Board of Directors

Schedule	Thursday 7 March 2019, 9:00 — 12:00 GMT
Venue	Boardroom - HRI
Organiser	Amber Fox

Agenda

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1. Welcome and introductions:

To Note

Presented by Philip Lewer

2. Apologies for absence:

Helen Barker, Mandy Griffin

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Approve

4. Minutes of the previous meeting held on 3 January 2019

To Approve

Presented by Philip Lewer

DRAFT Minutes of the Public Board Meeting held on Thursday 3 January 2019 at 9am in the Large Training Room, Calderdale Royal Hospital

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Gary Boothby	Executive Director of Finance
Alastair Graham	Non-Executive Director
Jackie Murphy	Chief Nurse
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Karen Heaton	Non-Executive Director
Andy Nelson	Non-Executive Director
Helen Barker	Chief Operating Officer

IN ATTENDANCE

Amber Fox	Corporate Governance Manager (minutes)
Victoria Pickles	Company Secretary
Mandy Griffin	Managing Director – Digital Health
Ruth Mason	Associate Director of OD & Training (on behalf of Suzanne Dunkley)
Renee Comerford	Nurse Manager, Frailty Team (Patient Story)

OBSERVERS

Paul Butterworth	Public Elected Governor
Jude Goddard	Public Elected Governor
Rosemary Hedges	Public Elected Governor
Alison Schofield	Public Elected Governor

1/19 Welcome and introductions:
The Chair welcomed everyone to the Public Board of Directors meeting.

2/19 Apologies for absence:
Apologies were received from Richard Hopkin, Suzanne Dunkley and Anna Basford.

3/19 Declaration of Interests
There were no declarations of interest.

4/19 Minutes of the previous meeting held on 6 September 2018 & 1 November 2018
The minutes of the previous meeting held on 6 September 2018 were approved as a correct record subject to a highlighted change to the wording on page 12, at a request prior to the last Board meeting by Paul Butterworth. The Chair reminded the Board the minutes are not verbatim minutes.

The minutes of the previous meeting held on 1 November 2018 were approved as an accurate record subject to the following amendments:

Page 5 – Winter Plan to be re-worded by the Chief Operating Officer
Page 10 – Reconfiguration paragraph to reference the 'Safer Programme'
AOB – Andy explained the Performance Review meetings were useful and encouraged Non-Executive Directors to attend.

OUTCOME: The Board **APPROVED** the minutes from the previous meetings held on 6 September 2018 and 1 November 2018.

5/19 Action log and matters arising

The action log was revised and confirmed as up to date.

6/19 Chairman's Report

The Chair updated the Board on the work he has been involved in since the last meeting.

The key highlights were:

- Involved in attending Quality Friday visits with the Chief Nurse
- Attended several Board to Ward visits which are helpful in getting to know how the hospital works and meeting colleagues around the Trust.

7/19 Chief Executive's Report

The Chief Executive acknowledged the progress made by the Calderdale Council Children Service Team who had recently been assessed and rated good overall with some outstanding features. He highlighted the importance of partnership. The Chief Executive also acknowledged Leeds Council's Childrens' Services had been rated as outstanding following a service level inspection. Linda Patterson added the Trust work very closely on safeguarding and have developed good relationships and it is positive to see this progress.

The Chief Executive reported an Integrated Care System meeting is taking place next week which is considering all partners of the ICS to get behind an initiative to support child sexual exploitation and how support can be provided. It is important to note the Trust are part of this progress.

The Chief Executive was invited to a meeting alongside other Chief Executives and accountable officers for Clinical Commissioning Groups, hosted by Simon Stevens, Chief Executive for NHS England and Ian Dalton, Chief Executive for NHS Improvement to discuss the long term plan. The Chief Executive highlighted the different ways of working will be challenging. There will be a focus on the fiscal reality and the financial position will remain challenging. There is an opportunity to assist acute providers with their financial position. There was reference to mental health providers and the expectation to be clear on this role. There was also a discussion on the preparation for Brexit.

Andy Nelson asked if there has been any further update on reconfiguration. The Chief Executive responded the Trust is talking with the regulators and scrutiny and the next steps will be further development on the Strategic Outline Case. The Trust will expect to receive further clarity on the next steps in the coming weeks.

8/19 Patient Story – Renee Comerford

Renee Comerford, Nurse Consultant for the Frailty Team shared a story demonstrating the impact of the frailty service in its first 12 months of operation. She explained that this was just one of several stories demonstrating the work of the team. Renee provided some background on the frailty service which is an integrated service linked with community and mental health and aims to provide a better pathway of care for patients who are frail or at the end of life.

Renee described a complex patient case of a gentleman who was a frequent attender and was not admitted to frailty as he was too unwell. The frailty team reviewed the patient who discovered the patient had delirium and a Deprivation of Liberty Safeguards (DOLS) was put in place. The frailty team decided to discharge the patient safely home with a family member and his delirium had resolved within half an hour. An advanced care plan was put into place and he has not been re-admitted to hospital since. On review of this patient story, the frailty team prevented a long admission, invasive treatments, poor patient experience and his delirium worsening. Renee highlighted the importance of

community care for palliative and mental health patients.

The Managing Director for Digital Health asked if there is anything more digitally that could help with the process. Renee said it's great that the team can see what's been happening to patients in ED electronically. The community team can also view SystmOne and are in conversations with Locala to enable them to write in the record for advanced care plans. Renee added mental health patients will be on SystmOne in the coming months.

The Chief Executive asked if mental health patients can leave the hospital undiagnosed. Renee confirmed patients can leave the hospital undiagnosed and delirium was not being reviewed by mental health. The Chief Executive asked the Chief Nurse and Chief Operating Officer to work with Renee on this and to work with the Chief Operating Officer to expedite the use of SystmOne.
Action: Chief Nurse / Chief Operating Officer

The Chief Executive asked why this could this not have been done 12 months ago. Renee explained the improvements that have been made which include:

- MDTs are working in collaboration
- Improvement in relationships
- Less working in isolation
- Team have learned from patient stories and continue to learn
- Fortnightly frailty meetings take place where all services come together to learn from experience
- Yorkshire Ambulance Service (YAS) play an important role in this

The Chief Nurse highlighted the progress that has been made so far with a Work together to Get Results exercise on mental health. The Chief Nurse added the Trust have struggled with advanced care plans and asked how this is progressing. Renee explained an exercise is taking place to train all staff on advanced care planning.

Linda Patterson stated the Trust should be completing dementia screening and a piece of work is taking place in the Community, led by Sal Uka and supported by Anne-Marie Henshaw as part of the Medical Initial Screening Programme deep dive. Dr Barbara Schofield is assisting with this improvement. The Chief Executive asked that this piece of work has a clear deadline for completion.

OUTCOME: The Board **NOTED** the patient story and thanked Renee and her team for the hard work to develop and deliver this service.

9/19 Update on the Care Quality Commission (CQC) Action Plan

The Chief Nurse presented the position on the CQC action plan as of 16 December 2018. There was a total of six must do actions completed, one on track which had since been completed, and two not progressing. These two actions relate to critical care and provision of an intensive care consultant at CRH, a proposal is being presented to Executive Board.

The Chief Nurse highlighted the positive progress from amber to green on the should do actions.

The CQC actions are reported through Divisional Performance Review meetings, the CQC Response Group and Divisional Performance, Safety and Quality Boards and describe the actions required to get to an outstanding CQC inspection.

Alastair Graham asked for an update on the intensive care staffing. The Chief Nurse

responded the recommendation was for specific anaesthetist cover at CRH. A paper was produced by the clinical team in critical care to understand the cost of this action and any mitigations. Given the change in service, the Executive team will be asked to decide whether to support this must do action. The Executive Director of Finance raised the issue regarding affordability and ability to recruit. The Chief Operating Officer re-assured the Board the Trust have had no incidents reported of harm on the current rota in place. Evidence can be presented if this is investigated further. A piece of work is imminent to take the clinical team through this evidence base process.

The Chief Executive asked how realistic it is to complete these actions by the end of March 2019. The Chief Nurse described the element of risk to drive the evidence to sustainability and the extra task of quality improvement to move the actions into blue to be maintained with evidence. Discussions are taking place at the CQC Response Group to support that the change has been sustained for must do and should do actions. Linda Patterson provided assurance the Quality Committee review the CQC action plan in more detail of timelines and concern on delays were escalated and are now on track. She also highlighted there is nothing of concern in the projected timelines. Andy Nelson asked if the CQC actions could be described as 'on track' or 'off track' in the next update. The Chief Nurse confirmed the action on ligature rooms is on track and completed.

OUTCOME: The Board **NOTED** the update on the CQC action plan.

10/19 High Level Risk Register

The Chief Nurse presented the High Level Risk Register and highlighted the new risks which are:

- 7338 (15) – The risk of an incomplete Electronic Patient Record due to clinicians failing to commit a clinical entry to the electronic system in a timely manner, due to an ability to 'save' an entry on to the system which is not submitted to the patient record until the 'signed' option is selected.
- 6829 (16) – The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispending Service to provide the required number of aseptically prepared parenteral medicines.
- 3793 (16) – Risk of delays for patients on the pending list in Ophthalmology requiring follow up appointments due to clinical capacity and consultant vacancies.
- 5511 (15) – Collective Fire Risk – There is a risk of increased fire spread at HRI due to inadequate Capital Funding for refurbishment work and subsequent fire compartmentation in ceilings; risers and ducts resulting in potential fire spread leading to damage to buildings, staff, patients, visitors and contractors and a failure to deliver clinical services.

Risks with a reduced score:

- 7318 (10) – CHS – This score had reduced from 15 to 10 due to urgent stone cladding repair work which has now taken place. The remaining cladding around the HRI is covered under another risk.
- 6949 (12) – The risk of the inability to deliver a two site Blood Transfusion / Haematology service has reduced from 15 to a 12 as two more staff have joined the rota and training continues with other identified staff.

Alastair Graham raised concern with risk 7318 being removed from the high level risk register as there are significant potential issues. The Executive Director of Finance explained due to timings the new risk is not yet on the risk register. The Company Secretary highlighted the results of the six facet survey will be used to reassess the estates risks.

Alastair Graham asked if the risk to patient records not being signed is an ongoing problem or has been fixed with only the backlog to clear. The Chief Nurse explained this is still being explored and the total was around 65k. The biggest issue is that the author may no longer be with the Trust; therefore, the risk is getting this incorporated into the patient record. The Managing Director for Digital Health explained this is a known Cerner issue that the Trust were not informed about. To date no harm has been identified. The Chief Nurse highlighted there is a risk this problem is still occurring which is an end user issue. Similar numbers are occurring in Bradford Teaching Hospitals.

Alastair Graham suggested incorporating the no deal Brexit scenario into the Risk Register.

Collective Fire Risk 5511 - The Chief Operating Officer mentioned the Capital Programme has allocated £450k to fire and asked if consideration can be given to re-assessing the risk. The Chief Executive asked if the revised risk be circulated to the Board for consideration.
Action: Circulate revised wording for risk 5511 to the Board following the Risk and Compliance Committee on 14 January – Chief Nurse

It was noted the Estates / Resus risk at HRI with a score of 20 is not in the Capital Programme and there was a suggestion the risk register is reviewed against the Capital Programme before final sign off. The Executive Director of Finance confirmed the risks were reviewed at the Joint Liaison Committee where a set of risks for CHS and CHFT were agreed. After an assessment of the ICU and resus risk, this will not be seen as a score of 20 and a proposal will go to the Risk and Compliance Committee on 14 January.

Andy Nelson asked if there will be a further discussion on the risk appetite statement and how the Risk Register and the Board Assurance Framework work together. The Company Secretary confirmed the risk appetite is based on the Board workshop which took place in October. The Risk Strategy is being reviewed at the Audit and Risk Committee and a discussion can take place on risks that don't move.

Karen Heaton re-iterated the concern on the collective fire risk 5511. Karen raised concern in the increase to risk 7240 around lack of budgetary control. The Executive Director of Finance explained the financial challenge has been flagged by the surgical division and escalation has been in place for 8 weeks. Meetings are taking place with the clinical teams to agree action plans.

Phil Oldfield asked if there was an opportunity to review the score of risks 6345 and 7078 regarding the nursing and medical workforce. The Medical Director explained significant gaps remain in areas such as Ophthalmology, Gastroenterology and Rheumatology is being mitigated by high agency spend. He highlighted there are still some very challenging areas in terms of medical workforce. The Chief Nurse confirmed there are still several gaps in the nursing workforce. She agreed to review the wording and mitigation of this risk to describe the degree of movement. This is still a high risk; however, there is an opportunity it could reduce from 20.

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

11/19 Director of Infection, Prevention and Control Quarterly Report

The Medical Director presented the quarterly Director of Infection, Prevention and Control report which covers the period from 1st April 2018 – November 2018. The key highlights were:

- From 1st April to end of November there have been 15 cases of C-difficile; compared to 19 for the same time period last year, November and December had

just 1 case which is an improvement
- There have been reductions in E. coli bacteraemia, CHFT participated in a summit with Community Partners and CCGs to reduce E. coli and sepsis which remains challenging
- There have been 2 MRSA cases attributed to the organisation
- Norovirus has been seen in the organisation; however, it is less than expected in previous years
- Influenza is increasing in the community and presenting to hospital, there might be challenges over the next few months
- The Trust had an external visit by NHSI following the increase in C. difficile rates from Quarter 1 & 2, the visit included interviews with the Deputy Chief Nurse, Infection Prevention Doctor and Matron, overall feedback was positive from the review

OUTCOME: The Board **APPROVED** the quarterly Director of Infection, Prevention and Control report.

12/19 GMC Survey 2018

Dr Sue Crossland, Director of Medical Education presented the results from the GMC survey in 2018. Over 70k took part in the national survey this year. Response rate for the Trust was 100% for the second year running. The feedback is rota gaps remain the most important element from Junior Doctors.

The key highlights for CHFT are:
- CHFT's score has dropped slightly from 80.46 to 77.51 and the Trust are now the 7th highest in the region out of 16, compared to 5th last year
- Slipped in satisfaction rates which are still high overall
- Acute Internal Medicine training is the best in region for overall satisfaction
- Emergency medicine rates are very high
- Improvements have been made in Ophthalmology from last year
- Urology has been a problem in the last few years, these concerns are being addressed
- Obstetrics and Gynaecology are a pink outlier in region, the Deanery recognise that O and G, whilst still scoring poorly, are not a significant outlier within the region and continue to work with the Deanery to improve trainees' experience, O and G training will be reviewed in January 2019 to see if any improvements can be made
- Core medical training is rotating with registrars
- Overall a positive survey and a breakdown of each specialty has been shared with leads

Karen Heaton observed the scores for most have reduced and raised concern about the national theme of the 'burnout' comment which stood out. She asked what happens to the data from the national survey and if it is acted upon locally and nationally. Dr Sue Crossland confirmed it is locally acted upon and nationally by the Royal College Of Medicine, Surgery etc. with a strategy to improve.

Linda Patterson observed the hygiene factors e.g. access to food, accommodation, forums as juniors can often be isolated and asked if the Trust should do more. The Trust recognise out of hours provision is important to this role. The Medical Director responded the Guardian of Safe Working is leading a forum to review what came out of the survey and is developing an action plan.

Action: Medical Director to work with the Managing Director for CHS on the out of hours facilities

The Managing Director for Digital Health asked if the hygiene factors are like other Trusts. Dr Sue Crossland explained that Bradford's canteen is open in evenings; however, most other Trusts rely on the same as CHFT.

The Chief Nurse added that the same problem applies to nurses who rarely leave the ward, this requires a bigger conversation in terms of wellbeing and out of hours.

Alastair Graham asked if there have been any lessons regarding core medical training following the reconfiguration in September / October. Dr Sue Crossland explained these results were before the reconfiguration and the outcome will be reviewed in the survey results in May / June 2019.

OUTCOME: The Board **APPROVED** the 2018 GMC Survey.

13/19 Nursing and Midwifery Hard Truths Requirement

The Chief Nurse presented the bi-annual safe staffing audit which demonstrates a robust mechanism is in place to set and monitor nursing and midwifery staffing levels.

The Chief Nurse highlighted the key points from the report:

- Shifts are being filled by qualified nurses or HCAs and CHFT maintains a stable position
- Spike in numbers of staff in September due to supernumerary nurses starting
- There has been a conversion from HCAs to registered nurses
- Sickness turnover rates have improved and return to work sickness interviews are being undertaken
- Focused effort on recruitment and retention with a career pathway in the organisation
- CHFT are aiming to have 47 registered Nursing Associates by 2020
- Starting to advertise for qualified nursing associates as part of the recruitment campaign
- Employed 48 new graduates who joined the Trust between September and November 2018
- Nursing colleagues are getting used to safer staffing tool, reviewing acuity and dependency
- Risk area is ED, there is some guidance which is being progressed to understand the mitigation around quality of care
- Continue to monitor and improve nurse staffing position

Alastair Graham highlighted the opportunity to review overseas recruitment given the rule change around the English language test.

The Chief Operating Officer highlighted the positive activity on the respiratory and acute floor at CRH who are keen to work on care hours per patient per day.

Karen Heaton explained it is admirable with regards to overseas recruitment and building on the multiple routes. She stated retention is concerning as a national issue where the national answer is Nursing Associates. The Chief Nurse raised concerns many senior nurses are choosing to go on an advanced clinical route which leaves gaps in leadership.

The Chief Executive referred to risk 5511 (Fire Training) and table 6 on page 7 of the report, where there is a disconnect in terms of fire safety training. The nursing workforce has the largest number of employees; therefore, 82.22% fire safety compliance rate needs to be prioritised.

OUTCOME: The Board **APPROVED** the bi-annual Nursing and Midwifery Hard Truths report.

14/19 Safeguarding Update – Adults and Children

The Chief Nurse presented the Safeguarding update from April 2018 to September 2018. The key points to note were:

- DOLS legislation in a hospital setting is changing which looks at reducing the number of applications where a decision can't be made, for example ICU patients or a patient in need of life sustaining treatment
- Historically only children's safeguarding training was mandatory, however since the introduction of the Adult Intercollegiate Document the adult safeguarding is now on a statutory footing, this will be reviewed in Q3 and Q4
- Several Ofsted and CQC inspections have provided the Trust with several actions
- Importance of partnership working was highlighted
- CHFT have been awarded the West Yorkshire Domestic Abuse Quality Mark, this quality mark is awarded when there is consistent and high-quality service provision to women, children and men affected by domestic violence and abuse, ED departments have worked hard to achieve this
- There is lots of work to do around historical child exploitation cases
- Safeguarding is everybody's responsibility regardless of their role within the Trust

OUTCOME: The Board **NOTED** the Safeguarding update for Adults and Children.

15/19 Review of Progress against Strategy

The Company Secretary explained the progress against strategy was discussed at the joint Board workshop with the governors in November 2018.

The Trust are coming towards the end of the 5-year plan on a page and need to start thinking about the forward plan. Early thoughts will be discussed with the Board later this quarter.

16/19 Quality & Performance Report – November 2018

The Chief Operating Officer highlighted the key points of operational performance:

- Solid performance in December
- November's performance score improved to 70%, highest since July
- Risks around diagnostic where demand is up, and capacity is constraining
- Data quality paper is going to Quality Committee
- Essential safety training is still a challenge
- High nurse staffing sickness in December
- Positive month in November for the emergency care standard
- Cancer targets achieved in November and December
- Improved stroke across indicators
- Stranded care has improved, just missed 95%, experience is good
- There was 1 Never Event in November relating to a Gynaecology patient who had a retained gauze roll post-surgery

Alastair Graham noted the position is stabilising around 70% which is positive. He highlighted the 38 day referral to tertiary service performance was at 43% November and asked if this is being reviewed. The Chief Operating Officer confirmed this is a result of different issues in different complex pathways. A Cancer Board has been established and a patient pathway tracker role has been established which will be responsible for all escalation directly with the consultant which has made a difference.

Andy Nelson suggested it would be helpful to see the targets on the report and asked for

a progress update on the complaints process. The Chief Nurse confirmed several actions with complaints are progressing and there was a lower number of out of date complaints at beginning of December. There is a proposal going to Divisions to ask if they would support the change for a central complaints process.

OUTCOME: The Board **APPROVED** the Quality & Performance Report for November 2018.

17/19 Governance Report

The Company Secretary highlighted several governance items for review and approval by the Board.

- Board Skills / Competencies
  The assessment shows that we have a good balance of skills and knowledge across the executive and non-executive members of the Board. It does show that there is a need for the Board to undergo external training as corporate trustees of the Charitable Trust and this has been identified as part of the Charitable Funds Committee self-assessment and has been arranged for later in the year.

  Andy Nelson highlighted the weaker areas around clinical quality, interdependency and legal awareness. The Company Secretary explained provisions have been made for the Board to seek legal advice and where needed supported by a Trust Solicitor.

- Risk Management Strategy
  The Risk Management Strategy is attached following an annual review. The main changes relate to roles and responsibilities for risk management due to the establishment of Calderdale and Huddersfield Solutions.

  Andy Nelson asked if Security and Resilience should it be referenced in the structure.
  Action: Governance Structure to be updated

- Use of Trust Seal
  The use of the Trust Seal during the last quarter was shared.

- Attendance Register
  The Company Secretary pointed out the very good attendance at decision making Board meetings which provides continuity and strengthens the Board. There is not an expectancy for the Director of Partnerships and Transformation or Managing Director for Digital Health to attend; therefore, they will be removed from the attendance register.

- Board meeting dates
  The Board meeting dates for 2019 are attached for information.

- Board to Ward visits feedback
  The summary of the Board to Ward visits feedback between July and August 2018 was received. The Chief Executive commented on the areas of good practice identified and asked where the issues from the analysis are being escalated. The Medical Director explained this was initially an engagement piece. The Company Secretary explained the first six months of visits were brought to a Board workshop for discussion; however, there is no mechanism for following up on issues.

  The Chair asked how the Board to Ward visits relate to the Quality Friday visits. The Chief Nurse explained the quality Friday visits are more from a listening perspective and looking for things that need assurance. There was an agreement to try link these

two together.
Action: Process to be reviewed by Chief Nurse and Chief Operating Officer

The Chief Executive re-iterated the feedback received from the Non-Executives on how the Trust might improve reports and an opportunity how reports are presented and structured. Feedback will be shared at the next Board meeting in March 2019.
Action: Non-Executives to share feedback on Board packs, reports and structure

OUTCOME: The Board **APPROVED** the Risk Management Strategy and **NOTED** the governance update.

18/19 2019-20 Capital Plan Overview

The Executive Director of Finance asked the Board to note the capital plan overview for next year. The Trust has identified the capital plan totalling £9.4m that requires the disposal of assets to create the available resource, including the sale of Glen Acre and Acre House which was agreed at Executive Board before Christmas. It is estimated this will have a £1.8m revenue impact and there is a plan to go to market from September onwards. Residual risk remains; however, this is planned to be met through an Emergency Capital bid for the MRI scanner at Calderdale and an uncommitted £1m contingency reserve to be released as risks are realised.

Andy Nelson asked for more detail at the next Board or Committee on how the £20M capital works will be spent on resource for the business cases. He also asked for connectivity between the capital and the risk. The Executive Director of Finance explained the £22M originally quoted in the press release was based on the STP bid in June, not the final capital bid. Meetings are being scheduled to discuss the profiling of this spend.

Andy Nelson and the Managing Director for Digital Health highlighted a scanning solution will be explored in Cerner to reduce the need for EDMS.

OUTCOME: The Board **NOTED** the 2019-20 Capital Plan overview.

19/19 Financial Summary Month 8

The Executive Director of Finance highlighted the following key points:

- The year to date deficit is £26.6m
- Achieving the planned £43.1m deficit for this financial year
- £18m of CIP in the forecast to deliver
- Project Echo - £1m risk in delivery
- Higher expenditure than planned in month 8
- There will not be a level of CIP as seen in previous years

OUTCOME: The Board **NOTED** the financial summary for month 8.

20/19 2019-20 Annual Plan

The Executive Director of Finance stated the first plan is due by 14 January 2019. The control total will be provided early in the new year.

The annual plan draft submission is due by 12 February 2019.

OUTCOME: The Board **NOTED** the 2019-20 Annual Plan

21/19 Update from sub-committees and receipt of minutes & papers

<u>Quality Committee – minutes from meeting 29.10.18</u>

Dr Linda Patterson, Chair of the Quality Committee provided a verbal update from the last meeting which focused on the divisional reports on quality. The key points to note were:

- There have been three reported never events. The Committee has asked for some work in relation to this and will receive an update at the next meeting
- The Committee had reviewed the process around serious incidents to include an assessment of the risks relating to any delay in implementing the actions resulting from the incident. This had resulted in a more comprehensive report
- Good news had been received in relation to improved compliance in completing the assessments for sepsis
- The Committee had received the new report from the CQC called 'opening doors' which looks at how you promote a safety culture within an organisation. This will be considered by the CQC Group and divisions prior to coming back to the Board.

Finance and Performance Committee – minutes from the meeting 30.11.18

Phil Oldfield, Chair of the Finance and Performance Committee gave feedback from the meeting held 2 January 2019. The key highlights were:

- The Committee had looked at what had contributed to the good performance over winter
- Discussion had been held on the operational planning process and the work required to achieve the deadlines
- The Committee had received a report on the financial impact of implementing the CQC recommendations. Further work is being done on how this can be mitigated as well as address some of the challenges. This will go to Quality Committee for review prior to coming back to Finance and Performance Committee
- The Committee also looked at progress against the Use of Resources assessment and the need to consider what is within the Trust's power to influence and what is part of the underlying structural deficit

Charitable Funds Committee – minutes from meeting 28.8.18 & 29.11.18

Philip Lewer, Chair of the Charitable Funds Committee provided a verbal update from the last meeting, the key points to note were:

- Recruitment of a charitable fundraiser is in progress
- There is some work underway to update the web profile of the charity
- The Chair has visited areas that have received charitable funding to see the impact of the funding available

Any Other Business

The Chair informed the Board Victoria Pickles is leaving the Trust early February 2019 and this will be her last Board meeting. Vicky has been at the Trust for 5 years. He thanked Vicky for all her advice and guidance and formally passed on his appreciation on behalf of the Board for all of her hard work and dedication.

Date and time of next meeting

Thursday 7 March 2019, 9:00 am

Venue: Boardroom, Huddersfield Royal Infirmary

5. Action log and matters arising

For Comment

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 3 January 2019 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
3.1.19 17/19	**GOVERNANCE REPORT** Security and Resilience Group to be added to the Governance Structure	VP		January 2019		
	Review the Board to Ward visits with the Quality Friday visits to link these two together	JM/HB	The Board to Ward visits have been combined with the Quality Friday visits	March 2019		
	Non-Executives to share feedback on Trust Board packs, reports and structure (self-assessment)	NEDs	Feedback has been received and a new cover sheet has been developed			
3.1.19 12/19	**GMC SURVEY 2019** Medical Director to work with the Managing Director for CHS on out of hours facilities for Jr Drs	DB	See paper under matters arising – Catering Retail Survey	May 2019		
3.1.19 10/19	**HIGH LEVEL RISK REGISTER** Circulate revised wording for risk 5511 'Collective Fire Risk' to the Board following the Risk and Compliance Committee on 14 January 2019	JM		January 2019		
3.1.19 8/19	**FRAILTY TEAM** Work with Renee Comerford and the mental health team to review delirium so patients don't leave undiagnosed Expedite the use of SystmOne with Locala so the Community Team can write advanced care plans	JM / HB		March 2019		
1.11.18 157/18	**CQC ACTION PLAN** To update the next Board on progress with the CQC action plan (RAG rating).	JM	On the Board agenda on 3 January 2019. CQC will be a standing agenda item at every Board meeting.	January 2019		3.1.19
1.11.18 144/18	**DOMICILIARY VISITS CONSULTATION** To investigate the domiciliary visits consultation and see what is possible for the Trust.	HB	The review of the Domiciliary Visits policy has been completed and discovered the Trust don't have one, the Trust have undertaken some; however, when	January 2019		3.1.19

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			requested following an assessment by the Consultant and approved by the General Manager. The Trust are currently updating the Access Policy; therefore, this will build it into this going forward to ensure our Trust offer what's in the best interest of the patient.			
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 in June 2018 – Board skills and competencies to be brought to the Board in January.	January 2019		3.1.19

Calderdale and Huddersfield NHS Foundation Trust

BOARD MEETING – MATTERS ARISING	
PAPER TITLE: Catering & Retail Survey	**REPORTING AUTHOR: Alison Wilson**
DATE OF MEETING: 7th March 2019	**SPONSORING DIRECTOR: David Birkenhead**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • Financial Sustainability	**ACTIONS REQUESTED:** • To note under matters – action log
PREVIOUS FORUMS: Board of Directors – January 2019	

EXECUTIVE SUMMARY:

Purpose: To collect feedback from Trust colleagues in relation to the existing retail and catering facilities available across the Trust.

Background: Feedback was provided to Trust Board in January 2019 from the Junior Doctors Forum which related to catering facilities available to colleagues and particularly those working weekends and out of hours. Trust Board requested further information from colleagues which was obtained via a Trust wide survey which was live for 3 weeks during February 2019. A total of 386 responses were received along with recommendations from those completing the survey.

Overview:- The current service provision is as follows:-

HUDDERSFIELD ROYAL INFIRMARY

Contracts provided by Compass Medirest through CHS Ltd::-

Costa	7:45am – 8:00pm Mon - Sun
Amigo (Shop)	7:30am – 7:30pm Mon – Fri
	9:00am – 6:00pm Sat & Sun
Spice of Life (Restaurant)	7:00am – 5:00pm Mon – Fri
Acre Mills (Deli Marche Costa)	8:00am – 4:00pm Mon – Fri

Vending facilities provided by CHS Ltd through Wilkes and available at Main Entrance, A&E, Dining Room, Ortho OPD which provides an income to CHS.

League of Friends (LoF) provide services from Orthopaedic OPD.

CALDERDALE ROYAL HOSPITAL

CRH Contract provided by ISS through PFI Contract of which Restaurant & Bring Me Food provides a monthly guaranteed income to CHFT:-

Costa	7:45am – 8:00pm Mon - Sun
Ingleton Falls (Restaurant)	7:45am – 5:00pm Mon – Fri
Bring Me Food Service	8:00am – 2:00pm Mon – Fri

(staff & visitors ring & order food for delivery)

Vending Facilities available at Ingleton Falls entrance, (including microwave), ED (including Costa), Level 1, Maternity Reception and Children's ward parent's area.

WH Smith provided via Albany	8:00am – 8:00pm Mon – Fri 9:00am – 8:00pm Sat & Sun
League of Friends (Drinks & Snacks)	9:45am – 12:15pm Mon – Fri 1:30pm – 4:00pm Mon – Fri

ACRE MILL

Provided via Compass Medirest through CHS Ltd as follows:-

Deli-Marche Coffee Shop 8:30am – 4:00pm Mon – Fri

The survey was launched for a 3 week period in February to understand colleagues' views and proposals on the current retail and catering offer. Whilst the majority of responses were aware of the retail facilities available to them the majority only used the services once per week. A total of 28 (7%) responses were received from colleagues working out of hours which could include Junior Doctors however, it was felt more work was required to engage with this Group. Over 46% felt the selection of food provided did not offer a good variety and 77% felt purchases did not represent value for money.

Whilst over 63% of staff felt the facilities were open at appropriate times this was an expected outcome given the majority of staff who completed the survey responded as day staff. A total of 32% felt that healthy options were clearly signed with 33% feeling this was not clearly display and the remaining responses were unsure.

A free text option was included in the survey and the themes are summarised in fig 1 below:-

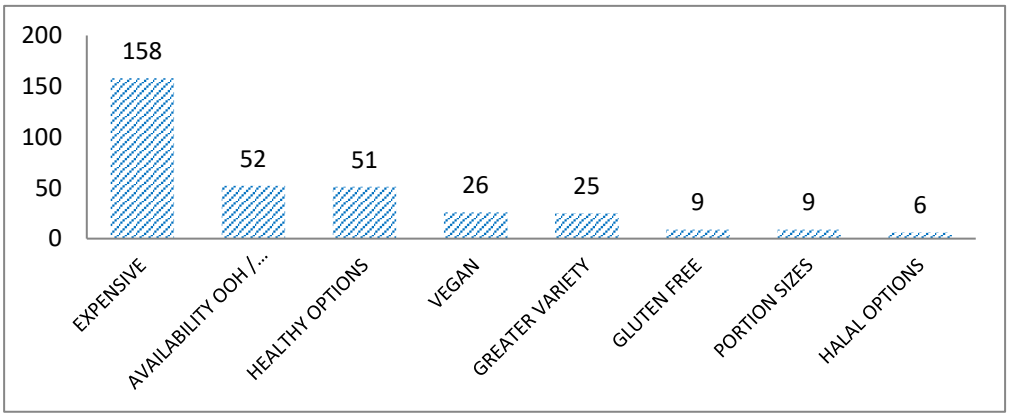


Figure 1 - Themes from Catering & Retain Survey free text

The main findings related to the cost, availability and healthy options being made available. Colleagues quoted the cheapest items available were often beans and chips but they were not the healthiest choices. A number of colleagues requested facilities such as a Subway or a Greggs type facility being made available along with a cost effective meal deal, dish of the day, fresh sandwiches, fresh fish and improved salad bars. This provides the Trust with further ideas to explore with providers.

Both Compass and ISS carry out limited business transactions at their restaurants between the hours of 3pm – 5pm with minimal footfall during this period.

Options currently being explored include an expansion to "Bring Me Food" option on both sites along with exploring options with the volunteer's team. These options may have cost implications to be considered before any changes are made.

The recommendations are to:-

- Set up a working group (to include Junior Doctors and out of hours staff) to consider providing a service colleagues want which also generates income for Trust
- Continue discussions with various providers on all sites to explore further
- Trust Board to take account of the findings and note ongoing actions

FINANCIAL IMPLICATIONS OF THIS REPORT:

There are opportunities for the Trust and CHS, via their partners, to provide a better offer to staff. There may be cost implications in increasing the offer but also income opportunities which all need further exploration.

RECOMMENDATION:

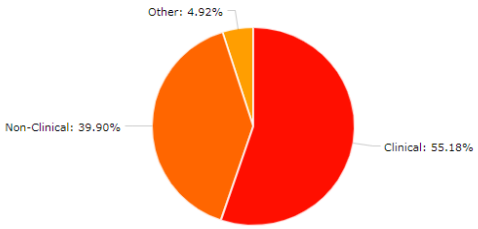
1. Set up a working group (to include Junior Doctors and out of hours staff) to consider providing a service colleagues want which also generates income for Trust and CHS
2. Continue discussions with providers with a view to a high level proposal being available in May 2019.

APPENDIX ATTACHED: YES

APPENDIX 1
CHFT RETAIL AND CATERING FACILITIES CHFT
February 2019

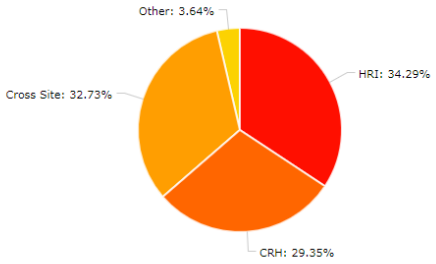
Staff Group

Replies	Number of responses	Percentage
Clinical	213	55.18
Non-Clinical	154	39.9
Other	19	4.92
Total	**386**	
Not answered	**0**	



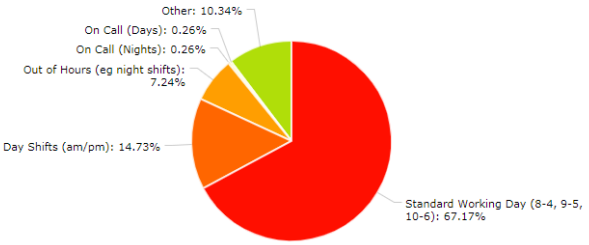
Place of Work

Replies	Number of responses	Percentage
HRI	132	34.29
CRH	113	29.35
Cross Site	126	32.73
Other	14	3.64
Total	**385**	
Not answered	**0**	



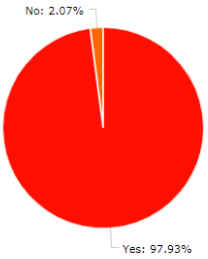
Working Hours

Replies	Number of responses	Percentage
Standard Working Day (8-4, 9-5, 10-6)	260	67.18
Day Shifts (am / pm)	57	14.73
Out of Hours (eg night shifts)	28	7.24
On Call (Nights)	1	0.26
On Call (Days)	1	0.26
Other	40	10.34
Total	**387**	
Not answered	**0**	



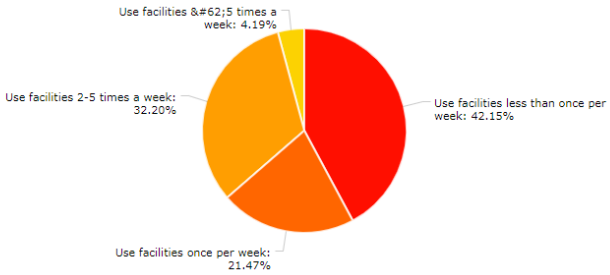
Are you aware of the retail facilities available?

Replies	Number of responses	Percentage
Yes	379	97.93
No.	8	2.07
Total	**387**	
Not answered	**0**	



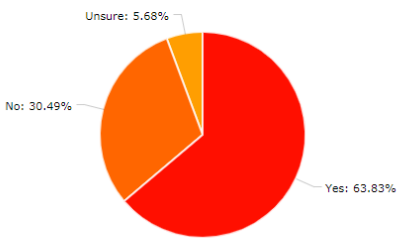
How often do you use the retail facilities?

Replies	Number of responses	Percentage
Use facilities less than ounce per week	161	42.15
Use facilities once per week	82	21.47
Use facilities 2-5 times a week	123	32.2
Use facilities> 5 times a week	16	4.19
Total	**382**	
Not answered	**2**	



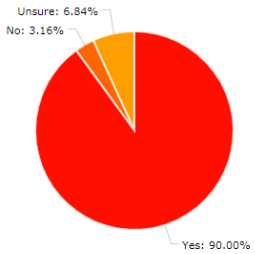
Are the facilities available at the appropriate times?

Replies	Number of responses	Percentage
Yes	247	63.82
No.	118	30.49
Unsure	22	5.68
Total	**387**	
Not answered	**0**	



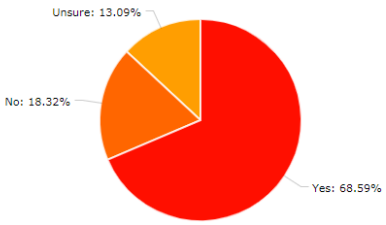
Are the facilities clean?

Replies	Number of responses	Percentage
Yes	342	90
No.	12	3.16
Unsure	26	6.84
Total	**380**	
Not answered	**4**	



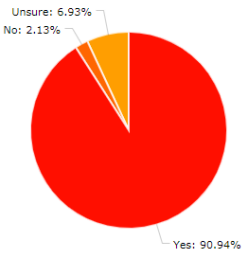
Are the prices clearly labeled?

Replies	Number of responses	Percentage
Yes	262	68.59
No.	70	18.32
Unsure	50	13.09
Total	**382**	
Not answered	**2**	



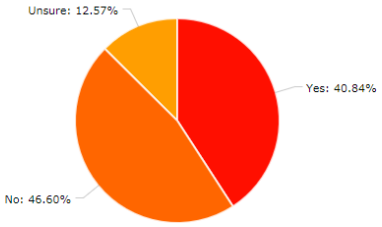
Are the staff helpful, courteous and smartly dressed?

Replies	Number of responses	Percentage
Yes	341	90.93
No.	8	2.13
Unsure	26	6.93
Total	**375**	
Not answered	**9**	



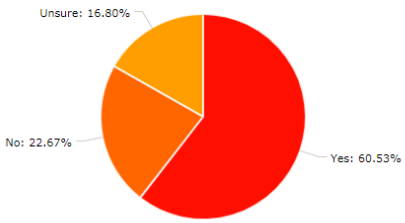
Is the selection of food offered a good variety?

Replies	Number of responses	Percentage
Yes	156	40.84
No.	178	46.6
Unsure	48	12.57
Total	**382**	
Not answered	**2**	



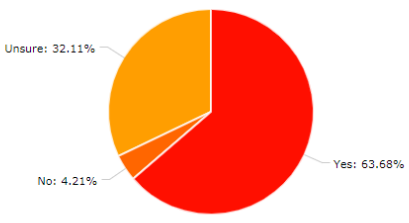
Do the facilities offer healthy eating options?

Replies	Number of responses	Percentage
Yes	227	60.53
No.	85	22.67
Unsure	63	16.8
Total	**375**	
Not answered	**9**	



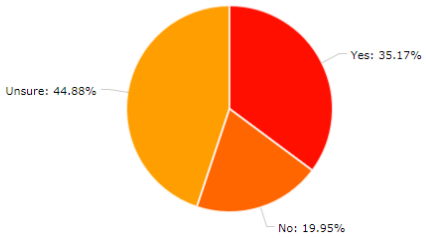
Do the facilities offer vegetarian options?

Replies	Number of responses	Percentage
Yes	242	63.68
No.	16	4.21
Unsure	122	32.11
Total	**380**	
Not answered	**4**	



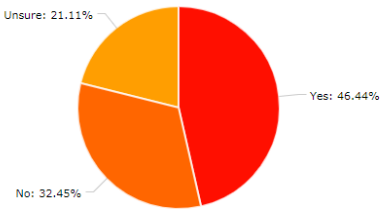
Do you have a cultural and dietary requirement?

Replies	Number of responses	Percentage
Yes	134	35.17
No.	76	19.95
Unsure	171	44.88
Total	**381**	
Not answered	**3**	



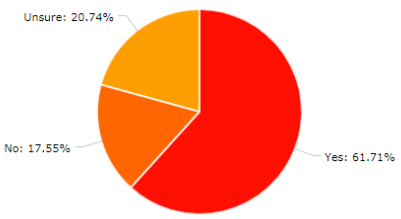
Is the quality of food good?

Replies	Number of responses	Percentage
Yes	176	46.44
No.	123	32.45
Unsure	80	21.11
Total	**379**	
Not answered	**5**	



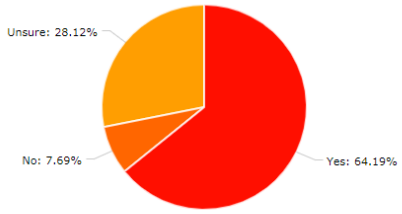
Is the hot food fresh & hot?

Replies	Number of responses	Percentage
Yes	232	61.7
No.	66	17.55
Unsure	78	20.74
Total	**376**	
Not answered	**8**	



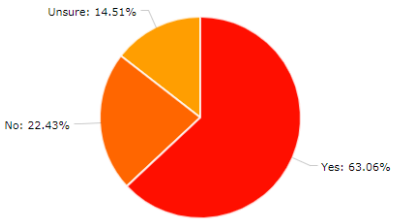
Is the cold food fresh & cold?

Replies	Number of responses	Percentage
Yes	242	64.19
No.	29	7.69
Unsure	106	28.12
Total	**377**	
Not answered	**7**	



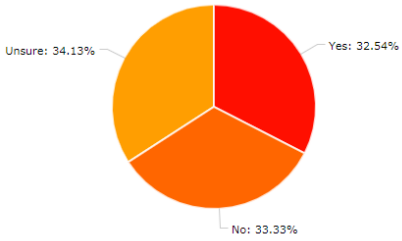
Is the food well presented?

Replies	Number of responses	Percentage
Yes	239	63.06
No.	85	22.43
Unsure	55	14.51
Total	**379**	
Not answered	**5**	



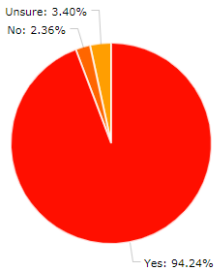
Is there a variety of clearly signed healthy options?

Replies	Number of responses	Percentage
Yes	123	32.54
No.	126	33.33
Unsure	129	34.13
Total	**378**	
Not answered	**6**	



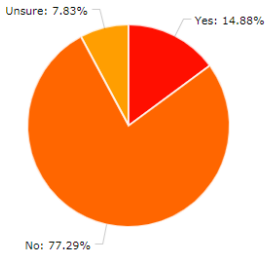
Is there a choice of hot & cold drinks?

Replies	Number of responses	Percentage
Yes	360	94.24
No.	9	2.36
Unsure	13	3.4
Total	**382**	
Not answered	**2**	



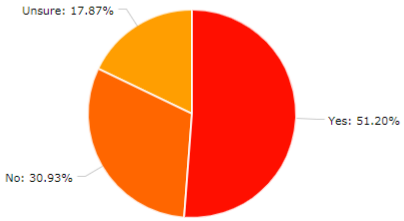
Did your purchase represent value for money?

Replies	Number of responses	Percentage
Yes	57	14.88
No.	296	77.28
Unsure	30	7.83
Total	**383**	
Not answered	**1**	



Did you enjoy what you purchased?

Replies	Number of responses	Percentage
Yes	192	51.2
No.	116	30.93
Unsure	67	17.87
Total	**375**	
Not answered	**9**	



6. Chairman’s Report

a. Council of Governors Election Timetable 2019

To Note

Presented by Philip Lewer

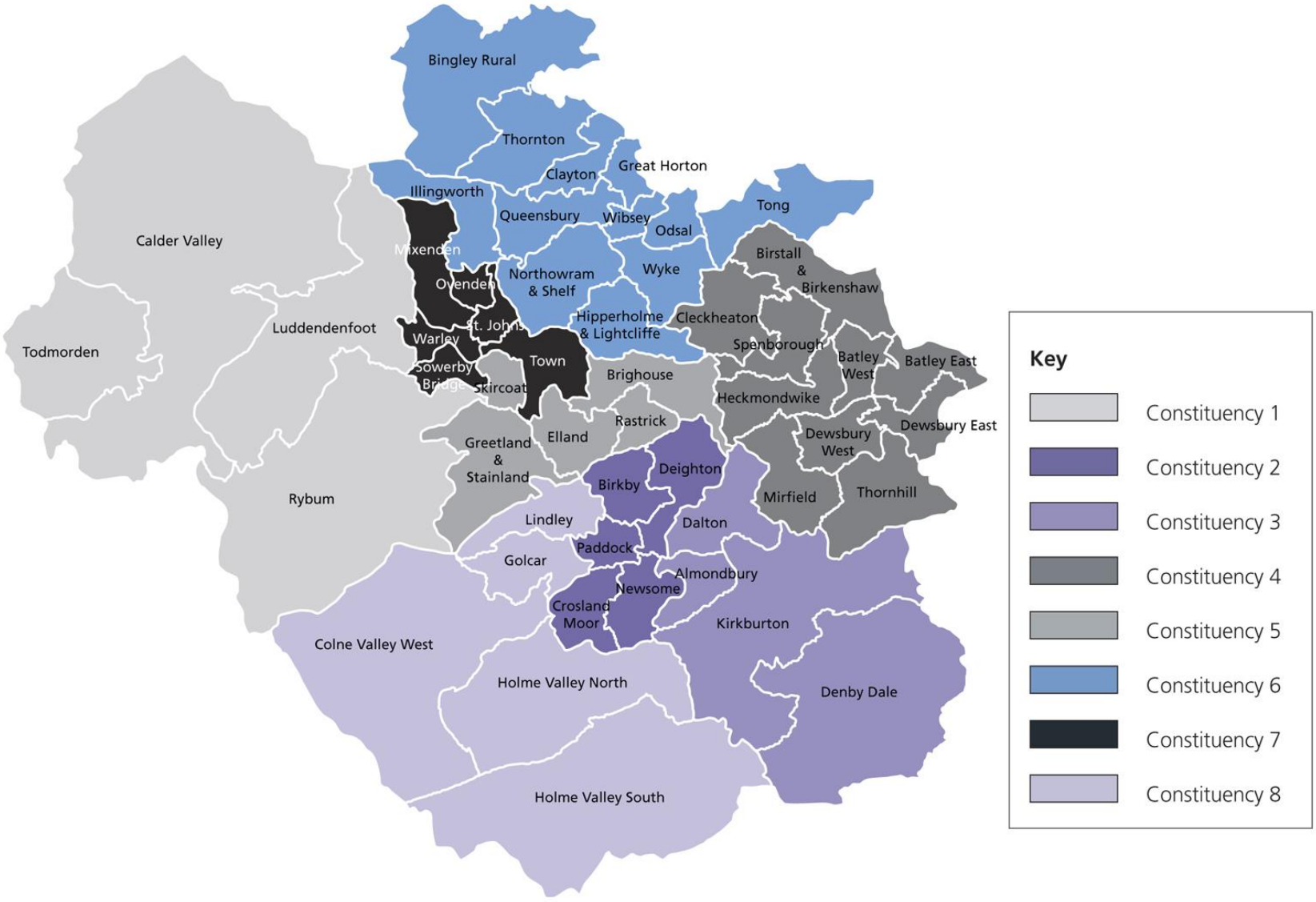
NHS
Calderdale and Huddersfield
NHS Foundation Trust

PROPOSED ANNUAL ELECTION TIMETABLE – 2019

DAY	DATE	ACTION
Tuesday	9 April 2019 (12.00 – 1.00 pm)	Briefing Sessions for prospective Candidates – Discussion Room 2, Learning Centre, Huddersfield Royal Infirmary
Thursday	11 April 2019 (5.45 – 6.45 pm)	Briefing Sessions for prospective Candidates – Large Training Room, Learning Centre, Calderdale Royal Hospital
Wednesday	17 April 2019	ERS/CHFT issue the Notice of Election. Nomination forms to be made available to CHFT
Monday	20 May 2019	Deadline for receipt of nominations
Tuesday	21 May 2019	ERS & CHFT publish summary of nominated candidates upon validation
Thursday	23 May 2019	Final date for Candidate withdrawal
Wednesday	29 May 2019	Electoral data to be provided by Trust. Uncontested report provided to Trust.
Tuesday	11 June 2019	Notice of Poll Published by ERS provided to Trust
Wednesday	12 June 2019	Voting packs despatched by ERS to members
Friday	5 July 2019	Close of Ballot
Monday	8 July 2019	Issue of Results to Trust
Wednesday	17 July 2019	Trust & Members Annual General Meeting – Formal Election Announcement

VACANT POSITIONS AND CANDIDATES ELIGIBLE FOR RE-ELECTION*	
NAME	**CONSTITUTENCY**
PUBLIC	
Rosemary Hedges (Reserve Register)	8 - Lindley, Golcar, Colne Valley West, Home Valley North, Home Valley South
Dianne Hughes	3 – Dalton, Almondbury, Kirkburton, Denby Dale
Veronica Maher*	4 – Birstall & Birkenhshaw, Cleckheaton, Spenborough, Batley West, Batley East, Heckmondwike, Dewsbury West, Dewsbury East, Mirfield, Thornhill
Nasim Esmail*	4 - Birstall & Birkenhshaw, Cleckheaton, Spenborough, Batley West, Batley East, Heckmondwike, Dewsbury West, Dewsbury East, Mirfield, Thornhill
Stephen Baines*	5 – Skircoat, Greetland & Stainland, Elland, Rastrick, Brighouse
STAFF	
Vacant Seat	10 - HPs/HCS/Pharmacists
Vacant Seat	13 - Nurses/Midwives

* = Eligible for Re-election


Bingley Rural
Thornton
Clayton
Great Horton
Illingworth
Queensbury
Wibsey
Odsal
Tong
Calder Valley
Mixenden
Ovenden
Northowram & Shelf
Wyke
Birstall & Birkenshaw
Luddendenfoot
Todmorden
Warley
St. John's
Hipperholme & Lightcliffe
Cleckheaton
Spenborough
Batley West
Batley East
Sowerby Bridge
Town
Skircoat
Brighouse
Heckmondwike
Rastrick
Elland
Dewsbury West
Dewsbury East
Greetland & Stainland
Deighton
Birkby
Mirfield
Thornhill
Rybum
Lindley
Dalton
Paddock
Golcar
Almondbury
Newsome
Crosland Moor
Kirkburton
Colne Valley West
Holme Valley North
Denby Dale
Holme Valley South
Key
Constituency 1
Constituency 2
Constituency 3
Constituency 4
Constituency 5
Constituency 6
Constituency 7
Constituency 8

7. Chief Executive's Report

a. The Topol Review – NHS Health Education England

To Note

Presented by Owen Williams

8. Progress on the Organisational Development (OD) Strategy including Staff Survey Response

For Assurance

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, 7th March 2019	**Sponsoring Director:** Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Title and brief summary: Presentation of the high level results and action plan for Staff Survey 2018. Progress on the Organisational Development (OD) Strategy.	
Action required: Note	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: 11 February 2019 Workforce Committee	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

Staff survey: The NHS National Staff Survey is carried out annually with full unembargoed results received on 26th February 2019. This presentation provides an overview of the key results for 2018 and key actions to address issues arising from the results.

