Public Board of Directors

Schedule	Thursday, 3 Jan 2019 9:00 — 12:00 GMT
Venue	Large Training Room, Learning Centre, Calderdale Royal Hospital
Organiser	Amber Fox

Agenda

9:00	1.	Welcome and introductions: Jude Goddard – Observer Rosemary Hedges - Observer Renee Comerford - Patient Story Dr Sue Crossland (Item 12 – GMC Survey 2018) Presented by Philip Lewer	1
9:01	2.	Apologies for absence: Richard Hopkin Suzanne Dunkley (Ruth Mason in attendance) Presented by Philip Lewer	2
9:02	3.	Declaration of Interests	3
9:03	4.	Minutes of the previous meetings held on 1 November 2018 & 6 September 2018 (highlighted change to be approved) Presented by Philip Lewer	4
		PUBLIC BOD MINUTES - 1.11.18 v2.docx	5
		FOR APPROVAL - PUBLIC BOD MINS - 6.9.18 v3.docx	17
9:08	5.	Action log and matters arising	30
		APP B - ACTION LOG - BOD - PUBLIC - as at 1 November 2018.pdf	31
9:13	6.	Chairman's Report Presented by Philip Lewer	33
9:18	7.	Chief Executive's Report Presented by Owen Williams	34

10:38	15.	Review of Progress against Strategy For Review - Presented by Victoria Pickles	128
10:48	16.	Quality & Performance Report – November 2018 To Note - Presented by Helen Barker	129
		QUALITY & PERFORMANCE REPORT .pdf	130
		Integrated Performance Report - Nov 18.pdf	132
10:58	17.	Governance Report 1.Board Skills / Competencies 2.Risk Management Strategy 3.Use of Trust Seal 4.Attendance Register 5.Board meeting dates 6.Board to Ward visits feedback To Approve - Presented by Victoria Pickles	143
		GOVERNANCE REPORT - JANUARY 2019 .pdf	144
		COMBINED BOARD SKILLS AND COMPETENCIES SELF ASSESSMENT TEMPLATE - 2018-19.pdf	147
		Risk Management Strategy 2019-2020 (FINAL) (4) 24 12 18.pdf	150
		8-18 - 31.8.18 - CHFT & CHS Shareholders Agreement.pdf	195
		9-18 - 31.8.18 - CHFT & CHS Operated Healthcare Facility Agreement.pdf	196
		10-18 - 10.9.18 - Lease of First Floor Offices at Lister Lane Surgery.pdf	197
		11-18 - 02.10.18 - Renewal Lease of Oak House.pdf	198
		12-18 -12.12.18 - Pennine Property Partnership and CHFT - Agreement to Vary the Contract .pdf	199
		13-18 - 21.11.18 - Renewal Lease of Oak House - 2nd floor.pdf	200
		ATTENDANCE REGISTER - 1.4.18 - 31.3.19.pdf	201
		Board of Directors Meetings - Future Dates.pdf	202
		BOARD TO WARD VISITS - JULY 2018 TO AUGUST 2018 V1.pdf	203

11:08	18.	2019-20 Capital Plan Overview To Note - Presented by Gary Boothby	211
		Planned capital expenditure 2019_20.pdf	212
		2019-20 Capital Plan overview for Board.pdf	214
11:18	19.	Financial Summary - Month 8 To Note - Presented by Gary Boothby	218
		Finance Headline Message - Month 8.pdf	219
		Finance Headline Message - Month 8 - Appendix - Trust Board Financial summary Month 8.pdf	221
	20.	2019-20 Annual Plan To Note - Presented by Gary Boothby	223
11:28	21.	Update from sub-committees and receipt of minutes & papers •Quality Committee – minutes from meeting held 29.10.18 and verbal update from meeting held 3 December 2018 (Linda Patterson) •Finance and Performance Committee – minutes from the meeting 30.11.18 (Phil Oldfield) •Charitable Funds Committee – minutes from meeting held 28.8.18 and 29.11.18 (Philip Lewer) To Note	224
		FINAL Quality Committee Minutes (29 Oct 2018) (Approved 3 Dec 2018).docx	225
		APP A - Draft Minutes of the FP Committee held 301118.docx	236
		Charitable Funds Minutes 28 August 2018.docx	242
		Charitable Funds - Minutes of previous meeting - DRAFT - Appendix - Minutes 29 November 2018.pdf	245
	22.	Date and time of next meeting Thursday 7 March 2019, 9:00 am Venue: Boardroom, Huddersfield Royal Infirmary	248

1. Welcome and introductions:

Jude Goddard – Observer

Rosemary Hedges - Observer

Renee Comerford - Patient Story

Dr Sue Crossland (Item 12 – GMC Survey 2018)

Presented by Philip Lewer

2. Apologies for absence:

Richard Hopkin

Suzanne Dunkley (Ruth Mason in attendance)

Presented by Philip Lewer

3. Declaration of Interests

4. Minutes of the previous meetings held on 1 November 2018 & 6 September 2018 (highlighted change to be approved)

Presented by Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

DRAFT Minutes of the Public Board Meeting held on Thursday 1 November 2018 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
Richard Hopkin	Non-Executive Director
Jackie Murphy	Chief Nurse
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development
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
Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director – Digital Health
Stuart Baron	Associate Director of Finance
Joanne Machon	Matron, Outpatients (Presenting a patient story)

OBSERVERS

Paul Butterworth	Public Elected Governor
Sian Grbin	Staff Elected Governor
Peter Bamber	Staff Elected Governor

144/18 Welcome and introductions:

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

Outpatients Patient Story

Jo Machon, Matron for Outpatients shared the story of a vulnerable patient who had experienced difficulties in accessing an outpatient appointment. Jo described multiple issues relating to transport, transport staffing, and appointment administration. In the end, the management team worked together to find a positive outcome for the patient.

As a result of this patient story, the following actions have been identified:

- Vulnerable patient alert to be explored in the Electronic Patient Record (EPR)
- Transport bookings are being reviewed
- Solutions to identify when appointments are cancelled and need to be re-booked
- Closer working with GPs to understand their involvement of care, this could help identify when patient problems or referrals no longer exist
- Flags in EPR for missed or cancelled appointments due to transport

It was highlighted that all of this learning would be incorporated into the work being done to transform outpatient services. The Managing Director for Digital Health highlighted this could be used as a case study for digital technology. The Director of Transformation and Partnerships added the Outpatient Transformation Programme will

be in Trust news this week looking for expressions of interest for using technology and bariatric consultants have expressed an interest. Linda Patterson asked if the Trust is looking into at the opportunities around domiciliary visits. The Chief Operating Officer agreed to review domiciliary visits to see what is possible. Alastair Graham added telephone consultations would also be another opportunity.
Action: Chief Operating Officer – Domiciliary Visits Consultation

145/18 Apologies for absence:
There were no apologies for absence.

146/18 Declaration of Interests
The Executive Director of Workforce and Organisational Development, Associate Director of Finance and Alastair Graham declared an interest in item 162/18, Calderdale and Huddersfield Solutions Ltd Update.

147/18 Minutes of the previous meeting held on 6 September 2018
The minutes of the previous meeting held on 6 September 2018 were approved as a correct record subject to the amendments below:

- CPE wording to be revised with the Executive Medical Director
- To confirm the Freedom to Speak Up role is being covered in the interim by the Executive Director of Workforce and Organisational Development

148/18 Action log and matters arising
The action log was revised and updated accordingly.

149/18 Chairman's Report
The Chair updated the Board on the work he has been involved in since the last meeting. The key highlights were:

- Meeting with the governors on a 1-1 basis continues
- Attended the NHS North East and Yorkshire Region Dinner hosted by McKinsey & Company on 16 October. He highlighted that he had completed a declaration in relation to the hospitality he received at the event and this was below the allowed amount
- Attended the League of Friends Annual General Meeting on 26 September
- Attended the Allied Health Professional open days
- A recent meeting took place with the local town councillors in Todmorden regarding Abraham Ormerod funds
- Attended Celebrating Success Marketplace judging event

150/18 Chief Executive's Report

a. West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding
The Chief Executive confirmed that the Memo of Understanding approved by the Trust Board on 6 September has now been finalised across West Yorkshire and Harrogate.

OUTCOME: The Board **SUPPORTED** the final West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding

The Chief Executive explained he had been invited to an event alongside the Executive Medical Director and Deputy Chief Nurse to discuss the long term plan for the NHS which is being co-produced between NHS England and NHS Improvement. The long term plan includes a commitment for £20.5 billion of additional money over the next five years into the NHS, with 3.9% growth targeted to the front line. There is a further requirement for funding of around 4%. In addition, social care funding needs an equivalent growth of 4%. The outcome of the meeting was to feedback on 3 elements, 1. Integrated care, 2. Workforce and 3. Productivity.

Andy Nelson asked if there was a requirement of capital funding. The Chief Executive responded there was no separation between capital and revenue funding and further work is required to understand the reality on capital.

Karen Heaton asked if one of the Board strategy events will focus on the long term plan. The Board will review where there is overlap and where there are disconnects at a future strategy event.

Richard Hopkin asked for feedback from the Chief Executive's meeting with the Minister for Health. The Chief Executive confirmed who was in attendance and explained it was a productive discussion regarding out of hospital care. There was acceptance that status quo was not an option and acceptance of a new model being discussed. It was agreed that certainty regarding capital funding is required prior to further scrutiny of the services.

151/18 Quarterly Quality Report (Q2)

The Chief Nurse presented the Quality report for quarter 2. The key points were highlighted in the presentation. She highlighted that the Trust had won a National Award at the Nursing Times on 31st October 2018 for end of life care

Q2 Draft Presentation Quality I

Linda Patterson assured the Board the detailed reporting goes through Quality Committee and is being monitored closely.

Alastair Graham welcomed the national award which helps palliative care delivery through A&E and introduces care plans to ensure patients can be transferred to most appropriate place of care.

Andy Nelson added that the report shows encouraging progress and asked what support is needed in terms of improving the complaints process. The Chief Nurse responded there are three elements that require support;

1. Complaints process
2. Better use of the Electronic Patient Record (EPR)
3. Resources, including making first contact with the complainant to understand the issues that need to be addressed

It has been identified that colleagues need support to have these difficult conversations which results in a backlog of complaints.

Linda Patterson confirmed a lot of this work is been taken up through performance management which is led by the Chief Operating Officer.

OUTCOME: The Board **APPROVED** the Quarter 2 Quality Report

152/18 Board Assurance Framework

The Company Secretary explained the Board Assurance Framework (BAF) is in a transitional phase and work is taking place nationally and regionally to understand if they are truly effective. She highlighted that the Trust had received good feedback on the Board Assurance Framework from the CQC this year.

The BAF was discussed at the Audit and Risk Committee and comments have been fed into the procedure document and BAF overall. The procedure describes how the Trust

uses the BAF and ensures it goes through the correct governance.

Richard Hopkin added as part of the summary review, the Audit and Risk Committee are expecting feedback from internal audit in terms of benchmarking the BAF. Internal Audit has reviewed 23 BAF's from different organisations and is having discussions with the Good Governance Institute.

Alastair Graham suggested there are three potential additional risks for the BAF, which are;

1. Failing to embrace digital technology, the Trust can tell a story on how this risk is being mitigated
2. Equality and Diversity – to reach different parts of the community and equality of access
3. Brexit – how Brexit might have an effect in terms of staffing and management of medicines

The Chief Executive confirmed Equality and Diversity is included in the strategy on a page.

Andy Nelson suggested risk 2.17 on the BAF describe scan for safety, vascular and the conversations with Leeds Teaching Hospitals regarding spinal and dermatology.

The Executive Director of Finance explained the ongoing work to understand the potential risk around Brexit. The Trust has been asked to respond to the regulators by 30 November on things to consider, which includes all contracts. There is lots of engagement with pharmacy colleagues and clinical leads. The Chief Executive confirmed Brexit is on the Trust's risk register.

The Company Secretary met with the Head of Governance and Risk last week to cross-check the risk register with the BAF. There was a conversation around the Brexit risk which is currently not on the high level risk register. If this is a long term strategic risk, it will need to sit on the BAF or be re-scored on the risk register.

Andy Nelson asked if there could be a way of improving the tracking of actions on the BAF risks. The Company Secretary explained a different layout is being introduced to include this.

Andy Nelson made a suggestion that the list of questions in appendix 3 should be used as preparation for the Board workshop. This will be taken forward and a shorter list of key questions will be developed for testing through the year.

OUTCOME: The Board **APPROVED** the Board Assurance Framework subject to the changes above.

153/18 High Level Risk Register

The Chief Nurse presented the High Level Risk Register for approval.

7324 (25) – The Chief Operating Officer explained the risk around healthcare waste collection is over scored and a further meeting is taking place this week with a suggestion to confirm the score of this risk in the meeting. The Chief Executive explained there is still a risk around mitigation and asked if a Quality Impact Assessment is in place.
Action: Chief Operating Officer to confirm if a QIA review is in place

Andy Nelson and the Executive Director of Finance have discussed whether the EPR risk is a discrete risk and the benefits should be reviewed as a separate item. There is further discussion whether to build this into the long term financial planning narrative. Phil Oldfield confirmed a paper will be brought back to Finance and Performance Committee

and will report back to Board in March with a further push to drive the benefits.

Richard Hopkin explained an annual review of risk management arrangements was discussed at the Audit and Risk Committee with a review of the high level risk register. The Committee were content there has been fair movement on the high level risk register with 15 new risks and 20 closed risks between November 2017 and September 2018.

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

154/18 Risk Appetite Statement

The Risk Appetite Statement was first approved in November 2016 in line with good practice from the Good Governance Institute and compares with other organisations.

The risk appetite has been reviewed in May and July and will be utilised going forward against risk and strategy in the Board Assurance Framework.

Richard Hopkin highlighted the new partnership risk which was discussed in the workshop. The Board committed to assign this risk appetite as high.

The Chief Executive explained the response to the business case needs to be reflected under Innovation / Technology and will be picked up at Finance and Performance Committee in January 2019.

OUTCOME: The Board **APPROVED** the Risk Appetite Statement

155/18 Winter Plan

The Chief Operating Officer presented the winter plan which has been developed based on learning internally and externally from winter 2017. All divisions have contributed and brought forward proposals. The winter plan compromises of internal winter funding and integrated care funding for West Yorkshire.

The winter plan has had final sign-off at the Urgent Care Board following a thorough review and is due to be presented to the A&E Delivery Board.

The Chief Operating Officer thanked all operational management colleagues who have committed to a double rota to support an increase in frailty services on-site management support. This will be in place from Boxing Day to the end of January 2019.

To date the Yorkshire Ambulance Service (YAS) winter plan has been received. The two local authority winter plans and Locala plans have not been yet been received and are due to go to the A&E Delivery Board in 2 weeks' time. It will be formally escalated if these are not received. The Chief Operating Officer confirmed the local authorities have been provided further funding for winter, £900k for Calderdale Local Authority and £1.8M for Kirklees Local Authority (revenue). The Chief Executive confirmed this is part of the £240m funding made nationally.

A table top exercise will take place in the next 2 weeks. Karen Heaton highlighted staff handled the pressures really well last year and asked if there will be a joined up approach with partners who were slow to respond. The Chief Operating Officer explained the Multidisciplinary Accelerated Discharge Event (MADE) is completed twice weekly as of 1 November with colleagues from partner organisations. The Trust approved staffing on 31st July and went out to advert on 1st October.

The Chief Nurse asked if providers hold each other to account. The Chief Operating Officer explained they have worked with the A&E Delivery Board on this; however, the changes on holding to account might not be felt during winter.

Alastair Graham highlighted mandatory training is being put on hold during the month of January to respond to winter pressures and suggested a phased approach through the winter period January – March.

Action: Chief Operating Officer to review and update Board members with conclusion

The Chief Executive asked that the Board support of the recommendations subject to receiving assurance from partner winter plans. The Chief Executive asked if the Trust management agreed to have no routine inpatient operating in the last quarter which will have patient consequences. The Chief Operating Officer confirmed this was agreed in annual planning.

Capacity management has been reviewed at Weekly Executive Board to assess how often it has been problematic in the last 12 months. The Trust will need to link systems to business continuity as the digital agenda increases. The Chief Operating Officer explained the ECG will further complement the plan; however, the Trust needs to ensure there are mitigations if the roll out doesn't go satisfactory. The Managing Director for Digital Health explained the Trust learned a lot from the clock change and how robust the business continuity plans were.

The Chief Executive and Executive Medical Director shared feedback from the FY1s during the planned 90 minute downtime. The Chief Operating Officer agreed to pick this up as part of business continuity feedback and planning.

The next Board will receive an update on Christmas activity and briefings will be circulated and received from other partners.

OUTCOME: The Board **SUPPORTED** the winter plan subject to partner organisations plans being signed-off

156/18 Gosport Report

In June 2018 NHS Improvement wrote to all NHS Trusts seeking assurance that none of the old style syringe drivers were still in use. The Trust took immediate action and confirmed there are none within the organisation. The report looked into a series of incidents which occurred 27 years ago at Gosport War Memorial Hospital where a total of 450 patients died and 200 patients were affected.

Of the 8 NHS Improvement assurance areas, 6 are compliant with good assurance and 2 are limited - Freedom to Speak Up lead, which will shortly be addressed and scrutiny of high usage areas of controlled drugs.

Internal audit were asked to review 20 cases on the utilisation of the individualised care of the dying process. This learning is being driven through the End of Life Care Group, led by the deputy Chief Nurse.

A learning from deaths summit, led by Sal Uka, Associate Medical Director took place on 12 July 2018 and will look at how to make these improvements. The detail is reported into the Quality Committee.

OUTCOME: The Board **NOTED** the Trust's actions in response to the Gosport report

157/18 Care Quality Commission (CQC) Report

The Chief Nurse presented the CQC report which was published on 20 June 2018. There are 23 must do and 40 should do actions. A total of 14 must dos were related to the community place and have been shifted to should do actions for the community division as the service that was inspected is no longer in operation.

Two of the must do actions are in relation to emergency department ligature risks. The

Chief Nurse explained progress to addressing the actions was being escalated to ensure it is completed by the end of next week.

Linda Patterson confirmed the CQC report has been reviewed in detail at the Quality Committee. She explained that the Chief Operating Officer and Chief Nurse have worked hard with divisions to get the must dos completed. There was an agreement if a must do is not completed it is added to risk register.

Alastair Graham asked how the Trust is getting medical staffing to the recommended state as the answer will be reconfiguration. The Executive Medical Director stated the CQC are expecting movement; however, it is difficult to see a way forward. The A&E requirement is 20 and at the moment there are 10-12. There was acknowledgement from the Executive Medical Director that the issues is not funding but is availability of staff. He assured the Board there are no clinical incidents arising due to these issues.

Karen Heaton raised concerns about the number of amber must do actions and suggested setting realistic deadlines from the offset. The Chief Nurse agreed the lessons had been learned about the need to hold to account to these deadlines.

The Chief Executive explained the regional Head of the CQC had attended the Weekly Executive Board for a sharing and reflecting session to consider how the Trust will move to the next level.

ACTION: Chief Nurse - Update at next Board in January 2019

OUTCOME: The Board **NOTED** the CQC Report and **SUPPORTED** the process for managing actions

158/18 Learning from Deaths – Quarter 3 Report

The Medical Director presented the Learning from Deaths report and assured the Board that the Trust is in line with other Trusts and is exceeding the national requirements.

The process for initial screening reviews is being revised and Phil Oldfield expressed caution so that certain specialities are not overloaded in completing reviews which are allocated in their job plans.

There have been 79 deaths escalated for a structured judgement review in the last 12 months.

Richard Hopkin highlighted the percentage of initial screening reviews is 31% and the target is 100%. Richard asked if the Trust is assured specialities completed their own reviews. The Medical Director stated the ambition was right at the time and the metrics have improved and learning is consistent. As a result, the target has been reduced slightly with the ambition to review as many deaths as possible. There is more confidence with consultants reviewing a death in their speciality and not allowing a consultant with primary responsibility of the patient to review the death. The Medical Director explained there isn't a requirement to complete the screening reviews that are being implemented.

OUTCOME: The Board **APPROVED** the Learning from Deaths Q3 Report

159/18 Quality & Performance Report – September 2018

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

The key highlights from the report were:

- Overall slight improvement on August position, maintained amber or green all year to date
- Have had one never event relating to oxygen, there will be an external review

- Continuing with ward decamp programme for infection control, the Chief Operating Officer would like to thank staff for managing this
- Stroke performance dipped in August, a recovery action plan is now in place and have seen an improvement in September
- Performance against cancer targets remains challenging, this has been escalated and aim to see improvement in November
- ECS remains a challenge particularly in Huddersfield impacted by an increased number of patients from Wakefield; the figure for October was 90.31%

Andy Nelson asked if the Trust can comply with a lower nursing fill rate. The Chief Nurse explained this is set by national guidance and is driven by acuity and dependency on ward and the requirement to care for patients safely. The Trust has recently appointed 6-8 nurses from overseas. The Trust is also going to look at Nursing Associates (Health Care Assistants) who are looking at stepping up in their career and there is a strategy of developing this.

The West Yorkshire and Harrogate extract from the Integrated Operational report published in September 2018 by NHS England is available in the reading room in Convene. This was a request by the West Yorkshire Association of Acute Trusts and will be provided monthly.

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

160/18 Car Parking

The Associate Director of Finance presented the proposals for car parking which aims to improve access to car parking. This has previously been discussed at Weekly Executive Board, Council of Governors and the Staff Management Partnership Forum.

The paper identifies actions to address car parking changes, in particular at Calderdale and includes a proposal to increase availability of car parking at Broad Street.

The Board are asked to approve phases 1 and 2 with the changes to the public car parking increase to be in effect from January 2019. A further paper will be brought back in March 2019 to address phases 3 and 4 following staff engagement.

Alastair Graham clarified this is the first increase following a 2 year freeze which brings the Trust in line across West Yorkshire.

Karen Heaton suggested a phased increase for the public, e.g. 10p increase from January and 10p increase in July. The Associate Director of Finance responded the increase will be in one go from January.

Andy Nelson asked for clarity on how staff are allocated permits. The Chief Executive confirmed the priority is of staff with patient facing contact, the Senior team are unable to use priority car parks and access is tiered to reflect this need. Part of the staff engagement is to review priority passes and car parking permits. It was noted clinical waste has affected parking by a significant number of car parking spaces, particularly at Calderdale Royal Hospital.

Linda Patterson stated she did not support raising public parking charges as she feels it is already high. Linda recommended freezing public changes and to go forward with the other changes. There being no seconder, the proposal was not voted upon.

The Chief Executive clarified the Trust have been at the lower end in terms of car parking charges and are now moving towards a benchmarking level.

Paul Butterworth shared his views which were the public should not pay when they are unwell; therefore, car parking charges should not be increased. Paul feels staffing charges are unfair and those on the bottom end of the pay scale pay 1.5% of their salaries and those on the top pay scale pay .3%. Paul said this is unfair and biased towards the highest paid staff and was surprised senior staff have not declared an interest.

OUTCOME: The Board **APPROVED** phase 1 and 2 and the consultation for phase 3 and 4 will come back to the Board in March 2019 following staff engagement

The Chief Executive advised colleagues to share their views on phases 3 & 4 before it is presented to Board.

161/18 Month 6 Financial Summary

The Executive Director of Finance highlighted the following key points:

- The deficit was £24.31m
- There is a risk to the forecast position, deficit of £44m rather than £43m; therefore, recovery plans are being developed with colleagues
- There are schemes at high risk, in particular, project echo
- Month 6 is the first month where medical agency spend is in trajectory and total nursing spend is within budget

OUTCOME: The Board **NOTED** the Month 6 Financial Summary

162/18 Calderdale and Huddersfield Solutions Update

a. Novation Report

To provide assurance that suppliers would continue to provide support to the Trust following the creation of Calderdale and Huddersfield Solutions Ltd, the novation report described the process the Trust took in writing to suppliers. The Trust continued to receive supplies from clinical suppliers and there has been no clinical risk.

Phil Oldfield highlighted there are 1200 suppliers and asked if there was rational for the supply base. The Executive Director of Finance explained the Trust have tried to rationalise in terms of agencies which will form part of the procurement strategy. Andy Nelson echoed the challenge of supply base.
Action: Executive Director of Finance to report back to F&P Committee on rationalising the supply base

OUTCOME: The Board **NOTED** the CHS Update and Novation Report

163/18 Medical Services Reconfiguration Update

The Chief Operating Officer presented an update on the Medical Services reconfiguration 10 months into the significant change across both sites. The key highlights from the report were:

- Positive improvement against KPIs
- Moved to a cardiology consultant of the week rota
- Cardiology service has also implemented a full 7 day working for clinical teams
- Review of elderly care is underway to early identify patient needs, concern only 40% of patients receive a comprehensive geriatric assessment, re-admission in frailty is being further investigated
- Respiratory, which saw a larger increase in number and acuity of patients were able to flex to cover 5D
- Previously the Trust had quite poor feedback from the deanery and it is anticipated this will improve in the next report
- Overall, a smooth reconfiguration which was clinical led and has now moved to business as usual, this will be the final update to Board

Phil Oldfield asked if the financial impact could be articulated for any future reconfigurations. The Chief Operating Officer confirmed the reconfiguration delivered financial benefits which are reported through safer.

The Chief Executive asked if the Trust have identified a shift in mortality death rates by site, given the shift on elderly medicine on the HRI site.
Action: Chief Operating Officer to look at mortality data

Alastair Graham highlighted this as a success story and gave credit to the engaged clinicians who suggested the change and the delivery of their own solutions.

OUTCOME: The Board **NOTED** the Medical Services Reconfiguration Update

164/18 Care of the Acutely Ill Patient

The Medical Director presented an update on care of the acutely ill patient. The key updates were:

- Acute Kidney Injury (AKI) and Sepsis continue to be prioritised for evidence-based care bundle improvement work
- The Deteriorating Patient Group has had a refresh with a new set of terms of reference to deliver in the digital age

Linda Patterson made a suggestion the Care of the Acutely Ill Patient update is monitored in detail through Quality Committee and doesn't come to Board, with Linda taking responsibility. Phil Oldfield added the Board have seen significant improvements and should only report back as an exception. Andy Nelson and Richard Hopkin seconded this decision.

OUTCOME: The Board **NOTED** the update on Care of the Acutely Ill Patient

165/18 Guardians of Safe Working Hours Report

The Medical Director presented the Guardians of Safe Working Hours report on behalf of Anu Rajgopal, Guardian of safe working hours. There has been an improvement with admin support now available. The key points to note were:

- There is now a process to address exception reports
- Feedback has been received from Jr Doctors in a survey on work conditions
- Rota gaps have been identified as detailed in the report
- No fines have been levied in this quarter, the total revenue raised from previous fines is £1,200, this will be used in consultation to enhance the junior doctor experience at CHFT
- Attendance at the Junior Doctors Forum remains poor; however, those in attendance are well engaged

OUTCOME: The Board **APPROVED** the Guardians of Safe Working report

166/18 Update from sub-committees and receipt of minutes & papers

<u>Audit & Risk Committee Terms of Reference</u>

Richard Hopkin confirmed the terms of reference have been updated as per the other Committees and there are no fundamental changes.

OUTCOME: The Board **APPROVED** the revised Audit and Risk Terms of Reference

<u>Audit & Risk Committee – minutes from meeting 17.10.18</u>

Richard Hopkin, Chair of the Audit and Risk Committee provided an update from the last meeting, the main areas to bring to the Boards attention were:

- New system for declarations of interest system, the Trust aims to have the new

system in place and rolled out in advance of the appraisal season for 2019/20
- The Trust's Declaration of Interest policy has been updated in order to ensure it is compliant with NHS England's new guidance
- Internal audit - good progress has been made in terms of overdue with 4% outstanding, there were 8 reports in total, 5 with significant assurance, 3 with limited assurance (Gosport report still in draft, incident reporting), overall progress was positive
- Concern around control of overtime and how staff are claiming, fraudulent activity is being investigated and approval of overtime is under scrutiny

Quality Committee – minutes from meeting 1.10.18

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

- The last meeting received a report on Sepsis which is showing good progress, the screening and collaborative work is progressing
- Safeguarding report was received, there is an issue to be concerned about regarding legislation which is due to change, this will cause an issue around mandatory training
- Safeguarding flagged that the Board need to be aware of any issues sectioned under the Mental Health Act that are incorrect – SLA report will be shared which highlights an error being made by Junior Doctors
- The Chief Executive raised the safeguarding concerns in the public media relating to a child exploitation case in Kirklees and asked the Board receive a report about how Calderdale and Huddersfield services are responding

Finance and Performance Committee – minutes from the meeting 28.9.18 and verbal update from meeting 30.10.18

Phil Oldfield, Chair of the Finance and Performance Committee gave feedback from the meeting held 30 October 2018. The key highlights were:

- Reviewed budgetary control, 30 interviews took place with budget holders around accountability versus responsibility, follow up session scheduled 13 November
- Update on CNST – premiums £118m per year, claims paid or settled total £146m, premiums are allocated centrally
- £800k rebate received on maternity systems
- The Trust were successful in challenging an overinflated claim which went to court, resources required will be scoped and feedback will go to Weekly Executive Board and F&P Committee in an effort to be more proactive in managing claims
- Dave Thomas attended F&P Committee 10 months ago to review the Cost Improvement Programme (CIP) and there were 37 recommendations, Dave will be asked to re-attend
- Presentation provided to F&P Committee will be shared on "What might make us fiscally unique?"

Council of Governors meeting – minutes were received from the meeting held 18.10.18

Workforce Committee - minutes from meeting 8.10.18

Karen Heaton, Chair of the Workforce Committee provided a verbal update from the last meeting, the key points to note were:

- Annual Library Strategy was signed off for the first time
- Deep Dive took place on sickness absence with Divisional Reps present
- Reviewed fire safety essential training and a number of recommendations and actions were agreed
- Deep Dive on Equality and Diversity took place in October with a rep with a protected characteristic

Any Other Business

Andy Nelson has been invited to attend Medicine's Performance Review Meetings which is a closer look at the real issues and provides more assurance.

The Associate Director of Finance requested the Board to delegate approval to the Executive Director of Finance to approve the submission of an application for grant funding for installation of LED across CRH and HRI on behalf of the Trust. The application is for c£2.5m with estimated annual savings of c£0.5m. If successful, this could replace a previously approved 0% loan for LED. The outcome of the submission is anticipated to be on 11 January 2019.

Date and time of next meeting

Thursday 3 January 2019, 9:00 am

Venue: Large Training Room, Calderdale Royal Hospital

Calderdale and Huddersfield NHS Foundation Trust

DRAFT Minutes of the Public Board Meeting held on Thursday 6 September 2018 at 9am in the Large Training Room, Calderdale Royal Hospital

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Dr David Anderson	Senior Independent Non-Executive Director
Gary Boothby	Executive Director of Finance
Alastair Graham	Non-Executive Director
Richard Hopkin	Non-Executive Director
Jackie Murphy	Chief Nurse
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development
Dr David Birkenhead	Executive Medical Director

IN ATTENDANCE

Amber Fox	Corporate Governance Manager (minutes)
Victoria Pickles	Company Secretary
Anna Basford	Director of Transformation and Partnerships
Lesley Hill	Managing Director – Calderdale and Huddersfield Solutions Ltd (CHS)
Bev Walker	Associate Director of Urgent Care (representing Helen Barker)
Peter Keogh	Assistant Director of Performance (Items 135/18 and 136/18)
Ian Kilroy	Resilience & Security Manager (Items 130/18 and 131/18)
Katie Berry	Quest Nurse - Community Health Service (Item 127/18 - Patient Story)

OBSERVERS

Paul Butterworth	Public Elected Governor
Sian Grbin	Staff Elected Governor

120/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and informed the Board it was Dr David Anderson's last Board meeting. The Chair formally thanked David on behalf of the Board for his commitments at the Board and his role as Senior Independent Non-Executive Director.

The Chair also advised the Board is was Lesley Hill's last Board meeting as she moves over to Calderdale and Huddersfield Solutions Ltd. The Chair formally thanked Lesley who had been on the Board since 2006 for her ongoing commitment in this capacity and the Board will look forward to working with Lesley in her new capacity.

121/18 APOLOGIES FOR ABSENCE

Apologies were received from:
Helen Barker, Chief Operating Officer
Mandy Griffin, Managing Director – Digital Health
Karen Heaton, Non-Executive Director
Andy Nelson, Non-Executive Director

122/18 DECLARATIONS OF INTEREST

Alastair Graham and the Executive Director of Workforce and Organisational Development and the Managing Director for CHS declared an interest in the Calderdale and Huddersfield Solutions update (item 139/18).

123/18 MINUTES OF THE PUBLIC MEETING HELD 5 JULY 2018

The minutes of the previous meeting held on 5 July were approved as a correct record subject to the following amendment:

Page 8 – Phil Oldfield***** provided an update from the Finance and Performance Committee.

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

124/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

The action log was updated and amended accordingly.

125/18 CHAIR'S REPORT

Annual General Meeting Minutes

The Chair referenced the minutes from the Annual General meeting held on 19 July 2018 that have been circulated. The Chair formally thanked Owen Williams for responding open and honestly to all the questions that were raised. The Executive Director of Finance responded to a number of questions that were raised that were in relation to performance and are now resolved. The Board were assured all questions raised at the Annual General meeting were answered.

Council of Governors Elections

The Chair shared the Council of Governors election results that were ratified at the Annual General meeting on 19 July. The Chair is meeting with all of the governors to discuss the role of the governor and has so far met with all of the new governors and stakeholder governors. The Chair also met with Cllr Shabir Pandor, Leader of Kirklees Council and has asked Kirklees Metropolitan Council to identify a councillor to sit on the Council of Governors as a stakeholder.

The Chair informed the Board he is meeting with all the Chair's across West Yorkshire and is sharing minutes from various forums with the Board for information.

The Non-Executive Directors time commitments are being reviewed to proportion the time commitments given, as the Trust loses a Non-Executive Director at the end of September 2018.

The Chief Executive pointed out the Board is effectively smaller by 2 roles and asked if the Trust need to alert our regulators or amend the constitution. The Company Secretary confirmed the regulators are already aware and the constitution will not need to change as it sets the maximum, not the minimum. The Chief Executive explained the Trust will need to be mindful of Non-Executive and Board capacity at future Workshops.

126/18 CHIEF EXECUTIVE'S REPORT

Response to the Secretary of State

The Chief Executive confirmed a special Board meeting was held on 2 August 2018 to discuss the proposal for submission to the Secretary of State and Commissioning Groups (CCGs). The remaining risk has been communicated to our regulators.

The Chief Executive reported that an agreement has been made with the regulators and CCGs as part of the covering letter, which references the fiscal amount and the ongoing risk regarding the site.

The Director of Transformation and Partnerships drew attention to the Public Calderdale and Kirklees Joint Health Scrutiny Committee taking place on 7 September where there will be representation from all respondents regarding the proposals, including NHS England and NHS Improvement. The Director of Transformation and Partnerships and the Executive Medical Director will be in attendance. Officers of both councils have also been invited to

attend in reference to the Council's response. In addition the Trust continues to engage with stakeholders and Local Medical Committees.

The Chief Executive informed the Board he has been invited to a meeting with the Health Minister with the local MPs, the CCGs and the Lead for the Integrated Care System taking place in London next week.

127/18 PATIENT/STAFF STORY

Flu Campaign Patient Story Video
The Chief Nurse invited the Board to watch a patient story from a staff member, Katie Berry, who had received her flu immunisation last year and subsequently became very ill. In the video Katie explained that she felt the vaccine had prevented her from developing more severe symptoms. Katie is very eager to share her message to raise awareness on the effects of the flu and the importance of receiving the flu vaccine which is prudent before the Flu Campaign starts.

https://www.youtube.com/watch?v=NYRUa1UrQik

Katie Berry explained the effects of the flu and how it deteriorated very quickly and how it felt like an acute asthma attack or chest infection. The Executive Medical Director stressed it is a devastating illness where lives can be lost.

The Board were very moved by the video and the Chief Executive highlighted the Flu Campaign has been successfully led by occupational health with support from nursing colleagues; however, acknowledged the Trust can do more. The Chief Executive asked for permission from Katie Berry to use this film as much as possible.

The Board formally thanked Katie Berry for sharing her story.

OUTCOME: The Board **RECEIVED** the patient story video and **NOTED** the upcoming Flu Campaign.

128/18 HIGH LEVEL RISK REGISTER
The Chief Nurse presented the High Level Risk Register which describes risks of the highest scoring (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

Two new risks have been added to the risk register at a risk score of 15:

1. Risk 7280 relating to unnecessary repeat blood specimen collection from the Family and Specialist Services risk register was approved as a new high level risk at the July Risk and Compliance Group at a risk score of 15.
2. Risk 7251, from the Surgery and Anaesthetics division risk register relating to patients with eye disease receiving a poor patient experience and delay due to Optovue OCT machines not functioning was approved as a new high level risk at the August Risk and Compliance Group at a risk score of 15. A business case is being developed.

Risk 6596, relating to not conducting timely investigations into serious incidents has reduced in score from 16 to 12 which removes it from the High Level Risk Register.

Alastair Graham asked for clarity on risk ownership for estates related risks and if these should be owned by Calderdale and Huddersfield Solutions. It was noted that each of these risks are being worked through to identify the appropriate Trust lead.

Risk 6903 Estates/Resus, HRI - Alastair Graham asked if the mechanical ventilation can take place in advance of October 2019. The Managing Director for CHS explained the ventilation can't take place without the full refurbishment. Alternative options are being explored for

resuscitation by the Managing Director for CHS and Associate Director of Urgent Care. A paper will be brought to WEB in a few weeks' time to determine the capital. The date for completion will be next Summer.

Dr David Anderson asked for an update on risk 7078 regarding emergency medical staffing. The Executive Medical Director explained the inability to appoint is a national problem due to the shortage of A&E doctors.

Richard Hopkin asked if there has been any significant improvement on risk 6895 regarding the financial IT systems. The Director of Finance confirmed there have been improvement in the way invoices are processed; however, the risk is still in the system as whilst glitches are resolved, new ones are emerging. An action plan will be brought to Executive Board next month.

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

129/18 WINTER PLAN 2018-19

The Associate Director of Urgent Care commenced her presentation by explaining a more detailed update will be provided at the next Board following detailed discussions at the A&E Delivery Board.

Winter Plan 2018-19 Presentation.pptx

Linda Patterson commended the Trust in managing to maintain performance last winter and highlighted lessons that should be learned and shared from this experience. Linda highlighted senior decision makers were asked to support upfront with all hands on deck and there is evidence this reduces admissions. The engagement of senior clinical staff and leadership is vitally important in the support of winter pressures.

The Chief Executive asked how the Board are assured there are plans in place to respond to the pressures this winter. The Associate Director of Urgent Care explained the winter plan is monitored weekly at performance meetings and meetings take place with senior managers to review patients on an individual basis. Phil Oldfield suggested this could be picked up during Board to Ward visits. Alastair Graham referenced the capacity issues and performance has always been challenging.

Sian Grbin informed the Board another Trust use single clerking in A&E which reduced waiting times from 8 hours to 4 hours. The Board welcomed receipt of this information to see if anything can be learned. It was agreed that Sian should contact colleagues in A&E to consider this further.

130/18 RESILIENCE & SECURITY MANAGEMENT FINAL REPORT

The Managing Director for CHS welcomed Ian Kilroy, Resilience & Security Manager and described the huge amount of work that has been put into Resilience and Security Management; including the establishment of the resilience and security management group. It was noted that the Trust lead for this work going forward would be the Associate Director of Urgent Care.

Ian Kilroy presented the report which describes where the Trust were to now. As part of the action plan, Strategic Leadership in Crisis (SLiC) development courses have been arranged for Director and Senior on-call manager groups and e-learning dynamic packages are now available for the on-call management team.

Ian Kilroy reiterated the amount of work undertaken by each Trust annually to comply to be a category 1 responder.

A Security Strategy is now in place which is still in the development stage and includes topics such as lone working, lock down, CCTV and keeping patients safe.

Richard Hopkin who is involved in the Security and Resilience Governance Group reported there has been good representation across the organisation and the team has made a lot of progress in terms of the strategy. The organisation has moved significantly over the last 6 to 9 months.

Alastair Graham asked if cyber security is part of the strategy. Ian responded confirming two table top exercises had taken place on cyber security and this is an ongoing journey.

The Executive Director of Workforce and Organisational Development previously came from a local authority and recognised further work needs to take place in terms of staff wearing badges and lock down. Ian Kilroy re-assured the Board they are looking at developing 'act' action for counter terrorism and agreed further work will be picked up in this Group.

OUTCOME: The Board **APPROVED** the Resilience & Security Management Final Report.

131/18 LOCAL HEALTH RESILIENCE PARTNERSHIP (LHRP) CORE STANDARDS

Ian Kilroy, Resilience & Security Manager was in attendance to present the Local Health Resilience Partnership Core Standards.

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

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

OUTCOME: The Board **APPROVED** the Local Health Resilience Partnership (LHRP) Core Standards.

132/18 DIRECTOR OF INFECTION, PREVENTION AND CONTROL QUARTERLY REPORT

The Executive Medical Director presented the quarterly DIPC report. The key updates were:

- 1 case of MRSA so far, 5 in total last year, this is a single case with little that could've been done to prevent
- C.difficile figure is higher than last year and breaching targets, the rolling 12 months doesn't show a drop in c.diff and all have been sporadic cases and are not linked
- MSSA bacteremia has reduced to 2 cases opposed to 10 at this point last year
- Carbapenemase Producing Enterbacteriacea (CPE) are Gram negative bacteria which are resistant to most and sometime all antibiotics. They are more common in certain parts of the world and in parts of the UK than West Yorkshire. There are concerns that the incidence of CPE is increasing and all patients are risk assessed and screened if necessary.
- Ongoing problems with isolating patients in a timely fashion due to wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling

Linda Patterson asked if the Antibiotics Policy which is being reviewed could assist with electronic prescribing, for example entering a stop date. The Executive Medical Director advised if a stop date is entered it will stop antibiotics review when it is appropriate. Entering

review dates should help; however, electronic prescribing has been in place historically and the audits on antibiotic compliance are good. Walk-rounds are undertaken by the microbiologist where EPR can facilitate with this. The Executive Medical Director confirmed a combination of work on antibiotics is underway.

OUTCOME: The Board **APPROVED** the Quarterly DIPC Report.

133/18 WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP MEMORANDUM OF UNDERSTANDING

The Company Secretary presented the Memo of Understanding which is being developed across West Yorkshire. All organisations within the partnership are being asked to approve the MoU during September 2018. The purpose of the MoU is about a commitment to work in partnership across West Yorkshire and Harrogate and does not change any governance arrangements.

By further developing understanding of mutual accountability and decision making as an ICS, we must achieve greater clarity in the relationship between 'the Partnership Board, System Leadership Executive Group and System Assurance & Oversight Group, especially the flow of information between them.

We strongly support the invitation for a provider chair to take on the role of Vice Chair of the Partnership Board. This would help shape the future development of partnership working to ensure all voices are heard.

Becoming an ICS is a journey so WYAAT recommends that the MoU should be reviewed within the first year to ensure that it is fit for purpose in the context of the NHS 10 year plan and as our thinking on mutual accountability and ICS decision making develops. It should be reviewed at least bi-annually thereafter.

Alastair Graham highlighted peer reviews and suggested it would be interesting to see what we might put forward. The Company Secretary explained this can be picked up as part of the workshop discussions.

OUTCOME: The Board **APPROVED** the West Yorkshire And Harrogate Health And Care Partnership Memorandum Of Understanding.

134/18 GOVERNANCE REPORT

a. Constitutional Changes

The Company Secretary explained as part of the setting up of Calderdale and Huddersfield Solutions Ltd, robust discussions took place regarding staff that are members of the Trust and have transferred into the new company. At the Council of Governors meeting, the Governors recommended staff that have transferred across retain their right of being a staff member with the same Terms and Conditions; however, new staff don't become a staff member as they will be on new Terms and Conditions. There was an agreement the Trust routinely publicise that these staff can become a public member of the Foundation Trust.

The Chief Executive asked for the rationale behind the decision. The Company Secretary explained the governors felt it was set up as a new company that is not part of the Trust. The Board highlighted the Wholly Owned Subsidiary is owned by the Trust and therefore everyone should be included as staff members. A special Council of Governors meeting took place in July for a broader debate as the Council of Governors has the right to approve or make amendments to the Constitution. The Chair acknowledged there was a split view from the governors and the solution came following a suggestion from the lead governor. The Chair highlighted upon meeting with some governors, a number of governors are comfortable offering staff membership.

The Chief Executive highlighted the importance of staff engagement and making people feel part of the Trust, and that we would still expect CHS staff to work to the Four Pillars of behavior.

The Chair clarified that both parties need to approve the alterations to the constitution and if it is not approved at Board, a joint meeting will be arranged of the Board and the Governors. The Board agreed there is a need for clarity on the reason behind the decision.

OUTCOME: The Board **DID NOT APPROVE** the alterations to the constitution; therefore, a **JOINT MEETING** will take place of the Board and Council of Governors.

b. Deputy Chair / SINED Appointment

The Company Secretary proposed the recommendation for Phil Oldfield to continue as Deputy Chair and take on the role as Senior Independent Non-Executive Director.

The Freedom to Speak Up Guardian was picked up in the CQC report and was suggested this role is not a Non-Executive Director in terms of visibility; therefore, the Director of Workforce and Organisational Development has developed a job description and will appoint into this role. The appointed Freedom to Speak Up Guardian will network with the Freedom to Speak Up ambassadors across the Trust. The Freedom to Speak Up role is being covered in the interim by the Executive Director of Workforce and Organisational Development .

OUTCOME: The Board **APPROVED** the appointment of the Deputy Chair and Senior Independent Non-Executive Director and **NOTED** the update on the Freedom to Speak Up Guardian.

c. Use of Trust Seal

The use of the Trust Seal in the last quarter was shared. A total of 4 documents have been sealed in the last quarter and were in relation to lease assignments for the Well Led Pharmacy.

