manage. This was attributed to a number of factors which have consequently challenged the division's ability to manage complaint responses within set timescales.

Factors have included:

1. Conflicting operational pressures associated with winter
2. An increase in new complaint numbers and complexity during this period
3. Notable workforce shortfalls
4. Associated skillset weaknesses in the team.

The consequence has been a growing number of complaint responses not being completed within the specified timeframes and the division struggling to recover its position. Steps have now been taken to prioritise the management of complaint responses and processes put in place to provide support and closer monitoring to the directorate teams within the division. This has seen a notable improvement in the timeliness and number of complaint responses that are now being completed which is recovering the division's position.

The redesign work on the division's processes, the close working with the complaints team and the additional support facilitated for investigators should create a position for the division to sustain recovery and manage complaint responses more effectively going forward.

- Reality
  - 23 outstanding complaints

- Response
  - Redefined divisional complaints panel
  - Re-articulated complaint processes
  - Directorate checking introduced
  - Facilitated additional training for investigators
  - Weekly directorate updates introduced
  - Close working with complaints team to streamline processes
  - Reviewed processes for managing responses to timescales – investigators update at complaints panel
  - Identified need for a complaint support role

- Result
  - A predicted trajectory of complaints in the division
  - As of today, the division are down from 75 to 56 complaints, and have nine overdue responses – four of which are with the complaints team.

AMo stated that the division are getting processes in place, but will have a lot of work to do. Discussion ensued on whether investigators within the division have an even spread of complaints between them, and it was stated that there may have been some difficulty with some investigators, but the division will ensure that they are evenly distributed. AMo was asked if the division had thought about what would make it more resilient and whether there were any plans for that. AMo stated that the division needs to improve the management of complaints investigation and a structure is needed to hold individuals to account.

Members of the Committee stated that the report does not indicate the division's definitive actions and is not clear on the causes for the overdue complaints. The issue is how robust and sustainable the processes are.

HB stated that this item was escalated from the Performance Review Meetings to the Quality Committee, however, the anticipated assurance has not been provided and therefore, the medical division's issue needs to be taken back through the performance channels as to what is required.

Both divisions were thanked for reviewing their complaints progress and the need for sustainability.

OUTCOME: That the medical division's issues are taken back through the performance channels to review what is required.

135/18 CARE QUALITY COMMISSION (CQC) REPORT

Jackie Murphy (Interim Chief Nurse) presented appendix H1 which gave an update on the processes for the development and delivery of the Trust CQC plan.

The plan is based on the 23 'must do' and 40 'should do' actions detailed in the CQC report which was published on 20 June 2018. Four of the 'should do' actions have been lifted from recommendations in the Use of Resources report.

- Trust action plan – this continues to be monitored by the CQC response group and will be submitted to the Quality Committee and Trust Board for formal approval
- Quality Summit – there is no requirement to hold a summit, however, it has been decided locally to hold one, a date for which is being finalised. The summit will provide an opportunity to work with partners from within the health economy and for local authorities to take forward the recommendations from the inspection report.

Discussion took place on the work ongoing and 'go sees' planned with other Trusts in order to prepare the Trust to achieving an outstanding rating. It was also asked whether mock inspections will take place in smaller areas, and JMy stated that areas which might have not ordinarily been inspected will be included. JMy also stated that some of the key risks in the action plan may not be able to be delivered on, depending on service reconfiguration.

A copy of the action plan (appendix H2) was available at the end of the report.

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

136/18 SERIOUS INCIDENT REPORT

Angela Legge (Senior Risk Manager) presented appendix I summarising the six new serious incidents reported to commissioners in May and June 2018, the details of which are included in the report:

- 2 falls
- 1 non-admission to the emergency department
- 1 spinal cord compression
- 1 neonatal death
- 1 delay in cancer pathway

15 reports were submitted to commissioners in May and June 2018, and in addition to these the South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT) also closed a serious incident relating to the death of a patient following attendance and discharge against medical advice in the emergency department at the Trust. The learning for this case as well as the recommendations and learning identified from all incidents are included in the report in more detail.

Discussion ensued on:

- How this learning is currently shared in the Trust and AL reported that learning is shared at the Patient Safety and Quality Board (PSQB) meetings and is available on the intranet. It was also suggested that clinical governance leads could share this learning at the clinical governance half day meetings, as this would be a good agenda item. AL also reported that since the last meeting (2 July 2018) when it was asked whether this learning is shared with junior doctors, this can now be confirmed that it is added to the junior doctor newsletter and cascaded to junior doctors via divisional governance.

- work being undertaken to review more comprehensively whether actions from incidents which have already taken place have been embedded

- How this learning may possibly be used in colleagues' appraisals to show that they are aware of and reading and learning the lessons following an investigation.

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

137/18 SERIOUS INCIDENT ANNUAL REPORT

Angela Legge (Senior Risk Manager) presented appendix J which provides an overview of the serious incident activity within the Trust during 2017-2018, the key themes and improvement work that has taken place as a result of the investigations.

- Serious incidents represented 0.5% of all incidents reported during 2017-2018
- There were 59 serious incidents declared in 2017-2018 compared to 67 in 2016-2017 and 44 in 2015-2016.
- Three serious incidents were delogged in 2017-2018 and are not included in the total numbers declared. Requests have been made for the delogging of a further two incidents, however, no response to these requests have yet been received from the Clinical Commissioning Groups.
- The medical division had the highest number of serious incidents in 2017-2018
- The two most frequent types of serious incidents were:
  - avoidable falls with harm
  - diagnostic incident including delay
- There was one never event in 2017-2018 for wrong site surgery. This represents a reduction from two in each of the previous two financial years.
- Work undertaken in 2016-2017 to improve the duty of candour process continues to have an effect through 2017-2018. The Trust remains fully compliant in initial apologies following serious incidents or other incidents meeting the duty of candour criteria.

AL reported that since the writing of the report and this meeting taking place, there were two delog requests with the Clinical Commissioning Groups. One request has now been accepted, which means that the total serious incidents for 2017-2018 are now 58 and not 59 as reflected in the report. It was queried whether the discrepancy could be amended in the 2017-2018 Quality Account to reflect the factual position.

Post meeting update: It was confirmed that the 2017-2018 Quality Account could not be amended; however, reference would be made in the 2018-2019 document with a footnote to acknowledge the change from 59 to 58 incidents.

AL was thanked for the very clearly presented report.

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

138/18 HIGH LEVEL RISK REGISTER

Angela Legge (Senior Risk Manager) presented appendix K summarising the movement on the high level risk register during July 2018. The usual risk register paper is not enclosed as this is not being reported to the Board this month, however, there is one closed risk and one new risk:

- Closed risk 7046 (Clinical Electronic Patient Record (EPR) risk)
  This risk has been closed following discussion with the Director of Nursing, Director of Digital Health, EPR Operational Group and Risk and Compliance Group in July 2018 as the issues detailed in the risk are no longer happening, have been resolved or mitigated.

- New risk 7280 (Blood sciences: Unnecessary specimen collections)
  Details of this new risk, currently scoring 15 and having previously been on the Family Specialist Services risk register for some time at a score of 12, are included in the report.

Discussion ensued that a further conversation may be needed regarding the new risk, as the risk is being received within pathology; however, the cause of the risk is on the wards. It was asked whether the risk should be reassigned, however it was stated that the Associate Director of Nursing was comfortable with the risk being on the Family and Specialist Services risk register. It was also stated that the risk needs to be submitted to the Weekly Executive Board to state where the main issues lie.

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

139/18 QUALITY AND PERFORMANCE REPORT

Helen Barker (Chief Operating Officer) presented appendix L which highlighted June's performance score of 69%. The safe domain maintained green, although harm free care dipped in-month. The caring domain has noted fluctuations in Friends and Family Test (FFT) performance although the accident and emergency response rates hit green for the first time. Infection Control indicators and fractured neck of femur (#NoF) have all achieved target and effective remains green. The responsive domain remains amber, although stroke managed to achieve three out of four targets, whereas cancer 62-day missed target for the first time since October. Within finance, cost improvement programmes (CIP) improved in-month, however only non-elective and accident and emergency activity are now above target. In workforce, appraisals for both medical and non-medical staff achieved target and sickness / absence performance was green for long and short term in-month.

Discussion ensued on recent hot weather, and how this is affecting patients and staff. LH reported that water fountains are being provided for both patients and staff, and staff have been provided with light-weight uniforms.

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

140/18 MEDICATION SAFETY AND COMPLIANCE MINUTES

LR briefly reported on the circulated medication and safety compliance group minutes (appendix M) from the meeting on 28 June 2018:

- The Medicines Safety and Compliance Group (MSCG) has replaced the previous Medicines Safety Group to ensure that medicines are managed in a safe and efficient manner throughout the Trust and that risks are controlled
- Two task and finish groups set up – one group to map progress for discharge to understand potential risks and the other group to progress the controlled drugs internal audit report action plan.

LR stated that a summary report from the Medication Safety and Compliance Group will be provided in future.

OUTCOME: The Quality Committee received the positive report.

141/18 ANY OTHER BUSINESS

Associate Director for Quality and Safety
JMy reported that Anne-Marie Henshaw has been appointed to the Associate Director for Quality and Safety post for six months, and will begin on 20 August 2018.

The Quality Committee conveyed congratulations to Anne-Marie on the appointment.

142/18 MATTERS TO REPORT TO BOARD OF DIRECTORS

- Reports received from the pressure ulcer collaborative, the falls collaborative and Looked After Children
- Progress provided from divisions on complaints
- Serious incident annual report received

143/18 EVALUATION OF MEETING

- Updates from divisions on complaints was valuable
- Good attendance from leads for update reports
- Very enlightening level of information received from guests

144/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix N) was accepted.