Organisational Development Strategy (The Cupboard): Organisational Development is how an organisation improves performance through its people. Our OD Strategy is for and about our people. Colleagues across the Trust have given their ideas, experiences and suggestions in order to create the best 'people strategy'. These ideas, experiences and suggestions, together with feedback from Investors in People and the National Staff Survey (including the 2018 high level results) have been collected together and organised into 'The Cupboard'.

'The Cupboard' is an innovative and interactive electronic store and can be accessed via the Trust's Intranet. 'The Cupboard' is CHFT's OD Strategy.

The Cupboard contains 7 key elements. These are our 7 'recipes for success'. The 7 recipe cards and their key ingredients are inside 'The Cupboard'. 'The Cupboard' will launch in April 2019 together with a Hot House event to develop a more detailed response to the 2018 Staff Survey results. The Cupboard is an evolving, living strategy and its development will be monitored by the Workforce Committee.

Main Body

Purpose:

To present the high level results and action plan for the 2018 National Staff Survey.

To present to Board the progress of our Organisational Development strategy (The Cupboard).

Background/Overview:

See Presentation

The Issue:

See Presentation

Next Steps:

A communication and engagement plan will be developed prior to the launch of the OD Strategy in Easter 2019.

A Hot House event will be held on April 8th to develop a more detailed action plan to address any issues arising from the 2018 Staff Survey. A Trust wide action plan and action plans by Division will be monitored through monthly Performance Review Meetings and the Workforce Committee.

Recommendations:

1. The Board is asked to note and support the approach to the 2018 National Staff Survey results.
2. It is recommended that progress against the OD strategy actions are monitored through the Workforce Committee.

3. It is recommended that an annual update on the progress of the OD strategy be presented to Board each April.

Appendix

Attachment:

There is no PDF document attached to the paper.

9. Care Quality Commission (CQC) Update

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Anne-Marie Henshaw, Assistant Director for Quality & Safety
Date: Thursday, 7th March 2019	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: UPDATE CARE QUALITY COMMISSION (CQC) INSPECTION RESPONSE AND PREPARATION - This paper provides an update on the delivery of the Trust's response to the CQC report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: CQC Response group	
Governance Requirements: Please see paper.	
Sustainability Implications: None	

Executive Summary

Summary:

This paper provides an update on the delivery of the Trust's response to the CQC report.

The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology, preparation of our next CQC inspection and CQC engagement activities.

The Board of Directors are asked to approve the movements in the plan as recommended by the CQC Response Group and approved by the Trust Quality Committee.

Main Body

Purpose:

The purpose of this paper is to provide an update on the delivery of the Trust's response to the CQC report.

Background/Overview:

At the last CQC inspection (June 2018), the Trust improved its overall CQC rating from 'Requires Improvement' to 'Good'. Our ambition is to achieve an overall rating of 'Outstanding' at the next inspection.

The overall 'Good' rating was aggregated from core service and domain ratings and ratings from the Use of Resources and Well Led inspections.

The Trust achieved:
- 'Requires improvement' for the safe question.
- 'Good' for all other core service questions.
- 'Requires improvement' for the Use of Resources inspection.

The June 2018 inspection identified:
- 9 'must do' actions.
- 54 'should do' actions.
-

Following the inspection action plans were developed and a process for monitoring progress via a schedule of core service updates to the CQC Response Group was implemented. The CQC Response Group reports to the Quality Committee. All actions are due for sign off by 31 March 2019.

The Issue:

Please see paper.

Next Steps:

Please see paper.

Recommendations:

Board of Directors are requested to:

1. Approve the movements in the plan as recommended by CQC Response Group and approved by the Trust Quality Committee.

2. Be aware of the actions that are not progressing.

3. Note activities to prepare for the next CQC inspection.

Appendix

Attachment:

Yes

Care Quality Commission (CQC) Update to Board of Directors

1. Background

At the last CQC inspection (June 2018), the Trust improved its overall CQC rating from 'Requires Improvement' to 'Good'. Our ambition is to achieve an overall rating of 'Outstanding' at the next inspection.

The overall 'Good' rating was aggregated from core service and domain ratings and ratings from the Use of Resources and Well Led inspections.

The Trust achieved:
- 'Requires improvement' for the safe question.
- 'Good' for all other core service questions.
- 'Requires improvement' for the Use of Resources inspection.

The June 2018 inspection identified:
- 9 'must do' actions.
- 54 'should do' actions.
-

Following the inspection action plans were developed and a process for monitoring progress via a schedule of core service updates to the CQC Response Group was implemented. The CQC Response Group reports to the Quality Committee. All actions are due for sign off by 31 March 2019.

2. Update on progress with 'must do' and 'should do' actions

The action plan was reviewed by the CQC at the Relationship meeting on 21 January.

CQC were satisfied with progress to date with the action plan. Most actions are due to be embedded 31 March 2019 and are on track to deliver. Two actions are not progressing to plan (MD8 and SD 9 – see below).

a. Must Do Actions

Rating	Must do actions
Delivered and sustained	5
Action complete	2
On track to deliver	1
No progress / Not progressing to plan	1
Total	9

'Must do' actions – movements December 2018 and January 2019

MD3	Medicines Management (U&EC)	BRAG rating from **Green** to **Blue**
MD5	Fridge Temperatures (U&EC)	BRAG rating from **Green** to **Blue**
MD6	Ligature room (U&EC)	BRAG rating from **Red** to **Blue**
MD7	Ligature risks (U&EC)	BRAG rating from **Green** to **Blue**
MD9	Paper prescription chart completion (CC)	BRAG rating from **Green** to **Blue**

One 'must do' action is not progressing to plan.

MD8	Medical staffing (CRH)(Critical care)	**Issue:** Not delivering in line with GPICS standard at CRH as consultants have other areas of responsibility when on call (this was also the position at the time of the previous inspection). **Reason for no progress:** Ability to deliver against this standard is dependent on centralisation of acute services. It is on the risk register (score of 8), the team monitor for any incidents / near misses – none reported. The Division have taken a paper to WEB February 2019 setting out options appraisal to mitigate the risk.

b. Should Do Actions

	Update due	Red	Amber	Green	Blue	Total
Critical Care	Mar-19			1	5	6
Urgent and Emergency Care	Mar-19	1	4			5
Community	Mar-19		4	15		19
Corporate including (UoR)	Mar-19		5	4		9
Maternity	Mar-19		3	2	3	8
Children and Young People	Mar-19		1	1	5	7
Total		1	17	23	13	54

Should do actions – movements December 2018 and January 2019

MD11 (SD)	Incidents - learning (Com IP)	BRAG rating from **Amber** to **Green**
MD12 (SD)	Staffing -numbers, skilled (Com IP)	BRAG rating from **Amber** to **Green**
MD13 (SD)	Staffing -skill mix (Com IP)	BRAG rating from **Amber** to **Green**
SD11	Sepsis screening (CC)	BRAG rating from **Green** to **Blue**
SD12	Incident reporting including near misses to be reported (CC)	BRAG rating from **Green** to **Blue**
SD13	Safety performance (cc)	BRAG rating from **Green** to **Blue**
SD16	Equipment checks (cc)	BRAG rating from **Green** to **Blue**
SD18	Response to complaints in a timely manner (Mat)	BRAG rating from **Green** to **Blue**
SD22	Closures of Huddersfield birth centre (Mat)	BRAG rating from **Green** to **Blue**
SD24	Security arrangements in maternity areas (Mat)	BRAG rating from **Green** to **Blue**

One 'should do' action is not progressing to plan:

SD9	Medical staffing (Urgent and emergency care)	**Issue:** Consultant cover does not meet the Royal College of Emergency Medicine guidance for consultant presence of 16 hours per day **Reason for no progress:** Compliance with guidance cannot be achieved whilst there are 2 units on 2 sites. The inability to recruit sufficient middle grades and consultants is on the high level risk register

3. <u>Timing of the next planned CQC inspection</u>

Our CQC Relationship Manager has indicated that completion of the Trust's regulatory planning document will begin in May 2019. This will begin the cycle of the next planned inspection visit and trigger release of the Provider Information Request.

With the information that we have at this point, we anticipate the next planned visit from October/ November. There could be an unannounced visit at any time.

4. Which core services are more likely to be re-inspected?

CQC will use the Trust's previous ratings and the latest information they have to decide which services to inspect alongside our annual inspection of the well-led key question.

CQC will take into account the Trust's own assessment of the quality of its core services as well as information from stakeholders and the CQC Insight report.

The maximum intervals for re-inspection are:

- One year for core services rated as inadequate (not applicable for CHFT).
- Two years for core services rated as requires improvement (not applicable for CHFT).
- **Three and a half years for core services rated as good.**
- Five years for core services rated as outstanding.

Medical Care, Surgery, End of Life Care, Outpatients and Community (Adults, Children and Young People, End of Life) were last inspected in August 2016 (Appendix 1). It is more likley these core services will be inspected in 2019. Additionally, there may be services where we tell the CQC we have improved from 'Good' to 'Outstanding' and they may also inspect these services.

5. Preparation for Next CQC Inspection

The Trust ambition is to achieve an overall rating of 'outstanding' at our next inspection. There are five key areas of focus for preparatory activities:

a. Sharing Learning - Quality Summit, 'Celebrating the Positives' and Networking

A Quality Summit with invited stakeholders from commissioning, partner organisations and CQC is planned for 18 April 2019. The purpose of the Quality Summit is to drive improvement through debate and discussion of key quality and safety issues, sharing learning and demonstrating progress against the CQC Quality Ratings. A committee has been convened to organise the event.

Two 'Celebrating the Positives' events have taken place; May 2018 and January 2019. The purpose of 'Celebrating the Positives' is to showcase the extraordinary work our colleagues are involved in and to share learning across Divisions. Using a 'Dragon's Den' approach, presenters have opportunity to select an Executive lead for their project and offers of help or support made by the Executive Team. The next event is planned for June 2019.

The CQC Team review each published CQC inspection report to highlight the range of findings from outstanding to inadequate, and learning, to core services so that they can benchmark their 'Health Check' self-assessments against reports and identify opportunities to undertake 'go sees' to learn from others improvement work and successes.

b. CHFT CQC 'Health Check' Process

The Trust has developed a 'CHFT CQC Health Check' framework for each domain and core service. The 'Health Check' approach uses existing processes and assurance tools to facilitate Ward and Department and Divisional colleagues:

- Review the associated inspection framework.
- Review the last CHFT report (for the associated core service).
- Review reports from other trusts.
- Complete the assessment documentation.

- Review the appropriate characteristics of ratings – working towards good / outstanding.

Feedback from Divisional colleagues is that this approach has created a greater awareness within Divisions about CQC inspection frameworks and how they relate to their services.

To date, all core services have self-assessed as 'good' overall.
The CQC team are now working with core services to identify outstanding practice.

c. External Body Accreditation and Invited Service Reviews

CQC take into account the findings and recommendations of external body accreditation inspections and Invited Service Reviews when determining the overall rating for a domain and/ or core service.

The CQC Team are working with core services and Divisions to identify relevant and recognised accreditation and quality assurance schemes and provide a risk based assessment to the Executive Team about prioritisation and cost. This will be presented to WEB during Quarter 4 2018-2019.

d. Focus on improvement across cutting inspection themes

There are three main areas of focused improvement actions for cross cutting inspection themes:

- Medicines Management (including storage and administration of controlled drugs and fridge monitoring).
- Mental Health (including Mental Capacity Act and Deprivation of Liberty).
- Patient experience in Outpatients Departments.

e. Peer Review

From April 2019 a programme of internal and external peer review will commence. The purpose will be to revisit actions and test out whether actions are embedded and consistent showing evidence of sustained improvement.

6. Engagement with CQC and Relationship Meetings

Engagement meetings between the CHFT CQC Inspection Manager and Relationship Manager and Chief Nurse been planned to take place quarterly, with meetings between the Relationship Manager and Assistant Director of Quality and Safety taking place monthly. To date, relationship meetings have been extremely positive with good progress noted against the post inspection action plan.

Engagement visits have been planned for January to September 2019 (Appendix 2). These include attendance at Trust Board of Directors (May 2019) and key governance meetings (Quality Committee, Patient Safety Group, Patient Experience Group, Serious Incident Review Group, Risk and Compliance Group), as well as core service visits to Critical Care, Community and the Emergency Department.

7. Request to Board of Directors

Board of Directors are requested to:

1. Approve the movements in the plan as recommended by CQC Response Group and approved by the Trust Quality Committee.

2. Be aware of the actions that are not progressing.

3. Note activities being undertaken to prepare for the next CQC inspection.

Appendix 1: CQC Inspection Results June 2018

Ratings for Calderdale Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Medical care (including older people's care)	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Requires improvement ↓ Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Maternity	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Services for children and young people	Good ↑ Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
End of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatients	Good Aug 2016	Not rated	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018

Ratings for Huddersfield Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Medical care (including older people's care)	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Maternity	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Services for children and young people	Good ↑ Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
End of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatients	Good Aug 2016	Not rated	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health inpatient services	Inadequate Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Community end of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community sexual health services	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Requires improvement ↓ Jun 2018	Requires improvement ↓ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement ↓ Jun 2018

Appendix 2: Planned Engagement Visits for CHFT CQC Relationship Manager

Date	Time	Meeting/ Visit	Venue
26th February	9.30am-11am	Meeting between CQC Chief Pharmacist and CHFT Pharmacy CD	HRI
5th March	10am-11.30am	Patient Safety Group	Meeting Room 3, Acre Mills
18th April	9am-12md	Quality Summit, Board Room HRI	
18th April	1pm -4.30pm	Critical Care Engagement Visit	
2nd May	9am-12.30pm	Board of Directors (Public Board)	Large Training Room, CRH
2nd May	1.30pm – 4.30pm	Community Engagement Visit	
13th May	2pm-4pm	Patient Experience Group-	Meeting Room 4, Acre Mills
23rd May	9am-4.30pm	Emergency Department Engagement Visit	
3rd June	3pm-5.30pm	Quality Committee	Meeting Room 3, Acre Mills
18th June	3pm-4.30pm	Serious Incident Review Group	Meeting Room 3, Learning Centre [TBC]
9th September	10am-12md	Risk and Compliance Group	Meeting Room 4, Acre Mills

10. Q3 Quarterly Quality Report

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, 7th March 2019	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: Quality Report, Q3 2018/19 - To provide an assurance to Board members regarding work to improve quality of services and present quality data for Q3 2018/19.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee 4 February 2019	
Governance Requirements: Relates to Board Assurance Framework risk 06/17 regarding high quality safe care.	
Sustainability Implications: None	

Executive Summary

Summary:

The attached paper and supporting presentation details quality improvement across the Trust as at Q3 2018/19, including care quality indicators, CQUINS.

Main Body

Purpose:

This paper and accompanying presentation details quality improvement across the Trust as at Q3 2018/19, including performance on care quality indicators, CQUINS provides

Information is included on progress with the three quality account priorities relating to safe care, care of the acutely ill patient, effective care, improving timely and safe discharge and experience, to improve end of life care is given as well as updates on quality during the three month period October to December 2018.

Background/Overview:

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

The Issue:

A presentation on key quality data as at Q3 2018/19 will be provided at the Board meeting.

The report summarises the information shared with the Board on quality over the last three months and provides information structured into the five care quality
domains of the Care Quality Commission.

Information on the 2018/19 quality account priorities of deteriorating patients, patient flow and end of life care at quarter 3 is also included within the enclosed quality report to assure the Board about progress in these areas.

Next Steps:

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

The next formal update on quality will be presented to the Board in the end of year Quality Accounts for 2018/19 in May as part of annual reporting for 2018/19.

Recommendations:

The Board is asked to receive the quality report for October to December 2018, quarter 3 2018/19 and the update on the three quality account priorities.

Appendix

Attachment:

PDF2 Narrative Quality Report Q3 2018 19.pdf

QUALITY REPORT for Quarter 3, 2018/19

Board of Directors - 7 March 2019

EXECUTIVE SUMMARY

This paper summarises:

i. assurances on quality that have been presented to the Board of Directors during quarter 3 2018 / 19
ii. an update on the three quality account priorities for 2018/19 for quarter 3.
iii. a presentation on quality indicators as at quarter 3, 2018/19

1. Quality reports to the Board:
There was one public Board meeting held during quarter 3 and the following reports relating to quality were presented to the Board: an outpatient story regarding appointment access, learning from deaths and the Gosport report.

1.1 Outpatient Story
On 1 November 2018 the outpatient matron shared the story of a vulnerable patient who had experienced difficulties accessing outpatient appointments due to transport and administration issues. The Board identified a range of actions to improve access to appointments for patients experiencing such problems.

1.2 Learning from Deaths

A report on learning from deaths for the 12 month period August 2017 to August 2018 was shared with Board members at the 1 November 2018 meeting. The report provided assurance on reviewing deaths and a thematic analysis of learning. It was noted that the process for initial screening reviews was being revised and work was planned to share learning across the Trust.

1.3 Gosport Report
The Board reviewed internal assurance against eight areas in response to incidents at Gosport War Memorial Hospital 27 years ago. The Board noted the Trust was compliant with six of the eight areas, with work taking place for the two areas with limited assurance, Freedom to Speak Up and scrutiny of high usage areas of controlled drugs. Following an audit commissioning on individualised care of the dying process learning is being progressed through the End of Life Care Group.

2. Update on 2018/19 Quality Account Priorities, Quarter 3
An update on the three quality account priorities for 2018/19, care of the acutely ill patient (safe), patient flow (effective) and end of life (experience) is given below.

2.1 Care of the Acutely Ill Patient

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

The Deteriorating Patient Group has had a refresh with a new terms of reference and membership agreed. The focus remains on the recognition of, response to and

prevention of deterioration in patients. Patients (over the age of 16) with NEWS (National Early Warning Score) of 5 or more are within the scope of this project.

Recognition – at present the focus for this arm of the project is the implementation of NEWS2 (National Early Warning Score version 2). This is an adapted version of the current NEWS as developed by the Royal College of Physicians and disseminated to Trusts through a National Patient Safety alert. The main changes will include the introduction of a score for Confusion when assessing consciousness and the acknowledgement of lower oxygen levels in patients with chronic lung disease such as COPD. Training through an e-learning package is underway parallel to an update of the Nervecentre server and iPod app. The implementation and evaluation of NEWS2 will continue into 2019-20.

In addition, there are plans to develop further targeted training to Health Care Assistants who we know perform the majority of patient observations on ensuring that these are accurate and timely.

Response - the Hospital Out of Hours Programme (HOOP) was implemented across both sites approximately two years ago and we have agreed to review the service. Although HOOP has been successful in remote task management there maybe scope to enhance the response to patients who deteriorate out of hours. For example, it is anticipated that all but two HOOP clinical coordinators will be able to prescribe by the end of financial year 2018-19. Furthermore, there are plans to review how the HOOP and critical care outreach teams operate that may allow for a single team to enhance cover and response 24/7. Such an amalgamation is not likely to happen until at least the summer of 2019.

Prevention Safety huddles remain the main focus of the part of the project. The pilot to introduce flat screen televisions onto the Acute Medical Units has been slow due to the actual availability of screens to do so. There were thoughts that a surplus of screens was available however it transpires that this is not the case. There will need to be further discussions about the funding required to buy new flat screen televisions on which we plan to project an adapted ward view. The latter will also need to be developed by the EPR team.

2.2 Patient Flow – Improving timely and safe discharge

Why we chose this

As we know there is a considerable evidence base for the harm caused by inefficient and untimely patient flow. Delays lead to poor outcomes for patients, both in terms of safety, experience and the level of need for the patients when they are finally discharged. The prolonged length of stay can have a direct impact on the decondition whilst in hospital. Safe and timely discharge planning for all patients is an essential part of their overall plan of care and treatment and should always start on admission.

Good patient flow and transfer of care across the health and social care system is now widely recognised as a key indicator of how the system is working in collaboration. The

agenda for the system Transfer of Care Group and A&E
Delivery Board has a clear focus on safer patient flow and discharge.

Improvement work

SAFER Patient Flow Programme

The work continues to be delivered through three work streams, bed avoidance, bed efficiency and bed alternates but now with a wider membership including colleagues from partner organisations. The terms of reference have been amended accordingly.

Schemes implemented through the work streams continue to embed:

- Trusted Assessor - referral into the reablement pathway
- Trusted Assessor - Nursing & Residential homes
- Home First Team focusing on stranded and super stranded patients
- Standardised MDT meetings
- Enhanced reablement moving rehab to home

The new scheme initiated in Q3 is:

- **Choice and Recovery Beds**
  We have a shared vision with colleagues from partner organisations for patients who are medically fit and require high nursing needs within a 24 hour facility on discharge. The patients are transferred to a community bed to have their assessments done and choose their preferred nursing home, rather than the hospital. This reduces risks of hospital acquired infections/falls, promotes opportunities for independence for patients and reduced deconditioning. We implemented the scheme/pilot in November 2018 across the two local authorities. The pilot will be evaluated in March 2019. Early indication is that patients and carers have provided good feedback and the quality of care within the nursing home has been good.

  Winter Pressures- NHSE Improvement Initiative to Reduce Patients with a long stay in hospital.

  Unnecessarily prolonged stays in hospital are a poor experience for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, low mood, prolonging episodes of acute confusion (delirium) and transmitting healthcare associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning).

  Tackling long stays in hospital will reduce risks of patient harm, disability and unwarranted cost particularly for those who are intrinsically vulnerable because they have mild or moderate frailty and/or cognitive disorder. For this patient group a different, more positive outcome can be achieved if the right steps are taken very early in their admission.

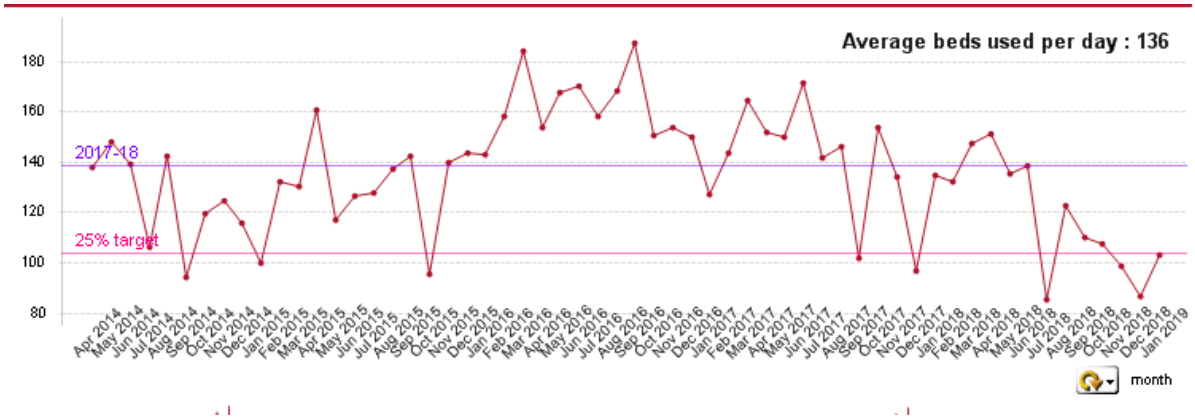
Hospital-related functional decline in older patients and the subsequent harm has dreadful consequences for many patients and is something we should not tolerate and with our system partners we have agreed that we will not.

Guidance from NHSE was received midyear in 2018 to all A&E Delivery Board Systems to support a reduction in patients with a long stay. They also provided each system with a target to achieve a sustained 25% reduction of overall long stay patients in Q4 2018/19. CHFT's data was analysed to provide a base line and a target to be achieved. The baseline was the number of beds daily used by patients whose LOS was over 21 days, this was then averaged over 12 months.

CHFT and partners have worked in collaboration to reduce the length of stay. Through tracking and progressing clinical pathways, improved discharge planning, earlier assessment, embedding improvement schemes and using the MADE events to provide opportunities to discuss and progress discharge plans for patients with complex needs.

How are we doing?

Below the table demonstrates the gradual improvement in the reduction of beds used for long stay patients since August 2018, it also shows that we are now at target however the improvement has to be sustained over quarter 4.



2.3. End of Life

Improving end of life care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die, whether their death is expected, it is vital that they receive appropriate end of life care. The Trust is looking to sensitively establish that patient's relatives felt that the needs of their loved one were met in a compassionate and appropriate way.

Improvement work

Bereavement Survey

The bereavement survey is part of the Trusts Learning from Deaths (LfD) programme. This programme supports a quality improvement plan relating to death and dying primarily for improved patient and family/carer experience and patient outcomes. We undertake an annual bereavement audit with a small number of patients with a response rate of 30%

In order to gather more feedback to both highlight the areas of excellent care and areas that we can improve on, a 6-month pilot audit has been undertaken on our four stroke wards at CRH. Prior to sending the survey, a bereavement card was sent to offer support and also inform them of the upcoming survey. We had a 47% response rate which is a big increase on the last bereavement survey (30%). The audit has now finished, and the results being shared with the stroke team and an action plan will be developed.

Bereavement cards

A bereavement card has been developed with input from our bereaved relatives. This card will be sent out 1-2 weeks after death to offer a phone number for relatives to ring if they have unanswered questions or need support. This is going to be trialled within the surgical division. The card has now delivered. Training and disseminating or cards has started. The bereavement cards sent from the stroke wards are going to continue too.

Bereavement café

The Chaplain department alongside the end of life care facilitator have developed - The marigold café which is a bereavement café started on the 7th September. It is to run the first Friday of every month on alternate sites. This is open to anyone who has suffered bereavement.

End of life care education

EOLC education is to become essential training for clinical staff. A DVD about the Individualised care of the dying document has been made to help staff support patients and families.

End of life care champions

We have trained 10 community CHFT nursing staff to become EOLC Champions. Our next cohort started on October 23rd 2018 with 24 nursing staff from both community and hospital. This 6-month course helps to increase confidence and skills in EOLC to bridge the gap between specialists and generalists and take everything they have learnt back to the areas they work and become a resource and support other staff. We are also starting HCA Champions in April 2019. The first cohort of Champions still meet regularly to continue the education and training There has been an increase in the use of EPaCCs by the Champions and also having Advance care planning and DNACPR discussions.

End of life care companions

The companions are here to sit alongside patients at the end of life, either if they have no family or their families need a break. 20 companions have been trained to support our dying patients, their families and the ward teams. We have some CHFT staff that volunteer as Companions as they wanted to give something back to the Trust and patients in our care.

Horizon group

This is a collaborative group which includes CHFT, Calderdale Council, the Council of Mosques and Overgate Hospice. The group was started to support and develop end of life concerns raised by Muslim patients and families with issues around end of life care – such as feeding and DNACPR. We feel we have improved the understanding and relationships between healthcare providers and the S Asian Community improving patient and families experiences of dying in CHFT. The group has also developed:

- Faith cards which have cultural and religious basics for each faith in our localities – to all wards and Hospice.
- An Audio tape produced locally but distributed nationwide by MacMillan Cancer Support.
- Improvements to education – cultural and religious aspects added to all end of life care training modules
- Changes in Hospice practices to enable faith to be celebrated.
- In 2019 we have planned to deliver a training day in the Sikh temple in Huddersfield and also in the Madni Mosque in Halifax. We are also staring to develop materials for the LGBTQ community.
- Worked with skills for care nationally to produce a training DVD on being Confident with difference.
  Improving timer

Reporting

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

3. Quarter 3 2018/19 Quality presentation

The attached presentation provides key points relating to quality indicators during quarter 3, 2018/19.

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Quarterly Quality Report
Q3 2018-19

Quality Committee
4 February 2019

Board of Directors
7 March 2019

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Summary

Indicator	Target	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19
HSMR (rolling 12 month)	100	86.10	82.74	83.56	Not yet Available	Not yet Available
SHMI	100	100.87	98.9	99.52	Not yet Available	Not yet Available
A&E within 4Hr Performance (Incl. CH)	95%	91.09%	87.82%	93.22%	91.09%	
% VTE Risk Assessments	95%	97.00%	97%	97%	97%	96.5%
MRSA	0	0	2	1	0	2
C. Difficile	6	11	17	12	3	1
Friends and Family Response Rate (Inpatient)	26%	33.93%	39.34%	39.51%	36.42%	33.6%
Friends and Family Response Rate (A&E)	13%	10.62%	10.50%	11.04%	14.31%	13.3%
Staff Sickness (YTD)	< 4.00% - Green 4.01 -4.5 Amber >4.5% Red	4.37%	3.62%	3.62%	3.97%	N/A

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Quality Account Priorities

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

Recognition

- Recognition
- Focus on plans to implement NEWS2
- Nervecentre upgrades complete
- Online training for NEWS2
- Response
- Plan to review HOOP 2 years post implementation
- Early discussions between HOOP and Critical Care Outreach teams
- Prevention
- Planning continues to use EPR to support QI on Safety Huddles

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Quality Account Priorities

Experience – End of Life

- The 6 month bereavement audit and bereavement card piloted on the 4 stroke wards at CRH has finished.
- 47 % response compared to our previous survey response which was 30%. The results are overall very positive and are being shared with the Stroke team to develop an action plan. The Stroke wards are continuing to send out bereavement cards.
- **Bereavement cards** – being delivered to the surgical division to be sent to all bereaved relatives across the surgical division. After a couple of months the plan would be to implement it Trust wide.
- **Bereavement café** – The Marigold Café - Monthly drop in café at HRI and CRH alternate months, commenced 7th September.
- **End of life care education** – to be essential training for all clinical staff.
- **End of Life Care Champions** - a further 24 qualified nursing staff across community and acute started training in October. The first cohort have increased the use of EPaCCs and having advance care planning discussions. HCA End of Life Care champions to commence in April 2019.
- **End of life care Companions** – we now have 20 companions to sit alongside and support patients and families in the last days of life
- **Community** – bereavement visit offered to all relatives of patients cared for by District Nursing service. 6 pilot sites identified to implement the Gold Standards Framework with community nursing teams.
- **Horizon Group** – Planning on continue to develop our relationship with the south Asian community and put on a training day looking at end of life care, plus we are putting on an event at the Sikh Temple and also working with the LGBTQ community. The Horizon group worked with the national body - Skills for care and developed a national training DVD about being 'confident with difference'.

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CQUIN

CQUINS

By Q4 the trust will be looking to achieve 80% of advice and guidance requests from GPs within 2 days. Q3 performance stands at 75% (against Q3 target of 70%) and is improving in line with trajectory.

Maintaining last year's reduction of attendances of those who could benefit from social interventions. Targets agreed for data quality threshold in ED datasets.

Commenced in Q3 and will end in Q4 – on track to hit 75% target of all frontline staff receiving vaccination

Community nurses continue to work to improve wound assessment

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Quality Account Priorities

Patient Flow – Improving Timely & Safe Discharge

(right patient, right place, right time)

•**Good patient flow and transfer of care across the health and social care system** is now widely recognised as a key indicator of how the system is working in collaboration and the agenda for the system Transfer of Care Group and A&E Delivery Board has a clear focus on safer patient flow and discharge. Weekly event in Community intermediate care beds facility to support discharge planning.

•**Choice and Recovery Beds-** pathway from hospital into community beds where all assessments and choice of the patients long term placement is made. All partners involved, patients outcomes and experience being measured. Pilot to be evaluated March 2019.

•**NHSE Guidance- Target to reduce patients with a long stay (over 21 days)** now part of SAFER Programme measures , aim to aid Trust resilience over winter. Good progress made over Q3 and have hit the target. Sustaining this reduction is the aim for Q4.

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Safe

- Ligature free room now in place in Emergency Department at both sites for safety of patients with mental health issues at both sites

- **3 Never Events :**
- 2 oxygen tubes connected to air outlets (1 occurred Feb 2018 identified through review) – checks made of air outlets on all wards to remove flowmeters, reiterate patient safety alert and building checks into routine ward checks

- 1 retained surgical item, November, best practice on using whiteboard to record accountable items reiterated with team leaders

- New performance metric in Board performance report to focus on harm (fall , PU or uti, vte) to patients whilst in our care - previous measure reported to Board included harms acquired prior to admission accounted for approx 6% harm prior to admission

Safe

Pressure Ulcers

- 1 category 4 pressure ulcer in Q3 (October), Medicine division, being investigated as a serious incident
- Review of attribution of pressure ulcers to CHFT when reporting incidents – data being revised
- Monthly CHFT Pressure Ulcer Improvement Collaborative continue to meet with leads from the medical and surgical division
- In September 2018 the CHFT PU collaborative commenced a 6 month NHSI participation programme with a focus on quality improvement methodology. Trust representation includes TVN, Matron, Ward managers and support from a data analysist. A Trust wide pressure ulcer reduction action plan has been completed with driver diagram to focus intervention strategies

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Safe

- **Medicines Management**
- Number of patients receiving a medicines reconciliation has improved from 59% (March 18) to 72.1% (Jan 19) and medicines reconciliation within 24 hours increased from 23 % to 39.8%
- Patient information leaflet being finalised to explain to patients about pharmacy service and safe storage of their medicines whilst in hospital
- Implemented daily pharmacy huddles to establish which wards need prioritising for take home medication (TTOs etc)
- Volunteers supporting pharmacy at HRI in delivering TTO's to wards Mon-Fri (reducing nursing time having to come to pharmacy to collect medicines)
- Pharmacy safe storage template developed to carry out spot checks on wards to ensure medications are stored securely
- Medicines Optimisation strategy updated

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Effective

- Following success of acute floor at CRH (merging acute medical unit and short stay ward), acute floor at HRI opened in December 2018

- Celebrating Success - overall winner Cardiology Rapid Access Team with new one stop model reducing time to diagnosis for patients and improving clinical outcomes and patient experience

- Frailty team at HRI extended to surgery in December 2018

- **Healthcare Associated Infections**
- 1 C difficile infection in Q3 (tolerance per quarter 5) (April 2017 last time 0 c diff in a month)
- MRSA 2 in Q3 (October 2018) – ward 17, ward 12, HRI

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Effective

Mortality

- Most recent SHMI released by NHS Digital in November 2018 (for July 2017 – June 2018) continues to remain in the “as expected category” and below 100 and HSMR continues to be a positive outlier

Sepsis

- Explored issue of sepsis alerts on whether patients had deteriorated or developed sepsis being bypassed on EPR. Found most bypasses due to multiple entries by staff viewing record who would not be carrying out clinical treatment

- # Neck of Femur – improved % of patients getting to theatre within 36 hours, with 83% (against a target of 85%). The 85% was met in Nov 18 for the first time since Jun 18.

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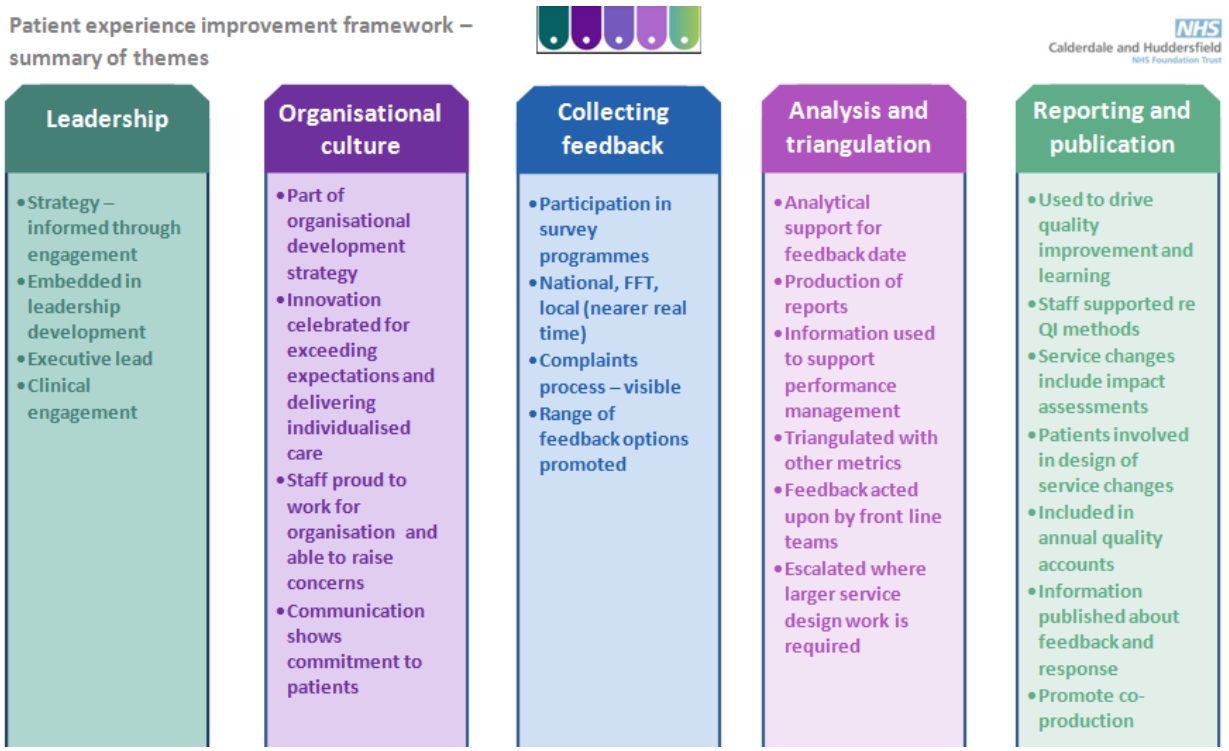
Caring

The Patient Experience and Caring Group is using a framework developed by NHS Improvement *'to help Trusts to focus on the key factors that need to be present in a provider focused on the needs of its patients.'* It is based on reports with a focus on patient experience such as FFT, PLACE, CQC.



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Caring

The Patient Experience and Caring Group is connected to a number of national / regional / local patient experience initiative, these are summarised below:

Formal feedback opportunities

PRASE: Patient Reporting and Action for a Safe Environment

PRASE involves collection of patient feedback around the safety of care. A questionnaire called the 'Patient Measure of Safety' (PMOS) is used to collect patients' feedback about their care and it is based on scientific evidence about the factors that are important for safety (e.g. communication, resources, and ward environment)

PRASE

Complete:

FSS:
CRH - ward 3

Surgery:
HRI – wards 11, 3, 22

Medicine:
HRI – wards 5, 1 2, AMU, 20 – part of research study using students rather than volunteers

Commissioned:

Surgery:
CRH – wards 8a, 8d

NHS England Always Events®

Always Events® are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system".

Surgery: HRI SAU – ambulatory area

Yorkshire Patient Experience Toolkit

A new toolkit designed and tested by the Regional Improvement Academy :
https://improvementacademy.org/tools-and-resources/the-yorkshire-patient-experience-toolkit.html

Improvement Academy

NOISELESS! LESS NOISE more sleep

Noiseless: Joint working with the University of Huddersfield re reduction in noise at night:

University of Huddersfield

Medicine: CRH wards 6b and 7b

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Caring

- **Divisional updates:**

  Reports to the Patient Experience and Caring Group during Q3 detailed a number of improvement initiatives that show a real focus on improving the patient experience through:

  – Feedback: encouraging feedback, receiving positive feedback and responding to feedback

  – Involvement :approaching service users as active partners in their care and engaging on service development and improvement

  – Delivering a patient centred culture recognising emotional and social needs

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Caring

- **Friends and Family Test (FFT)**

- Would recommend OPD amber and green Directorate scores

	October	November	December
Acute med		Amber	Green
Trauma & orthopaedics	Amber	Amber	
Diagnostics	Green	Green	
Children		Amber	Green

- Community, A&E and OPD services continue to work towards an improved would recommend rate

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Caring

- **Friends and Family Test (FFT)**

Response rate:

- All FFT services achieving a ‘green’ rating for each month in Quarter 3

Would recommend:

- Rated green for all Q3 months for inpatients, day cases and maternity
- Community moved from red to amber to green
- A&E from red to amber x2
- OPD remains red across each Q3 month, with a small number of Directorates achieving some amber and green months *(see next slide)*

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Caring

Friends and Family Test (FFT)

All FFT services achieving a ‘green’ rating for each month in Quarter 3

- Improvements by 1.5% in Out patient department % patients who ‘**would recommend’**, first time improved in 8 months

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Caring

Complaints

- Improvement in complaints closed in time in December 2018 at 63%, improving from 45% in October
- 16 complaints overdue at the end of Q3, none over 1 month overdue, (Q2 25 overdue)
- Medical Division continued to be supported by Governance and Risk team to improve complaints performance.

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Responsive

- **Stroke assessment bed** introduced at ED in CRH to improve access to appropriate care and timely admission within 4 hours to HASU – In Q3 reached the highest performance this year of % patients directly admitted to the stroke service within 4 hours, 70% (previous quarter 60%)

- **Virtual appointments -** Yorkshire Fertility Clinic holding virtual appointments for clients at early stages of treatment who are from further afield

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Well Led

Incident Reporting

- Targeted campaign to improve incident reporting by medical staff – Datix December
- **Investors in People Silver Award** received, improved rating reflecting engagement and quality of leadership at all levels
- CQC half day held with core services in November to explore health check documents and process, for the safe domain and progress with action plans from 2018 action plan.
- **Celebrating Success Awards** held December 2018

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Well Led

Themes from Quality visits in Q3

- Staff managing competing priorities
- Patient experience and delays
- Extent to which staff feel valued

Quality Improvement

- Workshop held with OD, quality, nursing and medics to inform strategic direction for quality
- Developing database of quality improvement projects across the Trust
- Plans continue to initiate quality improvement training in 2019/20

11. 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, 7th March 2019	**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 22 February 2019	
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 a meeting on 11 February 2019.	
Governance Requirements: Keeping the base safe Each risk on the risk register has a link referencing the related Board Assurance Framework strategic risk. The risks within the high level risk register relate to the following strategic risks on the Board Assurance Framework: 5/17 - realisation of EPR benefits 6/17 - high quality safe care 9/17 - estates and equipment 10/17- workforce 11/17 - leadership 13/17 - financial	
Sustainability Implications: None	

Executive Summary

Summary:

The high level risk register is presented to public Board meetings 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 high level risk register 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 22 February 2019.

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

iii. Details of movement during January and February 2019 which are detailed in the summary paper and include:

Four new risks have been added to the high level risk register since the risk register was last presented to the Board as detailed below.

7345, risk score of 16, risk regarding referrals of discharged patients to District Nursing Services
7396, risk score of 15, risk relating to connection of tubing for patients prescribed oxygen to air flow meter
7413, risk score of 16, risk relating to fire compartmentation at Huddersfield Royal Infirmary, HRI
7414, risks core of 15, risk relating to external structure at HRI

Three risks have been removed from the high level risk register for management by divisions on their local divisional risk registers, with rationale for the reductions in risk score detailed in the attached paper:

7309, integration between Nerve Centre and EPR
6299, medical devices maintenance
7251, Opthalmology equipment risk

Next Steps:

Following discussion with the Associate Director of Nursing for Medicine, work will take place during March 2019 to support the Medical Division directorates in recording and managing risks on directorate and

divisional risk registers.

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:

Combined HighLevelRiskRegister 22 feb 19 for 7 March Board.pdf

High Level Risk Register Board Summary – 22nd February 2019

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 Emergency Department
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7240 (20): Surgery and Anaesthetics financial risk

The Trust risk appetite is included below.

NEW RISKS

January 2019

7345 Score (16) Community
Community Referral to District Nursing Service

There is a risk of patients with a nursing need not being referred on discharge to the District Nursing service due to lack of referral facility on EPR and the discontinuation of the PASWEB referral pathway prior to the implementation of EPR. This may result in patients not receiving district nursing care, deteriorating at home and being re-admitted to hospital.

February 2019

7396 Score 15 Trustwide
Connection to piped air

For patients prescribed oxygen, there is a risk of staff connecting the tubing to an air flowmeter which has been inserted into the air outlet in the wall rather than the oxygen flowmeter in the oxygen outlet. This is because the outlets are adjacent throughout CRH, and the tubing fits both flowmeters.

The impact results in reduced oxygen saturations for a patient which could potentially lead to a deterioration in clinical condition and potential harm. There is also a reputational impact as connecting oxygen tubing to the air is a Never Event and reportable as a serious incident, with four such incidents having been identified in 2018/19.

7413 Score 15 Corporate
HRI Fire Compartmentation

There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.

7414 Score 15 Corporate
Building safety

There is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in harm to staff, patients and visitors.

RISKS WITH REDUCED SCORE

7309 Score 9 (↓16) Corporate Nursing
EPR NEWS 2 update Risk

There is a risk that the integration between Nerve Centre and EPR will not be complete within the timeframe

The risk has been reduced as progress has been made with the integration. The servers were updated to version 5 on the test server, with testing of this completed mid December 2018. The updated software was installed on live server 10th January 2019 and testing of News2 and EPR commenced.

6299 Score 12 (↓16) Calderdale and Huddersfield Solutions
Medical Devices maintenance risk

There is a risk of faulty high, medium and low risk medical devices (patient monitoring infusion devices, incubators, phototherapy equipment) due to lack of routine maintenance, staffing capacity and systems in Medical Engineering, resulting in potential patient harm and inability to meet CQC requirements for medical devices

The risk has been reduced as a new Chief Medical Egineer has now commenced which effectively now allows 2 Medical Engineers to concentrate on maintenance. The likelihood has now been reduced as there is now more resource to undertake maintenance of medical devices.

7251 Score 9 (↓15) Surgery and Anaesthetics
Ophthalmology equipment risk

This risk relates to Optovue OCT (Ocular Coherence Tomography) machines not functioning due to the storage limit on the machines being reached.

The risk has been reduced as the OCT image archive storage has been temporarily upgraded to give the department space until the OCT infrastructure is replaced.

February 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 22/02/2019

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19
QUALITY AND SAFETY RISKS										
10/17	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in Emergency Department	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
09/17	5806	Keeping the base safe	Urgent estate work not completed	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
09/17	6903	Keeping the base safe	Resuscitation HRI Estates risk	Director of Finance (GB)	=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
05/17	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Medical Director (DB)	=16	=16	=16	=16	=16	=16
	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)	=16	=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	=16
09/17	7271	Keeping the base safe	ICU Huddersfield – collective infrastructure	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
05/17	7280	Keeping the base safe	Unnecessary repeat specimen collection by not following EPR procedures	Director of Operations, FSS (RA)	=15	=15	=15	=15	=15	=15
05/17	7338	Keeping the base safe	Risk of incomplete EPR	Director of Nursing (JM)		**!15**	=15	=15	=15	=15
06/17	7315	Keeping the base safe	Out patient appointments capacity risk	Director of Operations, FSS (RA)	**=**15	=15	=15	=15	=15	=15
06/17	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (JM)			**!15**	=15	=15	=15
06/17	3793	Keeping the base safe	Opthalmology follow up appointment capacity	Divisional Director of SAS (WA)			**!15**	=15	=15	=15
06/17	7345	Keeping the base safe	Referral to the District Nursing Service	Director of Nursing (JM)						**!15**
06/17	7396	Keeping the base safe	0xygen connection	Director of Nursing (JM)						**!15**
09/17	7414	Keeping the base safe	Building safety, HRI	Director of Finance (GB)						**!15**
09/17	7413	Keeping the base safe	Fire compartmentation HRI	Director of Finance (GB)						**!15**
FINANCE RISKS										
13/17	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
13/17	7240	Financial sustainability	Expenditure above planned levels 2018/19	Divisional Director, SAS (WA)		**!16**	=16	↑20	=20	=20
13/17	7169	Financial sustainability	Financial plan 2018/19	Director of Finance (GB)	=12	=12	↑16	=16	=16	=16

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19
WORKFORCE 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 22/02/2019

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	= 6345 Nurse Staffing = 7078 Medical Staffing = 7271 ICU infrastructure, HRI	=7278 Financial sustainability
Likely (4)				=5862 Risk of falls with harm =7132 Patient scores in Emergency Department =7223 Digital IT systems risk =7248 Mandatory training =7169 Financial Risk =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity !7345 Referral to District Nursing Service	= 2827 Over reliance on locum middle grade doctors in Emergency Department = 5806 Urgent estate work not completed = 6903 HRI Resuscitation estates risk =7315 Appointment Risk =7240 Surgery and Anaestjetics division financial risk
Possible (3)					= 6011 Blood transfusion process = 5747 Vascular /interventional radiology service =7338 EPR !7396 Oxygen connection risk !7413 Fire compartmentation HRI !7414 Building safety, HRI
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

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**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**

High Level Risk Register as at 22 February 2019 Board Meeting 7 March 2019

22 February 2019

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The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
Very High	7278	Corporate	Finance and Procurement	Trustwide Finance	Jun-2018	Active	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		**February 2019** Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case for reconfiguration due for submission in April. The 2019/20 control total and planning guidance have now been received and the Trust has submitted a draft plan that has indicated that the Trust will accept this control total. This will allow the organisation to access non-recurrent MRET funding of £6.13m, Provider Sustainability Funding (PSF) of £7.33m and Financial Recovery Funding (FRF) of £14.81m reducing the overall planned deficit to £9.71m.	Mar-2019	Mar-2019		FPC	Gary Boothby	Philippa Russell
Very High	2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	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	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle	20 4 x 5	20 5 x 4	12 4 x 3		**February 2019** Additional Specialty Doctor has been recruited.. awaiting Visa Previously appointed CESR doctor now has GMC registration .Visa requisition in progress	Mar-2019	Aug-2019		WEB	David Birkenhead	Dr Mark Davies

							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.	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	grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.								
Very High	5806	Calderdale and Huddersfield Solutions	Estates	Estates Department	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 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	The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. Each of the risks above has an entry on the risk register and details actions for managing the risk.Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	12 3 x 4		**February 2019 Update** Asbestos removal in Block 3 Plant room started due to complete 12 March 19. Emergency cladding works started on high risk cladding panels due to complete March 19 Structural condition survey received 6 facet condition survey due to complete March 19	Mar-2019	Mar-2020		RC	Gary Boothby	Paul Gilling / Chris Davies

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													
Very High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	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	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		16 4 x 4	20 4 x 5	9 3 x 3		**February 2019** 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 5 started in September, 2 ready to start in February and 67 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	Mar-2019	Mar-2019		WF	Jackie Murphy, Suzanne Dunkley	Paul Casson/Rachael Pierce

								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)	Active recruitment activity, including international recruitment						has been amended to focus on one specialty. Adverts for surgery have continued and an adverts specific to Oncology and Urology are advertising to trial a new approach to test whether an increase in application numbers can be seen. Applications currently remain low. The nursing associate role is advertising until 31 January and is proving popular with 14 applications received so far.						
Very High	6903	Calderdale and Huddersfield Solutions	Estates	Estates Department	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	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		**February 2019 Update** Mechanical and electrical systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Mar-2019	Oct-2019		RC	Gary Boothby	Chris Davies

area to mitigate the risk.)

