Board of Directors

Schedule	Thursday 4 July 2019, 9:00 — 12:00 BST
Venue	Large Training Room, Learning Centre, Calderdale Royal Hospital
Notes for Participants	OBSERVERS: Caroline Gizzi, Director of Operations, Families and Specialist Services Division Robert Hakin, Associate Director Corporate Planning and Business Development, Leeds Teaching Hospitals
Organiser	Amber Fox

Agenda

9:00	1. Welcome and introductions: Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive from 1st July 2019 To Note - Presented by Philip Lewer	1
9:01	2. Apologies for absence: Andrea McCourt To Note - Presented by Philip Lewer	2
9:02	3. Declaration of Interests To Note	3
9:03	4. Minutes of the previous meeting held on 2 May 2019 To Approve - Presented by Philip Lewer APP A - DRAFT - PUBLIC BOD MINUTES - 020519 v2.docx	4 5
9:08	5. Action log and matters arising For Comment - Presented by Philip Lewer APP B - ACTION LOG - BOD - PUBLIC - as at 2 May 2019.docx	16 17
9:13	6. Chair's Report a) Progress with Non-Executive Director Appointments To Note - Presented by Philip Lewer	18

9:18	7. Chief Executive's Report a) Interim NHS Workforce Report b) Baby Friendly Initiative Report – Gold Award Status To Note - Presented by Owen Williams	19
	BFI Gold Standard Award briefing for Board.docx	20
	Gold assessment report - Calderdale and Huddersfield NHS FT 2019-04.pdf	22
9:28	8. 1 Year Strategy on a Page year ending 2020 To Approve - Presented by Anna Basford	48
	Strategy on a Page Year Ending 2020 Cover Sheet - July 2019 .pdf	49
	5 Year Strategy on a page year ending 2020.pdf	50
9:38	9. Care Quality Commission (CQC) Update To Note - Presented by Jackie Murphy	53
	CQC Update Cover Sheet - July 2019 .pdf	54
	CQC report to BoD Jul 19.v1.pdf	55
9:48	10. Director of Infection Prevention Control Annual Report To Approve - Presented by David Birkenhead	59
	Annual Director of Infection Prevention and Control (DIPC) Report Cover Sheet - July 2019 .pdf	60
	Annual DIPC Report - Appendix - DIPC Annual Report 2018-19 final 19-06-19.pdf	61
9:53	11. Freedom to Speak Up Annual Report To Note - Presented by Suzanne Dunkley	97
	Freedom to Speak Up Annual Report Cover Sheet - July 2019.pdf	98
	Freedom to Speak Up Annual Report - Appendix - Freedom to Speak Up Annual Report BoD 4.7.19.pdf	99
9:58	12. High Level Risk Register To Approve - Presented by Jackie Murphy	106
	High Level Risk Register - Cover Sheet - July 2019.pdf	107
	High Level Risk Register - Appendix - High Level Risk Register Summary QC and Board for 1 and 4 July 2019.pdf	109

10:33	17.	Update from sub-committees and receipt of minutes & papers • Finance and Performance Committee – minutes from meeting held 31 May 2019 • Quality Committee – minutes from meeting held 1 April, 29 April 2019 and 3 June 2019 • Workforce Committee - minutes from meeting held 17 May 2019 • Charitable Funds Committee – minutes from meeting held 22 May 2019 To Note - Presented by Phil Oldfield, Linda Patterson, Karen Heaton and Philip Lewer	174
		APP A - Draft Minutes of Meeting held 310519.docx	175
		FINAL Quality Committee Minutes (1 April 2019).docx	182
		FINAL Quality Committee Minutes (29 April 2019) (Approved on 3 June 2019).docx	190
		DRAFT Quality Committee Minutes (3 June 2019).docx	198
		17 May 2019 Workforce Committee minutes.pdf	207
		Charitable Funds Committee - Minutes 22 May 2019.docx	214
10:38	18.	Governance Report a) Update to the Scheme of Delegation b) Board Workplan 2019/20 c) Board meeting dates 2019/20 d) Use of Trust Seal e) Council of Governor Election Results To Approve - Presented by Amber Fox	218
		Governance Report - July 2019 - Cover Sheet.pdf	219
		Appendix 1 - BOD Annual Workplan 2019-2020 - BOD.pdf	221
		Appendix 2 - Board of Directors Future Dates Proposal - 2020-2021.pdf	225
		Appendix 3 - 2-19 -8.4.19 - Shawbrook Bank Limited Deed of Guarantee.pdf	226
		Appendix 3 - 3-19 -29.4.19 - Amendment Agreement for the LLP - Partnership Board of the Pennine Property Partnership.pdf	227

10:43	19.	6 Facet Survey To Note - Presented by Gary Boothby	228
		6 Facet Survey Cover Sheet - July 2019.pdf	229
		6 Facet survey 2019 - Appendix - 6 Facet Survey 2019 - report for Board.pdf	230
10:48	20.	Month 2 Financial Summary To Note - Presented by Gary Boothby	242
		Month 2 Financial Summary - July 2019 .pdf	243
10:58	21.	Calderdale and Huddersfield Solutions Verbal Update To Note - Presented by Gary Boothby	245
11:03	22.	GDPR Assurance Compliance Report To Note - Presented by Mandy Griffin	246
		General Data Protection Regulations and Data Protection Act 2018 Cover Sheet - July 2019 .pdf	247
		General Data Protection Regulations and Data Protection Act 2018 update - Appendix - Board update - GDPR and DPA - 040719.pdf	249
11:08	23.	Date and time of next meeting Thursday 5 September 2019, 9:00 am Venue: Boardroom, Huddersfield Royal Infirmary To Approve - Presented by Philip Lewer	252