OUTCOME: The Board **RECEIVED** the use of the Trust Seal in the last quarter.

d. Board Workplan

The updated Board Workplan was circulated and if there are any additions, the Board were asked to contact Amber.Fox@cht.nhs.uk or Victoria.Pickles@cht.nhs.uk.

OUTCOME: The Board **RECEIVED** the updated Board Workplan.

135/18 QUALITY & PERFORMANCE REPORT – JULY 2018

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

The key highlights from the report were:

- July is a positive month with the Trust achieving 70% for the first time and are aiming to achieve 75% by September which would result in a green position
- The **SAFE** domain has slipped to amber due to a Category 4 pressure ulcer and EDS below target
- The **CARING** domain is almost green with both Community FFT targets being achieved
- **EFFECTIVE** is green although fractured neck of femur and E-coli missed target
- The **RESPONSIVE** domain remains amber although Stroke missed 3 out of 4 targets – all key cancer targets have been achieved for 7 out of the last 9 months
- In **WORKFORCE** there was a small dip in Essential Safety Training hence overall reduction for the domain
- Within **EFFICIENCY & FINANCE** Agency usage and CIP deteriorated in-month

alongside Theatre utilization
- The model hospital page has been replaced by key indicator performance
- Infection Control figures for MRSA and preventable c.diff will be up to date next report due to being late reported for June

Linda Patterson commended the Trust on cancer performance. Linda also explained that Surgery and Medicine Divisions had been invited to the Quality Committee in July to look at their complaints handling. As a result Surgery has introduced different processes which have improved the complaints response time. There is less assurance from Medicine who will learn from Surgery to introduce different processes. A further update has been requested in 3 months to monitor progress. The Chief Nurse also provided assurance Community and Family and Specialist Services Divisions now have no backlog in complaints. There was acknowledgment Medicine receive a large volume of complaints; therefore, the Assistant Director for Quality and Safety and the complaints team are supporting the Medicine Division and expect to see an improvement.

Alastair Graham asked where the Trust is in terms of fire safety. The Director of Workforce and Organisational Development explained that historically, fire safety has been delivered to 12 people at a time and that the approach has now been altered and training will be delivered in a lecture theatre approach to capture a wider audience. At the moment, the Trust only has one Fire Officer who can deliver fire training, this specific training requires an accreditation and would come at a cost. A train the trainer opportunity will be considered; however, the Trust is trying to better use resources. Each Division have been asked to share their actions plans to achieve 95% in fire safety.

Phil Oldfield attended the Medical Division Performance Review meeting and highlighted that there was greater clarity required over the actions being taken to address operational and financial performance.

Paul Butterworth raised discussions that took place at Quality Committee with regards to responses going out to complainants. Paul described the complaints process for CHFT and highlighted all findings and responses are to be reviewed by a Senior Divisional Manager and Executive Director. Paul raised his concern and asked the Board to consider why this isn't being picked up in the review before responses go out.

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

136/18 **DATA QUALITY ASSESSMENT**

Peter Keogh updated the Board on the outcome of the Data Quality Assessment. The Intensive Support Team (IST) has reviewed the assessment tool populated by CHFT and subsequently met with Trust senior managers to discuss this in more detail; this report provides a summary of key areas requiring further action. It was noted that CHFT has a clear focus and good understanding of its Data quality issues. An upgrade to the patient administration system in May 2017 and associated actions has required additional resource which has been supported by CHFT, providing evidence of the Trust's hard work to ensure the transition was as smooth as possible, reflecting a positive and proactive approach. The Trust has assured NHS Improvement (NHSI) that we have the capability and capacity to take forward the recommendations in this report. This is being done through the attached action plan. The Trust has also agreed to run the tool every 6 months internally and have an NHSI assessment of this annually.

Peter explained CHFT continues to report on Referral to Treatment Times month on month following the introduction of an Electronic Patient Record.

An action plan is in place on the back of the Data Quality Assessment which will continue until March 2019. The red areas are being addressed at the Data Quality Group and Data Quality Board.

OUTCOME: The Board **RECEIVED** and **NOTED** the Data Quality Assessment.

137/18 **ANNUAL FIRE REPORT**

The Managing Director for CHS explained the Trust has made progress over the last 12 months in terms of fire safety; however, there is further work to implement to ensure compliance.

The annual fire report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2017/2018 in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum – Managing Healthcare Fire Safety.

Fire safety advice, support and training is provided by the Fire Officer who resides within the Estates and Facilities Division. The Trust is working on ensuring a fire warden is on every shift on a ward.

Space utilisation continues to be a challenge with the requirements to move departments rapidly resulting in missed opportunities to check adequate fire precautions / compartmentation / fire alarms are in place for the change of use. Often fire risk assessments are not considered before the move has taken place.

The lack of resources and facilities to repair fire doors has created a backlog of work; however, a new workshop at Huddersfield Royal Infirmary has been built and a revised workforce model should see staff allocated to fire door maintenance.

An audit is being undertaken on Fire Risk Assessments to provide assurance. Alastair Graham asked if a summary of this audit can be received at Board to understand if there are any issues that the Board need to address.
Action: Managing Director - CHS

Richard Hopkin raised the limited amount of capital resources and asked if the fire enforcement notice received years ago is no longer in place. The Managing Director for CHS confirmed the fire enforcement notice is no longer in place and advised the Trust are not at risk of another. The Trust has agreed to make improvements as part of ward upgrades; however, all ward upgrades have not yet completed. As a result, additional training has taken place to mitigate this risk and all mitigations are assessed by the authorised engineer for fire.

Paul Butterworth raised concern regarding the number of fire doors that are wedged open on his ward visits.

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

138/18 **MONTH 4 FINANCIAL SUMMARY**

The Director of Finance presented the highlight summary.

- The year to date deficit is £16.51m, in line with the plan submitted to NHSI
- Clinical income is below plan by £0.68m. The Aligned Incentive Contract (AIC) is now protecting the income position by £0.56m in the year to date (£0.51m at Month 3), see Appendix 1 for detail
- CIP achieved in the year to date is £3.54m against a plan of £3.78m, a £0.24m shortfall
- Agency expenditure remains £0.13m beneath the agency trajectory set by NHSI
- Current position is heavily reliant on releasing reserves, need to improve income trajectory
- The forecast is to achieve the planned £43.1m deficit; this relies upon full delivery of the £18m CIP plan including high risk schemes, there are significant risks in the Cost Improvement Programme (CIP)
- The Aligned Incentive Contract (AIC) protection remains at Trust level but has not extended

significantly in-month; however, the differential position by division has moved considerably. Surgery division is now being adversely impacted by the AIC whilst Medical division position includes £0.60m additional income under the AIC than the operational position would justify
- The risk of delivering the finance position is currently rated at a 12, this is being reviewed.
- Recovery plans have been requested from all Divisions, this does not provide full assurance

The Chief Executive recommended the recovery process by Divisions is reviewed or help is sought to look at things differently to improve the position.

The Director of Transformation and Partnerships suggested the issue is lack of understanding on the AIC. There was discussion Medicine are reporting on plan and forecasting by year end at M4, yet un-delivering on the aligned incentive value. The Chief Executive explained he would seek further assurance on the depth of understanding of this position with Divisions.

139/18 CALDERDALE AND HUDDERSFIELD SOLUTIONS UPDATE

The Executive Director of Finance provided an update on Calderdale and Huddersfield Solutions Ltd. A Board meeting was convened in private on 23rd August where a number of contractual documents were considered and approved with delegated authority given to sign the documents which took place on Friday 31st August.

The Managing Director for Calderdale and Huddersfield Solutions Ltd informed the Board the Subsidiary became operational on 1st September and 420 staff were TUPE transferred across. Induction week is taking place this week with all transferred staff. The transition plan is in place and will be going to the CHS Board later this month. The Memorandum of Understanding between CHS and CHFT allows six months for the service level agreements and key performance indicators to be in place and ensure governance arrangements are fully established. Moving forward, three monthly updates will be provided to Board. The Joint Liaison Committee between the Trust and CHS is being set up and the terms of reference are to be developed.

The Managing Director for CHS formally thanked the Project team, external advisors and the Executive Director for Finance (client side) for all of their hard work and support in setting up the Subsidiary.

Alastair Graham re-iterated the tight timescales and gave credit to all involved. Alastair informed the Board Airedale went live with their Wholly Owned Subsidiary on 1st March and Alastair met with the Chair of their subsidiary, these meetings will continue.

The Chair informed the Board the meeting on the 23rd August was very valuable and views were well represented, including external representation. The Chair passed on thanks to all who were involved and the governors will be contacted to make them aware that all views were heard.

140/18 REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF

The Executive Medical Director presented the annual report which updates the Board on the position regarding revalidation and appraisal of non-training grade medical staff as at the end of the revalidation and appraisal year (31st March 2018). The responsible officer for the Trust's management of medical appraisal and revalidation is the Executive Medical Director.

The key points were highlighted:

- As at 31st March 2018, 338 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 331 on 31st March 2017)
- In the 2017/18 revalidation year (1st April 2017 – 31st March 2018) 49 non-training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 20 non-training grade medical staff in 2016/2017

- Based on headcount, 94.7% of non-training grade appraisals were completed and submitted in the appraisal year (93.5% in 2015/2016)
- 5.2% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust, maternity leave, recent return from secondment etc.), this compares to 5.5% in 2015/2016
- Overall a good performance compared to peers

OUTCOME: The Board **APPROVED** the Revalidation and Appraisal of Non-Training Grade Medical Staff Annual Report.

141/18 WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT

The Executive Director of Workforce and Organisational Development presented the WRES action plan which outlines the progress which is managed at the Workforce Committee.

The key areas highlighted from the report were:

- Overall the Trust has 15.2% of its workforce from a BME background compared to 14.6% in the previous year
- The report for this year shows that there have been small decreases in non-clinical BME staff in AfC Bands 3, 5, 8a/b/c, 9, and VSM
- In the category classed as `under Band 1' (mainly apprentices) a significant decrease of BME staff, moving from 50% in March 2017 to 22.2% in March 2018
- Substantial increases have been seen in Band 1 (+19.4%) and Band 8d (+25%).
- An action plan has been developed to address issues and inclusive recruitment panels are being introduced
- Accountability of the action plan will sit with the Workforce Committee and will be received annually at the Board and quarterly at Quality Committee

The Board recognised that the Workforce Race Equality Standard needs to be higher on the agenda; as a result, the Executive Director of Workforce and Organisational Development will work with Board members to champion actions and extend invites to the Disability and LGBT Forum.

Action: Executive Director of Workforce and Organisational Development

OUTCOME: The Board **NOTED** the WRES report and action plan.

142/18 QUALITY OF APPRAISALS

The Executive Director of Workforce and Organisational Development presented the Quality of Appraisals report which was previously received at the Executive Board.

The key points highlighted were:

- The Trust achieved 96.2% for appraisals at the end of the season
- The 2017 NHS staff survey results showed a score of 2.99 out of 5 for the quality of appraisals, this is lower than the national average of 3.11
- 1 hour appraisal workshops have taken place to focus on productive conversations – 139 managers have attended
- A dedicated appraisals page on the intranet has been viewed 22,959 times during this year's appraisal season
- The Workforce and Organisational Development team will be carrying out SWAT checks on live objectives

The Executive Director of Finance suggested there appears to be some areas where appraisals are undertaken better and asked if there is some learning to take on board.

Paul Butterworth raised discussions taken place at Quality Committee regarding a matter of unfairness whereby not all staff had received incremental payments when they had not undertaken an appraisal. Paul felt all staff should be treated equally and should be paid the

incremental payment. Paul asked if there is a plan in place to ensure staff only receive increments once they have undertaken essential training and a quality appraisal moving forward. The Executive Director of Workforce and Organisational Development agreed to discuss this matter with Karen Heaton.

In response, the Executive Director of Workforce and Organisational Development confirmed the Trust did not fully communicate the new policy in relation to performance appraisal, mandatory training and increments. As a result, there was a risk of inconsistency being applied by managers. This manifested in a small number of staff that received increments when they should not have or had increments refused when this had not been applied by other managers. These incidents were escalated and swiftly dealt with by the Human Resources team meaning that all staff received their increment last year.
Action: Executive Director of Workforce and Organisational Development

143/18 UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES

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

a. Audit & Risk Committee – minutes from meeting 11.7.18

Richard Hopkin highlighted there is an ongoing review of the Board Assurance Framework and a formal event is taking place in October to receive feedback from Audit Yorkshire. The previous Audit and Risk Committee were asked to approve the process of signing off the annual reference costs submission to regulator. The Committee challenged this and asked for additional assurance from internal audit whereby as a result the Committee felt confident to approve. The Executive Director for Finance explained this was a new requirement of NHSI and he followed up locally to ensure that the Trust is not an outlier on this process.

The Audit and Risk Committee are making process on overdue actions from internal audit reports and hoping the reduction will continue.

b. Quality Committee – minutes from meeting 2.7.18 & 30.7.18

Linda Patterson informed the Board a report on Looked After Children and an annual report of serious incidents with a focus on complaints was received at the last Quality Committee. There was also an update received on pressure ulcers and falls.

The Gosport report will be received at the next Board meeting.

c. Finance and Performance Committee – minutes from the meeting 29.6.18, 31.7.18 and verbal update from meeting 31.8.18

Phil Oldfield provided an update from the Finance and Performance Committee and explained discussions took place around cash management and how to recover debt.

d. Charitable Funds Committee – minutes from meeting 28.8.18

The Chair attended the last Charitable Funds Committee to receive an overview of the investment portfolio. There was challenge from Phil Oldfield about investment split from areas. Cllr Megan Swift was in attendance at the meeting. The draft annual report and accounts were received and a review of the risk register took place. An update was provided regarding the flood work in Todmorden and the Chair has agreed to meet with the staff who have received these services. The staff lottery was reviewed with challenge from the Executive Director of Finance about how this is used.

e. Council of Governors – minutes from meeting 4.7.18 & 19.7.18

A joint meeting will be organised with the Board and Council of Governors.

f. Workforce Committee - minutes from meeting 10.07.18

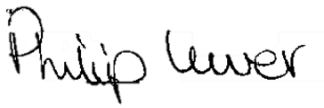
The minutes of the previous Workforce Committee were received.

OUTCOME: The Board **RECEIVED** the minutes and verbal updates from the relevant Sub-Committees.

DATE AND TIME OF NEXT MEETING
The next public meeting was confirmed as Thursday 1 November 2018 commencing at 9.00 am in the Large Training Room, Calderdale Royal Hospital.

The Chair closed the public meeting at 11:58 am.

Approval of Minutes



…….. 1 November 2018 ……..

Chair **Date**

5. Action log and matters arising

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 November 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED AT BOD MEETING	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
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 – slide	January 2019		
1.11.18 155/18	**WINTER PLAN** To confirm the plan for essential training during winter months: i. Phased approach Jan – March ii. On hold during January	HB	Essential Training will not be scheduled for areas involved in front line urgent care for January as per the plan; therefore, not expecting any change.	January 2019		19.11.18
1.11.18 153/18	**HIGH LEVEL RISK REGISTER** 7324 – To confirm is a QIA review is in place for the clinical waste risk	HB		January 2019		29.11.18
1.11.18 144/18	**DOMICILIARY VISITS CONSULTATION** To investigate the domiciliary visits consultation and see what is possible for the Trust	HB		January 2019		
6.9.18 142/18	**QUALITY OF APPRAISALS** To discuss incremental pay when staff have not undertaken a quality appraisal and essential training with Linda Patterson.	SD		November 2018		1.11.18
6.9.18 141/18	**WORKFORCE RACE EQUALITY STANDARD (WRES)** Work with Board members to champion WRES actions and extend invites to the Disability and LGBT Forum.	SD		November 2018		1.11.18

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 November 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED AT BOD MEETING	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
6.9.18 137/18	**FIRE RISK ASSESSMENTS** A summary of the Fire Risk Assessments audit to be received at Board to understand if there are any issues that the Board need to address.	LH	Fire Risk Assessments are included in the papers under Matters Arising.	November 2018		1.11.18
5.7.18 117/18	**RECONFIGURATION UPDATE** Further review of the impact of the recent interim medical services reconfiguration to be brought back to Board in 3 months.	HB	On the agenda.	November 2018		1.11.18
5.7.18 110/18	**HIGH LEVEL RISK REGISTER** Decision to reduce the EPR financial risk to be reviewed. The wording for the longer term financial sustainability risk (#7278) as it refers to the control total.	GB / F&P Committee		November 2018		1.11.18
7.12.17 183/17	**PATIENT STORY** The COO advised that at the end of the quarter she would bring a paper to Board updating on winter planning arrangements and conversations with partners.	HB	A winter plan presentation was presented to BOD on 6.9.19. A more detailed paper will be received at the next BOD in November once it has been through A&E Delivery Board.	November ~~September~~ 2018		1.11.18
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		

6. Chairman’s Report

Presented by Philip Lewer

7. Chief Executive’s Report

Presented by Owen Williams

8. Patient Story shared by Renee Comerford (Frailty)

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

To Note

Presented by Jackie Murphy

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

CQC Action Plan Update 16.12.18

Rating	Must Do Actions	Difference
Delivered and sustained	0	=
Action complete	6	+3
On track to deliver	1	-2
Not progressing to plan/ no progress *	2	-1
Total	9	

*MD8 Critical Care: The trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards. Update: Briefing Paper to WEB 20.12.18.
*MD7 Urgent and Emergency Care: CRH and HRI The provider must remove ligature risks identified in key areas of the department. Work due to be completed week commencing 17.12.18.

Should Do Actions	Update due at Response Group	Red	Amber	Green	Blue	Total	Difference
Critical Care	Dec 18			5	1	6	=
Urgent and Emergency Care	Dec 18	1	4			5	=
Community	Jan 19		7	12		19	+4 Amber to Green
Corporate (inc UoR)	Jan 19		4	5		9	+3 Amber to Green
Maternity	Feb 19		2	6		8	+4 Amber to Green
Children and Young People	Feb 19		1	5	1	7	+3 Amber to Green +1 Green to Blue
Total		1	18	33	2	54	

* Note: 10 ‘Amber’ actions are due to become ‘Green’ by 31.12.18

10. 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, 3rd January 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 19 December 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The draft high level risk register has been reviewed by members of the Risk and Compliance Group at a meeting on 20 December 2018.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

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

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

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

The Issue:

The attached 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 19 December 2018.

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

iii. Details of movement during November and December 2018 which are detailed in the summary paper and include:

Four new risks have been added to the high level risk register as detailed below.

7338, risk score of 15, risk of incomplete electronic patient record due to "save" and "sign issue
6829, risk score of 16, insufficient capacity of the Pharmacy Aseptic Dispensing Service for parenteral medicines
3793, risk score of 16, delays in Opthalmology out patient appointments
5511, risks core of 15, risk of fire spread at HRI

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

7318, stone cladding on ward block 1 at HRI, Calderdale Huddersfield Solutions, CHS
6949, inability to deliver two site blood transfusion service, Family and Specialist Services division ,
6895, delivery of core functions of finance and procurement, Corporate division
7324, healthcare waste collections, CHS
7272, optiflow devices risk, Medical division

One risk has an increased score, with risk 7240, increased from a risk score of 16 to 20, risk of expenditure being above planned levels for the Surgery and Anaesthetics division

Next Steps:

The Risk and Compliance Group has commissioned work to review risks relating to equipment which will be presented to the Risk and Compliance Group in February 2019.

Consideration will also be given early in 2019 to any risks relating to the impact of Brexit.

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 3 Jan 2019 High Level Risk Register November - December 2018.pdf

High Level Risk Register Board Summary –November/December 2018

Risks at 19th December 2018

TOP RISKS

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

7278 (25) Longer term financial sustainability risk
6903 (20): Estates/Resus risk, HRI
7271 (20) HRI ICU collective infrastructure risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7240 (20): SAS Financial Risk

The Trust risk appetite is included below.

NEW RISKS

7338 Score (15) Corporate – Agreed at Risk and Compliance Group 21 November 2018
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. 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.

The following risks have been agreed as new risks at the Risk and Compliance Group on 19 December 2019.

6829 Score (16) Family and Specialist Services Division
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.

3793 Score (16) SAS
Risk of delays for patients on the pending list in Opthalmology 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.

5511 Score (15) Calderdale and Huddersfield Solutions
Collective Fire Risk - There is a risk of increased fire spread at HRI due to inadequate Capital Funding for refurbishment works 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 REDUCED SCORE

7318 Score 10 (↓15) Calderdale and Hudderfield Solutions Ltd
There is a risk to life and building due to the very poor fixing condition of the stone cladding on ward block 1 west elevation resulting in falling stone debris.

Score reduced from 15 to 10 due to the urgent cladding repair work has now taken place making safe. The remaining cladding around the HRI is covered under another risk

6949 Score 12 (↓15) Family and Specialist Services
Risk of the inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites

Score reduced from 15 to 12 as two more staff have joined the rota and training continues with other identified staff

6895 Score 12 (↓16) Corporate
Risk of inability to fulfil core functions of the finance and Ppocurement department due to IT Systems failure resulting in failure to meet statutory deadlines.

Score reduced due to additional temporary resource in place in accounts payable, senior level communication with the system supplier and systems optimisation plan

Score reduced from 16 to 12 due to technical improvements being made to the system by the third party provider and the department putting mitigating actions in place which have stabilised the risk

7324 Score 12 (↓20) Calderdale and Huddersfield Solutions
Risk that healthcare waste including infectious clinical waste, cytotoxic waste, sharps, anatomical waste and medicinal waste will not be collected from the Trust on a daily basis

Score reduced from 20 to 12 due to the safe management of waste on site and its safe removal for treatment has been running under contingency arrangements for 2 months and revised contractual arrangements are in place.

7273 Score 9 (↓15) Medicine
Optiflow devices risk

Score reduced from 15 to 9 due to Implementation of swap commenced with agreement from Fisher and Paykel to swap 19 current machines for AirVO2 machines

RISKS WITH INCREASED SCORE

7240 ↑20 (16) SAS

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

December 2018 –SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 19/12/2018

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
10/17	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
06/17	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing (JM)	=16	=16	=16	=16	=16	=16
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 Royal Infirmary (HRI)	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
09/17	7251	Keeping the base safe	Ophthalmology equipment risk	Divisional Director of SAS (WA)		!15	=15	=15	=15	=15
09/17	6299	Keeping the base safe	Medical Devices maintenance risk	Director of Finance (GB)	=12	=12	!16	=16	=16	=16
05/17	7309	Keeping the base safe	EPR NEWS 2 update Risk	Director of Nursing (JM)			!16	=16	=16	=16
05/17	7338	Keeping the base safe	Risk of incomplete EPR record	Director of Nursing (JM)					**!15**	=15
06/17	7315	Keeping the base safe	Out patient appointments capacity risk	Director of Operations, FSS (RA)			**!15**	**=15**	=15	=15
06/17	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (JM)						**!15**
06/17	3793	Keeping the base safe	Opthalmology follow up appointment capacity risk	Divisional Director of SAS (WA)						**!15**
09/17	5511	Keeping the base safe	Risk of fire spread HRI	Director of Finance (GB)						**!15**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
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	↑20	↑20
13/17	7169	Financial sustainability	Financial plan 2018/19	Director of Finance (GB)	↓12	=12	=12	=12	↑ 16	↑ 16
Performance and Regulation Risks										
	None									
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 19/12/2018

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation =7280 Unnecessary repeat specimen collection = 7251 Ophthalmology risk	= 6345 Nurse Staffing = 7078 Medical Staffing = 7271 ICU infrastructure	=7278 Financial sustainability
Likely (4)				=5862 Risk of falls with harm =7132 Patient scores in ED =7223 Digital IT systems risk =7248 Mandatory training =6299 Medical Devices maintenance risk =7169 Financial Risk =7309 EPR NEWS2 update !3793 Opthalmology capacity !6829 Pharmacy Aseptic Dispensing Service	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 HRI Resus estates risk =7315 Appointment Risk ↑7240 SAS financial risk
Possible (3)					= 6011 Blood transfusion process = 5747 Vascular /interventional radiology service !7338 EPR !5511 Collective Fire risk HRI
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

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

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

High Level Risk Register
December 2018 – risks scoring 15 or more

19/12/2018 16:41:03

NHS
The Health Informatics Service
Informing Healthcare

TRUST BOARD 3 JANAURY 2019

Risk No	Div	Dir	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Further Actions	Review	Target	Tolerate	RC	Exec Dir	Lead
7278	Corporate	Finance and Procurement	Jun-2018	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £43.1m (£19.9m variance from the 18/19 control total). This includes loss of access to £14.2m Provider Sustainability Funding (PSF). The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raises concerns regarding going concern and value for money. The Trust does not currently have an agreed plan to return to in year balance or surplus.	Working with partner organisations across WYAAT and STP to identify system savings and opportunities Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Development of Business Case for reconfiguration Development of 25 year financial plans in support of Business Case Finance and Performance Committee in place to monitor performance and steer necessary actions Aligned Incentive contract with two main commissioners. On-going dialogue with NHS Improvement	Pressures on capacity planning due to external factors. Competing STP priorities for resources Progression of transformations plans are reliant on external approval and funding Impact of national workforce shortages 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		December 2018 Long term Financial plan continues to be developed in conjunction with regulators and department of health.	Jan-2019	Mar-2019		FPC	Gary Boothby	Philippa Russell
2827	Medical	Emergency Care	Apr-2011	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocated trainees.	20 4 x 5	20 5 x 4	12 4 x 3		September 2018 update 5HSTs and 3 ST3's in post as well as 1FY3 working on the MG rota. 2 further Locum MG doctors converted to Bank contracts October 2018 update 2 long term agency locum MGs have withdrawn their services due to changes in pay process/rates. Apparent reduced availability of short term agency locums. Unsure if this is due to reduced pool of available doctors as a result of national squeeze on agency pay rates. November 2018 update Some ongoing difficulties in identifying locums to cover night shifts. Being filled, but at rates above proposed agency cap. Controls and gaps in controls updated December 2018 Further regular Agency MG paid above cap has agreed to join the bank within cap. Currently working through notice period.	Jan-2019	Mar-2019		WEB	David Birkenhead	Dr Mark Davies
5806	Calderdale and Huddersfield Solutions	Estates	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks identified within the Estates Risk Register being: • 7220 Flooring: cracked, torn, blown flooring screed and vinyl resulting in possible slips, trips, falls	The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. Each of the risks above has an entry on the risk register and details actions for managing the risk.Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	6 3 x 2		September 18 Update - Ward flooring replacement complete on Ward 3 and Ward 11. Ward 15 is now 50% complete. Main entrance Infrastructure now in progress and is due to complete in October. Work progressing on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient. October 18 Update - Ward flooring replacement complete on Ward 3, Ward 11 and Ward 15 Main entrance Infrastructure progressing and is due to complete in October. Work progressing on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient. December 18 Update - Main entrance Infrastructure replacement now complete. Work progressing on fire safety, water safety, infrastructure replacement etc. to ensure the HRI	Jan-2019	Feb-2019		RC	Gary Boothby	Paul Gilling / Chris Davies

					• 6734 Pipework: Potential of water borne diseases due to the corrosion of services pipe work • 6735 Structural: if more openings are made through the structure it will make the building unstable. • 6736 Air Handling Units: non-compliance, & increased infection risk to both patients and staff • 6737 Windows: all elevations of the Hospital require replacing, prone to leeks and very drafty • 6739 Roofs: water ingress through roofs resulting in decanting services, wards and departments. • 6761 Ward Upgrade Programmes: Compliance with regulatory standards - Health & Social Care Act • 6762 Day Surgery: Non-compliance with relevant HTM standards • 6763 Environmental Condition: failure to bring areas of the Hospital to a condition B level • 6766 Road Surfaces: South Drive and Tennis Court car park in need of repairs potential for injury to public • 6767 Staff Residences: Properties not statutory compliant for accommodation in regard to fire and utilities. • 6769 Electrics: Statutory compliance to reduce the risk of electric shock and damage to equipment • 6770 Plantroom: Statutory and physical condition of the plant room to H & S regulations • 6332 Asbestos: risk of industrial disease to staff, patients and general public • 6771 Emergency Lighting: Statutory compliance in order to provide adequate emergency lighting • 5963 Equality Act: non-compliance with the Equality Act 2010 due to a inadequate physical access • 6764 Fire Detection: aged fire detection could lead to inadequate fire detection. • 6860 Electrical 3rd substation HV supply only 1 meter apart • 5511 Fire Compartmentation: inadequate fire compartmentation in ceilings; risers and ducts. • 6897 BMS heating controls failure will result no control over heating or air condition throughout the hospital • 6997 Structural Cladding - Loose Portland Stone creating a hazard • 5630 Poor condition of the WCs in HRI's public areas • 6848 Water Safety: non-compliance to statutory law across HRI due to the ageing infrastructure						estate remains safe and resilient. Trials on alternative flooring installations now taking place.							
6345	Corporate	Workforce & Organisational Development	Jul-2015	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16 4 x 4	20 4 x 5	9 3 x 3		December 2018 Applicants from the International recruitment trip to the Philippines continue to progress (119 offers were made in country, since March 2017, with on-going training and tests underway), 8 Nurses have started with the Trust in 2018, with 5 started in September and 68 still engaged in the recruitment process. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has been amended to focus on one specialty. Adverts for surgery have continued and an advert specific to Oncology is advertising to trial a new approach to test whether an increase in application numbers can be seen. Applications are currently low but expected over the Christmas period. The approach will continue from January 2019.	Jan - 2019	Jan - 2019		WF	Jackie Murphy, Suzanne Dunkley	Paul Casson/Rachael Pierce

6903	Calderdale and Huddersfield Solutions	Estates	Dec-2016	Keeping the base safe	Resus - There is a collective risk in regards to Resus from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: Ventilation - potential danger to staff and patients from nitrous oxide due to the lack of background air changes resulting in harm . (The Trust has been advised by their external independent Authorising Engineer to install mechanical ventilation to the RESUS area to mitigate the risk.) Electrical Resilience – lack of support infrastructure/ Medical IT i.e. UPS/IPS to ensure continuity of power supply in the event of a power outage resulting in harm to patients Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases Medical Engineering Risk - 4 Dameca Anaesthetic Machines - failure due to end of useful life resulting in unplanned disruptions/ harm to patients Operational Safety – the current space within each bed bay does not meet the minimum required space for operational safety resulting in harm to patients and staff Compliance / Statute Law – All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law resulting in prosecution	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of RESUS, currently this is not achievable due to Capital budget constraints. Refurbishment requires decant for around 6 months, Operational Plans & activity currently do not permit this length of decant.	20 5 x 4	20 5 x 4	0 0 x 0		October 18 Update - Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. High level cost estimates are due this month to develop a modular unit at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. December 18 Update - High level cost estimates now received to develop a modular unit at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Jan-2019	Oct-2019		RC	Gary Boothby	Chris Davies
7078	Corporate	Workforce & Organisational Development	Oct-2017	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) "	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3		December 2018 Following the BMJ advert for consultants in October appointments have been made to Care of the Elderly, Urology and Anaesthetics at Consultant level. An interview has been organised for the Ophthalmology applicant in April 2019, and one of the applicants for the Care of the Elderly posts will be interviewed in February 2019 when they are eligible for appointment to a substantive post. A number of FY3 posts have been advertised to cover trainee gaps at a junior level from February 2019. The specialties include Paediatrics, Emergency Medicine, General Medicine, Trauma and Orthopaedics, General Surgery and Urology. The adverts close the first week in January so that there is ample opportunity for people to apply and to ensure that the Resident Labour Market test has been undertaken so that if visas are required we can apply without delays. The links for the FY3 posts have been sent to those individuals that we met at the BMJ Careers Fair who expressed an interest in this type of opportunity. The Medical HR team are working with a number of external companies to try and source Medical and Dental staff in difficult to fill areas. Whilst this does generate an introduction cost to the organisation the corresponding reduction in agency expenditure means that this is cost effective. The Medical and Dental Annual Leave Policy is almost	Jan -2019	Jan-2019		WF	David Birkenhead	Pauline North

											ready for ratification and it is anticipated that it will be ready for publication in January 2019. Further work is being undertaken to assess how each medical vacancy will be covered or recruited to, and to identify what has been tried to date so that an options appraisal can be undertaken about how the post is filled in the long term.						
7240	Surgery & Anaesthetics	All Directorates S&A	Apr-2018	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. December 2018 Division remains in weekly escalation with a rotation by Directorate. Recovery plans have been identified and the current month 8 forecast deficit stands at £1.7m. Improvement £0.4m 19/20 planning is currently underway which is focusing on the recurrent nature of the challenges faced for 18/19	Jan-2019	Mar-2019		DB	Mr Ainslie	Joanne Hardcastle
7271	Calderdale and Huddersfield Solutions	Estates	Jun-2018	Keeping the base safe	Intensive care unit (ICU) HRI - There is a collective risk in regards to the ICU from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: • Ventilation – Imminent failure of the ventilation system due to end of useful life resulting in potential danger to staff and patients • Electrical Resilience –UPS/IPS power failure resulting in harm to patients from no functioning equipment • Flooring – causing trips/falls and infection control hazards for staff and patients • Electrical Infrastructure - failure of infrastructure • Plumbing infrastructure - failure with resulting infection hazards for staff and patients • Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases • Building Fabric - infections & failure due to moisture ingress within the plaster/concrete within ICU resulting in poor environmental conditions. • Compliance / Statute Law – Compliance / Statute Law – Failure of equipment or infrastructure	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		September18 Update - Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. New discussions on how to maintain the Ponta Beams are taking place with the maintenance provider Draeger. October18 Update - Ponta beam medical gas hose replacement scheme business case due to go to CMG for request for funding. December 18 Update - Ponta beam medical gas hose replacement scheme business case was temporarily postponed until next financial year.	Jan-2019	Sep-2020		DB	Gary Boothby	Chris Davies

					could result in HSE intervention													
7248	Corporate	Workforce & Organisational Development	Apr-2018	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts. Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our 9 mandatory training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 mandatory subjects alongside the 41 essential skills. This approach strengthens the importance of completing the essential skills designated to specific roles and by combing the two areas into one enhances the Trusts' requirement to reach 96% across all the training offerings.	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16 4 x 4	16 4 x 4	4 4 x 1		October 2018 A paper went to the Workforce Committee meeting on the 8 October giving a detailed 3 year recovery plan for all 50 EST subjects. A weekly compliance update to EB will commence on 25 October 2018. November 2018 Weekly compliance updates continue to be submitted to EB. Demonstrative videos are on the intranet explaining how to check individual and team compliance. Compliance by division, directorate, staff group and organisation is now listed on the intranet. December 2018 Weekly compliance updates continue to be submitted to EB and these now include role specific training as well as the 9 core subjects. Additional face-to-face sessions are being arranged for Data Security Awareness, Health & Safety and Conflict Resolution. Videos are being planned with access to them on the intranet.	Jan-2019	Mar-2019		WF	Suzanne Dunkley	Claire Wilson
7132	Medical	Emergency Care	Nov-2017	Keeping the base safe	The Trust EPR system whilst having the facility to record NEWS and PAWS assessments, it does not have the facility to calculate the score 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.	August 2018: Meeting with nerve centre being planned to see re: implementation in the ED. Audits continue monthly September 2018: Still awaiting nerve centre meeting. Documentation audits are showing improved results in recording NEWS and PAWS in the notes. October 2018 Still awaiting to hear from nerve centre. Also PAWS and NEWS audits still being reviewed. November 2018: Working closely with nerve centre to obtain if we can have a bespoke ED module built within the trust. December 2018 Awaiting a meeting with nerve centre to demo the system and make sure it is fit for purpose.	Jan-2019	Feb-2019		PSQB	David Birkenhead	Louise Croxall
7169	Corporate	Finance and Procurement	Jan-2018	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 - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - shortfall in income recovery	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Controls around use of agency staffing have been strengthened. Aligned Incentive contract with two main commissioners. Approval process for new investments through Commercial Investment Strategy Committee	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		December 2018 The year to date and forecast deficit are both currently in line with the plan, although the year to date position has relies 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 improves, a financial pressure will emerge in future months as contingencies are now exhausted. The forecast assumes full achievement of £18m CIP target, of which £3.79m is high risk and also relies on full delivery of an additional recovery requirement with a total value of £3.96m. Agency expenditure is now below the NHS Improvement ceiling. The forecast remains below the ceiling, but achieving this position through the winter months relies on the delivery of some challenging savings targets. 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.	Jan-2019	Mar-2019		FPC	Gary Boothby	Philippa Russell
7223	Corporate	THIS	Mar-2018	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Order comms) as well as corporate systems (Email etc). Due to:	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	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	August 2018 : No further update or change to score - Awaiting confirmation from E&F around the remedial Power/UPS following the outage in June. September 2018: As above, no further update. October 2018 - The CHS works to move back to resilient power feeds at HRI is now planned for November 2018. This will go some way to	Jan-2019	Mar-2019		RC	Mandy Griffin	Rob Birkett

					Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	- Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security					- Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).	mitigating the overall risk. BCP plans are in the process of being tested within divisions with emergency planning. Still work to do to close the gaps in controls. December 2018 The work from CHS to move back to resilient power did not take place. Awaiting confirmation from CHFT Ops around a suitable time to carry out the work as it involves the downtime of clinical systems. A recent power surge (Dec 18) affected some clinical systems within CHFT and other local NHS orgs due to not having a UPS in place however the supply is split over 3 phases to give some resilience. There are still other gaps in controls but this is currently the largest contributing factor to the likelihood of this risk.						
6299	Calderdale and Huddersfield Solutions	Estates	May-2015	Keeping the base safe	Patient Safety Risk There is a risk of faulty high, medium & 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.	Maintenance prioritised based on categorisation / risk analysis of medical devices Tight control of management of service contracts to ensure planned preventative maintenance (PPM) activity performed. PPM programme being developed. Progress monitored by Health & Safety Committee ensuring recruitment issues, database, risk analysis of devices is progressing. Also being monitored by the CQC Steering Group Recruitment of administrator and 1 Medical Engineer	1. PPM Programme development ongoing. 2. Complete review Medical Device database to ensure accuracy on medical devices needing maintenance. 3. Lack of information on what proportion of equipment has accurate recording of location on medical devices database 4. Medical Devices Assessor final report and action plan not yet received, meaning further actions required not yet known 5. Newly recruited Medical Engineer not yet in post. Completed	15 5 x 3	16 4 x 4	5 5 x 1		August 2018 - Peer review complete, High risk PPMs still not on target, agency staff commencing August 2018 to catch up on PPMs. Interviewing Chief Medical Engineer on 5th September. Short to long term plan drafted as a business case. October 2018 - PPM KPIs beginning to increase slowly, Chief Medical Engineer interview unsuccessful on 5th September. Short to long term plan drafted as a business case Dec 2018 - PPM KPI's continue to rise with Contractor Support and concerted effort by the team plus cleaning of database data. During November 2018 an appointment has now been made for a Chief Medical Engineer. (Michael Coughlan)	Jan-2019	Jan-2019		PSQB	Lesley Hill	M Coughlan
5862	Medical	All Directorates Medical	Aug-2013	Keeping the base safe	We have a risk of harm due to vulnerable patients who are more likely to fall due to the unfamiliar hospital environment. The impact is high levels of fractures, head injuries all causing increased length of stay with associated issues	Falls management policy Safety Huddles Falls bundles Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment Enhanced care team and assessment process Safety rails assessment Falls champions	Insufficient uptake of education and training of nursing staff, particularly in equipment. On occasion staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. Failure to use preventative equipment appropriately. Low levels of staff training. Failure to implement preventative care. Limited amount of falls prevention equipment. Increased acuity and dependency of patients Lack of access to falls prevention training for agency staff.	12 4 x 3	16 4 x 4	9 3 x 3		October 2018. Risk reviewed and remains unchanged 4 harm falls in Division. Review undertaken of 9 completed harm fall investigations YTD to review identified actions and trends.Actions from these investigations are not consistently being embedding in practice therefore focused Divisional approach has been identified around three keys areas: Training ESR on Falls prevention(September 91.51% Divisional)to achieve 90% compliance on all ward areas by Jan 2019. Improved compliance in completion of initial falls assessment and documentation standards(September 37.9% Divisional)monitored though ward assurance and aim to achieve 75% by end December 2018. Treatment and care delivery -Safety huddle implementation on all medical wards to include falls risk and review falls prevention interventions. December Update: no harm falls in November and falls decrease in number overall work on going through falls collaborative and falls action plan falls workshop planned in January with follow up organised in March 2019 - invitation to all wards and AHP to generate individual actions around falls prevention falls risk to be reviewed at each falls collaborative meeting	Jan-2019	Jan-2019		PSQB	Jackie Murphy	Helen Hodgson