Electrical Resilience – lack of support infrastructure/ Medical IT i.e. UPS/IPS to ensure continuity of power supply in the event of a power outage resulting in harm to patients

Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access

Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions

Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections

Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases

Medical Engineering Risk - 4 Dameca Anaesthetic Machines - failure due to end of useful life resulting in unplanned disruptions/ harm to patients

Operational Safety – the current space within each bed bay does not meet the minimum required space for operational safety resulting in harm to patients and staff

Compliance / Statute Law – All of the above does not meet the minimum requirement as stipulated

							in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law resulting in prosecution													
Very High	7078	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	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		**February 2019** All new doctors in training that rotated to CHFT in February were fully cleared to commence in post without delay. The Medical Education team arranged a focussed induction which was specific for medical and dental staff. FY3 interviews led to offers for 2 people in Emergency Medicine and 2 in Medicine, with interviews yet to be confirmed in General Surgery and Trauma and Orthopaedics. The Medical HR team are now working on pre-employment checks and clearances for the trainees that are due to come to us in April, along with sending work schedules, and updating pay arrangements for foundation trainees that will rotate to a different specialty in April. A number of recent appointments have been made which include Consultants in; Care of the Elderly, Diabetes and Endocrine, Urology, Breast Surgery and Interventional Radiology. There are a number of applicants for consultant posts in Radiology who will be interviewed late February 2019.	March -2019	Mar-2019		WF	David Birkenhead	Pauline North

Very High	7240	Surgery & Anaesthetics	All Directorates S&A	All Departments/Wards S&A	Apr-2018	Active	Financial sustainability	There is a risk of expenditure being above planned levels for the Division due to lack of budgetary controls, usage of agency and locum to support gaps in capacity to achieve contracted activity or higher than planned costs to maintain appropriate staffing levels relating to patient safety and quality or identification of pressures not evident within the planning process. Resulting in non-achievement of the Divisions planned contribution impacting on the Trusts ability to deliver its 18/19 I & E plan and remain a viable sustainable organisation	Pressures experienced in 17/18 have been incorporated and supported within the pressures funding approved for 18/19 Monthly budget holder meetings Monthly DMT, Divisional Board and Surgery PRM meeting to review performance Bi Monthly Directorate PRM to review performance Weekly Medical agency confirm and challenge meetings Bi weekly nursing agency confirm and challenge meetings Weekly CIP directorate meetings to ensure schemes are on track	Head & Neck General Manager Vacancy	9 3 x 3	20 4 x 5	16 4 x 4	Following the detailed forecast review at month 5 the potential deficit could be circa £2m. The risk register score is therefore recommended to be a 16. Actions to recover are focused around Release of workforce capacity including bank, agency and WLI - Executive decision awaited with regard to agency Opportunities for out of area activity - a number of Trusts and specialities have indicated they require capacity to deliver on performance targets. Where existing capacity can be used to facilitate this it may bring additional income at marginal cost Performance and productivity Medical job plan review Vacancy freeze Enhanced non pay governance	Division is now in weekly finance escalation. The weekly meetings are with the DOF, COO and Director of planning and Transformation. Each DMT is being reviewed on a four weekly cycle and a recovery plan developed There is weekly monitoring of the progress to recovery and profiled impacts by month Each month then completed will be assessed against the forecast including recovery plans to achieve assurance of actions taken The risk score has been increased to 20 to reflect that the likelihood of recovering to a position less than a £1m adverse is unlikely. This was assessed and agreed at the Surgery PRM on Monday the 29th of October and proposed and supported by the executive team. January and February 2019 Update The Division have concluded the weekly finance escalation meetings. The Division have agreed a revised control total through the February PRM of £1.8m adverse. This must be delivered to ensure the Trust achieves the 18/19 £43m control total. The drivers of this adverse variance have also been considered within the 19/20 planning submission for the Division	Mar-2019	Mar-2019		DB	Mr Ainslie	Joanne Hardcastle

Very High	7271	Calderdale and Huddersfield Solutions	Estates	Estates Department	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	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		**February 2019 Update** Mechanical and electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Mar-2019	Sep-2020		DB	Gary Boothby	Chris Davies

							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													
High	6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	Active	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 EL (97) 52 external audit which reported 4 major deficiencies limiting its capacity to make parenteral products, resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be developed before April 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are	Until the strategies outlined above to improve capacity have been implemented we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm and Sat am 8.30-12 Require ward staff engagement regarding potential impact on staff from making products on wards	15 3 x 5	16 4 x 4	3 3 x 1	Action Plan October 18 in place - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit.	**February 2019** Re-audit completed Jan 19. Awaiting final audit report. Verbal feedback at time of audit was positive. State of facilities will still be a major issue and auditor aware that will not be remedied until new unit opens in 2020. Auditor was positive about progress made with capacity plan	Mar-2019	March -2020		DB	Jackie Murphy	Elisabeth Street

									prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition, product catalogue, and from Feb 2020 - outsourcing radiopharmacy)											
High	7248	Corporate	Workforce & Organisational Development	Workforce Development	Apr-2018	Active	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated essential safety 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. The proposal has been agreed for 2019/2020. Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our essential safety 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 essential safety training subjects alongside the 29 role specific essential skills training. This approach strengthens the importance of completing the essential skills designated to specific roles and by combining the two areas into one enhances the Trust's requirement to reach 95% across all the competency offerings.	All electronic e-learning training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16	16	4	January 2019 Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support. Additional training dates have been added for safeguarding and MCA/DoLS level 3.There are sufficient places to train ALL staff who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.	**February 2019** Compliance is being monitored on a weekly basis by Workforce and Organisational Development. The Health & Safety presentation delivered at induction has been filmed and will be launched as an option on ESR 18 February. A message regarding Fire Safety training featured in CHFT Weekly on 7 February advising that sessions are now available to 'drop-in' to as well as book a place on ESR. Classroom sessions for Health & Safety have been booked and will take place on 27th and 28th February and 6 March. Arrangements are being made to share the engagement plan with divisional leads to assist in improving compliance. Role Specific – It is recommended that no further EST Role Specific subjects are added to the list of 34 until a robust plan is in place for compliance of those 34 subjects. Role Specific – any future additions to the list will need signed off at WEB once approved at the Nursing and Midwifery Committee.	March-2019	Mar-2019		WF	Suzanne Dunkley	Claire Wilson

							Risk:- There have been issues with ESR and the consequences of not being able to undertake e-learning. ESR was down for 15 days from 31 December 2018 - 14 January 2019. Impact:- Employees have been unable to access ESR to undertake e-learning and in turn affects our ability to reach and maintain 95% compliance.													
High	7132	Medical	Emergency Care	Accident & Emergency CRH/HRI	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	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.	**February 2019:** Nerve centre unsuitable for ED implementation in current format. Awaiting NEWS 2 go live at end of the month.	Mar-2019	Mar-2019		PSQB	David Birkenhead	Louise Croxall
High	7169	Corporate	Finance and Procurement	Trustwide Finance	Jan-2018	Active	Financial sustainability	Risk of not achieving the 2018/19 Financial Plan: The Trust has planned a deficit of £43.1m. There is a risk that the Trust fails to achieve its financial plans for 2018/19 due to: - £18m (4.5% efficiency) Cost Improvement Plan challenge is not fully delivered	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance	Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges - including impact of external pressures Volume of agency breaches remain comparatively high and a higher value for each breach.	25 5 x 5	16 4 x 4	9 3 x 3		**February 2019** The year to date and forecast deficit are both currently in line with the plan, although the year to date position has relied on the release of £1.00m of contingency reserves and a positive timing difference on the Winter Reserve to offset overspends in both pay and non pay. Unless the run rate continues to improve, a financial pressure could emerge in	Mar-2019	Mar-2019		FPC	Gary Boothby	Philippa Russell

							- expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - shortfall in income recovery	Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Controls around use of agency staffing have been strengthened. Aligned Incentive contract with two main commissioners. Approval process for new investments through Commercial Investment Strategy Committee New controls introduced for some non pay expenditure and overtime payments.						future months as contingencies are now exhausted. The forecast assumes full achievement of £18m CIP target, of which £1.98m is high risk and also relies on full delivery of an additional recovery requirement with a total value of £4.19m that is fully identified. Agency expenditure is now £1.33m below the NHS Improvement ceiling, with a favourable forecast position of £1.60m below ceiling. The risk of loss of income has been largely mitigated by agreement of an Aligned Incentive Contract (AIC) with the two main commissioners, although any out of area activity remains on a payment by results basis and any costs incurred as a result of overtrading against the AIC would not be covered by additional income generation.						
High	7223	Corporate	THIS	THIS -Operational	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 and failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure), resulting in an inability to effectively treat patients and deliver ompassionate	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	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	Jan 2019 The UPS is now in place across all 3 phases into the Data Centre. Divisional BCPs including 'no access to digital services' aim to be completed before 31st March 2019. **February 2019** No further update, position is as above.	Mar-2019	Mar-2019		RC	Mandy Griffin	Rob Birkett

								care, not achieving regulatory targets and loss of income	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					relevant standard (almost complete).							
High	5862	Medical	All Directorates Medical	All Departments/Wards 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	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	12 4 x 3	16 4 x 4	9 3 x 3		**February 2019 Update** There has been a significant rise in the falls number with 50 falls in January 2019. Falls collaborative lead and matron undertaking deep dive of these falls.	Mar-2019	Aug-2019		PSQB	Jackie Murphy	Helen Hodgson

									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	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.								
High	3793	Surgery & Anaesthetics	Head and Neck	Ophthalmology	May-2017	Active	Keeping the base safe	Risk of delays for patients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 3 x 2	16 4 x 4	3 1 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) - Glaucoma advert currently out, closing date extended by 2 weeks. - Review of medical workforce model with Consultant department education supervisor (in progress) - New Orthoptist injector commenced in post Jan 19 - Macular project to release 6 sessions to reinvest into providing additional capacity - Locum General Ophthalmologist JD written 13/2/19 - Medical staff not undertaking WLIs	**February 2019** - Glaucoma advert currently out, closing date extended by 2 weeks. - Review of medical workforce model with Consultant department education supervisor (in progress) - New Orthoptist injector commenced in post Jan 19 - Macular project to release 6 sessions to reinvest into providing additional capacity - Locum General Ophthalmologist JD written 13/2/19 - Medical staff not undertaking WLIs	Mar-2019	Jun-2019		DB	Will Ainslie	Pnt Laloe, Clinical Director

								Ophthalmology (happened in summer 2018)											
High	7345	Community	Community Nursing	District Nursing / Matrons	Oct-2018	Active	Transforming and improving patient care	Patient Safety Risk - There is a risk of patients with a nursing need not being referred on discharge to the District Nursing service. Due to lack of referral facility on EPR and the discontinuation of the PASWEB referral pathway prior to the implementation of EPR. Resulting in patients not receiving district nursing care deteriorating at home and being re admitted to hospital.	Wards have been advised to contact the DN teams via telephone to make referrals on discharge. Community Division to work with the other division to test out if this process is being followed and understood. Community Division are reporting incidents of non referral on to Datix to enable monitoring	System has not yet been tested	16 4 x 4	16 4 x 4	2 1 x 2	Directory of Community services circulated to wards and departments Ward staff encouraged to refer to District nurse via telephone E referral option being scoped Wards and discharge coordinators encouraged to invite District nurse to MDT	**February 2019** E referral template designed. Teams identified to trial the referral	Mar-2019	Jun-2019		PSC	Liz Morley	Caroline Lane
High	7396	Trustwide	All Divisions	All Departments/Wards	Jan-2019	Proposed for Acceptance	Keeping the base safe	For patients prescribed oxygen, there is a risk of staff connecting the tubing to an air flowmeter which has been inserted into the air outlet in the wall rather than the oxygen flowmeter in the oxygen outlet. This is because the outlets are adjacent throughout CRH, and the tubing fits both flowmeters. The impact is reduced oxygen saturations for a patient which could patient potentially leading to a deterioration in clinical condition and potential harm. There is also a reputational impact as connecting oxygen tubing to the air is a Never Event and reportable as a serious incident.	All terminal air ports to be capped off Trust purchased 100 electric nebulisers Training in relevant areas in the use of the use of the new devices Daily spot checks until all terminal air ports are permanently capped off Check of air outlets added to the must do checklist for ward staff. Medical Gas Pipeline Policy Medicine Code (section on Medical Gases) HTM Medical Gas Technical Memorandum on national standards NIV and Oxygen Group leading on Medical Gases Outlets are marked oxygen and air - and colour coded. Flowmeters state 'oxygen' or 'air', are different colours and only fit the relevant outlet (eg. air to air) Flaps were attached to air flowmeters Staff training Removal of air flowmeters is part of the Environmental Check	• The flaps on the air flowmeters can be easily knocked off - no alternate device with a more secure flap is available • Medical Device - Oxygen / Air training has been revised (Sept 2018) to cover the alert, but numbers trained so far on the new training is small. • Staff may leave flowmeters in the air outlet after giving nebulisers. • The Trust is not currently compliant with HTM Medical Gas Technical Memorandum on staff training • Lack of clinical staff awareness about the Never Event and risks of connecting patients to air. • The failure of the air flowmeters on the Environmental check does not flag up on the front of the Ward Assurance Tool • Patients often remove	15 3 x 5	15 3 x 5	3 3 x 1	1. Plan to deliver Medical Device Air / Oxygen training to all registered nursing staff by end April 2019, via cascade training. Assurance will come from the Medical Device Training Database, monitored by the Medication Safety and Compliance Group. 2. Action plan for assurance on compliance with the training as per the HTM Medical Gas Technical Memorandum to be developed at the NIV and Oxygen Group 3. Removable plugs being fitted to wall air outlets in all ward based areas 4. Clinical areas with piped air will need a documented risk assessment if plugs are not to be fitted. 5. Consideration of labelling of the air and oxygen outlets to be stronger. 6. Review of the	**February 2019** Permanent caps to cover medical air terminal units in progress Daily spot checks to ensure all medical airflow meters are removed from wall outlets Stop signs delivered To be attached to air supply Nebulisers now in place at CRH All respiratory wards have received nebulise training	Mar-2019	Apr-2019		QC	Jackie Murphy	Nick Scriven

									linked to the Ward Assurance Tool Quality Walkrounds have been periodically checking on the removal of air flowmeters	nebulisers, leaving flowmeters in place • NIV and Oxygen Group - previously separate now being combined for oversight with meeting for the first time in February 2019				assurance provided via the Ward Assurance Tool at the NIV and Oxygen Group 7. Monitoring of attendance at the NIV and Oxygen Group to ensure appropriate attendance. 8. Checklist on cleaning bed space to include that the air flowmeter has been removed						
High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Proposed for Acceptance	Keeping the base safe	HRI There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout	Number of Areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. For CHS to manage this in a prioritised risk based approached it is essential the Trust decants areas to enable CHS to complete building works to a satisfactory standard.	**February 2019** A walk around on wards between CHS, CHS Fire Officer and Matrons has taken place with the aim of de-cluttering wards to ensure a safe and effective evacuation is possible in the event of a fire. Prior to any fire compartmentation work, CHS and contractors require assurance the area is clear from asbestos. There is also the potential for asbestos migration therefore, all areas must undergo an asbestos survey prior to any building works taking place which adds to the duration of the works. Work planned for CHS to hard wire all toasters into most appropriate area in areas	Mar-2019	Apr-2019		FC	Gary Boothby	Alison Wilson

								CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher											
High	7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in incident and harm to patients, visitors and staff.	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	**February 2019** Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. March 2019 costings to be considered along with capital plan.	Mar-2019	Apr-2019		FC	Gary Boothby	Alison Wilson
High	7280	Family & Specialist Services	Pathology	Blood sciences	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	15 3 x 5	15 3 x 5	3 3 x 1	1. Lab to liaise with EPR trainers- completed 2. comms re use of disclaimer form to be sent out by lab.- completed 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 - underway lab staff to be trained to mark as collected those requests where barcode has been used and results issued	Update 10/12/2018- No change since last review, work ongoing to support clinical teams Update 01/02/2019- Work is still ongoing to support the clinical team in the click collect system.	Mar-2019	Mar-2019		PSQB	Rob Aitchison	Karen Mitchell

									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				6. Lab IT to liaise with EPR team to restrict addition of requests onto the phlebotomy list- underway 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)- underway 8. lab experts to support clinical teams in click-collect- well underway							
High	7315	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2018	Active	Keeping the base safe	Risk of delay to patient care, diagnosis and treatment caused insufficient outpatient appointment capacity to meet current demands resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and possible claims. Currently there are in excess of 11,000 patients awaiting appointments. circa 3500 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 8,000 follow up patients that have all exceeded the appointment due date. Please refer to following individual risks: 4050 6078	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3		20/1/19 New patients - specialty leads working through action plans to reduce ASIs. Follow-ups Proposal top reset the partial booking invite timescale so that it is closer to the appointment due date. This will free up appointment capacity for the backlog of patients overdue appointment. **February Update** New patient ASIs continue to rise. Main areas for concern are Ophthalmology, Cardiology, Gastro and ENT. Specialty leads are working through plans to improve the position. Changes to follow-up management will create some smaller volumes of capacity. Follow-ups. The partial booking invite timescale has been moved from 6 weeks	Mar-2019	Apr-2019		PSQB	Rob Aitchison	Katharine Fletcher

							6079 7199 7202							prior to appointment start date to 7 days. This has created a 5 week window to utilize capacity for the backlog of long waiters. Work commenced this week and has already delivered a reduction in backlog of over 700 in 3 working days. Progress is being monitored daily.						
High	7338	Corporate	Corporate Nursing	Workforce and Clinical Development	Oct-2018	Active	Keeping the base safe	The Risk of an incomplete Electronic Patient Record due to clinicians failing to commit a clinical entry to the electronic system in a timely manner. This is due to the fact there is an ability to 'save' an entry on to the system which is not submitted to the patient record until the 'signed' option is selected. The system at no point advises the clinician that their entry is still in a 'saved' state. The result of this is that the 'saved' entry is only viewable to the clinician who has entered the data, rendering the record incomplete. There are currently 65,000 entries on the system that have not been signed potentially since the start of EPR which equates to 0.5% of records.	Training of all staff prior to implementation and EPR training as part of induction. Standard Operating Procedure available on the Trust Intranet for staff to access. Clinicians with 10 or more 'saved' entries have been directly targeted via email highlighting the number of unsigned entries with appropriate instruction as to how to address. EPR banner viewable to clinicians launching the EPR system with appropriate advice on 'saved' and 'signed' entries. Ward Managers Forum informed - issue on their action log. Nursing and Midwifery Committee informed, appropriate teaching given and user guide supplied. Escalated to Data Quality Team Escalated to EPR Operation Group	This risk highlights that all staff do not understand the difference between a 'signed' and a 'saved' entry. That staff do not use Message Centre regularly to review any 'saved' entries. There are reports that clinicians use the 'save' functionality without due diligence. Potential training re-evaluation required. Greater emphasis required to routinely report, monitor and cascade the status of these records. Not clear in the system as to the difference between 'save' and 'sign'. No automatic prompt advising that the entry only viewable to the author.	15 3 x 5	15 3 x 5	8 2 x 4	1. Inform Divisional Leads as to current status. 2. Form a Task and Finish Group to evaluate available options to resolve this issue in the short and long term. 3. Monitor and report back none compliance until situation improves - to be determined as part of the Task and Finish Group. 4. Propose potential changes to the EPR system such as automate signing an entry after a designated time having a prompt to 'sign' an entry remove 'save' option 5. Review training for all cohorts.	**February Update** 1. Funding secured to produce computer tag with advice re sign not save . 2. Paper produced to present to Digital Health Forum on 14.02.19 to establish what to do with historical entries. 3. Cerner have advised that a prompt can be added to banner bar. Have advised that it is not possible to change the functionality within the system. 4. Report from Wirral advising that they sign all documentation meaning they do not have this issue. 5. Current figures show 38947 with a weekly rate of 194 - 250 in the last month.	Mar-2019	Mar-2019		NA	Jackie Murphy	Carol Gregson/Graham Walsh
High	5747	Family & Specialist	Radiology	Angiography & Fluoroscopy	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	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	**February 2019 update** Substantive consultant in post Ad-hoc locums supporting the service - agreement provisionally agreed with Leeds but unlikely to materialise currently	Mar-2019	Jun-2019		DB	Rob Aitchison	Sarah Clenton

							cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.						regional-wide response	NHS locum for 12 months due to start in June 2019						
High	6011	Family & Specialist Services	Pathology	Blood sciences	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		**February 2019** No change since last review. 'Buddy system' still being used for some samples – in that respect, we are more vulnerable than before due to uncovering of poor practice. Plan to close this risk and separately identify and score residual risks for bloodtrack and non bloodtrack areas - . had 2 WBIT in last 3 months, both in areas where bloodtrack is not used. Update 14/02/2019 Wait until new risks written prior to closure of 6011.	Mar-2019	Jun-2019		PSQB	Julie O'Riordan	Sarah Ramsden and Alison Milner
High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	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	**February 2019** Clinical documentation group now meeting on a monthly basis with representation from all Divisions. Review of paper documentation being carried out with a view to formulating a plan to reduce this along with associated changes required to implement into EPR.	March -2019	March -2019		WEB	Jackie Murphy	Carol Gregson/Graham Walsh

12. Learning from Deaths – Quarterly Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 7th March 2019	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Learning from Deaths – Quarter 3 2018/2019 Report - This report contains the Q3 Learning from Deaths for 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 contains the Q3 Learning from Deaths for the Board. It contains the revised process of Initial Screening Reviews, current performance on and learning from mortality reviews. The report also outlines the main changes to the LfD policy. Finally, there is a summary of the thematic analysis of 12 months of Structured Judgement Reviews.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board are asked to approve the Q3 report.

Appendix

Attachment:

Combined LFD Q3 BoD Report - March 2019 V3.pdf

Introduction

This report contains the Q3 Learning from Deaths for the Board. It contains the revised process of Initial Screening Reviews, current performance on and learning from mortality reviews. The report also outlines the main changes to the LfD policy. Finally, there is a summary of the thematic analysis of 12 months of Structured Judgement Reviews.

Initial Screening Reviews (ISR)

In the last 12 months, there have been a 1596 adult inpatient deaths, of these, 471 (29.5%) have been reviewed using the initial screening tool. The quality of care was assessed as follows:

Quality Care Score	Number	Percentage of all deaths
5 – Excellent Care	170	10.6%
4 – Good Care	199	12.5%
3 – Adequate Care	78	4.9%
2 – Poor Care	14	0.9%
1 – Very poor	1	0.06%

Poor or very poor care triggers further investigation using the structured judgement review process.

The table below shows the number of adult inpatient deaths per month and deaths reviewed broken down by month for 2018.

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total
Total deaths	193	172	158	130	117	116	96	113	120	124	126	131	**1596**
Total reviewed	57	60	39	34	48	40	26	44	41	25	27	30	**471**
% reviewed	29.5	34.8	24.7	26.2	41	34.4	27	38.9	34.1	20.1	21.4	22.9	**29.5 %**

Online ISR Tool

The online initial screening review tool has been revised and consolidated focussing primarily on initial assessment, ongoing care and end of life. Reviewers are asked to provide their judgement on the overall quality of care as described above. Specialities have been given the opportunity to identify additional specific question to enhance the information they have around death. The tool now includes speciality specific questions for Gastroenterology, Critical Care, Haematology, Oncology and Respiratory.

Speciality focused Initial Screening Reviews

Despite implementing a robust process to allocate all deaths for an ISR earlier in 2018 the organisation still only reviewed around 30% of all adult inpatient deaths. It was noted that uptake was significantly better in specialties who had agreed to review their own deaths. In Q3 of 18-19 the organisation made the decision to support speciality specific reviews with the understanding that consultants would not be allocated reviews outside of their speciality if they committed to completing review within their speciality. Quarter 3 performance for participating specialities:

Speciality	Deaths	Completed	Deaths	Completed	Deaths	Completed
	October		November		December	
Gastro	4	4	3	3	5	5
Surgery	6	0	4	2	8	0
Ortho	2	0	6	3	1	0
Stroke	12	10	7	0	7	0

Critical Care	8	8	10	6	13	3
Acute Care*	-	-	14	11	30	17

* Acute Care are now completing ISRs for patient who died within 72hours of admission to either Acute Floors or MAUs

From Q4 onwards specialty specific reviews will also take place in:
Respiratory
Cardiology
Oncology
Haematology
Elderly
Calderdale Community (Kirklees Community in discussion with Locala)

This process, whilst not screening all deaths, aims to achieve an initial review of more than 50% of all CHFT adult inpatient deaths by the end of 2019. Specialities will now present the learning from their reviews at the Mortality Surveillance Group on a 6 monthly basis.

In addition to adult inpatient, reviews also take place in ED & Maternity and Children. The data and learning from these reviews will be included in LfD reports for Q4 onwards.

LfD Policy

The LfD policy has been reviewed and updated. The changes include that the avoidability assessment has been removed from the SJR process in line with RCP guidance. The role and responsibility of the Learning from Death panel has been added. The escalation process from ISR to SJR and from to SJR to Serious Incident has been strengthened. The process for stillbirths and neonatal deaths has been revised. The policy also includes a greater emphasis on involving bereaved families and carers.

Structured Judgement Reviews (SJR)

In 2018, 99 deaths were escalated for an SJR. The table below shows the reason for escalation for a SJR and the number completed.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Escalated from ISR	2	2	2	1	2	1	1	0	2	0	0	0	13
Complaint	3	4	2	4	4	2	1	2	0	1	5	1	29
SI process	2	0	0	0	0	1	1	0	1	0	2	1	8
Elective	0	1	0	0	2	0	0	1	1	1	0	0	6
LD	0	1	2	1	1	0	0	2	0	1	1	1	9
Other	9	1	2	0	2	1	2	0	2	5	0	9	33
Total Requested	**16**	**9**	**8**	**6**	**11**	**5**	**5**	**5**	**6**	**8**	**8**	**12**	**99**

A total of 28 SJRs were requested in Quarter 3. The quality care scores for these are below

Quality Care Score	Number	Percentage
5 – Excellent Care	2	7%
4 – Good Care	5	14%
3 – Adequate Care	17	61%
2 – Poor Care	4	18%
1 – Very poor	0	0%

Future Plans and Sharing Learning

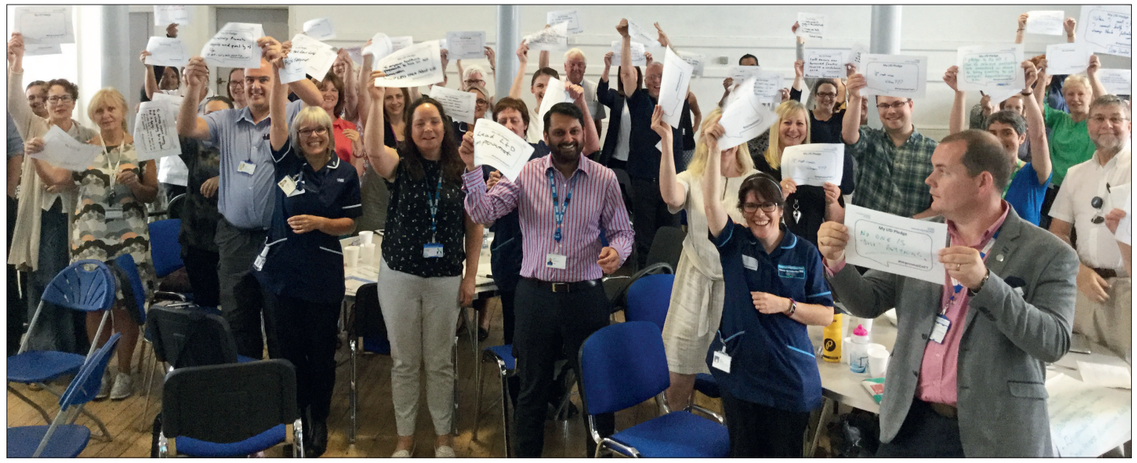
- Revise pathway for bereaved family or carers to raise any concerns in line with NQB guidance
- Disseminate learning across the Trust – by video linked to Trust news, Intranet, PSQB and audit meetings
- Action planning at Trust and Divisional level for Quality Improvement
- Implementation of new specialty specific ISR process
- Align LfD to the new Medical Examiner role (if approved)

SHARING LEARNING – IMPROVING CARE
ISSUE 7: NOVEMBER 2018

Positive Talking Points

Our commitment to improvement- LfD pledges

- To review processes for children going to the mortuary
- To be positive in my work and at home. A smile a day can make a difference
- Support identification of improvement opportunities and positive learning. Support a regular LfD Summit
- To encourage good communication on all levels
- Continue to monitor and support LfD programme at the Trust's Quality Committee and Board of Directors
- To talk to patients about advanced care planning
- Encourage the use of SPICT tool for community staff especially for patients without cancer i.e. long term conditions. #Letstalkaboutlife
- To actively promote dignity and quality of life
- When I meet a patient I cannot help I will always think 'Palliative care?'
- Help to improve the experience of death for hospitalised children and their families – e.g. Enable choice, Ward/ Home/Hospice, developing a proforma for staff 'what to do' when a child dies, additional staffing when a child is dying
- Support this agenda (LfD)
- I will do what it takes to deliver an embedded specialist palliative care team in all key wards, seven days a week.
- To create a card for families that is personal and child focused *we care with love
- Lead LfD improvement
- To support colleagues in providing palliative care to our patients
- Communicate at eye level
- #ACP
- To empower healthcare professionals to have an ACP convention #ACPletstalkaboutlife
- To create a stroke bereavement card for relatives
- To create cards for families of the patients after their loss. To always use #Hellomynameis
- I pledge to make sure all staff are aware of sending cards to the bereaved
- I will ensure our bereaved families receive a condolence card
- To encourage everyone to see that with kindness and compassion death need not be a failure
- I pledge to keep sight of the fact that my patient is a human being and that how I interact with him/her could positively or negatively affect their experience
- To actively support nursing staff when caring for a patient that is dying. To make sure it forms part of my routine workload and is seen as one of my priorities



Previous editions of the newsletter can be found here:
https://intranet.cht.nhs.uk/non-clinical-information/quality-and-safety/sharing-learning-improving-care-slic/

SHARING LEARNING – IMPROVING CARE

Focus on Learning from Death Summit

Learning from the care provided to our patients who die in hospital is a key part of clinical governance and quality improvement work. In February 2017, the CQC set out new requirements for the investigation of deaths for all trusts and this was followed by the publication by the National Quality Board in March 2017 providing further guidance for trusts entitled 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. We published a Learning from Death (LfD) Policy that outlines the process by which we, as an organisation, will learn from those who die in hospital.

Share your thoughts and ideas by emailing LfD@cht.nhs.uk

#hello my name is… Sal Uka

Sal Uka

I am an Associate Medical Director with responsibility for learning from death.

On the 12th July 2018, over 70 colleagues attended the Trust's first 'Learning from Deaths' summit. The event was supported by Chris Pointon, husband of the late Kate Granger, who shared his 'hello… my name is' story. In addition attendees shared the reality of the themes under the LfD Umbrella and contributed to the response to achieve the result for each theme. This newsletter aims to share the output with you.

Read on to find out about:

1. LfD Initial Screening Reviews (ISRs) & Structured Judgement Reviews (SJRs) (Mortality Reviews)
2. End of life care
3. Specialist palliative care
4. Death certification
5. Engaging with families & carers

The Governance and Risk Team will be publishing regular themed reports to encourage learning from our adverse events. If there is a topic you would like us to feature, please contact Laura Bailey (Directorate Secretary) on behalf of the editorial panel.

compassionate care

DEATH CERTIFICATION

REALITY:

- Important data
- No process for assuring factual accuracy
- Junior doctor completing death certificate
- Not prioritising completion of death certificate
- Abbreviations being used on the Medical Certificate of Cause of Death (MCCD)

RESULT:

- Timely – 5 days for registering the death from date of death (Calendar days)
- Accurate completions of Mode of Death
- Electronic reporting to coroner

RESPONSE:

- Discussion with senior doctors for reason of death
- Cause of death prior to death- Individualised Care of the Dying Document (ICODD)
- Mortality checklist
- Doctors induction
- Photocopy of death certificate for junior doctors to practice on
- Ring GP's – Hospital doctors to contact GPs re patient death?

LOOK OUT FOR:

- More education and training for junior doctors on how to complete MCCDs
- A training video on the intranet
- MCCDs forms on wards!

LFD INITIAL SCREENING REVIEWS (ISRS) & STRUCTURED JUDGEMENT REVIEWS (SJRS) (MORTALITY REVIEWS)

REALITY:

- ISR reviews performed on 25% of deaths
- SJR's show that we can improve our care
- Different teams using different processes
- SJR reviews – who is this feedback to?
- Is learning shared with right people?
- Don't feedback on good care

RESULT:

- Celebrate good examples of care
- Review all deaths to capture themes and share widely
- Nursing staff involved in SJR assessments
- All using online tool

RESPONSE:

- Multi-professional reviews to include Doctors and Senior Nurses
- Develop feedback methods to staff involved
- Identify things that went right and feed this back
- Identify how to make it better – opportunities to improve
- Regular mortality events – case reviews
- Training sessions for consultants
- Capture all reviews centrally and share results through audit meetings
- Capture family/carer views

LOOK OUT FOR:

- Themes identified from 12 months of mortality reviews
- Changes to the online mortality review tool and to the Initial Screening Process
- Including bereaved families and carers in the review process

SPECIALIST PALLIATIVE CARE

REALITY:

- Good community links/liaison with hospices
- Widespread access to SystmOne (crucial to good care) is lacking
- Fractured knowledge/processes
- Incomplete/varied understanding of what patients are eligible for SPC service
- Patients referred to SPC service late in process

RESULT:

- Early referrals to SPC team
- Increased understanding of SPC service offered
- Responsive/proactive SPC service
- Open, honest discussions about death/dying

RESPONSE:

- IT Connectivity
- Electronic triggers/prompts – Specialist Palliative Care (SPC) team
- Specialist Palliative Care Team staffing to allow embedded/ proactive practice everywhere/ everyday
- Building capability/capacity within teams
- Network of professionals to advocate for referral to SPCT

LOOK OUT FOR THE FOLLOWING DEVELOPMENTS WITH THE MACMILLAN ED/MAU PROJECT:

- Sharing of excellent results across the Trust (and outside the Trust) to share learning and gain support for a larger and more proactive team
- Hope for key clinical areas to have embedded Specialist Palliative Care In-Reach
- Hope for a seven day face to face service from Specialist Palliative Care

END OF LIFE CARE

REALITY:

- Not aware of SPICT tool
- Breakdown in communication
- Not recognising dying
- No support for staff
- Staff expectation of services available – education needed of services available
- Dying not symptom controlled

RESULT:

- Seamless care
- Recognising dying
- Clinical leadership
- Compassionate, dignified death
- Improved communication between primary and secondary care
- More End of Life Companions

RESPONSE:

- Improve advanced care plan discussions
- Recognise dying – Recognition/ Confidence
- Mentoring end of life champions within Consultants
- Appropriate facilities
- Shared goals across primary and secondary care – earlier communication
- Add end of life care to huddles/Board rounds/handovers
- Improve support

LOOK OUT FOR:

- End of life care training for front line staff to be part of essential training from November 2018.
- Bereavement Cards to be sent out across the Surgical division.
- End of Life care symbol to be used when someone is nearing the end of life to increase awareness and support

ENGAGING WITH FAMILIES & CARERS

REALITY:

- Little feedback from families/ carers
- No guidance on who, how and when to ask for feedback
- These might be difficult conversations for both families and staff
- Need to offer a choice to feedback or not
- Thank you's as important as areas for improvement

RESULT:

- Ask everyone for feedback
- Feedback – variety in various ways (email/phone/survey/1:1)
- Follow up on feedback with actions and a response
- Are we doing a good job?

RESPONSE:

- Engage with families and listen to what they have to say
- Signpost families for bereavement support
- Send a card of condolences as a trigger feedback/offer support
- Dedicated bereavement team
- Evaluate use of bereavement questionnaire piloted in Stroke

LOOK OUT FOR:

- Results from the pilot in Stroke
- New national guidance from NQB
- Plans for a new Medical Examiner role in 2019

13. Care of the Acutely Ill Patient

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 7th March 2019	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient Report - This paper provides an update on the work of the Care of the Acutely Ill Patient Programme.	
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 paper provides an update on the work of the Care of the Acutely Ill Patient Programme. The report focuses on the six work streams, each of which is supported by an action plan. The Board of Directors are asked to note improvements across all six work streams.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Board of Directors are requested to:
1. Note the work being undertaken by the Care of the Acutely Ill Patient Programme to improve outcomes for patients.
2. Note the improved position for SHMI and HSMR.

Appendix

Attachment:

Combined CAIP Report - March 2019 V2.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Board of Directors

PAPER TITLE: UPDATE CARE OF ACUTELY ILL PATIENT (CAIP) PROGRAMME Quarter 3 October-December 2018.	**REPORTING AUTHOR:** Anne-Marie Henshaw, Assistant Director of Quality. and Safety. Sal Uka, Associate Medical Director.
DATE OF MEETING: March 2019.	**SPONSORING DIRECTOR:** David Birkenhead, Medical Director.
STRATEGIC DIRECTION – AREA: Keeping the base safe. Transforming and improving patient care.	**ACTIONS REQUESTED:** To note actions of the CAIP Programme.
PREVIOUS FORUMS: None	
EXECUTIVE SUMMARY: This paper provides an update on the work of the Care of the Acutely Ill Patient Programme. The report focuses on the six work streams, each of which is supported by an action plan. The Board of Directors are asked to note improvements across all six work streams.	
FINANCIAL IMPLICATIONS OF THIS REPORT: None	
RECOMMENDATION: Board of Directors are requested to: 1. Note the work being undertaken by the Care of the Acutely Ill Patient Programme to improve outcomes for patients. 2. Note the improved position for SHMI and HSMR.	
APPENDIX ATTACHED: Appendix 1: CAIP Dashboard December 2018	

1. Background

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

a) Investigating causes of mortality and learning from findings.
b) Reliability in clinical care.
c) Early recognition and treatment of deteriorating patients.
d) End of life care.
e) Caring for frail patients.
f) Clinical coding.

The programme is underpinned by improvement plan. The improvement trajectory is monitored on a monthly basis through a task and finish group.

Programme governance arrangements include:
- Monthly reporting into the Clinical Outcome Group.
- Quarterly reporting into the Quality Committee.

The CAIP programme dashboard is in Appendix 1.

2. Update on progress

a) Investigating causes of mortality and learning from findings.

SHMI and HSMR performance continues to be monitored and reported monthly to the Mortality Surveillance Group (MSG):
- The rolling 12 month (Jul 17 – Jun 18) SHMI score is 99.52 **which is in the 'as expected' range - published December**
- The rolling 12 month (Oct 17 – Sept 18) HSMR score is 83.74 **which is a positive outlier - published December**

The 'mortality risk' on the risk register will be reviewed and further reduced if this is maintained.

Alerting Conditions
No alerting conditions in the latest release of data (Q3).

Learning from Death
The revised online initial screening tool is now active. The new tool was developed following feedback from speciality teams and an engagement programme with different speciality teams has taken place to support improvement in ISR

Further work includes revision of the information provided to relatives following the death of their loved one to ensure they are aware of the process to review deaths and given the opportunity to be involved if they wish.

b) Reliability in clinical care.

Acute Kidney Injury (AKI) and Sepsis continue to be prioritised for evidence-based care bundle improvement work.

AKI has been put forward as a HAELO improvement project (as with Sepsis and Falls previously).

The sepsis collaborative continues to drive improvements to improve outcomes for patients who are either admitted with or develop Sepsis during their inpatient stay.
During the quarter there has been little improvement in the urine output element of the care bundle and so the collaborative will escalate to the Nutrition and Hydration Steering Group (NHSG) for action.

A leaflet for relatives following a sepsis diagnosis and ongoing care has been developed. It is envisaged that this would be published once a quarter and shared across the trust as part of the sepsis awareness work.

The sepsis training strategy is being refreshed and work is being done to better understand how to improve the time to between the alert, medic review and administration of antibiotics. To support this work, the lead nurse for sepsis post has been extended.

Workplace training continues with new 1 min-3min-5min package of bitesize learning.

The Trust is on track with the CQUIN and achieved this for Q3.

c) Early recognition and treatment of deteriorating patients.

The 'Observations in Time' element of the programme is currently being refreshed, and improvement has been noted across Divisions.

Implementation of NEWS 2 (February 2019) will assist with identification of cases where it was not possible to complete observations on time.

d) End of life care.

Bereavement Survey
Each year, CHFT currently takes part in an annual bereavement survey, whereby Next of Kin (NOK) for deaths occurring in the month of May are sent a survey to comment on their experiences. Of the 90 surveys sent, the trust has a 30% response rate.

In order to gather more feedback to both highlight the areas of excellent care and areas that we can improve on, a 6 month pilot audit is being undertaken on our four stroke wards at CRH. Prior to sending the survey, a bereavement card was sent to offer support and also inform them of the upcoming survey. So far we have had a 51.5% response rate.

Bereavement cards
A bereavement card is being developed with input from our bereaved relatives. This card will be sent out 1-2 weeks after death to offer a phone number for relatives to ring if they have unanswered questions or need support. This is going to be trialled within the surgical division.

Bereavement café
The Chaplain department alongside the end of life care facilitator have developed - The marigold café which is a bereavement café started on the 7th September. It is to run the first Friday of every month on alternate sites. This is open to anyone who has suffered bereavement.

End of life care companions
The companions are here to sit alongside patients at the end of life, either if they have no family or their families need a break. 20 companions have been trained to support our dying patients, their families and the ward teams.

Horizon group
This is a collaborative group which includes CHFT, Calderdale Council, the Council of Mosques and Overgate Hospice.

DNACPR
Compliance around DNCAPR review dates and discussion date as now being reported directly from EPR, compliance has dropped slightly in relation to this whole sample approach. Noted that discussions are documented in the notes but the corresponding box not ticked on the form.

Integrated Care of the Dying Document (ICODD)
Completion rates for the integrated Care of the Dying Document continue to be below Trust aspirations and work continues to improve end of life and recognition of end of life training and care.

Work is continuing to incorporate the Integrated Care of the Dying Document into EPR.

e) Caring for frail patients.

The Acute frailty service is based at Huddersfield site where there is an acute floor with 22 frailty beds under the care of a geriatrician and the frailty team. The service is currently available 12 hours a day, seven days a week but an aspiration for the future is for it to be available overnight. Telephone support is available over the phone as required for any patients on the Calderdale site.

There has been an investment into the frailty service from the winter monies, which has allowed the frailty service to recruit an additional geriatrician, nurses, ACPs, therapists, Physician Associates, pharmacist and a Band 4 nurse. This investment has enabled the frailty team to avoid a further 100 admissions a month in comparison to last December with a further 194 new referrals seen a month.

The frailty team provides a service to the Surgical Assessment Unit with a plan will be to set up a frailty ambulatory service in a designated area.

Work is ongoing to develop key performance indicators for frailty.

f) Clinical coding.

The Clinical Coding Action plan aims to address some of the key issues affecting the quality of the coding, including EPR documentation, data quality and education and engagement.

The Clinical Coding Improvement Action Plan for 2018-20 was signed off at the Digital Health Forum in September.
The action plan focuses on areas to improve the completeness and accuracy of the coded data. The areas covered include data quality, documentation quality and ease of use within source systems, education-engagement and the Cerner EPR system.

There has been significant progress made against some areas of the action plan including Coding Audit, Coding Training and communication within the Coding Team but more work is still required around documentation, education and data quality.

All KPIs showing signed of improvement.

3. <u>Recommendations to Board of Directors</u>

Board of Directors are requested to:

1. Note the work being undertaken by the Care of the Acutely Ill Patient Programme to improve outcomes for patients.

2. Note the improved position for SHMI and HSMR.

Appendix 1: CAIP Dashboard December 2018.

CARE OF THE ACUTELY ILL PATIENT (CAIP) PROGRAMME

compassionate care

NHS Calderdale and Huddersfield NHS Foundation Trust

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	YTD	Target
Theme 1 : Investigating Mortality and Learning from findings															
In Hospital Crude Mortality Rate (all Admissions)	1.82%	1.93%	1.94%	1.64%	1.40%	1.17%	1.23%	1.24%	1.18%	1.23%	1.18%	1.24%	**1.36%**	1.22%	NA
Number of In Hospital Deaths	174	194	175	163	131	118	119	121	116	119	127	130	**131**	1112	NA
Deaths within 30 days of Discharge	86	118	63	92	83	65	77	72	69	43	48	48	**43**	548	NA
Total number of deaths (in hosptal & within 30 days of discharge)	196	218	184	186	179	137	181	139	184	191	195	212	**in arrears**	1418	NA
% of Deaths occurring in Hospital vs within 30 days of discharge	88.78%	88.99%	95.11%	87.63%	73.18%	86.13%	65.75%	87.05%	63.04%	62.30%	65.13%	61.32%	**in arrears**	61.35%	NA
% Structured Judgement Reviews - SJR	100.00%	100.00%	100.00%	100.00%	100.00%	85.70%	100.00%	100.00%	100.00%	100.00%	TBC	100.00%	**100.00%**	TBC	100.00%
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.64	98.98	98.98	98.98	99.52	99.52	99.52	Due Feb 19			Due May 19			99.52	100
SHMI - COPD (CCS = 127)														108.06	100
SHMI - Pneumonia (CCS = 122)														97.13	100
SHMI - Sepsis (CCS = 2)														102.48	100
SHMI - AKI (CCS = 157)														106.38	100
Hospital Standardised Mortality Rate (1 Yr Rolling Data)	86.16	85.19	83.91	82.47	83.34	82.90	83.56	82.02	82.95	83.74				83.74	100
HSMR - COPD	81.26	75.57	76.51	71.34	75.63	68.08	72.80	74.20	79.90	72.61				72.61	100
HSMR - Pneumonia	89.06	87.46	85.88	79.96	85.41	89.94	90.87	89.00	91.34	95.06	Due Jan19	Due Feb 19	Due Mar 19	95.06	100
HSMR - Sepsis	89.39	88.21	89.17	87.79	89.09	88.32	86.82	86.26	85.81	86.76				86.76	100
HSMR - AKI	113.13	104.11	96.76	87.95	86.98	89.28	82.57	91.03	90.01	90.43				90.43	100
Theme 2 : Reliability															
Sepsis - Bundle Completed														0.00%	95.00%
B (bloods)	72.24%	71.93%	75.97%	62.62%	79.29%	80.75%	82.49%	82.91%	81.52%	78.79%	84.28%	74.86%	**in arrears**	80.61%	95.00%
U (urine output)	47.69%	52.92%	49.12%	46.65%	52.53%	47.06%	51.98%	50.63%	57.82%	41.67%	46.29%	45.71%	**in arrears**	49.21%	95.00%
F (IV fluids)	95.73%	96.78%	96.82%	96.49%	97.98%	96.79%	96.61%	97.47%	96.68%	96.97%	98.69%	95.43%	**in arrears**	97.08%	95.00%
A (antibiotics)	92.88%	92.98%	94.70%	93.29%	96.97%	98.93%	97.74%	96.20%	96.68%	96.21%	96.51%	95.43%	**in arrears**	96.83%	95.00%
L (lactate)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**in arrears**	0.00%	95.00%
O (oxygen)	3.20%	2.63%	2.47%	5.11%	97.47%	97.33%	97.18%	94.94%	99.05%	97.73%	98.25%	98.29%	**in arrears**	97.53%	95.00%
Theme 3 : Early recognition and treamtnet of deteriorating patients															
% obs done on time (marker of recognition)	66.70%	66.82%	67.19%	66.04%	68.04%	69.98%	70.28%	70.16%	71.10%	69.40%	69.90%	70.70%	**70.30%**	**69.98%**	NA
% patients who scored a EWS of 5 or above (marker of response)	17.11%	12.89%	18.16%	14.74%	14.91%	14.20%	12.06%	11.17%	14.85%	11.50%	11.30%	9.80%	**11.50%**	**12.37%**	NA
Number of patients who had an EWS score of 5 or above who subsequently scored higher (market of response)	572	591	504	513	512	553	503	485	503	650	630	631	**710**	**5177**	NA
Theme 4 : End of Life Care															
DNACPR % Discussion Completion	93.62%	93.20%	93.41%	90.99%	83.33%	86.52%	79.14%	80.51%	86.08%	89.51%	81.92%	82.28%	**87.29%**	86.46%	95%
DNACPR Review date completion %	94.68%	95.15%	94.51%	90.99%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	100.00%	95%
% patients on the ICODD	38.60%	48.70%	42.44%	44.30%	40.00.%	50.43.%	37.93.%	37.50.%	38.05.%	35.83.%	41.13.%	45.24.%	**40.46.%**	**39.42%**	NA
Theme 5 : Faility															
Frailty - Admissions Avoided	75	106	107	80	106	156	131	152	107	123	135	157	**179**	790	NA
Frailty - Occupied Bed Days	2156	2868	2871	2885	2999	3194	3070	2387	2626	2167	3155	2772	**2886**	27557	NA
Theme 6 : Coding															
Average Diagnosis per Coded Episode	5.88	5.84	5.95	5.91	5.8	5.7	5.76	5.76	5.8	5.53	5.71	5.8	**5.89**	**5.76**	5.27
Average co-morbidity score	6.25	6.15	6.01	5.87	5.65	5.5	5.45	5.57	5.41	5	5.44	5.3	**5.68**	**5.45**	4.43
% Sign and Symptom as a Primary Diagnosis	9.03%	9.70%	10.30%	10.41%	10.43%	9.92%	9.90%	10.00%	9.70%	9.90%	9.40%	8.92%	**9.14%**	**9.46%**	9.40%
% Coded with Specialist Pallative Care	1.30%	1.20%	1.60%	1.30%	1.49%	1.51%	1.55%	1.39%	1.29%	1.37%	1.30%	1.36%	**1.25%**	**1.40%**	NA

14. Q4 Guardians of Safe Working Report (Anu Rajgopal)

To Approve

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 7th March 2019	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Guardians of Safe Working Report - Guardians of Safe Working Q4 Report (16th October 2018-15th Feb 2019)	
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:

Guardians of Safe Working Q4 Report (16th October 2018-15th Feb 2019)

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

Guardian of safe working hours Q4 Report 2019.pdf

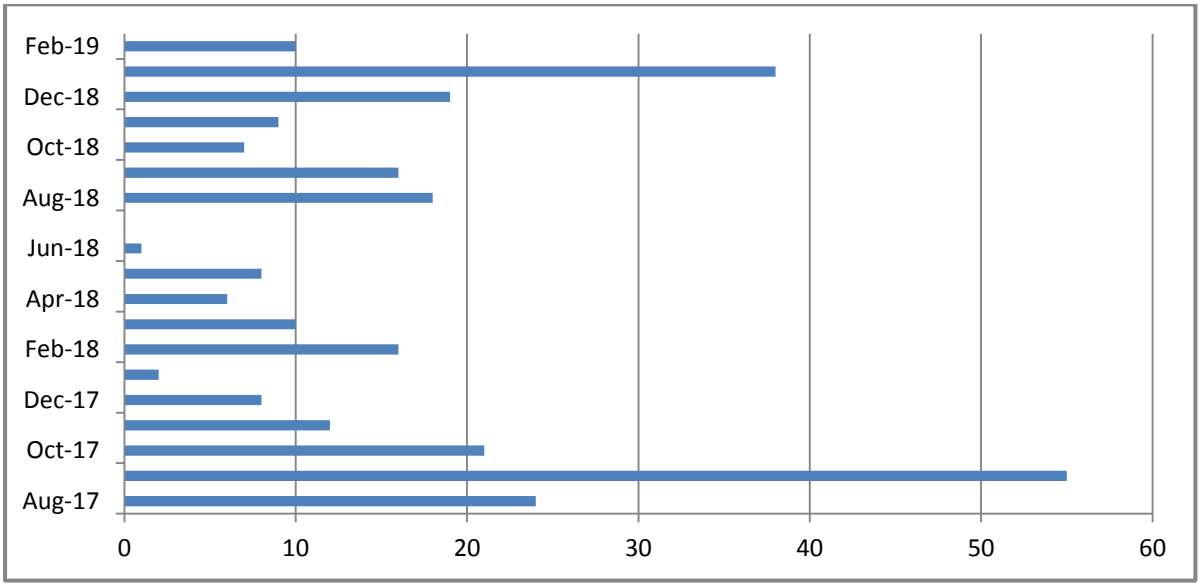
Guardian of safe working hours (GOSWH): CHFT

Q4 Report (16thOctober 2018-15th Feb 2019)

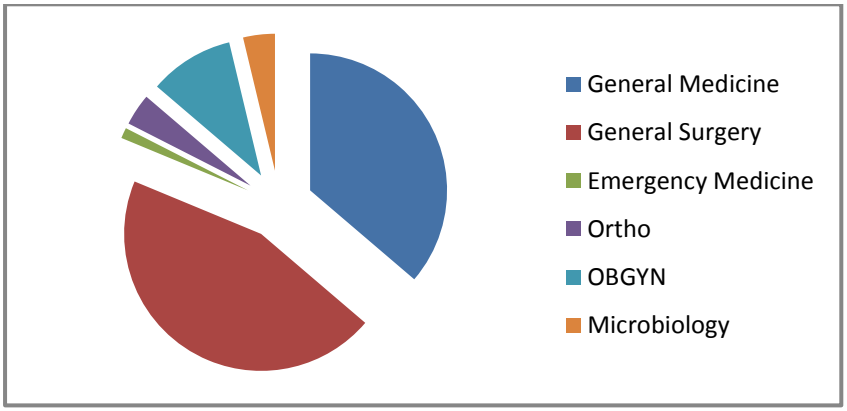
This last quarter has seen an increase in exception reports (ERs) which probably reflects the busy winter period and increased awareness. There is still a lack of understanding regarding exception reporting amongst a proportion of trainees and a number of supervisors. I am addressing this by initiating face-to-face sessions with groups of junior doctors and supervisors, using emails, newsletters and there is now a GOSWH website on the CHFT intranet.

a) Exception reports (16th October 2018-15th February 2019)

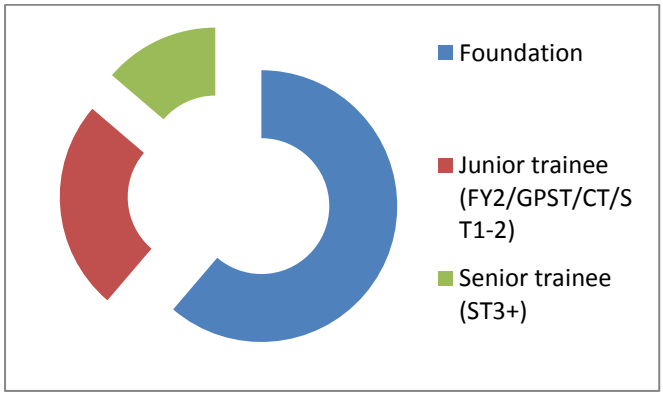
There have been a total of 80 exception reports this quarter which represents 110 episodes. Approximately 75% of these have been completed. The majority of incomplete exceptions are from general surgery and I have escalated this to the clinical lead.
Most exceptions (95%) are related to hours worked, the remainder are around educational opportunities.