NEXT MEETING

Monday, 3 September 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

PSQB Q1 reporting – divisional representation is expected to be in attendance

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 29 June 2018, 10.00am – 1.00pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer (in part)
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance (in part)
Betty Sewell	PA (Minutes)

ITEM

121/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

122/18 APOLOGIES FOR ABSENCE

Apologies noted for: Anna Basford and Brian Moore

123/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

124/18 MINUTES OF THE MEETING HELD 5 JUNE 2018

The Committee approved the minutes of the meetings held 5 June as an accurate record subject to clarification of the Outpatients Minute re cancelled appointments by patients.

125/18 MATTERS ARISING AND ACTION LOG

The following Matters Arising were updated:

ACTION LOG

173/16: EPR Business Benefits – It was agreed that this should be aligned with a presentation which is being developed for the Board.

ACTION: OW to check with MG re capacity – **OW, September tbc**

049/18: Outpatients Scoping Exercise – Due to the absence of key personnel this has not been completed, it was agreed that this would be circulated virtually before the next Committee meeting – **HB, before 31/7/18.**

113/18: Finance IT System Risk – It was noted that this would be an item for the next ARC meeting – **action closed.**

089/18: National Debt/Comparative Funding - It was agreed that this would be an

item for the September meeting and would cover more than the national debt, it was noted that the report would include some comparative metrics and an assessment of what the system is funded and what we are funded for the activity we do as a Trust in income terms – **GB/HB, 28/9/18**

101/18: Membership of Committees – Phil Oldfield agreed to progress with Philip Lewer with regard to membership - **PO**

095/18: Depth of Coding Briefing Paper – Following a request by the Committee for assurance that depth of coding would not be lost due to the Aligned Incentive Contract (AIC) the Associate Director of Finance provided a report which detailed the coding procedures. It was agreed that this would be reviewed again in December – **add to Work Plan for December**.

126/18 MONTH 02 FINANCE REPORT

The Deputy Director of Finance reported that at Month 02 the year to date position is broadly in line with plan. It was noted that there has been early slippage with CIP which is primarily linked to the system recovery plan; these schemes are forecast to be delivered in full by year end. Within other areas of expenditure, we are over-spending on medical staff; these variances have been offset by the planned release of contingency reserves. The Non-Executives (NEDs) raised concerns with regard to the early release of reserves and discussions took place with regard to providing enough assurance for the NEDs that the challenge is being taken, it was suggested that they may want to attend Divisional PRMs or the Fortnightly Agency Review in place of attending Turnaround Executive, the dates for these meetings will be issued to F&P NEDs for information.

It was noted that this position would be closely monitored over the next few months.

ACTION: Dates for the Divisional PRMs and Fortnightly Agency Reviews for the next 6 months to be issued to Non-Executives – **BS**

In terms of the CIP slippage the Chief Executive reported that the key messages are reflected within the report. It was noted that we have an undertaking to go back to regulators to set out our CIP position. Additional QIAs are taking place this week and there will be an absolute refresh at the next Turnaround Executive. The immediate question is how we deal with the gap and to ensure that slippage is not a continuing trend. Discussions took place with regard to the System Recovery Group (SRG) and the lack of progress, it was thought that it may be worthwhile to introduce a Star Chamber approach. It was agreed that correspondence would be drafted to go to CCGs to suggest implementation of the Star Chamber process and a verbal update will be given at the next F&P meeting.

ACTION: To draft/circulate correspondence to Calderdale CCG and Gtr. Hudds. CCG re the implementation of a Star Chamber approach for SRG. A verbal update will be given to the next F&P Committee with regard to any progress made – **OW/GB, 31/7/18**

It was noted that agency expenditure was within the agency trajectory set by NHSI despite the medical staffing pressure linked to CIP and the wider operational position which is key in terms of our overall UoR rating.

From a Capital point of view we are slightly behind but this is only a timing issue.

With regard to Cash we are in an extremely tight cash position which is extending the time taken to pay invoices which in turn is causing additional pressure within our Accounts Payable team. The tight cash position is the consequence of a number of legacy issues which includes the ISS negotiated settlement and the payment of the 'bonus' STF which was awarded at the end of the last financial year which is still to be received. In addition, the agreed pay award for staff is due to be paid in July which will include back-pay from April and the timing of receipt of cash to cover this payment has not been confirmed from the Centre.

Discussions took place with regard to how we are prioritising payments to mitigate any clinical risk. The Committee were assured that the priority process is reviewed through Cash Committee with clinical engagement and payment decisions are being made on a daily basis. It was noted that we are not in a position of strength to formally extend our payment terms. It was noted that payment of the ISS settlement and the payment of the expected CNST rebate would relieve the situation in the short-term.

ACTION: It was requested that a Cash Update will be added to the agenda for the next meeting – **KA, 31/7/18**

The Director of Finance drew attention to the Activity section of the Finance Report and the fact that we are delivering more activity than last year. With regard to GP referrals the Chief Operating Officer stated that it is important to get a weekly understanding of the GP referrals, however, the main concern is the increase in fast-track referrals and a declining conversion rate, which means we could be getting inappropriate fast-track referrals. Nationally the GPs are being asked to increase their number of fast-track cancer referrals and it is important that we look at how we are going to manage the outpatient capacity which is better at responding to the number of patients that need to be seen within 2 weeks.

Discussions took place with regard to the EPR implementation and still within some consultant clinics there is a perception that EPR issues still exist, however this is the minority rather than the majority. It was agreed that to be able to share individual clinical comparisons would be a powerful communication. Comparable information for pre, mid and post-EPR position over X number of months will be shared virtually with the forum.

ACTION: To develop communication which would share individual clinical comparisons pre, mid and post-EPR position over X number of months to be circulated virtually with the forum – **HB prior to next meeting**.

With regard to the bed base it was confirmed that Ward 8C has closed earlier than planned and some savings have been invested into enhanced therapy at home. However, it was noted that we have a site issue with less beds open at CRH and more at HRI than our plan and this is leading to questions with regard to our reconfiguration bed modelling, this will be reviewed.

The UoR metrics was discussed and it was explained that the implications of moving

from a 3 to a 4 would be more significant and that there would be more intervention from the Regulators. It was noted that in terms of the formal single oversight framework UoR it would be good governance for this Committee to have an over-sight of the official response to the UoR assessment.

It was noted that the narrative for the Financial Risk of not achieving Plan will be amended to read *"There is a risk that the Trust fails to achieve its financial plans for 2018/19…"*

The Committee **NOTED** the Month 02 financial position.

127/18 ALIGNED INCENTIVE CONTRACT (AIC) – COST OUT PROPOSAL

The Director of Finance referenced the paper which outlined our approach to monitor 'cost out' for this forum. Three potential areas of opportunities for cost out and the proposed treatments were highlighted. At Month 2, whilst AIC has allowed other additional CIP portfolios to be developed, no other direct contractual changes or cost reductions have been made. Actions are in place to engage colleagues which includes AIC Awareness Sessions which will be running from w/c 2 July in addition to a Trust-wide screensaver. It is proposed to create a new CIP portfolio, which will be subject to QIA, as opportunities are identified and to share progress on specific portfolios through this Committee.

128/18 CIP UPDATE

There was nothing further to report other than what had been discussed earlier in the meeting.

129/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported a positive improvement in all the domains with an overall performance score of 69%. In terms of the Model Hospital metrics, this will take time to be meaningful; however, Diagnostics and Infection Prevention Control were highlighted as areas where we need to improve in relation to our peers. It was noted that there is a gap around the % of temporary staff and sickness, this was February data and internally we know that sickness % has improved. A slight concern is that we are adrift in terms of our Friends & Family test particularly for HRI, A&E and Community Services. In terms of our Emergency Care Standard, we are showing red but we are above our peers.

It was noted that in terms of improvements and deteriorations from a F&P perspective long-term sickness absence has improved. Attention was draw to cancellations and the unprecedented performance of not cancelling patients due to a lack of beds, however, the FSS Division have been asked for a deep-dive into patients who have been cancelled for a clinical reason. Weekly Performance meetings are taking place Division by Division with Helen and Gary and this is having a positive impact especially with regard to our focus on activity.

It was also noted that from a staffing perspective we have released two locums earlier than anticipated due to the positive bed position. Our useage of Thornbury has now been turned off on Sunday nights which has had a positive impact in relation to performance without any evidence that this has impacted on harm, Thornbury is due to be turned off completely by the end of the month.
The Committee were asked to note that there is a pressure with maternity staffing

due to the high level of midwives on maternity leave, this is driving a challenge on staffing and escalation.

In terms of Responsiveness it was confirmed that there is a plan for the Stroke Assessment bed trial which is due to start in the next few days and there is a solution for the Speech and Language for Stroke in addition benchmarking for Ambulance handover is in a much improved position.

ACTION: It was requested that within the descriptive on the report against Wards would be useful to have the Specialty - **HB**

The Committee acknowledged the good progress which is being made and **NOTED** the contents of the report and the overall performance score for May.

130/18 COMPOSITE BENCHMARKING EXERCISE

The Chief Operating Officer provided the Committee with a report which looks at the three key regulatory indicators and how organisations are performing against all three metrics. The report shows that CHFT have consistently been the best performer based on the combined rankings from the three metrics. The internal and external communication of this story was discussed in detail and it was felt that we should celebrate success with colleagues and we should recognise the standard at which we are working.

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

131/18 DRAFT MINUTES FROM SUB-COMMITTEES

The Committee received and noted the following sub-committee minutes:-

Draft Capital Management Group – 13 June 2018

The frequency of the Cash Committee was discussed, it was agreed that it would stay quarterly due to the work which is taking place in between meetings in the key areas.