7309	Corporate	Corporate Nursing	Aug-2018	Keeping the base safe	This is a works issue with Bradford CHFT use Nerve Centre Technology to record and escalate patients physiological observation. Using the National Early Warning Score (NEWS). The NEWS is being updated to NEWS2. All organisation are required to change to News2 by January 2019 to comply with the NPSA alert circulated in April 2018. There is a risk that the integration between NC and EPR will not be complete within the timeframe. This is due to the delay in building the NEWs2 chart within EPR. As we are in partnership with Bradford with EPR,the Impact for CHFT is that Bradford will want to go live with News2 as soon as the new chart is built within EPR CHFT will require time to work on the interface between EPR & NC Within the NEWs2 chart build Bradford are requesting a hard stop alert for escalation of News of 5 or above. It is unknown if this will affect in the interface /integration with NC This would be detrimental to Patient Safety within CHFT.	The IPROC for the News2 App within NC was signed off yesterday. I have emailed NC and asked them to look out for the order. Nerve centre have agreed to prioritise CHFT for the NEWS2 update above Trusts Timeline for the work is 8 weeks EPR colleagues are in contact with Nerve centre and Cerna to understand work required for interface	Inability to bring forward the timeline of 1st January 2019 as we are in partnership with Bradford and there is a CCG issue which means Bradford will go live irrespective of our position Building of the NEWs2 chart in EPR is underway - we do not know at the moment how long this will take. We cannot start any testing of the News2 App with EPR until the chart in EPR is built. Work required for integration/interface of NC and EPR not identified as yet	16 4 x 4	16 4 x 4	6 3 x 2		Our Servers need updating to V5 NC will do this free of charge and we are liaising with them to get this done within the next 10days. We have updated servers before. This will require a short period of downtime 24.10.18 NEWs2 meeting with Bradford yesterday and SF (Bradford) and I will keep in contact and we will agree a launch date when we know where we are with the EPR build. I explained that from a CHFT point of view we would not be going live until we had the interface with NC/EPR. December 2018 Servers updated to V5 on test server. Testing of this completed today. V5 will be installed on live server 10th Jan. Testing with News2 and EPR to commence following this. No launch date for News2 as yet	Jan-2019	Jan-2019		EPR	Jackie Murphy	Catherine Briggs
7315	Family & Specialist Services	Appointment and Records	Aug-2018	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 8,000 patients awaiting appointments. circa 2,000 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 6,000 follow up patients that have all exceeded the appointment due date. Please refer to following individual risks: 4050 6078 6079 7199 7202	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3		Actions as per individual risks named above. Monitored at PSQB and Directorate Board and via weekly divisional performance meetings Support from Clinical Divisions and Performance Board to address backlog and meet current demands. December 2018 No update	Jan-2019	Apr-2019		PSQB	Rob Aitchison	Katharine Fletcher
7338	Corporate	Corporate Nursing	Oct-2018	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.	26.10.18 - Task and Finish Group - Actions 1.Cascade to Divisions and Flexible Workforce the individual users and the affected MRN numbers; appropriate guidance will be supplied as to how to address this within the system 2.Provide an update for staff in the form of flyers for handovers, a flash on the Trust screen to ensure at the end of a shift they have signed all progress notes, a video clip of how to address signing an entry using message centre and drop in's for General Managers in order to appreciate visually the issue of Saved not Signed. It is already incorporated in our training for all users and within the E learning package 3.Monitor on a weekly basis as to progress and feedback accordingly 4. Raise at Divisional Digital Board and PSQB. 5. Look into possibility of a Dashboard accessible to managers Nov 2018 Accepted by Risk and Compliance for the High Level Risk Register Needs review of Target Date December 2018 1. Information cascaded to Divisions but reported back that the report required refining. Agreement that the Surgical Divisional lead would review the refined report prior to cascading to all areas. 2. All clinical areas provided with flyers for	Jan-2019	Mar-2019		NA	Jackie Murphy	Carol Gregson/Graham Walsh

													handovers. An alert has appeared on the Trust screen publicising the importance of signing any clinical information that requires committing to the system. Video clip not produced as yet. 3. Report set up to run every week to monitor the status regarding this issue. There has been a reduction by 50% since the Risk was entered on to the Risk Register with regards current practice. Historical still require addressing. 4. Reviewed the EPR system regarding use of this functionality - reported back that the system is working as intended and that a change to the system is not recommended.						
7280	Family & Specialist Services	Pathology	Jun-2018	Keeping the base safe	Risk of: unnecessary repeat specimen collections (same EPR order) or rejected Specimens (incorrect EPR order used) Caused by: Failure to follow procedures in EPR at point of specimen collection. (not clicking collected) Resulting in: increased patient harm through repeat specimen collections and subsequent delays in patient care	1.Ward patients- the lab phones and requests new order to be sent down (samples processed) 2.Out patients- if there is a location sticker the lab will phone and find out if bloods required- if so new order with barcodes requested by lab (samples processed)	1. Not all ward staff have been trained correctly to order tests in EPR (see also 3 below) 2.Current lab procedures for allowing the labelling of samples without the need for disclaimer form is outwith the minimum data set policy and is facilitating the problem 3. Staff are not clicking collect once they have ordered and collected specimen- this results in order remaining live in EPR. (see also 1 above) 4.High volumes of outstanding orders in the system 5. Lab do not have an effective system in place for logging rejected specimens in APEX or feeding back to users (Lab IT system)- lack of awareness by service users of the number of specimens being rejected or collected incorrectly 6. Additional tests are being routinely added to phlebotomy lists 7. OP phlebotomy requests are being processed without appropriate requests - use of duplicates of request forms	15 3 x 5	15 3 x 5	3 3 x 1	1. Lab to liaise with EPR trainers 2. comms re use of disclaimer form to be sent out by lab. 4. cerner do not have resolution to outstanding worklists- international problem. Lab to continue to monitor situation 5. Lab to develop system for logging rejected requests in APEX- EPR lab staff to be trained to mark as collected those requests where barcode has been used and results issued 6. Lab IT to liaise with EPR team to restrict addition of requests onto the phlebotomy list 7.Comms to clinicians around end-date for lab accepting inappropriate requests from out patients.(feedback directly to clinicians on each incorrectly requested test in interim)	Update 02. October 2018- The path team with EPR trainers are continuing to roll-out training in click-collected. The next phase will be to concentrate on MAU cross site, provide advice and request that the risk of re-bleeding patients is added to relevant risk registers. Once the risk of re-bleeding patients is transferred to the other relevant risk registers the actual pathology risk can be amended to reflect the cost/time pressures and re-scored. Update 5/11/2018- Issue now understood in wider organisation- workstreams from trust planning sessions, support form labs provided to key areas. Awaiting transfer to relevant risk registers. GB to attend relevant divisional PSQB December 2018- No change since last review, work ongoing to support clinical teams	Jan-2019	Mar-2019		PSQB	Rob Aitchison	Karen Mitchell
6011	Family & Specialist Services	Pathology	May-2014	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust). - Solution identified and purchased - currently for implementation from August 2018. This solution will mitigate the current risk in full.	Lack of electronic system Lack of duplicate sampling Training compliance not at 100%	15 5 x 3	15 5 x 3	3 3 x 1		August 2018- Bloodtrack implementation ongoing in line with plan 4th September 2018 go live for Haemanetics project stages 1 & 2 place on Thursday 30th august and monday 3rd . Assessment of residual risk to be undertaken by managers during september 02. October 2018. No change since last review. Date planned mid-october to re-assess risk 05/11/2018. Process risk assessment highlights areas of weakness , particularly the community midwifery element and the deviations form blood track safe systems. Risk rating to be maintained at 15 until bloodtrack fully implemented and midwifery element mitigated, December 2018 No change since last review	Jan-2019	Mar-2019		PSQB	Julie O'Riordan	Sarah Ramsden and Alison Milner
5747	Family & Specialist Services	Radiology	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant in post Ad-hoc locums supporting the service Continue to try to recruit to vacant posts	Failure to secure long term locum support. Lack of clarity on regional commissioning arrangements relating to vascular services	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response	August &September 2018 Locum in place until 12th October. Continuing to pursue possible recruitment of substantive consultant. October 2018 update - Locum now in place until 9th November. Longer term support from LTHFT agreed in principle, detail still being decided. December 2018 Update: Discussions taking place with local Trusts in relation to providing a shared service. Target date updated to reflect current position and difficulties in sourcing a solution.	Jan-2019	Mar-2019		DB	Rob Aitchison	Sarah Clenton
6715	Corporate	Corporate Nursing	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing	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	20 4 x 5	15 3 x 5	6 3 x 2	Establish clinical documentation group	August 2018 Appointment made to Chief Nurse Information Officer (CINO) post. Use of ward assurance tool to review documentation. Chief Clinical Information Officer (CCIO) and CNIO	Jan-2019	Jan -2019		WEB	Jackie Murphy	Carole Gregson/Grahc

					occurs, poor communication difficulties with efficient multidisciplinary working.	documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	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				to revisit the Clinical Records Group September 2018 New Chief Nurse Information Officer and Chief Clinical Information Officer in post. Key objective is to re-instate the Clinical Records Group Ward assurance tool being tested in Surgery and Medicine with a view to full implementation by October 2018. Community version also being tested. October 2018 Chief Clinical Information Officer in post from 15th October - to recommence Clinical Records Group. Meeting between CNIO and CCIO to be arranged to recommence these. Ward Assurance Tool now on Knowledge Portal and being used by clinical staff - results under review. Digital Health Team in the process of working on a model ward, exploring areas of poor documentation and developing training plans to improve quality of documentation between all users of the system. December 2018 Clinical documentation group has had it's first meeting. Targeting individuals that are struggling with any issues. Quality Fridays are going to have a digital week.						
7251	Surgery & Anaesthetics	Head and Neck	Apr-2018	Keeping the base safe	There is a risk to patients receiving a poor experience and delays in out patient clinics due to the Optovue OCT (Ocular Coherence Tomography) machines at both Acre Mills and CRH Eye Clinics not functioning to expected levels. The machine can "crash" leading to inability to perform scans and access historical results for progression of eye conditions to determine diagnosis, treatment and management plans. This is resulting in a slower patient flow through clinics (increase complaints due to waiting times) due to the increase time taken per scan and reduction in clinic capacity available. The OCT machines 16TB storage limit has been reached - a temporary solution has been found to build an additional storage and backup system alongside current storage. Recent risk presented and reported on DATIX - the OCT's computer has registered somebody's else left eye OCT scan as another patients right eye OCT (this is now the 4th patient incident).	- Increase use of the Heidelberg OCT machine on Floor 2 to spread demand for scans during clinics - Encourage ophthalmologists to rationalise the use of OCT to pathologies for which it is mandatory - Ophthalmology IT system admin role approved Sep 2018 (funded 80% S&A, 20% THIS)	- Use of second floor OCT requires patients to travel between 2 floors during their visit - Patient's pathology still require OCT in many instances	9 3 x 3	15 3 x 5	1 1 x 1	- Explore technical options (Nov 2018) - Take Sys Admin role job description to job matching panel (due 1/11/18) - Advertise for SysAdmin (Dec 2018) - Haag-Streit are already investigating the recent risk, and there is nothing we can do to speed this process up except keep reporting these issues as they are seen and DATIX'ing them.	October 2018: We are down to 2 possible solutions for immediate issue of storage running out: 1. Modify the EXISTING server – Make existing OCT image archive the "secondary" archive, and add a new "primary archive". Both archives would remain accessible so scans can be compared quantitatively. Both archives would be backed up. This is dependent on the plan for backup of the 2 archives (which is different from existing backup of single archive using Trust backup storage) being viable. Meeting on 15th w/ relevant company that do the software to confirm this. If viable, should be able to go ahead and build as per plan. Some IT support from THIS likely required. Optovue will not be involved in support as they state this is an internal IT issue. 2. If the above is not viable, there is no other solution immediately available that involves live backup of data AND continued use of the current OCT archive as a "secondary" archive. Further storage is possible to put into place without backup (which we do not recommend for obvious reasons), OR we lose the ability to access data gathered over the last 10 years (for clinical analysis) in favour of having somewhere to at least continue saving new scan data (again, not recommended at this stage). December 2018 No Update	Jan -2019	Jan-2019		PSQB	Will Ainslie	Louise Corp
			NEW RISKS															
6829	Family & Specialist Services	Pharmacy	Aug-2016	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 ~ Oct 2019 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 - next planned 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 prepared in the units on both sites to reduce activity (to include: syringe drivers, adult	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 OCT 2018 attached	Aug 18 - remains high risk unit - with 4 majors on the May re-audit. urgent plans need to be made to reduce capacity during interim period whilst all aseptic work is undertaken at HRI during upgrade facilities at CRH Apr-Sept 2019 Oct 18 - met with auditor. No further issues highlighted. Further work to finalise robust capacity plan required. Meeting with senior nurses to discuss syringe driver issues- not all divisional representatives attended. Newsletter to be produced to highlight change in practice for nurses including potential interactions of drugs in syringe drivers. Dec 18- Plans to reduce capacity commenced. Some ready to use chemo now being purchased. Deputy chief nurses has requested delay in us stopping making syringe drivers to 15th Jan (single drugs) and 18th Feb (multiple drugs). Outsourcing of TPN still under review. Nutrition team plan to visit Chesterfield in January as Go See	Jan-2019	Dec-2018		DB	Jackie Murphy	Elisabeth Street

						peripheral nutrition, product catalogue, outsourcing radiopharmacy)											
3793	SAS	Head and neck	May 2017	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 and a bank consultant are undertaking waiting list initiatives and validations - Have 2 long term locum Consultants (AG & DM) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum 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	12 4 X 3	16 4 X 4	3 1 X 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	- Continue to explore the expansion of roles of the non medical staff within ophthalmology - Continue work with Primary Care Clinicians to reduce referrals in - discharge patients who DNA as per Access Policy - Band 2 HCA working through follow up list to appropriately allocate appointments / discharge where (completed) - Appointment centre issues reviewed with FSS division on 11/12/18 - Accommodating capacity with WLI (only 2 consultants participating in this) - WTGR session for ophthalmology with CEO due 13/12/18 - Three afternoon triage clinics being piloted in January 2019 with senior consultant - Oct 2018: Risk raised from 12 to 16 due to the volume of patients increasing to 2500 12 Dec 2018: holding list now 2645 and ASI 800. See 'Progress update' box above.	Jan – 2019	June 2019			Will Ainslie	Pnt Laloe
5511	Calderdale and Huddersfield Solutions	Estates	Apr-2013	Keeping the base safe	Collective Fire Risk - There is a risk of increased fire spread at HRI due to inadequate Capital Funding for refurbishment works 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.	Fire compartmentation survey undertaken in 2014 and capital funding made available to improve. Ongoing work to resolve compatmentation. Additional work completed in 2014 aimed at reducing the risks including upgraded fire detection, trained fire wardens (800+ trained in 2014), mandatory fire training for all Trust staff to encourage fire prevention and early detection of any fire.	1) The removal of on-going ward refurbishments in the capital plan has created the inability to undertake the compartmentalization within the ward area resulting in an uncompartmented condition. 2) The initial building design falls below the current compartmentalization standard. 3) The introduction of EPR and the computer on wheels has compounded the risk creating obstacles within fire evacuation routes delaying the horizontal evacuation method	12 3 x 4	15 5 x 3	5 5 x 1		June 18 Fire dampers to be installed in existing ductwork which penetrate new compartmentation walls. October 18 - Capital Planning for 18/19 is on-going, fire safety budgets will remain at the current level to ensure progress with the fire enforcement order action plans in 2013. Fire dampers are been fitted in the existing plants through the new compartment walls in Sub basement and duct areas. December 18 Half way through the installation of the fire dampers in existing ductwork breaching new fire walls.	Mar-2019	Mar-2019		HSC	Lesley Hill	Chris Davies

11. Director of Infection, Prevention and Control 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, 3rd January 2019	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Director of Infection Prevention and Control Quarterly BOD Report - This report covers the period from 1st April to 2018 - November 2018 and aims to provide assurance of effective infection prevention. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). Assurance against key performance and quality indicators is provided in the report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

This report covers the period from 1st April to 2018 - November 2018 and aims to provide assurance of effective infection prevention. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). Assurance against key performance and quality indicators is provided in the report.

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 report.

Appendix

Attachment:

DIPC REPORT BOARD OF DIRECTORS 3 JAN 19.pdf

BOARD OF DIRECTORS	
PAPER TITLE: **Director of Infection Prevention and Control Quarterly BOD Report**	**REPORTING AUTHOR:** **L Rudge, Deputy Chief Nurse** **J Robinson , Matron IPC** **G Boyd , Lead Doctor IPC**
DATE OF MEETING: 3rd January 2019	**SPONSORING DIRECTOR:** **D Birkenhead, Medical Director, Director of Infection Prevention and Control**
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To approve the report
PREVIOUS FORUMS: NONE	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link: http://nww.cht.nhs.uk/index.php?id=12474**	
EXECUTIVE SUMMARY: This report covers the period from 1st April to 2018 - November 2018 and aims to provide assurance of effective infection prevention. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). Assurance against key performance and quality indicators is provided in the report.	
FINANCIAL IMPLICATIONS OF THIS REPORT: None	
RECOMMENDATION: **To approve the report**	
APPENDIX ATTACHED: No	

Board of Directors
Director of Infection Prevention Control
Quarterly Report
1st April 2018 to 30th November 2018

1. Introduction

This report covers the period from 1st April to 2018 - November 2018 and aims to provide assurance of effective infection prevention. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). Assurance against key performance and quality indicators is provided in the report.

2. PERFORMANCE TARGETS QUALITY INDICATORS

The following table provides an overview of the current performance against targets and quality indicators for Infection Prevention and Contro.

Indicator	End of year ceiling	End of November	Actions/Comments
MRSA Bacteraemia (Trust Assigned)	0	**2**	
C.Difficile (Trust Assigned)	20	**15**	10 Non Preventable 5 Preventable
MSSA Bacteraemia (Post Admission)	9	**8**	Local ceiling based on 15/16 outturn 6 in the Medical division 2 in the Surgical division
E.Coli Bacteraemia (Post Admission)	39	**32**	Local ceiling based on 15/16 out-turn with a 10% reduction year on year. 25 in the Medical division 6 in the Surgical division 1 in FSS division
MRSA Screening (Electives)	95%	96.4	
Central Line Associated Blood Stream Infections (Rate Per 1000 Cvc Days)	1	0.53%	June Data Rolling 12 months
ANTT	90%	82.07%	Divisions have been tasked with improving

Competency Assessments (Doctors)			compliance.
ANTT Competency Assessments (Nursing And AHP)	90%	95.26%	
Hand Hygiene	95%	99%	

Quality Indicators

Indicator	Year-end agreed target	End of November	Comments
MRSA Screening (Emergency)	95%	93.3	
Isolation Breaches	**Non set**	270	This is a slight increase compared to the same time period last year. (214)
Cleanliness	Non set	96	Cleaning standards currently undergoing additional monitoring and review.

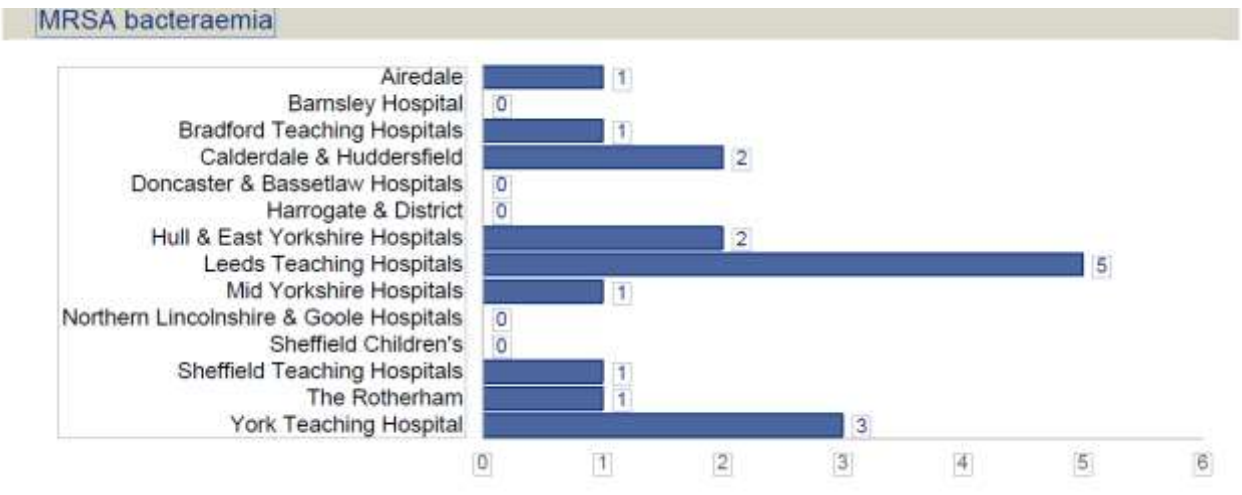
2.1 MRSA bacteraemia:

There have been 2 MRSA cases attributed to the organisation;

- A patient who had previously had 2 pre MRSA bacteraemia since the 1st April. Repeat blood cultures where taken atnumerous times during his hospital admission, it is classified as an ongoing infection but will appear on CHFT figures.

- A patient who was admitted onto ward 17 via MAU who had been discharged less than 48 hours before this admission with MRSA suppression treatment and there was a delay in determining if the treatment had been completed. There were additional clinical risk factors including leg ulcers, and a requirement for intermittent self catheterisation.

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



2.2 MSSA bacteraemia:
There have been 8 post-admission MSSA bacteraemia cases from the 1st April to the end of November 2018; compared to 10 for the same time period last year.
No comparative data is available with other Trusts.

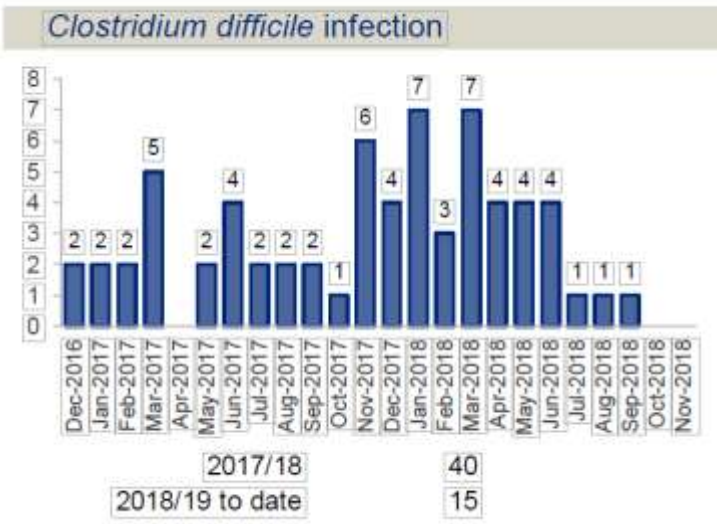
2.3 Clostridium difficile:
The ceiling for 2018/19 is for no more than 20 post-admission cases. From the 1st April to the end of November there have been 15; compared to 19 for the same time period last year. There have been no clusters or link cases identified.

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

- Completion of the Bristol Stool Chart and assessing patient bowel habits. Work is ongoing to improve access to, and use, of the Bristol Stool Chart within EPR.
- Delay in isolation – wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling.
- Antibiotic prescribing is generally in line with policy, although inappropriate antibiotic prescribing including extended courses of antibiotics has been highlighted in a couple of cases. Antibiotics guidelines are currently being reviewed.

The trust reviewed its performance against this key indicator and has developed a revised 5 point plan. Two main actions contained within the plan related to antimicrobial prescribing and a deep clean programme.

Since September the Antimicrobial guidelines have changed from Co-amoxiclav to Tazocin and a deep clean of high risk wards has now been completed.
This has had a positive impact on our current performance position as shown in the chart below.



The Trust had an external review by NHSI following the increase in C-diff rates from Quarter 1 & 2. The visit included interviews with the Deputy Chief Nurse, Infection Prevention Doctor and Matron and focus groups with the IPC team/Estates and In patient

Matrons followed by a number of ward and department visits. Overall feedback was positive from the review.

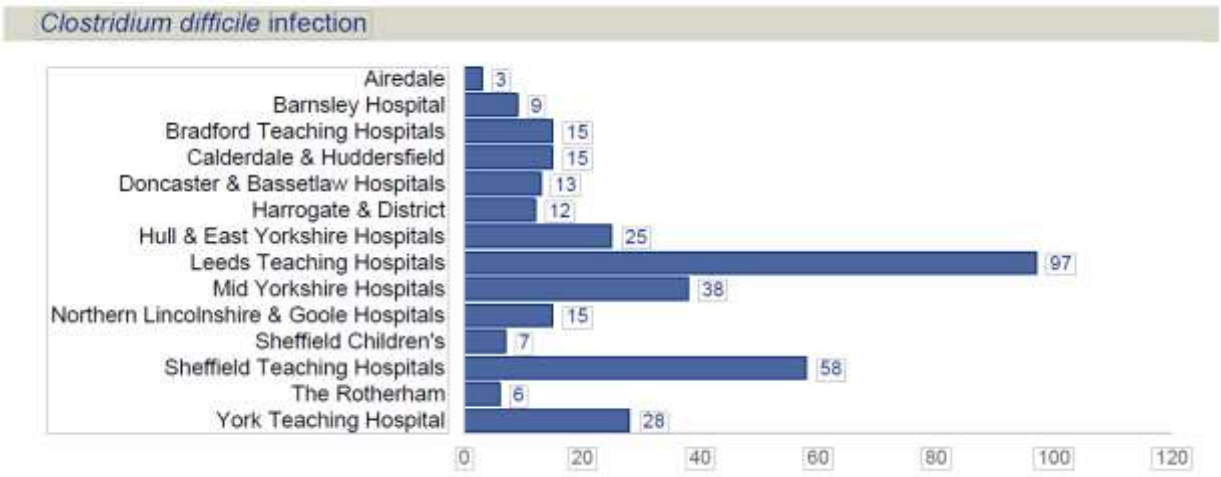
Key points from the review include

- Positive data improvements in CDI - the reviewer commented on the work that frontline colleagues had undertaken to help drive those improvements.
- Focus groups /individuals, wards and departments were engaged and understood their collective and individual roles in relation to infection prevention and control
- The governance structure was embedded with clear divisional ownership with processes for shared learning
- New processes have been implemented to improve environmental and equipment decontamination including a deep clean process and improvements in cleaning of trolleys in ED
- The IPC team and the facilities team work closely together and all demonstrated good links with clinical and non-clinical areas of the trust.

Areas for further consideration

- Hand hygiene audits and the limitations of the current process and options for redesigning the process
- Communication of key information
- Review process for closing the loop on IPC action plans and RCAs
- Feedback to Clinicians from audit and performance metrics.

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



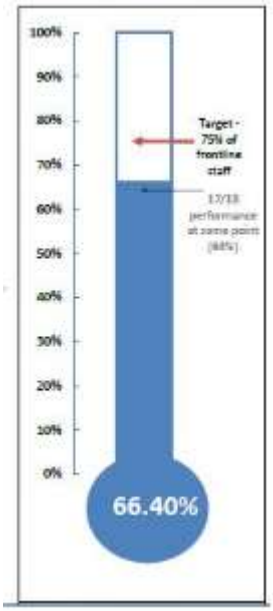
2.4 E. coli bacteraemia:

There have been 32 post-admission E-coli bacteraemia cases against the internal objective of 39; a meeting is arranged for January led by Kirklees CCG to review the health economy wide action plan.

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

WARDS CLOSED & BED DAYS LOST FIGURES					
MONTH	**HOSPITAL SITE**	**WARD**	**DAYS CLOSED**	**BAY/S CLOSED**	**BED DAYS LOST**
August	HRI	H20	9	-	49
	CRH	0	0	0	0
September	HRI	H8	8	0	8
	HRI	H20	9	0	45
	CRH	0	0	0	0
November	HRI	0	0	0	0
	CRH	C7A	3	0	4

2.6 Influenza:
The staff flu immunisation campaign is ongoing current performance is detailed below.



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

2.8 Isolation Breaches
There have been 270 isolation breaches since 1st April 2018 compared to 214 breaches for the same time period last year. The majority of breaches are patients with a previous history of MRSA colonisation at the time of admission to MAU, or patients being transferred and their infection status not being handed over. This information is visible within the EPR and the IPCT will continue to monitor isolation breaches and work with colleagues to reduce the number of breaches.

2.9 Audits:

46 Quality improvement environmental audits have been carried out since the beginning 1st April 2018 to 3oth November.

Compliance scores: **<75% = red rating**; **76% - 90% = amber rating; 91%+ = green rating.**

- 21 of the areas achieved a green rating.
- 21 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- X-ray at HRI achieved a RED rating of 63%. The department has worked hard to improve compliance and a re-audit is planned for 14th December.

3. INFECTION PRECENTION AND CONTROL SUREVEILLANCE

The IPC surveillance system is currently undergoing an upgrade which will hopefully assist us in the management of outbreaks and much improved SSI reporting, the anticipated 'go live' date is now the end of January due to some interface issues which are currently being resolved.

The IPCT continue to work both proactively and reactively and developing more collaborative working with the divisions.

4. INFECTION CONTROL SYSTEM WIDE SUMMIT

CHFT has participated in an infection and prevention control summit with CCG and Local Audthority colleagues in Quarter 3 to develop and mobilise a system wide approach to the IPC and to ensure cohesive and collaborative approachs are being undertaken across agreed shared priorties.The summit was also one of the key actions within the 5 point plan.

5. CONCLUSION

The report has provided an overview of the current performance. There needs to be a continued and sustained improvement focus to prevent hospital acquired infections and ensure performance targets and quality indicators are met.

6. RECOMMENDATIONS

The board is asked to approve the report.

12. GMC Survey 2018 (Dr Sue Crossland)

To Approve

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Crossland, Consultant - Acute Medicine
Date: Thursday, 3rd January 2019	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: GMC survey 2018 - Update the board on this years GMC survey	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: DMEC, previous report discussed at WEB	
Governance Requirements: Education and training	
Sustainability Implications: None	

Executive Summary

Summary:

The GMC survey 2018 shows that we are a good training trust overall. Despite our position slipping down the table a little, we maintain good or excellent training in most specialties. Where improvements areto be made, individual action plans have been discussed at the DMEC

Main Body

Purpose:

How our trainees feel about training within the organisation

Background/Overview:

Following on from the GMC survey in 2017

The Issue:

Maintaining and delivering high quality training in a time of great pressure and austerity

Next Steps:

Next report-2019 will be published May/June 2019

Recommendations:

For approval please

Appendix

Attachment:

gmcsurvey report 2018 for the board-pdf.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

GENERAL MEDICAL COUNCIL (GMC) NATIONAL SURVEY OF TRAINEE DOCTORS 2018

1. Executive Summary

The GMC have provided the following comments about the national scores which reflects the unhappiness in the UK training workforce at present:

In 2018 over 70,000 trainees and trainers took part in the national training surveys, giving their views on training posts, programmes and environments in England, Northern Ireland, Scotland and Wales.

The data generated by the surveys are a powerful quality assurance tool, providing the information we need to identify good practice and pinpoint the places where training doesn't meet our standards. The findings also show local and country trends, which drive policy developments and interventions designed to tackle problems and improve the training experience.

This year, we added new questions to the surveys to help us better understand the extent of burnout amongst doctors in training and trainers.

The results are stark. Long and intense working hours, heavy workloads and the challenges of frontline medical practice are affecting doctors' training experience and their personal wellbeing.

- Nearly a quarter of doctors in training and just over a fifth of trainers told us they're burnt out because of their work.
- Almost a third of trainees said that they are often or always exhausted at the thought of another shift. And well over a half of trainees, and just under a half of trainers, reported that they often or always feel worn out at the end of their working day.
- A fifth of doctors in training and trainers told us they feel short of sleep when at work.
- Two in five trainees and two thirds of trainers rated the intensity of their work as very heavy or heavy; and nearly half of trainees reported that they work beyond their rostered hours on a daily or weekly basis.
- And around a third of doctors in training and trainers said that training opportunities are lost to rota gaps.

Here are the headline facts for CHFT:

- Response rate for the Trust was 100% for the second year running.
- As predicted, the overall satisfaction scores across the region are down

- Our score has dropped slightly from 80.46 to 77.51. We are now 7t^{h} highest in terms of overall satisfaction regionally (5th last year). Although our overall satisfaction has dropped a little over the last few years, we still have overall excellent satisfaction rates.
- We are best in region for overall satisfaction for Acute Internal Medicine (2nd year in a row), Orthopaedics, Emergency Medicine (EM) FY1 (2nd year in a row) and EM GPST.We are fourth best in the region for general surgery
- We are positive outliers for EM FY1 (Green) [5th year in a row] and EM GPST
- The good news is that we have **no red outlier** specialties or specialty grades this year, both of whom have turned around. Ophthalmology which is now now 2nd best in region with leap of score from 63.4 to 83.8; anaesthetics HST is now 5th in region with leap of score from 60 to 82)
- We are pink outliers however for:
    - Core medical training (CMT) – this continues to give us some concern, and it is possible that the reconfiguration across both sites has had some impact. The main issues are to do with the rota-specifically, the trainees are concerned regarding the rota gaps they have to deal with on a daily basisi, and often feel under pressure to cover the gaps as well as their own jobs. Dr Rangaprasad Karadi is engaging with the current CMT trainees to see how we can improve, and in fact, the deanery are pleased with the progress that has been made in the last year, even though the improvement feels slow on the survey results.
    - Obstetrics and Gynaecology (O&G) - this is still a significant cause for concern. O&G have been poorly performing for a few years now. The scores for O&G HSTs are pink/red virtually across many indicators. Again, the Deanery recognise that O and G, whilst still scoring poorly, are not a significant outlier within the region and we will continue to work with the Deanery to improve trainees' experience.
- We no longer have any 'watched' specialty training programmes (ie programmes with conditions on them-however, some recent concerns regarding Urology are on the Deanery's watchlist-despite the GMC survey data showing no concerns-I will keep everyone updated on this following a meeting scheduled for January 2019.

**fifth year in a row*

2. GMC National Survey of Trainee Doctors 2018

2.1 The Trust participated, along with every other NHS provider in the UK, in the 2017 survey. This is the twelfth national survey, with annual surveys being undertaken since 2006.

The GMC state *'the survey data provides a snapshot of the perceptions of doctors in training about postgraduate training at one point in time. The reports can only be used as a screening tool to flag up possible strengths and possible areas of concern'.*

2.2 The key issues covered in the survey are in relation to:
- Patient Safety.
- Quality assurance, review and evaluation.
- Delivery of curriculum, including assessment.
- Support and development of trainees and local faculty.
- Educational resources and capacity.

2.3 All medical trainees in posts within programmes approved by the GMC are required to take part in the trainees' survey. Specifically for the Trust these include:

- Foundation trainees (Years 1 and 2).
- Core Trainees (Medicine and Surgery).
- Higher Specialty Trainees, including GP trainees in hospital posts.

2.4 The survey was undertaken between March 2017 and May 2018. ***The response rate for the Trust was 100% (highest in the region).*** The response rate nationally was 98.3%.

2.5 The detailed reports for each specialty have not been enclosed, but have been distributed to TPDs, College Tutors and Specialty Leads. Action plans have been discussed at DMEC

Specialties with less than three trainees do not have any GMC survey results

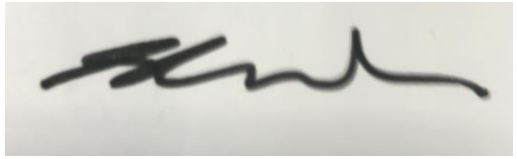
3 Patient Safety and Undermining Feedback

There are no significant patient safety issues, and we currently have no GMC input regarding this.\
Although there were no reported bullying issues

4 Action Required of the Board

The Executive Board is asked to:

(i) receive this report.



Dr Sue Crossland FRCP
Director of Medical Education
September 2018

Appendix 1 Trust position in HEYH

Report By is equal to / is in **Trust/Board**

and Indicator is equal to **Overall Satisfaction**

and Trust / Board is equal to **Airedale NHS Foundation Trust , Barnsley Hospital NHS Foundation Trust , Bradford Teaching Hospitals NHS Foundation Trust , Calderdale and Huddersfield NHS Foundation Trust , Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust , Harrogate and District NHS Foundation Trust , Hull and East Yorkshire Hospitals NHS Trust , Leeds Teaching Hospitals NHS Trust , Leeds and York Partnership NHS Foundation Trust , Mid Yorkshire Hospitals NHS Trust , Northern Lincolnshire and Goole NHS Foundation Trust , Rotherham Doncaster and South Humber NHS Foundation Trust**

and GEO LETB/deanery is equal to **Health Education Yorkshire and the Humber**

Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018
Airedale NHS Foundation Trust	Overall Satisfaction	76.50	76.06	74.21	81.33	78.34	76.93	71.67
Barnsley Hospital NHS Foundation Trust	Overall Satisfaction	72.50	76.68	73.74	77.32	76.06	75.09	70.23
Bradford Teaching Hospitals NHS Foundation Trust	Overall Satisfaction	79.80	81.76	83.89	80.89	81.78	78.58	77.78
Calderdale and Huddersfield NHS Foundation Trust	Overall Satisfaction	78.24	78.37	79.03	81.19	80.46	77.51	74.41
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Overall Satisfaction	76.26	76.69	76.19	79.54	78.98	79.04	77.38
Harrogate and District NHS Foundation Trust	Overall Satisfaction	77.02	76.58	78.44	80.45	78.85	79.99	77.80
Hull and East Yorkshire Hospitals NHS Trust	Overall Satisfaction	77.73	78.39	76.98	80.00	79.58	77.25	76.57
Leeds Teaching Hospitals NHS Trust	Overall Satisfaction	77.48	78.51	79.59	79.99	79.89	76.49	78.32
Leeds and York Partnership NHS Foundation Trust	Overall Satisfaction	86.30	84.24	86.03	87.10	88.55	86.49	84.65
Mid Yorkshire Hospitals NHS Trust	Overall Satisfaction	78.38	76.56	78.40	78.23	74.25	73.60	71.04
Northern Lincolnshire and Goole NHS Foundation Trust	Overall Satisfaction	74.99	79.17	76.65	75.26	76.46	68.19	72.18
Rotherham Doncaster and South Humber NHS Foundation Trust	Overall Satisfaction	84.33	90.33	88.21	82.86	83.08	81.23	75.38

13. Nursing and Midwifery Staffing - Hard Truths Requirement

To Approve

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Michelle Bamforth, Assistant to DON - Workforce Assurance Manager
Date: Thursday, 3rd January 2019	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: Safe Staffing Bi-Annual Report - Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and in doing so meets the expectations set out in the NQB national recommendations.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: BOD	
Governance Requirements: Safer staffing and workforce	
Sustainability Implications: None	

Executive Summary

Summary:

Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and in doing so meets the expectations set out in the NQB national recommendations.

Main Body

Purpose:

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's ten expectations) and the Care Quality Commission. The paper will provide assurances that nursing and midwifery staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance, providing a sustained focus on planning and delivering services in ways that both improve quality and reduce avoidable costs.

Background/Overview:

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

The Issue:

This paper acknowledges the challenges faced by the nursing workforce and identifies the Trusts response to this

Next Steps:

Recommendations are highlighted in this paper

Recommendations:

The Board ia asked to accept this paper as further assurance and evidence of the management of this complex workforce issue

Appendix

Attachment:

BOD Safe Staffing Report Jan 2019 final version LR updates inlcuded for JMK review.pdf

Calderdale and Huddersfield
NHS Foundation Trust

BOARD OF DIRECTORS	
PAPER TITLE: Safe Staffing Bi-Annual Report	**REPORTING AUTHOR:** L Rudge , Deputy Chief Nurse M Bamforth, Head Nurse
DATE OF MEETING:	**SPONSORING DIRECTOR:** J Murphy, Chief Nurse
STRATEGIC DIRECTION – AREA: • Keeping the base safe • A workforce for the future	**ACTIONS REQUESTED:** • To receive
PREVIOUS FORUMS: Not applicable	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	
EXECUTIVE SUMMARY: Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and in doing so meets the expectations set out in the NQB national recommendations.	
FINANCIAL IMPLICATIONS OF THIS REPORT: Enclosed within report.	
RECOMMENDATION: To receive this report	
APPENDIX ATTACHED: YES	

CONTENTS	
1.0	Introduction
2.0	Right Staff
3.0	Right Skills
4.0	Right Place and Time
5.0	Quality impact on Nursing and Midwifery staffing levels
6.0	Establishment Review December 2018
7.0	Conclusion
8.0	References

1.0 INTRODUCTION

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's ten expectations) and the Care Quality Commission. The paper will provide assurances that nursing and midwifery staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance, providing a sustained focus on planning and delivering services in ways that both improve quality and reduce avoidable costs.

1.1 Background

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

2.0 RIGHT STAFF

Calderdale & Huddersfield Foundation Trust ensure that there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times. There is a robust annual strategic staffing establishment review across all inpatient clinical areas. This is done by a triangulated approach using professional judgment, evidenced based staffing tools and benchmarking data with peers. This is done in line with the trusts annual planning cycle.

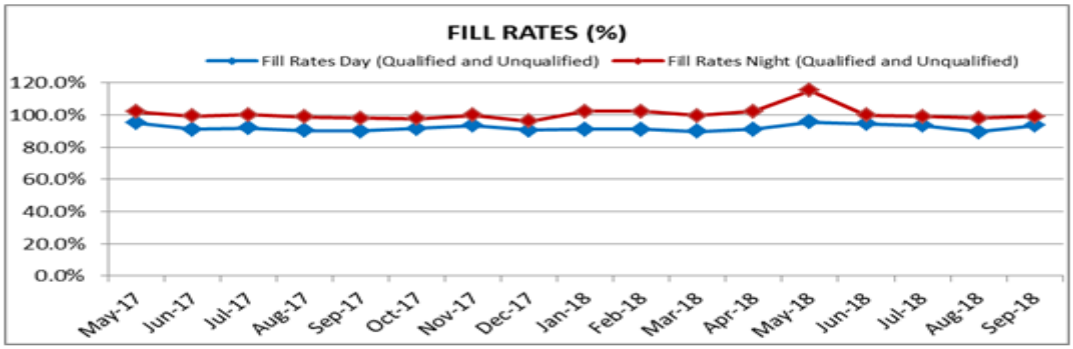
CHFT have developed an annual staffing review document (see appendix 1). This ensures that workforce planning is evidenced based and informed by national guidance. Each year a full and comprehensive staffing review takes place. The next review is scheduled for December 2018; the outcomes of the reviews are detailed in section 6.0 of this report.

The workforce plans and resulting workforce models contain sufficient provision for planned and unplanned unavailability, e.g. sickness, parent leave, annual leave and training requirements. This is set at 22%. Appendix 3 detail the list of evidenced based guidance used to set nursing and midwifery establishment levels at CHFT.

2.1 Fill Rates

As an example, table 1 indicates that average fill rates have been maintained over the last year. Whilst this enables assurance that safe staffing levels are being realised, this has been achieved through a level of non-contracted bank/agency staff support. Fill rates at the Trust have remained at a relatively steady state, with extra non-registered staff being enlisted to help supplement registered nurse vacancies and maintain CHPPD levels.

Table 1:



Fill rates are good benchmarks for organisations to determine how they have achieved planned care hrs against budgeted models. Caution must be applied when comparison is made against other providers as the base line is organisationally determined. From September 2018 acute Trust are no longer required to submit fill rate data to the centre, and Care Hours Per Patient Day (CHPPD) has become the principle measure of nursing, midwifery and health care support worker deployment on inpatient wards.

2.2 Care Hours per Patient Day (CHPPD)

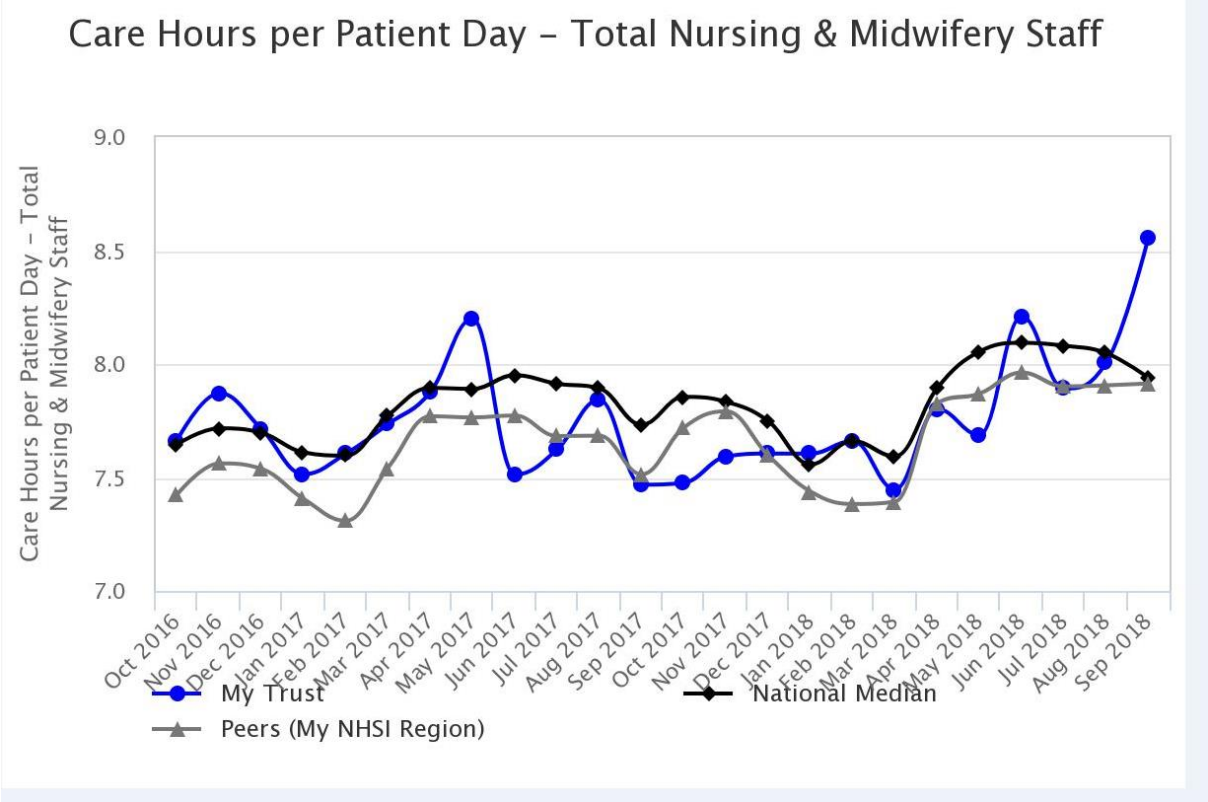
In line with the updated NQB guidance, CHFT report monthly on CHPPD data. This metric is included at Trust level in the monthly Integrated Performance Report Carter dashboard to the Trust Board of Directors.

The model hospital shows delivered CHPPD data from Trusts monthly “unified” safer staffing returns. Model Hospital CHPPD data offers a single, consistent and nationally comparable Metrix, representing both staffing levels and patient requirements. The data sets allow for a consistent way to articulate staffing deployment and facilitate comparison between wards within Trusts or with comparable Trusts within the STP. A key benefit is it differentiates registered nurse/midwifes from HCSW to ensure skill mix is well described and allows for benchmarking activity.

Average CHPPD levels recorded at CHFT over the last four months have maintained between 7.5 and 8.6.

The table below details how CHFT’s CHPPD levels compare with regional West Yorkshire Acute Trusts.

Table 2: National CHPPD Data from the Model Hospital Portal September 2018



CHPPD data is reviewed monthly by the Nursing and Midwifery Workforce Steering Group and the divisional Associate Directors of Nursing.

Overall the Trust has shown an improving picture in achieving planned CHPPD hours. The overall average is affected by an element of consistent over achievement within divisions. Interrogation of the data indicates that care hours greater than planned are due to increased patient acuity and dependency.

CHPPD methodology is applied to the nursing and midwifery workforce in three of the four clinical divisions. Nationally, CHPPD is not applied to community nursing provision.

2.3: Sickness and Turnover Rates:

Tables 3 and 4 describe that through focused absences management support the overall sickness and turnover rates of the nursing workforce have improve

Table 3:

372 Turnover by Month - Qualified

Division	Turnover % (FTE) 2017/10	2017/11	2017/12	2018/01	2018/02	2018/03	2018/04	2018/05	2018/06	2018/07	2018/08	2018/09
372 Community L3		0.55%	0.54%	0.54%	0.27%	1.12%				1.54%		0.43%
372 Corporate L3	1.30%		3.77%	1.30%		1.31%			1.26%	1.24%		
372 Families & Specialist Services L3	0.54%	0.41%	0.93%		0.68%	1.15%	0.91%	0.24%	0.64%	0.72%	0.26%	1.20%
372 Health Informatics L3												
372 Medical L3	1.06%	0.81%	1.18%	1.14%	1.29%	0.53%	0.55%	0.37%	0.19%	1.16%	0.78%	0.70%
372 Surgery & Anaesthetics L3	0.88%	0.12%	0.91%	0.72%		0.60%	0.53%	0.60%	1.44%	0.60%	0.80%	1.24%

	2017/10	2018/01	2017/11	2018/03	2017/12	2018/02	2018/04	2018/05	2018/06	2018/09	2018/07	2018/08
Turnover Rate (FTE)	0.78%	0.69%	0.47%	0.80%	1.10%	0.63%	0.55%	0.34%	0.65%	0.89%	0.96%	0.53%
Turnover Rate FTE (12m)	13.24%	12.87%	12.84%	12.81%	12.72%	12.67%	11.85%	11.14%	8.53%	8.38%	8.30%	8.09%

Table 4:

Qualified Nursing & Midwifery

Division	Total Absence % 2017/10	2017/11	2017/12	2018/01	2018/02	2018/03	2018/04	2018/05	2018/06	2018/07	2018/08	2018/09
372 Community L3	3.26%	3.08%	3.67%	5.47%	5.56%	3.40%	3.92%	2.59%	2.29%	2.07%	2.82%	4.17%
372 Corporate L3	2.98%	4.48%	3.41%	5.04%	2.98%	2.94%	1.47%	2.75%	2.01%	1.53%	2.71%	3.08%
372 Families & Specialist Services L3	3.89%	4.65%	5.00%	4.93%	5.02%	5.37%	4.38%	4.81%	6.31%	5.62%	5.08%	4.08%
372 Health Informatics L3												
372 Medical L3	4.94%	5.24%	4.92%	5.05%	5.03%	3.24%	3.29%	3.25%	2.83%	2.90%	3.30%	2.46%
372 Surgery & Anaesthetics L3	5.39%	5.78%	5.82%	6.20%	4.62%	3.77%	3.82%	3.38%	2.65%	2.99%	2.51%	1.94%
Grand Total	**4.52%**	**4.95%**	**4.96%**	**5.36%**	**4.88%**	**3.90%**	**3.68%**	**3.56%**	**3.52%**	**3.42%**	**3.43%**	**2.94%**

3.0 RIGHT SKILLS

To further strengthen the establishment review process at CHFT and in line with the NQB guidance, a training needs analysis of the nursing workforce has been commissioned. This will be aligned with Health Education England's quality framework and form part of the Trusts overall training and development strategy. The analysis will result in a clear position on training requirements and enable the nursing workforce to prioritise needs to support service delivery, staffing retention and quality of care.