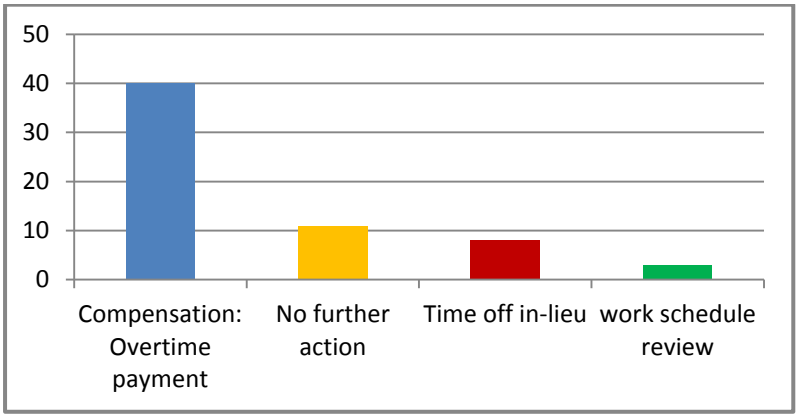
Exception reports by rota



Exception reports by grade



Exception reports by outcome



Main issues

In medicine, a significant proportion of ER's in December and January mentioned low levels of staffing at the senior level (registrar). One exception also highlighted the expansion of MAU and the new frailty ward as an 'increase' in beds without a corresponding increase in staffing. This was escalated to the relevant clinical director who has assured me that the bed: staffing ratio has in fact improved and they have additional consultant and advanced nurse practitioner support following this change.

In surgery, there was a flurry of exception reports as a result of busy post-take days. This has been escalated to the clinical lead.

We have had 3 exception reports this quarter from microbiology as a result of a breach in the stipulated 5 hours of continuous rest between the hours of 22.00 and 7.00. From February onwards, microbiology calls from only registrars and above will be accepted after 22.00 hours unless there is an acutely deteriorating patient.

The main struggle is following up exception reports and ensuring that they are completed in a timely manner. We have drafted a process of follow-up by the GOSWH and the medical HR team, with the issue being escalated to the relevant clinical director if not resolved within 14

days. Non-familiarity with the Allocate software is also causing delays in completing these ERs.

b) Work-schedule reviews

We have had three work schedule reviews requested this quarter.
One was in urology (FY1 grade), requested by a less than full-time (LTFT) trainee which was successfully completed and agreed by the trainee.
Another was requested by a trainee in Trauma & Orthopaedics (ST4 grade). This has taken long to progress despite follow-up by me and medical HR. The matter is ongoing and awaiting a final agreement within the division and then the trainee. It will affect subsequent trainees on that rota.
There has been review request from FY1s in medicine regarding their weekend rota which is currently being discussed within the division.

c) Fines

No fines have been issued, however I have requested medical HR and flexible workforce to follow up some exceptions in general surgery (foundation grade) due to multiple exceptions submitted by trainees around hours worked. I will report any breaches, if found, in my annual report.

d) Rota gaps

Medicine; There are no gaps at the junior level. The main problems are registrar-level gaps. (a total of 11 gaps across the two sites). These are being covered out of hours by bank/agency staff.
Surgery; Staffing has improved this quarter and for the first time in the last 5 years, the middle-grade level has a full complement.
Obstetrics and Gynaecology; There are mainly registrar-level gaps. However 2 MTIs were recruited in the last 6 months who are on the registrar rota. This is to be reviewed. There is an expected FY2 –level gap from April 2019, unless an FY3 is recruited.
Paediatrics; There were 2 gaps at the registrar level. This is expected to increase to 3.5 from February. Some of the ACPs are on the registrar rota (this is to be reviewed by the end of the month). These gaps are filled only out-of-hours by bank/agency staff.
Emergency medicine: They will have a full complement of junior trainees after February following the appointment of two trust-grade doctors and one WAST trainee. Registrar – level gaps persist, some covered by long-term bank staff. A minimum level of staffing is attained. They also have five advanced nurse practitioners (ACPs), some of who are on the junior trainee rota, one MTI and one FY3 to help fill these gaps.

e) Junior doctor awards

We are hosting the inaugural junior doctor awards at CHFT in May 2019. These are open to all doctors in training. There will be 5 categories for nominations including clinical leadership, medical education, research & audit, going above & beyond and compassionate care. In addition there will be an award for the 'junior doctors' choice' for supervisors. We have established a group (includes junior doctor representatives) that will be managing this event.

f) GOSWH Intranet page

I have set up an intranet page within the CHFT homepage under workforce and OD. My administrative support within Medical HR is helping me manage this. The website will give both trainees and supervisors access to guidance on exception reporting, the new rota rules, junior doctor forum dates and minutes, the quarterly and annual GOSWH reports amongst other relevant information.

f) Junior doctors forum (JDF)

The February JDF was cancelled due to the number of apologies received. This has been rescheduled for March

Anu Rajgopal
Guardian of safe working hours
February 2019

15. Integrated Performance Report – January 2019

(Rob Aitchison)

To Note

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 7th March 2019	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report: January 2019 - The Board is asked to approve the contents of the report and note the overall performance score for January 2019	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board: Thursday 28th February 2019	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

January's Performance Score has fallen by 3 percentage points to 68%. The SAFE domain remains at 61% with 2 never events having a major impact on performance. The CARING domain is now amber at 69% with worsening performance in FFT A&E would recommend rates and FFT Community response rates. EFFECTIVE domain is green for the third consecutive month. The RESPONSIVE domain is at 69% having missed 6 weeks Diagnostics target but has achieved all key cancer targets for the third consecutive month. In WORKFORCE there has been improvement in Return to Work interviews and a couple of Essential Safety Training areas. Within EFFICIENCY & FINANCE CIP has improved to amber in month which means the Financial element of the domain is now green for the first time since June 2018.

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 approve the contents of the report and note the overall performance score for January 2019

Appendix

Attachment:

Integrated Performance Report - Jan 19 (short version).pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

January 2019

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.

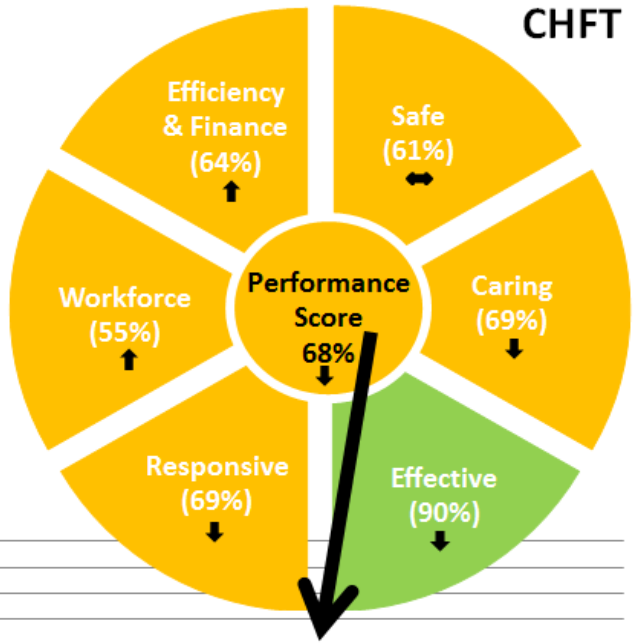
There have been no changes of any note since December's report.

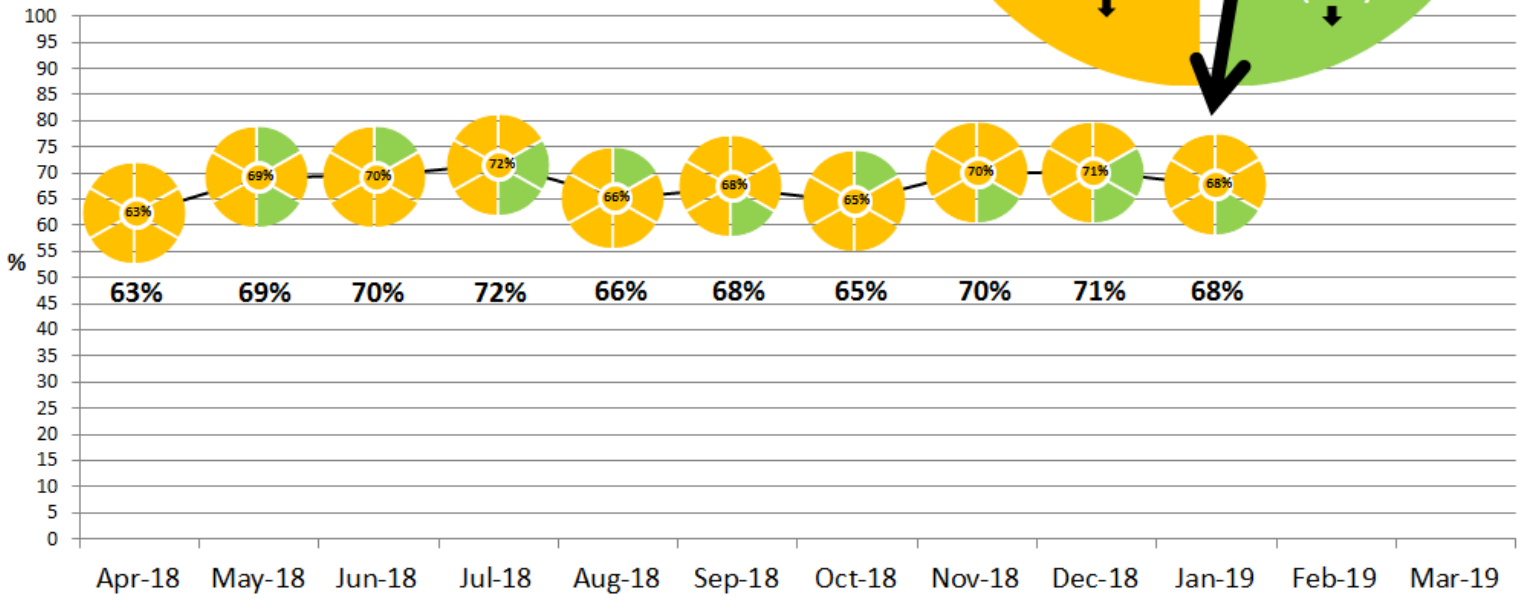
Performance Summary

January

RAG Movement

January's Performance Score has fallen by 3 percentage points to 68%. The SAFE domain remains at 61% with 2 never events having a major impact on performance. The CARING domain is now amber at 69% with worsening performance in FFT A&E would recommend rates and FFT Community response rates. EFFECTIVE domain is green for the third consecutive month. The RESPONSIVE domain is at 69% having missed 6 weeks Diagnostics target but has achieved all key cancer targets for the third consecutive month. In WORKFORCE there has been improvement in Return to Work interviews and a couple of EST areas. Within EFFICIENCY & FINANCE CIP has improved to amber in month which means the Financial element of the domain is now green for the first time since June.





SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT OP FFT A&E
FFT IP FFT Maternity	FFT Community
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI
RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Key Indicators

	17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	YTD	Annual Target	Monthly Target
SAFE														
Never Events	1	0	0	0	0	0	1	0	1	0	2	4	0	0
CARING														
% Complaints closed within target timeframe	48.70%	37.00%	44.00%	30.00%	31.00%	33.0%	53.0%	45.0%	49.0%	67.0%	50.0%	42.0%	95%	95%
Friends & Family Test (IP Survey) - Response Rate	31.40%	39.97%	39.75%	38.83%	36.47%	37.83%	34.93%	35.53%	30.65%	32.99%	35.53%	36.38%	>=25.9% /24.5% from June 18	
Friends & Family Test (IP Survey) - % would recommend the Service	96.90%	96.78%	97.98%	97.38%	97.42%	97.65%	97.70%	97.35%	97.81%	96.77%	97.42%	97.42%	>=96.3% / 96.7% from June 18	
Friends and Family Test Outpatient - Response Rate	10.10%	11.30%	10.45%	11.43%	11.40%	11.32%	11.61%	10.21%	11.01%	8.92%	10.71%	10.83%	>=5.3% / 4.7% from June 18	
Friends and Family Test Outpatients Survey - % would recommend the Service	89.70%	90.66%	90.99%	90.40%	90.79%	90.82%	90.96%	90.79%	91.54%	91.19%	91.47%	90.95%	>=95.7% / 96.2% from June 18	
Friends and Family Test A & E Survey - Response Rate	10.20%	10.74%	9.55%	12.85%	15.25%	14.53%	13.10%	13.71%	13.73%	12.66%	14.18%	13.04%	>=13.3% / 11.7% from June 18	
Friends and Family Test A & E Survey - % would recommend the Service	85.00%	84.65%	86.35%	84.28%	84.30%	82.15%	84.75%	82.56%	83.62%	84.14%	82.53%	83.82%	>=86.5% / 87.2% from June 18	
Friends & Family Test (Maternity Survey) - Response Rate	41.00%	33.20%	34.80%	34.80%	33.70%	35.60%	36.30%	35.10%	36.10%	31.00%	35.60%	34.95%	>=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%	98.10%	99.00%	99.70%	98.30%	98.26%	98.25%	98.56%	>=97% / 97.3% from June 18	
Friends and Family Test Community - Response Rate	6.50%	3.60%	6.30%	4.20%	4.40%	4.66%	6.98%	5.22%	6.67%	3.36%	2.30%	4.83%	>=1.5% / >=3.2% from June 18	
Friends and Family Test Community Survey - % would recommend the Service	90.00%	93.94%	92.59%	92.02%	97.42%	94.06%	93.18%	91.72%	95.87%	98.42%	98.07%	94.36%	>=94.2% / >=96.7% from June 18	
EFFECTIVE														
Number of MRSA Bacteraemias – Trust assigned	5	0	0	1	0	0	0	2	0	0	0	3	0	0
Preventable number of Clostridium Difficile Cases	8	3	1	1	0	0	0	0	0	0	0	5	<=20	< = 2
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.98											99.52	<=100	100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	82.47											84.42	<=100	100
RESPONSIVE														
Emergency Care Standard 4 hours	90.61%	91.52%	93.23%	94.78%	92.37%	91.15%	89.63%	90.31%	90.74%	89.19%	87.96%	91.11%	>=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%	59.02%	70.21%	68.33%	70.90%	69.70%	61.54%	63.62%	>=90%	90%
% Incomplete Pathways <18 Weeks	93.75%	93.77%	93.32%	94.05%	93.99%	93.18%	93.00%	93.15%	93.12%	92.19%	92.11%	92.11%	>=92%	92%
Two Week Wait From Referral to Date First Seen	94.09%	95.63%	98.78%	98.61%	98.82%	97.67%	98.79%	99.05%	99.39%	98.85%	99.17%	98.51%	>=93%	93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.88%	95.48%	95.28%	98.94%	95.24%	100.00%	100.00%	99.50%	98.92%	97.22%	96.72%	97.63%	>=93%	93%
31 Days From Diagnosis to First Treatment	99.83%	100.00%	99.37%	99.41%	100.00%	100.00%	100.00%	100.00%	99.37%	99.38%	98.78%	99.63%	>=96%	96%
31 Day Subsequent Surgery Treatment	99.26%	100.00%	100.00%	100.00%	97.22%	100.00%	100.00%	95.45%	100.00%	100.00%	100.00%	99.17%	>=94%	94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	>=98%	98%
38 Day Referral to Tertiary	45.49%	47.62%	40.00%	50.00%	50.00%	42.86%	52.00%	73.33%	47.06%	68.42%	45.45%	50.44%	>=85%	85%
62 Day GP Referral to Treatment	88.67%	90.66%	92.35%	83.98%	87.72%	83.51%	88.83%	85.97%	89.37%	92.22%	90.32%	88.33%	>=85%	85%
62 Day Referral From Screening to Treatment	94.87%	81.82%	91.67%	100.00%	100.00%	100.00%	88.89%	84.62%	96.00%	100.00%	95.65%	93.75%	>=90%	90%
WORKFORCE														
Sickness Absence rate (%) - Rolling 12m	4.10%	4.10%	4.07%	4.04%	4.01%	3.97%	3.92%	3.90%	3.84%	3.83%	*	-	4%	4%
Long Term Sickness Absence rate (%) -Rolling 12m	2.55%	2.54%	2.53%	2.51%	2.48%	2.45%	2.42%	2.41%	2.38%	2.37%	*	-	2.7%	2.7%
Short Term Sickness Absence rate (%) -Rolling 12m	1.55%	1.56%	1.53%	1.53%	1.53%	1.52%	1.50%	1.49%	1.47%	1.45%	*	-	1.3%	1.3%
Overall Essential Safety Compliance		95.00%	94.40%	93.96%	93.84%	91.56%	90.12%	91.02%	91.47%	91.45%	91.84%	-	95%	95%
Appraisal (1 Year Refresher) - Non-Medical Staff - Rolling 12m	93.50%	15.43%	62.67%	96.65%	96.74%	95.74%	95.76%	94.33%	93.81%	92.57%	91.50%	-	95%	95%
Appraisal (1 Year Refresher) - Medical Staff - Rolling 12m	69.88%	99.75%	99.70%	98.65%	96.59%	97.21%	97.42%	92.50%	89.24%	83.50%	63.00%	-	95%	95%
FINANCE														
I&E: Surplus / (Deficit) Var £m	-7.97	0.01	0.00	0.00	0.01	0.26	-0.02	-0.20	-0.03	0.00	0.01	0.02		

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
% Stroke patients Thrombolysed within 1 hour - at 100% best performance since July 2018. **The latest SSNAP results for Q3 show that CHFT has scored A for the very first time since SSNAP came into existence approximately 8 years ago. This puts the Trust in the top 20 percent of trusts delivering excellence in stroke care.**	Never Events - There has been a further two Never Events in January relating to the 'unintentional connection of a patient requiring oxygen to an air flowmeter'.	Control and command processes initiated and actions undertaken across the trust to mitigate further incidence this has included structured training, the introduction of air compressors and the capping off of the piped air system.
All 3 coding indicators (% sign and symptom, average co-morbidity, average diagnosis per coded episode) showed best performance in at least 10 months.	% Harm Free Care - At 91.69% lowest rate in over 12 months.	The ongoing work with the NHSI collaborative is focusing on reducing new pressure ulcers and preventing the deterioration of old pressure ulcers which should impact on the result in the next 6 months. The collaborative focuses on early assessment on admission to hospital and at each transfer between ward areas. Further work is being undertaken in monitoring ward assurance standards in documentation to provide evidence of care interventions.
All key cancer targets achieved for 3rd month running.	% Diagnostic Waiting List Within 6 Weeks - target missed in 2 out of last 3 months due to staffing issues with Echocardiography.	We have recently taken on two new bank members of staff which has increased capacity. We are therefore opening up more slots in the future months and booking in long waiters. It will take at least 6 months to clear the backlog. We have asked for an outsourcing company to provide a quote on clearing the whole backlog and are awaiting costs which we can then review as part of exploring all options available.

Executive Summary

The report covers the period from January 2018 to allow comparison with historic performance. However the key messages and targets relate to January 2019 for the financial year 2018/19.

Area	Domain
Safe (61%)	• **All Falls** - 193 highest number in 12 months. Particularly significant in Surgery with 50 cases compared to an average of 30. The Falls Collaborative lead Matron and Clinical Lead for Falls are working with ADNs to undertake a deep dive into the increased number of incidents in month. This will concentrate on identifying any themes or trends in relation to risk factors for falls (time, location and circumstances) so that focused work can be explored on the wards. Any learning from the deep dive will be developed into an improvement plan.
	• **% Harm Free Care** - At 91.69% lowest rate in over 12 months. % of Harm Free Care (new) is also below target at 96.6%. The ongoing work with the NHSI collaborative is focusing on reducing new pressure ulcers and preventing the deterioration of old pressure ulcers which should impact on the result in the next 6 months. The collaborative focuses on early assessment on admission to hospital and at each transfer between ward areas. Further work is being undertaken in monitoring ward assurance standards in documentation to provide evidence of care interventions.
	• **Never Events** - There have been a further two Never Events in January relating to the 'unintentional connection of a patient requiring oxygen to an air flowmeter'. Control and command processes initiated and actions undertaken across the trust to mitigate further incidence this has included structured training, the introduction of air compressors and the capping off of the piped air system.
	• **Health & Safety Incidents (RIDDOR)** - A Trust colleague fell off a chair and fractured their wrist. Reported as a RIDDOR to HSE and the chair removed and maintenance checked.
Caring (69%)	• **Complaints closed within timeframe** - Of the complaints closed in January, 50% (19/38) were closed within target timeframe. Medicine and Surgery Division have had escalation meetings with the Chief Nurse and Chief Operating Officer to discuss barriers to achieving closure in timescale. A breakthrough meeting has been held with Divisional and Quality Directorate colleagues. The backlog of complaints still in Division is expected to impact on performance and mitigating actions have been taken.
	• **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still < 92% against the 95.7% target. Outpatients as a whole continues to undergo a transformational programme of work, the FFT metrics are being monitored throughout the period to assess changes in patient satisfaction levels. The action plan is being worked through and an improved performance is expected over the forthcoming months. Work is ongoing within the directorates with regular customer contact meetings to address issues specifically with OP and appointments.
	• **Friends and Family Test A & E Survey - % would recommend the service**. Performance is now < 83% against the 87.2% target. Focused work is ongoing with CDU and minor injuries. We continue to review feedback comments to understand the main themes for the wouldn't recommend scores. We are working on an action plan to reduce waiting times to see a doctor, this will improve patients' experience of waiting longer at busy times in the department.
	• **Friends and Family Test Community - Response Rate. Performan**ce at 2.3% is lowest since January last year. We are targeting those teams that have nil collection in month.
	• **% Dementia patients screened following emergency admission aged 75 and over** - performance has improved a little to 32% but is still significantly below the 90% target. A rapid intervention task and finish group has been established which includes the daily monitoring of patients requiring a screen. Learning from the breakthrough meeting has enabled targeted actions which are demonstrating an improvement in January.
Effective (90%)	• **Number of E.Coli - Post 48 Hours** - there were 6 cases (4 Medicine) in month.
	• **#Neck of Femur** - performance in month was just below target at 82.86%, provision to undertake THR for hip fractures was introduced in January resulting in NO patient breaching waiting for an appropriate surgeon. Monthly MDTs and excellent clinical engagement continue.

Background Context

January was challenging in both ED departments due to the high volume of acutely unwell patients attending however winter plans in place ensured no corridor waits and much improved flow from the previous January. YAS EPR went live in December, which has impacted on the accuracy of the turnaround time data and work continues to improve this.

We continue to see flow improve over the acute floor at HRI following its launch on 22nd December. The unit continues to embed with a 2 weekly meeting in place to monitor progress and make appropriate changes. Moving to this model has also released an Acute Physician into the Emergency Department from 2pm-5pm Monday to Friday reducing admissions and working closely with the ED team. Nurse staffing remains a challenge as the combining of the 2 ward rotas has resulted in A/L etc. being over allocated. Learning from the CRH move is ongoing.

Infection control issues have been minimal with no ward closures in January. A small peak in Flu admissions but point of care testing has enabled rapid decision making and better use of isolation facilities.

Daily staffing huddles supported by weekly confirm and challenge in place for nursing teams has ensured safe staffing and management of bank and agency staffing. Out of hours sickness has seen an increase impacting on planning and increasing agency spend, information currently being collated to understand key themes.

Following on from the recent never events regarding patients being connected to Air instead of oxygen, the Trust has introduced nebuliser compressors. The compressors have now been rolled out on the CRH site and Air ports have been capped off. Training on the nebuliser compressors commenced 8th February on the HRI site.

The latest SSNAP results for Q3 show that CHFT has scored A for the very first time since SSNAP came into existence approximately 8 years ago. This puts the Trust in the top 20 percent of trusts delivering excellence in stroke care.

Executive Summary

The report covers the period from January 2018 to allow comparison with historic performance. However the key messages and targets relate to January 2019 for the financial year 2018/19.

Area	Domain
Responsive (69%)	• **Emergency Care Standard 4 hours** - at 87.96% in January, (89.66% all types) - most challenging month since March. In March we will be running a trust wide command and control centre to focus on all delays in the patient pathway. This will provide a focused approach to breach avoidance, with a supernumerary management team available to tackle issues in real time and exec level daily representation. We anticipate this will allow us to achieve the 95% target in March. • **Stroke targets** - 2 out of 4 targets achieved their targets with % stroke patients spending 90% on a stroke unit dipping just below target for the first time since August. Patients admitted directly to stroke unit within 4 hours missed target at 61.54%. The drop in patients spending 90% of their time on the stroke unit was largely due to inpatient strokes in other areas and patients not being transferred to the stroke unit. Education is ongoing with teams to highlight the importance of transferring to ASU. • **% Diagnostic Waiting List Within 6 Weeks** - target missed in 2 out of last 3 months due to staffing issues with Echocardiography. We have recently taken on two new bank members of staff which has increased capacity. We are therefore opening up more slots in the future months and booking in long waiters. It will take at least 6 months to clear the backlog. We have asked for an outsourcing company to provide a quote on clearing the whole backlog and are awaiting costs which we can then review as part of exploring all options available. • **38 Day Referral to Tertiary** - performance dipped to 45.5% in January. Upper GI have redesigned their service to improve their pathway and the H&N team and are in the process of streamlining their pathway to ensure day 38 is achieved where possible. Weekly meetings with GM's, CNS's plus a mini-MDT 3 times a week with lung clinician to provide awareness of day 38 and ensure pathway bottlenecks are avoided. A new trouble shooting role has been introduced to the Patient Pathway Coordinator team to assist with the avoidance of bottlenecks by liaising with patients, clinicians, diagnostic dept's, CNS's etc. • **Appointment Slot Issues on Choose & Book** - increase to 40%. Action plans in place including additional clinics, template review and the extension of polling ranges for specialties with largest numbers.
Workforce (55%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total is at its lowest position although monthly figures are now above 4%. RTWI performance has improved to above 70%. • **Essential Safety Training -** there were a couple of areas which showed improvement in month.
Finance (78%)	• **Finance**: **Year to Date Summary** The year to date deficit is £36.5m, a £0.02m favourable variance from plan. • This position belies the adverse variance seen in a number of areas in-month. The underlying overspend on medical staffing continues in-month at £0.38m above plan and pressure continues to be seen on unqualified nursing pay budgets. Non-pay costs are also above plan particularly those relating to the cost of premises. • These pressures have been offset in the reported position by recognition of additional income negotiated with commissioners (outside of the Aligned Incentive Contract (AIC)), capitalisation of some pay costs and prior year benefits. • Clinical contract income performance is below plan by £2.34m. The Aligned Incentive Contract (AIC) protects the income position by £2.21m in the year to date leaving a residual pressure of £0.13m. However, a proportion of this income protection (£2.07m) is as a result of CIP plans and management decisions where there is a corresponding reduction in cost. When these elements are adjusted for, the impact is reduced to £0.14m. • CIP achieved in the year to date is £13.30m against a plan of £13.59m, a £0.22m pressure. • Agency expenditure is £1.33m below the agency trajectory set by NHSI and is forecast to remain below the trajectory for the rest of the year. • **Key Variances** • Medical staffing expenditure continues above plan, with pressure on non-contracted pay costs including additional agency costs in January of £0.15m relating to previous months where either agency invoices have exceeded the value recorded on the Allocate system or agency shifts have been booked outside of the system. • There have been significant pressures on non-pay expenditure in month including a pressure of £0.21m relating to the new clinical waste contract with Mitie (hosted by LTHT), where invoices have exceeded the expected impact of the price uplift, increased utilities costs have created a further £0.20m pressure following a price uplift of 23% on electricity and a further £0.14m pressure relating to Radiology and Pathology send away tests charged from other providers. • There remains some pressure on unqualified nursing pay expenditure in part due to continued bank usage for one to ones and in part due to the opening of some additional capacity. **Forecast** • The forecast is to achieve the planned £43.1m deficit. • However, achieving the planned deficit for this financial year remains reliant on both the delivery of the full £18m of CIP and securing identified recovery actions in full. • The £18m CIP includes £1m for Project Echo which is at heightened risk in terms of its timing prior to the financial year-end. • Pressures in month leave a diminished level of flexibility to achieve the year end forecast.

Background Context

Paediatric demand has not seen the expected January peak however has experienced some medical workforce pressures due to sickness. Planning is now underway to mitigate the risk of a reduction in deanery registrars

The Paediatric team received formal confirmation that they have been accredited as a provider of Paediatric services by CHKS.

The Pathology team received their UKAS inspection for blood sciences during January - they received good feedback alongside a number of recommendations from inspectors and have retained their accreditation to provide services.

There were some issues with distribution of appointment letters from mail provider which led to an increase in DNAs. The issue was isolated and corrected with discussions ongoing with the supplier on compensation.

Cardiology continues to have issues with capacity due to the specialised nature of tests and the workforce gaps around West Yorkshire. Alternative options are being explored

Within Surgery the management team has not been at full capacity in January which has impacted upon the ability to oversee and improve/maintain performance on a number of KPIs. It is anticipated that these will be resolved in February/ March.

Elective and Day case activity delivery has been impacted on by on day cancellations due to short notice sickness, on top of long term, planned sickness absence. This has resulted in an increase in on day cancellations (20% of total cancellations due to staff availability). There have been no bed associated cancellations with the Friday adult day case model being particularly effective.

Listening events have been held with Community colleagues by COO and Director of Operations. There has been positive feedback and an awareness campaign was launched in CHFT weekly.

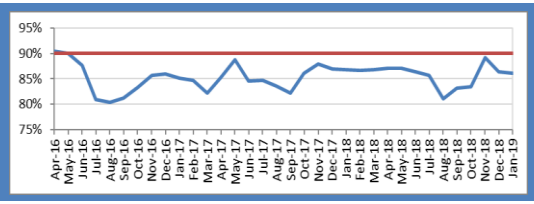
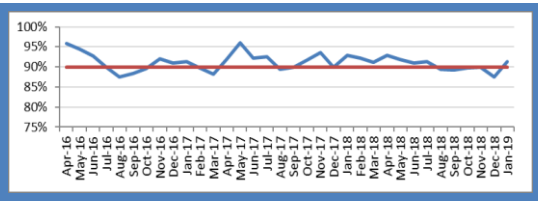
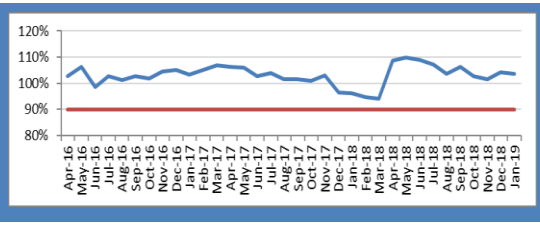
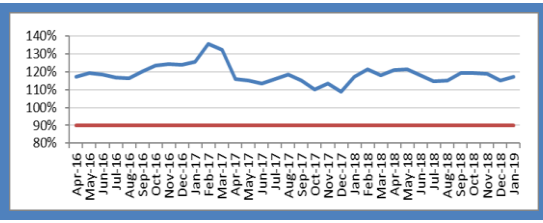
The Provider Alliance Board/meetings have been initiated with CHFT Executive level and Community Senior Management Team membership. This will be a key driver in the development of integrated community health and social care services.

CIP closure for 2018/19 has been ongoing alongside planning for 2019/20 CIPs, portfolios developed and housekeeping targets established.

Meetings with each division have been held to discuss and minimise 2019/20 pressures and agree plans for growth. These are being collated to establish final 2019/20 plan.

Focus on budget holder accountability is ongoing.

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.	86.13% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 6 74.55 - 7a/d 74.35 - Ward 17 72.7% - Ward 21 72.4% - 8A 73.7%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.35% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - Ward 12 68.8% - Ward 10 66.5%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to a level of vacancy. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	103.48% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - LDRP 73%	The low HCA fill rates in January 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.	116.99% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - 3 a,b,c,d	The low HCA fill rates in January 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.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT						Care Hours Per Patient Day		MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies	Ward Assurance
		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						
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual										
CRH ACUTE FLOOR	GENERAL MEDICINE	2,904.25	2,872.75	2,310.00	2,220.75	98.9%	96.1%	2,520.48	2,466.98	2,046.00	2,103.25	97.9%	102.8%	8.2	8.1		0	0	7.33	2.93	56.9%
HRI ACUTE FLOOR	GENERAL MEDICINE	3,194.83	2,926.70	2,826.33	2,432.33	91.6%	86.1%	2,728.00	2,660.75	2,035.00	2,051.75	97.5%	100.8%	11.1	10.4		2	2	10.24	0.00	66.2%
WARD 4	GENERAL MEDICINE	871.88	876.38	1,152.97	1,133.03	100.5%	98.3%	682.00	682.00	682.00	814.00	100.0%	119.4%	6.1	6.3		0	5	6.07	0.00	75.8%
WARD 5	GERIATRIC MEDICINE	1,686.53	1,378.03	1,174.83	1,448.75	81.7%	123.3%	1,023.00	968.00	1,023.00	1,175.00	94.6%	114.9%	5.6	5.7		0	7	2.55	0.00	71.0%
WARD 15	GENERAL SURGERY	1,828.83	1,401.33	1,523.00	1,709.67	76.6%	112.3%	1,364.00	1,329.83	1,364.00	1,463.50	97.5%	107.3%	6.5	6.3		1	8	4.94	0.00	70.7%
WARD 5BC	GENERAL MEDICINE	2,529.92	1,967.42	1,633.67	1,917.67	77.8%	117.4%	2,035.00	1,624.50	682.00	1,182.50	79.8%	173.4%	8.2	8.0		4	7	13.99	0.00	67.4%
WARD 6	GENERAL MEDICINE	1,733.08	1,291.58	1,223.67	1,764.58	74.5%	144.2%	1,023.00	1,019.08	1,023.00	1,375.00	99.6%	134.4%	6.6	7.2		0	1	5.30	0.00	67.6%
WARD 6C	GENERAL MEDICINE	1,124.33	870.00	798.00	713.33	77.4%	89.4%	682.00	682.00	341.00	363.00	100.0%	106.5%	5.2	4.7		0	4	10.77	4.83	68.3%
WARD 6AB	GENERAL MEDICINE	1,426.43	1,407.50	1,116.67	1,165.33	98.7%	104.4%	1,001.00	1,253.00	1,023.00	1,430.00	125.2%	139.8%	4.6	5.3		1	9	1.42	0.00	52.0%
WARD CCU	GENERAL MEDICINE	1,512.17	1,422.25	372.00	307.50	94.1%	82.7%	1,045.50	1,012.00	0.00	0.00	96.8%	-	8.8	8.3		1	0	3.81	0.00	72.8%
WARD 7AD	STROKE MEDICINE	1,738.33	1,291.00	1,589.67	1,944.83	74.3%	122.3%	1,019.50	978.75	1,023.00	1,217.50	96.0%	119.0%	7.1	7.2		0	8	1.74	5.30	67.7%
WARD 7BC	STROKE MEDICINE	2,575.82	2,060.42	1,681.67	2,006.87	80.0%	119.3%	2,046.00	1,642.72	682.00	1,278.58	80.3%	187.5%	10.6	10.6		0	1	2.26	0.00	75.8%
WARD 12	MEDICAL ONCOLOGY	1,643.50	1,255.50	768.00	1,121.00	76.4%	146.0%	1,023.00	704.00	341.00	693.50	68.8%	203.4%	6.1	6.1		0	6	3.45	2.16	67.5%
WARD 17	GASTROENTEROLOGY	2,074.50	1,508.50	1,143.00	1,116.67	72.7%	97.7%	1,023.00	1,012.00	682.00	671.00	98.9%	98.4%	5.5	4.8		0	1	6.30	0.00	64.4%
WARD 5D	GERIATRIC MEDICINE	1,123.00	989.33	837.00	823.67	88.1%	98.4%	682.00	669.50	341.00	616.00	98.2%	180.6%	4.7	4.9		0	6	0.73	0.00	69.0%
WARD 20	GERIATRIC MEDICINE	1,917.80	1,566.23	1,764.67	1,830.17	81.7%	103.7%	1,364.00	1,244.50	1,386.00	1,419.00	91.2%	102.4%	7.2	6.8		1	3	7.14	0.00	55.8%
WARD 21	TRAUMA & ORTHOPAEDICS	1,585.67	1,147.33	1,530.33	1,441.50	72.4%	94.2%	1,069.50	1,000.00	1,069.50	1,058.00	93.5%	98.9%	8.3	7.4		1	6	2.00	0.00	72.1%
ICU	CRITICAL CARE MEDICINE	4,275.00	4,091.17	768.50	700.50	95.7%	91.2%	4,267.50	3,815.25	0.00	22.00	89.4%	-	33.0	30.6		1	1	6.29	0.00	73.5%
WARD 3	GENERAL SURGERY	1,059.53	974.58	589.00	733.00	92.0%	124.4%	713.00	701.50	529.00	717.00	98.4%	135.5%	6.9	7.4		0	3	0.34	1.37	66.6%
WARD 8A	TRAUMA & ORTHOPAEDICS	1,008.77	743.15	721.50	725.08	73.7%	100.5%	713.00	610.50	356.50	356.50	85.6%	100.0%	9.4	8.2		1	4	1.32	0.00	61.1%
WARD 8D	ENT	935.33	859.55	790.83	757.67	91.9%	95.8%	713.00	681.50	0.00	207.00	95.6%	-	6.8	7.0		0	2	1.94	0.00	64.1%
WARD 10	GENERAL SURGERY	1,444.17	1,341.67	802.00	867.75	92.9%	108.2%	1,064.50	708.00	713.00	1,119.00	66.5%	156.9%	7.0	7.0		0	0	3.67	2.10	50.0%
WARD 11	CARDIOLOGY	1,651.00	1,522.50	1,124.50	1,047.58	92.2%	93.2%	1,242.00	1,102.50	713.00	770.50	88.8%	108.1%	6.1	5.7		0	10	5.99	0.00	67.1%
WARD 19	TRAUMA & ORTHOPAEDICS	1,718.67	1,454.17	1,175.00	1,260.83	84.6%	107.3%	1,069.50	1,058.00	1,069.50	1,229.83	98.9%	115.0%	7.6	7.6		2	16	0.00	0.00	77.6%
WARD 22	UROLOGY	1,228.00	1,187.00	1,121.83	1,110.33	96.7%	99.0%	713.00	713.00	713.00	713.00	100.0%	100.0%	5.5	5.4		0	3	2.21	0.00	45.5%
SAU HRI	GENERAL SURGERY	1,960.67	1,823.67	866.33	901.17	93.0%	104.0%	1,426.00	1,382.50	454.00	489.00	96.9%	107.7%	10.5	10.3		0	4			64.2%
WARD LDRP	OBSTETRICS	4,452.67	3,745.00	952.50	695.33	84.1%	73.0%	4,216.25	3,583.08	708.17	668.83	85.0%	94.4%	21.7	18.2		0	0			26.3%
WARD NICU	PAEDIATRICS	2,343.00	1,916.42	763.00	621.00	81.8%	81.4%	2,150.50	1,720.00	713.00	553.00	80.0%	77.6%	16.3	13.1		0	0	2.17	1.92	47.2%
WARD 3ABCD	PAEDIATRICS	4,005.83	3,727.83	713.00	539.83	93.1%	75.7%	4,045.50	3,713.25	521.50	356.00	91.8%	68.3%	13.1	11.7		0	0	-1.89	0.74	22.4%
WARD 4ABD	OBSTETRICS	419.50	357.50	138.00	138.00	85.2%	100.0%	276.00	276.00	138.00	138.00	100.0%	100.0%	0.9	0.9		0	0	-11.23	-1.60	12.8%
WARD 4C	GYNAECOLOGY	1,380.58	1,146.42	393.50	363.50	83.0%	92.4%	713.00	690.00	356.50	339.75	96.8%	95.3%	8.7	7.7		0	3	0.97	0.52	69.1%
TRUST		**59,353.60**	**51122.88**	**34364.97**	**35559.2**	**86.13%**	**103.48%**	**45653.73**	**41704.7**	**22728.67**	**26591**	**91.35%**	**116.99%**	**7.9**	**7.6**						

Hard Truths: Safe Staffing Levels (3)

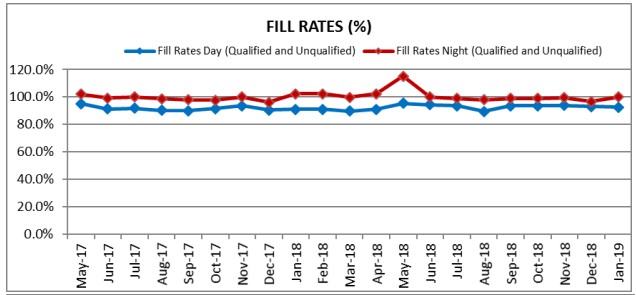
Care Hours per Patient Day

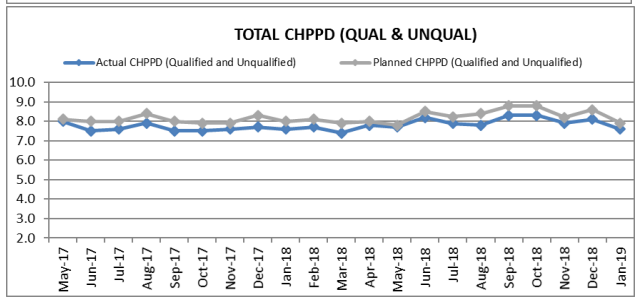
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Nov-18	Dec-18	Jan-19
Fill Rates Day (Qualified and Unqualified)	93.9%	93.1%	92.5%
Fill Rates Night (Qualified and Unqualified)	99.5%	96.7%	99.9%

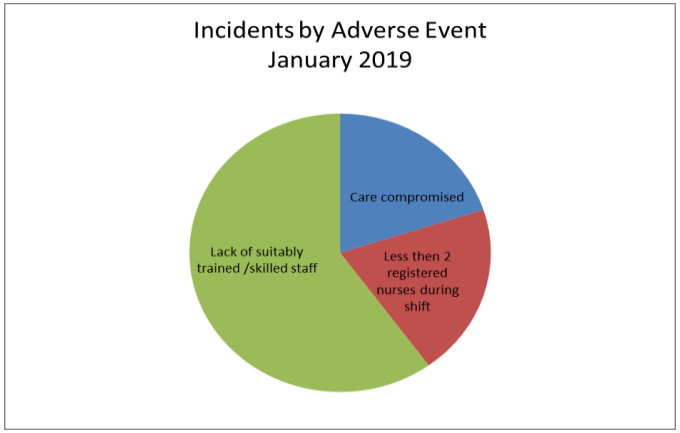
Planned CHPPD (Qualified and Unqualified)	8.2	8.6	7.9
Actual CHPPD (Qualified and Unqualified)	7.9	8.1	7.6

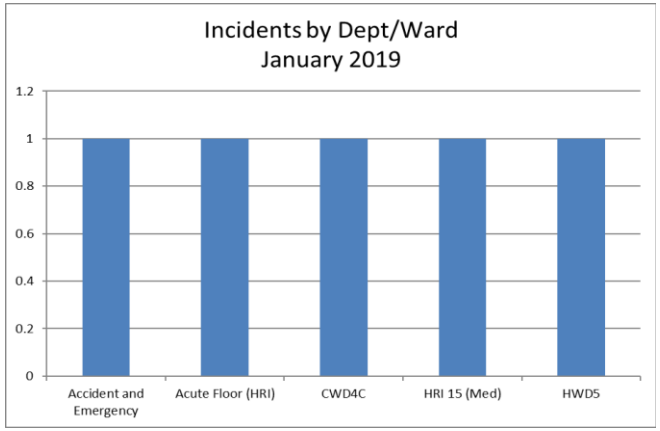
A review of January CHPPD data indicates that the combined (RN and carer staff) metric resulted in 18 clinical areas of the 30 reviewed having CHPPD less than planned. 8 areas reported CHPPD slightly in excess of those planned and 4 areas having CHPPD as planned. Areas with CHPPD more than planned was 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 correc t 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 5 **Trust Wide Red shifts** declared in **January 2019**
As illustrated above the most frequently recorded red flagged incident is related to "lack of suitably trained staff"
No datex's reported in January 2019 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.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.
2. Further recruitment event planned for March 2019
3. Applications from international recruitment projects are progressing well and the first 15 nurses have arrived in Trust, with a further 6 planned for deployment in Feb2019
4. A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. 57 candidates have now been transferred onto the OET programme.
5. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 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 4th June 2018. A further cohort commenced training in December 2018.
6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment & retention of the graduate workforce
7. A new module of E-roster called safe care has been introduced across the clinical divisions. Benefits will include better reporting of red flag event and real-time data of staffing position against acuity.

CQUINS - Key messages

Area	Reality	Response	Result
Overall		The CQUIN scheme for 2018/19 is, in the main, a continuation of the 2017/18 scheme. However, there are some key changes which include: - Suspension of CQUIN 8A - Reduction in AWaRe antibiotics rather than piperacillin - Higher target for Flu Vaccinations @75% - **ACHIEVED**	
Risky Behaviours	The required improvements to the separate elements of the risky behaviour CQUINs are not being realised. It is recognised that the targets for this CQUIN are challenging to achieve.	Ongoing monitoring of performance with ward level actions in place to improve compliance.	Improvements are expected by the end of Q4 but not likely to reach the ambitious target of 100% in all elements.

CQUIN - Key measures

Goal Reference	Provider Type	Financial Value of Indicator	Indicator Name	Description	Baseline	Targets Q1	Targets Q2	Targets Q3	Targets Q4	ACTUAL PERFORMANCE Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q1 Position	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q2 Position	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	Q3	Q4 Jan-19	Q4 Feb-19	Q4 Mar-19	Q4
1. Improving staff health and wellbeing																									
1a.1	Acute & Community	£213,082	Improvement of health and wellbeing of NHS staff	% Definitely takes positive action on health and well-being	25	N/A	N/A	N/A	30	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end
1a.2				% Experienced MSK in the last 12 months as a result of work activities	25	N/A	N/A	N/A	20	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end
1a.3				% Felt unwell in the last 12 months as a result of work related stress	37	N/A	N/A	N/A	32	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end
1b.1	Acute & Community	£213,082	Healthy food for NHS staff, visitors and patients	Maintain 16-17 changes	-	N/A	Written report for evidence	N/A	Written report for evidence	Written report due at the end of Q2			Written report due at the end of Q2	Written report due at the end of Q2			Written report due at the end of Q2	Written report due at the end of Q4			Written report due at the end of Q4	Written report due at the end of Q4			Written report due at the end of Q4
1b.2				Improve the changes made in 2017-18	-	N/A	Written report for evidence	N/A	Written report for evidence																
1c	Acute & Community	£213,082	Improving the uptake of flu vaccinations for frontline clinical staff	% Front line staff vacinated	71%	N/A	N/A	75%	75%	Data available from October 2018			Data available from	Data available from October 2018			Data available from October	65.6%	65.6%	71.9%	71.9%	75.5%			75.5%
2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)																									
2a.1	Acute	£95,887	Timely identification (screening) of patients with sepsis in emergency departments and acute inpatient settings	% Eligible patients screened for Sepsis in Emergency Admissions	100.0%	90%	90%	90%	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%
2a.2				% Eligible patients screened for Sepsis in Inpatients (LOS >0)	100.0%	90%	90%	90%	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%
2b.1		£95,887	Timely treatment of sepsis in emergency departments and acute inpatient settings	% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Emergency Admissions	92.9%	90%	90%	90%	90%	91.0%	97.0%	100.0%	96.0%	100.0%	97.0%	93.5%	96.7%	93.0%	86.0%	93.0%	90.0%	87.0%			87.0%
2b.2				% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Inpatients (LOS >0)	78.7%	90%	90%	90%	90%	77.3%	82.6%	78.9%	79.7%	85.7%	96.0%	87.0%	90.6%	92.0%	88.0%	91.0%	91.0%	84.0%			84.0%
2c	Acute	£95,887	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	% of antibiotic presciptions documented and reviewed within 72 hours	-	25%	50%	75%	90%	90% (April and May Only)			95.6%	Data available at quarter end			63.3%	Data available at quarter end			85.3%	Data available at quarter end			-
2d.1	Acute	£95,887	Reduction in antibiotic consumption per 1,000 admissions	% of antibiotic presciptions documented and reviewed within 72 hours	TBC	Submit to PHE	Submit to PHE	Submit to PHE	TBC	Data available at quarter end			42.2%	Data available at quarter end			43.9%	Data available at quarter end			45.0%	Data available at quarter end			-
2d.2				1% reduction (from 16/17 position) in Carbapenem	TBC	Submit to PHE	Submit to PHE	Submit to PHE	TBC	Data available at quarter end				Data available at quarter end				Data available at quarter end				Data available at quarter end			-
2d.3				1% reduction (from 16/17 position) in Piperacillin-Taxobactam	TBC	Submit to PHE	Submit to PHE	Submit to PHE	TBC	Data available at quarter end				Data available at quarter end				Data available at quarter end				Data available at quarter end			-
4. Improving services for people with mental health needs who present to A&E																									
4a	Acute	£255,698	Improving services for people with mental health needs who present to A&E	Number of ED attendances - Maintain attendance level of cohort 1 patients	245	61	61	61	61	24	20	14	58	20	14	12	46	9	12	9	30	9			9
4b				Number of ED attendances - Reduce the number of attendances by 20% of cohort 2 patients	397	79	79	80	80	26	25	32	83	22	21	14	57	23	20	16	59	14			14
4c				To improve the level of data quality for the fields:																					
				- Chief Complaint	N/A	N/A	75%	N/A	85%	N/A			N/A	Quarter Position Only			93.9%	Quarter Position Only			92.0%	Quarter Position Only			
				- Diagnosis	N/A	N/A	30%	N/A	50%								32.1%				37.5%				
				- Injury Intent	N/A	N/A	75%	N/A	85%								98.6%				98.4%				
6. Offering advice and guidance																									
6	Acute	£319,623	Advice & Guidance	% A&G responses within 2 days	-	50% (Internal Target)	60% (Internal Target)	70% (Internal Target)	80% (CQUIN Target)	67.9%	74.0%	69.9%	70.7%	69.8%	75.4%	74.2%	72.5%	68.1%	78.3%	78.9%	75.1%	83.2%			83.2%
9. Preventing ill health by risky behaviours – alcohol and tobacco																									
9a	Acute	£7,991	Preventing ill health by risky behaviours - alcohol and tobacco	% Patients screened for Tobacco usage	-	Create Training Plan	100%			Presentation completed			Yes	67.0%	67.9%	68.6%	67.9%	67.2%	67.9%	66.2%	67.1%	65.7%			65.7%
9b		£31,962		% Smokers given brief advice										15.0%	15.9%	15.4%	15.4%	14.2%	15.8%	15.4%	15.1%	15.4%			15.4%
9c		£39,953		% Smokers referred and/or offered medication										15.3%	12.2%	15.7%	14.4%	15.2%	12.2%	11.4%	13.0%	14.1%			14.1%
9d		£39,953		% Patients screened for Alcohol usage										63.7%	65.1%	65.1%	64.6%	63.5%	65.2%	62.8%	63.8%	63.0%			63.0%
9e		£39,953		% Alcohol users given brief advice										17.0%	16.2%	15.9%	16.4%	13.2%	15.8%	16.2%	15.1%	15.4%			15.4%
9a	Community	£15,981	Preventing ill health by risky behaviours - alcohol and tobacco	% Patients screened for Tobacco usage	73.0%	100%				Quarter End Position			74.0%	Quarter End Position			76.5%	Quarter End Position			77.2%	Quarter End Position			-
9b		£63,925		% Smokers given brief advice	100.0%					Quarter End Position			56.0%	Quarter End Position			91.9%	Quarter End Position			85.9%	Quarter End Position			-
9c		£79,906		% Smokers referred and/or offered medication	0.0%					Quarter End Position			5.4%	Quarter End Position			7.3%	Quarter End Position			0.5%	Quarter End Position			-
9d		£79,906		% Patients screened for Alcohol usage	4.0%					Quarter End Position			1.4%	Quarter End Position			14.8%	Quarter End Position			16.1%	Quarter End Position			-
9e		£79,906		% Alcohol users given brief advice or medication	0.0%					Quarter End Position			0.0%	Quarter End Position			7.7%	Quarter End Position			6.3%	Quarter End Position			-
10. Improving the assessment of wounds																									
10	Community	£383,547	Improving the assessment of wounds	% Patients with a chronic wound who have received a full wound assessment	50.0%	50% (Internal Target)	60%	70% (Internal Target)	80%	Quarter End Position			55.3%	Quarter End Position			61.6%	Quarter End Position			55.7%	Quarter End Position			-
11. Personalised care and support planning																									
11a	Community	£319,623	Personalised care and support planning	Cohort 1 patients having evidence of care and support planning	-	N/A	N/A	N/A	75%	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			-
11b				Cohort 2 patients improvements in patient activation assessments	-	N/A	N/A	N/A	50%	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			-

16. Governance Report

a. Board Workplan

b. Use of Trust Seal

c. Board of Directors Declarations of Interests

d. Non-Executive Directors (NEDs) tenure and review of roles

e. Fit and Proper Person Self-Declaration Register

f. Board of Directors Terms of Reference

g. Guidance for Reserving Matters to a private session of the Board of Directors

h. Updates to the Constitution and Standing Orders

i. New UK Corporate Governance Code

j. Board to Ward Visits Feedback

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 7th March 2019	**Sponsoring Director:** Andrea McCourt, Head of Governance and Risk
Title and brief summary: GOVERNANCE REPORT - FEBRUARY 2019 - This report brings together a number of corporate governance items for information, review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:

a. Board Workplan
b. Use of Trust Seal
c. Board of Directors Declarations of Interests
d. Non-Executive Directors (NEDs) tenure and review of roles
e. Fit and Proper Person Self-Declaration Register
f. Board of Directors Terms of Reference
g. Guidance for Reserving Matters to a private session of the Board of Directors
h. Updates to the Constitution and Standing Orders
i. New UK Corporate Governance Code
j. Board to Ward Visits Feedback

Main Body

Purpose:

To ensure effective corporate governance, and in line with the Trust Code of Governance, this report provides updates to the Board on current governance issues and presents key documents that form part of the Trust's governance framework for review and approval.