1. Welcome and introductions:

Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive from 1st July 2019

To Note

Presented by Philip Lewer

2. Apologies for absence: Andrea McCourt

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 2 May 2019

To Approve

Presented by Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Public Board Meeting held on Thursday 2 May 2019 at 9:00 am in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Gary Boothby	Executive Director of Finance
Alastair Graham (AG)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Phil Oldfield (PO)	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development (OD)
Dr David Birkenhead	Executive Medical Director
Karen Heaton (KH)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director

IN ATTENDANCE

Amber Fox	Corporate Governance Manager (minutes)
Andrea McCourt	Company Secretary
Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director – Digital Health
Donna Cole	Ward Manager, Ward 17 (Joined at 9:30 am for item 52/19)
Lindsay Rudge	Deputy Director of Nursing
Sal Uka	Associate Medical Director (for item 57/19)
Claire Wilson	Assistant Director of Human Resources (for item 62/19)

OBSERVERS

Brian Moore	Public Elected Governor
Alison Schofield	Public Elected Governor
Ruth Day	Hempsons
Andrew Davidson	Partner and Head of Employment, Hempsons
Media	Local Press
Caroline Wright	Communications Manager

44/19 Welcome and introductions:
The Chair welcomed everyone to the Public Board of Directors meeting.

45/19 Apologies for absence:
Apologies were received from Jackie Murphy and Linda Patterson.

46/19 Declaration of Interests
The Chair reminded colleagues to declare their interest at any point on the agenda.

47/19 Minutes of the previous meeting held on 7 March 2019
The minutes of the previous meeting held on 7 March 2019 were approved as a correct record subject to the amendments outlined below.

RH asked for clarity on page three where the Chief Nurse mentioned it is positive to stand in the future in these roles.

RH asked if the wording on page five under 'Care Quality Commission update' is correct which states 'several areas had improved to outstanding'. The Executive Director of

Finance explained there are several areas of improvement; however, there has been no official assessment. The Executive Director of Finance will send revised wording.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 7 March 2019, subject to the above amendment.

48/19 Action log and matters arising

The action log was revised and updated accordingly.

49/19 Chair's Report

The Chair updated the Board on the activity he has been involved in since the last meeting on 7 March 2019. The key updates were:

- Attended an Organ Donation Induction Day on 28 March 2019 in Birmingham
- Spent half a day with volunteers on 25 April 2019 in a question and answer session; feedback was shared with the Tea Trolley feedback
- Attended a WYAAT meeting and Richard Barker spoke highly of the Trust
- Attended a Yorkshire Chair's meeting on 2 April 2019 where the focus was on an overview of IT at Leeds Teaching Hospitals NHS Trust

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

50/19 Chief Executive's Report

The Chief Executive encouraged colleagues to review 'The Cupboard' which is now available on the intranet and internet. Feedback received so far has been positive and external partners have asked the Trust if they can be involved.

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

51/19 Reconfiguration of Hospital Services Strategic Outline Case

The Director of Transformation and Partnerships reported the strategic outline case was approved by the Trust Board on 22nd March 2019 and was submitted to NHS England and NHS Improvement on 25th March 2019. Letters of support from commissioners and the West Yorkshire and Harrogate Health and Social Care Partnership are included within the final strategic outline case.

AN asked if there could be a highlighted version with assurance of how the strategic outline case has been developed, including amendments that have been made. The Director of Partnerships and Transformation explained the minutes from the meetings on 22 March 2019 and the Estates Sustainability Committee evidence the changes made.

AG referred to section 4.3 and added the 6-Facet survey has now been completed and is yet to be analysed; however, confirms the scale of work to be undertaken at Huddersfield Royal Infirmary. He suggested there is an opportunity to refer to section 4.3 in a covering letter which supports the strategic outline case. The Director of Transformation and Partnerships confirmed the updating of the 6-facet survey is referred to throughout the document. The Chief Executive responded the publication of the 6-facet survey will require a conversation in public to understand where the Trust is now and understanding the long-term future.

The Chief Executive referred to the future hospital services model in section 1.4 and re-iterated the importance of community services and services closer to home which is not explicit in the title. The Chief Executive said there is as much commitment to what happens outside the hospital as inside the hospital.

OUTCOME: The Board **NOTED** the update on the reconfiguration of hospital services strategic outline case.

52/19 Patient Story – Elective Paracentesis on Ward 17

Donna Cole, Ward Manager for Ward 17 who has worked at the Trust for 30 years and a patient attended this part of the meeting to share a patient story on elective paracentesis.

Donna explained patients were previously sent to their GP's for a referral to Medical Assessment/Ambulatory Assessment Unit for decomposed liver disease and the average length of stay was 4.5 days. Patients that required a drain were transferred to Ward 17; however, a bed was never guaranteed and patients often were admitted via A&E as an emergency. This delay in drainage caused a high risk of infection.

Donna explained a service has been introduced on ward 17 where patients are now able to book drains in advance to reduce waiting times and the length of stay is now between 4-6 hours. This booking service is currently available two days per week. This has improved patient flow throughout the hospital and saves approximately £63,000+ per month. The team on Ward 17 have been fundraising and over £8,000 has been raised.

Donna introduced the patient who shared his story. The patient was contacted for a liver transplant and he was able to have a liver transplant straight away as he received draining so frequently. He explained the care from ward 17 has been fantastic and the team followed up with him after his surgery via Skype.

Donna explained their future vision for the service as there is an approximate 70% annual increase on alcohol related admissions. The ward aims to provide an in reach and outreach service for all newly diagnosed liver disease patients and extend the service to incorporate non-alcoholic liver disease patients. The ward aims to develop the service to provide ambulatory care and care of parenteral/enteral feeding tubes to prevent unnecessary A&E attendance.

Brian Moore asked why the service is only available for two days and not five days. Donna explained the service was planned for two days on a six-month trial; however, the demand has been so high and if reviewed, this will move to five days.

Alison Schofield asked Donna if the ward have any specific training needs. Donna explained she is the only staff member who can currently complete the drains and if the service was to run for five days, there would need to be another nurse trained.