132/18 WORK PLAN

The Work Plan was reviewed and noted by the Committee.

133/18 MATTERS TO CASCADE TO THE BOARD

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

- Composite benchmarking
- Depth of Coding – we would review again in December to track if coding has been affected by the AIC.
- YTD – on plan, CIP slightly behind in terms of gap, contingency reserves have been released but this was planned.
- Discussed how NEDs may find it useful to attend PRMs and Agency Review meetings.
- System Recovery – CIP from AIC to be added
- Cash – short-term shortfall, this will be closely monitored over the next few months.

- Performance is good against most of the metrics and we are ahead in terms of bed closures.
- Use of Resources – action plan in terms of mitigations back to the meeting next month
- Financial Risks

134/18 REVIEW OF MEETING

The Committee members found the discussions useful and the lighter agenda made for in-depth discussions. It was agreed that the IPR should be covered prior to Finance on the next agenda.

135/18 ANY OTHER BUSINESS

There were no items to note.

DATE AND TIME OF NEXT MEETING

Tuesday 31 July 2018, 9.00am – 12,00noon

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

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Tuesday 31 July 2018, 9.00am – 12.00 noon Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Phil Oldfield	Non-Executive Director (Chair)
Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation and Partnerships
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Brian Moore	Governor

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Linda Cordingley	Executive Assistant to the Chief Executive (minutes)
Karl Norwood	RCN - Shadowing Helen Barker

ITEM

136/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

137/18 APOLOGIES FOR ABSENCE

Apologies noted for Mandy Griffin and Owen Williams.

138/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

139/18 MINUTES OF THE MEETING HELD 29 JUNE 2018

The Committee approved the minutes of the meeting held 29 June as an accurate record.

140/18 MATTERS ARISING AND ACTION LOG

The following Matters Arising were updated:

173/16: EPR Business Benefits
ACTION: OW to report to September meeting.

049/18: Outpatients Scoping Exercise – HB to circulate prior to September meeting.

089/18: Type 1/Financial Benchmarking – HB and GB would co-ordinate and triangulate the wide range of data available which would help with the metrics in our use of resources action plan. The original drivers in terms of impact on deficit were the way care was delivered and the way A&E attenders arrived at the door, comparing Type 1 trusts. This had now been expanded to take account of PFI, long-term debt and a high proportion of non-elective data. Support is being sourced from NHSI to provide the required data for comparison.

ACTION: GB would have information to share internally before bringing to the Committee in September.

101/18: Membership of Committees – Philip Lewer was currently looking at structures of Committees going forward.

126/18: Month 02 Finance Report – PRM had now been circulated – **Action closed.** Star Chamber approach had been circulated to CCGs.

GB advised that the Partnership Transformation Board would meet later today (Systems Recovery Group reports into this Board) to discuss governance arrangements for the £16m worth of schemes as originally scoped. There was £16m in system recovery across 26 schemes (not included in our CIP). Half of these schemes had been discounted early in the process. £1.1m would be saved through system recovery, which included the Outpatient Transformation scheme and elements of the SAFER CIP scheme enabled through AIC, although the Trust would still have a shortfall of £1.5m against the QIPP in the contract. New schemes were not currently captured as CIP i.e. £165k medicine management schemes and a £78k opportunity around the community equipment service. Work on a system-wide Estate strategy was ongoing. The Trust was currently under-trading against the contracted activity levels to a total of £320k with a small variation for Q1 compared to our total contract.

129/18: Integrated Performance Report - Wards – specialty - hard truths information now on IPR. Thornberry turned off completely. – **Action closed.**

ACTION LOG
061/18: Nursing Review – HB would provide an update for the next meeting.

Use of Resources Action Plan
Use of Resources (UoR) was a domain of the CQC inspection regime. NHSI had completed a report which informed our CQC action plan. An overarching action plan had been returned to the CQC and would be monitored on a regular basis. The specific UoR actions were received. These had been extracted from the overall plan in terms of "must dos" and "should dos" and for internal purposes had been expanded to include actions to address the CQC's observations. Several actions had been routed into ongoing work. GB advised that the last visit covered the 2016/17 financial position. When the CQC come back they would look at the 2017/18 financial position. Some of the metrics were likely to deteriorate by this time based on 17/18 performance. It was agreed that assurance was required on the robustness of our data and our comparative position. Whilst recognising that the Trust would be an outlier on our WAU, the data on which this was based had been challenged. The nursing review pointed to us being an outlier. It was important to hit our agency trajectory, CIP, governance on CIP, implementation of GIRFT and the £43m deficit.

In terms of SD39 – this would need amending as NHS Digital had agreed to provide support in identifying benefits. Separately in terms of tracking benefits, £700k had been made available to the innovation fund to create new roles including some with a two-year lead time, therefore benefits would not be realised until next year.

The action plan could be described as a journey demonstrating our planned improvement. In terms of peer comparison the Trust would be directed to Model Hospital. It was noted that the Trust was hosting more people to look at our practices rather than us being signposted to places we should visit. It was noted that the Trust had been under a huge amount of scrutiny and it must be recognised that good performance costs more. This had been discussed with NHSI.

AN asked if we ranked better for our procurement. GB agreed to check as the latest rankings had not yet been published. It was recognised that this was a flawed metric and it was anticipated that our non-pay costs would improve compared to other trusts not doing WOS. It was agreed that there were further opportunities in procurement therefore Matthew Barker would be asked to present future strategies, barriers and contribution to WYAAT at a future F&P Committee. AB suggested that the scale of opportunity would be across WYAAT which should be fully optimised. GB advised that the contracts were the same across WYAAT although there were volume benefits. Leeds and Bradford had appointed a clinical person into their procurement teams to start to drive a different approach. It was agreed that different strategies would need to be deployed. AB suggested trialling in bariatrics and general surgery to identify further scope to optimise products.

It was noted that actions would be monitored by the relevant groups but ownership would remain with the F&P Committee. Timescale for the CQC to come back was 12 months from the last visit i.e. back end of Q4 or early Q1 next year. It was agreed that a full dashboard would come to the F&P Committee on a quarterly basis with measurable metrics and a narrative update on progress. Progress against the Use of Resources plan would be received by the Committee with a first snapshot by the September meeting.

141/18 INTEGRATED PERFORMANCE REPORT

Good month in terms of overall score – maintained 69%, maintained green and amber ratings. Operational teams would map through Cardiac, Endoscopy and Outpatient metrics, which was a manual process for touch time, to track through as we get to the next quarter.

Work was required on the signs and symptoms percentage. This would help with our mortality improvement and identify if our revenue stream was correct. A recent workshop with the coding team had produced clear actions which included signs and symptoms and primary diagnosis. A further workshop would be held in three months.

ECS – Q1 in upper quartile and delivered better than Q1 last year. End of June just short of 95%. Had we accepted our control total we would have been able to access our provider sustainability fund. Still in upper quartile for July. A formal review of our winter plan would go to Board of Directors in September. Allocation in terms of WY funding was £719k – ICS received £4m, split across the system in the same way as WYAZ1 and WYAZ2. Some would be spent externally. There would be a £6m Better Care fund for the two local authorities.
Cancer – slight fail on 62 days in June. Day 38 needed to improve to enable us to be in a strong position with Bradford who had a major issue with Urology. This has been escalated to NHSI. Treatments had been brought forward.
Stranded patients – there was a new target for LOS over 21 days. There was a need to reduce by 39 by December. This was on track through the SAFER programme.

HB advised that MADE events were being held weekly which was helping relationships and stranded numbers. A coaching team of four had been introduced in ward areas – funded for three months. If this evidenced benefits and improvements this would remain for the rest of the year.

Sickness Absence – this was the best position it had ever been.
Bed position – was better than plan. During the floor refurbishment Ward 14 had been used to decant. Flow was challenging during the first two weeks in July but no additional beds were opened (plus a positive impact on agency spend). There was learning around moving away from our default position of opening beds.
Nursing – weekly review with divisions to look at fill rates. Qualified numbers agreed and overfilling on unqualified. Enhanced peripatetic team filled all requests coming through last week.
Day case rate – red - surgical procedure unit under-utilised. Need to find a better way of listing patients.
OP clinics – new software implemented for hospital cancellation process. Previously running at 3000 cancellations per month. This had been reduced by 50% in the first couple of months of using the new software.
Theatres – closed by end of this quarter and activity absorbed elsewhere. This would be a CIP contribution. Work ongoing in Max-Fax to look at efficiency and skill mix.
Dashboard on frailty – readmission statistics would need to be included. Good performance although readmissions high. Ambulatory to admission should see a higher transition rate.
Data Quality – the self-assessment report showed a positive outcome. The Trust was attracting other trusts as "go see" to us. The formal Data Quality Board would report into the F&P Committee. The self-assessment would be completed every 6 months. NHSI would carry out an external review on a 12 monthly basis. HB agreed to circulate the report.
Model hospital – it was noted that the data was not current. It should be recognised that this was the lens used by our external auditors. A table of metrics with narrative would be provided on a quarterly basis, using the top weighted areas.
Staffing – it was recognised that we were overstaffing in clinical support. The hard truths report was a positive message. HB agreed to test the numbers (10 in July) around international recruitment to identify the level of traction.