Background/Overview:

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

b. Use of Trust Seal
The Trust Seal has been used once in the last quarter, Appendix 2.

1. Pennine Property Partnership LLP – St Luke's Hospital – agreement to vary the contract
The Board is asked to NOTE the use of the Trust Seal.

c. Board of Directors Declarations of Interests
The Declaration of Interests Register for the Board of Directors is attached at appendix 3. The Board is asked to APPROVE the register and advise the Corporate Governance Manager of any amendments. Following advice from the WYAAT Committee in Common, the Trust have reviewed their declarations in place in terms of West Yorkshire wider groups and create consistency across WYAAT in managing conflicts of interest.

d. Non Executive Directors (NEDs) Tenure and Review of Roles
An updates on re-appointments of two NEDs and a review of NED roles on Committees is confirmed at Appendix 4 and is for the Board to NOTE.

e. Fit and Proper Person Self-Declaration Register
The Board is asked to receive and approve the Fit and Proper Person self declaration register. Directors were asked during February 2019 to confirm their self-declaration of compliance against the regulations for the Fit and Proper Persons Test, attached at appendix 5. Any further amendments should be notified to the Corporate Governance Manager. The register will be updated on an annual basis and reported to the Board and included in the Annual Report.

f. Board of Directors Terms of Reference
The Board terms of reference describe the role and work of the Board. An annual review of the terms of reference has been undertaken. No significant changes have been made to the Board of Directors terms of

reference and the change in frequency of Board meetings has been amended. (Appendix 6).

The Terms of Reference and Annual Reports from the Sub Committees will be presented to the Board of Directors in May 2019. The Board is asked to APPROVE the Board of Directors Terms of Reference.

g. Guidance for Reserving Matters to a private session of the Board of Directors
It is the Trust's intention for all matters to be discussed in public, unless there are special reasons which are outlined in the attached guidance document (Appendix 7). This guidance has been developed based on national guidance. The Board are asked to NOTE the guidance.

h. Update of the Constitution and Standing Orders
The Trust's constitution and standing orders have been reviewed and refreshed. No material changes have been made. A list of the changes made are detailed in Appendix 8. The Board is asked to APPROVE the changes to the constitution and standing orders.

i. New UK Corporate Governance Code
The Code of Governance for NHS Foundation Trusts, last revised in 2014, is based on the UK Code of Governance issued by the Financial and Reporting Council. This UK Code of Governance, which reflects the latest thinking on good corporate governance, has been recently updated and came into effect on 1 January 2019. As yet NHS Improvement has not updated the Code of Governance for NHS Foundation Trusts based on this new iteration of the UK Code of Governance. Appendix 9 summarises the key points of the revised new UK Code of Governance and a link to the new UK Code of Governance is given.

j. Board to Ward Visits Feedback
A summary of the Board to Ward visits feedback between December and January 2019 is attached at Appendix 10. The Board is asked to RECEIVE the report and NOTE that the Board to Ward visits have been combined with the Quality Friday visits moving forward. A summary of these visits will be provided to the Board quarterly.

The Issue:

None

Next Steps:

None

Recommendations:

The Board is asked to APPROVE the following:
• Board Workplan
• Board of Directors Declarations of Interest
• Fit and Proper Person Self-Declaration Register
• Board of Directors Terms of Reference
• Changes to the Trust Constitution and Standing Orders

The Board is asked to NOTE the following:
• Use of Trust Seal
• Non Executive Directors (NEDs) tenure and review of roles
• Guidance for reserving matters to a private session of the Board of Directors
• New UK Corporate Governance Code
• Board to ward visits feedback

Appendix

Attachment: Yes

DRAFT BOARD WORK PLAN 2019-2020 - WORKING DOCUMENT – UPDATED 1.2.19 **Appendix 1**

	Public	Public	Public	Public	Public	Public
Date of meeting	**2 May 2019**	**4 July 2019**	**5 Sept 2019**	**7 Nov 2019**	**2 Jan 2020**	**5 March 2020**
Date of agenda setting/Feedback to Execs	8.4.19	3.6.19	7.8.19	14.10.19	25.11.19	3.2.20
Date final reports required	24.4.19	26.6.19	28.8.19	30.10.19	20.12.19	26.2.20
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 (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
REGULAR ITEMS						
Board Assurance Framework (Quarterly)	✓		✓		✓	
Care Quality Commission Update (CQC)	✓	✓	✓	✓	✓	✓
Calderdale and Huddersfield Solutions Ltd Update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) Report	✓	✓				✓
High Level Risk Register	✓	✓	✓	✓	✓	✓
Care of the acutely ill patient report		✓		✓		✓
Learning from Deaths – Quarterly Report		✓		✓Q3		✓
Guardian of Safe Working Quarterly Report		✓		✓		✓
Quality Report + Presentation focussed on one topic (may be used as patient/staff story) (NB – Quality Account in Annual Report)	Quality A/cs	✓	✓ Q1	✓Q2		✓ Q3

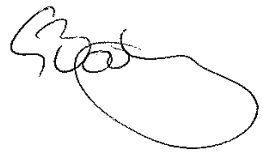
	Public	Public	Public	Public	Public	Public
Date of meeting	**2 May 2019**	**4 July 2019**	**5 Sept 2019**	**7 Nov 2019**	**2 Jan 2020**	**5 March 2020**
Nursing and Midwifery Staffing – Hard Truths Requirement	✓			✓	✓	
Safeguarding update – Adults & Children	✓ Annual report				✓	
Financial Update	✓	✓	✓	✓	✓	✓
Plan on a Page Strategy Update	✓ Annual report					
MINUTES FROM SUB-COMMITTEES						
Quality Committee update & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & Minutes	✓	✓	✓	✓	✓	✓
F&P Committee update & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee update & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
A&E Delivery Board Minutes	✓	✓	✓	✓	✓	✓
GOVERNANCE REPORT						
Standing Orders/SFIs/SOD review						✓
Non-Executive appointments (+ Nov - SINED & Deputy)			✓			✓
Board workplan		✓		✓		✓
Board skills / competencies					✓	
Board meeting dates		✓			✓	
Committee review and annual report		✓				
Annual review of NED roles			✓			
Use of Trust Seal		✓		✓		
Declaration of Interests - BOD (annually)						✓

	Public	Public	Public	Public	Public	Public
Date of meeting	**2 May 2019**	**4 July 2019**	**5 Sept 2019**	**7 Nov 2019**	**2 Jan 2020**	**5 March 2020**
Attendance Register	✓					
BOD Terms of Reference						✓
Sub Committees Report & Terms of Reference	✓					
Constitutional changes (as required)	✓					
Compliance with Licence Conditions	✓					
Quality Friday Visits Feedback		✓		✓		✓
ANNUAL ITEMS						
Annual Plan						✓
Appointment of Deputy Chair / Senior Independent Non-Executive Director (SINED)				✓		
Capital Plan					✓	
Emergency Planning Annual Report			✓			
Fit and Proper Person Self-Declaration Register						✓
Hospital Pharmacy Service (HPS) Annual Report	✓ (Annual Report)					
Health and Safety Annual Report		✓		✓ (update)		
Public Sector Equality Duty Annual Report (Equality & Inclusion - PSED)		✓ (update)				✓ (Annual Report)
Director of Infection Prevention Control (DIPC) Annual Report (ALSO SEE REGULAR ITEMS)		✓ (Annual Report)				
Fire Safety Annual Report	✓ (Annual Report)					
Medical Revalidation & Appraisal			✓			
Freedom to Speak Up Annual Report						✓ (Annual Report)
Review of Board Sub Committee Terms of Reference	✓					
Risk Appetite Statement				✓		

	Public	Public	Public	Public	Public	Public
Date of meeting	**2 May 2019**	**4 July 2019**	**5 Sept 2019**	**7 Nov 2019**	**2 Jan 2020**	**5 March 2020**
Winter Plan			✓	✓		
ONE-OFF ITEMS						
Council of Governors Elections		✓ (results)	✓			✓ (timetable)
Risk Management Strategy					✓	
Workforce Organisational Development (OD) Strategy, including staff survey results						✓
Local Health Resilience Partnership (LHRP) Core Standards			✓			✓
Performance management update				✓		
Digital Health Update		✓				

Appendix 2

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
1-19	09.01.2019		Variation Agreement - Pennine Property Partnership LLP – St Luke's Hospital – Agreement to Vary the Contract	NAME: Gary Boothby  TITLE: Executive Director of Finance
				NAME: Vicky Pickles  TITLE: Company Secretary

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT FEBRUARY 2019

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Declaration	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies.	Ownership/Part Ownership of private companies and businesses	Controlling Shareholding	A position of authority in a charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services
21.2.19	Philip Lewer	Chair	Member of the Committee In Common for the West Yorkshire Association of Acute Trusts Member of the West Yorkshire NHS Chairs meeting Member of the Pennine GP and CHFT Board to Board meetings Member of the Partnership Transformation Board	Nil	Nil	Nil	Nil
01.2.19	Owen Williams	Chief Executive	Trustee & Vice Chair – NHS Confederation Director – York Health Economics Consortium – fee paid to CHFT Senior Responsible Officer for the West Yorkshire & Harrogate Partnership, Estates & Facilities Management Group Member of the Committee In Common for the West Yorkshire Association of Acute Trusts	Nil	Nil	Nil	Nil
29.1.19	Dr David Birkenhead	Consultant Microbiologist / Executive Medical Director	Nil	Nil	Nil	Trustee Childrens' Forget Me Not Hospice	Provide Infection Control advice to the BMI, Huddersfield Wife – GP and

							member of Huddersfield Federation
28.1.19	Dr Linda Patterson	Non-Executive Director	Director Dr Linda Patterson Ltd – health consultancy	Nil	Nil	Trustee Healthcare Quality improvement partnership HQIP – oversees national clinical audits, clinical outcomes programme. appointed by Academy of Medical Royal Colleges.	Nil
29.1.19	Philip Oldfield	Non-Executive Director	Director of Tanzuk Consulting Limited	Nil	Nil	Nil	Nil
4.2.19	Helen Barker	Chief Operating Officer	Represent Chief Operating Officer's on West Yorkshire Emergency Care Network. Leading WYAAT work on Spinal Services and Gastro.	Company Secretary to husband's lighting business which supplies to the NHS. Does not supply CHFT. Expert Lighting Direct Ltd.	Nil	Nil	Company Secretary of husband's business.
28.1.19	Jackie Murphy	Chief Nurse	Trustee Overgate Hospice (currently on hold for 1 year)	Nil	Nil	Trustee Overgate Hospice (currently on hold for 1 year)	Nil
2.2.19	Richard Hopkin	Non-Executive Director	Capri Finance Ltd – own consultancy company. All part of 'Derwent' Group: - • Derwent Housing Association Ltd • Derwent FM Ltd • Centro Place Investments Ltd	Nil	Nil	Finance Director (part-time) of Age UK Calderdale & Kirklees, Age UK Support Services and Age UK Wakefield and District (Yorkshire and Humber) Various consultancy services via Capri Finance Ltd	Unpaid – Treasurer of Community Foundation for Calderdale
22.2.19	Karen Heaton	Non-Executive Director	Nil	Nil	Nil	Nil	University of Manchester – Director of Human Resources Confederation of British Industry (Employment & Skills Board) From 09/19
24.2.19	Andy Nelson	Non-Executive Director	Non-Executive Director – Disclosure & Barring Service	Nil	Nil	Nil	Nil

			Non-Executive Director & Strategic IT Advisor to the Management Board of The Law Society				
28.1.19	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships Member of the West Yorkshire Association of Acute Trusts Finance Group Member of the Partnership Transformation Board	Nil	Nil	Nil	Nil
24.2.19	Alastair Graham	Non-Executive Director	Director of Calderdale and Huddersfield Solutions Limited	Nil	Nil	Nil	Nil
12.2.18	Suzanne Dunkley	Executive Director of Workforce & OD	Nil	Nil	Nil	Nil	Nil
ATTENDEES AT BOARD OF DIRECTORS							
29.1.19	Anna Basford	Director of Transformation & Partnerships	Non-voting member of Calderdale Health and Wellbeing Board Member of the West Yorkshire Association of Acute Trusts Directors of Strategy and Chief Operating Officers' Group	Nil	Nil	Nil	Nil
29.1.19	Mandy Griffin	Managing Director – Digital Health	Nil	Nil	Nil	Nil	Nil

All the above Board of Directors have confirmed that they continue to comply with the Fit and Proper Person Requirement.

STATUS: Complete

Non-Executive Directors Tenures and Review of Roles

Main Body

Purpose:
This report brings together a number of items that evidence or strengthens the corporate governance arrangements and systems of internal control within the Trust.

Background/Overview:

1. **Confirmation of tenure of two Non-Executive Directors**
   The Remuneration and Nominations Committee (Council of Governors) met in February to discuss the re-appointment of Richard Hopkin and Karen Heaton following completion of their first three year term. It has been agreed that they will serve a second three year term to February 2022.

2. **Annual Review of Non-Executive Director roles**
   Following the approval of a second term for Richard Hopkin and Karen Heaton, as part of the annual appraisal process, the Chair has reviewed the additional roles undertaken by Non-Executive Directors and the balance against required time commitments.

   The Board is asked to **NOTE** that:
   - Phil Oldfield will continue as Deputy Chair, Senior Independent Non-Executive Director (SINED) and Chair of the Finance and Performance Committee until the end of his tenure in September 2019
   - Richard Hopkin will continue as Chair of the Audit and Risk Committee
   - Dr Linda Patterson will continue as Chair of Quality Committee until the end of her tenure in September 2019
   - Karen Heaton will continue as Chair of the Workforce Committee
   - Alastair Graham will continue as the Shareholder Non-Executive Director on the Calderdale and Huddersfield Solutions Ltd Board and therefore Chair the Calderdale and Huddersfield Solutions (CHS) Ltd Board in line with CHS' Standing Orders
   - Andy Nelson will continue to attend The Health Informatics Service (THIS) Board in addition to his Sub-committee responsibilities.

   The roles of Deputy Chair and Audit and Risk Chair come with a small additional remuneration which reflects the significant additional responsibilities and accountabilities and this will be reported in the 2018-19 Annual Report and Accounts.

Calderdale and Huddersfield NHS Foundation Trust

FIT AND PROPER PERSON SELF-DECLARATION REGISTER

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
22.2.19	**ADDY**	Melanie	Director of Ops for Surgery & Anaesthetics	-	2007	June 2018	Helen Barker	04.01.1982
25.2.19	**AITCHISON**	Rob	Director of Operations (FSS Division)	-	July 2009	June 2018	Helen Barker	July 2009
26.2.19	**AMEEN**	Asif	Director of Operations / Commercial Development	-	11.03.2016	May 2018	Helen Barker & Ashwin Verma	18.07.2016
22.2.19	**ARCHER**	Kirsty	Deputy Director of Finance	Chartered Management Accountant, ACMA (CIMA)	March 2018	May 2018	Gary Boothby	August 2008

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
28.2.19	**BARKER**	Helen	Chief Operating Officer	-	December 2015	June 2018	Owen Williams	01.01.2016
28.2.19	**BASFORD**	Anna	Director of Transformation & Partnerships	-	28.06.2016	June 2018	Owen Williams	July 2013
26.2.19	**BATES**	Julian	Assistant Director, Chief Information Officer, The Health Informatics	Member of Institute of Health Management	02.03.16 (expires 2.3.19 – Cricket Coach DBS)	June 2018	Mandy Griffin	13.02.1995
25.2.19	**BIRKENHEAD (Dr)**	David	Executive Medical Director	MB.ChB, MD, FRCPath	30.11.15 & 29.1.18 001511499967	August 2018	Owen Williams	01.12.1999
25.2.19	**BOOTHBY**	Gary	Executive Director of Finance	Assoc CMA 8659790 CIPFA 41612-CIP	30.11.17 (expires 29.11.19)	June 2018	Owen Williams	07.03.16

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
28.2.19	**DUNKLEY**	Suzanne	Executive Director of Workforce & OD	FCIP 31049644	December 2017	18 June 2018	Owen Williams	01.02.18
27.2.19	**EDDLESTON**	Jason	Deputy Director of Workforce and OD	CIPD 10327459	February 2019 to be progressed	April 2018	Suzanne Dunkley	08.02.1999
23.2.19	**GRAHAM**	Alastair	Non-Executive Director	N/A	December 2017	December 2018	Philip Lewer	01.12.2017
6.3.18 – Awaiting review	**GRIFFIN**	Mandy	Managing Director – Digital Health	-	Awaited	September 2017	Owen Williams	18.01.09
28.2.19	**HEATON**	Karen	Non-Executive Director	Member of CIPD	May 2016	February 2019	Philip Lewer	01.03.16
28.2.19	**HENSHAW**	Anne-Marie	Assistant Director of Quality and Safety	NMC 85A3198E – Registered Midwife and Teacher	February 2013	27 June 2018	Jackie Murphy & Julie O'Riordan	01.03.13

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
2.2.19	**HOPKIN**	Richard	Non-Executive Director	FCA (membership number 7311370)	14.12.17	February 2019	Philip Lewer	01.03.16
28.2.19	**LEWER**	Philip	Chair	-	26.2.2018	N/A	N/A	1.4.2018
26.2.19	**MCCOURT**	Andrea	Company Secretary	-	April 2015	30 April 2018	Juliette Cosgrove	May 2015
25.1.19	**MURPHY**	Jackie	Chief Nurse	NMC 8312713E	19.12.2018	17 August 2018	Owen Williams	July 2007
23.2.19	**NELSON**	Andy	Non-Executive Director	-	09.10.17	14 January 2019	Philip Lewer	01.10.2017
27.2.19	**OLDFIELD**	Phil	Non-Executive Director	ACA 7569142	12.12.17 Enhanced CRB	3 January 2019	Philip Lewer	September 2013
16.2.18 – awaiting review	**PARKER**	Cornelle	Deputy Medical Director	GMC 3286582	May 2017	19 January 2018 – management and 15 February 2018 –	David Birkenhead Dr N Scriven	08.05.2017

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
						clinical		
27.2.19	**PATTERSON (DR)**	Linda	Non-Executive Director	GMC 2232692	01.12.16	23 January 2019	Philip Lewer	01.10.2013
28.3.19	**RUDGE**	Lindsay	Deputy Chief Nurse	RGN 90E0076E	Awaited	28 June 2018	Jackie Murphy	1993
28.2.19	**WILLIAMS**	Owen	Chief Executive	-	08.07.16	11 February 2019	Philip Lewer	14.05.2012

APPENDIX 6

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTIUTION

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, for the information of the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees. The practice and procedure of the meetings of the Board of Directors – and of its committees – are not set out here but are described in the Board's Standing Orders.

2. PURPOSE

The principle purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors. The Board consists of executive directors, one of whom is the Chief Executive, and non-executive directors, one of whom is the Chair.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide safe,

accessible, effective and well governed services for patients, [service users, and carers;

- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:

- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Ensures that high standards of corporate governance and personal integrity are

maintained in the conduct of foundation Trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:
- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to foundation Trusts;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures that all required returns and disclosures are made to the regulators;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business.
- Agrees the schedule of matters reserved for decision by the Board of directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:
- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:
- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community.

- Meets its engagement obligations in respect of the Council of Governors and members and ensures that governors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and Council of Governors and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chairman and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

7. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS'

The non-executive directors are accountable to the Council of Governors' for the performance of the Board of Directors. To execute this accountability effectively, the non-executive directors will need the support of their executive director colleagues. A

well-functioning accountability relationship will require the non-executive directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The non-executive directors will need to encourage questioning and be open to challenge as part of this relationship. The non-executives also should ensure that the Board as a whole allows Council of Governors' time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS

The Board of Directors will meet at least 6 times a calendar year.

9. QUORUM

Six directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Corporate Governance Manager whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the Council of Governors and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the chair and chief executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

In order that the Board can be assured that it is operating at maximum effectiveness in discharging its responsibilities at set out in these terms of reference it shall self assess its performance following each Board meeting. Once a year a full review of effectiveness will be undertaken including attendance, decision making, assessment against responsibilities and completion of the business cycle.

Review date February 2020

Calderdale and Huddersfield NHS Foundation Trust

APPENDIX 7

GUIDANCE FOR RESERVING MATTERS TO A PRIVATE SESSION OF THE BOARD OF DIRECTORS

It is the Trust's intention for all matters to be discussed in public, unless there are special reasons as outlined in this guidance document.

Background

The Trust's Constitution (section 31.1) states that meetings of the Board of Directors shall be open to members of the public. However, members of the public may be excluded from a meeting for reasons of commercial confidentiality or on other proper grounds.

Within the Constitution's Standing Orders for the practice and procedure of the Board of Directors, it outlines that special reasons shall include, but not be limited to, the following:

- Discussion of any matter which contains confidential, personally identifiable information relating to a member of staff or a service user or carer.
- Discussion of any matter which contains commercially sensitive information relating to the Trust or a third party.

having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

Determination

Within the NHS Providers' guidance *The Foundations of Good Governance: A Compendium of Best Practice 2011* and NHS Leadership Academy's *The Healthy NHS Board 2013 - Principles for Good Governance,* it recommends that when determining which matters should be reserved for private consideration, the Trust should consider whether the information to be discussed would be exempt from disclosure under the Freedom of Information Act (FOI) 2000.

The table below outlines the exemptions most likely to apply to information considered by the Board of Directors as a point of reference. The final decision on whether items shall be discussed in public or private session shall be made by the Chair, having taken advice from the Chief Executive and Company Secretary, and in accordance with this guidance note.

FOI section	**Reason for exemption**
Section 22* Information intended for future publication	Drafts of documents not in final form that have firm plans for future publication that can be advised to the requestor e.g. - The Annual Report and accounts which can only be made public once has been laid before parliament - Draft consultation documents.

Section 31 31(1)(a), (b), (c) and (f) 31(1)(g)*, 31(2)(b) * or (j) * Law enforcement	- Disciplinary or legal investigations of members of staff or the Trust. - Processes for identifying any improper conduct. - Serious incident reports.
Section 32 Information contained in court records	Information that we hold that was created explicitly for or was used in any court proceedings.
Section 36 36(2)(b)(i)*, (b)(ii)* and (c)* Free and frank discussion and the effective conduct of public affairs	Exemption may only be considered if the Trust's qualified person (Chief Executive) has provided a written opinion that disclosing the information would prejudice the Trust's affairs. Information discussed could include: - Matters in the initial stages of enquiry. - Early stages of strategic thinking. - Sensitive 'live' issues. - Draft minutes of meetings. - Recommendations from external organisations. - Professional advice obtained. - Options papers. - Discussions about future public consultations
Section 38 Health and safety	Matters in relation to the health and safety of staff members, service users, carers or other members of the public.
Section 40 40(2) Personal data	Information containing the personal data of including staff members, service users, carers or other members of the public where the disclosure would not be fair to that person. This exemption only applies to the living, and consent to the disclosure being considered will not have been given and that the other legal bases for disclosure, as set out in the Data Protection Act, will need to be considered.
Section 41 Information provided in confidence	Information provided in confidence from another person or organisation, if releasing that information would lead to a claim for breach of confidence.
Section 42* Legal professional privilege	Legal advice including communications with law firms.

Section 43* 43(2)* Commercial interests	Disclosure of the information would be likely to damage the Trust's commercial interests or those of a third party. The Trust must be able to demonstrate exactly how the requested information would prejudice the Trust's or another party's interests.
Section 44 Prohibitions on disclosure	Information which is prohibited to be disclosed by law, stating which law prohibits the release of the information and why.

VP
February 2019

APPENDIX 8

Update to the Trust's Constitution and Standing Orders

Purpose:
This report summarises together changes made to the Trust's Constitution and Standing Orders, following an annual review by the company secretary.

Background/Overview:
The changes to the Trust's Constitution and Standing Orders are listed below.

Changes to the Constitution

1. Section 21 'Council of Governors – referral to the panel' has been removed from the constitution as NHS Improvement disbanded the independent panel for advising governors in January 2017 as the panel facility was not used by governors
2. Page 25 spelling of Thornton and Odsal corrected
3. Page 29 added 'the'
4. Throughout standing orders changed Chairman to Chair
5. Throughout standing orders and election rules changed from Membership Council and Councillors to Council of Governors and Governors.

Changes to the Standing Orders

1. Reference to Membership Council on page 5 changed to Council of Governors
2. Reference to Board Secretary changed to Corporate Governance Manager and Company Secretary on page 5
3. Reference to Membership Council changed to Council of Governors in sections 1.3 and 1.7, pages 9 and 10
4. Section 1.9 Membership Councillor changed to Governor
5. Section 2.3 added the word 'information' to confidential
6. Sections 2.7 'Setting the Agenda' and 2.9 'Notices of Motion' on page 12 amended from 7 working days to no less than 5 working days before a meeting
7. Page 18 amended the name of the Workforce Well Led Committee to Workforce Committee
8. Page 18 addition of the Joint Liaison Committee and the Estates Sustainability Committee under Committees established by the Board.

Recommendation

The Board are asked to approve the changes to the constitution and standing orders.

APPENDIX 9

THE NEW UK CODE OF GOVERNANCE

Summary

The new UK Corporate Governance Code (the code) came into force from 1 January 2019. Annual reporting compliance with the code is a listing requirement for companies with a premium listing in equity shares. The Code of Governance for NHS Foundation Trusts has historically been updated in line with the Code. This briefing summarises key changes set out in the code.

Key Points

The new UK code stresses the need for organisations to build trust by fostering strong relationships with their key stakeholders. It requires organisations to set and develop a corporate culture that is aligned with the organisation's purpose and its strategy, which promotes integrity and values diversity.

The new code is based on key general principles and on more specific provisions in common with previous iterations of the code. However in the new code there is greater emphasis on the application of the principles with clear, meaningful reporting to stakeholders. The code also places an onus on stakeholders to assess explanations of non-compliance carefully, not adopt a tick-box approach. It is also more concise and should prove to be easier to apply and report on.

The relevance of the new code to the NHS is twofold:

• First it represents the latest thinking on the application of good corporate governance which is a tried, tested and trusted framework for the leadership and direction of organisations in the UK, so it should be of interest to all board led organisations

• Secondly the Code of Governance for NHS Foundation Trusts, last revised in 2014, has been based on the UK Code and traditionally has been revised with each new iteration of the UK Code.

Key Changes

The main changes in the updated code include:

Workforce and stakeholders: There is a new provision to promote greater board engagement with the workforce to understand their views. The code asks boards to describe how they have considered the interests of stakeholders when performing their duty to promote the success of the organisation.

Culture: The new code places far greater emphasis than ever on the need for boards to create a culture which aligns the organisation's values with strategy. Importantly the code asks boards to assess how the board leads in generating and preserving value over the long-term, a significant move from achieving short term gain.

Succession and diversity: The code emphasises the need for boards to have the right mix of skills and experience to ensure constructive challenge and to promote diversity. It stresses the need to refresh boards and for robust succession planning. It also asks that meaningful

consideration is given to the length of term that chairs remain in post, so that a clear division of power exists between chair and chief executive.

The new code strengthens the role of the nomination committee in succession planning and ensuring a diverse board. It stresses the importance of external board evaluation including reports to the nomination committee on details of the contact the external board evaluator has had with the board and individual directors.

Remuneration: The new code emphasises that remuneration committees should take into account workforce remuneration and related policies when setting director remuneration. It also warns that formulaic calculations of performance related pay should be rejected in favour of the application of discretion when deciding pay awards.

In Summary

The new code represents a significant change that should have a positive impact on the application of corporate governance in the UK. As yet NHS Improvement has not yet updated the code for NHS foundation trusts to ensure it is also relevant for NHS trusts and in line with the UK Code of Governance. The code can be found on The Financial Reporting Council's website below.

https://www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code

APPENDIX 10

BOARD TO WARD VISITS – DECEMBER 2018 – MARCH 2019

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	NOTES/REPORTS/COMMENTS/ACTIONS
27.12.18	1:00 – 2:00 pm	Philip Lewer	Vicky Pickles	Gynaecology and Maternity wards, CRH (4C)	Rachel Roberts	**Areas of good practice identified:** • Wards were lovely, clean and tidy • Calm atmosphere • Good feel to the ward • Staff were very welcoming and positive. EPAU team had all been in the role for a significant length of time and talked about a good team spirit; the level of responsibility and accountability they felt for their role; the good level of patient care they were able to provide. • They all talked positively about the recent ward moves and how that had improved ways of working. In particular on the induction ward which had provided space for a day room for mums waiting to give birth. **Areas of concern/ improvement identified:** • No area for patients waiting for the EPAU clinic. • Medical review of patients on the gynae ward not happening in the morning. • Better signage to ward 4C to help patients **What the team are most proud of and any future developments:** • Really proud of the service they are able to provide. • Pleased with the way in the which the maternity services are now configured with the structure of the wards. • Very proud of the way in which the teams work together.
3.1.19	1:00 – 2:00 pm	Alastair Graham	Vicky Pickles	Occupational Health	Christine Bouckley	**Areas of good practice identified:** • Clearly a committed and compassionate small team. • Are seeing an increase proportion of staff in a preventative situation rather than curative. • Have a real impact on keeping people at work and

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	NOTES/REPORTS/COMMENTS/ACTIONS
						bringing people back in to work however this is hard to measure. • The Hot House was successful in engaging with staff and developing ideas. Now being taken 'on the road' to other parts of the Trust and has given the Trust a profile with NHS Employers. **Areas of concern/ improvement identified:** • Really need a new IT system that will be interoperable with primary care and OH teams across West Yorkshire. Currently working on paper systems and a not fit for purpose IT system. • Small number of staff and the service is hard to recruit to. • Insufficient medical cover – Christine having to cover medical role. • More slots required for counselling • Increasing numbers of colleagues with mental health concerns rather than physical health concerns which requires different skills and knowledge from the team. **What the team are most proud of and any future developments:** • Really proud of the service they are able to provide. • Would like to see IT improvements as a catalyst for modernising the service and potentially growing the service commercially. **Please detail below any necessary action that needs to be taken following the visit and the person responsible for ensuring this happens:** It was agreed to highlight the IT modernisation point to the Board.

APPENDIX 10

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	NOTES/REPORTS/COMMENTS/ACTIONS
4.1.19	12:00 – 1:00 pm	Andy Nelson	Vicky Pickles	Community Care, Broad Street Plaza	Debbie Wolfe	Awaiting feedback from Andy Nelson following more recent visits in February 2019.
23.1.19	9:00 – 10:00 am	Andy Nelson	Lesley Hill	Ward 6, HRI (Elderly Care)	Sarah Bray	Thanks to Sarah Bray for showing us around. We met a very helpful and committed team who are dealing well with the challenges of Elderly Care on a ward which is not ideal for providing such care. **Please detail below any necessary action that needs to be taken following the visit and the person responsible for ensuring this happens:** Remove cupboard in entrance – complete (Lesley Hill) Remove one confidential waste bin – complete (Lesley Hill) Put sockets on either side of entrance - part of fire safety plan (Lesley Hill) Remove cupboards behind nurses station on A and B sides and put in sockets - part of fire safety plan (Lesley Hill) Issue with fire door on B Side - on Estates work (Lesley Hill)

17. Plan on a Page Strategy Update

Presented by Anna Basford

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Anna Basford, Director of Transformation & Partnerships
Date: Thursday, 7th March 2019	**Sponsoring Director:** Amber Fox, Corporate Governance Manager
Title and brief summary: Strategic Plan on a Page Year ending 2019 – End of year summary - The purpose of this report is to provide a year end update for the Trust Board of the progress that has been made to implement the 2018/19 strategic plan on a page.	
Action required: Note	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: This paper has not been submitted to another forum.	
Governance Requirements: The risks of not delivering the Trust's strategic plan on a page has been assessed this is included in the Board Assurance Framework. The risks associated with each area of delivery within the plan has also been assessed and is included in the corporate risk register.The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.	
Sustainability Implications: None	

Executive Summary

Summary:

This report highlights that of the 18 deliverables included in the plan for 2018/19:
• None are rated red
• Two are rated amber
• Eleven are rated green
• Five have been fully completed

Main Body

Purpose:

To update the Board on progress to deliver the 2018/19 strategic plan on a page.

Background/Overview:

The Trust has an agreed five year strategy which is based on the vision of delivering outstanding compassionate care. Each year the Trust identifies key one year deliverables to support achievement of the 5 year strategy this is described in a plan on a page that describes the key deliverables against the goals of :
Transforming and improving patient care
Keeping the base safe
A workforce fit for the future
Financial sustainability
This report provides an update on the achievement of the key deliverables for 2018/19.

The Issue:

This report highlights that of the 18 deliverables included in the plan:
• None are rated red
• Two are rated amber
• Eleven are rated green
• Five have been fully completed

Next Steps:

This is the end of year 4 of the five year strategy. The one year view for the final year (2019/20) is being drafted building on this position and will be presented to the Board and discussed with Governors at a workshop in May, for final sign off at the Board meeting in July.

Recommendations:

Members of the Trust Board are requested to note the progress in respect of delivery of the 2018/19 strategic plan on a page.

Appendix

Attachment:

Progress against strategy report - end of year report March 2019 Updates (2).pdf

Calderdale and Huddersfield NHS Foundation Trust
Annual Plan Year ending 2019 – End of year summary

Introduction

The Trust's vision is:
Together we will deliver outstanding compassionate care to the communities we serve.

In June 2017, the Board of Directors agreed the refreshed 1 year plan for year ending 2018. The plan describes the four goals of the Trust:

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

These goals are underpinned by the four behaviours:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The plan sets out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering our goals have been assessed and are included in the Board Assurance Framework. The risks associated with each area of delivery have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

Objectives for the Year Ending 2019				
Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Achieve a regulatory approved proposal for the reconfiguration of hospital and care closer to home services that puts the patient at the centre of care	Deliver a Single Oversight Framework rating of 2 for the agreed quality and operational performance metrics	Achieve a retention rate of 90% and reduce vacancies by 10% to address recruitment and retention of key roles in CHFT	Deliver a regulatory compliant financial plan for 2018/19 including CIP
	Deliver all GIRFT actions in selected pathways of care to reduce variation and deliver agreed out comes	Achieve a BRAG rating of blue for all actions resulting from the findings of the CQC and Use of Resources inspection	Baseline / assess staff and patient equality & diversity experience and develop a plan of action to improve	Develop a regulatory and Integrated Care System compliant capital plan to meet the organisation's requirements
	Continue to meet 7 day NHS England standards (2,5,6 and 8) in agreed specialties	Launch the Quality Improvement Strategy and deliver the 18/19 agreed quality KPIs (including the 3 selected by the Council of Governors see separate page).	Create a health & wellbeing strategy to achieve 96% attendance and improve our overall engagement score	Maintain a Single Oversight Framework rating of 3 or better for financial and Use of Resources performance metrics
	Implement the agreed digital health next step proposal whilst deploying the technical infrastructure to create a shared care record across local health and social care community	Implement year 3 of the health & safety action plan; with specific focus on ensuring each service has tested their business continuity plan, has a COSHH super user (where required) and identified staff have completed risk assessment training	Create an OD Strategy to co-ordinate all workforce activities and develop an action plan to achieve our workforce key performance indicators and improve our overall engagement score	Progress key WYAAT work streams and capital bids including vascular; pharmacy; imaging; pathology; wholly owned subsidiary and elective procedures.
	Improve patient flow and achieve a 10% reduction in stranded (over 7 days) and super stranded (over 21 days) patients.	Develop & ensure delivery of the KPIs for the WOS to provide a safe environment that is efficient and supports effective patient care		

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2017/18.

Structure of Report

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

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

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

Summary

This report highlights that of the 18 deliverables:

- None are rated red
- Two are rated amber
- Eleven are rated green
- Five have been fully completed

This is the end of year 4 of the five year strategy. The one year view for the final year is being drafted building on this position and will be presented to the Board and discussed with Governors at a workshop in May, for final sign off at the meeting in July. This will be supported by a revised Board Assurance Framework and reviewed high level risk register. There will also be discussion about the new longer term plan, taking into account the progress with reconfiguration and the NHS Long Term Plan.

Recommendation

Note the assessment of progress against the 2018/19 goals.

- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Achieve a regulatory approved proposal for the reconfiguration of hospital and care closer to home services that puts the patient at the centre of care	**On track (green)**	Proposal for hospital reconfiguration sent to the Secretary of State for Health and Social Care in August 2018. Confirmation of allocation of £196.6M capital received in November 2018. Update provided to SoS at the end of January 2019 and also given to JOSC in February 2019. Strategic Outline Case being drafted in accordance with the timetable and due for submission to NHS I in April 2019.	**Lead: AB** Transformation Partnership Board Estates Sustainability Committee NHS I PRMs Council of Governors
Deliver all GIRFT actions in selected pathways of care to reduce variation and deliver agreed out comes	**On track (green)**	GIRFT programme in place managed through the PMO, with actions taken in a number of specialties. Work together to get results workshops also taken place with a number of specialties including general surgery, cardiology and ophthalmology. Work with the regional GIRFT lead to review services on a WYAAT footprint also in progress.	**Lead: OW** Weekly Executive Board Quality Committee Board
Continue to meet 7day NHS England standards (2,5,6 and 8) in agreed specialties	**Complete (blue)**	The Trust is now compliant with all core standards 2, 5, 6 and 8. Work continues on standard 5 and in addition to the 4 core standards plans to work towards compliance with standards 3 and 4 are being developed. It is believed that further compliance will only be achieved with full reconfiguration.	**Lead: DB** Quality Committee Weekly Executive Board
Implement the agreed digital health next step proposal whilst deploying the technical infrastructure to create a shared care record across local health and social care community	**On track (green)**	The Trust has used the Cerner Health Information Exchange (HIE) and the Medical Interoperability Gateway (MIG) to enable 'real-time' patient information to be shared across GP practices and the hospital. All GPs in Calderdale and Greater Huddersfield can now view the hospital electronic patient record in their system of choice (SystmOne and EMIS) - this is a real time view and not via a separate portal. Hospital clinicians can also now view the GP record for all Calderdale Patients within the hospital Cerner electronic patient record and this is technically enabled to 'go-live' for Greater Huddersfield patients in February 2019. Work has also commenced to progress digital inter-operability with the Calderdale Social Care System via the MIG.	**Lead: MG** Divisional digital boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.
Improve patient flow and achieve a 10% reduction in stranded (over 7 days) and	**Complete (blue)**	Trust delivered a reduction of 19% on stranded and super stranded patients and is sustaining this through the winter period	**Lead: HB** Weekly Executive Board IPR to Board

super stranded (over 21 days) patients.			NHS I PRMs

Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a Single Oversight Framework rating of 2 for the agreed quality and operational performance metrics	**Complete (blue)**	The Trust is currently achieving a SOF rating of 2 for performance.	**Lead: HB** NHS I PRMs Integrated Board Report Audit and Risk Committee
Achieve a BRAG rating of blue for all actions resulting from the findings of the CQC and Use of Resources inspection	**On track (green)**	Have completed all the actions resulting from the findings of the CQC with the exception of the ICU and ED staffing which requires Board decision on how this will be managed and mitigated. Celebrating the Positives events held to share learning and good practice.	**Lead: JM** Weekly Executive Board Quality Committee Board of Directors Council of Governors
Launch the Quality Improvement Strategy and deliver the 18/19 agreed quality KPIs (including the 3 selected by the Council of Governors see separate page).	**Off track – with plan (amber)**	KPIs being delivered as described in the plan. Discussed with the Council of Governors at a workshop in March and will be included in the Quality Report to be presented to Quality Committee, CoG and Board in April. Quality Improvement Strategy launch not completed however quality improvement activities taking place across the Trust including infection prevention and control, patient experience for bereaved families, response to deteriorating patient.	**Lead: JM** Board Quality Committee Weekly Executive Board Council of Governors
Implement year 3 of the health & safety action plan; with specific focus on ensuring each service has tested their business continuity plan, has a COSHH super user (where required) and identified staff have completed risk assessment training	**On track (green)**	Business Continuity plans completed as part of the preparations for a no deal Brexit. Testing taking place during March. Awaiting update on health and safety action plan. Risk assessment training has been commenced, with each session being fully booked. The feedback is extremely positive. These sessions will continue until the end of March 2019. COSHH superuser training is now complete.	**Lead: SD / HB (Business Continuity)** Quality Committee Board

		A new H&S action plan will be part of the Board Annual Review and Plan, which will be with Board of Directors in July 2019.	
Develop & ensure delivery of the KPIs for the WOS to provide a safe environment that is efficient and supports effective patient care	**On track (green)**	All governance arrangements for Calderdale and Huddersfield Solutions in place and signed off. SLAs and KPIs reviewed and approved at Joint Liaison Committee and CHS Board. Final progress report to be discussed at this board meeting.	**Lead: GB** Monitored through Health and Safety Committee to Quality Committee and reported six-monthly to the Board.

Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Achieve a retention rate of 90% and reduce vacancies by 10% to address recruitment and retention of key roles in CHFT	**On track (green)**	• As at December 2018, the retention rate is 90.65%, a steady growth from 87.7% in December 2017 • Turnover is at 8.94% against a target of 11.5%, the rate at December 2017 • Total vacancies are 304 fte, as at December 2018, 5.8% compared to 359 fte, 6.4% 12 months ago • Considerable success in recruiting to substantive Medical Consultant vacancies • Proportion of agency workers to substantive employed staff at 2.93% from a high of 9.41% in March 2018 as a result of recruitment success and strengthened 'as and when' bank arrangements	**Lead: SD** Workforce Committee
Baseline / assess staff and patient equality & diversity experience and develop a plan of action to improve	**Off track – with plan (amber)**	• Equality, Diversity and Inclusion (ED&I) Lead successfully recruited and scheduled to start in post on 25 March 2019 • BAME Network in place and developing activity programme • Inclusive mentoring scheme designed and implemented to support BAME colleagues. Second cohort to run Spring 2019 • LGBT+ forum now established with an action plan to improve that includes undertaking Stonewall index	**Lead: SD** Workforce Committee.

		assessment. • Work is underway to prepare for WDES (Workforce Disability Scheme) • Staff Survey 2018 is being used to create the baseline and action plan • Work underway to identify progress made in assessing patient equality and diversity experience • Annual plan has been prepared and will provide the key data for the baseline of staff and patient equality and diversity experience	
Create a health & wellbeing strategy to achieve 96% attendance and improve our overall engagement score	**On track (green)**	• Attendance above 96% with a sickness absence rate of 3.83% at December 2018 and an overall downward trend for the year from 4% • Staff Health and Wellbeing is a key element of our OD strategy – progress of the OD strategy will be presented to Board on 7th March	**Lead: SD** Workforce Committee.
Create an OD Strategy to co-ordinate all workforce activities and develop an action plan to achieve our workforce key performance indicators and improve our overall engagement score	**On track (green)**	• Strategy to be shared with Board of Directors on 7th March 2019 • Interactive 'live' web-based design • Themes include talent management (incorporating recruitment, retention, development, performance management), health and wellbeing, ED&I and colleague engagement • Content co-created with staff through series of events including tea trolley rounds hot house events as well as data from staff survey 2017 and 2018 and IIP accreditation	**Lead: SD** Workforce Committee.

Goal: Financial sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a regulatory compliant financial plan for 2018/19 including CIP	**On track (green)**	On plan to achieve a year end deficit of £43m as planned.	**Lead: GB** Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee / Estates Sustainability Committee Monthly regulator discussions
Develop a regulatory and Integrated Care System compliant capital plan to meet the organisation's requirements	**Complete (blue)**	Received £196.6m as the top priority bid through the West Yorkshire and Harrogate Health and Care Partnership capital bid.	**Lead: GB** Finance and Performance Committee Estates Sustainability Committee
Maintain a Single Oversight Framework rating of 3 or better for financial and Use of Resources performance metrics	**Complete (blue)**	The Trust is a SOF rating of 3 for financial and UoR performance metrics	**Lead: GB** Finance & Performance Committee Board
Progress key WYAAT work streams and capital bids including vascular; pharmacy; imaging; pathology; wholly owned subsidiary and elective procedures.	**On track (green)**	- Wholly Owned Subsidiary delivered and in place. Now working with other Trusts. - Supported WYAAT decision to recommend vascular network model with Leeds and Bradford as hubs - Participating in pathology, pharmacy, imaging and elective procedures	**Lead: ALL** Business cases to be reviewed by Board and WYAAT Committee in Common

18. 19/20 Annual Plan (Presentation)

To Approve

Presented by Gary Boothby

19. Month 10 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 7th March 2019	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Month 10 Financial Summary - A summary of the financial position as reported to NHS Improvement for Month 10.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Weekly Executive Board	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

See attached

Main Body

Purpose:

See attached

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

Month 10 Financial Summary BOD.pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

MONTH 10 FINANCIAL SUMMARY

BOARD OF DIRECTORS 7 MARCH 2019

Year to Date Summary

The reported year to date deficit is £36.53m, a £0.02m favourable variance from plan. This position belies the adverse operational variance seen in a number of areas in-month.

The underlying overspend on medical staffing continues in-month at £0.38m above plan. Pressure continues to be seen on unqualified nursing pay budgets and non-pay costs are above plan particularly against premises costs.

Medicine division has seen pressure particularly on non-contracted pay costs, with high consultant extra session costs in A&E in the Christmas and new-year period; an instance of medical agency invoices received at a higher value than recorded on the Allocate systems (£70k); and other agency invoices booked outside of the Allocate system (£40k). Operational adherence to these processes is paramount to maintain governance and for accurate expenditure capture. The adverse in-month variance to plan for the division is £0.21m.

FSS division have seen lower than planned NICU activity and income (which is outside of the AIC protection) (£140k). In addition pressure is seen from send away pathology tests and radiology charged from other providers (£140k). The combined impact of these and other smaller movements is a £0.31m adverse variance to plan in month.

Calderdale and Huddersfield Solutions (CHS) and Trust Estates costs have increased in two key areas, driving a combined in-month adverse variance of £0.42m. Firstly, invoices for clinical waste were received from Leeds Teaching Hospitals Trust (LTHT) in January for the first time since the transfer from the old provider, HES, to the new contract with Mitie, hosted by LTHT. These invoices revealed a £0.21m pressure which considerably outweighed that previously anticipated based on the information received on the price uplift. The key driver for this is understood to be transport costs that the Trust is committed to pay as local waste management capacity is not available and the company is transporting waste out of area to the South East.

Secondly, utilities expenditure has been realigned with the increased unit prices now being incurred at a higher level. The price uplift of 23% particularly impacts electricity and brings an additional pressure of £0.2m. Work with the budget holders in the service is ongoing to maintain the most up to date view of costs as a new contract is sought for best value.

These pressures have been offset in the reported position by recognition of additional income negotiated with non AIC commissioners, capitalisation of some costs and prior year benefits. All of these actions leave a diminished level of flexibility to achieve the year end forecast and so expenditure controls such as those around non-pay and overtime escalated approvals are more crucial than ever.

Appendix 1 shows the position against the clinical contract and the protection offered by the AIC.

Forecast

The year-end forecast is to achieve the planned £43.1m deficit.

However, the pressures on the year to date position at Month 10 play through to the year-end forecast with some areas breaching their agreed year-end target positions.

Divisional Forecast M10	Plan £'m	Actual £'m	Variance £'m	Target Variance Agreed @M8 £'m	Distance from Target £'m
Central & Reserves	(25.30)	(22.37)	2.93	2.92	0.00
Corporate	(42.09)	(41.85)	0.24	(0.25)	0.49
FSS	(4.09)	(5.07)	(0.98)	(0.59)	(0.38)
THIS	0.24	0.19	(0.05)	(0.08)	0.04
Medicine	27.91	28.31	0.40	0.46	(0.06)
Surgery	12.31	10.48	(1.83)	(1.88)	0.05
Community	2.93	3.08	0.15	0.10	0.05
PMU	2.76	2.82	0.05	0.05	0.00
CHS / Estates & Facilities	(17.72)	(18.62)	(0.91)	(0.46)	(0.45)
Total Deficit	**(43.05)**	**(43.04)**	**0.01**		

This places reliance on a level of technical accounting benefits, divisional recovery actions and expenditure control measures. All actions must be taken to bring the positions back to the agreed target levels.