3.1 Training and Education

Staffing establishments take into account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development to meet revalidation requirements, and fulfil teaching, mentorship and supervision roles. These include the support of the pre-registration and undergraduate students. Furthermore, particular attention is now focussed on the annual contracts around the allocation of universal credit from Health Education England (HEE) to spend locally on SSPRD training. Part of the Training needs analysis will inform HEE and the regional Universities what are training needs are – they can then develop curricular to meet this demand. Table 5 illustrates programmes that the nursing and midwifery workforce are recruited onto for the academic year of 2018/19 at the University of Huddersfield.

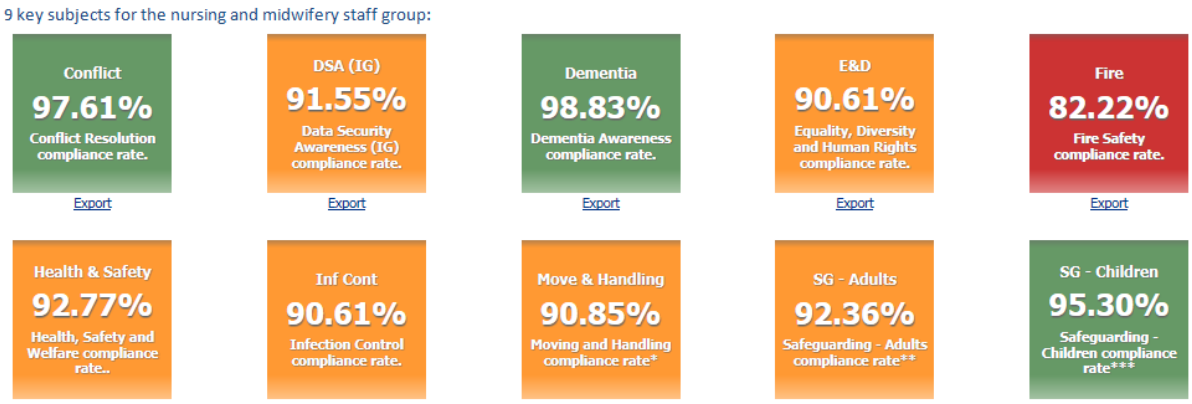
Table 5:

Programme	**Number of CHFT recruits**
Assessment of the new born baby	7
Independent prescribing	20
Acute care PGCert	4
Critical Care PGCert	2
ECG monitoring & interpretation	4
End of life PGCert	1

Health professionals PGCert	3
Leadership and management PGCert	1
Long term conditions	1
Emergency care PGCert	1
Tissues viability and wound management PGCert	2
Advanced Clinical Practice Masters	**TBC**
Supporting Learning in practice (SLIP)	66
Total	**112**

The table below indicates the Trust compliance rates against the 9 mandatory key subjects applicable to the nursing and midwifery staffing groups

Table 6:



3.2 Development And Modernisation Of The Nursing Workforce:

There is a national picture emerging of workforce changes occurring to overcome the recruitment and retention challenges in the health sector. The focus has been on the development of new roles in the unregistered members of the workforce in conjunction with existing staff developing new skills. The following is an overview of the approaches taken at CHFT to respond to gaps in workforce, recognising that each ward/department has different requirements depending on patient need.

- Apprentice Clinical Support Workers
- Trainee Nursing Associates
- New roles in the unregistered workforce, e.g.: Discharge co-ordinators, enhanced care workers
- Role development through the Calderdale framework methodology within maternity services
- Development of operating department assistants within theatres

Development of these roles provides assurance that the nursing workforce embraces the growth of future care models by creating an adaptable and flexible workforce, which will be responsive to changing demand and able to work across the care setting, care teams and boundaries.

CHFT currently have 27 trainee nursing associates in post across the clinical divisions, with a further 20 being recruited onto programme from December 2018. The result will be a cohort of 47

registered Nursing Associates by 2020 – giving the organisation real opportunity to develop nursing establishment levels in line with national guidance and quality assurance Metrix.

3.3 Recruitment And Retention

Recruitment into the nursing workforce remains a priority. The Trust continues to be represented at local and national careers events, attracting potential candidates to the organisation. Bi-annual recruitment fairs held on site complement the continual monthly recruitment campaigns that are running.

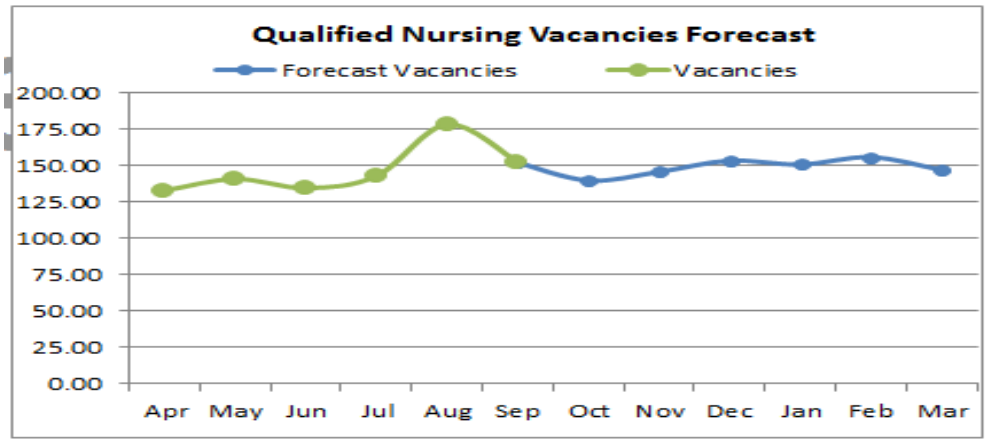
The table below reports the Trust's current nursing, midwifery and additional clinical services staffing vacancy position (Data from ESR September 2018). To note the described unqualified vacancy is inclusive of all staffing groups coded within ESR as "additional clinical services". This includes pathology, haematology and microbiology staff, as well as pharmacy, medical records and radiology staff. Most inpatient areas do not carry a vacancy factor for HCA and recruitment plans are in place for all known HCA vacancies

Table 7 Vacancy Position

Qualified			
Row Labels	**Sum of Actual (FTE)**	**Sum of Budgeted (FTE)**	**Sum of Vacancies (FTE)**
372 Community L3	182.23	181.35	-0.88
372 Corporate L3	83.85	75.65	-8.20
372 Families & Specialist Services L3	377.39	399.63	22.24
372 Health Informatics L3	0.91	0.91	0.00
372 Medical L3	534.39	624.57	90.18
372 Surgery & Anaesthetics L3	409.27	458.50	49.23
Grand Total	**1588.04**	**1740.61**	**152.57**

Unqualified			
Row Labels	**Sum of Actual (FTE)**	**Sum of Budgeted (FTE)**	**Sum of Vacancies (FTE)**
372 Community L3	81.42	78.58	-2.84
372 Corporate L3	37.27	32.91	-4.36
372 Estates & Facilities L3	0.00	0.00	0.00
372 Families & Specialist Services L3	308.94	334.37	25.43
372 Medical L3	382.07	370.61	-11.46
372 Pharmacy Manufacturing Unit L3	22.69	23.09	0.40
372 Surgery & Anaesthetics L3	266.34	264.64	-1.70
Grand Total	**1098.74**	**1104.20**	**5.46**

Table 8 Band 5 nursing trajectory.



3.3.1 Oversees Recruitment

As part of the strategy to increase the nursing workforce and reduce the use of temporary workforce the Trust carried out an overseas recruitment project in March 2017.

The trajectory for the recruitment phase has been slowed down by national policy around entry requirements. The Trust has responded to the NMC's announcement on alternative English qualifications which will be accepted to expedite deployment to the UK. The Trust has welcomed 15 nurses from the Philippines into the organisation who have all successful passed the OSCE exam and are now contributing to shift fill within the nursing workforce.
A further 5 colleagues have been successful in completing the ILETS/OET exam and have entered the NMC assessment queue, it is anticipated that they will join the Trust in late December 2018/early January 2019.

Another 15 nurses have recently passed the ILETS/OET exam in the Philippines. It is envisaged that they will be deployed to the UK early in the New Year.

3.3.2 Domestic Recruitment

The Trust continues to recruit expected number of new graduates from local Universities. This has been attributed to increasing the placement capacity for undergraduate nurses and thus giving exposure to the trust for new employees. CHFT secured 48 new graduates who joined the Trust between September and November 2018.

The Trust is also working closely with Huddersfield University to further increase the capacity to host pre-registration nursing students within the organisation. This year on year sustainable increase will contribute to the number of local graduating nurses who can then be recruited by the Trust. However, nationally recruitment to undergraduate nurse training programmes is down.

In addition, the Trust continues to work closely with Bradford University to facilitate the training of nurses wishing to return to practice (RTP). Since September 2016 the Trust has offered candidates the opportunity to be employed as a Band 3 trainee whilst completing the programme of study at the university. CHFT have 8 RTP students enrolled onto programme in September 2018, they will complete the programme and regain entry onto the NMC register in January 2019.

3.3.3 Retention

National data suggests that many new recruits to nursing leave in the first 12-24 months post registration. This is concerning as locally the vast majority of band 5 recruits to the nursing workforce are new graduates. Recommendation from Health Education England, NHSi and NHS employers is that this needs to be an area of increased focus for Trusts and care providers.

In order to improve retention rates within the nursing workforce the Clinical Education team have developed a new preceptorship policy and document. This is in line with national frameworks and approved by Health Education England (HEE). The package is supported by a comprehensive induction to employment and an on-going year-long graduate programme. This is offered to all new registrants and colleagues new to the organisation.

To support the retention of the nursing workforce an internal transfer protocol was introduced in 2015. This has been annually review, and proving to be successful. On average 2-3 nurses from inpatient areas apply for transfers on a monthly basis. The protocol streamlines the process for the applicant, whilst maintain stability in the releasing area.

CHFT have been recruited onto the NHSi's "Retention Direct Support Programme". This national programme will support the organisation to improve retention rates and variation in turn over. The direct and specialised support from the national team will allow the organisation to drive forwards and further develop retention strategies.

4.0 RIGHT PLACE AND TIME

Each divisional leadership team includes a Head of Nursing/Midwifery, who in conjunction with their matrons are responsible for ensuring that the correct levels of staff are in place in each ward. Staffing levels 'planned and actual' are reviewed on a shift by shift basis at the daily staffing meeting and decisions made regarding deployment of staff.

The nursing workforce ensures staffs are deployed in ways that ensure patients receive the right care, first time in the right setting. Key to delivering this has been through the implementation of Health roster and work through the roster management and controls work stream. The documented outcomes include:

- Improved service delivery and clinical safety - right people, right place, right time
- Improved productivity and utilisation of substantive and temporary staff - significant financial saving on Bank and Agency spend
- Reduction in avoidable costs - the drive to control expenditure
- Improved payroll accuracy - reduction in unnecessary overtime payments and enhancement errors
- Improved leave management
- Reduced sickness levels
- Improved rostering practice and access to rosters - increased roster efficiency
- Reduction in administration tasks and functions
- Improved leave management
- Improved reporting
- Improved workforce planning.

4.1 Efficient Deployment Of Nursing Staff

Systems are in place for managing and deploying colleagues across a range of care settings through the daily staffing meetings, ensuring flexible working to meet patient needs and making best use of resources. The implementation of the “safe care live” module ensures clinical capacity and skill mix are aligned to the needs of patients, thus making the best use of staffing resource. Clear escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed.

4.2 Acuity and Dependency Studies

CHFT are now fully operational with the safe care live module of the e-roster system. This allows for the clinical divisions to have, real time data that clearly shown demand against actual staffing levels. Table 10 below details how acuity is tracked over the month for an area and provides insight into how staffing levels are flexed not only to meet required safe staffing levels but also daily demand based on patient acuity.

Appendix 4 details current inpatient area staffing establishment levels against recommended levels from the Safer care Nursing Tool (SCNT) report which ran in November 2018. The audit period was for four weeks and covered the whole 7 day/week period.

There is an overall gap between the SCNT recommendations and the current budgeted establishment levels. It is important to highlight that a contributing factor to this is against an overall context of organisational ward moves during periods of infection control maintenance and reconfiguration of wards, which has affected the data over these period.

Table 10:

HRI Ward 10 Surgical HRI 471001 L5 (Night): Required vs Actual Hours

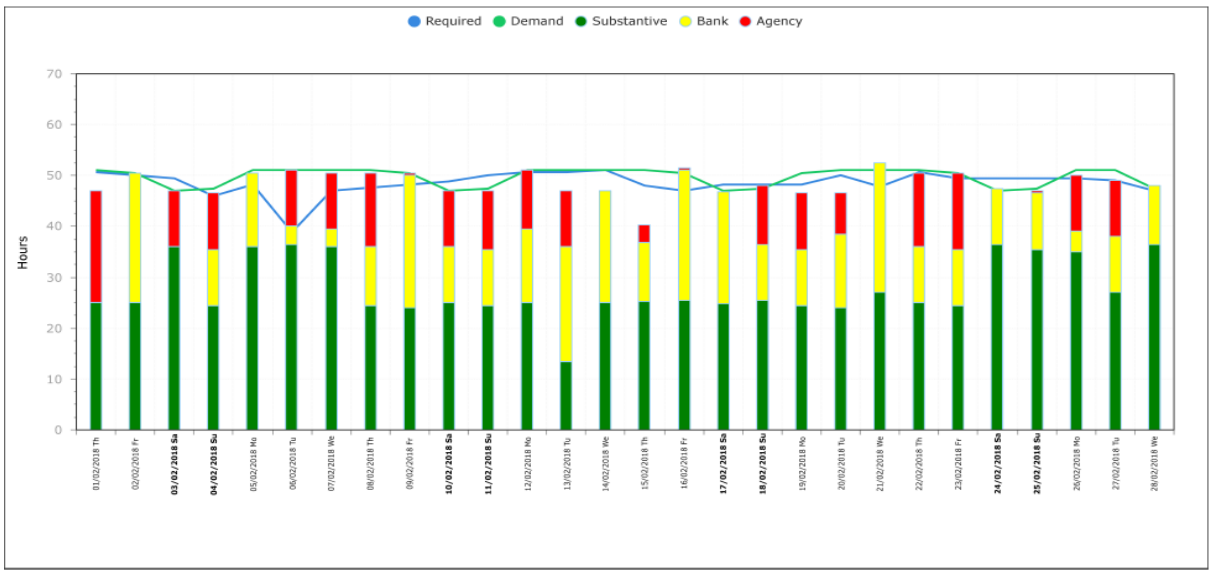


Table 11 is an example of the overall position safe care live can give operational staff, senior leaders and divisional teams at any point in the day. Shifts are “rag rated” to indicate clinical effectiveness and safety. This is calculated on staff on duty against the planned model and factoring in the live acuity data.

Table 11:

5.0 QUALITY IMPACT OF NURSING AND MIDWIFERY STAFFING LEVELS

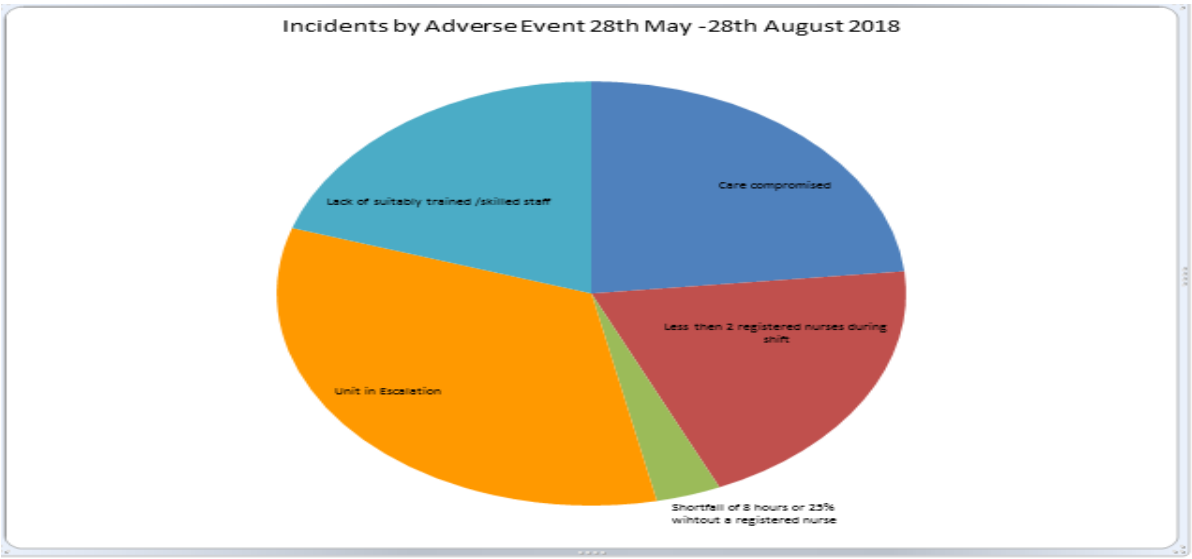
Red flags are currently reported via the Trusts incident reporting system and are designed to support the nurse in charge of a shift to assess systematically that the available nursing staff for each shift, or at least each 24hour period, is adequate to meet the actual nursing needs of patients on that ward. When they are reported an immediate response by the registered nurse in charge of the ward is required and appropriate actions are taken such as allocation or redeployment of additional nursing staff to the ward. These issues are also considered at the daily staffing safety briefs.

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

- Care compromised
- Less than 2 registered nurses per shift
- Shortfall of >25% time on shift without a registered nurse
- Unit in Escalation (maternity specific)
- Lack of suitably trained /skilled staff on duty

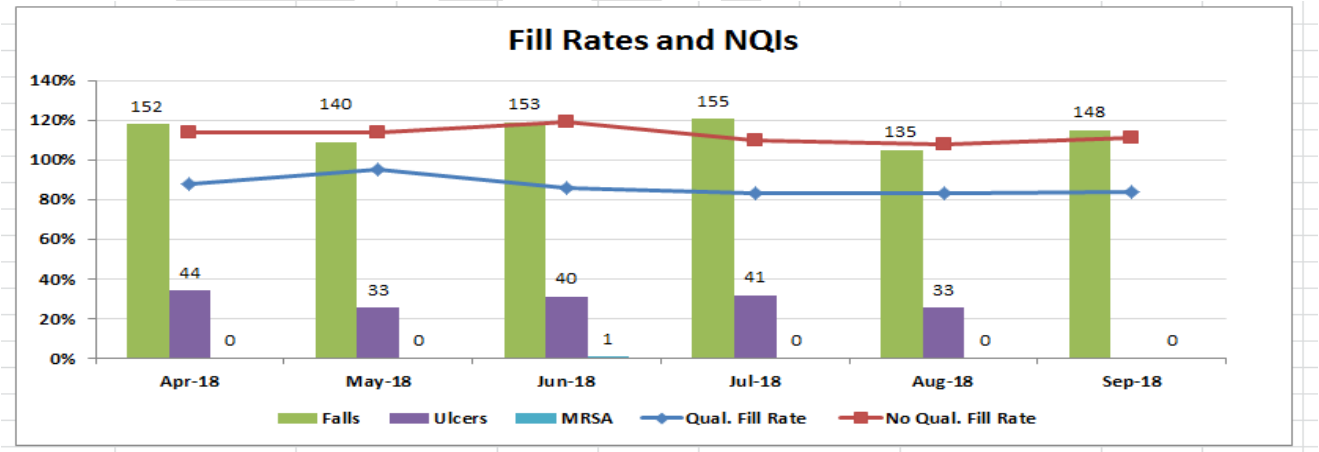
The following table’s illustrates the number of “Red Flags “identified over the months of June, July and August 2018 at CHFT

Table 12:



It is imperative that nurse staffing data (shift fill rate), is triangulated with the patient outcomes and nurse sensitive indicators. This is collated and presented each month to Trust Board in the IPR. The Nursing and Midwifery Strategy Group is held Bi- weekly, and part of the remit of this group is to also identify and highlight any themes/trends being reported on the incident reporting system. The monitoring of this data provides assurance in relation to the quality impact in association with nurse staffing and is outlined in Table 13 below

Table 13:



5.0 ESTABLISHMENT REVIEWS DECEMBER 2018

In December 2018 all nursing workforce models (WFMs) were reviewed by the nursing workforce model review panel. This ensured a consistent approach was utilised across each division to

complete the reviews using standardised templates and guidance. The resulting models and establishment levels are evidenced based, integrated with finance, activity and performance plans.

A comprehensive Quality Impact Assessment (QIA) has taken place where there is any workforce transformation or redesign including a change in skill mix and/or the introduction of new roles.

The process will be repeated through the 2019/20 workforce review process and is aligned to strategic workforce and business planning.

5.1 Surgery

The comprehensive review of establishments identified that previous modelling was accurate and that the current WFMs met the needs of the wards/departments. No investment or disinvestment was requested through the establishment process. However, some alterations have been proposed and supported through re-alignment of budgets across the division and by using appropriate skill mix opportunities. Details of changes are documented below:

- Ward 19 HRI

The panel supported the revised WFM within current budget to support a twilight shift on the ward. The ward have continued to have an increased number of patients with complex needs, frailty, and this does present the ward with challenge around needs for enhanced supervision. The additional care hours during this time period will meet patient acuity and dependency demand.

- Ward 21 HRI

The department proposed a reduction in Registered Nurse cover during the night, and the introduction of a band 5 twilight shift. This model still meet's regulatory requirements around safer staffing and is supported by the department's acuity and dependency data. Care hours will be reduced between the hours of Midnight at 7am.

This proposal was approved, to review in three month time to monitor quality indicators and impact.

- Ward 11 HRI

The panel supported the revised WFM within budget to increase the provision of band 6 senior cover as a temporary increase whilst recruiting to vacancies Additional band 5 coverage added to the early shift Monday - Friday, when acuity and dependency is at its highest and to meet patient demand.

5.2 Medicine

No investment proposed to the current nursing establishments within the division of Medicine. Some workforce model alterations have been made following reconfiguration of services and to meet service demand. Budgetary realignment and skill mixing opportunities have allowed for this.

- A&E Cross site

No changes to the current establishment have been made. However, work using the “BEST” acuity studies indicates that enhanced staffing models are needed within the departments. A full business case will be taken through the annual planning cycle and will detail any further proposal.

- Acute Floor HRI

A new model has been proposed to support the acute floor on the HRI site. This will be a 45 bedded medical assessment and frailty unit. The workforce will comprise of the current MAU staff and ward 6 SSU staff.

The model has a strong clinical leadership structure which will allow for senior nurse cover seven days per week. The model will also provide appropriate staffing ratios to meet NQB guidance for acute areas and align to RCN guidance for care of the elderly.

The senior nursing team within the division will ensure that staffing requirements are deployed equitably across the floor to meet patient demand. Work will also be undertaken to ensure the newly form team are competent and able to deliver the right care to patients at the right time in the right place.

- Ward 6 HRI (was ward 8)

Due to the reconfiguration of medical services, ward 8 will move to ward 6 HRI and become a 23 bedded medical elderly ward.

The panel approved an increase in RN cover for the late shift for the ward. This increase in care hours can be achieved within current budget. This model is to be reviewed in three months following relocation to monitor NQI’s.

- Respiratory Floor CRH

The division have proposed to configure a Respiratory floor model at CRH compromising of 47 beds, 8 of which will be monitored. The ward will support the respiratory pathway and complete the reconfiguration of respiratory service plans. The model includes A Ward Manager post with a Clinical Nurse lead post which is an increase in leadership across the floor. This will ensure strong clinical leadership and visibility, and ensure the workforce are trained and prepared to meet patient demand. The clinical leader will have focus on the operational management of the unit and concentrate on the flow of patients through the department. The proposal meets regulatory requirements and provides adequate registered nurse ratios to meet initiation of NIV recommendations.

The panel supported the WFM. This model is to be reviewed in three months’ time following reconfiguration to monitor NQI’s and compliance with the NIV pathway standards

- Acute Floor CRH

The panel supported the revised WFM presented by the division to use a skill mix opportunity to increase the provision of HCA cover per shift and reduce the RN fill. This model is supported by robust data form Safe care live and in line with SCNT recommendations.

5.3 Families and specialist services

No investment proposed to the current Nursing/Midwifery establishments within the division of Families and Specialist services. Some workforce model alterations have been made following reconfiguration of services and to meet demand. Budgetary realignment and skill mixing opportunities have allowed for this. Alterations to WFM are in line with national guidance and underpinned by professional judgment. The review has identified a CIP opportunity through the disinvestment of 2.2WTE specialist midwifery roles.

- Maternity ward 4

This is a newly configured maternity ward and comprises of the workforce and budget merged from previous wards 1d and ward 9. The new unit has an increased bed base of four; this is due to the relocation of four antenatal beds from the labour ward. The total bed base is 31.and the workforce has been aligned to meet the increased activity by transferring 4.7WTE midwifes from labour ward to ward 4.

- Labour ward and MAC:

The workforce on the unit has been aligned to meet the new configuration of maternity services, and 4.7 WTE midwifes transferred to ward 4 to support the additional antenatal beds on their. Moving the antenatal patients from the labour ward is supported by the changing environment available on ward 4 which is more appropriate for antenatal women requiring admission to hospital.

5.4 Community

No investment or disinvestment proposed to the current nursing establishment within the community division.

The division have moved to a five locality/Hub based model. Services and current workforce have configured to merge to this profile. Further review of the nursing establishment level will be required as this embeds and will be undertaken in April 2019

6.0 CONCLUSION

Nursing and Midwifery establishments are set, monitored and financed at appropriate levels in the Trust. The Trust continues to respond to both the local and national challenges in relation to the recruitment and retention of the workforce. There are clear governance arrangements and oversight in place to ensure that safe and sustainable staffing levels are achieved to ensure high quality compassionate care across the trust.

REFERENCES

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

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

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

Safer Care Nursing Tool (2014), Shelford Group

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

Appendix 1

Safe staffing guidance

July 2018:

Speciality:	Guidance:	Recommendation:
Adult inpatient areas	NICE Safe Staffing Guidelines National Quality Board guidance (NQB)	There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. A 1-8 ratio is recommended on days, and 1-10 on nights Each ward should determine its nursing staff requirements to ensure safe patient care. It then recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period Recommends use of Shelford Safer Care Tool and endorses the use of Health Roster and Safe Care
Children's and Young Peoples Service	RCN standards (2013)) Defining staffing levels for children and young people's services	Children < 2 years of age 1:3 registered nurse: child, Day and night. Children > 2 years of age 1:4 registered nurse: child, day and night The ward staffing complement must also have a supervisory ward sister/charge nurse and unregistered staff, who are not included in the above baseline bed side establishment. The following standards should be applied for all general inpatient wards as a minimum: • one Band 7 ward sister/charge nurse • one ward receptionist +/- admin support for sister • minimum of one health play specialist • one housekeeper • +/- one hostess. Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care.

		In addition to the Band 7 ward sister/charge nurse, a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team. This will provide an experienced nurse to advice on clinical nursing issues relating to children across the organisation 24-hours a day. High dependency care The nursing requirements for infants and children in NICU and PICU requiring high dependency care have been defined above. However, high dependency care is often provided outside of the intensive care unit in both specialist wards in tertiary hospitals and general wards in district general hospitals. The expertise and support for staff in these Settings vary considerably, necessitating staffing for high dependency care to be based on local requirements as well as national guidance. While use of a children's high dependency care assessment tool can assist the assessment of staffing requirements for high dependency care, the following registered nurse-to-patient ratios should be applied regardless of the setting: • 0.5:1 registered nurse: patient for children requiring close supervision and monitoring following surgery, those requiring close observation for mental health problems or with single system problems. • 1:1 registered nurse: patient, where the child is nursed in a cubicle, has mental health problems requiring close
Coronary Care units	British Cardiology Society (2011)	Recommends BACCN standards Staffing in the acute cardiac care unit should not fall below a ratio of one registered nurse to two patients.
Critical Care Units	British Association of Critical Care Nurses 2009 Standards for nurse staffing in critical care. (BACCN)	Critical Care units also require a number of staff to support the delivery of care to patients through: 1. Management of the unit by a designated lead matron, 2. Coordination of each shift by a supervisory/supernumerary senior critical care qualified nurse.

		3. Additional supervisory/supernumerary support for every 10 beds. (BACCN/ICS recommendation: 21 – 30 beds = 2 additional supernumerary registered nurses). This is the minimum recommended and the current layout of the units plus the relatively junior/inexperienced workforce increases the need to provide additional support. The support includes assistance with admissions, transfers, ensuring patient care is driven forward to reduce length of stay or time spent at level 3 e.g. that there are no delays in weaning plans 4. Education and Training for staff - the recommended service specification is that 50% of staff on critical care units should be in possession of a post registration award in Critical Care Nursing. The BACCN/ICS recommendation is 1 for every 75 staff. Each Critical care unit should have a dedicated clinical educator. 5. Technical support – The vast amount of medical devices within the unit requires a level of technical expertise to maintain the day to day integrity of the machines in the clinical environment 6. Care support Health care assistants are required to support the provision of care in each area of the unit
Critical Care Units	Guidelines for the Provision of Intensive care services Core Standards for Intensive care units 2013	Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care Supports BACCN standards
Emergency Departments	RCN Baseline Emergency Staffing Tool (2013)	BEST recommends minimum nurse to patient ratios when planning nursing establishments or for use on a shift-by-shift basis. The Best tool reflects the following ratios. One registered nurse to four cubicles in either “majors” or “minors” One registered nurse to one cubicle

		in triage One nurse to two cubicles in the resuscitation area. 1 band 7 (or equivalent) registered nurse on every shift at all times Major trauma (2 registered nurses to 1 patient) Cardiac arrest (2 registered nurses to 1 patient) Priority ambulance calls (1 registered nurse to 1 patient) Family liaison (1 registered nurse to 1 patient's family/carers) 1 Registered Children's nurse per shift
Neonatal Services	British Association of Perinatal Medicine (2011) Department of Health (2009)	The recommended staffing levels for neonatal services, minimum nurse to child ratio Intensive Care 1:1 High Dependency 1:2 Special Care 1:4 The DOH also produced best practice guidance for neonatal staffing which recommend a nurse co-ordinator on every shift (additional to those providing direct clinical care) and that units have a minimum of two registered staff on duty at all times (one which holds a qualification in the speciality)
Older People	RCN Safe Staffing for Older People's Wards (2012)	Recommends 1:5 – 1:7 nurse to patient ratio to deliver ideal, good quality care. 65:35% registered to un- registered skill mix.
Stroke	British Association of Stroke Physicians 2014 BASP	The Acute Stroke Unit provides sufficient trained nursing staff to provide high quality nursing care. In the first 72 hours of an acute stroke patient's admission, they will require more intensive monitoring and nursing input, requiring a minimum Level 2 nursing staff numbers to manage the acute stroke patient (2.9 WTE nurses per bed; 80:20% trained to untrained staffing ratio) is recommended. Thereafter a level of 1.2 WTE nurses per bed is appropriate.
Respiratory Units	British Thoracic Society/Acute medical society BTS Quality Standards for Non- Invasive Ventilation (NIV) in adults.	1-2 nurse to patient ratio for initiation of NIV and for the first 24hrs of care Patients to be nurses in designated beds with evidence of competency assessment for staff

Appendix 2: Annual staffing review guidance:

Calderdale and Huddersfield NHS Foundation Trust: Establishment Review Guidance 2018

Safe Staffing Establishment Reviews - Process

Contents

1.0 Introduction

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

2.0 Purpose:

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

3.0 Scope:

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

Director of Nursing

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

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

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

Associate Directors of nursing for the divisions/ Matrons

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

Ward Managers/ Team Leaders

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

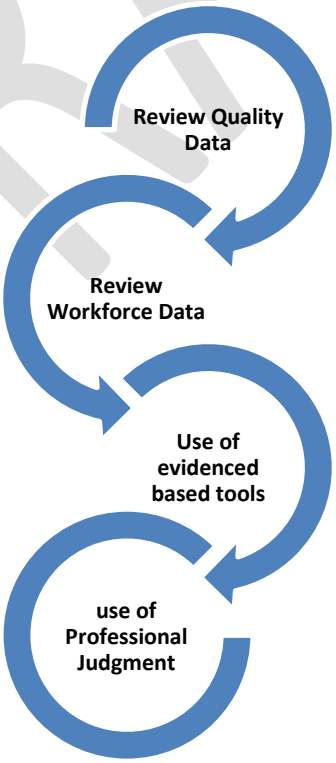
All clinical staff

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

4.0 Safe staffing establishment review principles

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

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



5.0 Reviewing Quality Data:

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

6.0 Reviewing Workforce Data:

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

7.0 Use of evidenced based tools:

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

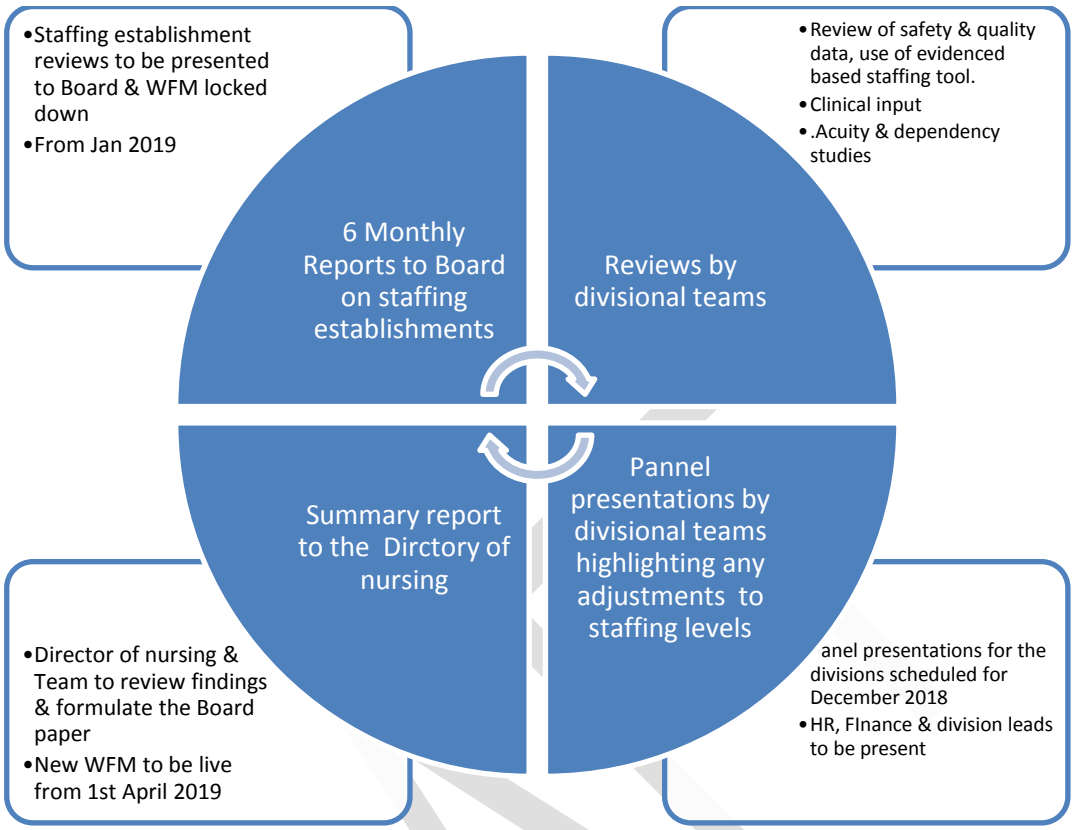
8.0 Use of professional judgement:

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

9.0 Timeline for establishment reviews:

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

10.0 Timeline detail



11.0 Writing the Review Report

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

12.0 Review Panel process:

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

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

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

Appendix 3:

Units of staffing measurement		
Type of measure	**Examples**	**How these can be used**
Staff to patient rates/ ratios	Care hours per patient day (CHPPD) reported as total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix	CHPPD is a unit of measurement that can be applied to any aspect of staffing, registered staff and/or whole care team. The Carter Report defines CHPPD as registered nurse hours plus healthcare support staff hours in a 24-hour period, divided by number patients at midnight (as a proxy for 24 hours of a patient stay). The concept of CHPPD can be adapted to all other staff groups with time allocated to wards or units: for example, physiotherapy hours per patient day, occupational therapy hours per patient day, etc.
	Nursing hours per patient day (NHPPD)	NHPPD is a unit of measurement used in inpatient settings internationally. It is able to summarise variations in numbers of staff and numbers of patients over the course of a 24-hour period. It typically refers to the number of registered nursing hours available per patient.
Patient to staff rates/ ratios	x patients per registered nurse x service users on caseload x women per midwife per year one-to-one observation	Typically used as a 'snapshot' of current responsibilities or as an average of responsibilities over a longer period. Actual numbers of staff and of patients/women/ service users will tend to vary over the course of a day in inpatient settings and over days/ weeks in community settings.
Registered to unregistered staff rates/ ratios	xx% of team are registered nurses xx% of team are midwives x:y ratio of registered nurses/ healthcare assistants	Difficult to interpret in isolation from other units of measurement, as a higher percentage/ ratio can be achieved by reducing healthcare assistants or by increasing registered nursing staff, but does give an indication of staff that will require supervision by registered nurses/midwives, in addition to their direct responsibilities.

Units of staffing measurement		
Type of measure	**Examples**	**How these can be used**
Whole-time equivalents (WTE)	Ward/unit/team has xx WTE in post Ward/unit/team is funded for xx WTE	Provides a unit of measurement that overcomes local differences in the proportion of staff who work part-time, converting all part-time contracts into their whole-time equivalent, *eg two staff working 30 hours per week plus one staff member working 15 hours is the equivalent of two staff working 37.5 hours per week, therefore 2.0 WTE*
Head count	Ward/unit/team headcount is xx registered nurses xx healthcare assistants x physiotherapists x occupational therapists	Provides a unit of measurement that is important when counting activity every employed staff member has to undertake, regardless of how many hours they work, *eg mandatory training.*
Fill rates	The ward/unit/team had xx% of planned staff overall The ward/unit/team had xx% of planned registered nurse/ midwifery staffing The ward/unit/team had xx% of required staff overall The ward/unit/team had xx% of required registered nurse/ midwifery staffing	This was previously calculated by dividing actual staff by planned or required staff and multiplying by 100 to convert to a percentage. Difficult to interpret in isolation from other units of measurement, as previous plans may not reflect patient acuity/dependency on the day, and the percentage total cannot distinguish between 'aiming high but delivering less' and 'aiming low and delivering even lower.' Where registered nursing/midwifery staffing gaps are covered by a higher number of healthcare assistants, or where fluctuating numbers of staff are required for special observation, overall fill rates become even more difficult to interpret.
Headroom/ uplift	xx% uplift xx% headroom	Building in capacity to deal with planned and unplanned but predictable variations in staff available, such as annual leave, maternity and paternity leave, compassionate leave, jury service, sickness and study leave. If the headroom/uplift allowance is lower than actual requirements this can lead to greater use of temporary/agency staff.
Note: for all units of staffing measurement, creating averages over days, weeks or months can potentially be misleading: a ward/unit/team that fluctuates markedly between too few or too many staff to meet patients' needs on different days of the week, or from week to week, will not be able to deliver the same quality of care as a ward/unit/team where staffing is more consistent.		

Methods of workforce planning		
Type of workforce tool	**Summary**	**Examples**
Acuity/ dependency models	Using a decision matrix, patients are categorised according to their requirements into levels of care with associated evidence-based staffing multipliers derived from wards delivering good quality care. In this way, it discriminates between patients with differing needs. Some models also factor in additional workload demands such as patient turnover.	Safer nursing care tool for adults, inpatient wards, acute admissions units, children and young people wards: http://shelfordgroup.org/library/documents/Shelford_Group_Safety_Care_Nursing_Tool.pdf Mental health and learning disability tools: https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability
The professional judgment model	Based on clinical staff views of the number of staff required for the usual patient casemix and usual activity on a particular ward/unit/ team (or in high dependency environments, the number of staff required for a typical patient)	Telford method http://www.who.int/hrh/documents/hurst_mainreport.pdf
Activity Monitoring tools	Uses care plans/care pathways and related nursing time. Data are collected based on the tasks undertaken/assigned to nurses, providing insights into the needs of and intelligence to inform decisions about staffing numbers, staff deployment, models of care, and skill mix.	Birthrate plus http://www.birthrateplus.co.uk/

Appendix 4: Safer care nursing tool acuity comparison:

		Funded establishments					Numbers per shift				
Ward	**Speciality**	**Reg**	**Ureg**	**Total**	**Ratio RN:HC**		**Ratio RN:bed**	**AM**	**PM**	**Night**	**Recommended establishment SNCT Oct/ Nov 18**
Acute Floor 46 beds	Med	43.39	26.88	70.27	62/38		1.53	8+5	8+5	8+5	63.40
MAU 28 beds	Med	27.68	24.37	52.05	50/50		1.96	5+5	5+5	5+5	51.13
Ward 6 HRI 23 beds	Med	19.73	12.19	31.92	62/38		1.46	4+3	4+2	3+2	30.14
Ward 12 21 Beds	Med	17.91	11.16	29.07	62/38		1.38	4+2	4+2	3+1	26.94
Ward 15 27 beds	Med	23.95	22.32	46.27	52/48		1.38	5+4	4+4	4+4	47.16
Ward 20 HR 30 beds	Med	23.95	23.35	47.30	51/49		1.58	5+4	4+5	4+4	44.12
Ward 17 HRI 24 beds	Med	23.15	13.89	37.04	63/38		1.54	5+5	5+3	3+2	35.66
Ward 7AD CRH	Med	20.42	19.13	39.55	52/48		1.52	4+4	4+4	3+3	42.28

Ward 7BC	Med	11.56	8.65	20.21	57/43			6+4	6+4	6+2	23
Ward 6A/B CRH	Med	22.24	16.63	38.87	60/40		1.21	4+4	4+4	4+2	Insufficient data to analyse – ward reconfiguring
Ward 8 HRI	Med	18.71	16.40	35.11	53/47		1.6	4+3	3+3	3+3	34.57
Ward 6c CRH	Med	12.59	10.48	23.07	57/43		1.54	3+2	3+2	2+1	Insufficient data to analyse – ward reconfiguring
Ward 5 HRI	Med	20.42	16.40	36.82	55/45		1.47	4+3	4+3	3+3	45.47 High volume of level 1b patients
Ward 5BC CRH	Med	33.40	17.31	50.71	66/34		1.58	6+4	6+4	6+2	53.39
Ward 5D CRH	Med	13.27	8.65	21.92	61/39		1.46	3+2	2+2	2+1	20.85
Ward 4	Med	11.56	13.89	25.45	45/55		1.7	2+3	2+3	2+2	31.95
Ward 19	Surgery	20.53	16.51	37.04	55/45		1.7	4+3	4+3	3+3	36.40
Ward 21	Surgery	19.73	19.13	38.86	51/49		1.94	4+4	4+4	3+3	29.98
Ward 8A	Surgery	12.85	7.92	20.77	62/38		1.3	2+1	2+1	2+1	16.25
Ward 8D	Surgery	12.07	6.03	18.10	67/33		1.29	2+2	2+2	2+0	Insufficient data to analyse
Ward 3	Surgery	12.79	8.17	20.96	61/39		1.40	3+2	2+1	2+1	20.34
Ward 10	Surgery	18.02	11.27	29.29	62/38		1.46	4+2	3+2	3+2	31.43
Ward 11	Surgery	20.95	13.89	34.84	60/40		1.34	4+3	4+3	3+3	35.7

Ward 22	Surgery	14.49	13.89	28.38	51/49		1.23	3+3	3+3	2+2	Insufficient data to analyse
SAU HRI	Surgery	25.17	9.81	34.98	72/28		1.52	4+2	4+2	4+1	36

14. Safeguarding Update – Adults and Children

To Approve

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	**Report Author:**
Board of Directors	Vicky Thersby, Safeguarding Lead
Date:	**Sponsoring Director:**
Thursday, 3rd January 2019	Jackie Murphy, Interim Chief Nurse

Title and brief summary:

Safeguarding Adults and Children Update Report - This report is the Safeguarding Adults and Children update for the Trust Board. The update provides information from April 2018 to September 2018. • The report provides an overview of Safeguarding activity, mandatory safeguarding training and supervision requirements and actions. • Impending changes to the Deprivation of Liberty Safeguards by the amendments of the Mental Capacity Act. • Update from the Trust wide 2018 Inspection • Progression of actions in relation to Calderdale (2016) and Kirklees (2018) Childrens and Children Looked After CQC Inspections. • Update from Kirklees Ofsted Inspection September and October 2016 • Achievement of the Domestic Abuse Quality Mark for the next 3 years • The redesign and configuration of the Children Looked After Service Specification (Calderdale)

Action required:

Approve

Strategic Direction area supported by this paper:

Keeping the Base Safe

Forums where this paper has previously been considered:

Safeguarding Committee Meeting - 6th November 2018 Quality Committee - 29th October 2018

Governance Requirements:

See Report

Sustainability Implications:

None

Executive Summary

Summary:

This report is the Safeguarding Adults and Children update for the Trust Board.
The update contains information from April 2018 to September 2018. The report provides an overview of activity and outlines key achievements and developments on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), safeguarding training compliance, mandatory children's safeguarding supervision requirements and actions.
The report documents recent CQC inspections and any potential further inspections pending. It outlines the new Children Looked After Service Specification and innovative developments, achievements, further plans and arrangements for safeguarding both adults and children.
This report provides overview and assurance that Calderdale and Huddersfield Foundation Trust (CHFT) is fulfilling its statutory safeguarding responsibilities and working in partnership across the Calderdale and Kirklees footprints.