The Chief Executive asked what proportion of the patients are from a BAME background. Donna responded that very few patients; however, there have been more from the Asian minority. The Chief Executive highlighted the Trust need to be confident that services are assessible to all.

Donna Cole explained Ward 17 currently don't take direct GP referrals and the first presentation is in A&E or MAU. Currently, patient pathways are on paper and the pathway can't be managed via the electronic patient record. The Chief Executive asked Donna to provide this information to the Managing Director for Digital Health.

AG commented on the 70% annual increase in alcohol related admissions and asked about the Trust's role in prevention. Donna confirmed the Trust liaise with charities such as 'Drink Aware' and are joined up with preventative services.

The Chair thanked Donna Cole and Geoffrey for attending the Board to share their story.

OUTCOME: The Board **NOTED** the patient story.

53/19 Board Assurance Framework

The Company Secretary presented the Board Assurance Framework updated during April 2019 which was presented to the Trust Board for approval.

The key changes were:

- Reduction in the score for 7-day services (risk reference 319)
- Commercial growth risk has been added
- The Company Secretary explained that the need for a risk around Health and Safety had been discussed; however, an external review of health and safety had been commissioned and the need for a risk would be reviewed once this report had been received.

A workshop on the Board Assurance Framework and high-level risk register is scheduled to take place in October 2019.

The Managing Director for Digital Health suggested the EPR benefits realisation risk needs to be reviewed in light of what is being presented to the Finance and Performance Committee.

KH suggested the Workforce Committee risk needs updating considering the recent launch of 'The Cupboard' and to include feedback from the Investors in People accreditation.

The Chief Operating Officer thanked the Company Secretary on the work as the new report provides more context to the board assurance framework.

RH highlighted risk 10.19 has a missing target score and asked for some consideration around whether the target scores of 10 or 12 are reasonable.

AN asked for an update on finance in terms of the reconfiguration. The Executive Director of Finance confirmed the risk is still a score of 25 on the board assurance framework and it has been agreed this would be reviewed at the Finance and Performance Committee.

AG noted the scores are reducing which is positive and suggested more debate is needed on finance.

OUTCOME: The Board **APPROVED** the Board Assurance Framework.

54/19 High Level Risk Register

The Deputy Director of Nursing presented the High-Level Risk Register as at 23 April 2019. Four risks have been removed from the high-level risk register which are:

- 7169 - achievement of in-year financial plan (2019/20)
- 5862 - falls risk reducing from 16 to 12 in the Medical Division
- 7540 - financial risk for 2018/19 in the Surgery and Anaesthetics division reducing from 20 to 9
- 7280 - risk regarding unnecessary repeat specimen collection reduced from 15 to 12 and managed within the Family and Specialist Services (FSS) Division

One new risk has been added relating to paediatric and neonatal staffing with a score of 15, risk 7253. KH explained this risk was discussed at Quality Committee this week to understand the impact on staff. The Chief Operating Officer added a Divisional performance meeting has taken place on 1 May and one Trust doctor has been appointed.

One risk has been closed, risk 6011 relating to the blood track system following implementation of the system.

AN reflected that the risk register has moved on and is clearer to understand. He added risk 7170 regarding medical staffing remains a challenge. AN explained he has attended

consultant panels and it feels to be improving. The Executive Medical Director confirmed the overall position has improved; however, overall there are still lots of gaps and challenges.

AN noted the Trust have undertaken the actions relating to the risk of inadvertent connection to air, 7396. The Chief Operating Officer responded to confirm the Royal College have visited regarding this risk, with a draft letter and final letter waiting which will help to reduce the score.

AG pointed out the ICU risk at Huddersfield Royal Infirmary (7271) has reduced to a 12 and asked what the Trust would have in place if ICU would be closed. The Chief Operating Officer responded the Trust have use of recovery space and confirmed there is a mitigation plan within Huddersfield Royal Infirmary with a number of locations for overflow.

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

55/19 Director of Infection, Prevention and Control Quarterly Report

The Medical Director presented quarterly Director of Infection, Prevention and Control report which covers the period from 1st December to 31st March 2019. The key highlights were:

- Intervention and reduction in c.difficile, at the end of March 2019 there have been 18 cases which is over a 50% reduction from 2017/18
- New way of measuring the c.difficile numbers currently revising 40 cases of patients discharged in the last 30 days, confident the performance will be maintained
- E.coli cases have increased and the national target is to reduce these by 50%, the Department of Health has increased the timeline for this target, these cases happen in community and are difficult to intervene, the Trust is reviewing the management of infection
- Norovirus has had little impact
- 398 isolation breaches since 1st April 2018 compared to 354 for the previous year, these are being risk assessed and monitored and is on the risk register (7237)

The Medical Director formally thanked Gavin Boyd, Infection Control Doctor who is departing as Clinical Director for all of his support and confirmed Anu Rajgopal is taking over in this role.

KH asked if ongoing MRSA cases keep showing in the figures. The Medical Director confirmed if they are recurrent, after 14 days, it will count as a new case, as opposed to ongoing.

RH asked if the Trust's e.coli position is out of line with other Trusts and if the revised targets are realistic. The Medical Director responded organisations that are seeing reductions are unsure why it is occurring, and nationally Trusts are fluctuating. He added this is an economy wide reduction which will be challenging as it is difficult to understand the intervention to reduce these cases by 50%.

Alison Schofield asked if there will be increase in self-testing in patient homes rather than a visit to the GP. The Medical Director explained this would not be possible as e.coli can be carried in the urinary tract which does not need treating as the Trust need to treat symptomatic patients.

OUTCOME: The Board **APPROVED** the Director of Infection, Prevention Control Quarterly Report.