Achievement is further reliant on both the delivery of the full £18m of CIP. The £18m CIP includes £1m for Project Echo which at heightened risk in terms of its timing prior to the financial year-end. Mitigation to this potential shortfall is being sought.

Month 10 Contract Position Summary

1. Summary in-month and YTD Month 10 Position – by Point of Delivery

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	3,186	3,160	-26	2.29	2.21	-0.08	30,523	30,599	76	21.97	21.69	-0.27
Elective	426	428	2	1.39	1.26	-0.13	5,229	4,678	-551	16.55	14.32	-2.24
Non-Elective	4,796	5,194	398	8.59	9.10	0.51	47,472	49,162	1,690	84.93	85.58	0.64
A&E	12,512	12,705	193	1.52	1.62	0.10	128,467	126,840	-1,627	15.56	16.01	0.44
Outpatient	32,271	32,541	269	3.83	3.78	-0.05	305,361	309,969	4,608	36.22	36.19	-0.03
Other NHS Tariff	11,234	10,851	-383	1.82	1.78	-0.03	106,147	106,976	829	17.12	17.05	-0.07
Other NHS Non-Tariff	152,272	153,698	1,426	6.29	5.86	-0.43	1,428,894	1,430,081	1,187	60.25	59.47	-0.77
CQUIN	0	0	0	0.58	0.58	0.00	0	0	0	5.73	5.69	-0.04
Sub-total - pre AIC adjustment	**216,698**	**218,577**	**1,879**	**26.31**	**26.20**	**-0.11**	**2,052,093**	**2,058,305**	**6,212**	**258.34**	**255.99**	**-2.34**
AIC Adjustment	-	-	-	-	0.04	0.04	-	-	-	-	2.21	2.21
Net Reported Position	**216,698**	**218,577**	**1,879**	**26.31**	**26.24**	**-0.07**	**2,052,093**	**2,058,305**	**6,212**	**258.34**	**258.20**	**-0.13**

In summary:

- The YTD position is now **£2.34m** below the contract PRE AIC with an AIC adjustment of **£2.21m**. This brings the net YTD position to **-£0.13m**.
- The YTD position on pass-through costs is an under-trade of -£0.46m which is off-set by a non-pay underspend and so the YTD net impact on I&E is a benefit of **+£0.33m**.

2. Month 10 Forecast Position vs Month 10 Actual Position

The net income position is £0.11m worse than it was forecast to be based on lower activity outside of the AIC protection. This is in the main driven by Pass through HCD's and NICU activity that has continued at the lower levels seen in M9 than seen in prior months.

3. Underlying Position

The YTD under-performance against the AIC is partially driven by a number of transformational changes and management actions with a total value of £2.07m. The remaining under-performance on the AIC is therefore -£0.14m below the AIC value. This is driven by a material under-performance on elective of -£1.45m, offset by over performance in A&E, non-elective and outpatients.

20. Public Sector Equality Duty (PSED) Annual Report

To Approve

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Vanessa Henderson, Membership Engagement Manager
Date: Thursday, 7th March 2019	**Sponsoring Director:** Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Title and brief summary: Public Sector Equality Duty (Equality, Diversity and Inclusion) Annual Report - The Board is asked to approve the Public Sector Equality Duty (Equality, Diversity and Inclusion) Annual Report for 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: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This equality report is to show the progress Calderdale and Huddersfield NHS Foundation Trust (CHFT) has made during 2018 in meeting its equality duties under:
• Section 149 of the Equality Act 2010 (the public sector equality duty) and
• The Equality Act 2010 (Specific Duties) Regulations 2011

Main Body

Purpose:

This report provides assurance to the Board on how the Trust is meeting the requirements of the Public Sector Equality Duty. The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the General Equality Duty. The report also contains the Equality in our Workforce Report.

Background/Overview:

CHFT strives to provide the highest quality of service to all of its patients. Equality, Diversity and Inclusion considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care.

The Issue:

This report highlights our approach and work to address any additional needs of those patients and colleagues who identify with a range of protected characteristics. The report gives examples of work/initiatives going on at CHFT to do this. It should be noted that this is only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

Next Steps:

Once approved by the Board, this report will be formally published on the Trust's website.
In 2019 the Trust will give renewed focus to its "Putting Patients First – a strategy for involvement and equality". This wider strategy identifies actions to enhance the patient experience, and to address specific needs of those with a protected characteristic. These in turn will also address the mandatory requirements of the EDS2 and the WRES.
As the Trust provides services to patients in both Calderdale and Greater Huddersfield, in 2019 it will run its own EDS2 event. This will give stakeholders from both areas the opportunity to assess us at the one event. It will also give us an opportunity to involve our wider membership as well as stakeholder groups.
Equality, Diversity and Inclusion will be a key component of the Trust's Organisational Development Strategy ("The Cupboard").

Recommendations:

The Board is asked to approve the Public Sector Equality Duty (Equality, Diversity and Inclusion) Annual Report for 2018.

Appendix

Attachment:

PSED Report 2018_CHFT_draft for Board.pdf

Calderdale and Huddersfield
NHS Foundation Trust

Public Sector Equality Duty Annual Report 2018

CONTENTS

SECTION

1 Executive Summary

This equality report shows the progress Calderdale and Huddersfield NHS Foundation Trust (CHFT) has made during 2018 in meeting its equality duties under:

- Section 149 of the Equality Act 2010 (the public sector equality duty) and
- The Equality Act 2010 (Specific Duties) Regulations 2011

This report provides assurance to the Board on how the Trust is meeting the requirements of the Public Sector Equality Duty. The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the general equality duty. The report also contains the Equality in our Workforce Report, at Appendix 1.

CHFT strives to provide the highest quality of service to all of its patients. Equality and diversity considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care. This report highlights our approach and work to address any additional needs of those patients who identify with a range of protected characteristics. The report gives examples of what we have been doing at CHFT to do this. It should be noted that this is only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

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

By adopting this definition we can be clear with both patients and staff about what we mean by Equality, Diversity and Inclusion and therefore develop a shared understanding of what we are trying to achieve.

2 The Legal and Compliance Framework

2.1 Equality Act 2010

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

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

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

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

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

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

By:

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

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

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

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

2.2 Care Quality Commission Requirements

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

The Trust had its first full CQC inspection in March 2016 and a further well led inspection in April 2018. Following the second visit the Trust was rated as 'Good'.

2.3 Mandatory Requirements – the Equality Delivery System 2 (EDS2) and the Workforce Race Equality Standard (WRES)

The Equality Delivery System 2 (EDS2) is a generic framework designed for both NHS commissioners and NHS providers. The framework helps NHS organisations to review and improve their performance for people with protected characteristics, and through it, to deliver on the Public Sector Equality Duty. It emphasises engagement with stakeholders and users, and encourages local adaptation to focus on local issues.

The EDS2 comprises 18 outcomes focused on the achievement of four goals and under the framework, we are required, in conjunction with local stakeholders, to analyse our equality and diversity performance, taking account of each relevant protected group. In order to achieve this, the Trust worked collaboratively with its Clinical Commissioning Groups (CCGs) and other providers in the local area during 2018 (see section 3.2 for more detail).

The Workforce Race Equality Standard (WRES) is now part of standard NHS contracting arrangements and requires providers to address the low levels of Black and Minority Ethnic (BME) employees within their workforce and specifically at board level.

Work in this area is reported in the Equality in our Workforce Report for 2018 (see Appendix 1).

3 Our progress in 2018

3.1 Embedding equality and diversity

The outcomes of the NHS' Equality Delivery System 2 (EDS2) help us to focus our work around equality and diversity, and to decide on our equality objectives.

We have identified our priority outcomes for 2016 to 2020 as:

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

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

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

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

Some examples of what we have done in 2018 to achieve these outcomes are shown below (it should be noted that this is not an exhaustive list and these are only examples of the work going on around the Trust):

Protected Group	What we have done	EDS2 Outcome
All	During 2018 we have worked with colleagues in our Project Management Office to further embed the EQUIP (equality impact process) into work schemes that may impact on patients with a protected characteristic. This has ensured that the needs of this group of patients are fully assessed before any schemes are implemented.	4.2
	Further work has been undertaken and a task and finish group set up to address the Accessible Information Standard requirements in our key patient facing areas: outpatients and diagnostics. An action plan has been developed.	2.1
Age (older people)	One of our elderly care wards at HRI introduced Dementia Pop-Up cafés during 2018. The aim of the cafes is to create a place where patients with dementia and memory problems can relax and interact with fellow patients, staff and their family and friends.	1.2
Age (older people) & Disability (visual impairment)	At CRH we have specifically introduced a new colour pallet to Wards 7A,D and 6A,B,C,D, which helps orientate patients with dementia. The scheme also helps patients with impaired vision as door frames/openings and bathroom facilities are highlighted.	1.2 & 2.1

Protected Group	What we have done	EDS2 Outcome
Age (younger people)	Children's Outpatients have linked with a local author and mother, to introduce books with a focus on cultural inclusion, differentiation and diversity for patients that may not be able to relate to some of the more common children's books. The author's books pull in all members of the community and as an example, "Bollywood Princess" has been used at Calderdale as a distraction technique for children coming in to have their bloods taken.	1.2 & 2.1
	The Children's Diabetes team has introduced a new app to help share key messages with local families of children who have diabetes. This is saving time for both the team and the families and has been well received. The app has been used for sending out patient surveys and favourable response rates have been achieved.	1.2
Age (younger people)/ Disability	In conjunction with a Consultant Paediatrician and our Paediatric Specialist Nurse Practitioner, our Matron Complex Care Needs Co-ordinator has introduced a policy for transition from children's to adults' services within secondary health care. Engagement with Kirklees Transition Group, patients and their parents took place prior to the policy being introduced.	1.2 & 2.1
Age (younger people)/ Sexual orientation	We invited a representative from the LGBTQ community from Barnardo's to attend the Paediatric Forum. The purpose was to provide training and raise awareness for staff about the issues faced by younger people around sexual orientation. Public facing supporting information has since been shared in clinical areas such as the teenage room and the OP clinics.	1.2
Disability (hearing impairment)	We continue to closely monitor the quality of BSL provision from our local provider, Topp Language Solutions. Fulfilment rates are monitored by our Procurement team and the rates during 2018 have been consistently high. Topp meet regularly with the local deaf community to get the views of users on the service they provide.	2.1
Disability (physical)	The upgrade of the public toilets in the main entrance on the HRI site during 2018 included the introduction of a semi-accessible toilet in the same area.	2.1
	We have held a number of Health and Wellbeing events, funded by Macmillan, aimed at cancer patients and their families who have completed treatment. They are education and support events to prepare the person for the transition to supported self-management. The events include advice on the relevant consequences of treatment and the recognition of issues, as well as details of who to	1.2 & 2.1

Protected Group	What we have done	EDS2 Outcome
	contact. They also provide information and support about psychological wellbeing, finance, healthy lifestyles and physical activity. The Lead Cancer Nurse, Clinical Psychologist, Macmillan Information Service and Cancer Nurse Specialist have input to the events and patient feedback has been extremely positive.	
Gender reassign-ment	Our Radiology Department has adapted its information posters which advise patients who may be pregnant to inform staff before their x-rays due to the risk of radiation to an unborn baby. This is to ensure that patients who are transitioning from female to male and who do not identify as female are protected in the same way.	1.2
	We have reviewed and updated our policy for eliminating mixed sex accommodation to ensure that the needs of transgender patients are met appropriately. The policy has a section containing comprehensive guidance for staff who may need to care for a transgender patient, including children and adolescents who may be exploring their gender identity.	1.2
Religion/ belief	Our work with the Horizon Group has continued in 2018, and its purpose has been to seek to promote end of life care amongst communities who may experience difficulty accessing services or be unclear about what services are available.	1.2 & 2.1
	Inter-faith relations continue to be an important part of the work of our Chaplaincy Department. In 2018, our Co-ordinating chaplain gave a presentation on peace-making and faith to a national symposium in Huddersfield.	1.2 & 2.1
Pregnancy/ Maternity	A new initiative has been introduced to enable parents to have a diary of their neonatal journey. The purpose is to give parents the best experience possible whilst on the unit and give them something that they can share with their friends and family as they can download the pictures to share. Parents' views on the initiative so far have been very positive.	1.2
	We have set up a facebook group for women and their families who are thinking of having a baby, have had a baby or are currently expecting a baby to share information. There is useful information for people to access such as links to antenatal courses, fetal movement information and public health information.	1.2
	A Maternity Voices Partnership (MVP) is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. The local MPV is currently engaging with local women via a survey to gain views of the Maternity	1.2

Protected Group	What we have done	EDS2 Outcome
	services – 'Let's Talk Maternity'. This has led to a proposal for a co-design event which will focus on the information that is made available to women during pregnancy and after delivery of their baby.	
Disability (learning)	The Trust is part of the first phase of the "Treat me Well" campaign working with Royal Mencap to improve the care of patients with a learning disability in hospital. Our Matron Complex Care Needs Co-ordinator heads up the working group, which meets monthly with members from Mencap, Kirklees Council, Cloverleaf advocacy and members of Kirklees Involvement network self-advocacy group. An easy read survey has been co-created with people with learning disabilities to capture feedback on their care; this will be used to prioritise our improvements.	1.2 & 2.1
	We have introduced easy read material in the Radiology Department for patients attending for an x-ray or a scan. The Radiology department, working in collaboration with the Matron Complex Care Needs Co-ordinator, patients, families and carers now offers "familiarisation" visits for any patient who may benefit from being familiar with the surroundings or conditions they will find themselves in before they come for their examinations.	1.2 & 2.1
	We have established a special needs blood clinic which takes place once a month for people with learning disabilities who have not managed to have bloods taken by mainstream services. The clinic uses distraction techniques tailored to the patient	1.2 & 2.1
Pregnancy/ Maternity & Disability (learning)	In conjunction with the Trust's Matron Complex Care Needs Co-ordinator, Maternity services have produced a toolkit – a pictorial guide – to help pregnant ladies with a learning disability and other ladies who may have additional communication needs. Easy read material is now also available for this group of patients.	2.1
Disability (physical)	At CRH, our estates staff worked closely with the Rehab team, whose patients regularly use the Courtyard Garden adjacent to Ward 5, to improve wheelchair access through the space.	2.1

3.2 EDS2

As part of its collaborative approach to the EDS2, early in 2018 staff from CHFT attended two grading panels (made up of members of third sector organisations) in Kirklees and Calderdale.

They presented on the topic of Inclusive Engagement to Improve Patient Experience at CHFT. This was an area that was flagged as requiring improvement at the event the previous year.

Overall the panels agreed with our grading of 'developing', although four of the panel members graded the Trust as 'achieving'.

3.3 Engagement Activities

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

In addition, governors attend familiarisation tours around clinical areas where they can observe services first hand and talk directly to staff and patients.

It is also Trust practice to involve governors and public members in recruitment panels for the appointment of hospital consultants, senior nursing staff and other senior staff.

The Trust has a large public membership which is compared with its local population to ensure that it is representative of the diverse communities that we serve. The data (see Appendix 2) shows that we continue to have under representation in three different sectors of our communities, namely younger people, males and those with an ethnic group of Asian/Asian British. These groups will be given special focus during recruitment activities in 2019.

In late 2018 we introduced a new method of recruiting members whereby patients receiving a new outpatient appointment letter would also receive details about membership to encourage them to join up. The impact of this change on membership numbers will be monitored during 2019.

The Trust continues to focus on efforts to engage with as wide a range of service users and stakeholders as possible. During 2018 we engaged fully with service users for a number of planned service changes, including the reconfiguration of our medical services which saw the Cardiology and Respiratory services being consolidated on the CRH site, and elderly services at HRI.

4 Strengthening Equality, Diversity and Inclusion - Workforce

4.1 Why Equality, Diversity and Inclusion is important to us

The UK's population is changing, and so is its workforce. Nationally and locally we have far more cultures and we are living much longer than we did when the NHS was born 70 years ago.

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

More people are continuing to work instead of retiring, women make up more than 70% of the NHS working population (83% of the CHFT workforce is female) and around one in ten of the UK population are from an ethnic minority, while one in four primary school children are from an ethnic minority.

The Trust's vision is to provide compassionate care to the populations of Calderdale and Kirklees. To do this, we need to understand the different needs of those changing populations, and what compassionate care looks like to them. By understanding our patients' different needs, we can adapt our environment and services to better suit them.

We also need to respect the different needs of the people who provide that compassionate care – our staff. More than 80% of our staff reside in either Calderdale or Kirklees and will therefore be both a member of the team, a protected characteristic and a patient at some point in their lives. By understanding the different needs of our staff we can create a positive productive culture which will lead to better patient care.

4.2 The benefits of Equality, Diversity and Inclusion

<u>Workforce</u>

Having staff at all levels from a wide range of backgrounds and skills can help develop a working environment producing ideas and solutions that might not come from a smaller array of diverse groups. A diverse workforce can also help an organisation better understand and meet diverse patient expectations and ultimately improve the patient experience.

The workforce benefits of Equality and Diversity are clearly laid out in the ACAS guide to Equality and Diversity:

- Encouraging greater awareness and tackling discrimination can help to reduce the chance of complaints, disciplinary action or an employment tribunal claim - and avoid the costs and disruption to the organisation;
- Improve team spirit - an employee or groups of employees who are being discriminated against are likely to be unhappy, less productive and de-motivated, and this can have a negative impact on the whole workforce;

- Attract, motivate and retain staff, and enhance an organisation's reputation as an employer. If staff who have been discriminated against feel undervalued or 'forced out' and leave, the organisation will run up the costs of recruiting, training and settling in new staff when its reputation as both a business and employer may be damaged;
- The presence of a diversity of perspectives will mean there is less emphasis on conformity to past norms and more creativity;
- Heterogeneity in groups produces better decisions and problem solving through a wider range of perspectives.

Principles

We want to be a best practice organisation in the field of Equality, Diversity and Inclusion.

The following principles will guide us in the development of appropriate actions to achieve this aim:

- We will adopt a collaborative approach to improvement with staff and patients, constantly working with them to improve;
- Our staff will constantly seek to understand the different needs of our patients so that they can adapt their practices to deliver improved patient care and satisfaction;
- Each protected characteristic will be treated as important as the next;
- We will research successful organisations within the Health sector and beyond to learn lessons from leaders in the field;
- We will be an early adopter of all national NHS workforce E&D initiatives, eg WDES (workforce disability equality standard).

How we will collaborate with staff and patients on our plans

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

4.3 Appointment of Equality, Diversity and Inclusion Lead

In 2018 CHFT recognised the need to embed equality, diversity and inclusion more fully across the organisation, and appointed a Lead for Equality, Diversity and Inclusion. Previously responsibility for this important area had been shared between staff with Equality and Diversity as part of their portfolio. The post-holder will also be the Trust's Freedom to Speak Up Guardian.

4.4 Equality and Diversity Training

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

Equality and diversity training is mandatory for all employees. Compliance rates are monitored by Executive Board as part of the Weekly Essential Safety Training paper.

Colleagues are required to repeat their equality and diversity training every three years and essential safety training compliance is closely monitored at a divisional level by HR Business Partner colleagues.

5 Conclusions/Looking ahead to 2019

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

In 2019 the Trust will give renewed focus to its "Putting Patients First – a strategy for involvement and equality". This wider strategy identifies actions to enhance the patient experience, and to address specific needs of those with a protected characteristic. These in turn will also address the mandatory requirements of the EDS2 and the WRES.

As the Trust provides services to patients in both Calderdale and Greater Huddersfield, in 2019 it will run its own EDS2 event. This will give stakeholders from both areas the opportunity to assess us at the one event. It will also give us an opportunity to involve our wider membership as well as stakeholder groups.

Equality, Diversity and Inclusion will be a key component of the Trust's Organisational Development Strategy ("The Cupboard").

6 How we will measure progress and success

Workforce

An ED&I action plan will be developed each financial year which identifies the key in year activities that will help us achieve our ED&I vision.

1. Section 149 of the Equality Act 2010, through our annual report
2. WRES action plans
3. Staff Survey, IIP and FFT
4. E&D action plans, patients and workforce
5. Annual gender pay gap report
6. Workforce committee quarterly meeting

Key actions - 2019

Workforce

The key actions for workforce Equality, Diversity and Inclusion are outlined below. Identify key targets for the workforce across all protected characteristics:

- Develop a consistent forum for seeking views of staff from all protected characteristics
- Be an early adopter of the WDES
- Progress actions against our WRES
- Develop a plan to address our gender pay gap in medical and dental grades
- Identify barriers to progression and promotion in middle grades
- Assign aspirational targets to apprentice intake

7 Contacts and Enquiries

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

APPENDIX 1

EQUALITY IN OUR WORKFORCE REPORT

1. Introduction

Equality and diversity related to the workforce is led by the Director of Workforce and Organisational Development. This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 31 December 2018. In accordance with the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

The Trust published its Workforce Race Equality Standard (WRES) in September 2018. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES became operational from 1 April 2015. The standard has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BAME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust is progressing work to capture colleagues 'Disability Status' in line with the Workforce Disability Equality Standard (WDES) which is due to be published in August 2019.

2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 31 December 2018 against the same date in the previous four financial years.

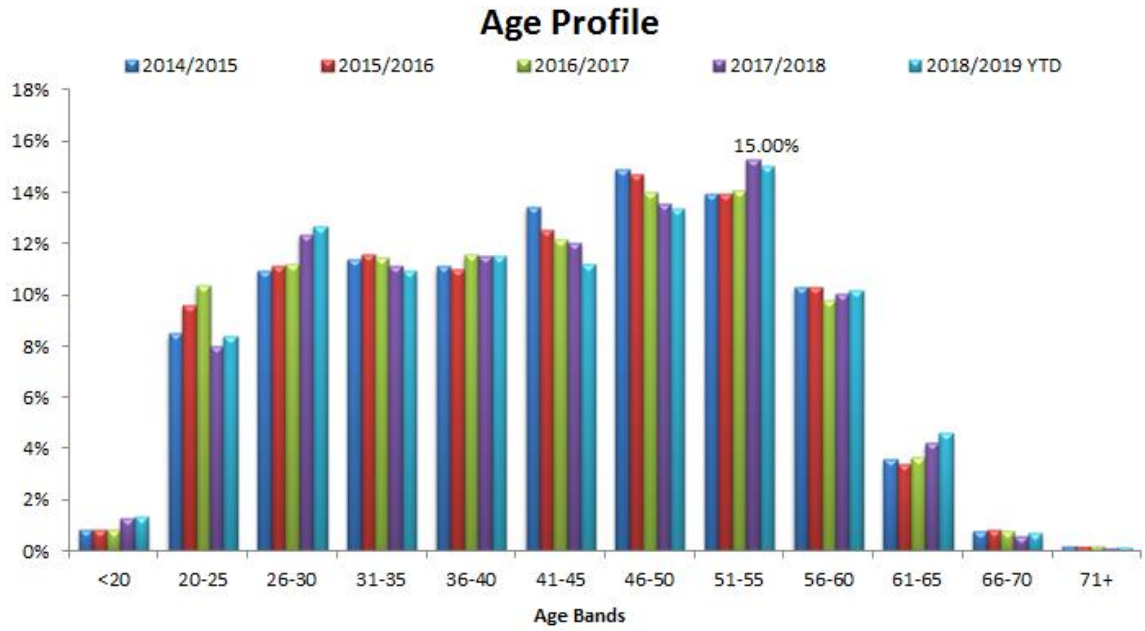
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

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

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

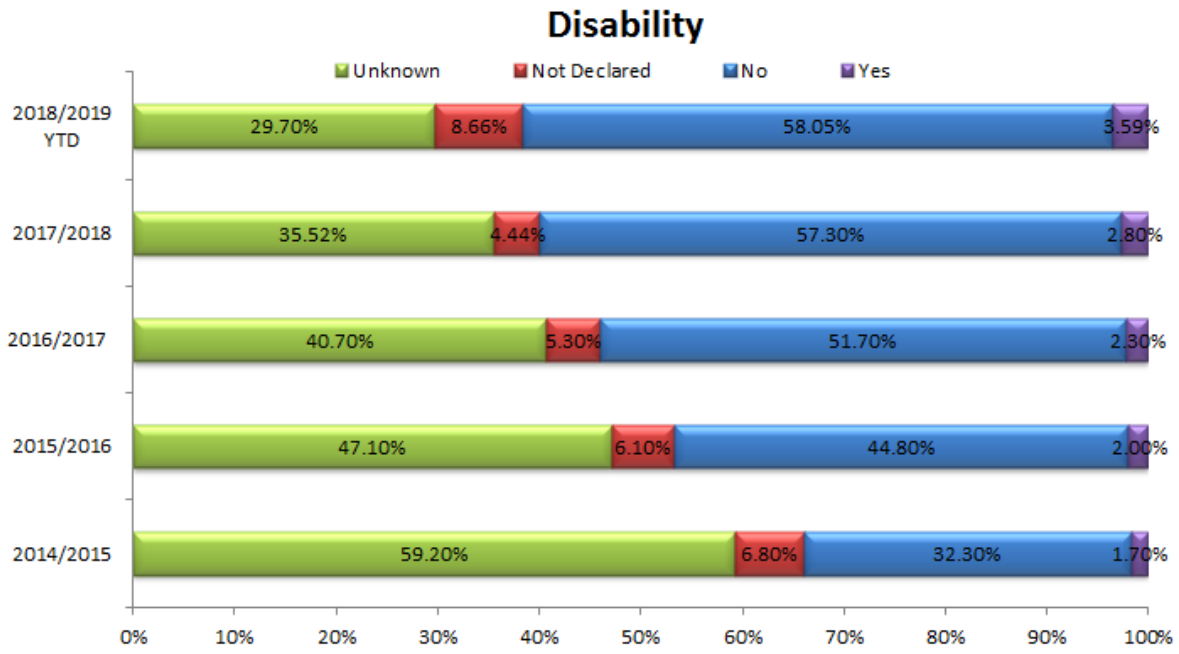
Age Profile

The highest proportion of Trust employees are in the age bracket 51-55.



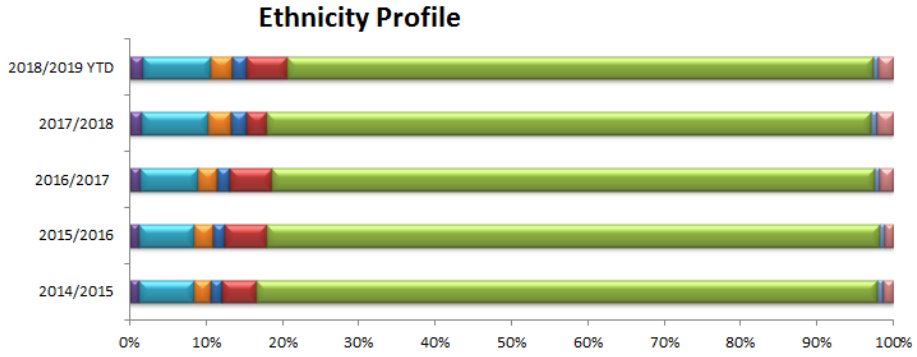
Disability

Information on the profile of the Trust's workforce in terms of disability is not sufficient to provide a valid analysis of the data. Data quality has improved over the last 5 years; however there is still 38.4% of the workforce where information around disability is unknown. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



Ethnicity

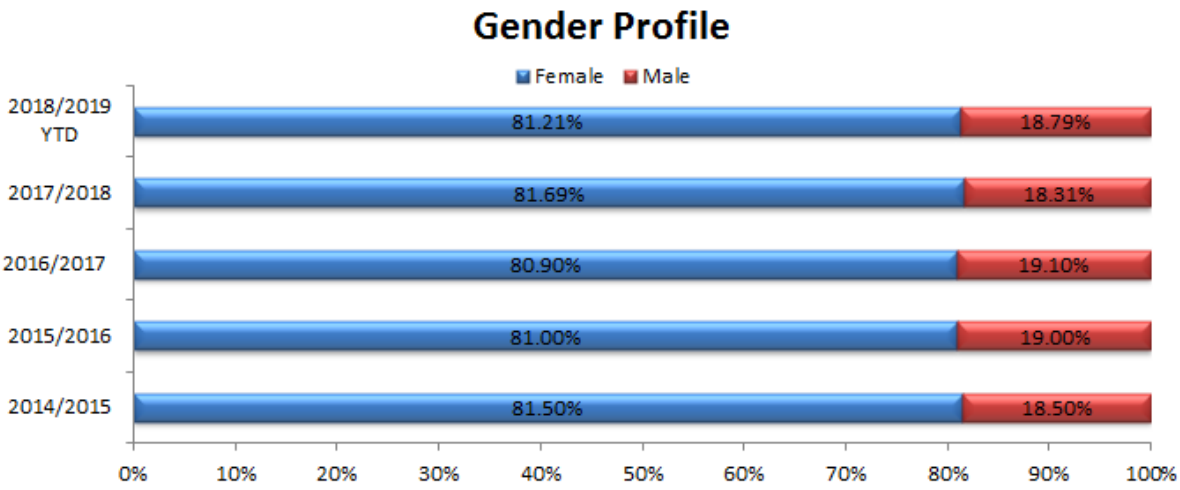
The ethnicity profile of the Trust has not shown much change over the last 4 years, the biggest profile remain white British (76.77%)



	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019 YTD
Any other ethnic group (including Chinese)	1.10%	1.10%	1.30%	1.54%	1.65%
Asian and Asian British	7.20%	7.30%	7.60%	8.65%	8.91%
Black and Black British	2.20%	2.50%	2.50%	3.00%	2.74%
Mixed Race (dual heritage)	1.40%	1.50%	1.60%	2.06%	1.93%
Not Known	4.50%	5.40%	5.50%	2.57%	5.29%
White - British	81.00%	80.10%	79.00%	79.20%	76.77%
White - Irish	0.70%	0.70%	0.70%	0.75%	0.73%
White (not British or Irish - includes White unspecified)	1.40%	1.20%	1.80%	2.23%	1.98%

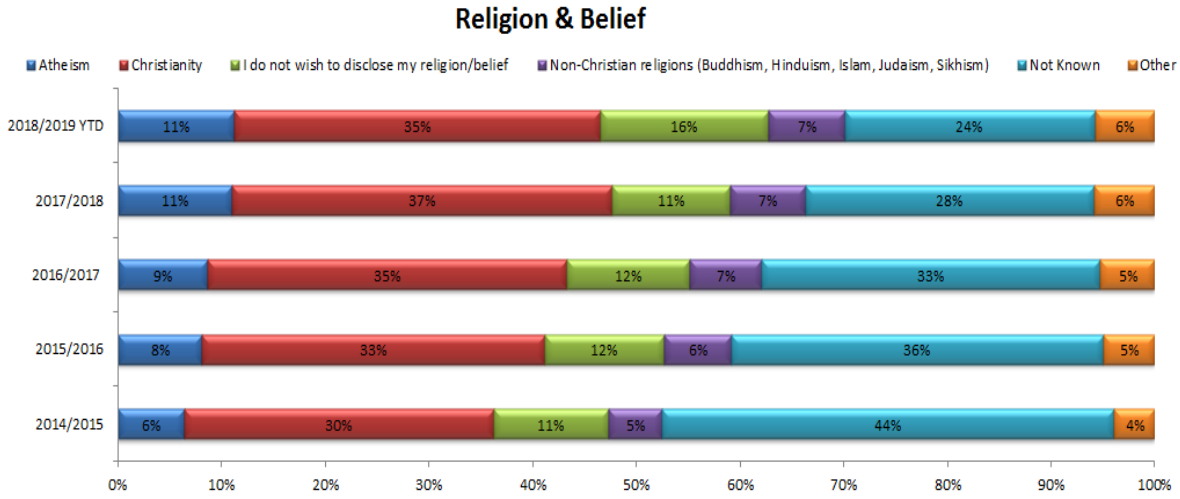
Gender

The proportion of men working for the Trust is significantly lower than the national workforce. However, the health and social care sector traditionally employs more women than men.


Gender Profile
Female
Male
2018/2019 YTD
81.21%
18.79%
2017/2018
81.69%
18.31%
2016/2017
80.90%
19.10%
2015/2016
81.00%
19.00%
2014/2015
81.50%
18.50%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

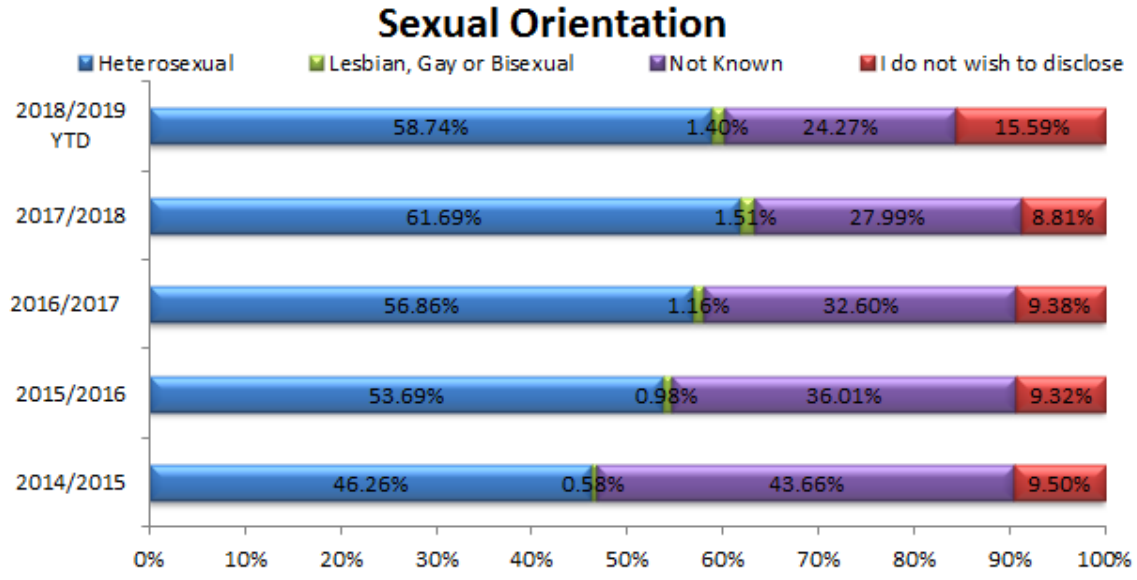
Religion & Belief

Data quality has continued to improve; however there is still 24% of the workforce where information around religious belief is unknown.



Sexual Orientation

Data quality has continued to improve; however there is still approximately 24% of the workforce where information around sexual orientation is unknown.



3. Staff joining the Trust

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

The charts below reflect all recruitment activity for the period 1 January 2018 to 31 December 2018, and provide a breakdown (%) of applicants, applicants shortlisted and applicants recruited.

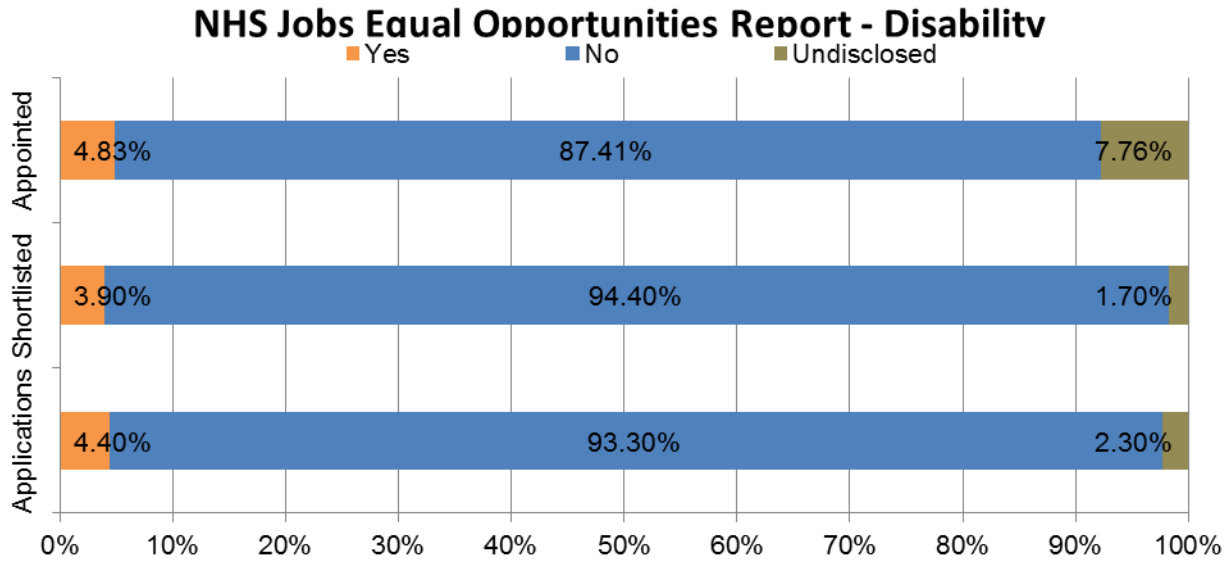
Age Profile

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

Age Group	Applications	%	Shortlisted	%	Appointed	%
Under 20	366	4.00%	271	4.40%	18	3.10%
20 - 24	1806	19.70%	1262	20.50%	131	22.59%
25 - 29	1825	19.90%	1292	21.00%	107	18.45%
30 - 34	1479	16.10%	1019	16.60%	74	12.76%
35 - 39	1003	10.90%	669	10.90%	53	9.14%
40 - 44	715	7.80%	423	6.90%	60	10.34%
45 - 49	778	8.50%	479	7.80%	56	9.66%
50 - 54	621	6.80%	381	6.20%	37	6.38%
55 - 59	424	4.60%	255	4.10%	32	5.52%
60 - 64	130	1.40%	81	1.30%	12	2.07%
65+	34	0.40%	15	0.20%	0	0.00%

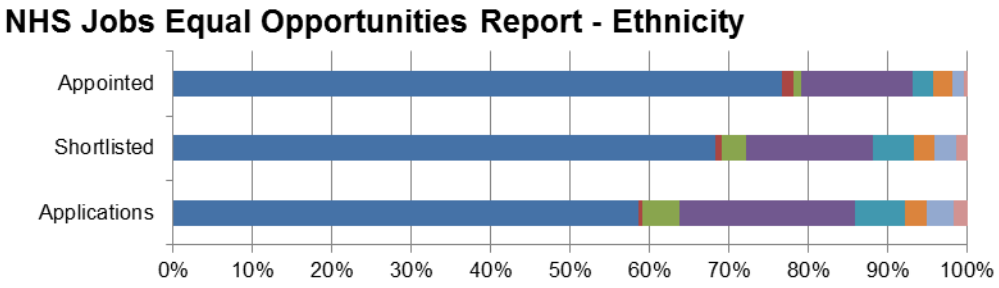
Disability

4.40% of the 9181 applicants, 3.90% of the 6147 shortlisted and 4.83% of the 580 appointed declared as disabled.



Ethnicity

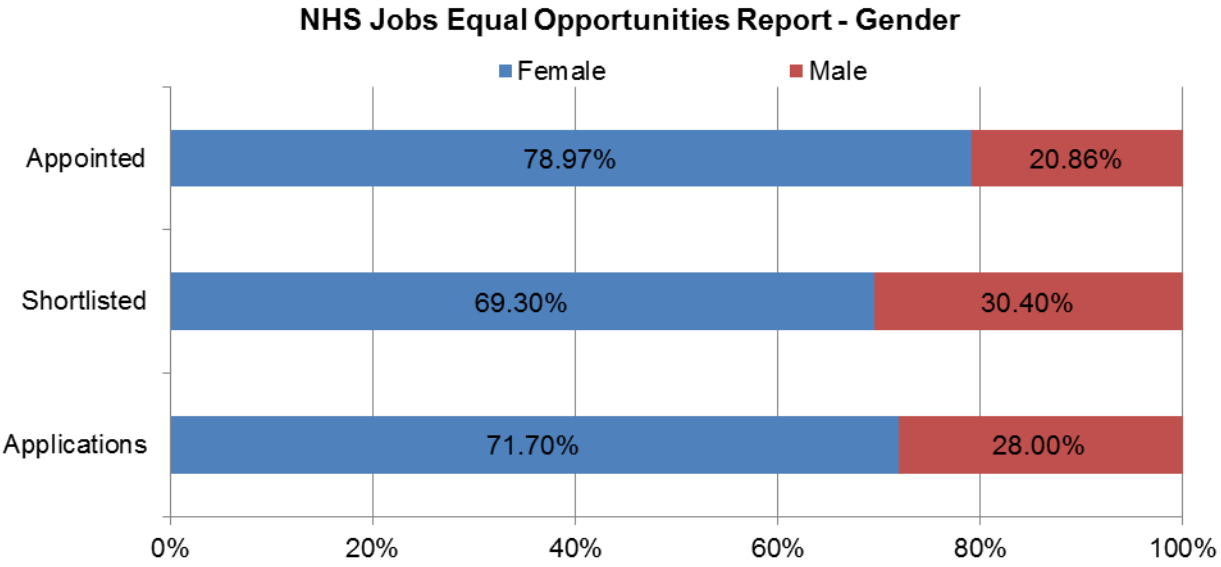
Over 50% of all applications, applicants shortlisted and applicants recruited identify as 'White – British'. 25.4% of applicants recruited identify as 'Asian & Asian British' but the number actually recruited drops to 15.3%



	Applications	Shortlisted	Appointed
WHITE - British	59.60%	68.70%	83.90%
WHITE - Irish	0.50%	0.90%	1.60%
WHITE - Any other white background	4.70%	3.00%	1.00%
Asian & Asian British	22.50%	16.20%	15.30%
Black & British	6.40%	5.20%	2.94%
Mixed Race	2.80%	2.50%	2.58%
Any Other Group(Including Chinese)	3.40%	2.80%	1.57%
Undisclosed	1.70%	1.40%	0.50%

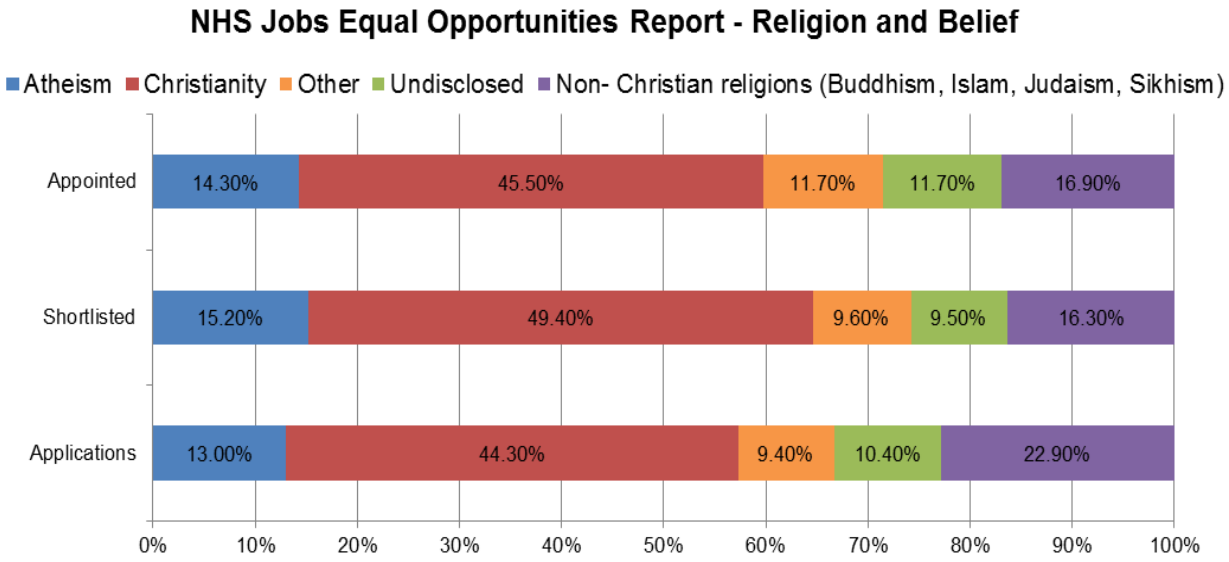
Gender

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



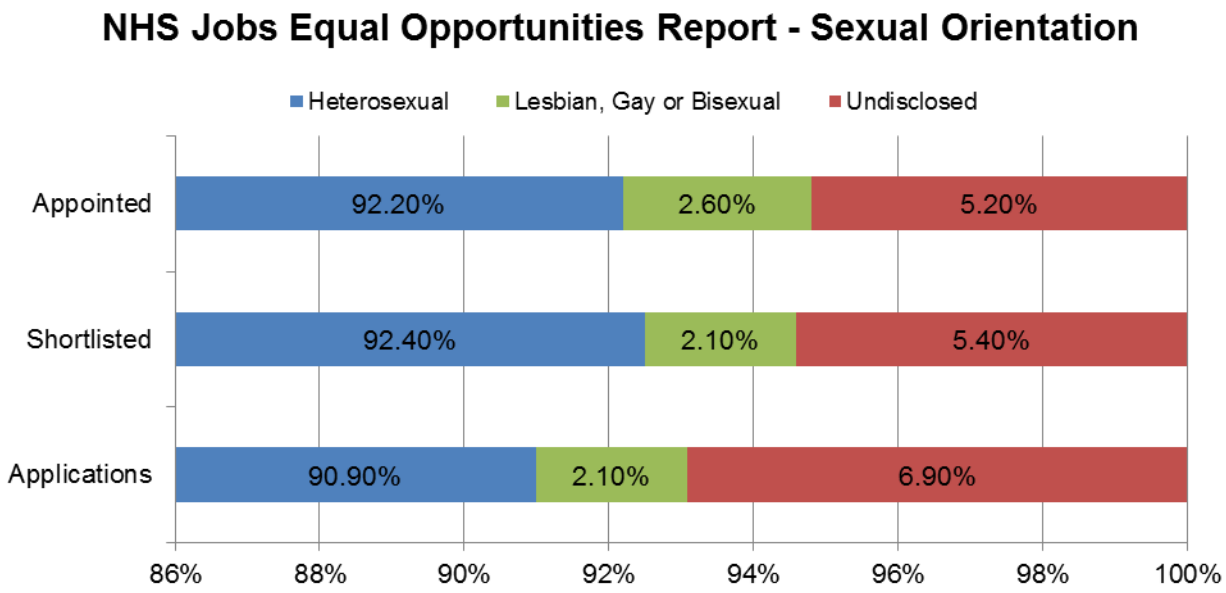
Religion & Belief

Over 40% of all applicants, applicants shortlisted and applicants recruited identify as Christian.



Sexual Orientation

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

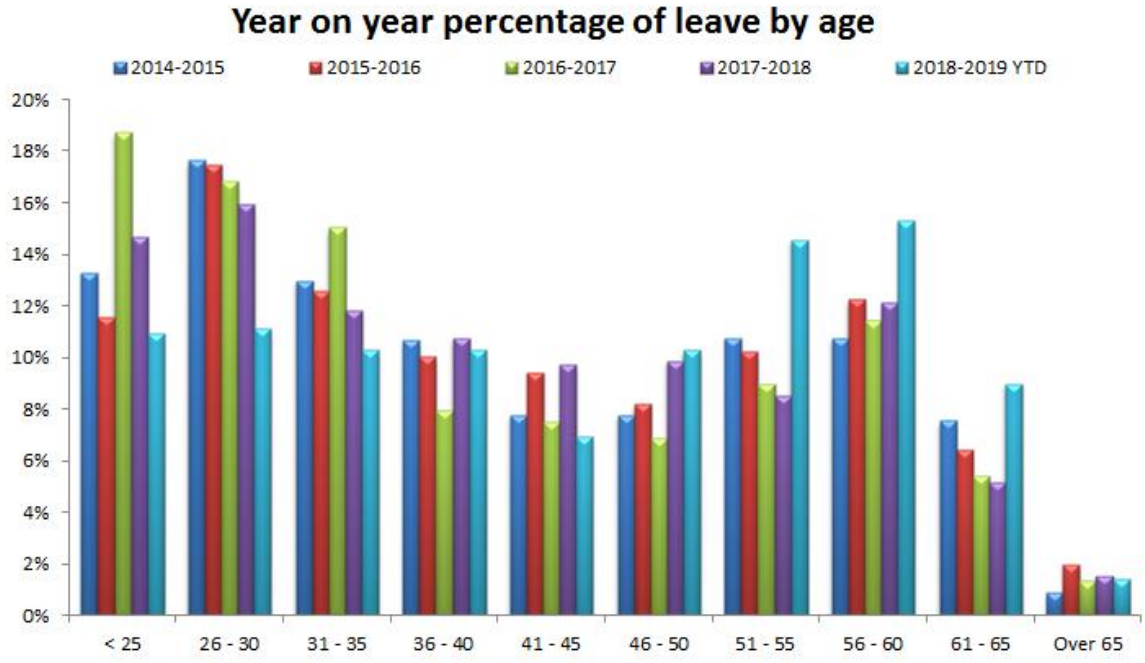


4. Staff leaving the Trust

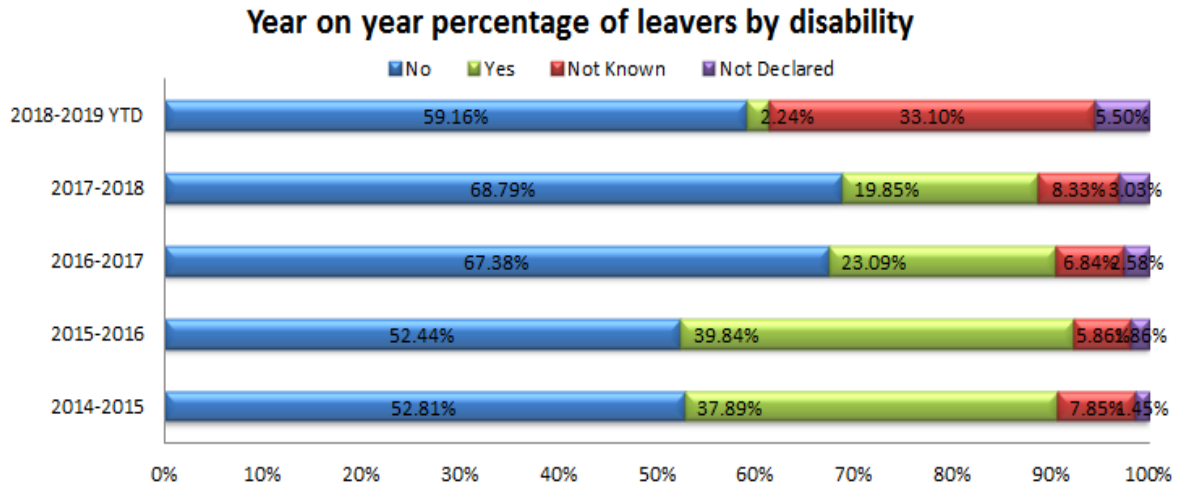
This section shows data regarding staff that left the Trust between 1 April 2014 and 31 December 2018; broken down using the equality and diversity indicators.

Age Profile

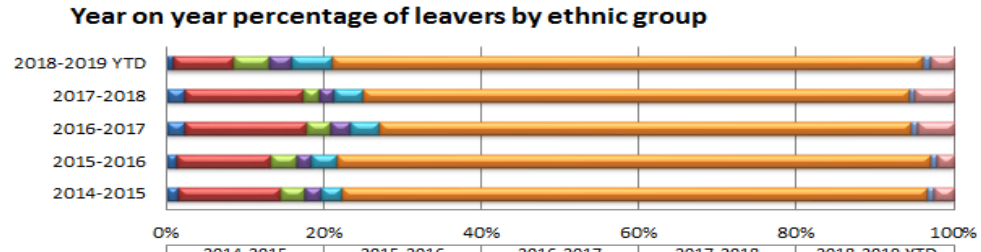
During the current year to date, turnover is highest amongst staff aged 55-60 (15.3%).