142/18 MONTH 03 FINANCE REPORT

The plan was on track as in Month 01 and Month 02 but continued to be reliant on the release of contingency reserves (£0.5m year to date). CIP was underachieving to date, being £0.12m under CIP target. Other pressures were medical and nursing pay. Although there was an element of medical pay related to CIP there were wider pressures outside of this. Nursing CIP costs were on track but there was an element of overspending pressure. The level of activity was below contract but the AIC was protecting the income position by £0.5m. The underlying position, if the two benefits of the AIC and reserves release weren't present, would leave the Trust £1m overspent. CIP will need to achieve the full £18m in order to deliver the £43m deficit position. There was no value in this year's plan for WYAAT programmes.

The I&E position on agency spend was on trajectory for Month 03. Capital was behind plan but this was a timing difference. Cash and borrowing was on plan and Creditor payments were much improved in month. The £4.2m ISS debt had now

been settled and £2.9m received in respect for Sustainability and Transformation Funding from 2017/18.

The overspend on medical and nursing pay was high in Month 01, although slightly better in Month 02 and better still in Month 03. Actions were moving us in the right direction although less so with medical pay which was overspent by £500k. Some of this was due to CIP phasing. Detailed work was being undertaken in PRMs around agency and additional shifts and what was driving overspend. There were gaps in junior doctor provision with a noticeable difference in terms of the number of posts we have compared to other WY organisations. This had led to a bigger spend on juniors as the Deanery appeared to fund less posts on our junior rotas. WYAAT was looking at the bank rate which may impact in year. We were running live data collection for four weeks. Of the breaches, 94% of WY medical agency breaches were at CHFT. 25% of the North's breaches were with CHFT. We were an outlier in terms of recruitment.

ACTION: It was agreed to provide the agency usage report to the Committee.

With regard to Capital it was noted that there was a bid for emergency capital in relation to HRI Estate, an MRI scanner and a Gamma camera, which were outside of our capital plan. The bidding process would be agreed by November therefore the Trust was not likely to get any monies until April 2019. There was slippage in some areas of the capital plan against which commencement of work on the Aseptic Suite had been agreed at £390k in year.

It was also noted that new capital monies had been announced last week to support improving winter positions. The Trust would bid against this fund.

The next stage of our digital journey ie Medisoft, voice recognition (VR) and cardio-vascular ECG carts would require additional capital. The Trust would bid for the ECG carts against new money (£500k). VR would require capital of £30k to pilot which had been agreed to progress.

143/18 Q1 UNDERLYING POSITION

Corporate – the Trust was currently incurring set up costs of the WOS which would be recouped at the WOS go live. Estates & Facilities had been called to a Star Chamber to recover its CIP. Other areas were THIS - £118k overspend after three months. Mandy Griffin had provided a recovery plan. Medicine had been asked for a recovery plan to get their run rate back to zero. There was wider discussion at TE. The Chair asked for assurance on getting back on track. GB said this would be done through monthly reporting at PRMs. The recovery action plans and trajectory would be provided at the next Committee meeting and time allocated for full discussion.

It was noted that Medicine was holding more than a third of the Trust's CIP. HB was looking at the extra support they would need to recover. GB stated that Medicine currently planned to take out £6m. This would still be a worse position than last year's plan. AB advised that the Outpatient Transformation scheme would release costs.

144/18 CASH UPDATE

The £4.2m ISS settlement from last year had now been received. The Q4 STF bonus payment of £2.9m had also been received. Payment of approved invoices was almost up to date. The metrics would result in a decline in long-standing,out of date invoices being paid. If I&E stayed on track over future months the position would improve. Measures taken through last year were now reaping benefits but not necessarily cash benefits. The ISS settlement of £700k would be a cash payout in Year 6 or 7. There were some PMU-related invoices (£88k) over 360 days and £220k over 180 days. The Trust was working with the CCGs and Locala to settle accounts. It was noted that the Cash Committee was overseeing the focus on outstanding debt. It was agreed that a progress report would be available for next month's meeting.

145/18 AIC COST OUT PROPOSAL

GB advised that this Committee would monitor AIC delivery. A report would be brought to next month's meeting.

146/18 DATA QUALITY BOARD (DQB) TORs

The Committee approved the terms of reference for a newly established Data Quality Board to provide assurance around data quality. HB agreed to look into any duplication with the IG & Risk Management Strategy Committee which reported into the Audit & Risk Committee. It was agreed that the Data Quality Board would provide a quarterly report and an annual report to the F&P Committee.

POST MEETING NOTE: HB has looked into this and can confirm the Information Governance relates more to use of information, GDPR etc., whereas the DQ Board will be focussing on the quality of the data used.

HB is comfortable, therefore, having checked, that there is no duplication or confusion going to be caused

147/18 CIP UPDATE

It was noted that the £120k shortfall in Estates was improving month on month. The overall CIP plan had a shortfall of £1.5m. TE was monitoring through additional pipeline schemes and a Star Chamber. Month 01 was off plan but work on medical profiling enabled delivery and catch up for the year end.

It was noted that Project Echo currently had no impact on CIP (completion mid to end of March 2019).

148/18 TO RECEIVE DRAFT MINUTES FROM SUB-COMMITTEES:
CAPITAL MANAGEMENT GROUP – 12 JULY 2018

The draft minutes were received.

149/18 WORK PLAN 2018

The Work Plan was reviewed and noted by the Committee, the following items to be added:

- Use of Resources – Bi-monthly
- Model Hospital Metrics - Quarterly
- Procurement process and opportunities – October meeting

150/18 MATTERS TO CASCADE TO BOARD

- More challenge required to SRG
- IPR – good overall performance. Areas of focus were A&E targets, 62day cancer, OP improvement, theatre surgical unit
- Data Quality Self-assessment – to be completed every six months
- Data Quality Board – accepted recommendation to report to F&P quarterly with annual review
- Finances – YTD on plan but underlying concern of potential £1m
- CIP – potential challenge of £1.5m at year end
- Noted agency trajectory below plan driven by M1 and M2. M3 closer to plan

151/18 REVIEW OF MEETING

Members agreed there was good debate which enabled clear focus on salient points and better balance between performance and financial performance.

152/18 ANY OTHER BUSINESS

No items raised.

DATE AND TIME OF NEXT MEETING

FRIDAY 31 August 2018, 10.00am – 1.00pm

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

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Tuesday, 28 August 2018

Present: Philip Lewer, Gary Boothby, David Birkenhead, David Anderson, Jackie Murphy, Phil Oldfield (via phone), Cllr Megan Swift.

In attendance: Carol Harrison, Andy Hill, Antonia Cavalier, Lyn Walsh (minutes)

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Investment Portfolio Presentation.
A Cavalier gave a very informative presentation to the Committee. She explained CCLA are an asset management company for the not for profit sector. The presentation detailed the portfolio that the Charity is invested in and is managed to protect the capital and income over the long term from inflation. P Oldfield questioned the percentage split of the funds and this was explained to him (a copy of the presentation is to be sent out to him). D Anderson asked about any capital gains tax paid. It was confirmed that no tax was paid as it is a charitable fund. A Cavalier explained the ethical polices in place on the fund and discussed risk. She stated that if a further discussion was needed on splitting funds or changing objectives she was happy to help but any movement between funds would cost 4%.
As a point of interest, J Murphy asked how they vet the companies that they invest in. A Cavalier explained that they buy in a research service to do this and also screen the information and go out to see the companies. G Boothby asked how long we had held investments with CCLA and what is the current commitment. This was confirmed as being over 20 years and that it is standard to have a 3 year contract with a 2 year extension. It was discussed that in 2014 there was a review when 3 portfolios were put together into the one we hold today.

3. Minutes of the last meeting
The minutes of the last meeting held on 22 May 2018 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

4. Matters arising
~ launch of new brand on intranet. L Walsh updated that this had been delayed due to ongoing work on the WOS and was now expected to be September. There have been drafts of website pages and materials.

~ Fundraiser recruitment. G Boothby updated that this had also been delayed due to the WOS but it was still a priority and should stay on the agenda.
~ Todmorden sub- committee (good news story). L Walsh updated that this has not yet gone to communications but suggested it be added to the intranet pages which was agreed.
~ Community Foundation for Calderdale – Activity & impact report –decision required. C Harrison has sent out the information provided by the community foundation which is now clearer and we have a better audit trail. The Committee was satisfied that the community foundation had done what was asked of them. It was agreed that £37.5k funds would be released to them. P Lewer is planning a further visit to see them. **Action Release £37.5k Funds**

5. Draft Annual Report & Accounts 2017/18.
C Harrison presented the Report and Accounts to the Committee which they had seen as a draft at the previous meeting. The accounts are currently in the process of being audited, after which it was agreed by the Committee that P Lewer and G Boothby would be delegated the responsibility of signing them off. J Murphy suggested that they be made available to a wider audience and more PR done to promote the charity. G Boothby said he would share the report with exec colleagues. J Murphy suggested a Q&A with trust news as not everyone was aware of charitable funds and how they work.

6. Quarter 1 Sofa and Balance Sheet 2018/19
C Harrison presented the paper describing a slow start to the year donation wise at £57k but by July this has picked up to £123k with legacies and further donations. Gains on the fund were £147k in the first 3 months. G Boothby updated that there had been fundraising of £18k for specific coronary items.

7. Quarter 1 2018/19 Expenditure Summary
C Harrison presented this paper and its contents were noted. There is currently £251k of outstanding commitments. G Boothby updated that £16k had been discussed for new water coolers.

8. Funds of the Charity –an overview
C Harrison presented the paper which provided information to the new members of the Committee. Describing how we hold 120 funds which have been reduced from 270 with 2,400 transactions being made, she explained how every 2 years an exercise is undertaken to look at inactive funds of which there were 17 this time. The fund managers of the 17 funds were questioned over future plans and further consolidated into 6 funds. P Oldfield asked a questioned regarding gift aid - do we claim it. It was confirmed that we claim it from all just giving donations but it was up to the general offices to give the gift aid forms to people who make donations. **Action C Harrison to identify how much gift aid we have claimed.**

9. Risk register update
L Walsh to seek guidance from Andrea McCourt to then circulate for comments outside of the meeting.