56/19 Medical Revalidation and Appraisal of Non-Training Grade Medical Staff Report

The Executive Medical Director presented the medical revalidation and appraisal of non-training grade doctors. The key points to note were:

- As at 31st March 2019, 373 doctors were included in the revalidation process
- 86 non-trading grades have been allocated a revalidation date
- Appraisals are required every year, the completion is 99.7% with one doctor who did not undertake their appraisal within the timeframe, this is an improved position from last year
- 40.5% of medical appraisals were completed in March, it remains a challenge for doctors to undertake their appraisal in a timely manner, work continues to spread the appraisals throughout the year to strengthen the process
- An external review of appraisals will be undertaken this year or the following year

KH suggested asking for feedback on the quality of the medical appraisal and how useful the appraisal was in their development.

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

57/19 Learning from Deaths Thematic Review

Sal Uka presented the Learning from Deaths thematic review report. The key points to note were:

- Care is assessed by reviewing the medical record
- Overall good quality of care in approximately 85% of cases reviewed
- Excellent junior doctor initial management
- Majority of themes are like previous themes over the years and fit into existing groups such as End of Life and the Deteriorating Patient Group

KH noted the review dates were between August 2017 and July 2018 and suggested the Board would like to understand what has happened since this date and asked how the good practice is shared. Sal confirmed the good practice is shared through Divisional patient safety quality boards (PSQB) and they are creating a video to share good practice.

The Chief Executive asked for evidence that the equality impact assessment has been completed. There was discussion around mortality rates of different backgrounds and a suggestion this needs to be reflected to be confident an equality and disability lense has been applied.

Brian Moore asked if Junior Doctors are coached in communication. Sal Uka responded to confirmed Junior Doctors are not coached; however, there is more interaction and bedside manner taught in training. The Chief Executive added there is a broader conversation about communication in a digital world and to trust in intuition.

OUTCOME: The Board **APPROVED** the Learning from Deaths thematic review report.

58/19 Fire Safety Annual Report

The Managing Director for Calderdale and Huddersfield Solutions Limited presented the annual fire safety report. The key points to note were:

- Positive progress has been made this year in terms of fire safety; however, there is further work to ensure full compliance
- Work is ongoing to ensure 60-minute compartmentation is in place across HRI, this will be followed by a plan to restore 30-minute compartmentation to wards and other clinical areas
- A new round of fire risk assessments is being carried out
- Continue to provide fire warden training which includes fire extinguisher training

- Fire training is provided on induction
- A new Director responsible for fire safety for CHFT is being appointed

KH explained following a review of the integrated performance report at the Quality Committee it showed fire training has improved. She asked if the method of fire training delivery has contributed to the improvement. The Director of Workforce and Organisational Development responded there is a blended offer of training and there has been discussion between CHS and CHFT to carry out a training needs analysis to offer appropriate training based on staffing group and this should be included in the report. This may mean that some staffing groups receive face to face training annually where others do not.

RH highlight the importance of undertaking a fire risk assessment before a ward moves to look in advance at fire safety implications. The Managing Director for CHS confirmed this is now improving with a check list for ward moves and to further understand the patient flow implications. The Chief Operating Officer confirmed a ward move checklist is required and will be built in moving forward.

RH raised concern regarding compartmentation and asked this to be reviewed as part of the action plan to address it. AG added there needs to be future proof fire safety for the new and refurbished buildings in terms of the reconfiguration.

The Chief Operating Officer explained the phrase 'misuse of toasters' should not be used and assured the Board that chairs and beds are not on corridors in ward areas. The Managing Director explained there is more electrical equipment in wards and non-ward corridors and a programme is ongoing to have more sockets in rooms.

The Chief Operating Officer explained most ward areas in six-weeks will have enough fire wardens trained with one fire warden per shift and this is ongoing progress.

OUTCOME: The Board **APPROVED** the Fire Safety annual report.

59/19 Integrated Performance Report

The Chief Operating Officer presented the key updates for March 2019, which were:

- It has been a positive year with a lot of effort made with no domains in the red in the 12-month period
- Highest level of performance over the last 12 months, Q4 is the most challenging quarter
- March's performance has peaked again at just over 73%
- Emergency care standard 4 hours has improved to 94.46% in March, a local trajectory has been agreed with NHS Improvement and the Trust has delivered to this trajectory
- The Trust are 8th nationally for referral to treatment for cancer out of 128 Trusts
- More focus on strategic planning

AN asked how the scores compare to last year and asked if these have been baselined. The Chief Operating Officer explained the 1 April 2019 report will include a narrative of the changes e.g. essential training in month and in year to date position.

KH explained a review of complaints has taken place at Quality Committee and several complaints remain open if all the detail has not been dealt with. There is further work to understand is more can be done. The Chief Executive added a deep dive is taking place at the next Quality Committee. The Chief Operating Officer explained they are monitoring re-opened complaints to measure the quality of complaints.

The Chief Executive suggested the Board focus on the achievements made in year, not only on areas where performance has been below target but also on areas with good performance to understand how the improvement is occurring. The Chief Operating Officer explained there is weekly attention to detail on the performance metrics, from both clinical and operational staff. She added there is more focus on improving performance rather than reporting on performance. All colleagues work towards the Trusts' 4 pillars which is a key driver, putting the patient first. She explained a performance master class has been developed and all operational and clinical managers attend every Wednesday with an expert on one of the metrics.

The Managing Director for Digital Health noted the strengthened position and link between The Health Informatics Service (THIS) and CHFT to deliver more accurate information on performance and improvement in how the data is provided.