Year on year percentage of leave by age
2014-2015
2015-2016
2016-2017
2017-2018
2018-2019 YTD
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
< 25
26 - 30
31 - 35
36 - 40
41 - 45
46 - 50
51 - 55
56 - 60
61 - 65
Over 65

Disability


Year on year percentage of leavers by disability
No
Yes
Not Known
Not Declared
2018-2019 YTD
59.16%
2.24%
33.10%
5.50%
2017-2018
68.79%
19.85%
8.33%
3.03%
2016-2017
67.38%
23.09%
6.84%
2.58%
2015-2016
52.44%
39.84%
5.86%
1.86%
2014-2015
52.81%
37.89%
7.85%
1.45%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

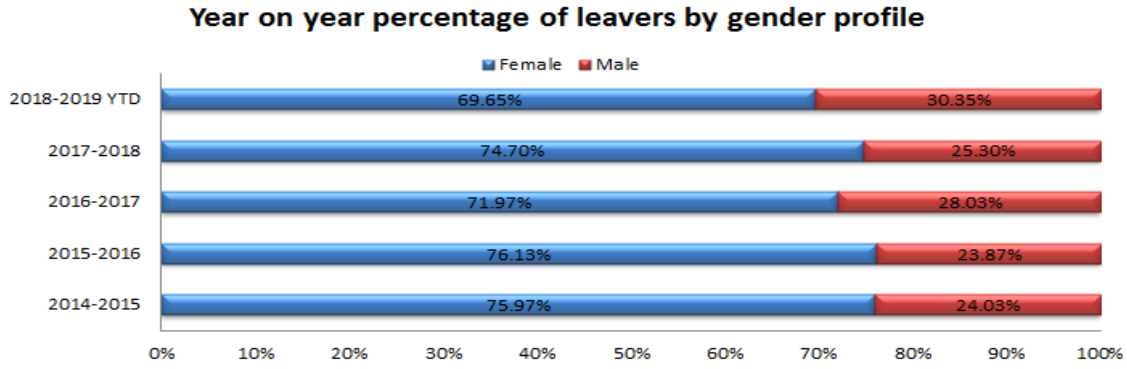
Ethnicity



	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019 YTD
Any other ethnic group (including Chinese)	1.45%	1.33%	2.35%	2.27%	0.81%
Asian and Asian British	12.98%	11.89%	15.47%	15.15%	7.74%
Black and Black British	3.10%	3.37%	2.91%	1.97%	4.48%
Mixed race (dual heritage)	2.13%	1.86%	2.58%	1.82%	2.75%
Not Known	2.62%	3.19%	3.70%	3.79%	5.30%
White - British	74.22%	75.24%	67.49%	69.24%	74.95%
White - Irish	0.97%	0.89%	0.90%	0.76%	0.92%
White (not British or Irish - includes White unspecified)	2.52%	2.22%	4.60%	5.00%	3.05%

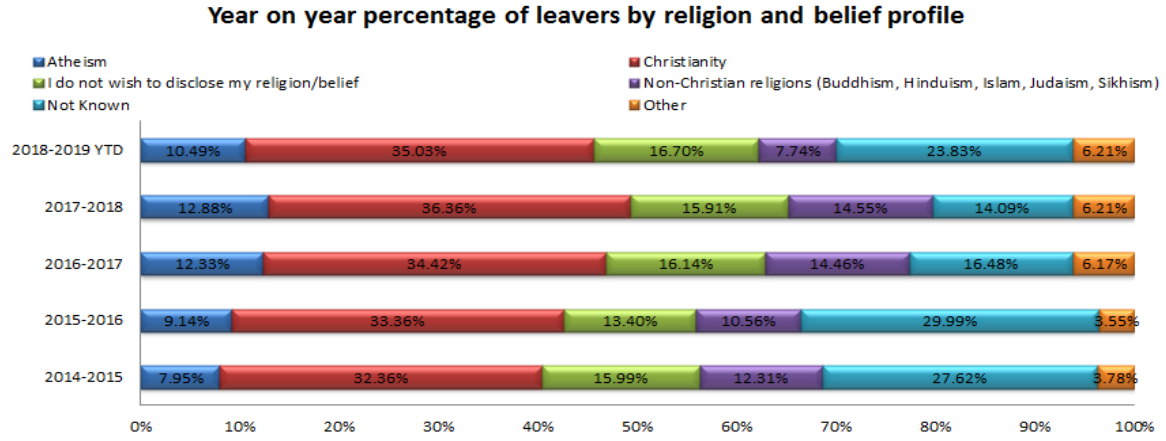
Gender

Again turnover is higher amongst female employees (69.7%) with the Trust employing a significantly higher amount of female employees to male. Therefore, this is expected.



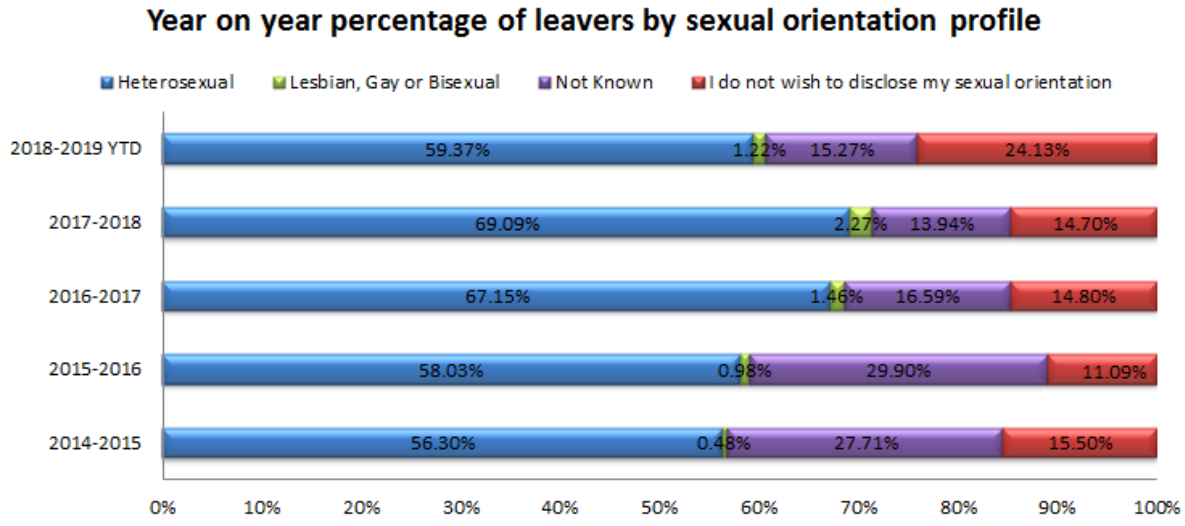
Religion & Belief

As with 2017-18, the majority of leavers in 2018-19 are Christians (35%),



Sexual Orientation

The majority of leavers in 2018-19 are Heterosexual. The percentage of Leaver with 'Not Known' sexual orientation has increased from 13.9% to 15.3%.



5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust employees as at 31 December 2018. This section looks at the organisation pay and measures this against the key equality and workforce indicators.

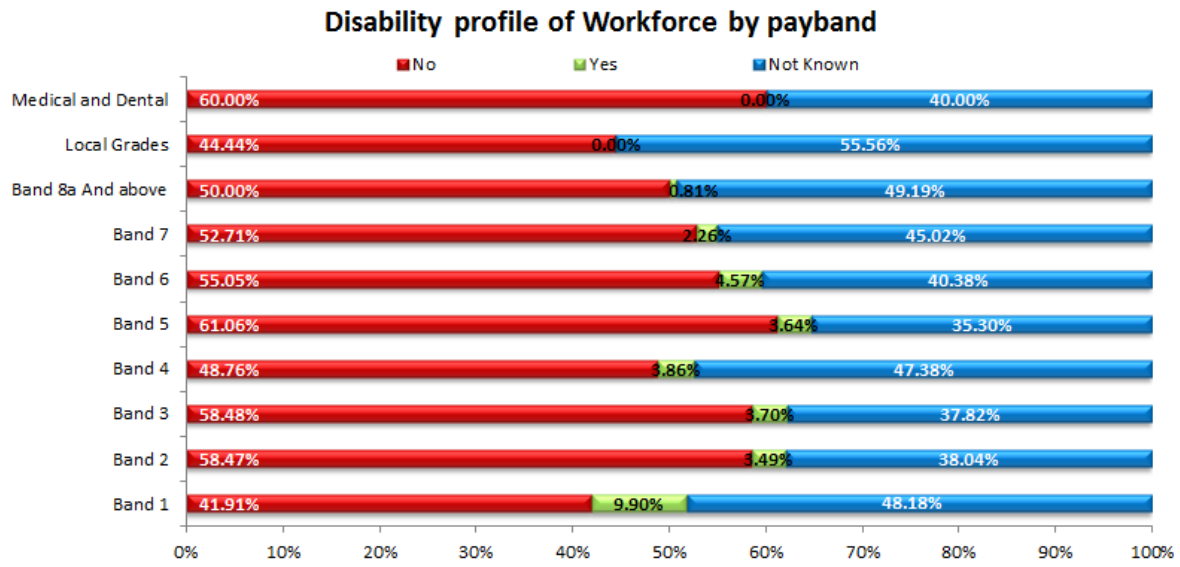
Age Profile

The most common pay band in the Trust is Agenda for Change band 5 with 22% of colleagues in this band. Within band 5 just over 16% of people on this band are between 26 and 30 years old.

Age Band	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
<25	4.62%	12.29%	10.14%	4.41%	13.97%	3.61%	1.36%	13.49%	30.00%	10.22%
26 - 30	6.27%	12.38%	10.92%	11.02%	16.38%	12.54%	7.24%	14.00%	7.50%	19.59%
31 - 35	5.61%	9.63%	8.77%	8.26%	11.50%	15.30%	12.67%	10.34%	7.08%	11.58%
36 - 40	9.90%	8.39%	11.31%	8.82%	12.08%	15.20%	11.76%	12.58%	7.92%	14.48%
41 - 45	5.94%	8.31%	11.70%	11.85%	11.64%	12.22%	16.74%	11.76%	10.00%	12.44%
46 - 50	14.19%	11.46%	12.48%	18.46%	9.68%	15.20%	16.74%	15.82%	16.25%	13.63%
51 - 55	20.79%	14.12%	15.01%	20.11%	11.50%	16.58%	20.81%	13.18%	15.83%	9.37%
56 - 60	18.81%	14.12%	13.65%	12.95%	9.46%	6.16%	9.95%	4.77%	2.50%	4.60%
61 - 65	11.55%	8.22%	5.46%	3.58%	3.35%	2.55%	2.04%	2.74%	1.67%	2.90%
Over 65	2.31%	1.08%	0.58%	0.55%	0.44%	0.64%	0.68%	1.32%	1.25%	1.19%

Disability

Information on the profile of the Trust's workforce in terms of disability is not sufficient to provide a valid analysis of the data. Data quality has improved over the last 5 years; however there is still 38.4% of the workforce where information around disability is unknown. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



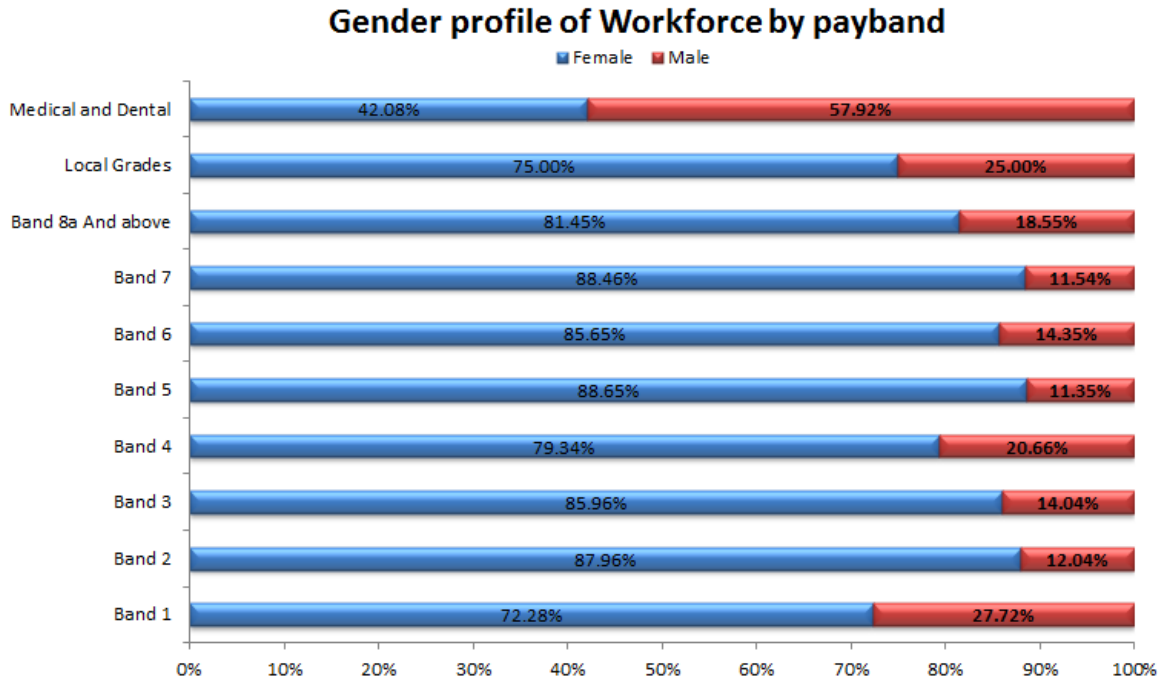
Ethnicity

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

Ethnicity	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
White - Irish	0.33%	0.91%	0.97%	0.28%	0.80%	1.17%	0.23%	0.00%	0.83%	0.34%
White - Britsh	57.10%	78.99%	84.41%	85.12%	76.56%	87.25%	88.01%	92.57%	81.67%	39.52%
Any other white background	2.97%	1.58%	0.78%	0.83%	2.91%	1.28%	0.23%	0.00%	0.83%	5.28%
Asian & Asian British	2.31%	7.06%	5.46%	3.86%	9.24%	4.46%	4.98%	2.70%	6.67%	34.24%
Black and Black British	5.61%	3.99%	1.56%	2.75%	3.28%	1.17%	1.13%	0.00%	1.67%	3.41%
Mixed Race (Dual Heritage)	1.98%	2.66%	1.95%	1.93%	1.46%	0.74%	1.81%	2.03%	2.08%	3.41%
Other Ethnic (Including Chinese)	0.33%	0.83%	0.00%	0.55%	1.89%	1.28%	0.45%	0.68%	0.00%	8.01%
Not known	29.37%	3.99%	4.87%	4.68%	3.86%	2.66%	3.17%	2.03%	6.25%	5.79%

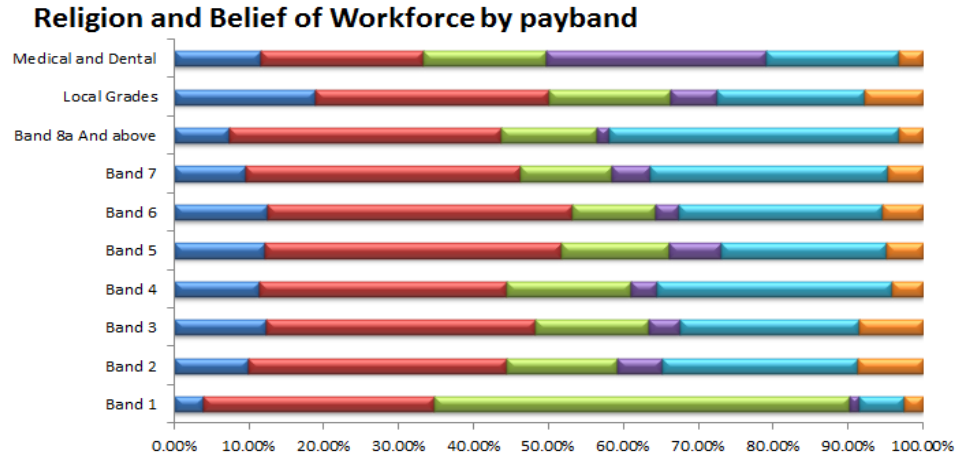
Gender

Men are over-represented in the Medical and Dental pay band (57.92%) compared with the workforce profile as a whole. Where the majority of colleagues are female (81.21%)



Religion & Belief

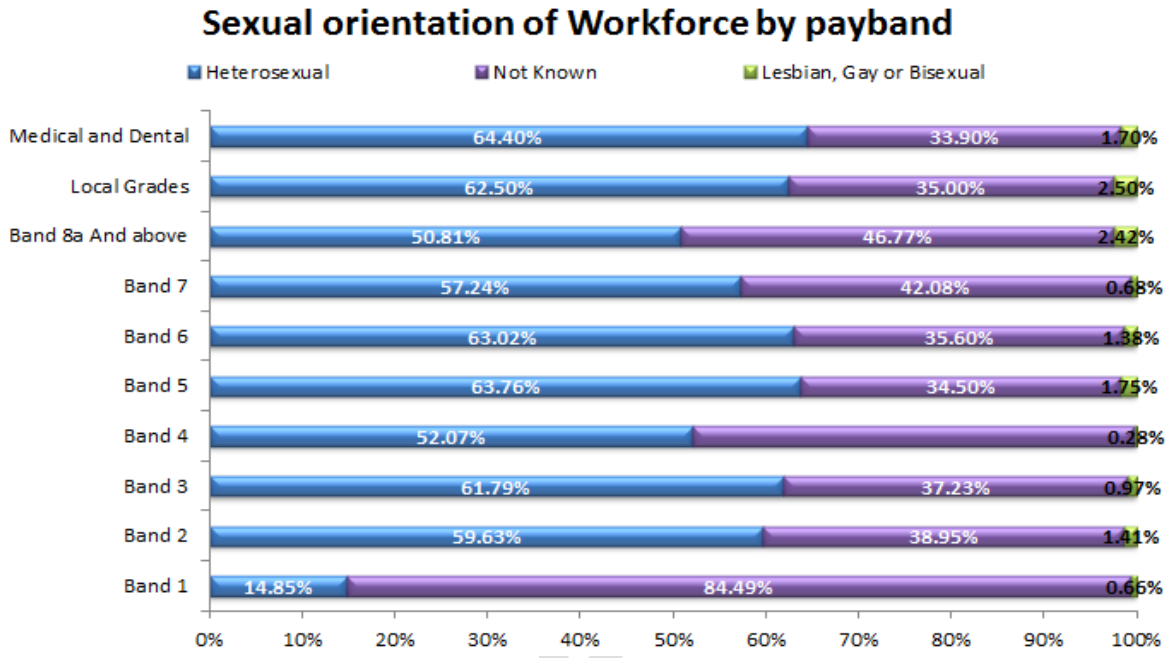
Progress is been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	3.96%	9.97%	12.28%	11.29%	12.15%	12.43%	9.50%	7.26%	18.75%	11.58%
Christianity	30.69%	34.47%	35.87%	33.06%	39.59%	40.70%	36.65%	36.29%	31.25%	21.64%
I do not wish to disclose my religion/belief	55.45%	14.78%	15.20%	16.53%	14.34%	11.05%	12.22%	12.90%	16.25%	16.35%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	1.32%	5.90%	4.09%	3.58%	6.99%	3.19%	5.20%	1.61%	6.25%	29.47%
Not Known	5.94%	26.08%	23.98%	31.40%	21.98%	27.21%	31.67%	38.71%	19.58%	17.72%
Other	2.64%	8.80%	8.58%	4.13%	4.95%	5.42%	4.75%	3.23%	7.92%	3.24%

Sexual Orientation

Not known information is predominant in all pay bands with the most significant being in Band 1 (84.5%) and Band 8 and above (46.8%)



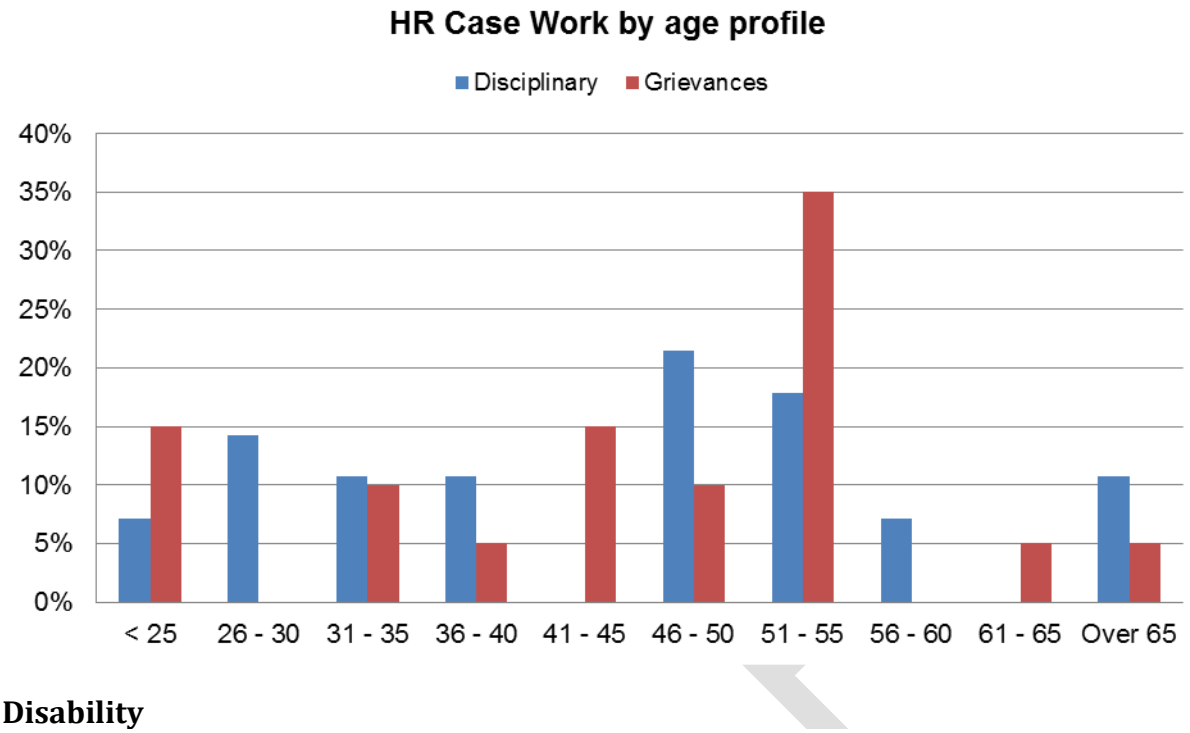
6. Disciplinary, grievance and bullying and harassment

Overall, between January 2018 and December 2018 there were:

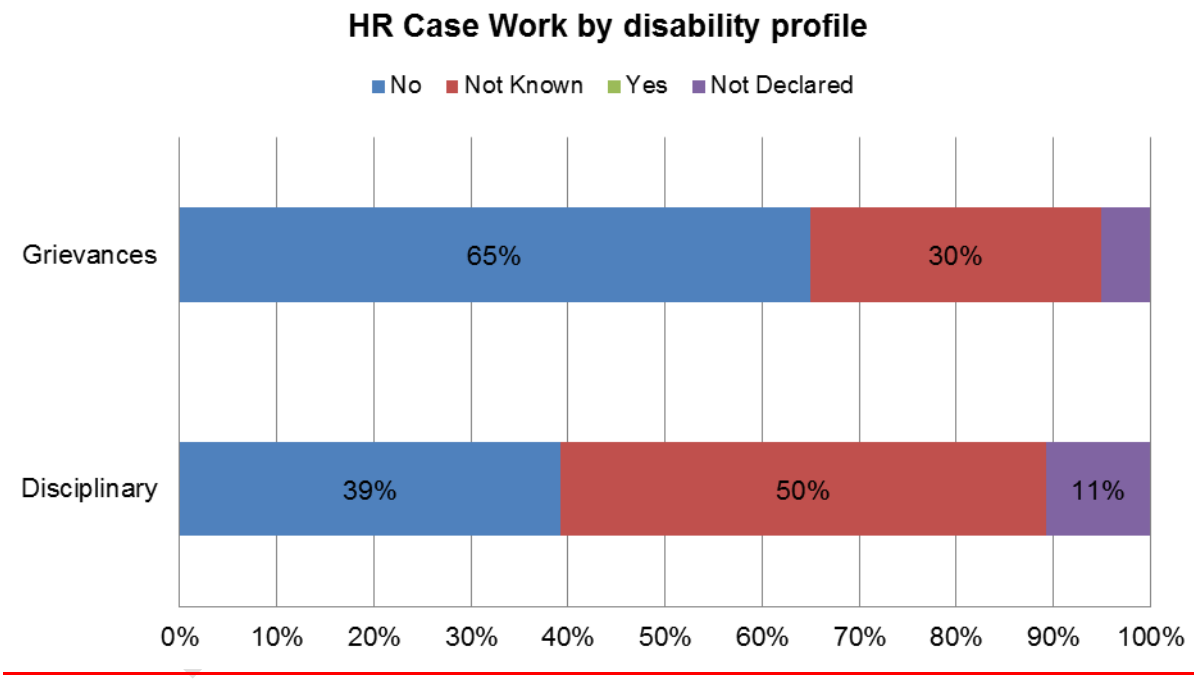
- 28 disciplinary investigations.
- 16 grievance investigations
- 4 bullying and harassment investigations

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

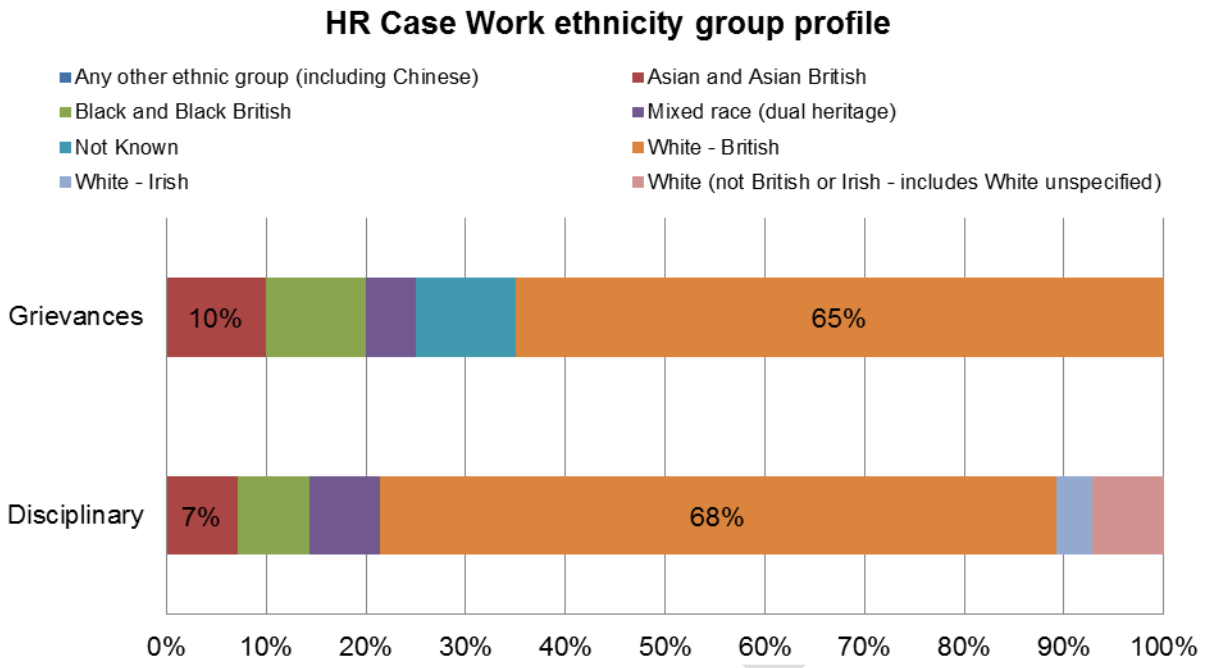
Age Profile



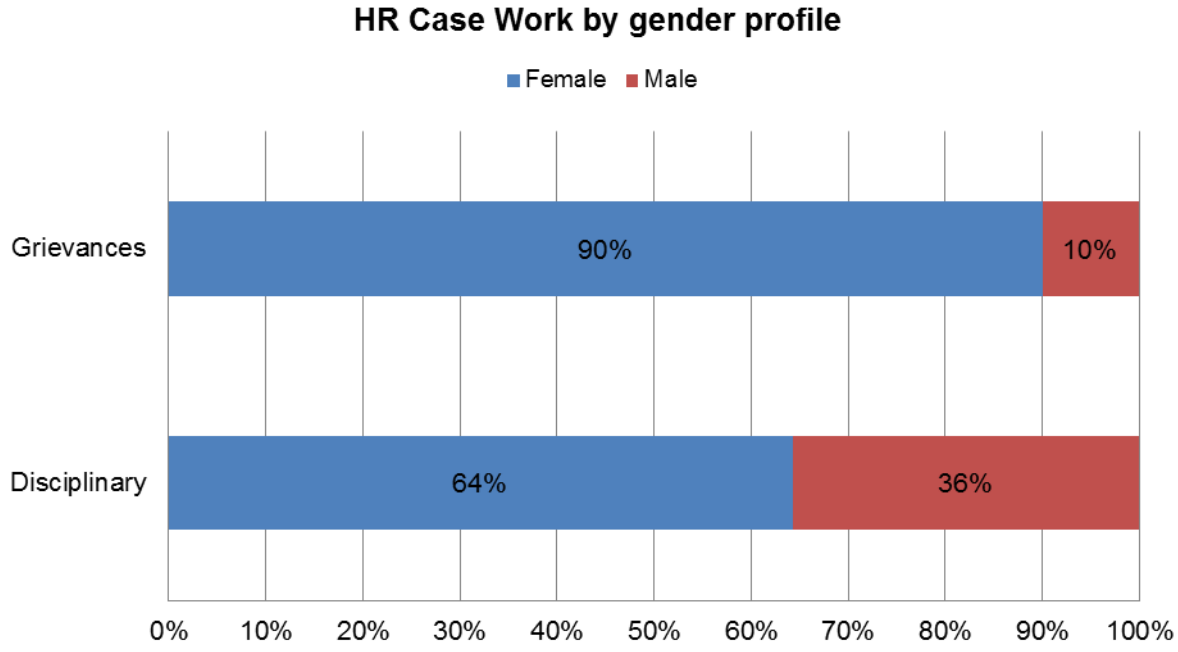
Disability



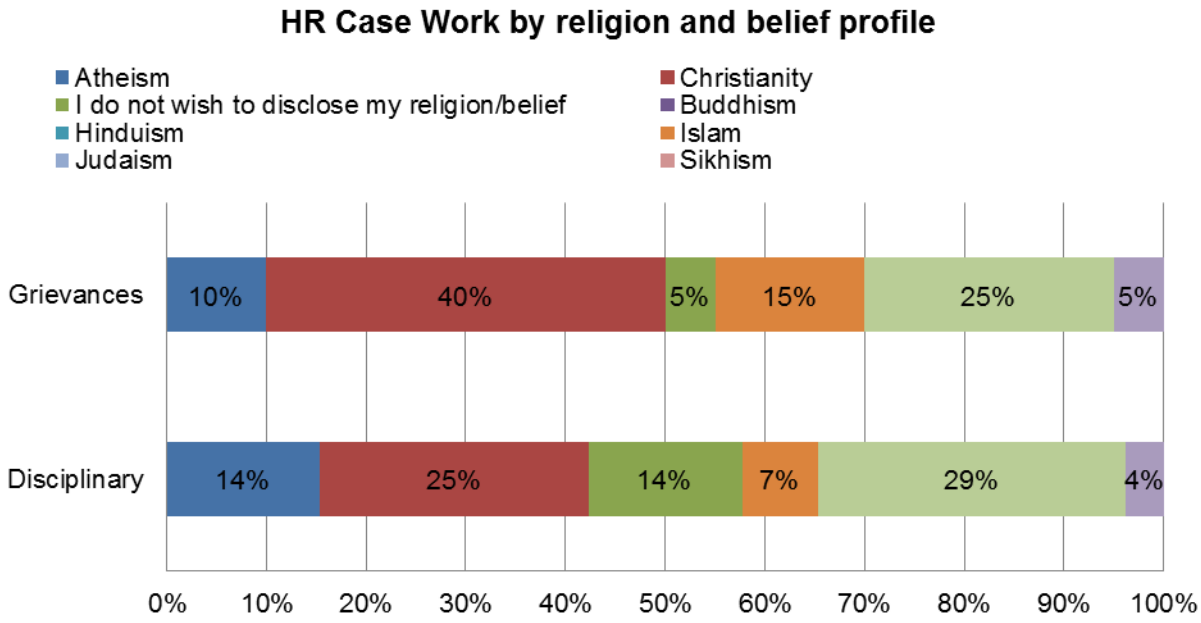
Ethnicity



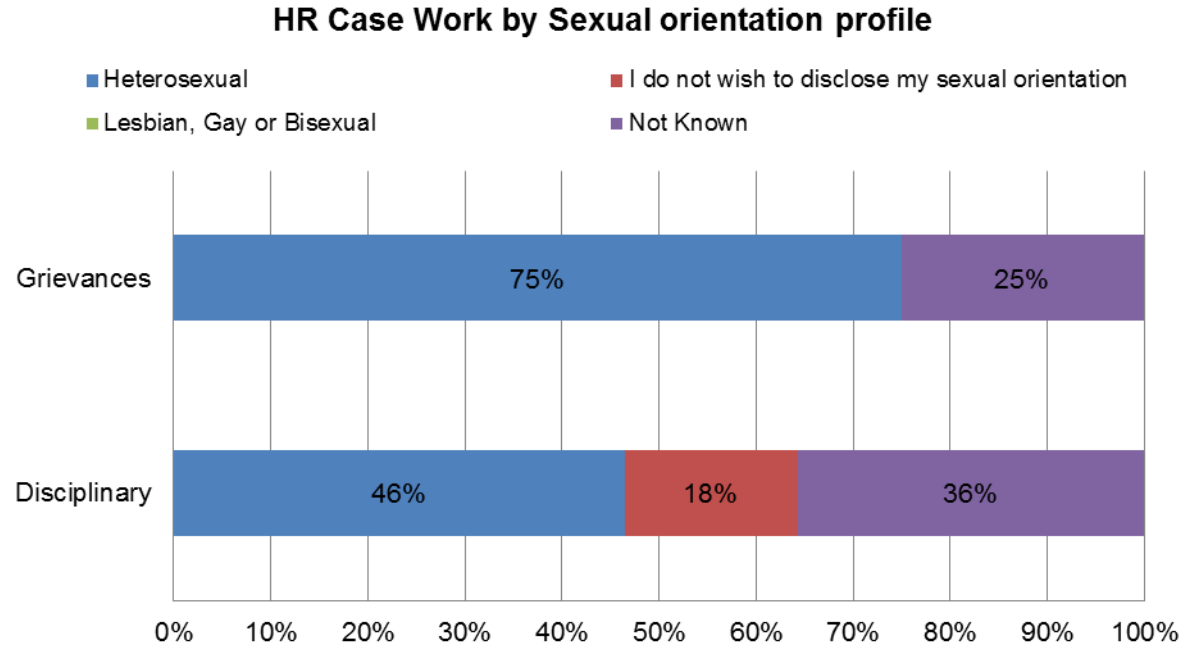
Gender



Religion & Belief



Sexual Orientation



7. Policies and programmes in place to address equality issues

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

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

The Trust strives to widen participation into apprenticeship opportunities through ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation in to the employment market. CHFT is a lead employer for a Calderdale Project Search initiative to support young people with learning disabilities to gain valuable work experience. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing. In most cases, completion of an apprenticeship at CHFT leads to a substantive position and therefore the opportunity to further develop and progress via advanced and higher apprenticeships. So far in 2018/19 CHFT have filled 85 entry level vacancies with apprentices and supported 66 existing staff to undertake an apprenticeship as part of their career development.

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

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

The Trust published its annual Workforce Race Equality Standard (WRES) in September 2018. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black, Asian and Minority Ethnic (BAME) staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust is part of the 'Moving Forward' programme which is led by Leeds Teaching Hospitals NHS Trust to develop BAME colleagues at bands 4, 5 and 6 into future leaders. This forms one of the actions in the Trust's WRES action plan.

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

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

8. Improving workforce equality data

In 2018, we have:

- Improved the quality of diversity information stored within the Electronic Staff Record (ESR).
- Encouraged colleagues to update their personal information via ESR Self Service.
- The Trust continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in September 2018

APPENDIX 2

MEMBERSHIP DATA

Membership Representation as at December 2018 by Age, Ethnicity & Gender

	Members	% of total members	Eligible membership*	% of eligible membership
Age (years)				
17-21	95	1.2%	52215	8.2%
22+	7995	98.8%	573203	90.2%
Ethnicity				
White	7203	86.2%	529668	83.3%
Mixed	162	1.9%	9659	1.5%
Asian or Asian British	717	8.9%	79829	12.6%
Black or Black British	222	2.7%	10162	1.6%
Other	37	0.5%	3935	0.6%
Gender				
Male	2820	34.9%	309248	48.6%
Female	5269	65.1%	326568	51.4%
Transgender	1	0.0%	Not available	-

* 2011 Census Data

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

21. Calderdale and Huddersfield Solutions (CHS) Verbal Update

To Note

Presented by Gary Boothby

22. Update from sub-committees and receipt of minutes & papers

• Finance and Performance Committee – minutes from meeting held 01.02.19

• Audit and Risk Committee – minutes from meeting held 23.1.19

• Quality Committee – minutes from meeting held 2.1.19

• Council of Governors – minutes from meeting held 24.1.19

• Workforce Committee - minutes from meeting held 11.2.19

To Note

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Assurance Report from Committees

Committee / Date: **Quorate:** **Minutes Reviewed by Chair:**	**Finance & Performance Committee – 1st February 2019** **Yes** **P Oldfield**
Considered:	• YTD performance and risks around delivery to the financial plan • Draft EPR realisation benefits post go live status • Operational performance indicators affecting A&E, Refer to treat, cancer wait times, safety indicators • Update on risks and mitigation taken to address Finance system issues • Outline planning dates and assumptions for 2019/20 Budget • Balance between budget challenge and CIP levels in draft planning
Key Risks:	• Key risk around financials relate to delivery of CIP in year with exposure of circa £1M identified. Underlying performance strong and mitigating actions being discussed for delivery of plan. Committee agreed to re-consider risk rating at 1st March meeting – consensus is that should see reduction of in year risk of non delivery. • Key long term risk remains longer term sustainability of Trust. Control total proposed for 2019/20 is £9.7M deficit. Work ongoing to confirm deliverability of plan with current view that some risk but the proposed control total appears of the right quantum
Positive Achievements:	• Operational performance has continued to be strong and compares very favourably with the National performance levels across range of indicators • Range of benefits (direct and facilitated) articulated and quantified to date indicate that EPR benefits are delivering financially although at a lower level than originally planned, which will impact pay back period. Further work ongoing and an updated report to F&P on 1st March

NHS
Calderdale and Huddersfield
NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 1 February 2019, 9.30am – 12.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnership
Gary Boothby	Director of Finance
Helen Barker	Chief Operating Officer
Owen Williams	Chief Executive
Phil Oldfield	Non-Executive Director (Chair)
Richard Hopkin	Non-Executive Director

IN ATTENDANCE

Betty Sewell	PA (Minutes)
Kirsty Archer	Deputy Director of Finance
Mandy Griffin	Managing Director, Digital Health (In part)
Philip Lewer	Chair of Trust
Sian Grbin	Governor

ITEM

017/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

018/19 APOLOGIES FOR ABSENCE

Stuart Baron

019/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

020/19 MINUTES OF THE MEETING HELD 2 JANUARY 2019

The Committee approved the minutes of the meeting held 2 January 2019 as an accurate record.

021/19 ACTION LOG AND MATTERS ARISING

179/18: Outpatient Services – Due to various reasons HB informed the Committee that the information is still not available, this has been followed up and it was agreed that it will be deferred – **HB, 29 March 2019.**

Matters Arising

009/19: RH picked up on the Use of Resources (UoR) discussions at the last meeting. It was confirmed that the evaluation of investment would go to the Audit & Risk Committee and that Finance & Performance would review EPR. GB also reported that at the last Commercial Investment & Strategy Committee (CI&SC) it had been agreed that at the next CI&SC meeting in March a number of investments will be reviewed.

022/19 EPR BENEFITS REALISATION

The Managing Director of Digital Health reported to the Committee that following the paper submitted in October planned workshops had taken place which initiated a process that led to the selection of a small group of benefits so that a more detailed

review could take place. The benefits selected covered themes around access and the removal of paper as well as the cash releasing benefits that were part of the original business case.

The Digital Health team completed their reviews on the identified benefits and were able to confirm values against the majority. A number of reviews did highlight the need for re-education and changes in the workflow, these areas need to be addressed before the benefits are realised.

A question was asked around the annual savings for Clinical Coding and whether this benefit will be realised under the existing arrangements with the Commissioning body. Following discussions, it was noted even though our contract arrangements have changed, Clinical Coding should be included as a benefit for the purpose of the business case.

MG explained that lots of work has taken place around the whole coding process and the data quality aspect. It was acknowledged that the EPR project had not generated cash but that the benefit has been good quality coding. Regarding Clinical Records and the savings relating to staffing costs, MG reported that there had definitely been savings with the re-deployment of staff but not a reduction, however, staffing numbers continue to be monitored. It was also noted that any EPR cash releasing benefits will be linked to a CIP scheme.

MG also reported that Cerner have a scanning solution which will take documentation into EPR directly which will release the cost of paper and resource needed to manage our existing Electronic Document Management System (EDMS). The recent demonstration of this had a very positive response from colleagues.

The Chair commented that he was encouraged by the findings of the initial report and that he recognised that not all benefits would be cash out but that if benefits could be articulated as savings in areas such as the reduction in bed numbers it should be included in the final report.

The Committee **NOTED** the contents of the paper and that the final report would be **RECEIVED** at the **29 March 2019** meeting.

021/19 **116/18:** The Director of Finance presented the Governance Structure to the Committee on behalf of the Company Secretary.

It was noted that it was still to be decided where the Security & Resilience Group feeds in and that this was still being discussed outside this forum. It was also noted that it was felt that the Health & Safety Committee should be a formal Sub-Committee of the Board which would include Security. PL agreed to discuss with Non-Executive Directors (NEDs) to try to find a solution.

AB raised the issue that the Re-configuration Governance would also require to be refreshed and it was also recognised that the Estates & Sustainability Committee will shortly come to an end. It was agreed that the Governance Structure would require changes and that this will be discussed with NEDs.

OW commented that at the Committee in Common, declarations of interest such as involvement in WYAAT and ICS will need to be declared so should be included on the Governance Structure.

ACTION: To discuss with NEDs to try to find a solution regarding the necessary changes to the Governance Structure and take back to the Board – **PL/VP**

The Committee **REVIEWED** and **NOTED** the Governance arrangements which would go back to the Board once amended.

023/19 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported the December performance which has improved to 71%, the highest since July. In context, prior to the Christmas period, all Winter plans were in place and final moves were made around the deep-clean programme, the Surgical Assessment Unit (SAU) was re-deployed to the same floor as Theatre and an Acute Floor at Huddersfield was established which replicates the model at Calderdale. Generally, the Christmas and New Year period was managed well, and letters will be drafted to our partners to thank them for their input. The only area which was problematic was the Medical Team in A&E, this area is reliant on agency staff and they choose not work over the Christmas period. There was also some short-term sickness in Nursing over the Christmas and New Year period which put pressure on the wards.

The following headlines were also noted: -

- Our 7 and 21 day length of stay is in a good position and better than the national average.
- Referral to Treatment for Cancer, both regulatory standards were achieved
- Emergency Care Standard – slightly under 90%, which is significantly better than the national average.
- Diagnostics also delivered
- Our Infection Prevention position is much improved from last year this reflects the focus on hand hygiene and even though there is no direct evidence, the deep clean cannot be ignored.
- Frailty Team – length of stay is better and benefits can be seen, however, the time taken to carry out a frailty assessment is causing some breaches in A&E. Consideration is being taken to introduce a Frailty Assessment Unit in A&E, in addition, the Frailty Team are going to trial over-night working to understand our decision making. They are also pro-actively tracking a number of patients to review the possibility of earlier assessments.
- Masterclasses are being run within the Weekly Performance meetings to ensure DoOps and General Managers understand each matric.

HB reported that the overall picture showed a good position in December and that we are managing January better than last year.

RH asked a question regarding the reason for the increase in our PPH %, HB confirmed that she would ask our Head of Midwifery to respond via email to Richard.

ACTION: The Head of Midwifery to respond to the question raised by RH - **HB**

Regarding the integration of Central Operations and Community, HB reported that a total of 5 teams have moved into the Community Division which Bev Walker will manage. The intention is to work with the locality model keeping patients out of hospital.

RH also asked HB to update the Committee regarding Data Quality following a presentation at Audit & Risk Committee. HB reported that in terms of our incomplete waiting list we are still on track to delivery no more than 29k patients, but this is still reliant on validation. HB has been working with the North East Business Intelligence Unit and NHS Improvement around opportunities to alternate some of that validation. There are a couple of areas of data quality where we are unable to provide the relevant assurance, some relate to the configuration of EPR, there will be extra capacity in Data Quality over the next few months and updates will be provided.

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

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024/19 DEMENTIA DEEP-DIVE

The Chief Operating Officer gave the presentation included in papers for information and assurance.

The Committee **NOTED** the good progress to date.

025/19 MONTH 09 FINANCE REPORT

The Deputy Director of Finance reported that for Month 9 our Income continued to be in line with the planned deficit. The Agency position remains down below the NHS trajectory and is in line with the Performance Report. We continue to forecast to remain on plan to year-end, however, our recovery actions will need to be delivered to achieve the planned deficit. The forecast to achieve our CIP includes Project Echo which is at heightened risk in terms of its timing prior to the financial year-end. Conversations are taking place with Commissioners to try to mitigate this risk, however, we are still flagging to Regulators our position. It was noted that the additional controls put in place at Month 8 seem to be having an impact.

The key message from the Director of Finance is that we need to drive change forward working closer with budget holders.

ACTION: The Risk Assessment will be reviewed at the next Finance & Performance Committee ready for the Board meeting on the 7 March 2019 – **KA/GB**

Capital & Cash - it was noted that Capital is underspent year to date, but it does include additional funding secured for the Integrated Cardiology System, we continue to forecast to spend all our internally generated capital in year but there are elements which will phase into next year. Cash borrowing is less than expected due to the fact that we have secured a grant for the funding of energy efficient lighting and the need for the interest free Salix Loan is no longer required. The Director of Finance explained that the LED lighting scheme will be monitored through CIP, it was also recognised that the success in obtaining the grant for the scheme would be a good evidence base for the CQC Use of Resources.

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

026/19 FINANCE & PROCUREMENT SYSTEM UPDATE

The Deputy Director of Finance presented a paper which described the approach taken to address and escalate the system issues following the upgrade by NEP in December 2017. The upgrade adversely affected functionality in a number of areas and system issues caused potential operational risk to the Trust's ability to maintain supply of goods and services essential to operational performance and safety.
It was noted that some initial transitional issues were resolved, however, residual issues continue.

It was also noted that CHFT instigated and hosted a WYAAT Silver Lining task and finish group. This has resulted in knowledge sharing; the reinstatement of user groups focussing on specific functional areas across a wide footprint of organisations; and the agreement of outstanding key issues for further escalation to the system supplier. To address this latter point CHFT have taken a lead on a joint letter from Directors of Finance across the WYAAT and YAS group to NEP. In the meantime, the internal improvement work and meetings with CHFT, York Teaching Hospitals and NEP and their supplier Oracle are ongoing.

HD asked a question regarding the issues we had prior to the upgrade and whether the upgrade has made things easier for end users and have we had conversations with them in terms of feedback. GB explained that there is a challenge around receipting of goods especially following the extra controls which have recently been introduced, the importance for colleagues to implement the 'vacation rule' has been highlighted and training has been provided.

Discussions turned to the configuration of our supply chain and the quantities and frequency of orders and the opportunities for tighter control, it was noted that we need to have confidence that the right decisions are being taken by end users.

ACTION: To raise supply chain issues with CHS - **GB**

Following discussions it was requested that a draft letter, detailing our request for compensation, would be drawn up addressed to the lead of NEP to be signed by OW.

ACTION: To draft a letter to the lead of NEP for OW to sign – **KA**

The Committee acknowledged the positive response from the teams impacted by the upgrade and thanked them for their commitment.

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

027/19 2019/20 DRAFT FINANCIAL PLAN

The Director of Finance explained that the paper already circulated gave the detail behind the presentation which would highlight the key elements and issues for discussion within this forum. It was noted that as far as the Trust is concerned our Draft Plan will be the basis for the revised reconfiguration business case which is due by the end of March.

It was noted that considerable debate had taken place with Executives regarding the recovery challenge which had not resolved and OW welcomed the views of the NEDs in attendance today.

Discussions took place regarding the advantages of both the CIP and budgetary control approach. It was noted that accountability and responsibility and how we focus on the skill set and competency to have effective Budget Managers is key to enable a step change. SG gave her view from a nursing perspective regarding budgetary control and it was identified that regular conversations do not take place at ward level and this should be key. OW suggested that there should be development in this area to try to break the cycle.

Further debate took place regarding the proportion of the required cost reduction that should be targeted through each of these methods and OW proposed an £11m CIP and £2m to be delivered via budget management processes. HB re-enforced her view the need that all areas should be the focus of budgetary controls not just clinical areas.

The Chair confirmed that NEDs would be supportive of a more budgetary control direction, however, the challenge will be the £6m gap. OW thanked the NEDs for their steer and that at the next meeting there would be further detail around how we bridge the £6m gap.

The Committee **ACCEPTED** the Control Total of £9.7m and **NOTED** the contents of the paper and presentation.

028/19 CIP UPDATE

There was nothing further to note.

029/19 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were **RECEIVED** by the Committee: -

- Draft Capital Management Group held 15 January 2019.

030/19 WORK PLAN

The Committee **NOTED** the Work Plan.

031/19 MATTERS TO CASCADE TO THE BOARD

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

- The 2019/20 Plan was discussed and the £9.7m Control Total was accepted by the Committee. There will be further work to bridge the £6m gap.
- EPR – positive response from the benefit realisation paper, further report to come back to the Committee in March.
- Governance Structures reviewed – Philip Lewer and NEDs to discuss further – also noted the Declarations for ICS/WYAAT required.
- IPR – good performance noted in December following through into January.
- Finance – on plan and forecast to remain on plan to year-end.
- Project Echo - risk mitigated.
- Review of risks on the Risk Register at the next meeting.
- Capital – secured a grant of £2.5m for the funding of energy efficient lighting
- Finance & Procurement system upgrade discussed and progress noted.

OW asked PO to call out to the Board our consistency regarding continued improved Performance for information.

032/19 REVIEW OF MEETING

It was agreed that the meeting had once again provided good discussion.

033/19 ANY OTHER BUSINESS

The following points were raised:-

- We are expecting a Secretary of State response to be published today which may attract media interest.

SG asked for the following points to be noted/considered:-

- Staff do fundraise for extra things on the ward.
- Staff do bridge the gap when we are short-staffed to help with savings.
- If budgets are set too tight it can have a knock-on effect to sickness and absence.

DATE AND TIME OF NEXT MEETING
FRIDAY 1 March 2019, 9.30am – 12.30pm
Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 23 January 2019 in Room 4, Acre Mills Outpatients commencing at 10:00 am

PRESENT

Richard Hopkin	Chair, Non-Executive Director
Linda Patterson	Non-Executive Director
Andy Nelson	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
Mobeen Kauser	External Audit Manager, KPMG
Victoria Pickles	Company Secretary
Adele Jowett	Local Counter Fraud Specialist
Claire Partridge	External Audit Partner, KPMG
Kirsty Archer	Deputy Finance Director
Helen Barker	Chief Operating Officer
Rob Aitchison	Director of Operations, Family and Specialist Services Division

OBSERVERS

Philip Lewer	Chair
Brian Moore	Public Elected Governor
Andy Hill	Regional Finance Trainee

1/19 APOLOGIES FOR ABSENCE

Apologies were received from Jackie Murphy, Amber Fox and Andrea McCourt.

2/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

3/19 MINUTES OF THE MEETING HELD ON 17 OCTOBER 2018

The minutes of the meeting held on 17 October 2018 were approved as a correct record.

4/19 ACTION LOG AND MATTERS ARISING

The actions arising from the meeting in October were discussed and the action log was updated.