10. Minutes from the Staff Lottery Committee meeting held on 12 June 2018

These were noted. G Boothby asked how well was the staff lottery publicised and do we need wider representation on the Committee. It was decided that this would be looked at along with an admin replacement for J Cruickshank who had recently retired. J Murphy suggested that there should be some myth busting around how the staff lottery worked and what could be purchased. The example of a piece of kit was used that should be provided by the Trust in normal day to day operations. C Harrison said that yes the Trust should provide core items but that anything seen as a nice to have extra could be considered.

11. Any other business

There was no other business to be discussed.

12. Date and time of next meeting

The next meeting will be on Thursday, 29 November 2018 at 2 pm in Meeting Room 4, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
28 August 2018
Action Log - 2018/19

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Chase VP re brand launch on Intranet promote good news stories.	**LW**	Nov-18	ongoing
Matters arising	28.08 - 4	Discuss fundraiser recruitment	**GB**	Nov-18	ongoing
Matters arising	28.08 - 4	Contact Comms re Tod good news article. To be added to Intranet site.	**LW**	Nov-18	see action 1
Risk Register update	28.08-9	Amend Risk Register after consulting A McCourt. Circulate outside of meeting.	**LW**	Nov-18	
Comm. Foundation of Calderdale	28.08 - 4	Release monies once Committee happy	**CH**	ASAP	
Fund of the Charity- an overview	28.08-8	Identify how much gift aid has been claimed	**CH**	Nov-18	

APPENDIX A

Calderdale and Huddersfield NHS Foundation Trust

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

PRESENT:	
Philip Lewer	Chair
Publicly Elected Governors	
Brian Moore	Public elected – Constituency 8 /Lead Governor
Stephen Baines	Public elected – Constituency 5
Paul Butterworth	Public elected – Constituency 6
Rosemary Hedges	Public elected – Constituency 1
Diane Hughes	Public elected – Constituency 3
Alison Schofield	Public elected – Constituency 7 (+ carer)
Kate Wileman	Public elected – Constituency 4 (Reserve Register)
Staff Governors	
Dr Peter Bamber	Staff elected – Constituency 9
Linzi Smith	Staff elected – Constituency 11
Sian Grbin	Staff elected – Constituency 13
Stakeholder Governors	
There were no stakeholder governors present at the meeting	
IN ATTENDANCE:	
Alastair Graham	Non-Executive Director
Alison Wilson	General Manager, Estates
Amber Fox	Corporate Governance Manager
David Anderson	Non-Executive Director/SINED
Gary Boothby	Executive Director of Finance
Helen Barker	Chief Operating Officer
Lesley Hill	Executive Director of Planning, Estates & Facilities
Lindsay Rudge	Deputy Chief Nurse
Lisa Williams	Assistant Director of Service Development
Mandy Griffin	Managing Director, Digital Health
Owen Williams	Chief Executive
Sharon Appleby	Transformation Programme Manager
Victoria Pickles	Company Secretary
APOLOGIES FOR ABSENCE WERE RECEIVED FROM:	
Anna Basford	Director of Transformation and Partnerships
Brian Richardson	Public elected – Constituency 5
Chris Reeve	Nominated Stakeholder - Locala
David Birkenhead	Executive Medical Director
Jackie Murphy	Chief Nurse
Lynn Moore	Public elected – Constituency 7
Suzanne Dunkley	Executive Director of Workforce and OD
Veronica Maher	Public elected – Constituency 4

1. WELCOME AND INTRODUCTIONS

The Chair opened the meeting and introductions were made around the table.

2. Digital Health Stabilisation and next steps

The Managing Director for Digital Health presented the story on Digital Health and what the future state will look like. The Managing Director for Digital Health reminded the Council of Governors that Calderdale and Huddersfield NHS FoundationTrust had implemented the electronic patient record (EPR) in partnership with Bradford Teaching Hospitals Trust, with CHF T going live in May 2017 and Bradford in September 2017.

She described the process to achieve stabilisation. All but one of the 99 items on the stabilisation plan had been resolved. There remained a number of larger issues to address. A number of forward projects have been agreed with Bradford including those to make the EPR function better and address the fractured work flows.

The key ambition is to become a UK reference site for Cerner. The business as usual team are now in place that look after the Core EPR, this is a shared resource with Bradford. The Electronic Patient Record has transformed the way care is delivered and a Digital Health Team was implemented on 4 June 2019 with training and change resources and this team will focus on re-education. One element outstanding from the stabilisation plan is the regular day attender which is being built next week.

An EPR upgrade is scheduled for early next year and in addition the drug catalogue in EPR will be updated in November.

The Trust were 113th in the country when it came to our Digital Maturity, last October the Trust were 13th place and are technically the 3rd highest in the country. The adoption rate of the Trust has been 1st class for usage across the UK.

There are now 3,000 patients registered on the patient portal and can view and print their records via the YourEPR application. Patients are asked to sign-up to the patient portal when they attend an Outpatient appointment; however, if they prefer, they can request access to their copy letters and results will still be sent to their GP.

The Electronic Document Management System (EDMS) will cease and a scanning solution is being explored from Cerner. The outstanding un-validated letters in EPR are now in the 100's and all rules have been put in place to stop this from re-occurring.

The Director for Digital Health was thanked for her presentation and enthusiasm.

3. DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

4. MINUTES OF THE LAST MEETING – 4 APRIL 2018 & 8 MAY 2018

The minutes of the last meeting held on 4 April 2018 and 8 May 2018 were approved as an accurate record.

5. MATTERS ARISING

No further matters arising.

6. CHAIR'S REPORT

a. UPDATE FROM CHAIRS INFORMATION EXCHANGE MEETING – 25.6.18

The Chair reported on the minutes from the meeting held on the 25 June 2018 which had been included with the agenda (Appendix B). The next meeting was scheduled to be held on the 18 December 2018.

OUTCOME: The Council of Governors **RECEIVED** and **NOTED** the Chairs Information

Exchange Minutes – 25.6.18

PERFORMANCE AND STRATEGY

7. CARE QUALITY COMMISSION REPORT

The Chief Executive announced the fantastic news the Trust received with achieving the CQC rating of 'Good' overall. The Chief Executive noted his thanks to the wider workforce, volunteers, our partners and our governors. It is important to reflect on the contribution which has been a joint effort, including patients as their feedback also counts. The Chief Executive explained the CQC will move to a Single Oversite Framework now which is a judgement on how we use resources. The ratings received following the inspection this year were as follows:

- Safety = Requires Improvement
- Caring = Good
- Response = Good
- Effective = Good
- Well-Led = Good
- Use of resources – Requires improvement

Our Trust is the 1st Trust in the North of England to be assessed under the new framework. The CQC prepared for 10-50% of those Trusts that were already designated as 'Good' or 'Outstanding' to go backwards under the new regime.

The Chief Executive highlighted moving from 'requires improvement' to 'good' cannot be understated given our underlying deficit position. He highlighted the importance of celebrating this status of the CQC 'Good' rating and the real achievement it reflects.

The next steps is action planning and this will be shared with the Quality Committee, Finance and Performance Committee, Board of Directors and Council of Governors.

Maternity services are now classed as 'Good' with some elements of outstanding practice which is a great move forward after receiving a 'requires improvement' from the previous inspection.

The Chief Executive passed on thanks to Brendan Brown, our former Executive Director of for his leadership and approach to working with the CQC.

A governor raised disappointment there is no place of safety for mental wellbeing patients, the main area of concern being A&E. The Chief Operating Officer reported that work on this had begun on the two sites. Alastair Graham reference the discussion at the Board of Directors on the 'Treat me Well' campaign.

OUTCOME: The Council of Governors **NOTED** the CQC update

8. RECONFIGURATION UPDATE - LETTER FROM THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

The Chief Executive made reference to the letter received on 12 May. There is particular focus on a Care Closer to Home and a reduced bed numbers model; however, there is concern in how the Trust can be confident on demand. NHS Improvement and NHS England (the regulators) have a deadline of 10 August to respond to the Secretary of State. If an agreement can't be made, a decision will be made by the Secretary of State. The Chief Executive highlighted the regulators do not see a model of having three A&Es across Calderdale, Kirklees and Wakefield which serves 930,000 patients and a solution with lower capital is required.

The outcome will likely be a modified plan for HRI with more flexibility on the A&E

capacity. The reconfiguration will not impact on the plans to have a single ICU. The Chief Executive clarified that it is likely that the overall current bed base will remain in place until Care Closer to Home shows evidence it is making a change.
He pointed out that the Trust had worked with its clinical staff and the clinical commissioning groups to develop the draft proposals for submission to the regulators.

The Chief Executive referenced the enforcement notice which is still active for the Trust.

OUTCOME: The Council of Governors **NOTED** the reconfiguration update

9. OUTPATIENT TRANSFORMATION PROGRAMME

Lisa Williams, Assistant Director of Service Development described the Outpatient Transformation project launching with partners in Commissioning Groups across Greater Huddersfield and Calderdale in partnership with Healthwatch. The projects were started around 1 year ago with the focus on delivering care differently e.g. nurse led follow ups and one stop clinics.

The project team visited other organisations such as Stockport, Airedale and Morecambe Bay to find out 'What Good Looks Like' and how to shorten the patient journey and empower patients in the community to support self-care. The project team reviewed feedback from the Healthwatch survey which described more use of Digital technology, virtual clinics and the struggles with car parking.