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

60/19 Governance Report

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

a) Scheme of Delegation Review

The purpose of the Scheme of Reservation and Delegation is to set out the powers reserved to the Board of Directors and those that the Board has delegated. Updates include alignment with the Trust Standing Financial Instructions, lead changes and addition of a scheme of delegation relating to the Mental Health Act 1983 which formalises a service level agreement in place with South West Yorkshire Partnership Foundation Trust. It was noted that for the scheme of delegation, item 37 confidential information, the lead should state Managing Director for Digital Health.

b) Board of Directors Attendance Register 2018-19

The Board is asked to review and confirm the Board of Directors attendance register for the period 1 April 2018 to 31 March 2019.

c) Board Committees and Revised Governance Structure

Following a review of the Board Sub-Committees, a revised governance structure has been discussed with both Executive Directors and Non-Executive Directors. Further work will be undertaken involving the Chief Nurse and Chief Operating Officer on the sub-group reporting structure to the Quality Committee during Q1 2019/20.

The Managing Director for Digital Health explained there should be more focus and assurance on cyber presented in reports. AN expects cyber to be reported through the Audit and Risk Committee. RH agreed to this suggestion and any issues highlighted will be escalated to Board.

d) Sub-Committees Self-Effectiveness

In line with best practice during January to April 2019, all Board sub-committees have been assessing themselves against their terms of reference and how well the committee operates across a number of categories using a structured checklist. The outcome of the assessment is shared with each Committee. A meeting of Board Committee Chairs is planned, and the outcomes of the self-effectiveness report will be discussed at this meeting.

e) Updated Quality Committee Terms of Reference

The terms of reference of the Quality Committee have been reviewed in January 2019 the main changes are to receive internal audit reports (with a quality element)

and seek assurance on recommendations and changes to the membership, including the requirement for two Non-Executives to attend rather than three.

f) Constitutional Changes - Proposal to appoint an additional partnership governor

The Trust established Calderdale and Huddersfield Solutions Limited (CHS) as a wholly owned subsidiary in September 2018 and it is proposed that the Constitution be amended to include Calderdale and Huddersfield Solutions Ltd as an additional stakeholder / partnership governor. This proposal had been supported by the Council of Governors in their April meeting.

g) Compliance with Code of Governance

As part of our annual reporting process we are required to provide a report stating compliance against the Code of Governance on a comply or explain basis. An assessment of compliance was reviewed and approved by the Audit and Risk Committee at its meeting on 17 April 2019. Specific disclosures within this document will be included in the Annual Report for 2018/19 in line with national guidance.

h) Compliance with NHS Improvement (Monitor) License Conditions

The NHS Provider licence requires the Board to submit an annual self-certification that the Trust which will be completed by the deadlines.

OUTCOME: The Board **APPROVED** the following items:

- Scheme of Delegation
- Board of Directors Attendance Register 2018/19
- Revised Governance Structure
- Quality Committee Terms of Reference
- Changes to the Trust Constitution to appoint an additional partnership governor for Calderdale and Huddersfield Solutions Ltd

OUTCOME: The Board **NOTED** the following:

- Sub-Committees Self-Effectiveness
- Compliance with Code of Governance
- Compliance with NHS Improvement (Monitor) License Conditions

61/19 Month 12 Financial Summary

The Executive Director of Finance presented the month 12 financial summary year ending 31 March 2019, the key updates were:

- Within the year to date planned deficit of £43.04m
- Improved against planned agency trajectory, over £2m under the agency plan, 130 providers at Q3 failing this trajectory
- Underspent against the capital programme which relates to external funded projects
- The revaluation of assets has resulted in the Trust reporting an impairment taken to income and expenditure of £26.51m. Whilst this charge increases the total reported deficit to
  £69.61m, the impairment is excluded for control total purposes on the basis that is it both exceptional and non-cash impacting.
- Cost Improvement Programme (CIP) achieved for the year is £18m as planned

AG asked for clarity on the underspend on the capital programme. The Executive Director of Finance responded to confirm that the underspend related to delays in approval and receipt of external monies, rather than spending against internally generated funds. The plan does not match the opening plan as there has been an element of funding provided in year for ECG carts and the Trust have spent less in National pathology exchange. The Executive Director or Finance explained the Trust has

delivered plan; however, the Trust has breached capital department expenditure limit (CDEL) due to changes in the CDEL level as a result of the in year asset revaluation. Regulators were made aware during the last quarter.

The Chief Executive stated the auditors are aware in terms of the Trust's revaluation position and this has been shared at the Finance and Performance Committee. The Executive Director of Finance explained auditors have supported the process and have not flagged any concerns.

RH flagged the accounts will show a £69m deficit and a qualified audit report will be received regarding these concerns. The Executive Director of Finance explained this was planned at the start of the year.

The Chair thanked the Chief Executive and the Executive team for delivering the Cost Improvement Programme and the amount of efforts from staff.

OUTCOME: The Board **NOTED** the Month 12 Financial Summary.

62/19 Gender Pay Gap Reporting

Claire Wilson, the Assistant Director of Human Resources presented the gender pay gap report as of 31st March 2019 as it is mandatory for all public sector organisations to report annually on gender pay gap, this is the second year of reporting for CHFT. Calderdale and Huddersfield Solutions (CHS) employees are included in this report but will not be included in next year's report.

Appendix 2 detailed a comparison of 2018 and the difference in reporting, for example, clinical excellence awards and long service awards are included in bonus pay this year, opposed to ordinary pay.

Appendix 4 details the West Yorkshire Association of Acute Trusts (WYAAT) gender pay gap benchmarking and the bonus at CHFT is higher as there are several organisations that don't provide long service awards.

KH asked if there is any concern with the results and suggested that CHFT is not significantly different to other organisations. Claire explained there have been no surprises and highlighted there are now more females joining the medical workforce. KH raised the difference in male and female bonus payments and asked to see an action plan. She also reminded the Board an Executive and Non-Executive were going to be a champion for gender pay gap.

Action: Champion to be identified for gender pay gap – Executive / Non-Executive

AG recognised the position is slightly worse based on the previous year and acknowledged there is an increase of pay on agenda for change. Claire explained more men receive clinical excellence awards at a higher value pay and it is largely the female workforce that receive long service awards at a lower bonus pay. Claire explained eligible females are more likely to receive clinical excellence awards. KH said this was positive and she has witnessed this on the award panels.