5/19 Current Data Quality Issues

Rob Aitchison, Director of Operations – Family and Specialist Services explained that the Trust has historically done well with data quality however since the roll out of the Electronic Patient Record (EPR) there is not currently full assurance in data quality. Following EPR the number of open pathways went up to 38000. Have been working to reduce this and the regulator has asked that this is down to 26000 by the end of March. Need to treat 92% of patients within 18 weeks and have continued to achieve this throughout. Some of this is about how systems work but part has been about how clinicians are practising. Learning has taken place but there is more we need to do.

Other indicators include:

- Appointment Slot Issues - These are patients referred to the Trust and are not offered an appointment at first time of asking. We have 15 – 30% of patients who don't get an appointment at the first attempt. There was a significant increase between September and October to 3000 patients. Cancer patients excluded from this and the Trust is one of the top performing trusts in relation to cancer referrals.
- Incomplete orders - This relates to next steps following an outpatient appointment. Some of these are patients who didn't require a follow up and therefore this is a data quality aspect. There is some work with clinicians to ensure they correctly place an order.
- Holding list - This is the way in which the Trust ensures that patients who need a follow up are seen appropriately. Don't have assurance around this. Patients who are still waiting for a follow up are clinically validated to ensure that they are safe to wait. 2600 have gone over 3 months from the expected follow up appointment date. It presents both a patient safety and regulatory performance risk for the Trust. At the last CQC inspection, the Trust gave full assurance that this would be managed however there are a significantly higher number of patients on this list at this point.

Some of this has additional cost implication as it requires admin time to validate and rectify the position.

Linda Patterson asked if this was about capacity or process. The Director of Operations responded that the Trust has an outpatient plan which is on track. The issue relates to a number of factors: the order in which patients are placed; engagement with clinicians; the number of patients being referred although all are seen within the 18 week time frame. It is the patient experience which is impacted. GPs have expressed frustration at outpatient appointments. Have done some work to ensure that the trust is picking up the care and people don't need to go back to the GP.

The Chief Operating Officer added that part of the problem with the EPR is that the offered time frames are 3-6 months rather than a choice of each. Patients who need to be seen within 6 weeks should leave clinic with their appointment. There is a plan to change the system and in the meantime patients are booked at the six month period. There is a need to clarify this position with clinicians to ensure that patients do not come back too early before the diagnostics are ready.

The improvement plan should take eight to 12 weeks and an update will come back to the Committee in April. It was also agreed to circulate the action plan.

ACTION: RA

The Deputy Director of Finance highlighted that data quality is a line on the Use of Resources assessment and has been included on the Internal Audit plan for 19/20.

OUTCOME: The Committee **RECEIVED** the update and **AGREED** to receive a further update report at its meeting in April.

6/19 COMPANY SECRETARY'S BUSINESS

1. Board Assurance Framework

The Company Secretary presented the updated Board Assurance Framework. It was noted that a further board workshop would be arranged to look at the Board Assurance Framework and the high level risk register. The Executive Director of Finance explained that a process had been agreed through the Joint Liaison Committee as to how risks between the Trust and Calderdale and Huddersfield Solutions Ltd would be managed and this this would be shared with the Trust Board and included in the workshop.

ACTION: AF

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Board Assurance Framework

2. Governance Structure Review

The Company Secretary described the work that has been undertaken to review, standardise and streamline the governance structure. It was noted that there was an outstanding decision to be made in relation to a number of groups looking at deteriorating patients. It was also noted that the Security and Resilience sub group needed to be reviewed and added to the structure.

OUTCOME: The Committee **NOTED** the governance structure.

3. Annual Report and Accounts Timetable

The timetable for the production and audit of the Annual Report and Accounts was presented for information. The Executive Director of Finance highlighted an issue in relation to the departure of the Company Secretary and the risk around the production of the Annual Report.

OUTCOME: The Committee **NOTED** the Annual Report and Accounts timetable.

7/19 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review Waiving of Standing Orders

The Executive Director of Finance provided details regarding the Trust's waiving of standing orders to enable volume and value to be monitored during the second financial quarter of 2018/2019. There were six instances totalling £197,000 in the context of £14.7M of spend in the period. The largest individual item was £85,000 for which there was no alternative supplier as this was an upgrade to a system.

2. Review of Losses and Special Payments

The Deputy Director of Finance presented the report for the quarter. It was noted that £23,000 relates to three claims to NHS resolution for damages or costs. £15.8K is in relation to expired medicine in context of £1.25M of medicine stocks. The Company Secretary highlighted that the Trust is efficient with our medicine stock holdings and this may present a risk in relation to Brexit planning. The Deputy Director of Finance explained that the plan to create a single store across West Yorkshire has slipped. There have been no bad debts written off. A focused piece of work has been done to try to reduce some of the debt.

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

8/19 CHS Accounting Overview

The Deputy Director of Finance presented the report. The proposal in relation to accounting has been discussed and agreed with the External Auditor and it is consistent with other CHS organisations. It was noted that there is a lot of focus on inter-company transactions to ensure the group accounts are reconciled and that this is discussed at the Joint Liaison Committee.

Brexit Preparations

The Deputy Director of Finance outlined the preparations being made for Brexit including a review of the potential risks across all areas of the Trust via the weekly Brexit Task and Finish group.

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

9/19 Internal Audit

1. Review Internal Audit Follow-up Report

The Internal Audit Manager explained that the number of overdue recommendations has gone down however there are a lot of actions due for the final quarter and there needs to be focus on this to ensure that they are delivered. Some concern was expressed over certain long outstanding recommendations.

2. Review Internal Audit Progress Report

The Internal Audit Manager explained that there had been changes to the plan due to additional work relating to Gosport, Controlled Drugs and Death Certificates. 60% of the plan had been completed and it was six weeks ahead of the previous year leaving only a relatively small number of audits left to start.

Discussion took place about the internal audits relating to quality and the need to ensure that these are on the agenda for the Quality Committee and other Committees as appropriate. It was agreed that the Company Secretary would undertake a review of the Internal Audit plan and align audits to the appropriate Board sub-committee where relevant.

The Committee considered the consultant's study leave audit. It was noted that the policy is out of date and isn't in line with current practice and there is no overall oversight. This was being addressed by the Deputy Medical Director.

The Internal Audit Manager explained that the Information Governance Toolkit (IGT) audit had intended to be both retrospective and prospective. However, the IGT had been removed and replaced with the data protection toolkit. The audit report therefore may not be issued in final form and instead the findings be reflected in the Data Protection Toolkit report in due course.

OUTCOME: The Committee **RECEIVED** the progress report.

10/19 Local Counter Fraud

1. LCFS Progress report

The Local Counter Fraud Specialist (LCFS) provided an update on current investigations including an issue in relation to overtime requests.

The Committee discussed how the national figures in relation to potential fraud are arrived at and whether this affects the work plan. The LCFS responded that work is targeted to risky areas but is not driven by the figures. It was agreed to receive a presentation on the areas of fraud risk at the next meeting.

ACTION: AJ

The LCFS provided an overview of the investigation work ongoing. The Committee discussed learning and the need to tighten budget control procedures and accountability. The Executive Director of Finance described the work that has been undertaken to address this alongside a review of the home working policy as there will be an increasing requirement for people to work flexibly. It was agreed that the LCFS should have input to this policy.

OUTCOME: The Committee **RECEIVED** the progress report.

11/19 External Audit

1. Sector Update

The sector update was received. The External Auditor highlighted Quality accounts and indicators and it was noted that the governor selected indicators may include the SHMI indicator. Given that this may lead to issues with KPMG being able to give an opinion, it was agreed to liaise with the External Auditor on these indicators.

2. Audit plan

The External Auditor explained that they are required to give an opinion on the financial statements and this should be a true and fair opinion this year, as for last year. It is likely that the Use of Resources opinion will be qualified as last year. It was noted that materiality has changed as this is set based on revenue. This has moved up from 1.0% to 1.8% but is still within the 'normal range'. The reporting threshold to ARC is £330,000 (2018 - £250,000) however smaller amounts will be reported if they relate to control issues.

The External Auditor highlighted the two new areas of risk outlined in the report relating to the PFI and expenditure recognition. However, the one relating to the PFI would be removed if the refinancing does not go through this year. It was noted that the Value for Money conclusion was likely to be in line with the previous year and the independence of the External Auditor was also noted. The reported fees were consistent with the tender plus CHS however there may be an additional fee in relation to the PFI discussion.

OUTCOME: The Committee **NOTED** the sector update and audit plan.

12/19 ITEMS TO RECEIVE AND NOTE:

- Information Governance & Records Strategy Committee Minutes – 10.12.18
- Risk & Compliance Group Minutes – 18.9.18, 22.10.18, 21.11.18
- Data Quality Board Minutes – 14.11.18, 11.12.18

It was agreed to confirm where the Resilience and Security Group reports to.

ACTION: AF

OUTCOME: The Committee **RECEIVED** the minutes from the relevant groups.

13/19 ANY OTHER BUSINESS

There were no other items of business to note.

14/19 MATTERS TO CASCADE TO BOARD

It was agreed to bring the following items to the attention of the Board:

- Data Quality issues
- BAF update and the progress made
- The governance review
- Annual reporting timetable and concern over risk of the departure of the Company Secretary
- Brexit risk
- Internal Audit reports- there has been some improvement although there is concern around the ones outstanding; limited assurance reports; the links to other committees
- Counter Fraud – overtime and budget controls

- Audit Plan for 2018/19.

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled to take place on Wednesday 17 April 2019 at 10:00 am in the Medium Training Room, Learning Centre, Calderdale Royal Hospital.

The extra-ordinary meeting to sign off the annual report and accounts is scheduled to take place on Tuesday 21 May 2019 at 10:00 am in the Medium Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair formally closed the meeting at 12 pm.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 2 January 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

001/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Christine Mills **(CM)**	Public Governor
Jackie Murphy **(JMy)**	Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Alison Schofield **(AS)**	Lead Governor
Saima Hussain **(SH)**	Alison's Carer

002/19 APOLOGIES

Jason Eddleston	Deputy Director of Workforce and Development
Karen Heaton	Non-Executive Director
Elisabeth Street	Clinical Director of Pharmacy
Lindsay Rudge	Deputy Director of Nursing

003/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

004/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 3 December 2018 were approved as a correct record.

005/19 ACTION LOG AND MATTERS ARISING

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

Serious incident risk assessment
Andrea McCourt (Head of Governance and Risk) presented appendix C, which provided an update on outstanding actions from completed serious incidents. An action from the last meeting requested that any outstanding actions were risk assessed and RAG rated, with the ratings being:

- High (red) – significant risk
- Moderate (amber) – risk of further harm arising
- Low (green) – unlikely to lead to harm

Within divisions, there were no overdue actions assessed as a significant risk, however:

- Family and specialist services – 20 outstanding actions relating to five reports, with one action being rated as moderate
- Community division – 13 outstanding actions relating to three reports, with one action being rated as moderate.
- Medical division – 62 outstanding actions relating to 20 reports, with six actions rated as moderate

Discussion ensued on the significant workload of monitoring and completing actions for the medical division due to them having the highest number of serious incidents. It was stated that the report was a helpful development providing the ability to identify actions not completed and those that require senior involvement with other organisations. It was also stated that the RAG ratings will now be used on future action plans, and that the report should become part of a quarterly routine assurance for this Committee going forward.

AMC was thanked for producing the paper.

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

006/19 CARE QUALITY COMMISSION (CQC) UPDATE

Jackie Murphy (Chief Nurse) provided a verbal update on CQC. There are currently two actions which are rated as no progress:

- MD 8 – Medical staffing *(CRH – critical care)*
  The issue is the non-delivery of GPICS (Guidelines for the provision of intensive care services) standard at CRH, as consultants have other areas of responsibility when on call (this was also the position at the time of the previous inspection). The ability to deliver against this standard is dependent on centralisation of acute services. It is on the risk register (score of 8), the team monitor for any incidents / near misses – none of which have been reported.

- SD 8 – Medical staffing *(urgent and emergency care)*
  The issue is that consultant cover does not meet the RCEM (Royal College of Emergency Medicine) guidance for consultant presence of 16 hours per day. Compliance with guidance cannot be achieved whilst there are two units on two sites. The inability to recruit sufficient middle grades and consultants is on the high level risk register.

A paper is being submitted to the Weekly Executive Board to ensure that we will be 100% compliant or whether mitigation is needed against the recommendations. It was stated that with the reconfiguration of medical services, this may change.

Work has now completed on the ligature rooms (MD 6), and movement on 10 should do actions due to be delivered by the end of December 2018 was made. Updates on these are due at the next CQC Response Group meeting on 15 January 2019.

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

007/19 OPENING THE DOOR TO CHANGE

The Chair made reference to a report published by the CQC in December on Opening the door to change: NHS safety culture and the need for transformation, which shares the findings of a review examining the issues that contribute to the occurrence of Never Events and wider patient safety incidents in NHS Trusts in England. The key recommendations also align with proposals raised in the NHS Improvement's current consultation on a new national patient safety strategy.

Discussion ensued on the learning that can be gained from the useful report, which focusses attention on safety culture and provides prompts on what has been done, what has been achieved and what can be done differently. It was stated that the report will be submitted to the CQC Response Group, Patient Safety Group and the Serious Incident Review Group.

Further discussion took place on any actions which may link to this Committee, and it was stated that the report will be reviewed and any relevant actions will be responded to.

008/19 SERIOUS INCIDENT REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix E, summarising 10 new serious incidents reported to commissioners in September, October and November 2018.

- Four in September 2018 *(Fall, Never event, Infection, Lost to follow-up)*
- Three in October 2018 *(Allegation of sexual assault, Never event, Medication)*
- Three in November 2018 *(Category 4 pressure ulcer, Neonatal death, Never event)*

Discussion ensued on the three never events, with two involving oxygen tubing inadvertently being connected to an air outlet - the first occurring in September 2018, and the second discovered in October 2018 following a review of all incidents, but was initially reported as a no harm incident in February 2018, shortly after the incident became a never event nationally in January 2018. Work has been ongoing across the organisation to address the risk by promoting the preventative measure, ensuring regular checks that flowmeters have been removed from air outlet ports so no connection can be made. The third never event in November related to a gynaecology patient who had a retained gauze roll post-surgery. The surgical division is working closely with colleagues in the Families and Specialist Services division to review the incident and identify learning to inform any further actions.

The Trust has been asking experts from neighbouring Trusts to help on serious incident investigations involving maternity and neonatal care. From 3 December 2018, such cases are being investigated by the Healthcare Safety Investigation Branch (HSIB). Serious Incidents reported to the HSIB will be reported via this report to the Quality Committee in future.

There were eight completed serious incident investigation reports, details of which are included in the report.

Discussion ensued on the never events and it was stated that this is a national concern. CHFT are currently average alongside other Trusts in national benchmarking data. Over time, although the numbers of incidents reported have increased, the numbers of serious incidents have fallen, and this is a positive change. Work is ongoing with the Clinical Commissioning Groups to ensure that we are escalating the right amount of incidents.

The events also represent a small percentage of all incidents reported, and a thorough report on actions taken can be provided. Further discussion took place on whether support for colleagues following serious incidents. Colleagues receive immediate line manager support and a family liaison support team is also available for both families and colleagues.

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

009/19 HIGH LEVEL RISK REGISTER

Andrea McCourt (Head of Governance and Risk) presented appendix F, highlighting risks as at 19 December 2018:

- Eight top risks scoring 20 or 25:
  - 7278 (25) *Longer term financial sustainability risk*
  - 6903 (20) *Estates / Resuscitation risk, HRI*
  - 7271 (20) *HRI ICU collective infrastructure risk*
  - 2827 (20) *Over-reliance on locum middle grade doctors in the Emergency department*
  - 5806 (20) *Urgent estates schemes not undertaken*
  - 6345 (20) *Nurse staffing risk*
  - 7078 (20) *Medical staffing risk*
  - 7240 (20) *Surgical financial risk*

- Four new risks:
  - 7338 (15) *Risk of an incomplete Electronic Patient Record*
  - 6829 (16) *Risk of insufficient capacity from Pharmacy Aseptic Dispensing Service*
  - 3793 (16) *Risk of delays for patients on pending ophthalmology list requiring follow-up appointments*
  - 5511 (15) *Collective fire risk – risk of increased fire spread at HRI due to inadequate capital funding for refurbishment works*

- Five risks with a reduced score:
  - 7318 *Risk to life and building due to poor condition of stone cladding*
    Reduced from 15 to 10
  - 6949 Risk of the inability to deliver a two site Blood Transfusion / Haematology service
    Reduced from 16 to 12
  - 6895 *Risk of inability to fulfil core functions of the finance and Procurement department due to IT Systems failure resulting in failure to meet statutory deadlines*
    Reduced from 16 to 12
  - 7324 *Risk that healthcare waste will not be collected from the Trust on a daily basis*
    Reduced from 20 to 12
  - 7273 *Optiflow devices*
    Reduced from 15 to 9

- One risk with an increased score:
  - 7240 *Risk* of expenditure being above planned levels for the surgical division
    Increased from 16 to 20

It was reported that some risks will not change until reconfiguration is complete.

A copy of the complete high level risk register was also available in the report.

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

010/19 BOARD ASSURANCE FRAMEWORK

A copy of the Board Assurance Framework (appendix G) was attached and reviewed.

OUTCOME: The Quality Committee noted the report.

011/19 CLINICAL OUTCOMES GROUP

Dr David Birkenhead (Medical Director) presented appendix H, highlighting the key points for escalation to the Quality Committee from the October, November and December 2018 meetings:

- Frailty - The acute service is based at HRI and has recruited additional staff. This investment of staff will enable the service to complete a comprehensive geriatric assessment on all frail patients which provides a holistic assessment and not just the presenting illness. This should improve patient experience and reduce length of stay and readmissions of frail older people. Assessments can be completed in patient's homes preventing admission.
- ICODD – work is ongoing with Bradford for a joint build of the Individualised Care of the Dying Document into the Electronic Patient Record.
- Sepsis - The Trust's Hospital Standardised Mortality Ratio (HSMR) figure for sepsis is 87.97, and ranked 26th out of 135 acute trusts. Both Emergency Department and inpatient performance for antibiotic administration within one hour has improved above 90% in both groups.
- Medical Examiner role - The medical examiner role is a non-statutory role (statutory from 2020) and will be the interface between bereaved relatives and the medical team. An ME is anticipated to be introduced from April 2019, and the role will need to be an

independent doctor(s) from within the trust. This will present a challenge to ensure we provide a daily service. A business case is to be prepared and submitted to the Weekly Executive Board in January 2019.

- Organ donation report – a six-month report was provided. Two solid organ donors proceeded to donation resulting in four patients receiving transplants in the first half of this financial year. This has exceeded national benchmarking.
- NICE guidelines – update received, with robust process in place. Will always be areas on non-compliance.

Discussion ensued on an attempt to re-establish the Clinical Outcomes Group to have a different emphasis on work during the year. The group was set up to decrease Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio, which is now underway.

Updates from the Mortality Surveillance Group meetings in October and November 2018 were also provided, highlighting the learning from deaths process, a report on which is due at this meeting on 29 April 2018.

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

012/19 QUALITY AND PERFORMANCE REPORT

Jackie Murphy (Chief Nurse) presented appendix I highlighting November's performance score which has improved to 70%, the highest since July 2018. The safe domain has deteriorated to amber due to a never event. The caring domain has improved to green with better performance in outpatients, the emergency department and Community Friends and Family Test would recommend. The effective domain has improved to green with Fractured Neck of Femur achieving target. The responsive domain has improved having achieved all key cancer targets and 3 out of 4 stroke indicators for the second month, although the diagnostics 6 weeks target was missed for the first time since May. In workforce, essential skills training have deteriorated in month alongside appraisal rates for medical staff. Within efficiency and finance income and expenditure: surplus/deficit has improved to amber and Cost Improvement Programme was within target in month.

- Stroke targets - 3 out of 4 targets achieved for second month. Only patients admitted directly to stroke unit within 4 hours missed target at 70.9% (a 'C' SSNAP (Sentinel Stroke National Audit Programme) score), best performance since January. Three of the indicators achieved an 'A' SSNAP score in month. There is now a monthly meeting in place to review all actions relating to the aim of achieving an 'A' for SSNAP that is sustainable across all areas/domains.
- Target for % of diagnostic waiting list within 6 weeks was missed for the first time since May due to echocardiography.
- Performance for % of dementia patients following emergency admission aged 75 and over has deteriorated to its worst position since February at 22%, following its best month in October, and is significantly below the 90% target. Dedicated resource is working approximately 1.5 days a week for the next 4 weeks to educate front line clinical teams about the importance of the screen, as well as providing encouragement and practical help to locate the tool. This will then be reviewed. A paper will be submitted to the Weekly Executive Board at the end of December.
- Meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C,Diff), Methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia coli (E.coli) all hit target for the first time in 12 months.
- Harm-free care (all) was 92.81%, this is a decrease from last month and is below the 95% target. The majority of harm has been attributed to old pressure ulcers. Performance for the % of Harm Free Care (new) is on target at 98%.

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

013/19 ANY OTHER BUSINESS

Next meeting
The Chair stated that a paper on serious service failure will be provided for the next meeting.

Never Events
Divisions are requested to provide a position statement in relation to never events as part of their PSQB reports for the meeting 4 March 2019.

014/19 MATTERS FOR BOARD

- Update on CQC progress received *(item 006/19)*
- CQC report on opening the door briefing *(item 007/19)*
- Briefing on the three never events *(item 008/19)*
- Good news on sepsis *(item 011/19)*

015/19 EVALUATION OF MEETING

What went well……
- Succinct meeting
- Clear information provided for new members.

016/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix J) was accepted.

017/19 QUALITY COMMITTEE 2019 MEETING DATES

A copy of the meeting dates for 2019 was tabled and will be circulated again with the minutes of this meeting.

NEXT MEEETING

Monday, 4 February 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

FUTURE MEETINGS

All taking place 3:00 – 5:30 pm in Acre Mill Room 3, Third Floor, Outpatients Building, HRI

- Monday, 4 March 2019 *(including PSQB Q3 reports)*
- Monday, 1 April 2019
- Monday, 29 April 2019
- Monday, 3 June 2019 *(including PSQB Q4 reports)*
- Monday, 1 July 2019
- Monday, 29 July 2019
- Tuesday, 3 September 2019 *(including PSQB Q1 reports)*
- Monday, 30 September 2019
- Monday, 4 November 2019
- Monday, 2 December 2019 *(including PSQB Q2 reports)*

APPENDIX A

Calderdale and Huddersfield NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 4:30 PM ON THURSDAY 24 JANUARY 2019 IN THE BOARDROOM, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Philip Lewer	Chair

Publicly Elected Governors

Brian Moore	Public Elected - Constituency 8
Christine Mills	Public Elected - Constituency 2
Dianne Hughes	Public Elected - Constituency 3
Jude Goddard	Public Elected - Constituency 1
Rosemary Hedges	Public Elected - Constituency 8
Sheila Taylor	Public Elected - Constituency 2
Stephen Baines	Public Elected - Constituency 5
Lynn Moore	Public Elected - Constituency 7

Staff Governors

Linzi Smith	Staff Elected - Constituency 11
Dr Peter Bamber	Staff Elected – Constituency 9
Sian Grbin	Staff Elected – Constituency 13

Stakeholder Governors

Helen Hunter	Healthwatch Kirklees

IN ATTENDANCE:

Karen Heaton	Non-Executive Director
Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance
Suzanne Dunkley	Executive Director of Workforce and OD
Amber Fox	Corporate Governance Manager (minutes)
Jackie Murphy	Chief Nurse
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive
Andrea McCourt	Head of Governance and Risk
Mandy Griffin	Managing Director – Digital Health
Anna Basford	Director of Transformation and Partnerships

01/19 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Alison Schofield	Public Elected - Constituency 7 / Lead Governor
Annette Bell	Public Elected - Constituency 6
Brian Richardson	Public Elected - Constituency 5
John Richardson	Public Elected - Constituency 3
Paul Butterworth	Public Elected - Constituency 6
Felicity Astin	University of Huddersfield

Chris Reeve	Locala
Nasim Banu Esmail	Public Elected - Constituency 4
Salma Yasmeen	South West Yorkshire Partnership NHS FT
David Birkenhead	Medical Director
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Alastair Graham	Non-Executive Director
Linda Patterson	Non-Executive Director

02/19 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors and staff colleagues to the meeting. Introductions were made around the table for the new governors.

03/19 DECLARATIONS OF INTEREST

There were no declarations of interest. The Chair reminded the Council of Governors and staff colleagues to declare their interest at any point in the agenda.

04/19 MINUTES OF THE LAST MEETINGS HELD 18 OCTOBER 2018

The minutes of the previous minutes held 18 October 2018 were approved subject to approval by the governors to an amendment made by Sian which is highlighted below;

Brian Moore raised a concern about the privacy of the Closed Facebook Group for governors and he felt that all Trust business should happen on site. This was seconded by John Richardson and Christine Mills. Those who spoke out in favour of it in the meeting were Peter Bamber, Linzi Smith and Rosemary Hedges. Brian Richardson, Paul Butterworth and Stephen Baines also commented after the meeting they found the page useful. Sian Grbin explained that the page should be private i.e confidential as it is by invitation only and a platform for governors to talk in private.

05/19 MATTERS ARISING / ACTION LOG

The action log was reviewed and updated accordingly.

Management of Complaints – This action turned green (complete) as the meeting had been arranged; however, feedback received from Paul Butterworth highlights the complaints target has not reached a 95% performance rating. Therefore, he asked that this action remains ongoing as the performance has not improved.

06/19 CHAIR'S REPORT

Chair Appraisal Process

The Chair reported that the Chair Appraisal Process is due to start, and the governors will receive a form to submit their feedback. The proposal will be explained and led by the Lead Governor. Brian Moore offered to support this

process which he supported last year as Lead Governor.

As part of this process, the Chair has listed all the meetings and business he has been involved in since he started the Trust. Governors can comment or challenge this as part of the appraisal process.

Formal Meeting Attendance Register
The formal Council of Governors attendance register to cover the period from 1 April 2018 – 21 March 2019 was circulated for information.

Governors/Non-Executives Informal Workshop – 14 February 2019
The next Governors and Non-Executive Directors informal workshop is scheduled on Thursday 14 February 2019. The Governors were asked to bring any agenda items to our attention as soon as possible to plan for this workshop.

07/19 PERFORMANCE AND STRATEGY

a. Performance Report

The Chief Operating Officer reported a positive position for November 2018, the main highlights from the report were:

- All domains are in the green
- Emergency Care Standard achieved over 90% in November and reached 90% in December, CHFT are in the top 3rd nationally and have two of the busiest A&E's in the region (top 20%) – this is a good picture considering staffing is challenging
- Cancer – achieved all targets in December 2018; however, it will be a challenge to achieve the 62-day cancer referral target in January
- Delivering planned waiting list on referral to treatment (RTT)
- Mortality remains in a good position
- Diagnostic capacity is a challenge, particularly in cardiology due to a shortage of workforce. The Trust is looking at alternatives and have invested in training our own which is a two-year training programme
- Infection, Prevention and Control is in a good position. The Infection Control team decanted and deep cleaned all wards which will continue going forward
- Stroke – positive performance, weekly monitoring in place, only 1 area is less than a B in the national performance
- Overall good performance in the last quarter of the year with lots of hard work from colleagues

The Chief Operating Officer explained the Stroke Sentinel National Audit Programme is about ensuring patients are getting the correct level of input and a stroke bed. There are 16 categories which are scored between A - E. The Trust are aiming to achieve all A's.

Sian Grbin highlighted the short staffing issues and wanted to understand why the

indicators for workforce show green on the report. The Chief Operating Officer will pick this up with Sian separately.

Peter Bamber highlighted concern around diagnostic capacity being a challenge. The Executive Director of Finance confirmed this is not in relation to doctors, the shortage refers to technicians e.g. echo-cardiogram. Peter asked how the Trust can make these vacancies more attractive. The Trust is working closely with the cardiologist team with Working Together to Get Results meetings taking place, alongside a weekly meeting and the Trust is looking at training nursing colleagues. The cardiology shortage is a national problem across West Yorkshire. The primary percutaneous coronary intervention (PCI) service is all in Leeds.

Rosemary Hedges highlighted the good news in the community division whereby the Calderdale CCG confirmed their intention to build an alliance contract with their existing contractual providers. Rosemary asked if these staff would remain under our employ on these arrangements and are not at risk of transferring to another organisation. The Chief Executive confirmed this is not another wholly owned subsidiary and is an opportunity to work with other providers e.g. SWYFT, Locala, GP Federations etc. The Trust aim to play a leading role in this arrangement.

Brian Moore pointed out the agency overspend in November of £1.43m against plan. The Executive Director of Finance re-assured the Council that agency spend is under plan year to date (YTD) and is forecasting under plan at year end.

The Chief Executive explained the Trust reviewed the three top elements (Emergency Care Standard, RTT, cancer 62 days) over the last two years and current years to understand where the Trust ranks nationally. CHFT is in the top five in the country. The Trust is working to a high standard and expect to be in the top 10 in the current year. This data will be shared once available.

The Company Secretary highlighted an email from Paul Butterworth which raised the complaints target of 95% has not been achieved and YTD is only 40%. The Chief Nurse responded that the Trust is trying to focus efforts into achieving an improved response time. Historically, the Trust has never been near the target due to the complexity of complaints, which raises the question how realistic the target is. The Trust is performance managing the responses, supported by the Head of Governance and Risk, in order to achieve a quality response in a timely fashion. The Chief Nurse and Chief Operating Officer are meeting with Divisions to understand how to best support them and where improvements can be made. The Chief Nurse has seen a much-improved quality of complaint response letters.

Sian Grbin pointed out the number of closed complaints has improved to 63%. Effort has been made to close long-standing complaints in a timely fashion. The Head of Governance and Risk explained the timeframe of complaints depends on the severity and complexity of complaint e.g. 25 days or 40 days if complex.

The Trust has started sending out surveys to understand the experience of the complainant.

Peter Bamber asked how CHFT compares with other Trusts. The Head of Governance and Risk explained national benchmarking data is available; however, there is no national target for responding to complaints. A 'Go See' visit took place to Morcambe Bay where their target to close complaints was 60 days. The nature of complaints is very different which makes it difficult to benchmark across specialties.

Helen Hunter from Healthwatch Kirklees explained they deliver the NHS complaints advocacy service and offered to share learning to improve the Trust's processes. The Chair welcomed this and thanked Helen for offering this support.

The Chief Executive re-iterated the challenge with the complexity of complaints as they can involve more than one organisation and/or GP Practice.

b. Financial Position and Forecast – Month 8

The Executive Director of Finance summarised the key points from the Month 8 position;

- YTD deficit is £29.3m, in line with plan
- Month 9 shows a slight improvement
- Overspend by £43m, on track to deliver
- CIP achieved in the year to date is £9.40m against a plan of £9.88m, a £0.48m pressure, there is risk within plan relating to material CIP schemes of £1m, the Trust are working on further cost control with divisions to hit this plan
- Session with the governors in relation to next year's plan has taken place
- National Press – additional money is going into acute providers to improve their deficit position, if the Trust accept, there will be a £10m deficit for next year; however, this will require a savings challenge to be agreed and this will be brought back to the Board for approval

Peter Bamber asked what it means if the Trust can accept the control total. The Executive Director of Finance explained the Trust chose not to accept the control total for 2018/19 and would not accept for 19/20 if it is an unrealistic plan. The reality now is a much more favorable proposition and the Board are working through understanding the savings challenge. Peter Bamber highlighted that this will come with conditions. The Executive Director of Finance clarified there are fewer conditions than in previous years on this money and new guidance suggests it's about delivering the money.

The position in 19-20 could be a £10m deficit after £27m of additional support funding. Rosemary Hedges asked how the Trust will move from £43m deficit to a £10m deficit. The Executive Director of Finance explained the monies referred to a marginal rate admissions tariff plus 2 tranches of sustainability funding. The

Executive Team are proposing this at the Finance and Performance Committee this month.

The Chief Executive stated the Trust is approaching £60M of CIP achieved over the last 4 years and the ability to reduce CIP is more challenging.

Rosemary Hedges asked for clarity on the Aligned Incentive Contract. The Executive Director of Finance explained this is a fixed value contract, with some thresholds. Income is still monitored the same as through the payment by results methodology. The Aligned Incentive Contract allows the Trust to deliver care in appropriate pathways and see patients in a different way. Rosemary felt nervous around the word 'incentive'. The Executive Director of Finance confirmed it is incentivised to only see patients that need care or in an improved way e.g. digitally. Rosemary asked what if demand outstrips the budget and asked if there may be restrictions. The Executive Director of Finance responded that the system would work together to address this demand and that the contract allowed the system to provide care differently, potentially at a lower cost.

The Chief Executive described the Integrated Care System (West Yorkshire and Harrogate Health and Care Partnership) which allows Trusts to support one another with demand and capacity. This aligns with the long-term plan.

Sian Grbin asked if the Trust won't get income for community-based settings. The Chief Operating Officer described the Nursing Home Facilities that are in place. The costs are cheaper in the community than the acute organisation and CHFT now have a lower number of delayed discharges as a result of these beds in the community. The Trust is paying for the first few days of this process through its agreed contract values and not having income reduced by having less patients in CCHFT beds. The process is working well and is safer for patients, this is identified by reviewing re-admissions, quality of discharge and attending visits with the District Nursing team.

Stephen Baines commented on the 1.5-3.5% debt charges (£15m borrowings) and capital loans of 2.1%. The Executive Director of Finance stated the new debt would be 1.5% if the Trust accepted the new control total and if financed at the new rate, the Trust would see a £700k benefit.

c. Q2 Update on the Quality Priorities

The Head of Governance and Risk provided an update on the areas of improvement work for Q2 (July – September 2018). This information was shared at the Board of Directors in November 2018.

SAFE – Improving outcomes through recognition, response and prevention of deterioration in patients
EFFECTIVE - Improving Timely and Safe Discharge (right patient, right place, right

time)
EXPERIENCE – End of Life Care

The stranded patient metric and long stay metric are now part of the SAFER Programme measures and twice weekly Multi Agency Discharge Events have been introduced with senior colleagues from partner organisations to review discharges. Sian Grbin asked if delayed discharges are due to tertiary care. The Chief Nurse explained the bigger delays of transfer of care are patients waiting to go to nursing homes, care homes and the Trust is working in a more disciplined way to improve this.

The Head of Governance and Risk presented the quality priorities shortlist for next year. Information will be circulated in the newsletter and members will be asked to vote 1 out of each category to focus on next year. At the Council of Governors Workshop in December, Andrea McCourt gave a presentation on the quality priorities where they were shortlisted from 9 to 6.

The Company Secretary explained that new guidance for Quality Accounts mandates the indicator that external audit will review this year and states that they will mandate the governor select indicator to be mortality. Nationally, the guidance wants Trusts to select the mortality rate indicator; however, the Trust were already in the process before the guidance came out and the wider membership will choose.

[Following the meeting External Audit confirmed that this relates to indictors and not priorities. These are two separate elements to the Quality Account. The Governors have selected the priorities. The mandate relates to the indicator.]

08/19 UPDATE ON RECONFIGURATION

The Director of Transformation and Partnerships provided an update on reconfiguration and the indicative timeline.

The Chief Executive reported a meeting has requested by Jenny Shepherd, Chair of Calderdale and Kirklees 999 Call for the NHS and will include the Chair of North Kirklees Support the NHS, Chair of Hands Off HRI and Chair of Huddersfield Keep Our NHS Public. The Chief Executive explained the same presentation provided today will be presented to the above colleagues and scrutiny and colleagues can share this information.

Stephen Baines stated as this is not a PFI project and lifetime costs are built into the revenue budget, in 10 years the building could fall to disrepair without routine maintenance. The Executive Director of Finance stated it is public dividend capital funding with a requirement to create a depreciation fund.

Rosemary Hedges asked for clarity on the A&E model as only one will receive blue light ambulances and that this should be clearer in the presentation. The Director of Partnerships and Transformation confirmed both sites will have consultant led service and 24/7 anaesthetic cover and A&E will be equipped for walk-ins. The proposal states patients who require a 'blue light' ambulance and likely admission to an acute hospital will go straight to Calderdale Royal Hospital or another tertiary centre.

Rosemary asked if this balances the budget earlier than expected, will the two hospitals continue functioning. The Director for Partnerships and Transformation explained it is difficult to see the future, the proposal is to maintain two hospital sites; however, there are challenges on the HRI site with the building and there are alternate models being proposed for Kirklees by the Local Authority.

The Chief Executive added over the last 4-5 years, there has been consolidation of cardiology and respiratory to CRH and elderly medicine moved to HRI. The long-term question is where services are provided. He anticipates the conversation in five years' time about what happens at patient homes will be very different. An application is currently being trialled regarding physio recovery.

Peter Bamber raised concern with the shortage of doctors, nurses, midwives, and therapists. He questioned the ability to have enough A&E doctors and asked what the reasoning was to have two A&E's that required A&E doctors and anaesthetists. Jude Goddard and Lynn Moore agreed with Peter. Peter highlighted the importance of 'right place, right time' rather than the closest. The Chief Executive noted the original proposal addressed this scenario and talked about a new build; however, the Secretary of State asked for an alternative. The Director of Transformation and Partnerships explained the staffing at Calderdale was not affected and additional staff have been recruited to keep the HRI site.

The Trust will report back following the meetings that take place.

09/19 CAR PARKING CHARGES

Brian Moore stated the minutes from the Board of Directors in November approved and implemented the car parking charges increase. He referenced the minutes from the Council of Governors meeting in October where a long discussion was held and a significant number of Governors had expressed that they felt no increases should be made.

The Governors views were collated and made known at the Board meeting. Brian felt this was a tick box exercise and the only comment made at the Board of Directors was from Paul Butterworth.

The Chair challenged this and confirmed there was discussion at the Board, stating the strong views that were expressed by the governors. The Company Secretary

had shared a summary of all the governor's views with all Board members. The consensus was the governors were not in agreement. This was announced at the start of the meeting and can be echoed by Paul Butterworth who was in attendance.

Peter Bamber disagreed and explained there was not a unanimous view from the governors as there was a complexity of views between public and staff parking. Peter added it is not easy to summarise what the governors felt and questioned if it is normal to minute the governor's views at the Board.

Sian Grbin felt if the governor's views were considered and consulted upon, this should have been noted in the minutes. The Board acknowledged they received the comments from the governors at the Board meeting.

Peter Bamber asked Brian for clarity of his concern. Brian confirmed if the governor's views were written in the minutes it wouldn't be raised as a concern as they were reported. The Company Secretary suggested a solution to report the feedback at the next Public Board meeting as part of the Chair's report which will be included in the minutes. This was agreed and will be on the next Public Board agenda.
Action: Corporate Governance Manager

The Chair thanked Brian for bringing this matter of concern up. Veronica Maher added there is a difference between announced and discussed. The Company Secretary confirmed the Chair said, 'the governors have expressed their thoughts and have made strong views, can you confirm you've received a copy of these?'

Lynn re-iterated her concern around car parking for disabled people in that they would never receive the 30 minutes free. She also felt there should be notices in clinics in relation to the flexibility of parking charges if a clinic overruns.

10/19 COUNCIL OF GOVERNORS REGISTER – RESIGNATIONS / APPOINTMENTS

The Council of Governors Register was shared for information. Linzi Smith highlighted there are only three staff governors out of six and asked how the Trust can recruit more. The Company Secretary explained as part of the Election Process for this year, the Trust are asking Sian, Peter and Linzi to help encourage others to promote the vacant staff seats. The election this year will be much more targeted where the vacancies are.

Sian Grbin previously tried to get staff interested; however, the feedback is that they don't have time and it won't make a difference. The Company Secretary confirmed this will be addressed in the marketing. Lynn Moore added staff should have protected time to be a staff governor.

11/19 DRAFT ELECTION TIMETABLE 2019

The draft election timetable for 2019 was shared for information.

12/19 NEW CONSTITUENCY NAMES

The Company Secretary stated the election process is entirely independent, undertaken by Electoral Reform Services (ERS). ERS suggested the Trust change the constituencies from numbers to names to make them easier to understand.

OUTCOME: The Council of Governors **APPROVED** the new constituency names.

13/19 REVIEW ANNUAL COG MEETINGS WORKPLAN

The Council of Governors meetings workplan for 2019 was shared for information.

14/19 UPDATES FROM SUB-COMMITTEES

Quality Committee

The Chief Nurse reported there have been four never events reported where a patient was connected to air rather than oxygen, no harm has arisen from these cases. One of these cases was a legacy case following a review. The Trust are acting accordingly to prevent an event in future. Sian Grbin supported this and confirmed all air ports have been removed on the Children's ward with the exception of one in the sister's office and laminated signs are on the nurses' station.

15/19 ANY OTHER BUSINESS

Brian Moore suggested that future Council of Governors meetings are scheduled at an earlier time. The agreement was the private session between Governors and the Chair will start at 2:00 pm and the public Council of Governors meeting will start at 3:30 pm.

Action: Corporate Governance Manager to change times of future meetings

Brian Moore informed the Council of Governors Vicky Pickles is leaving and this is her last Council of Governors meeting. Brian formally thanked Vicky on behalf of the Council of Governors for all her help which was greatly received. Brian is sorry to see Vicky leave and expressed she deserves a heartfelt thanks for all the work she has done since taking over from Ruth Mason. The Council of Governors wishes Vicky well in her new role.

DATE AND TIME OF NEXT MEETING

Thursday 11 April 2019, 4:30 – 6:30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair formally closed the meeting at 19:00 pm and invited attendees to the next meeting.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Monday 11 February 2019, 2.30pm – 4.30pm, CE Office, Trust Offices, CRH/Discussion Room 2, Learning & Development Centre, HRI

PRESENT:

Rob Aitchison	(RA)	Director of Operations, FSS
Helen Barker	(HB)	Chief Operating Officer
David Birkenhead	(DB)	Medical Director
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Leigh-Anne Hardwick	(LH)	Human Resources Business Partner
Karen Heaton	(KH)	Non-Executive Director (Chair)
Diane Marshall	(DM)	Human Resources Business Partner
Ruth Mason	(RM)	Associate Director of Organisational Development
Jackie Murphy	(JM)	Chief Nurse
Charlotte North	(CN)	Assistant Director of Human Resources
Jackie Robinson	(JR)	Human Resources Business Partner
Alison Schofield	(AS)	Lead Governor
Helen Senior	(HS)	Staff Side Representative

IN ATTENDANCE:

Gary Boothby	(GB)	Director of Finance
Mandy Griffin	(MG)	Managing Director, THIS
Adam Matthews	(AM)	Workforce Information Analyst

01/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

02/19 **APOLOGIES FOR ABSENCE:**

Andrea Dauris, Director of Operations, Community
Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Alastair Graham, Non-Executive Director
Anne-Marie Henshaw, Assistant Director of Quality and Safety
Azizen Khan, Assistant Director of Human Resources
Julie O'Riordan Divisional Director, FSS
Sharon Senior, Staff Side Representative
Ashwin Verma, Divisional Director, Medical
Bev Walker, Associate Director of Urgent Care
Claire Wilson, Assistant Director of Human Resources
Debbie Wolf, Head of Therapies

03/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

04/19 **MINUTES OF MEETING HELD ON 8 OCTOBER 2018:**

The minutes of the meeting held on 8 October 2018 were approved as a correct record.

05/19 **ACTION LOG (items due this month)**

The action log was reviewed and updated accordingly.

68/18 - Equality and Diversity Workforce Metrics targets would be shared with the Committee at its meeting in May 2019.

81/18 – EST in year recovery plan would be shared with the Committee at its meeting in May 2019.

83/18 – CQC Post Inspection Action Plan to be updated and shared prior to the next meeting.

06/18 **QUALITY AND PERFORMANCE REPORT – WORKFORCE (DECEMBER 2018)**

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

AM provided an overview of main points of the report:-

Establishment/Turnover

- Establishment (FTE) reduced by 14.11 but the staff in post (FTE) decreased by 28.11, which led to vacancies (FTE) increasing by 14.00
- Turnover decreased to 8.94% in December 2018. The highest turnover remains within the Healthcare Scientists staff group at 10.67%. Turnover with Medical & Dental continues to decrease – currently at 8.82%.

Sickness absence (as at November 2018)

- In-month sickness absence increased to 3.80% in November 2018 from 3.65% in October 2018.
- The rolling 12 month position improved to 3.84%, equating to an average of 13.93 FTE days lost per FTE.
- Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 30.23% of sickness absence in November 2018, increasing from 29.54% in October 2018.
- The RTWI completion rate dropped to 62.50% in November 2018 from 66.67% in October 2018.

Essential Safety Training

- Performance has improved in 6 of the 9 core suite of essential safety training. Only Dementia Awareness is currently above the 95% target.

Appraisal

- Compliance for both non-medical and medical appraisals dropped in December 2018. For non-medical this is due to colleagues returning from long term sickness absence or maternity leave and not having an appraisal.
- The Medical Education Team have asked Clinical Directors to ensure all Medical colleagues are appraised before the end of March 2019.

Workforce Spend

- Substantive spend has increased by £0.05M in December 2018.
- Bank expenditure has increased in December 2018, up £0.04M from November 2018.
- Agency spend decreased significantly to £0.61M in December 2018 from £1.06M in November 2018.

Employee Relations

- There were 63 open cases at the end of December 2018. This is a significant increase from the 23 reported last month. This is due to HR Advisers now recording absence management cases on ESR.

Recruitment

- The time to inform recruitment is no longer a reported metric on Trac. This has been replaced on the Workforce Performance report by a new metric, the average number of days from the date a vacancy was authorised to the actual start date.
- All 4 of the other recruitment metrics reported improved in December 2018.

HB queried the lower establishment figure against the planned figure. JE confirmed that the Trust will not deliver its vacancy projection as reported to NHSI. Figures will be clearer at the start of the next financial year as Calderdale and Huddersfield Solutions data had been included in the original plan.

HB confirmed the time to hire had improved and there was discussion if this was the same position across all vacancies. It was agreed to look at individual staff groups.

The Committee expressed concern regarding the worsening position of RTWIs. MA reported there is confusion in terms of the recording procedure for RTWIs. It was confirmed RTWI recording is via ESR only. JE confirmed clarification would be issued as a as a priority.

HB raised an issue in terms of contractual notice periods. It was noted that CHFT has shorter notice periods than other West Yorkshire trusts. JE confirmed work will be undertaken to compare the Trust's position.

Discussion took place about the challenges in meeting EST target figures. The HR BPs continue to work with Divisions to support the recovery of compliance rates. JE advised that an activity plan for 2019/2020 is in the process of being designed with full participation of Divisional colleagues. This will be shared with Executive Board in March 2019. Fire safety training is a particular concern, it was noted alternative methods of delivery are being pursued.

ACTIONS:

- Refresh advice and guidance to ensure clarity about recording instructions for RTWIs **(AM)**
- Identify actions to drive an improvement in the Trust's RTWI compliance rate **(AK/HRBPs**).
- Compile an analysis of comparative employment contractual notice periods from WYAAT Trusts **(CN)**
- Explore 'time to hire' performance for individual staff groups **(CN)**

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

07/19 **WORKFORCE DATA DEEP DIVE: EMPLOYEE RELATIONS**

AM presented to the Committee detailed data with regard to disciplinary, grievance and bullying and harassment cases.

48 disciplinary, grievance and bullying and harassment cases were opened in 2018. Six of these remain open in a process. The deep dive captured data at divisional level, staff groups, gender, ethnicity, sexual orientation, disability, age and religion.

KH suggested it would be useful to identify outcomes in grievance, bullying and harassment cases to understand if there is any learning from individual cases. HB was also interested to see cases linked to staff survey results.

The Committee requested to see year on year data to be brought to the last quarter Committee meeting.

JE confirmed that Nicola Hosty will commence in post as the Freedom to Speak Up Guardian/Equality, Diversity and Inclusion Manager on 25 March 2019. Improvement in visibility and recognition of the importance of these matters may result in an increase in reported bullying and harassment cases.

KH commented that colleagues may express a view via exit interviews rather than choose to go through a formal process.

ACTIONS:

- Provide a year on year trend report **(AM)**
- Include outcome data **(AM)**
- To consider triangulation of staff survey results **(AM)**

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

08/19 **ASSURANCE ON SICKNESS ABSENCE AND RETURN TO WORK INTERVIEWS**

Specific Corporate areas were requested to attend the meeting to provide assurance

THIS

MG reported a December 2018 sickness absence percentage of 3.7% (0.67% ST and 3.03% LT). One of the 3 LT absence cases have since returned to work. January's figures are expected to have improved.

RTW Interviews in December were at 84.2 %. MG reported a difficulty had been supporting agile workers in the field. A closer management project has now been implemented with support of the HR BP.

Central Operations

DM provided an overview of the current position. An increase in both short-term and long-term sickness absence had been recorded. A hot spot in one area of the overall team was noted along with the reasons. DM outlined the actions being taken to address sickness absence such as adhering to absence policy, Occupation health input, regular 1:1s, ensuring annual leave is managed appropriately and checking data for accuracy.

RTWI were at 69.2% in December. The worst performing areas had been highlighted. DM confirmed session with the E-Roster team on how to record had taken place.

Workforce and OD

JE reported sickness absence at its highest since May 2018. January figures show ST at 1.31% and LT at 2.02% (3.33% overall). Currently zero cases of LT absence. Hot spot areas have been identified.

RTWI in December reported at 60%. Worst performing areas identified.

JE confirmed that the Directorate reviews its workforce metrics at a monthly forum.

Quality

DM reported sickness absence in December at 3.5% (ST at 0.36% and LT at 3.14%). It was noted this is the lowest sickness absence since January 2018. Hot spot area identified, which is a team of 5. Immediate response was the issue of additional IT equipment to help carry out the role. JM confirmed that a deep dive is to be undertaken in the Directorate to better understand the position in order to deliver significant improvement.

RTWI in December reported at 66.7%. Worst performing areas identified.

Finance
GB reported sickness absence in December at 2.37% (ST at 1.49% and LT at 0.88%). Currently zero LT absence. To note the last 6 months of data is purely in relation to Finance colleagues due to the establishment of Calderdale Solutions and the split of Procurement colleagues.

GB commented on themes of sickness absence, in particular stress and anxiety. It was recognised that an organisation called Advisor Plus will shortly commence sessions with the Trust focussing on colleague mental health and wellbeing.

RTWI reported at 100%.

ACTIONS:
- To conduct a deep dive into sickness absence for the Quality Directorate **(JM/DM)**

OUTCOME: The Committee **NOTED** and **SUPPORTED** the responses to workforce issues.

09/19 **QUARTERLY ESCALATION FROM PRMs**

Essential Safety Training
This item was discussed above in agenda item 06/19.

Return to Work Interviews
This matter was discussed above in agenda item 06/19.

10/19 **CQC POST INSPECTION ACTION PLAN**

This item was deferred to the next meeting.

ACTION:
- To update the CQC action plan **(CW)**

11/19 **OD STRATEGY (THE CUPBOARD) UPDATE**

RM provided an update of the progress in the creation of the strategy. RM described how colleague feedback from IIP interviews, Staff Surveys, Hot Houses and Tea Trolleys have contributed to the 'recipe cards' of the strategy. It was noted the Strategy is being developed as a web-based product.

RM presented the video recording of the 7 December 2018 OD Kitchen event. The video was well received by the Committee.

RM confirmed the Strategy would be submitted to the 7 March 2019 Board of Directors meeting with a planned go live date of 1 April 2019. A communications plan is currently being worked up.

ACTIONS:
- To share the ED&I recipe card and test its relevance/coverage **(RM/AS)**
- Arrange a meeting between AS and Nicola Hosty as part of induction programme **(TR)**

OUTCOME: The Committee **SUPPORTED** the OD Strategy.

12/19 **ANY OTHER BUSINESS**

There were no items to discuss.

13/19 **MATTERS FOR ESCALATION**

There were no matters for escalation.

14/19 **DATE AND TIME OF NEXT MEETING:**

8 April 2019, Review Quality & Performance Report – Workforce,
11.30am – 12 noon, DR 2, Learning Centre, HRI

8 April 2019, Hot House,
12.30pm – 2.30pm, Discussion Rooms 1 & 3, Learning Centre, HRI

23. Date and time of next meeting

Thursday 2 May 2019, 9:00 am

Venue: Boardroom, Huddersfield Royal Infirmary

To Note

Presented by Philip Lewer