The Outpatient Transformation Project is consulting with as many forums as possible with support from Anna Basford. There has been attendance at the GP Board, GP Federation and a Board of Partners has been created to steer this project including Directors, Clinical Directors and the Associate Medical Director.

The Project asked for a Governor to volunteer to help drive this project forward. Alison Schofield volunteered declaring an interest in chronic pain and will report back with updates to Council of Governors.

A governor raised more clarity is needed regarding Care Closer to Home and patients that are still being taken further away from home for Specialist appointments. Patients require more information to understand the reason they need to attend an appointment, such as specific equipment is required.

Lisa Williams attended the Digital Conference where a clinician described the transformation of their Stroke clinics via Skype.

OUTCOME: The Council of Governors **NOTED** the Outpatient Transformation Update and Alison Schofield volunteered to help drive this project forward

10. TRUST PERFORMANCE

a. Financial Position and Forecast

The Executive Director of Finance reported the Trust has not accepted the 18/19 NHS Improvement Control Total of a £23.2m deficit and is therefore not eligible to receive any of the £14.2m Provider Sustainability Funding allocated for this financial year, (previously Sustainability and Transformation Funding).

The year to date deficit is £9.24m as planned, in line with the plan submitted to NHSI.

The total forecast deficit is £43.04m, just within plan.

The National Pay Award for all staff (excluding including doctors and apprentices) will cost the organisation £8M and only £2.3M funding was in the plan.

Sian Grbin asked how much funding was for the conversion to a treatment room on the Cardiology Ward at CRH as feedback was it was in the millions, within the PFI. The Executive Director of Finance agreed to look into this and report back on the breakdown of costs.

ACTION: Executive Director of Finance

b. Performance Report (including Good News Stories)

The Chief Operating Officer reported a positive position with improvements from April into May with 4 amber, 2 green and no red domains.

The main highlights from the report were:

- The SAFE domain is now green following improvements in Harm Free Care including pressure ulcers
- Agency spend has reduced
- Cancelled operations are reducing and it has been the lowest month ever despite reducing bed base
- Sickness levels are on a positive reduction
- Positive recruitment into consulting staffing in the Medicine Division
- Complaints closed within timeframe - 2 Divisions have been escalated and are asked to attend the next Quality Committee
- Paediatrics have received a CHKS accreditation (National Healthcare Intelligence and Quality Improvement Service)
- Emergency care standard – closed June down at 94.78%, both sites have improved, Huddersfield was above 90% in June and Calderdale delivered over 95% every day of the month in June with very high attendance – there are discussions around how to acknowledge this achievement
- Finance & Performance Committee are looking at how we rank against the 3 metrics (national standards of emergency care, cancer and referral to treatment) and we are the best performing organisation in England thank you to all of our staff

11. Update on Wholly Owned Subsidiary

The Executive Director of Planning, Estates & Facilities informed the Governors the business case for the Wholly Owned Subsidiary is now available on the internet under Publications and Full Business Case. The project is on track to go live the end of August.

She explained that the TUPE consultation with staff is underway. The Trust is providing 'letters of comfort' with assurances from Board on the principles and agreement in relation to the transfer of staff. The team is also working with Unions on an agreement to protect these principles. The Executive Director of Planning, Estates & Facilities reported they are currently working on terms and conditions for new staff as well as the legal agreements.

There are still constructive relationships with our Unions, Unison and GMC. It was noted Unison didn't get enough votes to warrant strike action.

The Executive Director of Planning, Estates and Facilities described the significant amount of engagement taking place with staff. Alastair Graham added a number of Meet the Board sessions have taken place as part of the consultation. Work will start to take place around engagement and communications on the wholly owned subsidiary to inform the rest of the organisation.

The Executive Director of Planning, Estates and Facilities explained that she had met with

the Calderdale Scrutiny Panel who had agreed to send a letter to the Trust about their views. This has not yet been received and there had been a mixture of views expressed at the meeting.

A governor asked about the costs incurred as part of the set up of the company and if these costs are refundable to the Trust. The Executive Director of Finance explained the costs incurred are being considered; however, the Trust achieved a saving of over £2M to invest in patient care in last financial year. The money saved so far was around historical capital purchases over last 10 years, to reclaim an element of VAT. A governor responded this is an endemic in the health service and systems should be changed to allow hospitals to receive VAT back without diluting the NHS.

Discussion took place around how governors can have their views on the Wholly Owned Subsidiary recorded. The Chair asked them to write to the Company Secretary (Victoria.Pickles@cht.nhs.uk) stating whether or not they are in agreement. This will be recorded and reported at a future meeting. The public governors not in attendance will be informed.

ACTION: All Governors to send views to Company Secretary

Proposed changes to the Trust's Constitution to the staff membership categories
The Company Secretary asked the Council of Governors to decide if the Wholly Owned Subsidiary staff that transfer remain Foundation Trust members and have the right to stand as governors should they choose. Any new staff members wouldn't become a Foundation Trust member until they have been employed for 1 year.

Feedback from the lead governor was the Wholly Owned Subsidiary is a separate company not employed by the Trust and that the same conditions as ISS staff should apply as they are a 3rd party. The Company Secretary responded the contractual relationship is entirely different.

The Company Secretary informed the governors what it means to be a staff member is available in the Constitution on the policies database.

The suggestion was staff who have been members of the Trust to remain as members. Voting was deferred to the next meeting on the 19th July and governors are asked to read the papers and take any advice and guidance outside of the meeting.

OUTCOME: The Council of Governors **NOTED** the update on the Wholly Owned Subsidiary and will **WRITE** to Vicky Pickles with their views. **VOTING** on the Constitution will take place on 19 July

12. Car Parking Charges Prices Proposal

The Executive Director of Planning, Estates and Facilities explained that the item on car parking was brought to the Council of Governors as part of the consultation process prior to going to the Board for a decision. Feedback from the Governors would be presented at the Board meeting where the item is discussed.

Alison Wilson presented the car parking proposal which set out future arrangements for parking charges, access to spaces and additional parking options. The majority of complaints in Estates and Facilities are regarding car parking, particularly Acre Mill and the automatic number plate recognition scheme. In August last year, the contract was terminated and the same system at Huddersfield was brought in along with a chip and pin payment machine at Acre Mills. Since then, the number of complaints has reduced.

There are still complaints being received from members of the public struggling to find car parking spaces. Work is taking place with Calderdale Council to find parking spaces and

permits and a review of staff car parking is going to be rolled out across the Trust.

In terms of public parking, the proposal it to increase the cost from £2.80 to £3.00 which falls in line with partner sites. The proposal will also introduce a weekly pass for regular visitors and a 24 hour increase.

In terms of the income generation, based on the current usage of car parking at CRH, HRI and Acre Mill the total increases would realise a potential income of £86k for public parking and £35k for staff parking over 12 month period.

Alison Schofield raised the issue of charging for blue badge holders to park and a feeling that this had not properly been consulted upon. She asked that consideration be given to someone attending the disability forum to explain the parking arrangements. She also asked that greater clarity be given to the public as to who is entitled to free parking. A governor raised there should be no charges if a patient or visitor was to stay for treatment for a week. Alison Wilson explained there are certain categories that are allowed free parking and at the moment a weekly stay would cost £49.

Sian Grbin raised a question about the number of hospital that charge staff to park as figures showed that it was a third of hospitals nationally. The Executive Director of Planning, Estates and Facilities said that she did not recognize those figures and would check the available data. Sian explained the unpaid hours of staff would be larger saving than parking and feels parking costs should go down, not up.

The Chief Operating Officer explained that the Board had to make difficult decisions in light of the Trust's financial position and would welcome any other ideas the Governors have around savings. It was agreed to consider holding a joint workshop between the Board and the Council of Governors to consider the financial position and ideas for generating savings.

ACTION: Company Secretary / Corporate Governance Manager

The Executive Director of Finance explained the money would have to be spent in different ways if there were no parking charges. Staff on the lowest paid band will see a 5% parking increase and 9% staff increment.

The Company Secretary asked that Governors provide a response to her on their views on the car parking proposal. These would then be collated and presented to the Board alongside the item on car parking as part of their decision making.

OUTCOME: The Council of Governors **AGREED** to provide a response to the Company Secretary on the Car Parking Charges proposal.

GOVERNANCE

23/18 COUNCIL OF GOVERNORS REGISTER

The updated register of members as at 1 July 2018 was received for information. Governors will be updated on the Register at the end of this month 31 July 2018.

OUTCOME: The Council of Governors **APPROVED** the Register

24/18 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

There have been no changes to the Register of Interests since the last meeting and the Chair requested that any amendments be notified to the Corporate Governance Manager as soon as possible.

OUTCOME: The Council of Governors **APPROVED** the Register of Interests

25/18 UPDATE ON PROCESS FOR ELECTION OF LEAD GOVERNOR

The Company Secretary informed the Council of Governors there have been 2 applications for election of lead governor. This would require a competitive process. Information and instructions will be sent out next week with 2 weeks to respond.

OUTCOME: The Council of Governors **RECEIVED** the update on process for election of Lead Governor

26/18 PROPOSAL FOR FUTURE COUNCIL OF GOVERNORS MEETINGS

The Company Secretary presented the proposal for future meetings with the purpose to give governors more opportunity to hold the NEDs to account for the performance of the Board. Feedback was requested on the proposal in advance of the meeting and so far has been in agreement.

The recommendation for 'Holding to Account' training was following the last training event and this will include training on induction and a full course every 2 years. There was general support for this element.

There was general support for a private Council of Governors meeting. The Trust will provide a room for an agreed date and location.