The Chief Executive referred to the BBC website which reported the pay gap at end of March 2019. There is a total of 1,311 organisations where men are paid less than women. The Chief Executive acknowledged the Trust has a higher gender pay gap than the health sector average and he challenged conversations in the Trust to address this.

KH suggested using milestones to demonstrate the trajectory which can evidence small gains over a length of time e.g. 3 or 5-year change. She also highlighted the need to review the equality side.

RH recognised the commitment for a gender balance at Board level. KH re-iterated that there are two Non-Executive Director vacancies and the need to be balanced. RH stated the need to get the right person and skills. The Chief Executive discussions have taken place to understand how to meet the criteria of the best candidate and include diversity and equality needs.

AG suggested a 'Go See' takes place. Claire explained Barnsley is in a similar position and is difficult as other Trusts have a different workforce and outsourced staffing.

OUTCOME: The Board **NOTED** the Gender Pay Gap Report.

63/19 Update from sub-committees and receipt of minutes

The following minutes were received:

- Finance and Performance Committee – minutes from the meeting 29.3.19
- Audit & Risk Committee – minutes from meeting 17.34.19
- Quality Committee – minutes from meeting 4.3.19
- Workforce Committee – minutes from meeting 8.4.19
- Charitable Funds Committee – minutes from meeting 22.5.19
- A&E Delivery Board – minutes from meeting 12.3.19
- Council of Governors meeting – minutes were received from the meeting held 11.4.19
  Brian Moore reported several items discussed, including the constitution. Brian suggested a member of the Council of Governors meets with the Company Secretary to review the anomalies in the constitution. The Chair has met with several governors to focus on making improvements and the last Council of Governors meeting was a positive meeting.

Any Other Business

The Managing Director for Digital Health announced that the Health Informatics Service (THIS) were successful in winning the Bradford, Craven and Airedale contract to supply their IM&T services. This now completes the tender process and secures the contract with Calderdale, Kirklees and Wakefield and Bradford, Craven and Airedale for the next seven years.

PO raised discussion taken place at Finance and Performance Committee in relation to the incentive scheme and £300k of provider sustainability funding. He stated this is a manageable risk worth taking.

Date and time of next meeting
Date: Thursday 4 July 2019
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

The Chair formally closed the meeting at 11:21 am.

5. Action log and matters arising

For Comment

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 2 May 2019 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
2.5.19 62/19	**Gender Pay Gap** Non-Executive and Executive champion to be identified for gender pay gap	SD		July 2019		
7.3.19 33/19	**Learning from Deaths** Thematic review of learning from deaths presented to the next Board	DB	On the May agenda	May 2019		2.5.19
7.3.19 33/19	**Learning from Deaths** Board Workshop on Learning from Deaths to be scheduled	AM	The options for an upcoming Board workshop are 5 December 2019 or 6 February 2020.	May 2019		
7.3.19 32/19	**High Level Risk Register** Board Workshop on the Risk Register and Board Assurance Framework to be organised	AM	Scheduled for the Board Workshop on 3 October 2019.	May 2019		2.5.19
7.3.19 32/19	**High Level Risk Register** Circulate a chart of falls throughout the year to see the variation	JM	A paper was circulated under matters arising.	May 2019		2.5.19
3.1.19 17/19	**GOVERNANCE REPORT** Security and Resilience Group to be added to the Governance Structure	AM / NEDs	The Non-Executive Directors are meeting on 7th March to agree reporting arrangements. An updated structure and proposal will be come back in May 2019.	May 2019		2.5.19

6. Chair’s Report

a) Progress with Non-Executive Director Appointments

To Note

Presented by Philip Lewer

7. Chief Executive's Report

a) Interim NHS Workforce Report

b) Baby Friendly Initiative Report – Gold Award Status

To Note

Presented by Owen Williams

Date of Meeting:	**4th July 2019**
Meeting:	**Board of Directors**
Title of report:	**Unicef Baby Friendly Initiative Gold assessment award**
Author:	**Joyce Ayre**
Sponsor:	**Helen Barker**
Previous Forums:	**N/A**

Actions Requested :

- For information

Purpose of the Report

To update the Board of CHFT Unicef Baby Friendly Initiative Gold Standard Award.

Key Points to Note

Background:
Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Facilities implement the standards in stages over a number of years and are externally assessed by Unicef UK at each stage. When all the stages are passed they are accredited as Baby Friendly. The initial accreditation lasts for two years; after this, re-assessments take place on a regular basis to ensure that the standards are being maintained and to explore how the service is building on the good work it has already done. CHFT first received accreditation in 2002 and has been awarded reaccreditation on five occasions since then.

Reality:
After successful re-assessment the services are eligible to be assessed against the Achieving Sustainability standards, which if passed, lead to a Gold award. Gold services will no longer have to undergo large external re-assessments to maintain their accreditation, but rather will be re-validated via the annual submission of a portfolio and three-yearly re-validation meetings with an external assessor.

On 10 April 2019, CHFT was assessed for the Gold Award using four criteria: Leadership; culture; monitoring; progression **achieving the Gold Award** with recommendations to action. There are only 7 other Trusts in the country with the Gold Award. CHFT is the first in the Yorkshire and Humber.
If Locala Calderdale receives their accreditation we will be the FIRST joint accreditation of maternity and health visiting service in England.

Whilst all criteria were achieved, the Maternity Unit achieved a lower score in relation to staff feeling that their voice would be listened to which required further action.