Main Body

Purpose:

See Report

Background/Overview:

See Report

The Issue:

See Report

Next Steps:

See Report

Recommendations:

To receive and approve the contents of the report

Appendix

Attachment:

BOD SAFEGUARDING UPDATE REPORT JAN 19.pdf

1. INTRODUCTION

This report is the Safeguarding Adults and Children update for the Trust Board.

The update contains information from April 2018 to September 2018. The report provides an overview of activity and outlines key achievements and developments on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), Safeguarding Training Compliance, Mandatory Children's Safeguarding Supervision requirements and actions.

The report documents recent CQC inspections and any potential further inspections pending. The report outlines the new Children Looked After Service Specification and innovative developments, achievements, further plans and arrangements for safeguarding both adults and children.

This report provides overview and assurance that Calderdale and Huddersfield Foundation Trust (CHFT) is fulfilling its statutory safeguarding responsibilities and working in partnership across the Calderdale and Kirklees footprints.

2. MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and the Deprivation of Liberty Safeguards (DoLS, 2009).

There is a current MCA DoLS Policy in place and DoLS data is captured monthly and reports are shared with the safeguarding committee meeting. CQC are notified of all DoLS authorisations and outcomes, and this is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the safeguarding team. All authorisations are shared weekly with Matrons and Ward Sisters, and the relevant local authority is kept updated regarding any changes in a patients pathway or condition. The Safeguarding Team continue to support the ward teams in making their own DoLS applications.

The decision of the Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWC Civ 31 significantly changed the approach when considering DoLS in a hospital setting, for example in circumstances where the patient is in need of life sustaining treatment. Essentially, if the root cause of a person's loss of liberty is their physical condition, then there is no basis for state detention / deprivation of liberty. The case in question related to a patient in ICU (hence why DOLS applications are no longer made for ICU patients).

The Local Authority DoLS teams in both Kirklees and Calderdale are continuing to receive numerous applications from both care homes and hospitals which has resulted in a significant backlog to review and process. This is a national issue for all local authorities. The prioritisation of reviewing urgent applications is looked at on a case by case basis. Due to the large number of DoLS applications received by the local authority their priority in reviewing these authorisations has changed favouring patients in longer term placements in care homes rather than those with a shorter hospital stay.

The safeguarding team continues to work closely with the DoLS managers for Calderdale and Kirklees councils to support consistency in applications across the CHFT footprint.

2.1 DoLS Data in Q1 and Q2

2017	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2017-18	166	15	60	28
2018-19	103	15	58	17

There has been a significant decrease in the number of DoLS applications by the Trust in comparison to Q1-2 data in 2017. Last year there were 166 applications and Q1-2 in 2018-19 there are 103. Reasons that contribute to this decrease include:

- Response by the Local Authorities DoLS teams in both their prioritisation of applications and the application of the Ferreira Case both in ICU and in non- ICU settings (these applications are being declined at point of referral), as well arguing that care and treatment cannot be delivered elsewhere albeit in some cases.
- The Safeguarding team are monitoring patients longer who lack capacity to decide whether or not they understand the reason they need to remain in hospital before applying for a DoL Safeguard. These situations are usually acute presentations of delirium and alcohol withdrawal that resolve quickly and therefore would invalidate the DoLS. During this time the principles of the Mental Capacity Assessment (MCA) are followed and at approximately 48 hours this is reviewed. This shows greater understanding of the MCA.

2.2 The Mental Capacity (Amendment) Bill

The Bill has been published and is now being introduced through Parliament, allowing for implementation and training, it could be expected to come into force perhaps in late 2019, early 2020.

The Bill abolishes the Deprivation of Liberty Safeguards, by deleting Mental Capacity Act 2005 (MCA) Schedule A1 and 1A, it instead adds a new Schedule AA1 – which we anticipate will be known as the 'Liberty Protection Safeguards'), as proposed by the Law Commission in March 2017.

What the Bill does:

- does not address any integration with the Mental Health Act
- the issue of overhauling the law relating to consent / capacity under 16 years of age has also been left alone.
- the new scheme applies only over age 18, contrary to the Law Commission recommendation, overlooking the opportunity to bring this into line with the MCA as a whole at age 16
- the focus is on deprivation of liberty (DoL) alone, rather than wider amendments to the MCA, and so the amendments proposed by the Law Commission to put “particular” weight on P’s wishes in any MCA best interests decision making are absent there is no statutory definition of DoL – so the Cheshire West Supreme Court Judgment from March 2014 prevails
- MCA s4B is revised – implementing a new and apparently wider definition of life sustaining treatment / vital act emergency circumstances in which a DoL will be lawful, pending any formal authorisation
- hospitals (both NHS and independent sector) will become responsible for authorising their own DoLs and for a DoL to be authorised, it must be “necessary and proportionate”, as determined by the hospital
- an approved Mental Capacity Professional will bring independent scrutiny, but only where “it is reasonable to believe that the person cared for does not wish to reside in that place …or to receive that care” – ie effectively only in the case of “objection” by the patient / service user

- authorisations of a DoL may last for up to 12 months initially, and can then be renewed for up to 12 months, but subsequent renewals can be for up to 3 years
- the Court of Protection continues to have jurisdiction over any appeal against an authorisation of a DoL.

Ongoing and Further work

- To scope the impact of the Draft Bill and provide specific briefings for the Trust Board next year.
- Continue to support and encourage wards to complete their own DoLS applications
- Provide MCA specific package to Maternity Services using a train the trainer model approach

3. TRAINING

The Safeguarding Team continue to provide and facilitate safeguarding training through a suite of eLearning packages.

At Level 1 these include Childrens and Adults (including Prevent level 1). A combined package for Level 2 of Children, Adults and MCA DoLS and a separate Female Genital Mutilation (FGM) package, with Level 3 training delivered in face to face classroom sessions.

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 where all staff groups will be reviewed regarding their current level and benchmarked against the new document.

The CQC report for CHFT published this year noted that not all areas had met 95% training compliance. Training compliance is sent monthly to Divisional leads and discussed quarterly at PSQB meetings.

Despite ensuring that there are sufficient level 3 training places provided and facilitated by the team for non-compliant staff and those likely to come out of compliance in 2018-19, there continues to be non-attenders at training sessions and some members of staff have still not booked onto training sessions. This means that the predicted target of 95 % compliance of all levels has not been met, additional sessions will be developed to support meeting the required compliance.

Level 2 eLearning training was met at 95% in Q1; however this is now decreasing on a month by month basis.

3.1 Training compliance

3.1.1 Community Division

Division	Competence	Q1 Compliance (%)	Q2 Compliance (%)	Change in % compliance
372 Community L3	Female Genital Mutilation	95.9%	92.5%	-3.5%
	Mental Capacity Act - 3 Years	75.0%	100.0%	25.0%
	Mental Capacity Act Level 2 - 3 Years	96.5%	95.4%	-1.1%
	Mental Capacity Act Level 3 - 3 Years	93.8%	91.6%	-2.2%
	Prevent WRAP - No Renewal	96.9%	96.1%	-0.8%
	Safeguarding Adults - Level 1 - 3 Years	94.8%	93.0%	-1.8%
	Safeguarding Adults Level 2 - 3 Years	96.6%	96.1%	-0.5%
	Safeguarding Adults Level 3 - 3 Years	96.1%	92.8%	-3.3%
	Safeguarding Children - Level 1 - 3 Years	94.8%	91.2%	-3.6%
	Safeguarding Children Level 2 - 3 Years	95.9%	96.3%	0.4%
	Safeguarding Children Level 3 - 3 Years	87.7%	88.5%	0.8%

Training now below 95% compliance

- There is a reduction of 3% in FGM compliance

- Adults Level 3
- Children level 1

Training at risk of becoming below 95% target

- Children, Adults and MCA Level 2

Training target 95% not met

- MCA and Childrens Level 3
- Adults Level 1

3.1.2 FSS Division

Division	Competence	Q1 Compliance (%)	Q2 Compliance (%)	Change in % compliance
372 Families & Specialist Services L3	Female Genital Mutilation	95.5%	95.3%	-0.2%
	Mental Capacity Act - 3 Years	89.7%	97.3%	7.6%
	Mental Capacity Act Level 2 - 3 Years	95.0%	93.2%	-1.9%
	Mental Capacity Act Level 3 - 3 Years	85.1%	84.2%	-0.9%
	Prevent WRAP - No Renewal	93.9%	93.5%	-0.5%
	Safeguarding Adults - Level 1 - 3 Years	98.9%	97.9%	-1.0%
	Safeguarding Adults Level 2 - 3 Years	95.9%	93.9%	-2.0%
	Safeguarding Adults Level 3 - 3 Years	87.0%	85.1%	-1.9%
	Safeguarding Children - Level 1 - 3 Years	98.9%	97.9%	-1.0%
	Safeguarding Children Level 2 - 3 Years	98.2%	95.2%	-3.0%
	Safeguarding Children Level 3 - 3 Years	92.4%	91.7%	-0.7%

Training now below 95% compliance

- MCA and Adults Level 2

Training at risk of becoming below 95% target

- FGM
- Childrens Level 2

Training target 95% not met

- MCA, Childrens and Adults Level 3
- Prevent

3.1.3 Medicine Division

Division	Competence	Q1 Compliance (%)	Q2 Compliance (%)	Change in % compliance
372 Medical L3	Female Genital Mutilation	88.7%	92.1%	3.4%
	Mental Capacity Act - 3 Years	92.7%	94.2%	1.4%
	Mental Capacity Act Level 2 - 3 Years	93.4%	87.0%	-6.5%
	Mental Capacity Act Level 3 - 3 Years	70.2%	75.1%	4.9%
	Prevent WRAP - No Renewal	85.7%	85.3%	-0.5%
	Safeguarding Adults - Level 1 - 3 Years	98.7%	98.7%	0.0%
	Safeguarding Adults Level 2 - 3 Years	93.8%	87.6%	-6.1%
	Safeguarding Adults Level 3 - 3 Years	75.6%	79.6%	4.0%
	Safeguarding Children - Level 1 - 3 Years	98.7%	99.4%	0.6%
	Safeguarding Children Level 2 - 3 Years	94.2%	88.8%	-5.5%
	Safeguarding Children Level 3 - 3 Years	72.9%	81.3%	8.3%

Training target 95% not met

- FGM
- Prevent
- MCA Level 1, Level 2 and Level 3
- Children and Adults Level 3

To note that Level 2 Children, Adults and MCA DoLS has reduced by 6% from Q1 to Q2

3.1.4 Surgery and Anaesthetics

Division	Competence	Q1 Compliance (%)	Q2 Compliance (%)	Change in % compliance
372 Surgery & Anaesthetics L3	Female Genital Mutilation	N/A	N/A	N/A
	Mental Capacity Act - 3 Years	95.8%	95.7%	-0.1%
	Mental Capacity Act Level 2 - 3 Years	96.0%	92.1%	-3.9%
	Mental Capacity Act Level 3 - 3 Years	77.0%	82.7%	5.6%
	Prevent WRAP - No Renewal	90.6%	90.8%	0.1%
	Safeguarding Adults - Level 1 - 3 Years	100.0%	99.4%	-0.6%
	Safeguarding Adults Level 2 - 3 Years	95.5%	92.3%	-3.2%
	Safeguarding Adults Level 3 - 3 Years	72.7%	78.4%	5.7%
	Safeguarding Children - Level 1 - 3 Years	100.0%	98.7%	-1.3%
	Safeguarding Children Level 2 - 3 Years	96.2%	92.7%	-3.5%
	Safeguarding Children Level 3 - 3 Years	85.7%	100.0%	14.3%

Training now below 95% compliance

- MCA, Children and adults Level 2

Training target 95% not met

- MCA Level 3
- Prevent
- Adults Level 3

Further and Ongoing Work

- Review the Adult Intercollegiate Document and staff groups who require particular levels of safeguarding training and supervision, and the content and length of the training currently provided
- Review numbers of staff at the end of Q3 who are required to complete level 3 training and explore delivering additional sessions
- Plan training sessions for 2019-20

3.2 Safeguarding Childrens Supervision

All staff who work with children require mandatory safeguarding supervision. A significant piece of work was completed in 2017-18 to assign all staff on the Electronic Staff Roster (ESR) system who are required to participate in mandatory supervision. This meant that supervision compliance is now reported divisionally and individual staff are aware when supervision is required.

Supervision %	Apr-18	Sep-18	Increase
% of staff having undertaken supervision – Trust Overall	53%	66%	13%
% of staff having undertaken supervision - Community	79%	85%	6%
% of staff having undertaken supervision - Medicine	21%	62%	41%
% of staff having undertaken supervision - FSS	59%	64%	5%

This data shows the increase from the beginning of Q1 to the end of Q2. All Divisions and overall compliance is increasing month on month.

Trust overall compliance is 69%

Ongoing and further work

- To continue to share compliance with Divisions and for Divisions to ensure that staff attend delivered training sessions and complete mandatory training on ESR.

4.0 REGULATORY COMPLIANCE

4.1 Trust Inspection 2018

The Care Quality Commission (CQC) Trust wide inspection in 2018 resulted in no direct actions relating to the safeguarding agenda.

There were a number of should do actions that were evident in the final report that were related to Safeguarding :

- Development of a Mental Health Working Group and Mental Health Strategy
- Continuing to ensure that staff complete their mandatory training
- Strengthening knowledge in relation to MCA DoLS
- Have a process to measure the outcomes of Mental Health Patients to identify opportunities to improve patient care
- Training relating to mental health is available for staff who work with children and young people
- Improving understanding of recognising and responding under the MCA and MHA

Further work

- This work will be progressed as part of a developing a Mental Health and CHFT working group
- Training is currently being reviewed and planned for 2019-20
- The publication of the Intercollegiate Document for Adults 2018 provides an opportunity for a review over Q4 of all staff groups in relation to Adult safeguarding training.

4.2 Children's and Children Looked After CQC Inspection (Calderdale 2016 and Kirklees 2018).

Both these reviews were conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

Individual action plans, progress and assurance are monitored by the CCG through the Safeguarding Committee meeting attended by the CCG Designated Nurse for Safeguarding Children.

- For Calderdale 2016 Inspection
    - One action is close to completion regarding new job description for the Named Nurse For Children Looked After. This has been reviewed in line with changes in the new Children Looked After Service Specification with the new Designated Nurse for Children Looked After (Calderdale)

- From the Kirklees Inspection there are 4 overall actions outstanding, which are detailed below

1. To ensure that staff in the Emergency Department at Huddersfield Royal Infirmary make full use of the prompts within the child's patient record designed to explore social and family history and any suspicious or worrying presentations. This action is progressing (2 amber, 2 green).

2. Ensure that the future plans for the transformation of children's emergency care services that service the Huddersfield area incorporate robust plans to deploy adequate paediatric qualified staff. This action is amber.

3. SWYPFT and CHFT must work together to ensure staff in the emergency departments and the children's wards are fully aware of the pathway for children and young people who self-harm and of the availability of out-of-hours mental health support. This action is progressing (8 green, 3 amber)

4. Locala and CHFT must strengthen the assessment of the emotional health and wellbeing of looked after children within initial health assessments. This action is completed (all 7 actions green)

4.3 Section 11

Under Section 11 of the Children Act 2004 places duties on organisations and individuals to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children. CHFT completed two Section 11 requests this year from both Calderdale and Kirklees.

1. Kirklees Safeguarding Children Board requested CHFT complete an online self-assessment which was submitted earlier this year. This online assessment was against 10 standards with a further 61 questions to complete. There are 11 questions that are partially met and the remainder are fully met and actions are being progressed.
2. Calderdale Safeguarding Childrens Board and Adults Board requested completion of a joint adult and children self-assessment. This was against 8 standards and 27 questions. There are 23 fully met and 4 actions partially met and actions are being progressed.

<u>Ongoing and Further Work</u>

- To continue to progress actions with Divisions and work with the Clinical Commissioning Group to complete these.

4.4 Kirklees Ofsted Inspection update

Ofsted Inspection of Kirklees Children's Services in September and October 2016 focused on local services for children in need of help and protection, looked after children and care leavers and an inspection of the Independent Safeguarding Children's Board. The resulting overall outcome was inadequate.

The next Ofsted monitoring visit for Kirklees Childrens Services will take place in December 2018 and it will focus on the front door. In preparation from this, the Director of Childrens Services for Leeds City Council and the Commissioner appointed by the Secretary of State have visited the front door and their feedback has been positive. Kirklees will then have a full inspection in the New Year 2019. A formal partnership with Leeds was made to give Kirklees the support and capacity needed which was agreed by the Minister for Children and Families. From July 2017 the Leeds Director of Childrens Services for Leeds has also been the Director of Childrens Services in Kirklees and has led the delivery of the Improvement Plan. Health colleague Board members are from Greater Huddersfield CCG, North Kirklees CCG, Locala, Head of Joint Commissioning for Children and Chair of Kirklees Safeguarding Childrens Board.

CHFT continues to support the Safeguarding Board by attending both the Board and the sub-groups providing any data requested by the Board to support in identifying vulnerable children, providing challenge at Board and sub-groups and its participation in Serious Practice Review panels and delivering SMART action plans through scrutiny at the Safeguarding Committee meeting.

Ongoing and Further Work

- To continue to support the improvement plan and work with Kirklees Safeguarding Childrens Board

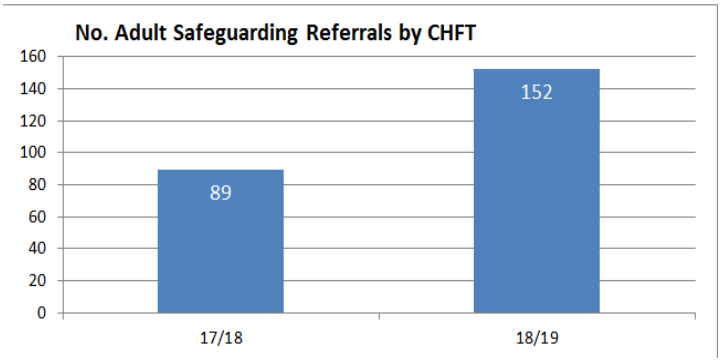
4.5 Calderdale Ofsted Inspection

Calderdale Childrens Services are also anticipating an Ofsted Inspection however there has been no indication as to when this will occur.

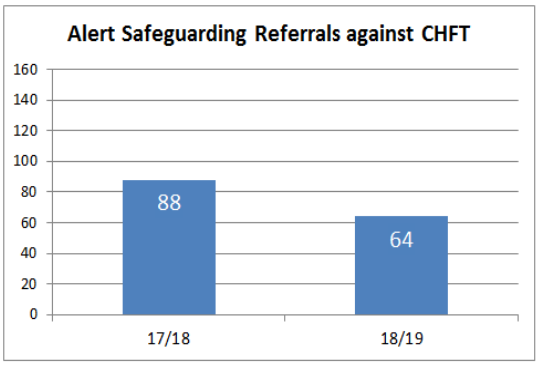
5. ADULT SAFEGUARDING

There is a change to the Named Professional Lead for Adult Safeguarding who is now in post This role now incorporates the lead for Domestic Abuse, Prevent and MCA DoLS.

There has been an increase of 63 referrals made by CHFT staff in relation to safeguarding concerns that were identified by staff and reported through the multi-agency safeguarding adult's procedures. This shows an increased awareness of staff in identifying and recognising what abuse is. All adult safeguarding referrals are recorded and reported both on datix and to the Safeguarding Committee.



Both neither legislation or guidance stipulates what would meet a particular threshold for reporting through the multi-agency safeguarding procedures; each concern is reviewed on a case by case basis. However, local authorities have interpreted this definition differently throughout the country. The safeguarding team work collaboratively with local authorities in Kirklees and Calderdale to ensure all referrals are investigated in line with the West and North Yorkshire and York Multi-agency Safeguarding Adults Policy and Procedures.



This data shows that there has been a reduction in the number of allegations made against CHFT by other partner agencies from 88 to 64. There is a reduction by 24 referrals in comparison to Q1-2 2017-18 / Q1-2 2018-19.

The implementation of the new and updated Safeguarding Adults multi-agency Policies and procedures this year has focused on a 'Making Safeguarding Personal' approach. This new approach asks the alleged victim what outcomes they are wanting through referral into the procedures. This approach will continue to be implemented over the coming months. Implementation will enable more outcome focused approach.

Ongoing and completed actions 2018-19

- The Safeguarding Team has commented on the Nutrition Policy, the Allegations Policy and included the new PIPOT guidance in to this policy (Persons in a Position of Trust Guidance issued by the Safeguarding Adults Board).
- The Safeguarding Adults Policy has been reviewed and updated in line with the New Multi-agency Safeguarding Adults Policy and Procedures, and also the Prevent Policy.
- The Safeguarding Committee Subgroups have developed robust action plans and have oversight of all safeguarding work required including embedding learning from external and internal reviews.
- To continue to develop systems that are lean and accessible for staff to enable them to carry out their role in safeguarding being everybody's business.
- Further training has been arranged with the Police to deliver 'Missing Persons' training
- Further work regarding embedding the new pressure ulcer guidance, falls reporting and ensuring that outcomes are more consistently reported and recorded regarding 'Making Safeguarding Personal.'

6. MENTAL HEALTH

CHFT works in partnership with SWYPFT formally through the service level agreement and the clinical working protocol. We are utilising the values described in our 4 pillars when developing a mental health strategy with our partners. There are reciprocal representatives and papers shared at SWYPFT's Mental Health Act Committee and CHFT's Safeguarding Committee meeting.

The Mental Health Act office (SWYPFT) has asked that CHFT Trust Board be notified of an error in the processing and completion of a detention under section 5(2) of the Mental Health Act (MHA) 1983. The paperwork was not completed correctly by two junior medical colleagues and it was not possible to rectify the error, therefore this was an unsafe section. Subsequent actions were taken to ensure compliance and this was supported by the Mental Health legislation team.

. Three actions arose from this incident:

1. Facilitating receipt and scrutiny training for senior nurses,
2. Ensuring that medical colleagues are aware of how to complete section 5(2) paperwork and
3. Informing the Trust Board of this incident.

The Mental Health Liaison Team (MHLT) support and work with CHFT trust staff to ensure that all patients who are referred are reviewed and supported in a timely way. The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.

The Service Level agreement between SWYPFT and CHFT has been re-reviewed and signed for a further 12 months. This service level agreement formalises partnership arrangements between both Trusts and ensures that CHFT are compliant in fulfilling their statutory duties. The Protocol has been re-reviewed and in its final stages of agreement between CHFT and SWYPFT.

There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.

Statistical information regarding the use of the MHA within CHFT is made available to the Safeguarding committee meeting every month. These figures comparatively have not varied from Q1-2 2017 to Q1-2 2018.

	2017 -18 Q 3-4	2018-19 Q1-2
Section 5(2)	3	5
Section 2	13	12
Section 3	1	3

Ongoing and Further Work

- To continue to work collarboratively and in partnership

7. DOMESTIC ABUSE HUB CALDERDALE

Since January 2016 CHFT has hosted the commissioned Domestic Abuse Health Practitioner role that is based in the Domestic Abuse Hub in Calderdale. This role represents all of the health partners in Calderdale and provides a coordinated and joined up approach for sharing and contributing to multi-agency information sharing. Following a change in the arrangements this role has reduced from two practitioners to one.

There are ongoing discussions with local health partners to review and consolidate the current and future arrangements and operational functionality within Calderdale given the reduction in resources. Commissioning of this service in 2018/19 requires further clarification and discussions with CCG are in place to agree next steps.

Ongoing work

- Further updates will be provided to the Trust Board once ongoing and future arrangements have been clarified.

8. DOMESTIC ABUSE QUALITY MARK

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.

This has been achieved through hard work and commitment of the team in ensuring that all 14 quality mark standards have been met for level 1 (Safety and Good Practice) and a further 5 for level 2 (Policies, Routine and Triggered Enquiry). The Quality Mark is awarded for 3 years and re-reviewed.

9. CHILDREN LOOKED AFTER AND CARE LEAVERS (CALDERDALE)

Our Children Looked After Team are based at Brighouse Health Centre and are the CHFT commissioned service who work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of children who are looked after (CLA) and young people in Calderdale are met. The team provides advice and support to health and social care practitioners in order to improve health outcomes for CLA and young people.

This year the CLA Health Service Specification has been redesigned with an agreed configuration of the service. This has allowed a more co-ordinated and joined up service for CLA and young people and expansion of the team which is led by the Named Nurse for Children Looked After.

- The Designated Nurse CLA role is now located in the CCG with existing funding remaining as part of the commissioned service resulting in a remodelled workforce to meet the revised specification.
- An additional two posts from Locala are seconded into the remodelled service to support in delivery of the new specification which now covers all CLA and Young people.
- The new service will now carry out Review Health Assessments up to a 50 mile radius and beyond in consultation with the relevant service in the placement area.

This service is closely monitored by both the Safeguarding Committee and partners of CMBC and CCG.

10. CHILD SEXUAL EXPLOITATION (CSE)

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity

(a) in exchange for something the victim needs or wants, and/or

(b) for the financial advantage or increased status of the perpetrator or facilitator.

The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Children aged 12-15 years of age are most at risk of child sexual exploitation although victims as young as 8 have been identified, particularly in relation to online concerns. Equally, those aged 16 or above can also experience child sexual exploitation, and it is important that such abuse is not overlooked due to assumed capacity to consent.

As active Safeguarding Board members at both Kirklees and Calderdale Safeguarding Childrens Boards and their subgroups we support and work as a partner with the Boards to protect children and promote their welfare, keeping children safe from harm and abuse, and the implementation of this operationally at CHFT.

CHFTs Safeguarding Childrens, Adults and Domestic Abuse Policies reflect guidance and links to multi-agency procedures for staff to follow. We disseminate learning from Serious Case reviews to staff through our Learning and Audit subgroup of the Safeguarding Committee and a virtual notice board to divisions and frontline staff. We are currently delivering bespoke training to Emergency Department staff which includes CSE and the potential risk factors associated with this. This is also delivered as part of our Level 3 childrens safeguarding training.We also have developed and implemented an Under 18 Risk Assessment Proforma which includes CSE. This is used in the Integrated Sexual Health Service, Maternity and Gynaecology services.

11. CONCLUSION

The safeguarding update report demonstrates that safeguarding children, young people, families and vulnerable adults remains a trust key priority. It demonstrates that CHFT is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework.

Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2018-19 in line with other Trust priorities and the wider partnership priorities.

Our key underpinning message is that Safeguarding is everybody's responsibility regardless of their role within the Trust.

15. Review of Progress against Strategy

For Review

Presented by Victoria Pickles

16. Quality & Performance Report – November 2018

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 3rd January 2019	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: QUALITY & PERFORMANCE REPORT - The Board is asked to note the overall performance score for November.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board, Finance & Performance Committee, Quality Committee	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

November's Performance Score has improved to 70%, highest since July. The SAFE domain has deteriorated to amber due to a never event. The CARING domain has improved to green with better performance in Outpatients, A&E and Community FFT would recommend. EFFECTIVE domain has improved to green with #NoF 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 EST has deteriorated in month alongside appraisal rates for medical staff. Within EFFICIENCY & FINANCE I&E: Surplus / (Deficit) has improved to amber and CIP was within target in month.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

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

Appendix

Attachment:

There is no PDF document attached to the paper.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Quality and Performance Report

November 2018

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

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

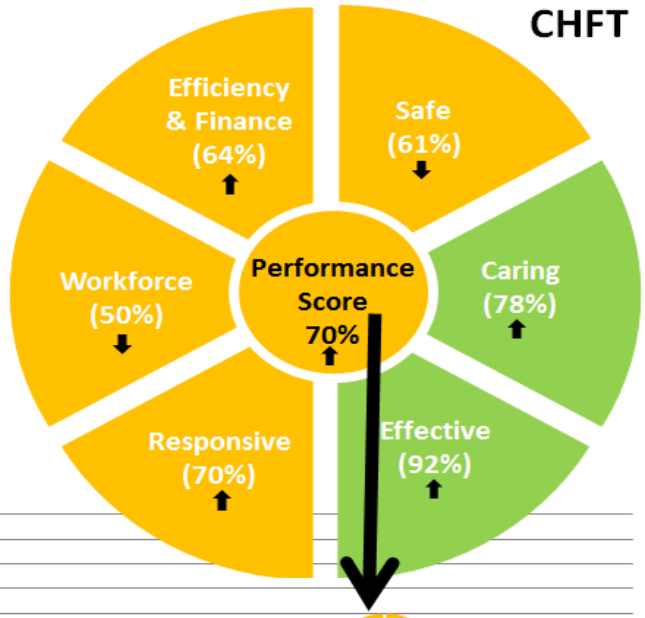
There have been 2 MRSAs reported for October since last month's report was produced resulting in overall performance for the Trust reducing from 67% to 65%. In addition the Effective domain went from green to amber.

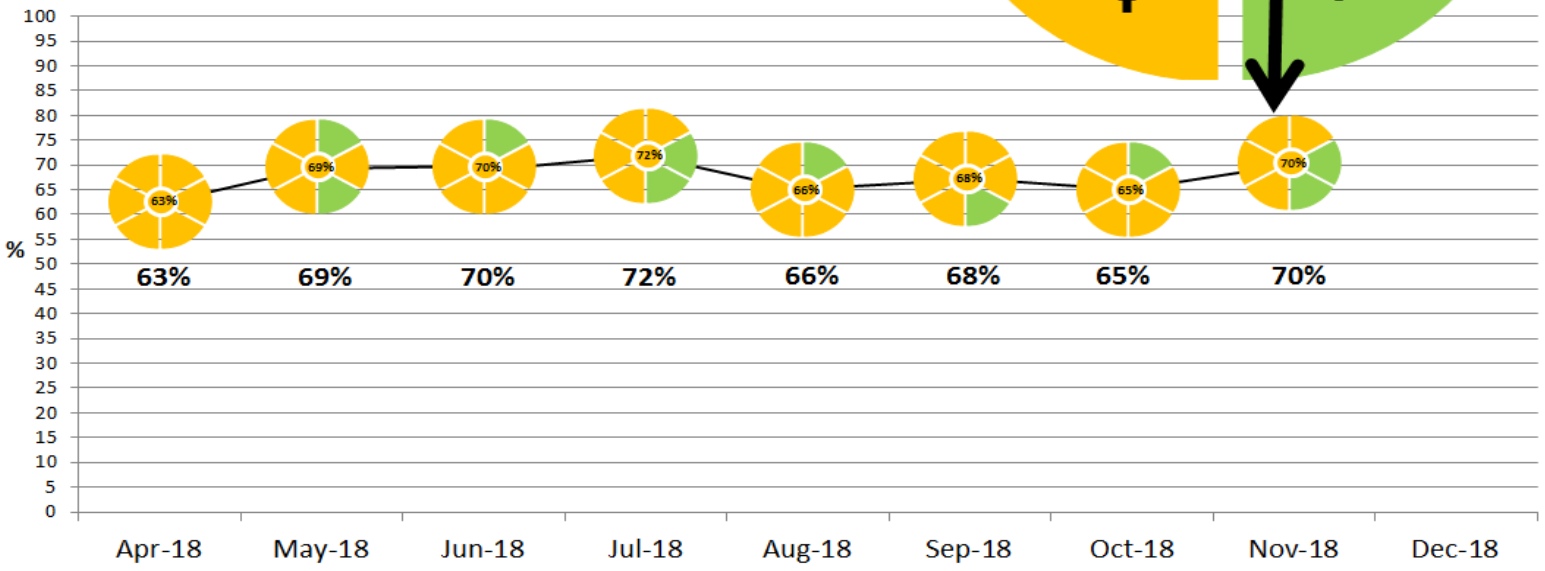
Performance Summary

November

RAG Movement

November's Performance Score has improved to 70%, highest since July. The SAFE domain has deteriorated to amber due to a never event. The CARING domain has improved to green with better performance in Outpatients, A&E and Community FFT would recommend. EFFECTIVE domain has improved to green with #NoF 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 EST has deteriorated in month alongside appraisal rates for medical staff. Within EFFICIENCY & FINANCE I&E: Surplus / (Deficit) has improved to amber and CIP was within target in month.





SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
FFT IP FFT Maternity	FFT A&E FFT OP 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	YTD
SAFE										
Never Events	1	0	0	0	0	0	1	0	1	1
CARING										
% Complaints closed within target timeframe	48.70%	37.00%	44.00%	30.00%	31.00%	33.0%	53.0%	45.0%	49.0%	40.0%
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%	37.96%
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%	97.48%
Friends and Family Test Outpatient - Response Rate	10.10%	11.30%	10.45%	11.43%	11.40%	11.32%	11.61%	10.21%	11.00%	11.08%
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%	91.50%	90.77%
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%	12.69%
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%	84.28%
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%	34.80%
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%	98.60%
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%	5.08%
Friends and Family Test Community Survey - % would recommend the Service	90.00%	93.90%	92.60%	92.00%	97.40%	94.06%	93.18%	91.72%	95.87%	93.38%
EFFECTIVE										
Number of MRSA Bacteraemias – Trust assigned	5	0	0	1	0	0	0	2	0	3
Preventable number of Clostridium Difficile Cases	8	3	1	1	0	0	0	0	0	5
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.98									98.98
Hospital Standardised Mortality Rate (1 yr Rolling Data)	82.47									82.95
RESPONSIVE										
Emergency Care Standard 4 hours	90.61%	91.52%	93.23%	94.78%	92.37%	91.15%	89.63%	90.31%	90.74%	91.75%
% 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%	62.90%
% Incomplete Pathways <18 Weeks	93.75%	93.77%	93.32%	94.05%	93.99%	93.18%	93.00%	93.15%	93.12%	93.12%
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%	98.39%
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%	98.91%	97.78%
31 Days From Diagnosis to First Treatment	99.83%	100.00%	99.37%	99.41%	100.00%	100.00%	100.00%	100.00%	99.28%	99.76%
31 Day Subsequent Surgery Treatment	99.26%	100.00%	100.00%	100.00%	97.22%	100.00%	100.00%	95.45%	100.00%	98.95%
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%
38 Day Referral to Tertiary	45.49%	47.62%	40.00%	50.00%	50.00%	42.86%	52.00%	75.00%	42.86%	48.63%
62 Day GP Referral to Treatment	88.67%	90.66%	92.35%	83.98%	87.72%	83.51%	88.70%	85.65%	90.27%	87.68%
62 Day Referral From Screening to Treatment	94.87%	81.82%	91.67%	100.00%	100.00%	100.00%	85.71%	78.95%	95.45%	91.67%
WORKFORCE										
Sickness Absence rate (%) - Rolling 12m	4.10%	4.10%	4.07%	4.04%	4.01%	3.97%	3.92%	3.90%	*	-
Long Term Sickness Absence rate (%) -Rolling 12m	2.55%	2.54%	2.53%	2.51%	2.48%	2.45%	2.42%	2.41%	*	-
Short Term Sickness Absence rate (%) -Rolling 12m	1.55%	1.56%	1.53%	1.53%	1.53%	1.52%	1.50%	1.49%	*	-
Overall Essential Safety Compliance		95.00%	94.40%	93.96%	93.84%	91.56%	90.12%	91.02%	91.47%	-
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%	-
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%	-
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	0.01

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
% PPH ≥ 1500ml - all deliveries - target has been met for the last 4 months.	Never Event - There was 1 Never Event in November relating to a Gynaecology patient who had a retained gauze roll post surgery.	Surgery is working closely with FSS colleagues to review the incident and identify learning to inform any further actions.
Friends and Family Test Community Survey - % would recommend the Service - at 95.87% just below target but best performance since July.	% Diagnostic Waiting List Within 6 Weeks - missed target for first time since May due to Echocardiography.	3 locums left the Trust in October and there are currently only 3 members of staff able to scan. Recruitment of 1 x full time bank physiologist ongoing and should be in post early January. This will provide approximately 250 extra slots per month. This is with a view to become permanent substantive after 3 months. Staff are working overtime to increase capacity. Recruitment advert has had one application to be interviewed in January (band 6). The backlog of outpatients will continue to increase until more scanning staff are available. Outsourcing companies have been contacted to provide scanning and reporting but extremely expensive.
Infection Control - MRSA, Cdiff, MSSA, E.Coli all hit target for the first time in 12 months.	Appraisals - dip in performance over the last couple of months particularly for medical staff.	Appraisal compliance will continue to be reported outside of the appraisal season to ensure that those colleagues that return from long term sickness absence and maternity leave have an appraisal. HR Business Partners will work with Divisions to ensure that those colleagues that have not had an appraisal, have one undertaken as soon as possible.

Executive Summary

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

Area	Domain
Safe	• **Never Event** - There was 1 Never Event in November relating to a Gynaecology patient who had a retained gauze roll post surgery. Surgery is working closely with FSS colleagues to review the incident and identify learning to inform any further actions. • **% Harm Free Care** - Reduced to 92.81% in month. Lowest performance since July. % of Harm Free Care (new) is on target at 98%. • **Category 4 Pressure Ulcers Acquired at CHFT** - There has been one in Medicine attributed to the IMS directorate Ward 7D (Stroke Rehab) that is being investigated.
Caring	• **Complaints closed within timeframe** - Of the 57 complaints closed in November, 49% (28/57) were closed within target timeframe. The number of overdue complaints was 5/82 (6%) compared to 16/82 (20%) in October. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance has improved to 91.5% but is still below 95.7% target. 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. The OP transformation project is expected to have a positive impact on patient experience. • **Friends and Family Test A & E Survey - % would recommend the service**. Performance has improved to 83.6% also still below the 87.2% target. We have reviewed the comments from HRI ED. We are addressing the long waits through our ED action plan and will use some of the comments as feedback in staff huddles for reflection. • **Friends and Family Test Community Survey - % would recommend the Service**. Performance is now just below 96.6% target at 95.87%, best since July. • **% Dementia patients following emergency admission aged 75 and over** - performance 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 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. CCIO working with EPR team to look at improving prompts and new daily dashboard about to 'go live' highlighting patients requiring a screen. Paper will go to WEB at the end of December.
Effective	• **#Neck of Femur** - achieved target for first time since June.

Background Context

All divisions have been working on specific directorate action plans in line with the CQC Health Checks.

Medicine is actively working on a management plan for Winter and work is underway on the developments of key projects on the back of the annual planning days.

The division is also working on improving the patient's journey from admission and reducing waiting times to be transferred to a bed from ED. This campaign is called '10 before 10' and its purpose is to try and ensure that 10 beds are available in the Division by 10am.

The first stage to create the Acute Floor has taken place with SAU moving to ward 1 and MAU moving to ward 9, the project is now moving into the second stage.

The Rapid Access Team (Arrhythmia Clinic) has a new one-stop model which provides an approach where patients will attend, have their ECHO, see the specialist nurse and see the consultant all in one appointment. The waiting time is 2-4 weeks and the consultant supporting the clinic is an Arrhythmia expert.

The HPV programme is nearly complete across all wards in the division. Ward 20 continues to complete outstanding actions from the infection control plan.

The Elderly Care wards at HRI are joining together to each focus on a specific aspect of a patient's journey through our service, and they are calling this 'Pride in our Care'.

The division has had the initial meeting with the executive team to discuss priorities for next year, key areas of CIP and pressures and developments. Each directorate has worked through the IMAS model to review each specialty's Outpatient demand and capacity in more detail.

The latest quarter SSNAP results for July – September 2018 (Q2) have been published. We have gone from a C in Q1 to a high B in Q2.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** - at 90.74% in October, (92.05% all types) - small improvement on last month. The workforce review in ED is ongoing, with workforce planning for doctors and ACP's taking place in Q4 to ensure we have the right workforce to meet demand. • **Stroke targets** - 3 out of 4 targets achieved for 2nd month. Only patients admitted directly to stroke unit within 4 hours missed target at 70.9% (a C SSNAP score), best performance since January. 3 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. • **38 Day Referral to Tertiary** - following a 75% achievement in October, performance has deteriorated to 43% in November. • **Appointment Slot Issues on Choose & Book** - still around 30%. There has been a noticeable increase in ASIs over the last two months, some of this has been attributed to reduced clinic capacity over the Christmas period along some additions being added to the ASI following a review. In Surgery additional capacity has been gained with further to be sourced to address long waiters. A number of clinical posts being filled.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total is at its lowest position although there was a small increase in month. RTWI performance has fallen in month to 67% following the 70% achieved in September. • **Essential Safety Training** compliance has improved overall in month however only Dementia Awareness is achieving the 95% target.
Finance	• **Finance**: **Year to Date Summary** The year to date deficit is £26.62m, a £0.01m favourable variance from plan. • The position includes a benefit of £0.16m due to Medical Staff pay awards which were implemented in October and not backdated as assumed in the plan. This is a timing difference, will reduce month on month and is not expected to impact on the foreast.ealth pay announcement on Medical Staff pay which confirmed that pay awards would be implemented in October and not backdated as assumed in the plan. This is a timing difference, will reduce month on month and is not expected to impact on the forecast. **Aside from this the position is slightly worse than plan.** • Clinical contract income performance is below plan by £1.88m. The Aligned Incentive Contract (AIC) protects the income position by £1.7m in the year to date leaving a residual pressure of £0.18m. However, a proportion of this income protection (£1.41m) 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 £0.29m. • CIP achieved in the year to date is £9.40m against a plan of £9.88m, a £0.48m pressure. • Operational budgets are now overspent by £1.06m year to date, a slight worsening compared to month 7. However, the underlying Operational overspend is actually closer to £1.94m, mitigated by a number of non recurrent benefits: capitalising of salaries (£0.19m), a one-off additional CNST Maternity Incentive payment (£0.42m) and by bringing forward the remaining benefit of the planned element of the Incentive payment (£0.27m). The remaining pressure has been mitigated by the release of all of the Trust's contingency reserves in the year to date a total of £1.00m and the release of some year end provisions (£0.15m). In addition a proportion of the winter element of the reserve has been released in the short term to offset the shortfall on CIP and will need to be reinstated as CIP is achieved per the re-profiled forecast. • Agency expenditure is £0.5m 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 particular pressures in month in Surgery and Medicine. The year to date adverse variance to plan at Trust level of £2.7m. However, against the agency trajectory there was a big improvement in month with Medical Agency dropping well below the planned level in month. • There are also significant pressures on non-pay expenditure particularly on the cost of premises, Pathology contracts and clinical supplies. • Nursing pay expenditure reduced to the planned level in month (excluding the impact of pay awards), with lower substantive pay than that reported in October. **Forecast** • The forecast is to achieve the planned £43.1m deficit; this relies upon full delivery of the £18m CIP plan including high risk schemes. • The underlying position is driving an additional recovery requirement with a total value of £3.96m. The full value of the recovery requirement is being pursued through a range of recovery actions and opportunities, some of which are already delivering.

Background Context

Within Surgery ward 21 has started the national pressure ulcer collaborative work and is currently developing action plans to work through key improvements.

Orthopaedic team continues to manage trauma and #NOF demand with effective escalation into the Division.

Dementia screening continues to be a priority and is being led by the Divisional Director. Changeover of junior medical staff has had some impact on performance.

Refreshed approach to Data Quality is being worked through to enable a more targeted approach and support to individual clinicians.

Directorate teams have been supported to manage activity and performance through weekly meetings in the Division and attendance at weekly Masterclasses supported by Executive colleagues.

There was good news for the Community division when Calderdale Clinical Commissioning Group confirmed their intention to build an alliance contract with their existing contractual providers and the wider health and social care system to deliver the strategic vision of Care Closer to Home.

This clarified that Calderdale Clinical Commissioning Group would not be procuring a new contract, however, in the spirit of openness and transparency, they would be advertising their intentions.

During November, the Radiology team continued to work with Leeds Teaching Hospital to develop a model of support to the CHFT Interventional Radiology service. The CHFT service continues to run on 1 permanent consultant with support from colleagues at Leeds to provide 1 day on-site CHFT support and support to out of hours on call. In the new year Leeds will be in a position to increase this support to 2 days per week.

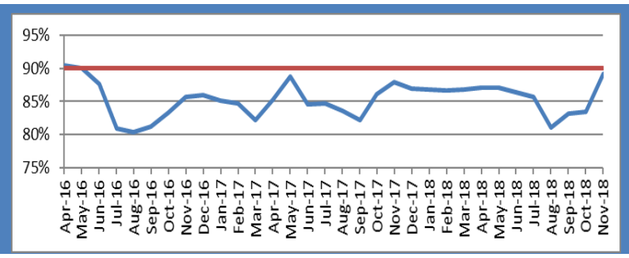
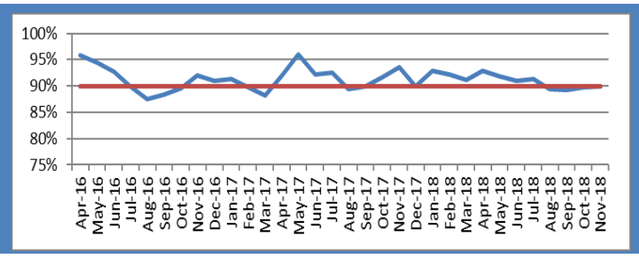
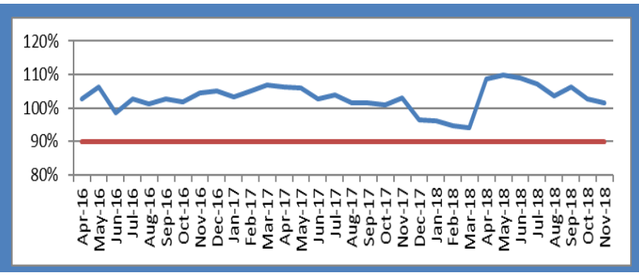
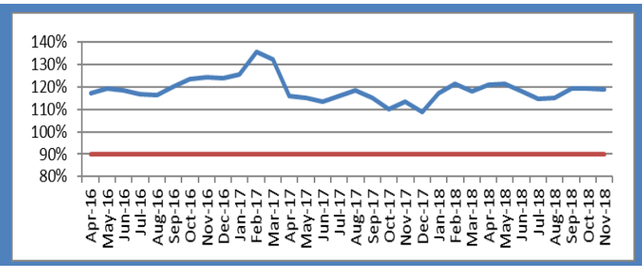
Paediatric services continued to see higher levels of activity during November. The inpatient service also supported a higher than average volume of out of area transfers due to capacity pressures at neighbouring Trusts. The service has reviewed the intra-hospital transfer policy to ensure that transfers only occur when other Trust services are suspended.