There was a difference of opinion around Divisional Reference Groups allocation for three years. The Company Secretary explained that any governor can raise a concern if they don't believe it is working or if they would like to change and this would be accommodated where possible.

The Chairs Information Exchange meeting was discussed. The Company Secretary highlighted that only the Chairs of the Divisional Reference Group currently attend this meeting and therefore are privy to information that is not open to all. By circulating the Summaries on a Page from each DRG and extending the private session with the Chair it is hoped that this will give greater opportunity for all governors to have access to information. As a result it was agreed to cease the Chairs Information Exchange meeting.

The Company Secretary provided re-assurance the feedback has been received from some of the governors not in attendance.

OUTCOME: The Council of Governors **APPROVED** the proposal for future Council of Governors meetings

30/18 UPDATE FROM BOARD SUB COMMITTEES

The updates from Board Sub-Committees were deferred to the next full meeting

a. QUALITY COMMITTEE
b. CHARITABLE FUNDS COMMITTEE
c. PATIENT EXPERIENCE AND CARING GROUP

OUTCOME: The Council of Governors Sub Committees/Groups updates were **DEFERRED** to the next full meeting.

32/18 INFORMATION TO RECEIVE

a. Updated Council Calendar – The updated Calendar was noted.

33/18 ANY OTHER BUSINESS

Paul Butterworth raised a concern that to receive incremental pay staff need to have undertaken their appraisal; however, staff who haven't undertaken an appraisal are still receiving increments. This will be raised with Workforce Committee and the Company

Secretary will provide a response to Paul Butterworth.

ACTION: Company Secretary

DATE AND TIME OF NEXT MEETING
Date: Thursday 19 July 2018 commencing at 4.00 pm
Venue: Large Training Room, Learning Centre, CRH

Date: Thursday 19 July 2018 – Joint BOD/COG Annual General Meeting commencing at 6.00 pm
Venue: Large Training Room, Learning Centre, CRH

APPENDIX A

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 4PM ON THURSDAY 19 JULY 2018 IN THE LARGE TRAINING ROOM, LEARNING CENTRE, CALDERDALE ROYAL HOSPITAL

PRESENT:

Philip Lewer	Chair

Publicly Elected Governors

Stephen Baines	Constituency 5
Annette Bell	Constituency 6
Paul Butterworth	Constituency 6
Diane Hughes	Constituency 3
Brian Moore	Constituency 8 / Lead Governor
Lynn Moore	Constituency 7
Alison Schofield	Constituency 7 (+ Carer)
Kate Wileman	Constituency 4 (Reserve Register)

Staff Governors

Linzi Smith	Constituency 11

Stakeholder Governors

Felicity Astin	University of Huddersfield

IN ATTENDANCE:

Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates & Facilities
Victoria Pickles	Company Secretary
Amber Fox	Corporate Governance Manager (minutes)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Veronica Maher	Public Elected – Constituency 4
Brian Richardson	Public Elected – Constituency 5
Rosemary Hedges	Public Elected – Constituency 1
John Richardson	Public Elected – Constituency 3
Dr Peter Bamber	Staff Elected – Constituency 9
Sian Grbin	Staff Elected – Constituency 13
Rory Deighton	Nominated Stakeholder – Healthwatch Kirklees

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. UPDATE ON WHOLLY OWNED SUBSIDIARY

The Company Secretary explained that at the previous Council of Governors meeting it had been agreed to set up a special meeting to discuss the item on

proposed changes to the Trust's Constitution regarding staff membership.
Since the previous meeting there had been a number of emails from Governors setting out their views on whether or not staff employed by the Wholly Owned Subsidiary should be included within the staff membership of the Trust. The Chair highlighted that to make changes to the Trust's Constitution there needs to be support from 50% of the Council of Governors prior to ratification by the Trust Board and then final approval by NHS Improvement.

The Company Secretary described the original recommendation which was to include all staff that work or will work for the WOS to be classed in the staff member constituency within the Trust membership. She explained that Brian Moore had shared an alternative recommendation to also include ISS staff. The Company Secretary described the challenge of this given the different contractual relationship between the Trust and companies who provide services within the PFI building.
The Company Secretary shared an alternative recommendation put forward by Peter Bamber which suggested that existing staff that transfer into the WOS should continue as members of the staff consistency; however, this would not apply to any new staff employed by the WOS. This has been seconded by Sian Grbin who also urged caution from the Council of Governors.

Brian Moore's second recommendation is the same rules to apply for any individual employed by any organisation e.g. portering, full time or part time (min 8 hours per week) in the Trust or a company that services the Trust for a minimum of 12 months, working at the Trust and associating Trust sites. The Company Secretary confirmed the Digital staff e.g. THIS and HPS are employed by the Trust and are on the Trust payroll; therefore, they are already staff members of the Trust.
The difference with ISS is that they are contracted through the PFI provider and have no direct contractual arrangement with the Trust. The Executive Director of Planning, Estates and Facilities explained the Trust would need to ask ISS and Engie whether they would agree to open up membership to their employees.
Discussion took place around the role of members and their ability to elect a governor and the impact this has on the ability to influence the way in which colleagues are supported. As a wholly owned subsidiary, the Trust will still have the ability to influence.

Stephen Baines highlighted that it could be considered part of the terms and conditions of the staff that are due to TUPE into the WOS and therefore they should be able to remain members of the Trust. Alison Schofield added existing staff who are transferring over should take membership with them as it is important to feel valued.

The recommendation that staff membership should apply to any employee TUPED across as part of their terms and conditions will remain members of the Trust and any new employees joining the organisation will not be eligible to join. This was seconded by Stephen Baines, Annette Bell and Paul Butterworth. It was agreed to

remove 1.4.1 of the paper and provide the proposed rewording.

Paul Butterworth noted any staff employed by ISS should be informed about their right to become a public member of the Trust. The Company Secretary agreed to take this forward.

ACTION: Company Secretary

OUTCOME: The Council of Governors **APPROVED** the amendments to the Trust Constitution subject to the change to 1.4.1
The Company Secretary thanked the governors for their important contributions.

33/18 ANY OTHER BUSINESS

The Company Secretary explained that at the previous Council of Governors meeting there had been a request that governors be asked to declare their agreement / disagreement of the WOS. Responses have been received from most but not all and there had been some requests to only share anonymized information.

The responses from those who have declared are as follows:

- Agree - 6
- Disagree - 6
- Neither agree or disagree - 2

It had also been agreed at the previous meeting to provide feedback to the Company Secretary on the car parking proposal. The Company Secretary thanked governors for their responses and explained that these would be shared with the Board at the same time as the car parking proposal so that Board members understand the views of the Council of Governors.

Linzi Smith highlighted staff that pay for permits out of their salary have been told they need to pay again at Princess Royal. The Executive Director of Planning. Estates and Facilities explained the Trust don't own Princess Royal; however, staff should be able to claim on parking.

Kate Wileman raised the importance of governors getting together with the Non-Executive Directors to hold them to account and believes this should be mandatory.

The Chair provided a further update on the response to the Secretary of State letter. A workshop will be held in private with the Overview and Scrutiny Panel next Tuesday 24 July. The Company Secretary explained our regulators and CCGs are working towards a tight time scale of 4 weeks. The meeting between NHS England and NHS Improvement is taking place on Monday afternoon; the Company Secretary will share an update following this meeting.

ACTION: Company Secretary

Paul Butterworth referenced the email asking for the governor's views on meetings. The Company Secretary responded this is being turned into a Programme based on the feedback received and will be shared at a future meeting.

DATE AND TIME OF NEXT MEETING

Date: Thursday 18 October 2018 commencing at 4:00 pm
Venue: Boardroom, HRI

The Chair formally closed the meeting at 16:46 pm and invite attendees to the next meeting.

Brian Moore thanked the Governors for attending this extra-ordinary meeting.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Tuesday 10 July 2018, 2.30pm – 4.30pm, Room 4, 3rd Floor, Acre Mill Outpatients, Huddersfield

PRESENT:

Mel Addy	Director of Operations, S&A
Rob Aitchison	Director of Operations, FSS
David Anderson	Non-Executive Director
Stephen Baines	Council of Governors
Chris Burton	Staff Side Chair
Suzanne Dunkley	Executive Director of Workforce and Organisational Development
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director (Chair)
Azizen Khan	Assistant Director of Human Resources
Diane Marshall	Human Resources Manager
Charlotte North	Assistant Director of Human Resources
Vicky Pickles	Corporate Secretary (dial in)

IN ATTENDANCE:

Michelle Bamforth	Head Nurse for Professional and Workforce Development
Dr Talal Ezzo	Consultant in Cardiology/Specialty and Associate Specialist (SAS) Tutor
Adam Matthews	Workforce Information Analyst

61/18 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

62/18 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
David Birkenhead, Medical Director
Jackie Murphy, Chief Nurse
Chris Burton, Staff Side Chair
Jason Eddleston, Director of Workforce and Organisational Development
Claire Wilson, Assistant Director of HR
Will Ainslie, Director of Operations, Surgery & Anaesthetics Division
Ashwin Verma, Divisional Director, Medical Division
Asif Ameen, Director of Operations, Medical Division
Debbie Wolfe, Head of Therapies

63/18 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

64/18 **MINUTES OF MEETING HELD ON 11 MAY 2018:**

The minutes of the meeting held on 11 May 2018 were approved as a correct record.

65/18 **ACTION LOG (items due this month)**

Items due this month were discussed in the meeting.

MAIN AGENDA ITEMS

FOR ASSURANCE

66/18 **Workforce Good News Story**

Dr Talal Ezzo attended the meeting to explain about the Trust's success in the development of SAS doctors' career progression, recruitment and retention.