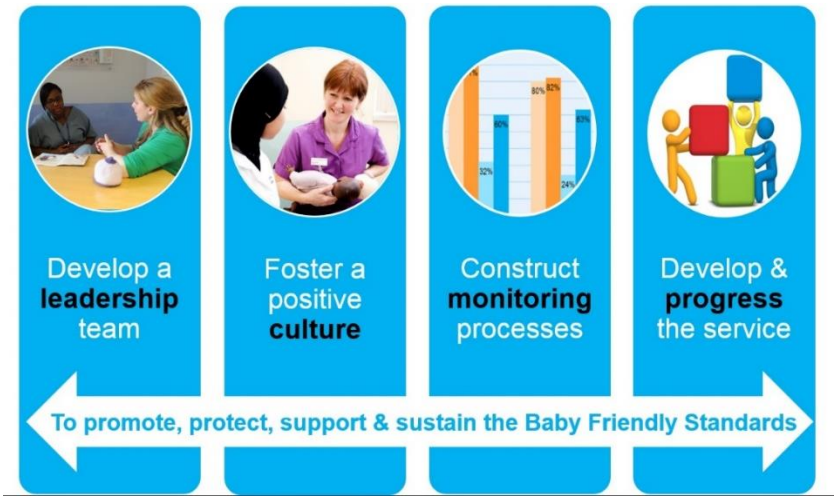
Response:
Concerns raised about staff feeling listened to were also identified via the Professional Midwifery Advocate face to face sessions. The leadership team requested a facilitated WTGR sessions with maternity staff, 2 sessions were held, supported by the Directors; the work is ongoing and will be built into the Divisional response to the Trust staff survey.

An action plan is being developed and incorporated into the WTGR /FSS staff survey actions and sent to Unicef within the required time frame. The Infant Feeding Advisors will form part of the FSS team to support implementation and embed actions needed. The action plan will be monitored via FSS Governance processes.

EQIA – Equality Impact Assessment
This is incorporated into the assessment criteria and evidence submitted. It is important across all elements of the Unicef criteria to ensure equality of access and provision.
Recommendation
The Board are asked to note this report and the significant amount of work undertaken over several years to secure Gold Award status. The action plan developed to be monitored through Divisional PSQB and Quality Committee.

Unicef UK Baby Friendly Initiative

Gold Assessment report



Calderdale and Huddersfield NHS Foundation Trust

on 10 April 2019

Unicef UK Baby Friendly Initiative
1 Westfield Avenue, Stratford, London, E20 1HZ
Tel: 0207 375 6144 bfi@unicef.org.uk
unicef.org.uk/babyfriendly/

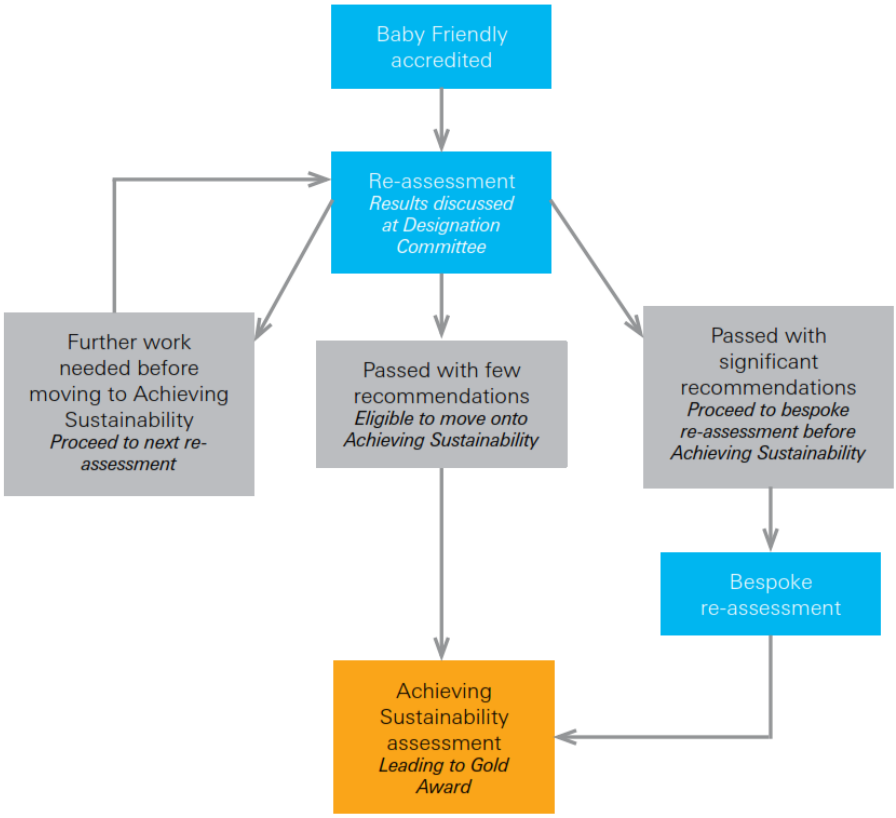
Contents

Background

Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Facilities implement the standards in stages over a number of years and are externally assessed by Unicef UK at each stage. When all the stages are passed they are accredited as Baby Friendly. The initial accreditation lasts for two years; after this, re-assessments take place on a regular basis to ensure that the standards are being maintained and to explore how the service is building on the good work it has already done.

After successful re-assessment the services are eligible to be assessed against the Achieving Sustainability standards, which if passed, lead to a Gold award. Gold services will no longer have to undergo large external re-assessments to maintain their accreditation, but rather will be re-validated via the annual submission of a portfolio and three-yearly re-validation meetings with an external assessor. Re-assessment costs will be replaced with an annual licence fee.

Introducing any significant change into a large organisation requires a great deal of effort, and it then takes time for changes to become embedded into everyday practice. These Achieving Sustainability standards are designed to help with this longer-term implementation. They do not describe the direct clinical care of babies, their mothers, and families, but rather they are an organisational roadmap for how to implement the standards in a way that is both effective in the short term and sustainable over time.