The Pharmacy team continued to provide an enhanced service to wards during the weekend. This will continue during the winter months and so far has supported an increase in the percentage of drug records being reconciled during a weekend.

The Radiology consultant team took part in the first Work Together Getting Results session led by Executive Colleagues. This session was used to look at what is working well and what further steps can be taken to improve the service in future.

Our maternity team continued to safely manage a number of vacancies and absence within the team. The position is expected to start to improve early in the new year.

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.	89.16% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 6 56.4% - Ward 17 70.3%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy. This is managed on a daily basis against the acuity of the patients. The low fill on ward 6 is due to reconfiguration of services and a reduced bed base
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	89.98% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - Ward 6 66.7% - Ward 12 65.6%	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. This is managed on a daily basis and CHPPD is maintained. The low fill on ward 6 is due to a reduced bed base associated to re-configuration
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	101.46% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 69.6% - LDRP 72% - NICU 55.8%	The low HCA fill rates in August 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.	118.67% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	There have been no HCA shifts that have had a fill rate of below 75%. Fill of greater than 100% is attributed to 1-1 care and skill mixing opportunities to meet RN under fill.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	DAY						NIGHT						Care Hours Per Patient Day							
	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies	Ward Assurance
	Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual										
CRH ACUTE FLOOR	2,550.00	2,887.08	2,025.00	2,054.83	113.2%	101.5%	2,310.00	2,418.00	1,980.00	1,852.67	104.7%	93.6%	8.5	8.9		7	13	9.67	1.97	62.4%
HRI MAU	1,890.00	1,823.45	1,890.00	1,810.50	96.5%	95.8%	1,650.00	1,585.97	1,320.00	1,296.83	96.1%	98.2%	16.3	15.7		9	9	5.80	0.00	52.3%
WARD 4	810.00	777.33	1,170.00	1,155.67	96.0%	98.8%	660	660.00	660	1,001.00	100.0%	151.7%	6.7	7.3			3	4.32	0.00	72.6%
WARD 5	1,620.00	1,294.50	1,170.00	1,358.63	79.9%	116.1%	990.00	992.75	990.00	1,088.25	100.3%	109.9%	6.1	6.0		1	9	3.55	0.00	58.2%
WARD 15	1,755.00	1510.5	1620	1,640.67	86.1%	101.3%	1320	1,263.25	1320	1474	95.7%	111.7%	6.8	6.6		2	3	2.94	0.00	73.1%
WARD 5BC	2,340.00	1,898.48	1620	1,921.50	81.1%	118.6%	1980	1669.333	660	1012	84.3%	153.3%	10.1	10.0		3	4	12.03	0.00	66.8%
WARD 6	1,530.00	862.25	945.00	941.50	56.4%	99.6%	990.00	660.00	660	671.5	66.7%	101.7%	9.0	6.8			1	4.33	0.00	60.9%
WARD 6C	945.00	846.25	810	680.5	89.6%	84.0%	660.00	659.50	330	350.5	99.9%	106.2%	5.3	4.9			6	10.77	4.83	63.9%
WARD 6AB	1,305.00	1209.9667	1080	1301.35	92.7%	120.5%	990	1,056.00	990	1,280.25	106.7%	129.3%	5.0	5.5		1	10	2.04	0.00	49.8%
WARD CCU	1,428.00	1,242.83	360	357.25	87.0%	99.2%	990	968	0	0	97.8%	-	9.4	8.7			1	3.81	0.00	74.4%
WARD 7AD	1,620.00	1,291.03	1,530.00	2,039.57	79.7%	133.3%	990	990	990	1,320.00	100.0%	133.3%	7.1	7.8			2	3.38	4.30	65.9%
WARD 7BC	2430	2005.3	1620	1885.4	82.5%	116.4%	1,980.00	1617	660	1199	81.7%	181.7%	10.6	10.7			3	-18.69	0.00	74.7%
WARD 8	1395	1199.1667	1170	1681.75	86.0%	143.7%	990	862.83	990	1,496.00	87.2%	151.1%	6.6	7.6		2	5	2.87	0.00	72.6%
WARD 12	1620	1222	810	1015.5	75.4%	125.4%	990	649	330	671	65.6%	203.3%	5.7	5.4		1	1	3.65	1.16	67.1%
WARD 17	1980	1392.1667	1170	1065.667	70.3%	91.1%	990	979.00	660	704.00	98.9%	106.7%	6.2	5.4			5	5.50	0.00	60.4%
WARD 5D	1035	967.58333	810	803.1667	93.5%	99.2%	660	660.00	330	407.00	100.0%	123.3%	7.8	7.8		1	6	-0.27	0.00	63.9%
WARD 20	1755	1531.05	1755	1976.667	87.2%	112.6%	1,320.00	1,239.50	1,320.00	1,745.25	93.9%	132.2%	5.5	5.8		2	5	8.14	0.00	55.0%
WARD 21	1485	1258.1667	1485	1372.333	84.7%	92.4%	1,035.00	941.75	1,035.00	1,092.50	91.0%	105.6%	8.8	8.1		1	6	4.00	0.00	72.6%
ICU	3900	3607.7	795	553.25	92.5%	69.6%	4,141.00	3,200.00	0	0	77.3%	-	50.2	41.8		1		4.43	0.00	68.5%
WARD 3	915	979.66667	795	664.6667	107.1%	83.6%	690	678.5	345	345	98.3%	100.0%	6.5	6.3		2		0.34	0.00	65.1%
WARD 8A	900	737.1	690	818.1	81.9%	118.6%	690	645	345	492	93.5%	142.6%	7.9	8.1			1	1.32	0.00	71.7%
WARD 8D	795	870.01667	795	690.4667	109.4%	86.9%	690	690.00	0	298.5	100.0%	-	5.8	6.5				2.94	0.00	62.8%
WARD 10	1260	1304.4833	795	881.5	103.5%	110.9%	795.00	715.00	690	1,078.00	89.9%	156.2%	7.4	8.3		2	2	2.67	2.10	85.1%
WARD 11	1870	1630.9167	1140	998.25	87.2%	87.6%	1,035.00	1,023.50	690	690	98.9%	100.0%	8.6	7.9		1	2	4.07	0.00	48.1%
WARD 19	1590	1313.3333	1140	1187.083	82.6%	104.1%	1,035.00	1,011.75	1,035.00	1,125.00	97.8%	108.7%	8.8	8.5		1	4	3.80	0.00	75.7%
WARD 22	1140	1162.4167	1140	1106.833	102.0%	97.1%	690	689.67	690	690.5	100.0%	100.1%	5.8	5.8		1	3	1.18	0.00	45.7%
SAU HRI	1830	1787.3333	947	935.6667	97.7%	98.8%	1,380.00	1,361.00	345	357.5	98.6%	103.6%	6.0	5.9		2	1	0.00	0.00	57.5%
WARD LDRP	4140	3536.9167	915	659	85.4%	72.0%	4,140.00	3,327.92	690	651.1667	80.4%	94.4%	21.9	18.1				0.00	0.00	24.3%
WARD NICU	2175	1853.9167	900	502.1667	85.2%	55.8%	2,070.00	1,637.00	690	519.5	79.1%	75.3%	12.8	9.9				2.77	1.92	33.9%
WARD 3ABCD	3840	3650.8333	1268.5	963.1667	95.1%	75.9%	3795	3324	345	356.5	87.6%	103.3%	9.7	8.7				-2.64	0.00	18.5%
WARD 4ABD	1890	1929.35	690	644	102.1%	93.3%	1,380.00	1,355.50	690	679.5	98.2%	98.5%	4.5	4.5				0.41	0.00	19.3%
WARD 4C	1140	1127.5	450	352.1667	98.9%	78.3%	690	701.5	345	310.5	101.7%	90.0%	8.9	8.4				1.77	0.52	70.7%
Trust	**56878**	**50710.6**	**35500.5**	**36018.8**	**89.16%**	**101.46%**	**44716**	**40232.2**	**22125**	**26255.4**	**89.97%**	**118.67%**	**8.21**	**7.90**						

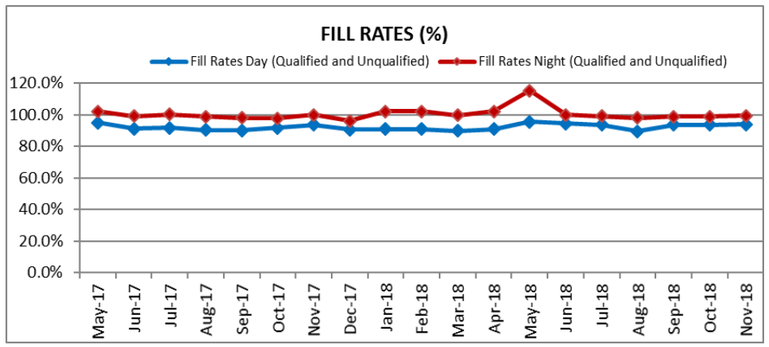
Hard Truths: Safe Staffing Levels (3)

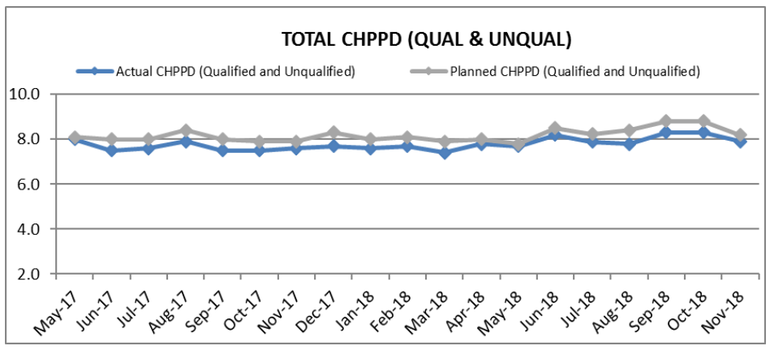
Care Hours per Patient Day

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

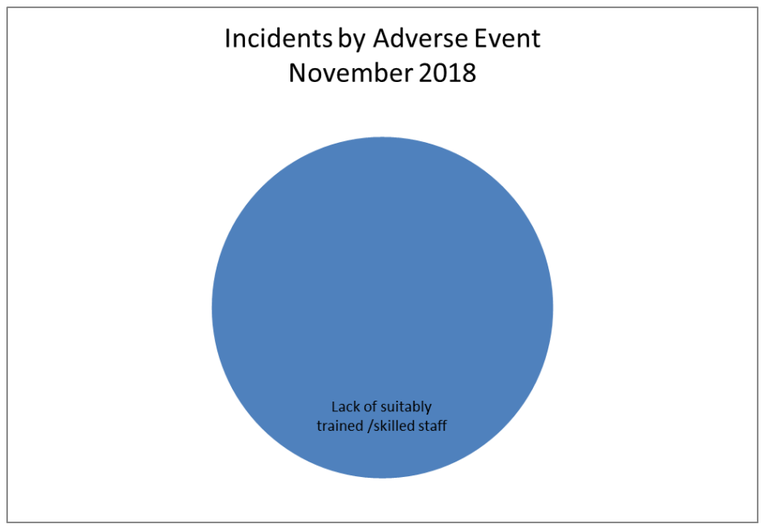
	Sep-18	Oct-18	Nov-18
Fill Rates Day (Qualified and Unqualified)	93.5%	93.5%	93.9%
Fill Rates Night (Qualified and Unqualified)	98.9%	98.9%	99.5%
Planned CHPPD (Qualified and Unqualified)	8.8	8.8	8.2
Actual CHPPD (Qualified and Unqualified)	8.3	8.3	7.9

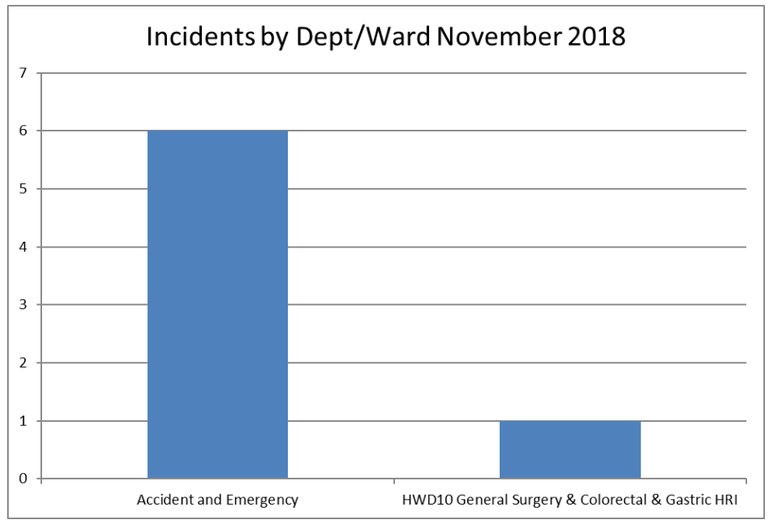
A review of November 2018 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 19 clinical areas of the 32 reviewed having CHPPD less than planned. 10 areas reported CHPPD slightly in excess of those planned and 3 areas having CHPPD as planned. Areas with CHPPD more than planned were due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There were **7 Trust Wide Red shifts** declared in **November 2018.**
As illustrated above the most frequently recorded red flagged incident is related to "lack of suitably trained staff"
No datex's reported in November 2018 have resulted in patient harm.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

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, on top of the monthly band 5 recruitment assessment days.
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 December 2018
4. A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. 57 candidates have now been transferred onto the OET programme.
5. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017. A proposal has being developed to up-scale the project in line with the national and regional workforce plans. A second cohort of 20 trainees commenced training on 4th June 2018. A further cohort are planned for 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

17. Governance Report

1.Board Skills / Competencies

2.Risk Management Strategy

3.Use of Trust Seal

4.Attendance Register

5.Board meeting dates

6.Board to Ward visits feedback

To Approve

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 3rd January 2019	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - JANUARY 2019 - This report brings together a number of governance items for review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

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

a. Board Skills / Competencies
b. Risk Management Strategy
c. Use of Trust Seal
d. Attendance Register
e. Board meeting dates
f. Board to Ward visits feedback

Main Body

Purpose:

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

Background/Overview:

a. Board Skills/Competencies
The Board of Directors are asked to undertake a self-assessment of their skills and competencies as part of an annual review. The composite information regarding the Board Skills and Competencies is attached. This assessment will be used to help identify any required development and also the assessment of what skills are required when consideration is given to future board vacancies.

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 as a whole to undergo training as corporate trustees of the Charitable Trust and this has been identified as part of the Charitable Funds Committee self assessment and will be arranged for later in the year.

The Board is asked to REVIEW and COMMENT on the report.

b. 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. The Governance structure has been updated and the Divisional Digital Boards have been added into the risk flow chart which review digital risks as these were introduced during this year. The Board is asked to APPROVE the Strategy.

c. Use of Trust Seal
The Trust Seal has been used 6 times in the last quarter.

1. CHFT & CHS Shareholders Agreement
2. CHFT & CHS Operated Healthcare Facility Agreement
3. Lease of first floor offices at Lister Lane Surgery
4. Renewal Lease of Oak House (+ renewal of 2nd floor Oak House)
5. Pennine Property Partnership and CHFT Agreement to vary the contract

The Board is asked to RECEIVE and NOTE the report.

d. Attendance Register
The Board attendance register for the year April 2018 - March 2019 is attached. The Board is asked to RECEIVE the report.

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

f. Board to Ward visits feedback
The attached is a summary of the Board to Ward visits feedback between July and August 2018. There are 8 upcoming visits being scheduled for the next quarter which are described in the report. The Board is asked to RECEIVE the report.

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to:

- REVIEW the Board Skills / Competencies report
- APPROVE the Risk Management Strategy
- NOTE the use of the Trust Seal
- RECEIVE the Attendance Register
- NOTE the 2019 Board meeting dates
- RECEIVE the Board to Ward feedback

Appendix

Attachment:

Governance Report.pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD SKILLS AND COMPETENCIES SELF-ASSESSMENT 2018-2019
Collated Template – 3 January 2019

The proposition for this assessment is that the Board can regard itself as competent if there is a good spread of in depth and working knowledge for each domain across the Executive Directors and Non-Executive Directors. This assessment is used to satisfy the Board that it is fit for purpose and to inform recruitment processes to ensure that any gaps that arise at short notice, or can be predicted through turnover, are filled.

The domains are determined by the Board, having regard to the provisions set out in the Code of Governance for Foundation Trusts by the Foundation Trust Regulator.

KEY:
E – denotes Essential domain
D – denotes Desirable domain
✓ - **Area of sufficiency or strength – considers self competent**
★ - **Area requiring some development – moderate experience or skill**
△ - **No or little experience/skill – development required**

		EXECUTIVE DIRECTORS	**NON-EXECUTIVE DIRECTORS (1 response outstanding)**
DOMAIN	(See Key)	✓ - **Area of sufficiency or strength – considers self competent** ★ - **Area requiring some development – moderate experience or skill** △ - **No or little experience/skill – development required**	✓ - **Area of sufficiency or strength – considers self competent** ★ - **Area requiring some development – moderate experience or skill** △ - **No or little experience/skill – development required**
Strategic risk & governance management	**E**	✓ - 6	✓ - 5

Financial expertise	**E**	✓ - 5 ★ - 1	✓ - 4 ★ - 1
Audit expertise	**E**	✓ - 3 ★ - 3	✓ - 3 ★ - 2
THIS expertise	**E**	✓ - 4 ★ - 2	✓ - 3 ★ - 2
Strategic thinking and practice	**E**	✓ - 6	✓ - 5
System management and system thinking to include customer relationship management and partnership working	**E**	✓ - 5 ★ - 1	✓ - 5
Current and future policy environment	**E**	✓ - 3 (professionally competent) ★ - 3	✓ - 2 ★ - 3
Leadership and organisational development	**E**	✓ - 4 ★ - 2	✓ - 4 ★ - 1
Improvement and change management	**E**	✓ - 5 ★ - 1	✓ - 5
Performance management	**E**	✓ - 6	✓ - 4 ★ - 1
Health and Social Care experience	**E**	✓ - 4 ★ - 1 △ - 1	✓ - 2 ★ - 3
Clinical quality & interdependencies	**E**	✓ - 3 ★ - 3	★ - 4 △ - 1
Commercial focus & entrepreneurial skills	**E**	✓ - 4 ★ - 1 △ - 1	✓ - 3 ★ - 2
Human resources management	**E**	✓ - 5 ★ - 1	✓ - 5
Legal awareness	D	★ - 6	✓ - 3 ★ - 2
Health & Safety	D	✓ - 3 ★ - 3	✓ - 3 ★ - 2

Corporate communication/media	D	✓ - 2 ★ - 4	✓ - 4 ★ - 1
Community Development experience	D	✓ - 3 (professionally) ★ - 2 △ - 1	✓ - 3 ★ - 1 △ - 1
Ambassadorial skills to develop networks that complement the development of the Trust	D	✓ - 4 ★ - 2	✓ - 3 ★ - 2
Equality & Diversity experience	D	✓ - 5 ★ - 1	✓ - 3 ★ - 2
Knowledge as a Corporate Trustee	D	✓ - 1 ★ - 5 (as external Trustee)	✓ - 4 △ - 1
Formal Qualifications & Training – please specify field(s)		• BA Hons, FCIPD • MBA, DMS, CBI • BA(Hons), ACMA, CGMA, CPFA • MC ChB, ND, FRCPATH • Registered Nurse, BA Health and Community Care Management, MA Leadership and Management	• Fellow of the British Computer Society • FCA (Accountancy)

Board Directors are also required to have an awareness of their personal impact in terms of Board working and behaviours. This will be continually assessed using both formal and informal evaluation tools.

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP-2018-115
Review Date: January 2020
Review Lead: Head of Governance and Risk

NHS
Calderdale and Huddersfield
NHS Foundation Trust

RISK MANAGEMENT STRATEGY

2019-2020

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP-2018-115
Review Date: January 2020
Review Lead: Head of Governance and Risk

Document Summary Table		
Unique Identifier Number	G-101-2017	
Status	Approved	
Version	2	
Implementation Date	January 2017	
Current/Last Review Dates	N/A	
Next Formal Review	January 2020	
Sponsor	Chief Nurse	
Author	Head of Governance and Risk	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		
Executive Board		
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk and Compliance Group	Assistant Director of Quality and Safety	21 November 2018
Quality Committee	Non-Executive Director	3 December 2018
Audit and Risk Committee	Non-Executive Director	November 2018
Other Stakeholders Consulted		
N/A		

Does this document map to other Regulator requirements?	
Regulator details	
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 16: Complaints Regulation 17: Good Governance Regulation 19: Fit and Proper Persons
NHS Improvement	Single Oversight Framework

Document Version Control	
Version no	
1	Risk Management Strategy incorporating Raising Concerns / Freedom to Speak Up
2	Minor amendment made to section 9.5 to include additional information in relation to compliance registers following internal audit report

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP-2018-115
Review Date: January 2020
Review Lead: Head of Governance and Risk

CONTENTS

Appendices

1. Introduction

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

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

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

2. Vision and Statement of Intent

2.1 Risk Management and Strategic Objectives

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

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

Our strategic objectives to deliver this aim are to:

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

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

Risk and risk management is not about doing nothing for fear that we might make a mistake. Rather, risk policy and risk management are concerned with promoting an understanding of an organisation's strategy, operating environment and the associated risks and putting in place appropriate processes and procedures to identify, assess and manage risk. Risk identification, assessment, management and assurance is best understood as

a constant cycle of activity: risks emerge, alter their significance and scale and may disappear without warning. Anticipation and early action to manage risk is the best defence. Her Majesty's Treasury offers guidance to all organisations in receipt of public funding as to how they may incorporate good practice. This guidance concludes it is essential that an organisation should:

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

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

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

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

2.2 Risk Management Three Lines of Defence

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

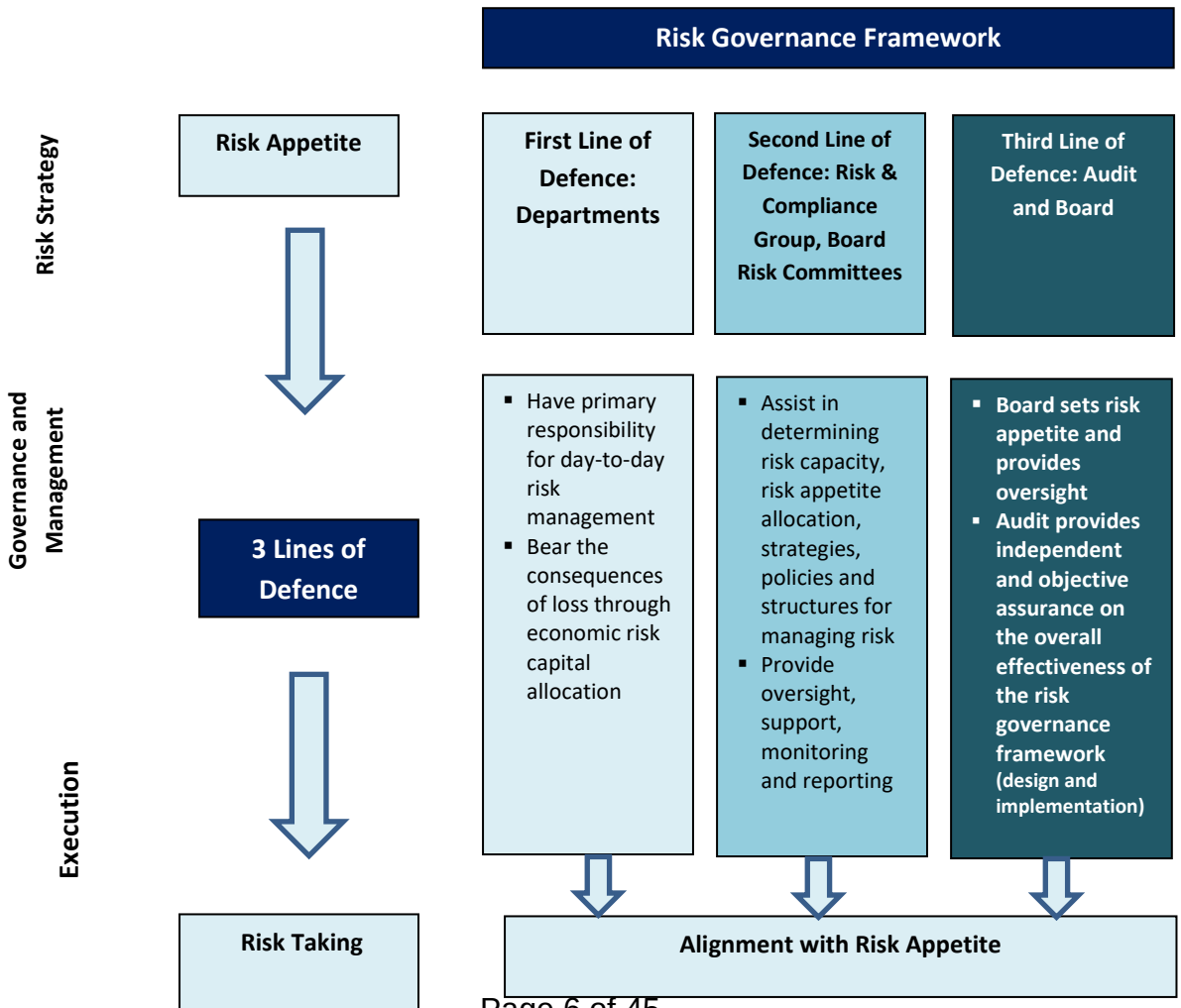
First line of defence – our front-line staff are the first line of defence. They must understand their roles and responsibilities for risk management using Trust processes and they must own and manage risk, as well as implementing operational management at directorate and divisional level.

These are the teams with ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

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

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

Figure 1 – Risk Management Three Lines of Defence



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

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

2.3 Vision and Statement of Intent

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

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

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

2.4 Risk Management Objectives

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

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

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

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

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

- All staff recognise their personal contribution to risk management

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

2.5 Risk Scope

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

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

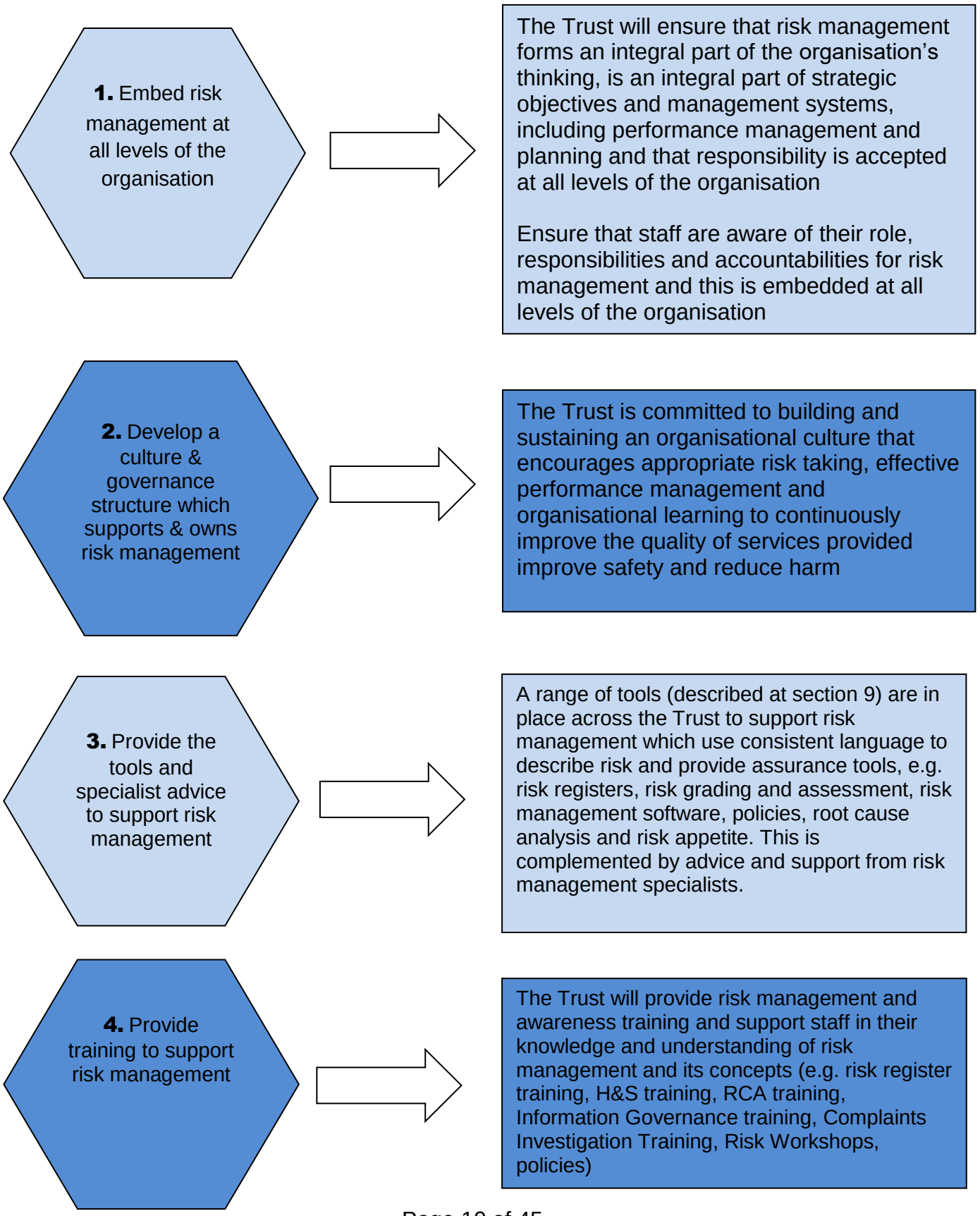
3. Components of the Trust Risk Management Strategy

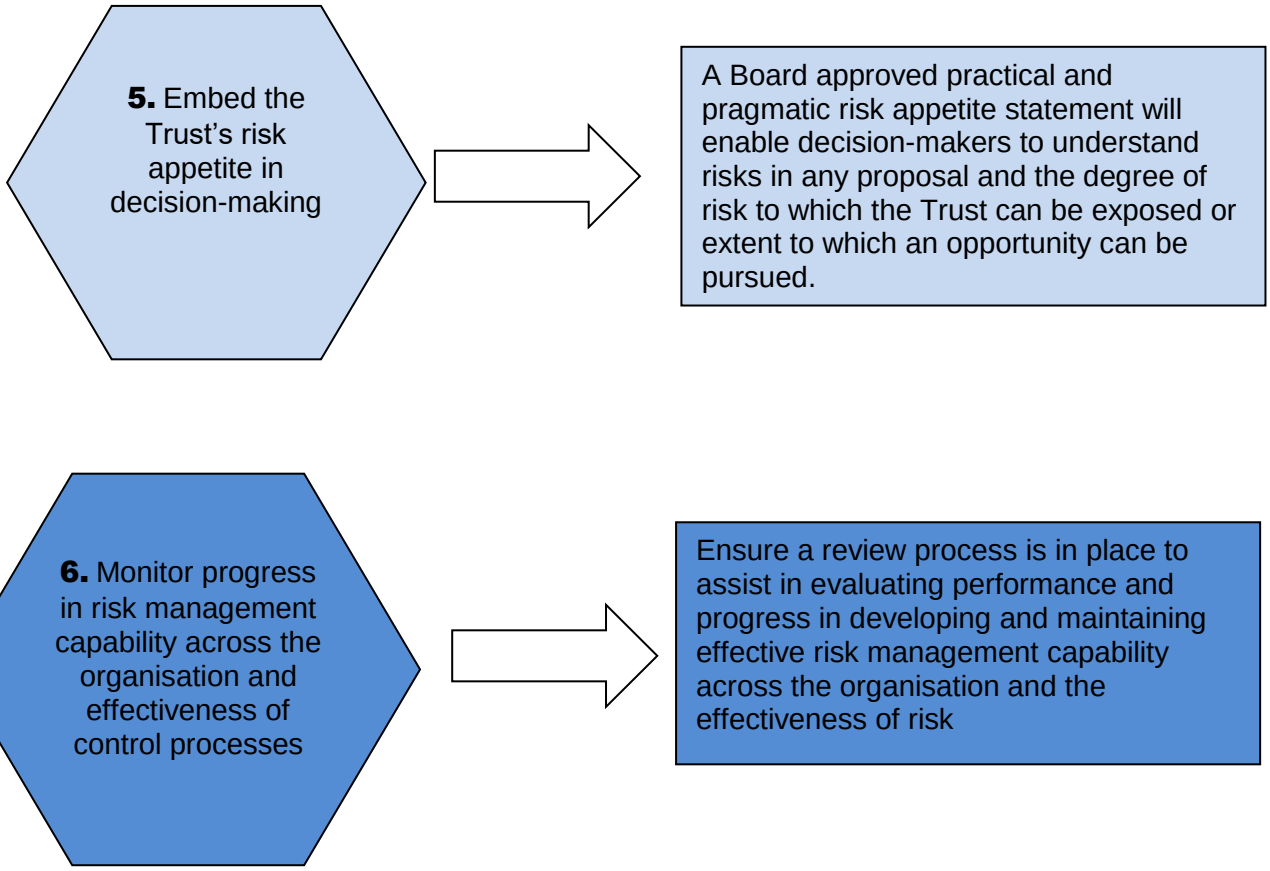
The components of the Trust's Risk Management Strategy to deliver this vision are given below.

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


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

Details of each component are given below:



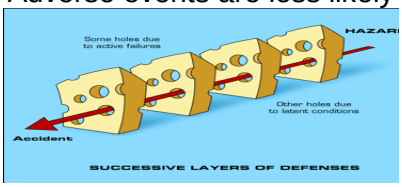

5. Embed the Trust's risk appetite in decision-making
A Board approved practical and pragmatic risk appetite statement will enable decision-makers to understand risks in any proposal and the degree of risk to which the Trust can be exposed or extent to which an opportunity can be pursued.
6. Monitor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

4. Benefits of managing risk

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

Achievement of objectives is more likely

Adverse events are less likely



Opportunities can be better identified and explored

Outcomes are better: safety, effectiveness, efficiency

We reduce firefighting and fewer costly surprises and re-work

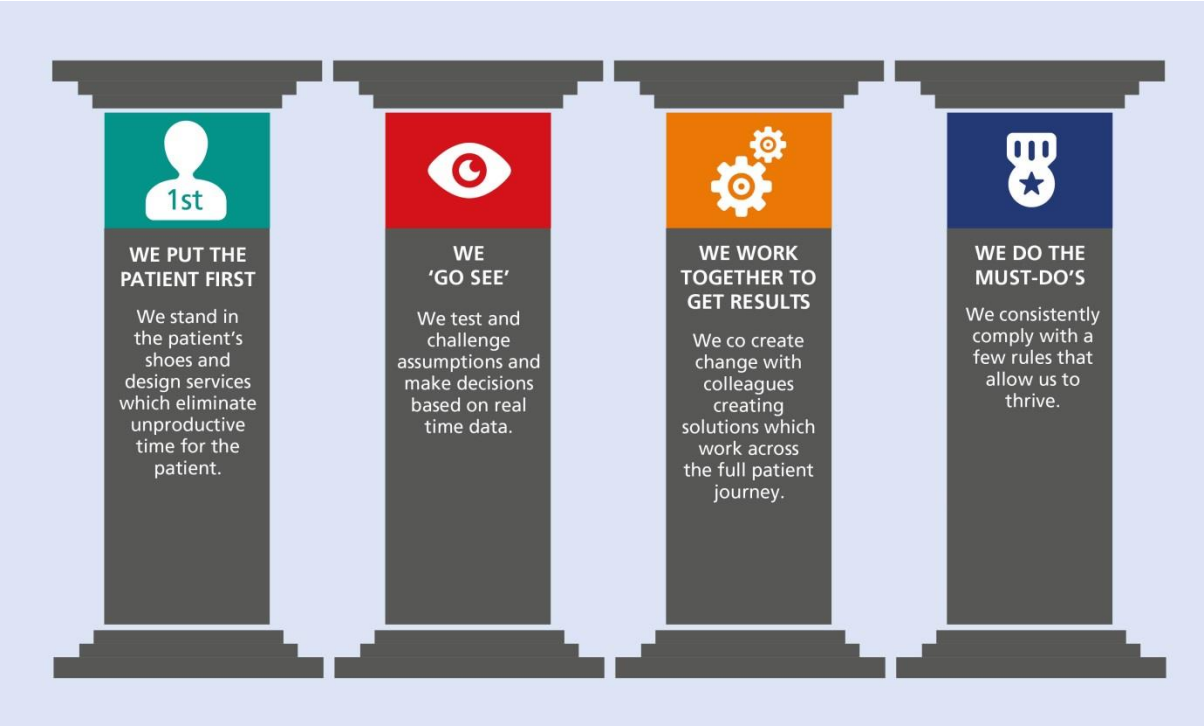
Performance is improved

Decision-making is better informed, more open and transparent

Reputation is protected and enhanced

5. The way we work

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



A pro-active approach to managing risk

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

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

This means:

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

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

This means:

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

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

This means:

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

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

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

This means:

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

In the interests of openness and candour, responding to concerns raised and learning from mistakes, formal disciplinary action will not usually be taken as a result of an investigation into an adverse event. However, the Trust's Disciplinary Policy outlines circumstances in which disciplinary action will be taken, e.g. professional misconduct. Should disciplinary action be appropriate this will be made clear as soon as the possibility emerges from an investigation and advice would be taken from the Workforce and Organisational Development department.

6. Risk appetite

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

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

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

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

Risk level / appetite	Key Elements
MINIMAL (as little risk as possible)	Preference for ultra-safe delivery options with a low degree of inherent risk and only for limited reward potential
CAUTIOUS	Preference for-safe delivery options with a low degree of inherent risk and limited potential for reward
OPEN	Willing to deliver all potential delivery options and choose while also providing an acceptable level of reward and value for money
SEEK	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk
MATURE	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Expressing the Trust's Risk Appetite

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

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

Risk Categories

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

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

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

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

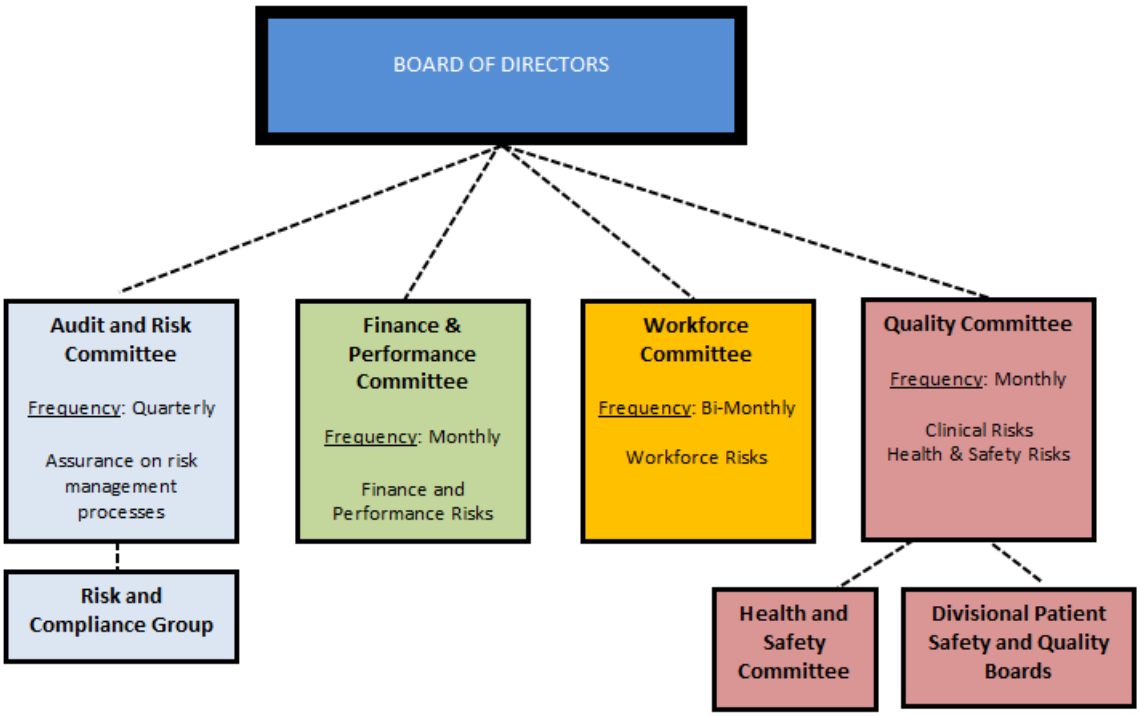
The Risk and Compliance Group will review the significant risks on the high level risk register to ensure that risks are acceptable within the Trust risk appetite.

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

7. Organisational Structure for Risk Management

7.1 Organisational Structure

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



*For a full list of sub groups reporting to Board Committees please refer to Appendix 2.

7.2 Roles and responsibilities of Committees responsible for risk

Board of Directors

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

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

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

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

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

- Set corporate strategy and priorities and monitor progress against these; the Board must decide what opportunities, present or future, it wants to pursue and what risk it is willing to take in developing the opportunities presented

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

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

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

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

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

Audit and Risk Committee

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

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

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

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

Finance and Performance Committee

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

Workforce Committee

The Workforce (Well Led) Committee provides assurance to the Board of Directors on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust and is responsible for identifying any workforce and training risks.

Quality Committee

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

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

8. Accountabilities, Roles and Responsibilities for Risk Management

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

The Chief Executive has overall accountability and responsibility for:

- ensuring the Trust maintains an up-to-date Risk Management Strategy, is committed to the risk management principles in the Trust statement of intent and has a risk appetite endorsed by the Board
- promoting a risk management culture throughout the organisation

- ensuring an effective system of risk management and internal control is in place with a framework which provides assurance to the Trust management of risk and internal control
- ensuring that the Annual Governance Statement contains the appropriate assurance requirements for risk management
- ensuring priorities are determined and communicated, risk is identified at each level of the organisation and managed in accordance with the Board's appetite for taking risk

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

8.3 Non-Executive Directors

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

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

The Senior Independent Non-Executive Director is Philip Oldfield who is also the Deputy Chair.

8.4 Executive Directors

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

Lead Executive Director	Risk Area
Chief Nurse The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director. They ensure organisational requirements are in place which satisfies the legal requirements of the Trust for quality and safety, patients and staff. This includes delivery of processes to enable effective risk management and clinical standards. The Board Assurance Framework lead is the Company Secretary.	• Board lead for clinical risk management: – Risk Management Strategy and Policies – Risk appetite – Monitoring the management of risks across divisions and escalate as needed • Serious Incidents and Incident Reporting • Patient Advice and Complaints Service • Patient Experience • Quality and Quality Improvement • Safeguarding and Deprivation of Liberties • Mental health act compliance • Quality regulatory compliance

Medical Director The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Chief Nurse and leads the quality improvement strategy. Responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation. The Medical Director is supported in this by the Deputy Medical Director and Associate Medical Directors.	• Clinical medical risk • Infection Prevention and Control • Caldicott Guardian information risks – delegated to the Deputy Medical Director • Responsible Officer for GMC • Medicines Management – delegated to Chief Pharmacy Officer • Clinical audit and effectiveness • Compliance with NICE guidance • Quality Improvement • Research & Development – delegated to Deputy Medical Director
Director of Finance The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within the Trust and actions to control these.	• Financial risk • Procurement risk • Counter fraud and reporting to NHS Protect • Financial regulatory compliance • Estates risks for the Trust • PFI contract
Chief Operating Officer The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.	• Performance risks • Performance regulatory compliance • Safe and sustainable operational services • Security Management • Trust Resilience
Director of Workforce and Organisational Development The Director of Workforce and Organisational Development has executive responsibilities which include identification and assessment of risks associated with recruitment, employment, supervision, training, staff development and staff well–being.	• Freedom to Speak Up Guardian • Staffing risks including training, workforce planning, recruitment and retention, • Health and Safety, including external reporting for RIDDOR • Workforce Policies • Professional registration • Staff Well Being

8.5 Board Directors

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

Director of Transformation and Partnerships The Director of Transformation and Partnerships has lead responsibility for service redesign and reconfiguration and working together with our partners across the local health and social care economy.	• Risks in relation to service reconfiguration and transformation • Partnership risks

Managing Director – Digital Health The Managing Director promotes the need to manage information and IT risks, for the security of patient records and IT business continuity arrangements.	• Information governance risks, including general data protection and external reporting to the Information Commissioner • Senior Information Risk Officer – delegated to head of informatics, is responsible for ensuring the Trust manages its information risks, through the development of information asset owners and information asset administrators • Electronic Patient Record

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

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

CHS provides advice and management on the following risks:

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

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

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

8.6 Assistant Director for Quality and Safety

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

8.7 Clinical and Divisional Directors

Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of

responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

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

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

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

8.8 All Staff

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks
- Identify, assess, manage and control risks in line with Trust policies and procedures
- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, eg comply with incident and near miss reporting procedures

- Be responsible for attending mandatory and essential training and relevant educational events
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been assessed

8.9 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of Contractors' policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFT's health and safety rules and the staff member responsible is fully aware of the contractor's activity for which they are engaged and, if applicable, are in possession of the contractor's risk assessment and method statement for their activity.