Dr Ezzo was concerned at the SAS doctors' lack of career progression opportunities. Dr Ezzo approached the Divisional Director in Medicine and other senior clinicians to discuss the challenges this group of doctors' face. The meeting resulted in the establishment of a Certificate of Eligibility for Specialist Registration (CESR) Support Group. The CESR process allows doctors to achieve their Certificate of Completion of Training (CCT) and gain entry onto the GMC specialist register which provides essential requirements to apply for a consultant post at CHFT.

There are currently 3 pilot sites in the Trust – Emergency Medicine, MAU and Gastroenterology.

Work undertaken at CHFT has been recognised by Health Education England (HEE) as a good example of SAS doctors wanting to progress their career to consultant level. HEE has awarded CHFT £30k to implement the principles of the HEE SAS development and retention programme within Emergency Medicine - where the Trust experiences great difficulties in providing senior doctor presence.

In addition, NHS Employers was also impressed with the work at CHFT and published a case study on its website.

Dr Ezzo reported the positive effects the programme is creating, morale is higher and it is seen as a real culture change. The programme at CHFT has also sparked interest from other Trusts.

The Committee both congratulated and thanked Dr Ezzo and those involved on their great success in the programme and suggested this good news story should be a comms article for the whole Trust to hear about.

ACTION: VP to write a comms good news article.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the CESR Programme.

67/18 **WORKFORCE PERFORMANCE REPORT**

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

AM provided an overview of the main highlights from the June 2018 report.

- 42.01 new starters – increase from previous month
- 40.25 leavers – slight decrease from previous month
- Turnover decreased slightly from May 2018
- Sickness absence lowest rate in 5 years at 4.07% (May 2018 figures) with June's data looking to decrease further.
- There has been an increase in return to work interviews but still below target.
- 94.19% appraisal compliance
- 15 active employment cases

AG queried the length of time between conditional and unconditional offer of employment. It was noted the length of time attributed to the recruitment of the overseas nurses seemed to

be a significant factor in the time to hire data.

SD highlighted the focus on reducing long-term sickness absence. HR BPs continue to work closely with their Divisions in supporting colleagues to return to work. MA and RA both highlighted the effectiveness of the HR BPs move into their respective Divisions.

ACTION: AM to explore possible factors skewing time to hire data.

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

68/18 **WORKFORCE METRICS**

A data slide for each workforce metric had been shared with Committee members ahead of the meeting.

a. Recruitment and Retention

730 new starters between 1 July 2017 – 30 June 2018: 15% left already.

Initiatives include:-

- Working group to focus on recruitment and retention of medical workforce
- Task and finish group established to review leaver survey structure and new starter survey to be introduced
- Analysis of starter and leaver surveys used to review processes and determine interventions
- Corporate induction
- Ensure colleagues are welcomed and feel part of a team

ACTION: AM to include percentage figures for the 8 staff groups.

b. Health and Wellbeing (including attendance)

- Sickness absence 4.07%. Model Hospital shows we are green.
- Average of 14.85 days lost per employee over 12 months.
- cost of sickness for May 2018 = £558k.
- 30% of absence attributed to anxiety/stress/depression/other psychiatric illness. Health and wellbeing strategy to examine these issues.

c. Colleague Engagement (including staff Survey, IIP and FFT)

2017 Staff Survey results – allow colleagues to respond to the results.
IIP progressing to Silver – last strap of process is census survey plus interviews with 50 colleagues. Continue with journey to Platinum as part of our journey to 'Outstanding'.
FFT – go back to sample survey to improve response rates.

d. Essential Safety and Essential Skills Training

Essential Safety Training (EST) – previously mandatory training

Essential Skills – required for particular role

Target will remain at 95%

e. Appraisals (Compliance and Quality)

Overall target achieved.

Focus on quality – 2017 Staff Survey results show CHT below national average for acute Trusts.

f. Agency Spend

£180k below the planned position for agency spend as at 31 May 2018.

- Working group to focus on recruitment and retention of medical workforce.
- Close monitoring of performance indicators
- Divisions to agree budgeted establishments
- Input from divisional Finance colleagues, HR Business Partners and Business Intelligence Team to enable better monitoring of recruitment activity

g. Skill Mix/Calderdale Framework (CF)

The 6 service areas are progressing. The CF facilitator training commences on 13 September 2018.

h. Equality and Diversity Proposed Targets

Targets given are based on WYAAT averages. CHFT to agree its targets at the October 2018 Hot House.

BAME:
48.6% of Medical and Dental colleagues are BAME background.
Low percentage (9.86%) in senior manager roles.
15.81% of CHFT colleagues are BAME background. WYAAT average target is 17.27%.

Disability:
Work progressing to increase disclosure of disability.

Gender:
80% of CHFT workforce are women. WYAAT average target is 77%.

Sexual Orientation:
LGBTQ forum being established to be led by colleagues and supported by the Trust.

ACTION: Agreed targets to be shared with the Committee.

WRES report

The draft report had been circulated with papers to the Committee meeting for review and approval prior to submission to the Executive Board and Board of Directors for information. The WRES Report will be published before 28 September 2018.

AK explained the 9 indicators for measurement of the report, 4 x linked to workforce, 4 x linked to NHS Staff Survey results plus one other regarding Board representation.

Indicator 1 result: Overall the Trust has 15.2% of its workforce from a BME background compared to 14.6% in the previous year.

Indicator 2 result: The data shows that the period April 2017 to March 2018 the likelihood of BME staff being appointed after being shortlisted has increased. Overall however White staff are now even more likely to be appointed than BME staff.

In response to Indicators 1 and 2 above the action plan commits to improving recruitment processes and look to include a BME person as a panel member for Band 7 and senior

management appointments.

Indicator 3 result: The information shows that the possibility of a BME colleague entering the disciplinary process is over twice as likely as a White colleague. An increase from the previous year. The action plan indicates that a robust case management process is in place.

Indicator 4 result: The data shows that the uptake of non-mandatory training is consistent across the workforce. The action plan confirms that the Inclusive Mentoring programme concluded on 11 July 2018 and the Trust has trained 6 individuals to roll out the programme. In addition, the launch of a comprehensive development programme for Agenda for Change pay bands 2 – 7 (clinical and non-clinical) to support them in career progression / promotion.

Indicator 5 result: The average (median) percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months within acute Trusts is 28%. In comparison the Trust's ranking is below (better than) the average. The latest survey shows the percentage has seen a significant increase (+7.25%) when compared to the previous year.

Indicator 6 result: The average (median) for BME staff experiencing harassment, bullying or abuse from staff within acute Trusts is 27%. In comparison the Trusts ranking is below (better than) the average. White staff have reported a slight reduction when compared to the previous year, while BME staff have shown an increase from 23.08% to 25%.

Indicator 7 result: The average (median) for BME staff within acute Trusts believing that the Trust provides equal opportunities for career progression or promotion is 75%. In comparison the Trust's ranking is below (worse than) the average. White staff have seen a small increase when compared to the previous year. BME staff have seen a significant drop from 76.47% to 68.48%.

Indicator 8 result: The average (median) for BME staff within acute Trusts who in the last 12 months have personally experienced discrimination at work from Manager/team leader or other colleagues is 15%. In comparison the Trusts ranking is above (worse than) the average. White staff have seen a marginal increase. While BME staff report a significant increase in discrimination.

Indicator 9 result: No change in the BME composition of the Board from 2016/2017 to 2017/2018.

The Committee discussed the results along with the associated actions. Subject to the following actions the Committee approved the report for submission.

ACTION: AK to incorporate into the Action plan to improve recruitment and selection processes by including a BME person as a panel member for all Band 6, 7 and 8a interviews.

AK to incorporate unconscious bias into recruitment and selection training.

TR to note progress of Action Plan to be discussed at the January 2019 Committee Meeting.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the report for publication.

69/18 **CQC POST INSPECTION ACTION PLAN – CONFIRMATION OF AND PROPOSED MONITORING OF WORKFORCE ACTIONS**

SD advised that post CQC Inspection an action plan had been drawn up with actions identified and linked to the relevant Board Sub-Committee with responsibility for monitoring

progress.

The actions allocated to the Workforce Committee were agreed by the Committee with progress to be monitored at each Committee meeting.

ACTION: TR to add CQC Post Inspection Action Plan as a standing agenda item.

OUTCOME: The Committee **RECEIVED** and **AGREED** the proposal.

70/18 **QUARTERLY ESCALATION FROM PRMS**

SD confirmed the Workforce Committee will act as an escalation platform where Divisions will be asked to provide assurance to the Committee that any workforce issue off track has a plan in place to bring back on line.

SD advised there are no escalation issues at this time.

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

ITEMS TO RECEIVE AND NOTE

71/18 **ANY OTHER BUSINESS:**

Following the June 2018 Apprenticeship Hot House, SD advised that the outputs from the event have been integrated into the Apprenticeship teams to progress. Apprenticeship career ladders will be produced for sharing at a future Executive Board.

72/18 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

73/18 **DATE AND TIME OF NEXT MEETINGS:**

Health and Wellbeing Hot House: 7 August 2018, 2.30pm – 4.30pm, Learning & Development Centre, HRI

Equality Diversity & Inclusion Hot House: 5 October 2018, 9.30am – 11.30am, Learning & Development Centre, HRI

Workforce Committee: 8 October 2018, 1.30pm – 3.30pm, Room 4, Acre Mills Outpatients

Recruitment & Retention Hot House: 7 December 2018, 9.30am – 11.30am, Learning & Development Centre, HRI

25. Date and time of next meeting

Thursday 1 November 2018, 9:00 am (Public)

Venue: Large Training Room, Calderdale Royal Hospital