9. SYSTEMS and PROCESSES for MANAGING RISK

9.1 Policies

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

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

9.2 Incident Reporting

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

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

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

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

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

9.3 Board Assurance Framework (BAF)

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

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

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

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

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

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

9.4 Risk Registers

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

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

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

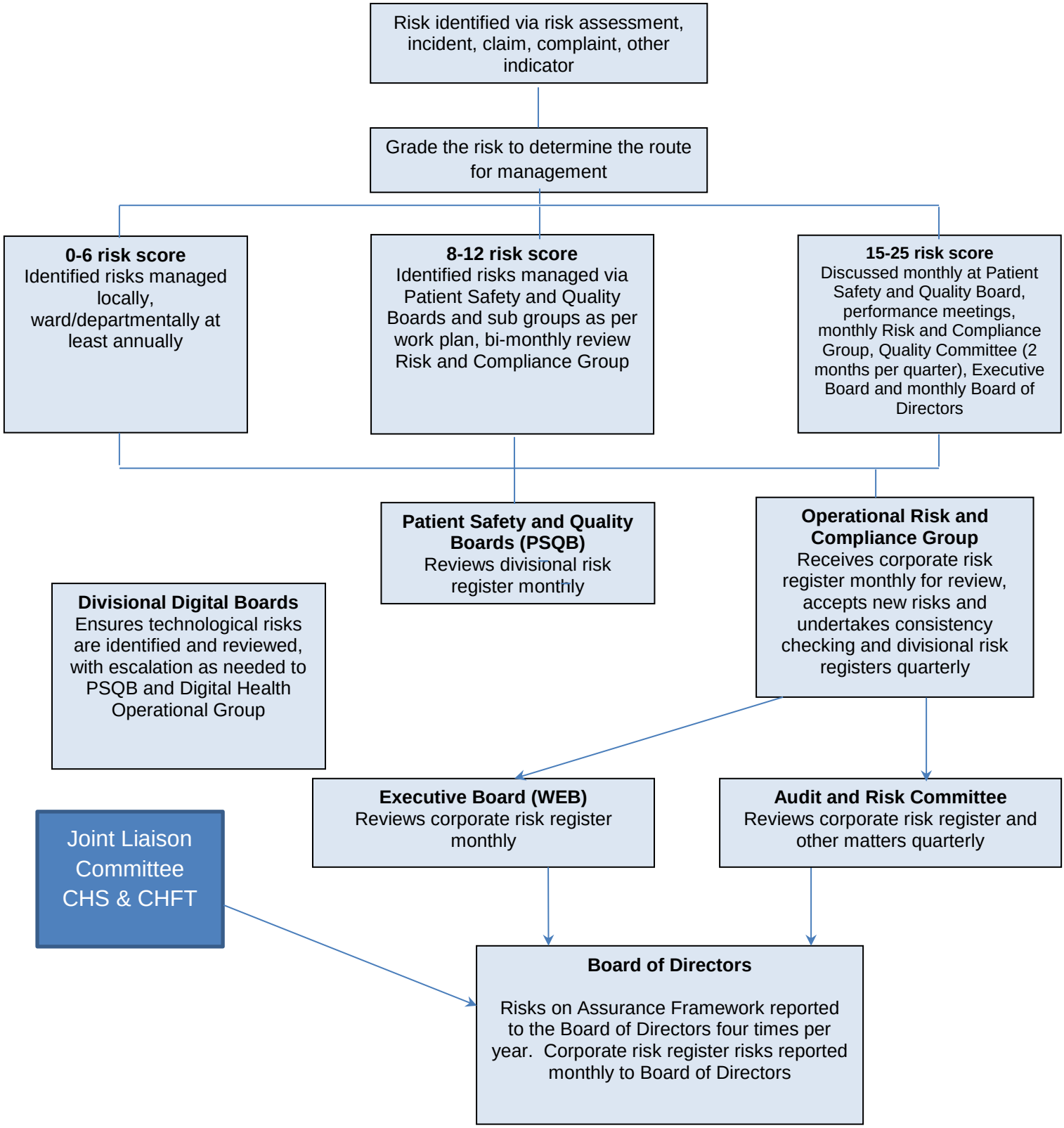
The high-level risk register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk and Compliance Group and presented to the Board of Directors.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions, including risks regarding technology from divisional Digital Board meetings. The Risk Management Policy details the process for risk register reporting.

The diagram overleaf depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP-2018-115
Review Date: January 2020
Review Lead: Head of Governance and Risk

Structure and flow chart for the management of assurance and risk



9.5 Compliance Register

As part of good governance and being a well-led organisation, to ensure that the Trust manages risks and responds to issues highlighted in external reviews, each division and corporate services maintain a register of compliance. This register provides an overview of compliance with regulatory standards, (financial, performance, estates and quality). Guidance is provided to divisions to ensure consistency of the content of compliance registers.

The register is a systematic approach to recording external assessments of standards through inspections, peer reviews and accreditations, in line with the Trust policy for Managing External Agency Visits, Inspections and Accreditations, ensuring an organisational overview of any aspects of non-compliance, forward planning for future assessments and identification of potential risks.

The register details the date and type of assessment, level of compliance, actions required, consequence of non-compliance and any associated risks. It also includes the date the next assessment is due.

Each division presents their compliance registers to the Risk and Compliance Group for review every two months. Divisional compliance registers are reviewed at divisional Patient Safety Quality Board meetings to provide assurance that appropriate information is recorded and actions are being progressed.

9.6 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review and implement policies, procedures and guidelines for the effective control of risks.

Responsibilities of staff at all levels for risk are given at section 8. Details of Trust risk management specialists are given at Appendix 3.

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager Data Protection Officer	Information Governance Risks, including general data protection (GDPR)
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks Fit and Proper Persons
Chief Nurse	Clinical Risk
Director of Workforce and OD	Health and Safety Risks
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Resilience and Security Manager	Emergency Planning and business continuity risks Security Manager
Fire Safety Manager Health and Safety Advisor	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines Management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Clinical Governance and Risk Team Assistant Director of Quality and Safety Head of Governance and Risk Senior Risk Manager and Risk Manager Head of Complaints and Legal Services Clinical Governance Support Managers / Quality and Safety lead	All risks and risk management tools, processes and training.
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

9.7 Risk Management Software

The Trust uses two risk management databases, Datix, for incident reporting, complaints, concerns, claims and inquests to support identification, management and investigation into adverse events and a bespoke database for the risk register. The Datix system allows the Trust to share information and triangulate data on an individual and aggregate basis. This provides an easy way for staff to report and get feedback on incidents, ensure an appropriate level of investigation based on severity, capture actions and learning from adverse events and analyse data to identify themes and trends for the whole organisation.

A bespoke database is used for the management of the risk register, which allows reporting and analysis at directorate, divisional and Trust-wide level.

9.8 Risk Identification and Assessment

Risk assessment is a systematic and effective method of identifying risks and determining the most effective means to minimise or remove them. It is an essential part of risk management within the Trust.

The formal pro-active method of identifying operational risks within the Trust is through the use of risk assessments. Clinical and non-clinical risk assessment is used to populate directorate, divisional and corporate risk registers. The Board of Directors is responsible for identifying strategic risks associated with the strategic direction of the organisation.

All risk assessments in all departments should be regularly updated and formally reviewed on an annual basis.

It is essential to identify the scale and significance of a risk. It is important to distinguish between these elements and to provide a clear and applied assessment; a risk may be extreme in scale without having great significance and vice versa. Equally it is important to assess and manage cumulative risk.

Guidance for staff on risk assessment is given in the Risk Management Policy.

9.9 Risk Grading Matrix

Staff should use the risk grading matrix, adapted from a national model by the National Patient Safety Agency for the NHS, to ensure a consistent approach to assessing risks.

The risk grading matrix provides a description of risk types and defines an impact score from 1 – 5 and a likelihood score from 1 – 5. The impact score multiplied by the likelihood score determines the actual grading of the risk – refer to Appendix 4 for details.

The information produced from the risk assessment is used to populate the risk register.

For assessment of the severity of incidents, the Trust uses the grading scale given at Appendix 9 which grades no harm incidents as green, incidents with minimal harm as yellow, incidents with moderate or short term harm as orange and incidents where there is severe or long term harm or death as red incidents.

Complaints are assessed in line with the grading policy within the complaints policy which is based on patient experience.

9.10 Root Cause Analysis / Learning

Formal root cause analysis is used throughout the Trust providing a structured approach for the analysis and identification of learning from incidents, complaints and claims. This is used in investigations to identify how and why incidents occur and inform actions and learning to prevent harm.

The Trust uses the Yorkshire and Humber contributory factors' framework, a tool from the Improvement Academy with an evidence-base to optimise learning and address causes of patient safety incidents from incidents within hospital settings. It takes a systems approach and identifies situational factors, local working conditions, latent/organisational factors and latent/ external factors and general factors that contribute to error, providing an opportunity to learn from error and prevent factors that cause harm to patients.

The Trust has a clear framework for undertaking root cause analysis for all moderate harm and severe harm incidents. This ensures that action is taken to prevent the potential for recurrence locally and at a corporate level. Specific root cause analysis processes have been developed for specific incidents, i.e. pressure ulcers, infection related incidents. These are detailed in the Incident Reporting Policy.

10. Risk Management Training

In order to develop a risk aware culture and to ensure successful Implementation of this strategy there needs to be training for staff.

Risk management training and awareness already occurs in a number of different methods, e.g. Board workshops, risk register training, root cause analysis training, complaints investigation training, Datix training as well as ad hoc training.

11. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

12. Monitoring the Effectiveness of this Strategy

The strategy will be reviewed on a three year basis or sooner as required.

A review process will be developed to assist in evaluating performance and progress in developing and maintaining effective risk management capability within divisions and corporate functions across the organisation and the effectiveness of risk management control processes. This will include leadership for risk management, local ownership of risk, equipping staff to manage risk well, governance arrangements to support the risk management framework, policies and procedures.

13. Associated Documents/Further Reading

The relevant policies and procedures listed in section 9.1 should be read in accordance with this strategy.

APPENDIX 1 - Definitions

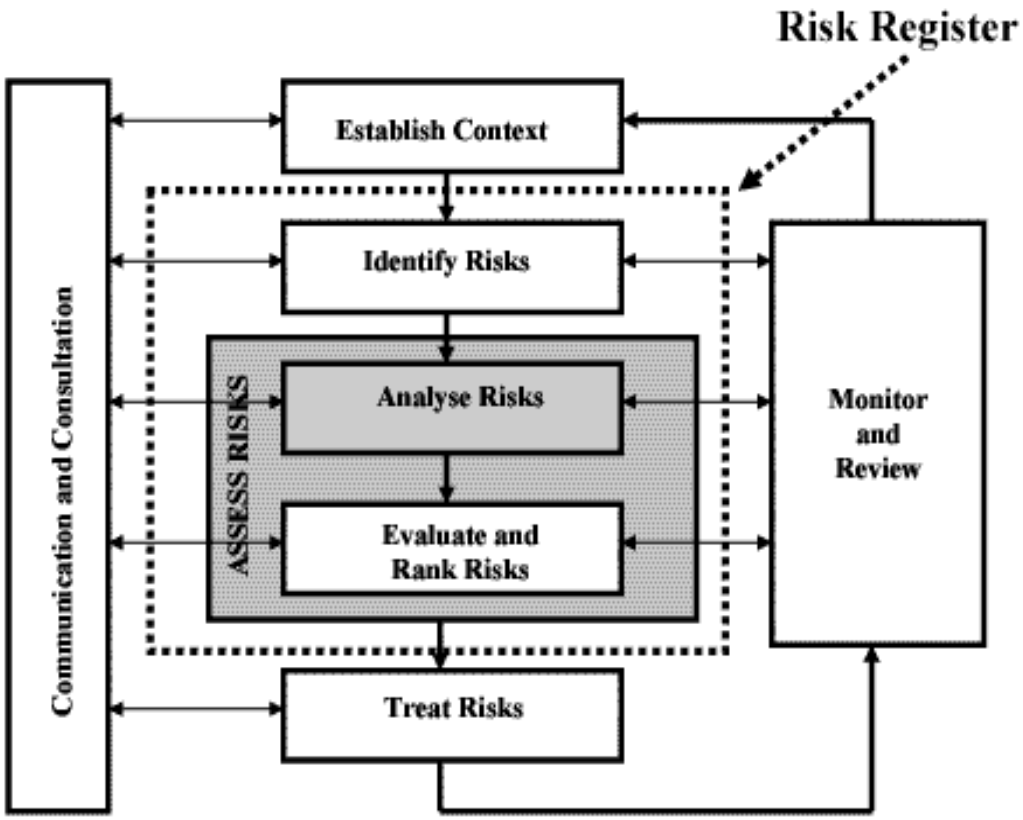
Risk is the chance that something will happen that will have an impact on the achievement of the Trust's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the risk occurring). See section 9.8 and Appendix 4.

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

The **risk management process** is the systematic application of management policies, procedures and practices to the task of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk. It is described in the diagram below.

Significant risks are those which, when measured according to the grading tool at Appendix 4, are assessed to be significant, with a risk score of 15 or more. The Board will take an active interest in the management of significant risks.

Cumulative risks are individual risks from different areas which, when added together, may combine to become a significant risk.



Risk Management Overview from AS/NZS 4360:1999

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP-2018-115
Review Date: January 2020
Review Lead: Head of Governance and Risk

GOVERNANCE STRUCTURE

A&E Board (System Resilience Group)

Partnership Transformation Board

WYAAT Committee in Common

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Philip Lewer
Frequency: Quarterly

Council of Governors
Chair: Philip Lewer
Frequency: Quarterly

Nominations & Remuneration Committee
Chair: Philip Lewer
Frequency: Ad hoc but at least once annually

Audit and Risk Committee
Chair: Richard Hopkin
Frequency: Quarterly

Estates Sustainability Committee
Chair: Peter Roberts*
Frequency: Monthly

CHS & CHFT Joint Liaison Committee
Chair: Gary Boothby
Frequency: Quarterly

Finance & Performance Committee
Chair: Phil Oldfield
Frequency: Monthly

Nominations & Remuneration Committee
Chair: Philip Lewer
Frequency: Ad hoc at least once annually

Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

Quality Committee
Chair: Linda Patterson
Frequency: Monthly

Risk & Compliance Group
Chair: CN
Frequency: Monthly

Information Governance Group
Chair: CIO
Frequency: Quarterly

Clinical Records Group

Capital Planning Group

Commercial Investment & Strategy Committee

Divisional and Corporate Performance Reviews Executive Lead &
Chair: **COO**
Frequency: Monthly

Performance Management

Risk Management

Strategic Development

Divisional Management Boards and Patient Safety & Quality Boards
Chair: **DD**
Frequency: Monthly

Directorates (Speciality)

Trust Executive Board
Frequency: Weekly

Chair: CEO
Frequency: Weekly
One meeting per month focused on performance

Turnaround Executive
Chair: **CEO**
Frequency: Weekly

CQC Response Group (task & finish)
Chair: DofN
Frequency: Fortnightly

Research and Development Group
Chair: Deputy Medical Director
Frequency: Quarterly

Medication and Safety Compliance
Chair: Deputy DON
Frequency: Monthly

Cancer Board
Chair: COO
Frequency: Monthly

Safeguarding Committee
Chair: Chief Nurse
Frequency: Monthly

Blood Transfusion Group

Falls Collaborative

Resuscitation Group

Thrombosis / VTE Group

Pressure Ulcers Group

Point of Care testing Group

Radiation Protection Group

Medical Devices and Procurement Group

Patient Safety Group
Chair: AD Quality
Frequency: Monthly

Infection Prevention Group
Chair: Medical Director
Frequency: Monthly

Serious Incident Panel
Chair: **CEO**
Frequency: Bi-monthly

Dementia Group

Family and Friends Group

Patient Experience Group
Chair: AD Quality
Frequency: Six Weekly

Deteriorating Patient Collaborative

End of Life Care Group

Clinical Effectiveness and Audit Group

Nutrition Steering Group

Mortality Surveillance Group

Organ Donation Committee

Sepsis Collaborative

Health & Safety Group
Chair: DofPEF
Frequency: Monthly

Clinical Outcomes Group
Chair: Medical Director
Frequency: Monthly

APPENDIX 3 - Related Policies

There are a number of key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. Other key policies include:

This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance:

Risk Management / Corporate

- Being Open / Duty of Candour Policy
- Complaints policy
- Control of Substances Hazardous to Health (COSHH)
- Claims policy
- Emergency Preparedness, Resilience and Response Policy
- External Visits Policy
- Fire Safety Strategy
- Health and Safety policy
- Incident Reporting, Investigation and Management policy
- Major Incident policy
- Inquest Policy
- Information Governance Strategy and associated policies
- Policy for Developing Policies
- Risk Management Policy
- Safe Management of Contractors
- Safeguarding
- Security Strategy
- Waste Management Policy

Workforce and Organisational Development

- Capability policy
- Freedom to Speak Up: raising Concerns Policy
- Induction policy
- Mandatory Training Policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Promoting Good Health at Work Policy
- Race Equality Scheme

Clinical

- Blood Transfusion policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Falls Prevention and Management policy
- Infection Control policies
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Policy on the implementation of NICE guidelines
- Safeguarding Adults Policy
- Safeguarding Children Policy

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

APPENDIX 4 – Risk Management Specialists

Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As the Trust Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that the Trust creates and manages its information risks, through the development of a network of Information Asset Owners (IAAs) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that the Trust has a robust Strategy of policies and procedures for the management of the Trust's information, both corporate and clinical/patient.

The Information Governance Manager liaises with the Trust's Caldicott Guardian and Senior Information Risk Owner to ensure that the Trust meets and complies with the standards set out in the Information Governance Toolkit.

Data Protection Officer –the data protection officer is responsible for collection and protection of personal data and ensures the Trust follows the law and appropriate regulations

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee's risk responsibilities system. This role also ensures that the Trust is aware of any compliance issues, i.e. via the Single Oversight Framework from NHS Improvement, and that any risks associated with new business or service change which may impact on the Trust ability to adhere to the Single Oversight Framework are appropriately reported throughout the organisation.

Chief Nurse
The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of the Trust for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation, report directly to the Chief Executive and the Board, challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions;

assess the impact of all existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance structures.

Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Chief Nurse and leads the quality improvement strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where the Trust is involved.

Director of Workforce and Development has executive responsibility for health and safety

Director of Finance has responsibility for managing the PFI provider and Calderdale Huddersfield Solutions to manage estates risks.

Chief Operating Officer has responsibility for security management and Trust resilience.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Safety Manager
This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. They also provide specialist advice to design consultant/architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Health and Safety Advisor
The Health and Safety Advisor is responsible for monitoring all staff related incidents on a regular basis and ensuring this is reported to the Health and Safety Committee. They will organise health and safety training and education of staff to support CHFT's compliance with health and safety requirements. Duties of all employees are detailed in the health and safety policy.

Resilience & Security Manager
The overall objective of the Trust Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency

Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for the Trust (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within the Trust, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
The Trust has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
The Trust has a Radiation Protection Board chaired by the divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian
The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support the Trust to become a more open and transparent place to work.

Head of Governance and Risk - has day-to-day responsibility for risk management process, quality governance and safety management including:

- the development of risk management strategy and policies
- administration of risk management systems
- oversight of risk exposures facing the business
- provision of risk management training and support to divisions
- the maintenance of the corporate risk register
- support the development of local risk registers
- lead in triangulating and sharing lessons for learning from adverse events
- risk management training
- management of legal services

The Senior Risk Manager and Risk Manager also provide advice and support on risk management to staff

Head of Safeguarding - has day-to-day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners.

Appendix 5 - Risk Grading Matrix

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

UNIQUE IDENTIFIER NO: G-101-2017
EQUIP-2018-115
Review Date: January 2020
Review Lead: Head of Governance and Risk

Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2 Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly	Expected to occur daily
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

Table 3 Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risks on the risk register, the scores obtained from the risk matrix are assigned grades as follows

1- 6	Low Risk
8-12	Moderate Risk
15-25	Significant Risk

APPENDIX 6 - Incident Grading Matrix

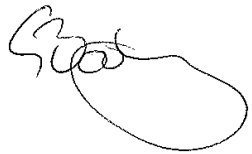
Degree of Harm (	Description	Severity grading
No harm / near miss Impact prevented (near miss)	An incident that might have had the potential to cause harm but was prevented, resulting in no harm	Green
No harm Impact not prevented	An incident that occurred but no harm resulted	Green
Low / Minimal harm	An unexpected or unintended incident where patient (s) required extra observation or minor treatment and caused minimal harm to one or more persons	Yellow
Moderate / Short term harm	An unexpected or unintended incident where patient(s) required further treatment or procedure which caused significant but not permanent harm (e.g. increase in length of hospital stay by 4-15 days)	Orange
Severe / permanent or long term harm	An unexpected or unintended incident that appears to have resulted in permanent harm	Red
Death caused by the patient incident	An unexpected or unintended incident that directly resulted in death	Red

CHFT RISK APPETITE October 2018 **Appendix 7**

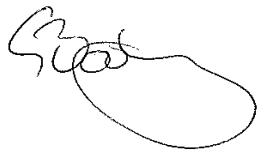
Risk Category	This means	Risk Level Appetite	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards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

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

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
8-18	31/08/2018	23/08/2018	Calderdale and Huddersfield NHS Foundation Trust & Calderdale and Huddersfield Solutions Ltd Shareholders Agreement in relation to Calderdale and Huddersfield Solutions Ltd	NAME: Gary Boothby  TITLE: Executive Director of Finance NAME: Victoria Pickles  TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
9-18	31/08/2018	23/08/2018	Calderdale and Huddersfield NHS Foundation Trust & Calderdale and Huddersfield Solutions Ltd Operated Healthcare Facility Agreement for the provision of services at Trust Facilities/Sites	NAME: Gary Boothby  TITLE: Executive Director of Finance
				NAME: Victoria Pickles  TITLE: Company Secretary

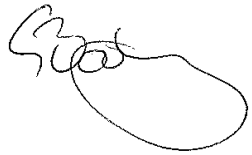
REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
10-18	10.09.18	10.09.18	Lease relating to first floor offices at Lister Lane Surgery, Lister Lane, Halifax between Balagopal Krishna Kumar and Calderdale and Huddersfield NHS Foundation Trust	NAME: Helen Barker  TITLE: Chief Operating Officer
				NAME: Victoria Pickles  TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
11-18	4.10.18	4.10.18	Lease renewal for Oak House which is THIS head office. It is a five year lease with a break at Year 3. The rent is £47k per annum. The lease has been agreed following negotiations between Rob Birkett and Tracy Mundell of THIS, Capsticks, the Trusts legal provider and Towngate PLC, the Landlord.	NAME: Victoria Pickles  TITLE: Company Secretary NAME: Mandy Griffin  TITLE: Managing Director – Digital Health

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
12-18	12.12.2018		Pennine Property Partnership LLP and Calderdale and Huddersfield NHS Foundation Trust – Agreement to Vary the Contract	NAME: Gary Boothby  TITLE: Executive Director of Finance
				NAME: Vicky Pickles  TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
13-18	21.12.18		Lease renewal for Oak House which is THIS head office. This lease is for Part 2nd Floor Woodvale House, which is on the same complex of Oak House. The lease has been agreed following negotiations between Rob Birkett and Tracy Mundell of THIS, Capsticks, the Trusts legal provider and Towngate PLC, the Landlord. The lease is for 3 years and has an initial rent of £12k + VAT per annum and a provisional service charge of £3250 per annum.	NAME: Helen Barker  TITLE: Chief Operating Officer NAME: Jackie Murphy  TITLE: Chief Nurse

Attendance	✓	Apologies	×	Not Exec BOD members	-

ATTENDANCE REGISTER – PUBLIC BOARD OF DIRECTORS
1 APRIL 2018 – 31 MARCH 2019

DIRECTOR	5.4.18	3.5.18	7.6.18	5.7.18	19.7.18 AGM	23.8.18	6.9.18	1.11.18	3.1.19	7.3.19	TOTAL
Philip Lewer (Chair)	✓	✓	✓	✓	✓	✓	✓	✓			/10
Alastair Graham	✓	✓	✓	✓	×	✓	✓	✓			/10
Andy Nelson	✓	✓	✓	✓	✓	×	×	✓			/10
Brendan Brown	✓	✓									/10
David Anderson	✓	✓	✓	✓	✓	✓	✓				/10
David Birkenhead	✓	✓	✓	× Rep	✓	✓	✓	✓			/10
Gary Boothby	✓	✓	✓	✓	✓	✓	✓	✓			/10
Helen Barker	✓	✓	✓	✓	✓	✓	×	✓			/10
Jackie Murphy			✓	✓	× Rep	✓	✓	✓			/10
Karen Heaton	✓	✓	✓	✓	✓	✓	×	✓			/10
Lesley Hill	✓	✓	✓	✓	✓	✓	✓	×			/10
Linda Patterson	✓	✓	✓	✓	✓	×	✓	✓			/10
Owen Williams	✓	✓	✓	✓	✓	×	✓	✓			/10
Phil Oldfield	×	✓	✓	✓	×	✓	✓	✓			/10
Richard Hopkin	✓	✓	✓	✓	×	✓	✓	✓			/10
Suzanne Dunkley	✓	✓	✓	× Rep	✓	×	✓	✓			/10
Victoria Pickles	✓	✓	✓	✓	✓	✓	✓	✓			/10
Anna Basford	✓	✓	✓	×	✓	✓	✓	✓			/10
Mandy Griffin	✓	✓	✓	✓	×	×	×	✓			/10

Public Board of Directors Meetings Dates

Dates	Location	Time
Thursday 3 January 2019	Large Training Room, CRH	9:00 – 12:00 pm
Thursday 7 March 2019	Boardroom, HRI	9:00 – 12:00 pm
Thursday 2 May 2019	Boardroom, HRI	9:00 – 12:00 pm
Thursday 4 July 2019	Large Training Room, CRH	9:00 – 12:00 pm
Thursday 5 September 2019	Boardroom, HRI	9:00 – 12:00 pm
Thursday 7 November 2019	Large Training Room, CRH	9:00 – 12:00 pm

Dates	Location	Time
Thursday 2 January 2020	Boardroom, HRI	9:00 – 12:00 pm
Thursday 5 March 2020	Large Training Room, CRH	9:00 – 12:00 pm

BOARD TO WARD VISITS – JULY 2018 – AUGUST 2018

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
2.7.18	4.00pm	Andy Nelson	Suzanne Dunkley	Emergency Department, HRI	Louise Croxall	Louise Croxall	**From:** <Suzanne.Dunkley@cht.nhs.uk> **Date:** 2 July 2018 at 17:58:50 BST **To:** <louise.croxall@cht.nhs.uk> **Cc:** <alphagrangeconsulting@outlook.com> **Subject: Thank you** I just wanted to say a big thank you for showing us around the ED department at HRI today. It was evident to see your commitment and compassion for patients! We discussed patient flow and how we may hit 220 visitors since midnight last night with a mix of p2-3 patients in the main and no p1s whilst we were with you. We discussed sun burn and minor injuries as some of the main reasons for visitors over the last week or so. There's a clear system to triage patients and having two nurses in triage today helped the initial wait stay at 7 minutes. It was also good to see the ED version of EPR and how it clearly helped us track patients and their symptoms and diagnosis. I'm really keen on the patient AND colleague

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							experience and would like to keep popping in if I may to offer support and to get to know the team and their requirements better. If it would be OK with you I'd like to do that weekly so that colleagues get to know me. Anyway, thanks once again, you are doing a great job. Suzanne Dunkley
11.7.18	1:00pm	Alastair Graham	Vicky Pickles	ED, CRH	Louise Croxall	Andrew Elwers	
31.7.18	1.30pm	Richard Hopkin	Ruth Mason	SAU - HRI	Emma Melkowski	Karen Melling	Good: • Mobile phone for use for referrals from ED – much quicker • Displayed action cards with clear protocols • Surgical patient flow system for elective patients means everyone including ward clerks can see the 'Big picture' • Staff pledge wall with photos of all staff, visible and positive • FFT comments are now in super green category • As a result of EPR, started a whatsapp group for all staff to help deal with EPR issues, this has been so successful they have kept it on, 'The A Team Group chat' is used for handover notes and general comms • Team are fantastic, great support of each

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							other, area has good reputation and received great feedback from students, staff want to work here • Staff are eager with a good appetite for change, good positive leadership from Fran Howland and Karen Milling, they have embraced EPR <u>Concerns/ Recommendation</u> • Pain relief – patients waiting sometimes long time for pain relief or anti-spasmodics, want these to be administered by nurses, the team is working on Patient Group Directive, so this can be actioned, waiting for sign off by the Nursing and Midwifery committee • Avoidance clinics – recommending they have a Urology avoidance clinic e.g. vascular • Ambulatory waiting room – bedside points e.g. oxygen suction, can these be removed? Currently a waiting room and occasionally this area is converted for an area with beds • 10 trauma beds have been taken out, massive impact on SAU e.g. big mix of patient acuity, demands on nurses, dementia patients with challenging behaviour, not appropriate for patients or staff, orthopaedic patients usually cared for on ward 19 and 21, staff on these areas are having to attend to these

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							patients on SAU too • The IV area is an open space at the end of the female beds area, open to view and opposite to patient beds, this is not private, staff open to distraction and not good for patients to observe, can this area be partitioned off? • Can SAU have an ultrasound sonographer allocated to SAU? Often a long delay for sonography, this would make things much quicker and efficient
2.8.18	12:00	David Anderson	Anna Basford Lisa Williams	Fracture Clinic / Orthopaedic Outpatients, HRI	Jane Cash – Nursing Sister in Charge	Corinna Hampshire	Anna Basford, David Anderson and Lisa Williams, Assistant Director of Transformation and Partnerships had a walk round the Fracture Clinic and Orthopaedic Outpatient Department at Huddersfield Royal Infirmary. We met with Jane Cash who is the Nursing Sister in Charge of the Department, and also with two Orthopaedic Plaster Technicians. We were grateful for the time given by staff during our visit. All staff conveyed a positive and cohesive message regarding the quality of care they provide and team work within the department. During our visit four issues were raised with us. I have noted these below: 1. The plaster room has been re-located and the size of this is a challenge, it would be

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							helpful if this could be reviewed and the facility expanded from 3 patient 'beds/ trolleys' to 4. Anticipating the possible increase in demand in winter, staff are concerned the current accommodation may be inadequate to meet demand. 2. The fracture clinic currently has a high level of attendance and there is programme of work in progress through the Outpatient Transformation Programme to redesign pathways of care and deliver virtual clinics. Staff we spoke to were very positive about this development and the benefits it will deliver in relation to patient experience, outcomes of care and efficiency. 3. There is a shortage and difficulties in recruiting Orthopaedic Plaster Technicians - a possible approach could be to increase CHFT pay band for this as staff advised us other Trusts are offering a higher level of remuneration and CHFT is not competitive in respect of recruitment and retention. 4. It would be helpful if work could be undertaken to redesign pathways for GP urgent orthopaedic referrals in hours. Currently these come to the Orthopaedic treatment room in the department however this is not staffed to be able to accommodate this demand – also this is a 9am to 5pm service and problems arise if patients attend and need a longer time to address their needs.

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							Staff feel the service is being used as an orthopaedic ambulatory assessment unit but it does not have adequate resource to do this safely as it is not appropriately staffed and only operates between 9am to 5pm.
31.8.18	9:00	Phil Oldfield	David Birkenhead	HPS	Burrinder Grewal	Andrew Myers, Roger Brookes, Julie Thompson	Investment plan approved by Board - Private investment - NHS application for growth funding, initial feedback positive - Henry Boot – loan funding - £20M to extend next door - Ernst and Young (EY) advice re VAT + corporate structure - 50:50 split between Private / NHS direct Business growth fund – review opportunity Growth in Clinical Trials - 5 contracts won in year - new business - Increased reputation Brexit - May be positive – manage deliver of shortage medicines - Challenge of planning for the unknown – regulatory mechanism Licensing - Application ready – timescale 3-6 months post application submission - Easier to export Development - Plastics – about to introduce

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							- Tablets – very difficult – hard to formulate, equipment expensive, no current plans although could be high rewards - Worth exploring company re prefilled mapline syringes – have done the development but no capacity to manufacture; therefore, would need £2m investment to manufacture here – business case? Challenges - Managing rate of expansion - Working as a commercial company - Less flexible - Faster decision making i.e. private sector Help - Try to sort out the HR issues and ability to pay flexible
31.8.18	2.00	Philip Lewer	Vicky Pickles	Paediatrics, HRI (Ward 18)	Fiona Stuttard		The ward was lovely, clean and tidy. Calm atmosphere and a good feel to the ward. The ward was quiet. The only area of concern flagged was the ongoing uncertainty of ward 18 and its separation from the rest of paediatrics. They would like certainty as to when and if there will be any move. The team are really proud of their Friends and Family Test results, which are excellent.

DATE	TIME	NON EXEC	EXEC	AREA	MATRON/CONTACT	WARD MANAGER	NOTES/REPORTS/COMMENTS/ACTIONS
							Little girl was on the ward, both her and her mum said they had been well cared for. Liked the ward and the staff and had been on paediatrics at CRH before transfer to HRI. The whole process was managed well. The only issue identified is the split site. The girl needed an MRI under sedation and although she was a medical patient, she had to come to HRI for the MRI due to anaesthetic input. It is a continuing issue of split site.

Upcoming Visits

LOCATION	LEAD MATRON / WARD MANAGER	DATE
Maternity, Ward 4C, CRH	Rachel Roberts	Thursday 27 December 2018
The Health Informatics Service, Oak House	Margo Smith	
Quality Team, Glen Acre House	Andrea McCourt	
Occupational Health, CRH	Christine Bouckley	Thursday 3 January 2019
Ward 8, HRI (Elderly Care)	Sarah Bray	
Infection Control	Jean Robinson	Thursday 24 January 2019
Gynae Outpatients, CRH / HRI	Rachel Roberts	
Community Care – Broad Street Plaza	Debbie Wolfe	Friday 4 January 2019

18. 2019-20 Capital Plan Overview

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday, 3rd January 2019	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Planned capital expenditure 2019/20 - See Executive Summary	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this paper is to provide an overview of the planned expenditure on capital for 2019/20 following the Capital Panel held on 23rd November 2018. The Trust has identified the capital plan totalling £9.4m that requires the disposal of assets to create the available resource. 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.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board are asked to:
• note the process followed and the proposed capital plan, subject to finalisation of the Trust's Annual Plan;
• note the requirement to dispose of assets to incur the planned expenditure;
• note plan to manage residual risk through the contingency reserve; and
• note the requirement to secure emergency capital funding for the MRI scanner investment at c£3m.

Appendix

Attachment:

2019-20 Capital Plan overview for Board.pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Planned capital expenditure 2019/20

3 January 2019

1. Purpose

The purpose of this paper is to provide an overview of the capital planning and draft capital plan for 2019/20.

2. Background

The Trust annually sets a capital plan that has to manage and mitigate a number of significant risks from an Estate, IM&T and medical equipment perspective. The financial demand each year is greater than the available resource for the Trust and this is required to be managed through investing in areas of greatest need. This prioritisation requires input from specialists in each area to inform the risk associated with not investing.

3. Capital process overview

The process of prioritising the limited capital resource has been reviewed. A 3 R's approach was undertaken with key desired outcomes being for greater engagement than previous years and earlier agreement in line with contractual requirement with CHS.

Result

- Agreed the 2019/20 capital programme before 31st December 2018
- Share the planned programme with colleagues including WEB and Finance & Performance Committee
- Understand the clinical and operational risk of schemes to be progressed and those not supported
- Advise colleagues to prepare detailed business cases in January to be agreed through CISG and CMG before 31st March 2019.
- Minimise effort on schemes that are not likely to progress
- Ensure agreement and engagement and complete the process once - GIRFT

Reality

- Bids are presented at Capital Management Group (CMG) and prioritised by CMG. This has limited clinical engagement as clinical divisions send finance to represent
- Recommendations are then taken to CISG and questions asked without appropriate colleagues to respond being represented
- Significant duplication of discussions to different forums / stakeholders

Response

- 'Capital Planning Panel' reviewed mini bids presented on 23 November 2018
- Panel included appropriate representation to agree which schemes are to progress – GIRFT
    - Panel members:
        - Gary Boothby;
        - Ashwin Verma;
        - Anne-Marie Henshaw;
        - Lyn Walsh;
        - Eileen Crosbie;
        - Sree Tumula;
        - Rosie Robinson; and
        - Rob Aitchison.
- Mini bids were presented by bid sponsors who were given a timed 'pitch' opportunity
- Risks were articulated clearly by sponsors for the panel to understand

The above process was concluded, and a capital plan is proposed for 2019/20.

4. Capital resource

The Trust's available capital resource (CDEL limit) is set by a calculation as part of annual planning. The ability to increase available resource is limited to borrowing through a loan or disposing of assets, with the sales value being available to spend on capital.

The proposed capital plan below is predicated on the Trust disposing of a number of properties to generate additional resource, these being:

- Acre House; and
- Glen Acre House.

Colleagues from CHS are working to maximise the disposal value of the estate and that disposal is planned for within the financial year.

5. Planned capital expenditure

The following table provides the high level summary following the evaluation.

Area of spend	2019/20 Plan (£000)
Estates	2,038
IM&T	1,500
Medical Equipment	3,116
Contingency	1,000
PFI, Lease equipment & Other	1,693
Total	**9,374**

A detailed listing is provided within Appendix 1.

In addition to the above the Trust is seeking additional capital resource through an Emergency Capital bid for the required investment in an MRI scanner at CRH. This is expected to be in the region of £3m. Other capital risks remain within the Trust that will be required to be managed through the £1m contingency reserve.

6. Recommendation

The Board are asked to:

- note the process followed and the proposed capital plan, subject to finalisation of the Trust's Annual Plan;
- note the requirement to dispose of assets to incur the planned expenditure;
- note plan to manage residual risk through the contingency reserve; and
- note the requirement to secure emergency capital funding for the MRI scanner investment at c£3m.

Appendix 1

Scheme	Proposed Plan Value £000
CLINICAL & IMT SYSTEMS	
EDMS Hardware Refresh	700
Electronic Observations	250
TOTAL - SYSTEMS	**950**
IT INFRASTRUCTURE	
Core servers/Infrastructure	250
Clinical systems	100
PC's/Laptops	200
TOTAL - IT INFRASTRUCTURE	**550**
Total IT Plan	**1,500**
BUILT ENVIRONMENT	
HTM Fire (Estates)	300
Ventilation Systems (Estates)	150
Building Management System	50
CQC Environmental (Estates)	200
Hot & Cold Water Services (Estates)	300
Roofs (Estates)	300
Hospital Building External / Structural	128
HTM 04-01 Pipework & Compliance	200
HTM 06-01 Electrics	50
HTM 05-02 Fire Doors	150
Ward Flooring	50
Plant room refurb	10
Lift Lobbies	20
Non Ward Window Replacement	100
Lifts Control Gear	30
TOTAL - BUILT ENVIRONMENT	**2,038**
FSS Equipment	
Falsified Medicines Directive (FMD)	24
5 X Sysmex POC analysers	14
Gamma camera replacement	1,400
Aseptic unit refurbishment / extension	800
Pacs	30
GE OEC 9900 image intensifer	25
TOTAL FSS Equipment	**2,293**

Medicine Equipment	
Fibroscan	63
2nd Balloon pump	27
Total Medicine Equipment	**90**
Surgical Equipment	
Fluid Warming plates x 8 CRH 6 HRI 3 DSU (19/20 proposed financial value is to only provide 50% of these proposed units)	76
Fess Microdebrider x2 kits Theatres (1 each site)	40
Transfer trolleys HRI	12
Ophthalmology Optivue RTVUE OCT (Acre Mills)	500
Total Surgical Equipment	**628**
Community Equipment	0
Corporate Capital Costs	0
PMU Equipment	
Weighing management system (Combics replacement)	75
Lytzen filters	30
Total PMU Equipment	**105**
TOTAL - EQUIPMENT REPLACEMENT	**3,116**
- PFI lifecycle costs	1,693
Contingency	1,000
Total 2019-20 Plan	**9,347**

19. Financial Summary - Month 8

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, 3rd January 2019	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Finance Headline Message - Month 8 - A summary of the financial position as reported to NHS Improvement for Month 8.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Turnaround Executive	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

See attached

Main Body

Purpose:

See attached

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

Trust Board Financial summary Month 8.pdf

FINANCE HEADLINE MESSAGE – MONTH 8

BOARD OF DIRECTORS
3 JANUARY 2018

Year to Date Summary

- The year to date deficit is £26.62m, a £0.01m favourable variance from plan.
- The position includes a benefit of £0.16m due to Medical Staff pay awards which were implemented in October and not backdated as assumed in the plan. This is a timing difference, will reduce month on month and will not impact on the forecast. Aside from this the position is worse than plan.
- Medical staffing expenditure continues above plan. The year to date adverse variance to plan is £2.70m. Against the trajectory, Medical agency fell below the planned level in month although overall pay cost has not benefited to the equivalent degree due to the switch to higher cost bank.
- There are also significant pressures on non-pay expenditure particularly on the cost of premises, Pathology contracts and clinical supplies.
- Out of area income has also reduced in month from the projected level bringing additional pressure.
- Operational budgets are now overspent by £1.06m year to date, a slight worsening compared to month 7. However, the underlying operational overspend is £1.94m, mitigated by a number of non-recurrent benefits: capitalising of salaries (£0.19m), a one off additional CNST Maternity Incentive bonus payment (£0.42m) and by bringing forward the remaining benefit of the planned element of the Incentive payment (£0.27m). The release of all of the Trust's contingency reserves in the year to date (£1.00m) and the release of some prior year provisions benefit (£0.15m). In addition a proportion of the winter element of the reserve has been released in the short term to offset the shortfall on CIP and will need to be reinstated as CIP is achieved per the re-profiled forecast.
- The greater pressure seen against the plan in month plays through to the forecast position.
- Appendix 1 shows the position against the clinical contract and the protection offered by the AIC.

Forecast

- Achieving the planned £43.1m deficit for this financial year is now reliant on both the delivery of the full £18m of CIP and an additional recovery requirement with a total value of £3.96m.
- Recovery plans are in train to the value of £3.41m. The forecast at Month 8 assumes further recovery of £0.55m. This will necessitate immediate further grip and control action in order to deliver sufficient pay back in the final quarter of 2018/19. These measures are being instigated.

Month 8 Contract Position Summary

1. Summary in-month and YTD Month 8 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	3,226	3,215	-11	2.33	2.22	-0.11	24,827	24,705	-122	17.90	17.62	-0.27
Elective	578	494	-84	1.81	1.50	-0.31	4,342	3,849	-493	13.69	11.82	-1.87
Non-Elective	4,846	5,082	236	8.51	8.71	0.19	37,721	38,991	1,270	67.62	67.93	0.30
A&E	12,436	12,238	-198	1.51	1.56	0.05	103,136	101,450	-1,686	12.49	12.80	0.31
Outpatient	32,283	31,944	-339	3.83	3.71	-0.12	248,515	251,039	2,524	29.49	29.28	-0.21
Other NHS Tariff	10,915	11,314	399	1.76	1.79	0.03	86,032	86,840	808	13.81	13.81	0.00
Other NHS Non-Tariff	145,050	147,407	2,358	5.95	5.83	-0.12	1,154,206	1,157,437	3,232	48.12	48.03	-0.09
CQUIN	0	0	0	0.59	0.57	-0.01	0	0	0	4.61	4.57	-0.04
Sub-total - pre AIC adjustment	**209,334**	**211,694**	**2,360**	**26.29**	**25.89**	**-0.40**	**1,658,778**	**1,664,311**	**5,533**	**207.73**	**205.86**	**-1.88**
AIC Adjustment	-	-	-	-	0.33	0.33	-	-	-	-	1.70	1.70
Net Reported Position	**209,334**	**211,694**	**2,360**	**26.29**	**26.22**	**-0.06**	**1,658,778**	**1,664,311**	**5,533**	**207.73**	**207.56**	**-0.18**

In summary:

- The YTD position is now **£1.88m** below the contract PRE AIC with an AIC adjustment of **£1.70m**. This brings the net YTD position to **-£0.18m**.
- The YTD position on pass-through costs is an under-trade of -£0.28m which is off-set by a non-pay underspend and so the YTD net impact on I&E is a benefit of **+£0.10m**.

2. Month 8 Forecast Position vs Month 8 Actual Position

Month 8 pre-AIC is £0.18m worse than it was forecast to be, with AIC protection of £0.07m against this. The net income position is therefore £0.11m worse than it was forecast to be. This is in the main driven by North Kirklees activity that is lower in M8 than seen in previous 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 £1.4m. The remaining under-performance on the AIC is therefore -£0.29m below the AIC value. This is driven by a material under-performance on elective of -£1.3m, offset by over performance in A&E, non-elective and outpatients.

20. 2019-20 Annual Plan

To Note

Presented by Gary Boothby

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

•Quality Committee – minutes from meeting held 29.10.18 and verbal update from meeting held 3 December 2018 (Linda Patterson)

•Finance and Performance Committee – minutes from the meeting 30.11.18 (Phil Oldfield)

•Charitable Funds Committee – minutes from meeting held 28.8.18 and 29.11.18 (Philip Lewer)

To Note

QUALITY COMMITTEE

Monday, 29 October 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

184/18 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Helen Barker **(HB)**	Chief Operating Officer
Anne-Marie Henshaw (AMH)	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Jackie Murphy **(JMy)**	Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Samantha Lindl **(SL)**	Personal Assistant – Human Resources **(for item 191/18)**
Ruth Mason **(RMa)**	Associate Director of Organisational Development and Training - Human Resources **(for item 191/18)**
Dr Rob Moisey **(RMo)**	Clinical Director – Acute Medicine **(for item 190/18)**
Dr Cornelle Parker **(CP)**	Associate Medical Director (for Dr David Birkenhead)
Vicky Thersby **(VT)**	Head of Safeguarding **(for item 194/18)**

185/18 APOLOGIES

Alistair Graham	Non-Executive Director
Lindsay Rudge	Deputy Director of Nursing
Dr David Birkenhead	Medical Director

186/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

187/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 1 October 2018 were approved as a correct record.

188/18 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

Re-opened complaints

Following discussions at previous meetings regarding dissatisfaction with complaints and where a complainant's final response has been returned, a review of re-opened complaints was carried out with the following results:

In 2017/18, 11% of complaints were re-opened (based on the number of complaints closed in the year), and in 2018/19, to the end of August 2018, 10% of complaints were re-opened (30 out of 303). A survey is being undertaken to further understand complainants' level of satisfaction (or otherwise) with the complaints process. Responses from the survey will be included within the complaints report to the Patient Experience and Caring Group.

There are currently no national benchmarks for re-opened complaints cases, therefore, it was agreed that a baseline of around 10% will be taken in order to see if the figures can be reduced.

It was reported that some colleagues find it challenging to have difficult conversations with complainants, and there is increased surveillance that initial phone calls with complainants are being made and that responses are accurately answering the complaint.

189/18 CARE QUALITY COMMISSION (CQC) UPDATE

Anne-Marie Henshaw (Assistant Director for Quality and Safety) gave a verbal update from the CQC Response Group.

There are three areas to update progress from the post-CQC action plan. Two are still outstanding – the ligature rooms at CRH and HRI. The blockages with the progression of these actions have been escalated through the Performance Review Meeting and also a separate escalation to the Chief Operating Officer and Chief Nurse. The issue on the HRI site is due to the access door, which is being pursued by the Chief Operating Officer with the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) on Friday. The specifications do not meet the standards of SWYPFT. Following a final walkround, most of the issues on the CRH site have been completed.

Health checks are being rolled out in all divisions, with checks of the 'safe' domain taking place in October.

A system-wide review involving CHFT, the Clinical Commissioning Groups and other providers will take place early to middle of next year and will look at the interface between community services for people who are aged 65 and over across three areas

- Cases where health and wellbeing is maintained in the usual place of residence
- Crisis management
- Step down

Information is being gathered for a potential provider information return (PIR) from CQC. The review will not affect the current ratings, but will give a general view on how to improve services.

Discussion ensued on the severity of the ligature rooms' risk, which is on the risk register. The Chair stated that it is imperative that a further update is provided which will be raised at the Board of Directors' meeting on Thursday.

Action: Update on ligature rooms risk to be provided for Thursday's Board meeting.

190/18 SEPSIS UPDATE

Dr Rob Moisey (Clinical Director – Acute Medicine) was in attendance to give a verbal update on sepsis performance.

Sepsis is reported to the Clinical Outcomes Group on a monthly basis and is also part of the CQUIN (Commissioning for Quality and Innovation) process. The current sepsis Hospital Standardised Mortality Ratio (HSMR) is 87.68, with the Trust ranking 29th nationally out of 132 trusts. A dashboard which includes all sepsis performance data and improvement measures has been created. CQUIN data is currently at 100% for the timely identification (screening) of patients with sepsis and antibiotic prescription documents reviewed within 72 hours is now at 97%.

Discussion ensued on the quality improvement work being done in the emergency department to identify sepsis sooner, where the time a patient arrives in the department is recorded, rather than the time when the first observations are taken. The Electronic Patient Record trigger now being used for sepsis screening was also discussed, which alerts when sepsis is suspected.

The Quality Committee congratulated RMo on the good progress and stated that this was a good example of the Electronic Patient Record impacting on care. The Committee agreed that due to progress being made with sepsis, the reporting can be monitored through the Clinical Outcomes Group and the CQUIN process, with quarterly reporting via the divisional patient safety and quality board reports.

Dr Moisey was thanked for the update and left the meeting at this point.

191/18 SCHWARZ ROUNDS

Ruth Mason (Associate Director for Organisational Development and Training) and Samantha Lindl (Personal Assistant – Human Resources) were in attendance to provide an update on progress with Schwarz rounds – a group forum which gives colleagues an opportunity to reflect on the emotional aspects of their work.

In 1994, a health attorney called Ken Schwartz was diagnosed with terminal lung cancer. During his treatment, he found that what mattered to him most as a patient were the simple acts of kindness from his caregivers, which he said made "the unbearable bearable". Before his death, he left a legacy for the establishment of the Schwartz Centre in Boston, to help to foster compassion in healthcare. In 2009, Schwartz Rounds were brought to the UK by the Point of Care programme at The King's Fund and continue to be implemented by The Point of Care Foundation.

The Trust is signed up to the point of care foundation, with trained clinical leads and facilitators on an established steering group. The first group will take place on Thursday, 24 January 2019. This is an exciting opportunity for colleagues and an integral part of the rounds. The next steps are for communication, posters, intranet pages, screensavers and messages on payslips to be circulated and for anyone to share an event that was significant to them where a Schwarz round can be considered.

A nine minute YouTube clip titled Understanding Schwarz Rounds was shown, with subsequent discussion. It was stated that a Schwarz round could be considered for the Governance and Risk team as events are usually flagged up through serious incidents. Schwarz rounds could also be used to share good news stories. It is envisaged that these sessions will be held every other month.

The Quality Committee thanked RM and SL for their presentation, and requested an update following a few months' reporting.

ACTION: An update to be provided after three months' reporting – March 2019

SL and RMa left the meeting at this point.

192/18 SERIOUS INCIDENT REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix D summarising four new serious incidents and nine learning summaries of serious incidents submitted to commissioners in July and August 2018:

- New serious incidents:
  - delay in administering blood sugar to a neonate
  - no apparent medical review prior to death
  - delay in diagnosis of cancer
  - Fall

- Nine serious incident reports:
  - Patient in ambulance sent to Leeds rather than being brought to emergency department

- Cancer referral where the treatment pathway exceeded 104 days
- Delays in the cancer treatment pathway
- Possible misdiagnosis in ED (now de - logged)
- Category 4 pressure ulcer
- Clostridium difficile transmission
- Baby born at home, either stillborn or died shortly after birth
- Delay in identification of spinal cord decompression
- Fall

AMcC reported that the learning report was recently submitted to the Weekly Executive Board to ensure that learning is taking place. A recent annual planning day also supported a refreshed approach to learning which will be complete by end of January 2019. This will be reported at this Committee as well as a range of forums.

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

193/18 HIGH LEVEL RISK REGISTER

Andrea McCourt (Head of Governance and Risk) presented appendix E highlighting risks as at 24 October 2018.

- Eight top risks scoring 20 or 25:
  - 7278 (25) *Longer term financial sustainability risk*
  - 7234 *(20) Healthcare waste collection*
  - 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*

- Five new risks:
  - 7324 (20) *Risk of healthcare waste not being collected on a daily basis*
    minor rewording to the risk is being undertaken
  - 7240 (16) *Risk of expenditure being above planned levels for the surgery and anaesthetics division*
  - 7309 (16) *CHFT use of NerveCentre technology to record observations requires updating by January 2019 and there is a risk that the integration with the Electronic Patient Record will not be completed within the timeframe*
  - 7315 (15) *Risk of delay to patient care, diagnosis and treatment caused insufficient outpatient appointments*
    There are some challenges with the delivery, but work is undergoing for the Electronic Patient Record to link to the revised National Early Warning Score (NEWS2)
  - 7169 (16) *2018/19 financial plan risk*
    minor rewording to the risk is being undertaken

Discussion ensued on risk 6715 – risk to patient safety, outcome and experience due to inconsistently completed documentation. It was reported that now the Electronic Patient Record is more embedded, improved assurance on documentation can now be reviewed due to improved data from all sources. It was also stated that the new Chief Clinical Information Officer is now in post and the Clinical Records Group has also been reinstated.

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.

194/18 SAFEGUARDING ADULTS AND CHILDREN REPORT

Vicky Thersby (Head of Safeguarding) was in attendance to present appendix F and to update on safeguarding adults and children. The report provides an overview of activity from April 2018 to September 2018, outlining key developments on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), Safeguarding Training Compliance, Mandatory Children's Safeguarding Supervision requirements and progress; recent CQC inspections and any potential inspections, and the Children Looked After Service Specification update and re-configuration of services.

- Mental Capacity and Deprivation of Liberty Safeguards – The trust is committed to ensuring that all colleagues follow the principles and practice of the Mental Capacity Act (MCA), and the Deprivation of Liberty Safeguards (DoLS), with an MCA/DoLS policy in place and all patients who are subject to an urgent or standard authorisation are shared with matrons and ward sisters on a weekly basis and the relevant local authority kept updated regarding any changes with the patient. There was a significant reduction in the number of urgent DoLS applications in the last two quarters, from 166 to 103, which shows a greater colleague understanding of the MCA.

- The Mental Capacity (Amendment) Bill – this bill has now been published and being introduced through Parliament, and expected to come into force by late 2019, early 2020. The Bill abolishes the DoLS, by deleting the MCA Schedule A1 and 1A, and adds instead a new Schedule AA1 – which is anticipated to be known as the 'Liberty Protection Safeguards'. Work is to take place on the impact of the draft Bill.

- Training compliance is broken down into divisions and not all areas met the 95% training compliance. Further work is to take place on the number of colleagues who are required to complete level three training at the end of quarter 3

- Safeguarding Children's Supervision – all colleagues who work with children require mandatory safeguarding supervision, and from the beginning of quarter 1 to the end of quarter 2, there has been an increase in compliance, with the overall Trust compliance now at 69%.

- Regulatory Compliance
  - CQC inspection – a CQC inspection in 2018 resulted in no direct actions relating to safeguarding, but there were a number of 'should do' actions relating to safeguarding, which will be progressed as part of a developing mental health and CHFT working group.
  - Children's and Children Looked After CQC Inspection (Calderdale 2016 and Kirklees 2018) – one action from the 2016 inspection regarding new job descriptions is close to completion and the four actions from the 2018 inspection are all progressing.
  - Section 11 – the Trust completed two requests this year from both Calderdale and Kirklees
  - Kirklees Ofsted inspection – inspections in September and October 2016 focussed on local services for children in need of help and protection, looked after children and care leavers, and an inspection of the Independent Safeguarding Children's Board. The resulting overall outcome was inadequate. The next Ofsted monitoring visit for Kirklees Children's Services will take place in December 2018 and a full inspection in the New Year 2019. Calderdale Children's Service also anticipate an Ofsted inspection, however, there is no indication on when this will occur.

- Adult Safeguarding - Gwen Clyde Evans who was previously the Domestic Abuse Lead for CHFT has now taken up post as the Named Professional for Adult Safeguarding. This role now incorporates the lead for Domestic Abuse, Prevent and MCA DoLS. There has been an increase of 63 referrals made by CHFT colleagues in relation to safeguarding concerns. This shows an increased awareness of colleagues in identifying and recognising what abuse is.

- Mental Health – The Trust works in partnership with the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and is developing a mental health strategy which ensures partnership arrangements follow the four pillars. SWYPFT asked that the Trust Board are notified of an error in the processing and completion of a detention under section 5(2) of the Mental Health Act 1983. The paperwork was not completed correctly by two junior doctors and it was not possible to rectify the error, therefore this was an unsafe section. A mental health act assessment took place within 24 hours of the insufficient section 5(2) and a section 2 was instigated; however the section 2 paperwork was not accepted by CHFT at that time. This was remedied as soon as the omission was noted two days later. The assessment and detention under section 2 was recorded in the patient's clinical notes and a file note added to the MHA file to ensure clarity of actions. This was supported by the Mental Health legislation team.

  The Chair was asked whether the Board has been notified. VT reported that JMy will be providing a briefing paper to the next meeting of the Board of Directors.

- Domestic Abuse Hub Calderdale – Since January 2016, CHFT has hosted the commissioned Domestic Abuse Health Practitioner role that is based in the Domestic Abuse Hub in Calderdale. This role represents all of the health partners in Calderdale and provides a coordinated and joined up approach for sharing and contributing to multi-agency information sharing. Following a change in the arrangements this role has reduced from two practitioners to one, and funding will be available for only one partner from April 2019.

- Domestic Abuse Quality Mark - 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.

- Children looked after and care leavers (Calderdale) – the designated nurse role now sits in the clinical commissioning group with existing funding remaining as part of the commissioned service to fund two additional posts. An additional two posts from Locala are seconded into the commissioned service to support in delivery of the new specification which now covers all CLA and Young people. The new service will now carry out Review Health Assessments up to a 50 mile radius and beyond in consultation with the relevant service in the placement area.

The Committee discussed the 95% mandatory training compliance target, which all divisions have been informed of, and also being reviewed through Performance Review Meetings. It was stated that there is a vast amount of work in safeguarding and for the team, and it was asked whether it is being managed. VT reported that different ways of working are being explored and during the annual planning event, there were a lot of ideas put forward, and safeguarding was in the top 15. There is a lot of success work within the report and very noteworthy that no actions were received following the CQC inspection. It was also noted that due to changes in legislation, safeguarding can be challenging, however, this is maintained through good leadership. Congratulations and thanks were conveyed to VT for the report.

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

195/18 MEDICINES SAFETY AND COMPLIANCE GROUP

Jackie Murphy (Chief Nurse) presented appendix G, which highlighted key points from the new Medicines Safety and Compliance Group (MSCG), which was established in June 2018 and replaced the previous Medicines Safety Group. The remit of the group is to ensure that medicines are managed in a safe and efficient manner throughout the Trust and that risks in relation to medicines are controlled. Assurance processes will be developed for all aspects

of medicines management and reporting tools and dashboards are to be developed. Outstanding actions from the previous Medicine Safety Group are to be carried over to the new group.

Key points:

- New chair – Elisabeth Street, Clinical Director of Pharmacy
- Terms of reference were reviewed and approved, with sub-groups confirmed.
- A separate Task and Finish group to review discharge issues to be established.
- Draft dashboard to measure medication safety assurance presented and agreed.
- Annual medicines management audit template was reviewed. Query on audit template regarding ambient temperature monitoring in clinic rooms. Pharmaceutical companies require majority of medicines to be stored < 25 degrees, however, CHFT currently do not monitor temperatures in many/any areas. This is to be discussed at the next meeting.
- Concerns raised with assurance for the safe management of schedule 4 and 5 Controlled Drugs (CD) i.e. codeine. Lack of documentation for issuing of codeine TTO (to take out) packs therefore no audit trail. To be discussed at October's CD subgroup.
- Monitoring of schedule 4 and 5 CDs is currently poor and exploring options of use of ADioS software to monitor unusual patterns of usage. Demonstration to be shared with colleagues to seek opinion on whether this will enable tighter controls.

Other issues identified:

- Closure of Calderdale aseptic facility / capacity issues have highlighted need to review what is currently made. This may result in syringe drivers having to be made up on wards. Discussions with senior nurses to be arranged to discuss risks and ensure any additional training is put in place
- Anecdotally, information that some clinical areas have wooden CD cabinets which do not meet legislative requirements (they should be metal). An audit to take place for areas that are non-compliant / need replacing.
- Issue of patients' own drugs not being secured safely. Pharmacy team to develop patient leaflet to explain the 'journey of their medicine' for inpatients and also explain the requirements to lock up their own drugs securely.

JMy also reported that that there was a 'must do' action from the CQC regarding controlled drugs in the Emergency Department. Following a quality visit, it was reported that this has much improved.

Discussion followed on whether a member from the Medicine Safety and Compliance Group is on this Committee.

ACTION: To invite Elisabeth Street (Clinical Director of Pharmacy) to attend this meeting.

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

196/18 CLINICAL OUTCOMES GROUP REPORT (including update from Mortality Surveillance Group)

Cornelle Parker (Associate Medical Director) was in attendance to present appendix H, summarising key points for escalation from the Clinical Outcomes Group meeting held in September:

- The Summary Hospital-level Mortality Indicator (SHMI) was noted below 100 at 99.9
- The Acute Kidney Injury collaborative has widened its membership to include the critical care outreach team and nursing staff. Dr Mansoor Ali is leaving the Trust at the end of the month, with no locum or substantive replacement as yet
- Still awaiting clarity on the proposed role of the Medical Examiner

Updates from the Mortality Surveillance Group meeting held in September were also provided:

- Clinical coding – department has lost three experienced coders and causing pressure with team.

Discussion took place on whether there was any improvement in how accurate the standard of clinical information being input into the Electronic Patient Record is. It was stated that the coding team carry out an incredible clinical role and their perspective is that it provides more accurate data, although data is not filed in admission order which means coders having to open every case to be coded. It was stated that elements will be refined moving forward and that this will fit into the role of the Clinical Documentation Group and monitored by the new Chief Clinical Information Officer.

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

197/18 PATIENT EXPERIENCE AND CARING GROUP REPORT

Jackie Murphy (Chief Nurse) presented appendix I, highlighting activity and issues for escalation from the August and September Patient Experience and Caring Group meetings:

- Chaplaincy update - some excellent examples of initiatives that demonstrate colleague and patient engagement and partnership working (internal and external) were reported, including agreeing healthcare services to Black, Asian and minority ethnic (BAME) Communities; Working alongside Trust colleagues to set up an art competition and exhibition; Supporting the Marigold Café (jointly with Age Concern) – a drop-in café for bereaved relatives, and End of life companions which is working well with 14 companions recruited with seven more in training.

- Learning disabilities update - a real commitment to ensuring patients with a learning disability receive an experience that recognises their individual needs. This included their personal needs (TVs and DVDs being purchased through League of Friends and working with Estates to accommodate a changing places facility), emotional and social needs (identifying a 'quiet room'), and increasing independence (improving the content of easy read leaflets and making them more accessible to colleagues and to the public). The matron for complex care has led some work with other agencies to support children in their transition to adult services and brought together special schools and colleges and staff to better understand and inform training needs.

- Dementia strategy - Revised strategy shared which recognises the importance of partnership working and engagement with patients and carers in order to deliver individualised care through a skilled workforce.

- Outpatient improvement work - Patient feedback regarding outpatient services from complaints, concerns and Friends and Family Tests have identified waiting in clinic, consultations and access to appointments as the three main issues raised. Information is being gathered to gain an overview of any related improvement activity.

- National surveys - the National Survey of Adult Inpatients 2017 was published in June 2018. The Trust scored about the same for all questions compared to others except for one, which was better - '*after leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?.* The Trust was also noted to have made a statistically significant increase since last year in the score for one of the questions: '*During your hospital stay, were you ever asked to give your views on the quality of your care?*' Further national surveys will be carried out over the next few months, in Urgent and Emergency Care and Children and Young People.

- Divisional updates - Reports demonstrated a number of improvement initiatives that support a patient-centred culture:

  - The emergency department introduced information to help patients understand their patient journey, looking at creating a video;
  - The Neonatal intensive care unit have developed a child friendly play area for visiting children and families;
  - The catering team have purchased a trolley specifically for heating special diet meals which included gluten free, halal and dysphasia diets;
  - ward 6A are working with the palliative care team to have a weekly palliative care round recognising needs of patients who may be in their last year of life;
  - the surgical divisional wards are encouraging patients / relatives to ask if they have any questions / concerns about their plan of care, this is linked to some co-design work that the surgical assessment unit team are leading with NHS England to develop an 'always experience', where patients / relatives will always know their plan of care.

Discussion followed on the work to be done on the significant issue of complaints in the outpatient services. This issue is being followed-up by the outpatient workstream and it was stated that further assurance is needed on progress.

ACTION: Request an update from the division following a deep dive into complaints at the January 2019 meeting.

198/18 QUALITY AND PERFORMANCE REPORT

Helen Barker (Chief Operating Officer) presented appendix J, highlighting that September's performance score has improved by two percentage points to 67%. The safe domain has deteriorated to amber as there has been a never event in the medical division. The caring domain's performance has improved as the accident and emergency Friends and Family Test 'would recommend' has gone from red to amber in-month. The effective domain is now green (90%) with improvements in child mortality and Methicillin-sensitive Staphylococcus aureus (MSSAs). The responsive domain has improved but remains amber with cancer 62 days screening missing target but better performance in the stroke targets. In the workforce domain, all nine essential safety training areas have deteriorated again in-month. Within efficient and finance, agency usage has improved in-month whereas income and expenditure: surplus / (deficit) has deteriorated.

- Responsive domain
  - The emergency care standard continues to be issue on the HRI site. Work is being carried out due to an identified ambulance activity shift. There was concern that patients were waiting over 10 hours in the emergency department, however, there is a data flaw, which continues to show patients when they have been discharged. A meeting is being held this month regarding that.
  - Stroke patients thrombolysed within one hour – there is concern as only 40% against a 55% target was achieved compared to the usual 80% plus. A meeting has been arranged to understand if monthly data can be made available on a weekly basis. The stroke team reviewed its performance at the Performance Review Meeting last week and have a clear action plan.
  - 38 day referral to tertiary – 40% for September
  - 62 day referral from screening to treatment – this just missed the 90% target at 83.3% for September. Lessons have been learned that patients went passed their 62 days and are being treated in October. An emergency meeting was held on Friday with clear actions on those patients and will be reviewed at the next Cancer Board meeting.

- Safe domain - a never event took place relating to the misconnection of a patient onto air instead of oxygen. A historical never event of the same nature was also discovered following a deep dive. This is now being investigated. Initial actions are being taken with regards to the first incident and double-checks are being made with a plan to review against the patient safety alert and to also to have an external review.

- Caring domain – some work is being done with the outpatients Friends and Family Test feedback where patients were reporting waiting times as a poor experience. As part of a Quality Friday visit, Drs Sal Uka and Cornelle Parker (Associate Medical Directors) and Jackie Murphy (Chief Nurse) visited the Acre Mill site where patients were positive on their experiences, however, nurses told of frequently over-running clinics. Work is ongoing to reduce this.

- Effective domain:
  - the Summary Hospital-level Mortality Indicator (SHMI) is now below 100 at 99.98% - the first time at this level.
  - There have been no Clostridium difficile cases in the last quarter, with the efforts by the Infection Prevention and Control team starting to pay dividends.
  - The hydrogen peroxide vapour (HPV) programme is now into its fifth week. This is being managed really well.

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

HB left the meeting at this point.

199/18 QUALITY REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix K, which summarises assurances on quality that have been presented to the Board of Directors between July and September 2018. The report also updates on the three quality account priorities for 2018/19 for quarter 2 and the quality indicators as at quarter 2, 2018/19.

During the three month period July to September 2018, three reports relating to quality were presented to the Board which include an update on the electronic record in maternity and how this has helped investigations, learning from deaths and the benefits of the influenza vaccine.

The three quality account priorities for 2018/19 are care of the acutely ill patient (safe domain), patient flow (effective domain) and end of life care (experience domain).

Discussion ensued on the patient flow programme and challenges with reducing the number of patients stranded in hospital seven days and over and those with the longest length of stay of 21 days and over. The best opportunity for patients to be discharged within 48 hours of admission should also be reviewed by looking into bed days, plan for every patient, consultant reviews, etc. The Chair stated that a paper by the Nuffield Trust on what hospitals can do to improve length of stay is a good read. The report will be submitted to the Board of Directors on Thursday, and it was stated that the report should include that the quality account priorities are incorporated into job plans and Trust objectives, which all executives are aware of.

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

200/18 INFECTION CONTROL COMMITTEE MINUTES

A copy of the infection control committee minutes (appendix L) from August 2018 were circulated for information.

201/18 ANY OTHER BUSINESS

There was no other business.

202/18 MATTERS FOR BOARD

- Sepsis update received
- Safeguarding report received and a paper is due to be submitted to the Board regarding a processing error under section 5(2) of the mental health act.
- Ligature room issue to be followed up.

203/18 EVALUATION OF MEETING

What went well……

- Meeting finished at 5:20 pm
- Good quality discussions, debates and report with key themes clearly defined
- Quality report showing that quality account priorities are being worked on consistently

Would be better if……..

- More people were in attendance. The governor and non-executive director were not in attendance.

204/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix M) was accepted.

The Chair stated that future meetings currently have a date, and are subject to amendment.

Discussion ensued on specific reports from divisions to be added to the workplan - complaints, outpatients, etc, as well as nasogastric tube training which will be part of the divisional reports and safeguarding training and supervision, which should be in a better position by the end of the year.

205/18 APPENDIX OF ACCOMPANYING PAPERS

The accompanying papers for all reports can be found in appendix N.

DATE AND TIME OF NEXT MEETING

Monday, 3 December 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**
PSQB Q2 Reports (Divisional representatives are expected to be in attendance**)**

MINUTES APPROVED BY QUALITY COMMITTEE ON 3 DECEMBER 2018

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 30 November 2018, 10.00am – 1.00pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships
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
Philip Lewer	Chair of Trust
Sian Grbin	Lead Governor

ITEM

208/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

209/18 APOLOGIES FOR ABSENCE

There were no apologies to note.

210/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

211/18 MINUTES OF THE MEETING HELD 30 OCTOBER 2018

The Committee approved the minutes of the meeting held 30 October 2018 as an accurate record subject to a few minor amends – the latest Risk Rating was confirmed as 16.

212/18 ACTION LOG AND MATTERS ARISING

193/18 – CNST: The email which Andrea McCourt had circulated prior to the meeting was discussed and it was noted that Helen Barker has had further conversations with Andrea with regard to the identification of EDs and it should be more explicate in the next report to identify the risk for CHFT.

ACTION: To follow up with AMc with regard to her response to POs questions following her email - **BS**

196/18 – IPR, Data Quality: HB updated the Committee with regard to a request from NHSI for further opportunities in terms of the incomplete RTT pathways. Short-term overtime has been implemented and a deep-dive has taken place around 4 of the data quality indicators and time at WEB to go through each indicator has been proposed. It was noted that the Data Quality Committee has changed its Terms of Reference to report into the Quality Committee and this will be on the Agenda for that meeting in January – **action closed**.

214/18 MONTH 07 FINANCE REPORT

The Deputy Director of Finance confirmed that we are still reporting to be on plan YTD but that this is a much tighter position than the previous month. In terms of the other YTD metrics, we are still on track with the agency trajectory and we are underspent on Capital. The AIC continues to offer a level of protection and this enables a number of actions which would not have been available under the PbR contract. The latest positions of the Forecast Recovery Actions were highlighted and it was noted that the scale of the pressure has increased but that there has been a number of positives, in particular the Maternity Incentive Scheme which has resulted in an additional bonus. The recovery actions include scope to capitalise expenditure as a backstop recovery action but further operational recovery actions are being sought from Divisions in the first instance and weekly escalation meetings continue with those Divisions who have challenges.

In depth discussions took place with regard to the reduction of the Agency Trajectory which is still not translating into a reduction in the total pay bill. It was suggested that there should be a way of capturing the benefit realisation within a clear narrative. It was noted that 1:1 out of hours cover is our biggest spend and conversations are taking place with regard to the Nursing Associate model and how we can do something different. Discussions then turned to reference costs and our fixed cost base.

In summary it was noted that we are on plan but have identified a £2.8m risk and the full value of the recovery requirement is being pursued through a range of recovery actions and opportunities. It was also noted that in terms of the extra costs for the waste management contract this has yet to be quantified. All risks in the delivery of the forecast were discussed including the winter allocation.

In relation to the £4m CIP schemes still rated high risk some schemes have already been delivered and replacement schemes have been identified for those which are very high risk. There are a couple of areas that are amber or red on the dashboard but these are forecast to deliver.

ACTION: To provide the Committee with a clear narrative of the benefit realisation in reducing the Agency Trajectory which should give assurance of the actions we are taking to bring staffing costs down – **GB/HB , 1 February 2019**

ACTION: To provide a fiscal analysis to ensure our must does/should dos have been captured in relation to maintaining our 'Good' rating with the CQC – **GB/HB/JM, 2 January 2019**

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

215/18 ANNUAL PLANNING 2019/20 – TIMESCALES AND KEY MILESTONES

The Deputy Director of Finance presented a paper which highlighted the challenging timescales for the planning submissions particularly in light of the fact that a number of the key documents awaited from the Regulator will only become available during the course of the process. The key milestones where reviewed and the initial plan submission date of the 14 January 2019 was noted. It was also noted that the Control Totals will be issued mid-December 2018 and will be based on the 2017/18 forecast out-turn, this will be a very challenging Control Total for the Trust.

ACTION: It was agreed that the initial Annual Plan will be an agenda item for the January meeting – **KA, 2 January 2019**

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

216/18 CIP UPDATE

In addition to the points raised within the Month 7 item, it was noted that scoping for next year has started and a target is still to be agreed.

213/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported the following:-

The overall performance score for October is 67%, the Safe domain has improved to green despite a never event which occurred in February. Caring has deteriorated slightly as the A&E FFT has gone back to red. Following the Quality & Performance WEB yesterday there is a piece of work to do from a Workforce perspective in connection to the appraisal season and how this is captured in future.

Other points to note were highlighted as follows:-

- Winter Plans – recruitment started in August and staff will start to come into post from October, money will only be released when evidence is provided that staff are in post. KPIs will be established to monitor the position on a weekly basis.
- Sickness/Turnover/Vacancies – all better than plan. There was debate at the Q&P WEB that we are still not seeing an impact on nursing agency spend and this will be tracked in November to triangulate this information.
- Following the success of the Acute floor at Calderdale and as part of the deep-clean process, there is a plan to make an Acute floor at HRI, this will improve patient movement.
- Flu – the uptake of the flu jab is slightly ahead of plan.

The key points in terms of Workforce were noted as follows:-

- Essential Skills to maintain a target of 95% is proving to be a challenge and a risk for CQC.
- Sickness – push on return to work interviews, there is an increasing trend in short term sickness on nights and weekend shifts.

It was noted that in terms of acute flow we are still in discussions with North Kirklees CCG and Mid-Yorks around patient flow following the Dewsbury reconfiguration and the closure of their A&E. Patient numbers have been verified and the impact has been significant, Calderdale CCG are keen that this is resolved quickly.

- Length of Stay – 13 patients over 50 days stay and 1 patient with 100 days stay, this is the first patient for 6 weeks with 100 days stay. The focus has been with the Discharge Team which has made a difference. Stroke is an area where we still have a high number of long stay patients and to implement a single Therapies Directorate is being considered.
- Stroke SSNAP position is back to a 'B' and this is being tracked in Weekly Performance with the aim of achieving an 'A'.

- Cancer – a good performance, however, screening is still an issue. We have increasing risk around MRI capacity and demand in general has increased for diagnostics with the recent departure of two Radiologists and this will be escalated with the Cancer Alliance.
- RTT – positive position and we will deliver on our trajectory of incomplete pathways.
- Appointment slots – there has been an issue with the national referral system which came to light in July which has affected a number of Trusts including CHFT, this may hit our 18 week position in February/March and this is being managed.
- Referrals – generally they are slightly down but the use of Fast-track is up.

With regard to the IPR predictor a review going back 3/4 months will be undertaken to look at what we thought would happen has actually happened. At the moment December looks a positive position but it is usually a challenging time, the following predicted positions were highlighted:-

Safe – risk around harm-free care
Caring – we are taking a cautious view regarding Outpatient FFT mainly due to patient experience booking outpatient appointments and an optimistic view with regard to an improvement in A&E FFT.
Effective – the completion of the deep-clean puts us in a good position. The #NoF is better but an increasing number of patients are being seen who require a total hip replacement this is causing us issues and could be a risk.
Responsive – Day 38 position the best it has been for a long time.

It was noted that the Dewsbury A&E closure has had an effect and steady progress is being made with our ambulance turn-around time.

With regard to the Dementia Assessment for over 75's the best we have achieved to date is 40% with a target of 90%, it was thought that this is still realistic and the team responsible have been asked to provide a deep-dive to the next Quality & Performance WEB.

ACTION: To provide the F&P Committee with the results of the Dementia Assessment Deep-Dive – **HB**

The Committee received an update with regard to winter preparedness, it was noted that our winter plan has been based on all the lessons learnt from last year and we have more medical engagement and are as prepared as possible.

The Committee **NOTED** the exceptional performance position.

An update with regard to theatre productivity/utilisation and outpatient activity was requested. The Director of Transformation & Partnerships reported that in relation to theatre productivity we have had intervention from external organisations with a level of success, however, a fresh approach for the year ahead is owned by the Surgical Division and the clinical leadership. This approach will be based on using a simplified analysis of the utilisation to give a visual presentation to see where cases could be added to the list. A portal has been established and indicative scoping has taken place looking at the gross potential saving. It was also noted that this will be a

high priority/profile for CIP with Anna Basford being the lead Director in charge of this scheme working closely with Gary Boothby. Both Anna and Gary attended the Surgical Board this week and the visual articulation of opportunities was well received. Executive colleagues have also had a conversation as to how they can support clinical colleagues with the step change for different working patterns.

In addition we are driving to bring in additional activity where capacity is under-utilised, spinal surgery is a significant area where we could potentially be a satellite site for Leeds Teaching Hospital. We also have examples of additional activity for out of area bariatric surgery and there may be an opportunity to bid to tender for the possibility of becoming an exemplar site for bariatric surgery. There are also examples in orthopaedics where lists have been optimised by implementation of simple changes which will help with productivity.

With regard to outpatient transformation work and how we deliver things differently it was noted that we have seen an increase in outpatient attendance this year and through benefit analysis we can challenge the impact on the service lines which have implemented an outpatient transformation either through digital technology or moved to a one-stop session.

ACTION: To receive a report for Outpatient Activity and ask Clinical Director, Will Ainslie, to attend the F&P Committee meeting to present the Theatre Productivity/Utilisation work to the Committee – **AB, Feb/March**

217/18 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were **NOTED** by the Committee:-

- Draft Cash Committee held 23 October 2018
- Draft Capital Management Group held 14 November 2018

218/18 WORK PLAN

The Work Plan was **NOTED** by the Committee and the following items are to be added to the Plan:-

- CQC – **2 January 2019**
- Result of the Investment Evaluations – **GB, 29 March 2019**

219/18 MATTERS TO CASCADE TO THE BOARD

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

- Financial Performance on plan at Mth 7 – risks noted including waste management.
- Pay discussion – agreed to bring a paper back to the February meeting looking for an explanation of our total pay, agency rates/action plans and fill rates.
- Budget Timetable – noted the timing of the information coming from NHS I and the issues around the Control Total were noted.
- Operation IPR – Performance very strong, issues raised around Diagnostics and MRI capacity
- Readiness for winter.
- Ward moves.

- The impact of the Dewsbury A&E closure was noted in terms of beds especially at HRI
- Theatre and Outpatient productivity progress was discussed.

220/18 REVIEW OF MEETING

It was noted that the time for a comprehensive discussion around the IPR was well received.

It was suggested that Owen Williams and Philip Lewer, as part of their 1:1, should review the content of the Sub-Committees to avoid duplication of discussions and to help with this Philip Lewer agreed to ask Vicky Pickles to review the items covered in the Quality Committee, Finance & Performance Committee and Workforce and Organisational Development Committee. It was also agreed that Philip would schedule a meeting with Committee Chairs.

ACTIONS:

- To review Sub-Committee content to avoid duplication of information/ discussions – **OW/PL/VP**
- To schedule a meeting with Committee Chairs - **PL**

221/18 ANY OTHER BUSINESS

The Director of Finance asked for the following items to be noted:-

- Authority had been granted to the Director of Finance from the Board to submit a grant for Energy efficiencies.
- Also, there had been a requirement for Procurement to submit a return to DHSC and NHSI with an assessment of risk in relation to our supply of goods with regard to Brexit, this was submitted today.

DATE AND TIME OF NEXT MEETING

2 January 2019, 11.00am – 2.00pm

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

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Tuesday, 28 August 2018

Present: Philip Lewer, Gary Boothby, David Birkenhead, David Anderson, Jackie Murphy, Phil Oldfield (via phone), Cllr Megan Swift.

In attendance: Carol Harrison, Andy Hill, Antonia Cavalier, Lyn Walsh (minutes)

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Investment Portfolio Presentation.
A Cavalier gave a very informative presentation to the Committee. She explained CCLA are an asset management company for the not for profit sector. The presentation detailed the portfolio that the Charity is invested in and is managed to protect the capital and income over the long term from inflation. P Oldfield questioned the percentage split of the funds and this was explained to him (a copy of the presentation is to be sent out to him). D Anderson asked about any capital gains tax paid. It was confirmed that no tax was paid as it is a charitable fund. A Cavalier explained the ethical polices in place on the fund and discussed risk. She stated that if a further discussion was needed on splitting funds or changing objectives she was happy to help but any movement between funds would cost 4%.
As a point of interest, J Murphy asked how they vet the companies that they invest in. A Cavalier explained that they buy in a research service to do this and also screen the information and go out to see the companies. G Boothby asked how long we had held investments with CCLA and what is the current commitment. This was confirmed as being over 20 years and that it is standard to have a 3 year contract with a 2 year extension. It was discussed that in 2014 there was a review when 3 portfolios were put together into the one we hold today.

3. Minutes of the last meeting
The minutes of the last meeting held on 22 May 2018 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

4. Matters arising
~ launch of new brand on intranet. L Walsh updated that this had been delayed due to ongoing work on the WOS and was now expected to be September. There have been drafts of website pages and materials.

~ Fundraiser recruitment. G Boothby updated that this had also been delayed due to the WOS but it was still a priority and should stay on the agenda.
~ Todmorden sub- committee (good news story). L Walsh updated that this has not yet gone to communications but suggested it be added to the intranet pages which was agreed.
~ Community Foundation for Calderdale – Activity & impact report –decision required. C Harrison has sent out the information provided by the community foundation which is now clearer and we have a better audit trail. The Committee was satisfied that the community foundation had done what was asked of them. It was agreed that £37.5k funds would be released to them. P Lewer is planning a further visit to see them. **Action Release £37.5k Funds**

5. Draft Annual Report & Accounts 2017/18.
C Harrison presented the Report and Accounts to the Committee which they had seen as a draft at the previous meeting. The accounts are currently in the process of being audited, after which it was agreed by the Committee that P Lewer and G Boothby would be delegated the responsibility of signing them off. J Murphy suggested that they be made available to a wider audience and more PR done to promote the charity. G Boothby said he would share the report with exec colleagues. J Murphy suggested a Q&A with trust news as not everyone was aware of charitable funds and how they work.

6. Quarter 1 Sofa and Balance Sheet 2018/19
C Harrison presented the paper describing a slow start to the year donation wise at £57k but by July this has picked up to £123k with legacies and further donations. Gains on the fund were £147k in the first 3 months. G Boothby updated that there had been fundraising of £18k for specific coronary items.

7. Quarter 1 2018/19 Expenditure Summary
C Harrison presented this paper and its contents were noted. There is currently £251k of outstanding commitments. G Boothby updated that £16k had been discussed for new water coolers.

8. Funds of the Charity –an overview
C Harrison presented the paper which provided information to the new members of the Committee. Describing how we hold 120 funds which have been reduced from 270 with 2,400 transactions being made, she explained how every 2 years an exercise is undertaken to look at inactive funds of which there were 17 this time. The fund managers of the 17 funds were questioned over future plans and further consolidated into 6 funds. P Oldfield asked a questioned regarding gift aid - do we claim it. It was confirmed that we claim it from all just giving donations but it was up to the general offices to give the gift aid forms to people who make donations. **Action C Harrison to identify how much gift aid we have claimed.**

9. Risk register update
L Walsh to seek guidance from Andrea McCourt to then circulate for comments outside of the meeting.

10. Minutes from the Staff Lottery Committee meeting held on 12 June 2018

These were noted. G Boothby asked how well was the staff lottery publicised and do we need wider representation on the Committee. It was decided that this would be looked at along with an admin replacement for J Cruickshank who had recently retired. J Murphy suggested that there should be some myth busting around how the staff lottery worked and what could be purchased. The example of a piece of kit was used that should be provided by the Trust in normal day to day operations. C Harrison said that yes the Trust should provide core items but that anything seen as a nice to have extra could be considered.

11. Any other business

There was no other business to be discussed.

12. Date and time of next meeting

The next meeting will be on Thursday, 29 November 2018 at 2 pm in Meeting Room 4, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
28 August 2018
Action Log - 2018/19

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Chase VP re brand launch on Intranet promote good news stories.	**LW**	Nov-18	ongoing
Matters arising	28.08 - 4	Discuss fundraiser recruitment	**GB**	Nov-18	ongoing
Matters arising	28.08 - 4	Contact Comms re Tod good news article. To be added to Intranet site.	**LW**	Nov-18	see action 1
Risk Register update	28.08-9	Amend Risk Register after consulting A McCourt. Circulate outside of meeting.	**LW**	Nov-18	
Comm. Foundation of Calderdale	28.08 - 4	Release monies once Committee happy	**CH**	ASAP	
Fund of the Charity- an overview	28.08-8	Identify how much gift aid has been claimed	**CH**	Nov-18	

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Thursday, 29 November 2018

Present: Philip Lewer, Gary Boothby, Jackie Murphy, Phil Oldfield

In attendance: Carol Harrison, Rhianna Robb, M Kausar (KPMG), Lyn Walsh (minutes)
Apologies: L Patterson, S Taylor.

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Audit Highlights Memorandum & Management Letter
M Kausar from KPMG discussed the 2017-18 audit. There were no findings to report on and no issues or adjustments. The mandatory communications and auditor independence were explained.

3. Draft Letter of Representation
The letter was noted and then signed by G Boothby & P Lewer.

4. Draft Annual Report & Accounts 2017/18
The draft annual accounts had previously been reviewed at the last meeting with minor changes in wording since then. These were approved by the Committee and then signed off by G Boothby and P Lewer and taken by M Kausar for final KPMG sign off. P Oldfield questioned the age of the legacies noted in the accounts; C Harrison explained that it can take some time for the legacies to come in once we are informed of them. He asked that the 2014 legacy be chased up. **Action C Harrison to chase up.**

5. Minutes of the last meeting
The minutes of the last meeting held on 28 August 2018 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

6. Matters arising
~ launch of new brand on intranet.
L Walsh updated that the intranet had been updated within the finance pages with more charitable funds information. However, the external CHFT site was yet to be updated. P Lewer has asked V Pickles to expedite the action.

~ Fundraiser recruitment.
G Boothby updated that a further delay has occurred due to a challenge from HR about the post being fixed term. V Pickles has a meeting 30/11/18 with HR to discuss further. G Boothby has asked that she escalate this back if there are further issues. P Lewer asked about a previous study done by Huddersfield University students around fundraising. It was noted that this did support the need for a part time fund raiser. G Boothby and P Lewer to do some further work and bring back to next meeting.

7. Risk Register update
L Walsh updated that she had sought help from A McCourt who did come back with further suggestions and advised setting up a meeting with R Robinson, Risk Manager. Risk 4056 around strategy was discussed. It was decided that G Boothby would draft a strategy with help from J Murphy. P Lewer suggested that this could be tested at a Board workshop. P Oldfield commented on the policy on accepting funds and donations under £15k being pooled together. He suggested further debate on funds; donations and clear policies. G Boothby asked that the Committee approve the risks being re-scored as they seemed high and that this could be done outside the meeting. P Lewer would like Board approval of the risks once the work is completed.

8. Quarter 2 SOFA and Balance Sheet 2018/19
C Harrison presented this. Donations have not increased to date but we are spending more. Market value on the portfolio looks to have increased by £260k. There is a £165k legacy expected. G Boothby updated that after Capital planning for 2019-20, some items had been agreed which would suit bids from charitable funds.
J Murphy would like to further explore ideas on changing processes on making bids against charitable funds to change people's mind set and make the process more engaging. P Lewer asked that it be noted that he had visited the League of Friends' charity on both sites to see how they operate.

9. Quarter 2 2018/19 Expenditure Summary
C Harrison presented this paper and its contents were noted. Expenditure on courses seems to have increased. Funding for the Enhanced Care Team had previously been extended to November 18. C Harrison asked where future funding was coming from. G Boothby and J Murphy are to look at this outside the meeting. J Murphy updated that £8k had been donated by Sovereign Healthcare for the nursing fund.

10. A Ormerod Sub-Committee Update
~ Age Concern Todmorden bid
It was agreed in principle that 3 years funding would be granted but only paid out yearly. Emphasis could be on digitalisation. P Oldfield would like some assurance that they are able to make this sustainable in year 4. G Boothby to ask T Donaghey about any available space in the Todmorden building. **Action: G Boothby or P Lewer to draft a letter to Age Concern.**
G Boothby asked the Committee to consider a scheme withdrawing services from Todmorden to save money; he explained that this had not been previously approved due to an adverse effect on patients. He suggested could there be a bid for premium

costs incurred from the A Ormerod fund. P Lewer was uncomfortable with this and the legality needs looking in to. P Oldfield said he wouldn't be averse to this for a time limited period subject to restrictions and being sustainable in the future. J Murphy suggested a better digital model. This is to be discussed further. P Lewer went to see Age Concern and wrote to the pastor to make sure the Christmas lunches were open to all. **Action G Boothby to build a case with metrics and to be discussed with the committee outside the meeting.**

~ Non Exec representation

It was agreed that P Oldfield would replace D Anderson.

~ Borough Council request re advertising AO fund

The Committee agreed that this was not appropriate.

11. Minutes from the Staff Lottery Committee meeting held on 11 September 2018

These were noted.

12. Any other business

There was no other business to discuss.

13. Date and time of next meeting

The next meeting will be on Wednesday, 27 February 2019 at 1.30pm-3.00pm in Meeting Room 3, Acre Mills.

Action Log - 2018/19

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Chase VP re brand launch on Intranet promote good news stories. P Lewer has asked VP to expedite this.	**LW**	Dec-18	ongoing
Matters arising	28.08 - 4	Discuss fundraiser recruitment. VP to update on progess after 30-11-18 meeting.	**GB**	Dec-18	ongoing
Matters arising	28.08 - 4	Contact Comms re Tod good news article. To be added to Intranet site.	**LW**	Dec-18	see action 1
Risk Register update	28.08-9	Amend Risk Register after consulting A McCourt. Circulate outside of meeting. GB Draft Strategy.	**LW/ GB**	Feb-19	ongoing
Age concern - A Ormerod	29.11-10	Draft a letter to Age Concern re space in Tod HC	**GB/ PL**	Feb-19	
Todmorden premium costs	29.11-10	Build a case with metrics, discuss outside meeting	**GB**	Feb-19	
Draft Annual Report & Accounts	29.11-4	2014 legacy to be chased up	**CH**	Feb-19	

22. Date and time of next meeting

Thursday 7 March 2019, 9:00 am

Venue: Boardroom, Huddersfield Royal Infirmary