The Achieving Sustainability Standards

THEME 1: LEADERSHIP

DEVELOP A LEADERSHIP TEAM THAT PROMOTES THE BABY FRIENDLY STANDARDS

- There is a named Baby Friendly lead/team with sufficient knowledge, skills and hours to meet their objectives
- There is a mechanism for the Baby Friendly lead/team to remain up-to-date with their education and skills
- A Baby Friendly Guardian with sufficient seniority and engagement is in post
- The leadership structures support proportionate responsibility and accountability
- All relevant managers are educated to support the maintenance of the standards.

THEME 2: CULTURE

FOSTER AN ORGANISATIONAL CULTURE THAT PROTECTS THE BABY FRIENDLY STANDARDS

- There is support for ongoing staff learning
- There are mechanisms in place to support a positive culture, such as staff recognition schemes, mechanisms for staff to feedback concerns and systems to enable parents' and families' feedback to be heard and acted upon.

THEME 3: MONITORING

CONSTRUCT ROBUST MONITORING PROCESSES TO SUPPORT THE BABY FRIENDLY STANDARDS

Mechanisms exist to ensure that:

- Baby Friendly audits are carried out regularly according to service needs
- All relevant data is available and is accessed
- Data is analysed effectively and collectively to give an overall picture
- Action plans are developed in response to findings
- Relevant data is routinely reported to the leadership team
- Relevant data is routinely reported to Unicef UK.

THEME 4: PROGRESSION

CONTINUE TO DEVELOP THE SERVICE IN ORDER TO SUSTAIN THE BABY FRIENDLY STANDARDS

- The service demonstrates innovation and progress
- There is evidence to demonstrate that outcomes have improved
- The needs of babies, their mothers and families are met through effective integrated working.

Assessment result

What we found overall:
We found that Calderdale and Huddersfield NHS Foundation Trust has submitted sufficient evidence to meet the standards required for the **Gold Award***. This can be considered passed upon receipt of written acknowledgement to this report's recommendations.

Calderdale and Huddersfield NHS Foundation Trust is highly commended for the quality of the evidence submitted and the thorough way in which the necessary processes to embed and further develop care related to the Baby Friendly standards has been planned and implemented.

The Baby Friendly standards are embedded into care. There are many well established structures in place which enable effective leadership and accountability across all levels. Senior managers interviewed verified that they had an in depth understanding of Achieving Sustainability standards and were aware of the value of maintaining and further embedding this within their service. The Guardian demonstrated, knowledge, sensitivity and commitment to the Baby Friendly standards, her enthusiasm to advocate for improved outcomes for babies, their mothers and families through sustainability of the standards was inspiring.

The Infant Feeding team have the hours and capacity to provide effective project management and implement good care within the maternity services. In addition, there is an excellent specialist service. There is evidence of integrated working within the community, of particular note is the peer support programme and Baby Cafes which are well evaluated, and effective monitoring suggests they are helping to support a rise in breastfeeding prevalence rates.

Sufficient evidence has been submitted in order for the Gold assessment to be passed*, further details are contained within this report. We recommend that the Designation Committee consider the evidence presented and agree to make the Gold Award upon receipt of written acknowledgement and action plan to this report's recommendations.

Francesca Entwistle
10 April 2019

*See staff survey comments.

The results in detail: Criteria to be met for the Gold Award

This report explains how each of the four standards have been met. Each section details:

- the documents submitted
- whether each of the criteria have been met
- key achievements
- what is needed should additional evidence be required before the Gold Award can be made (requirements)
- recommendations which we will expect to be addressed in advance of the first annual review.
- suggestions which we believe may further enhance sustainability and are therefore presented for consideration.

Theme 1 - Leadership

Overview of documents submitted:

- Submission form
- Job descriptions, Band 7
- Organisational, and leadership team organogram
- Agenda and Minutes, Infant Feeding Advisory Group meetings
- Guardian biography
- Maternity Dashboard
- Managers training curriculum and lesson plan

The evidence submitted meets the required standard to have met Theme 1 – Leadership

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 1: Leadership					
There is a named Baby Friendly lead/team with sufficient knowledge, skills and hours to meet their objectives	✓				
There is a mechanism for the Baby Friendly lead/team to remain up-to-date with their education and skills	✓				
A Baby Friendly Guardian with sufficient seniority and engagement is in post	✓				
The leadership structures	✓				

support proportionate responsibility and accountability					
All relevant managers are educated to support the maintenance of the standards.	✓				
Percentage of managers trained	80%				

We found that the following is working well:

- The Infant Feeding team is well established, providing excellent leadership for the Baby Friendly project, supported by a strong and diverse team across the service.
- The project Baby Friendly lead works 0.6wte contract, band 7, she is supported by 2 band 7 midwives on 0.4wte contracts each, one band 6 – 5 hours a week, one band 3 - 5 hours a week and one band 2 0.2wte. There are 29 breastfeeding champions working within the service and 35 active peer supporters.
- The senior management team are committed to ongoing training needs of the staff and the Infant Feeding team, new staff are trained within 6 months of joining the service, a variety of learning opportunities are provided, face to face, in practice, workshops and e-learning. Electronic monitoring of staff training provides a robust monitoring tool and helps to ensure compliance.
- Good practice is evidenced, for example; if a midwife moves placement from labour ward to work in community, training is provided to meet the needs of her new role. Students are encouraged to gain infant feeding experience and supported in their learning, there is good communication between the University and the infant feeding lead.
- The Baby Friendly Guardian has been trained and clearly understands how Baby Friendly works, she is a positive and enthusiastic advocate, with the power and influence at Board level to ensure the sustainability of Baby Friendly.
- The management team are well educated in Baby Friendly, supportive, kind and caring that the standards are embedded and maintained within the service. There is a clear understanding of the financial commitment to Achieving Sustainability and the annual fee going forward.

We recommend the following:

- The organogram is comprehensive and provides a good overview of the structure of the Trust. We recommend that a further organogram is developed to explain how those have impact on the Baby Friendly standards report to each other, how they receive information and how information is disseminated, with more explicit detail of who reports to who – this should include the project lead.
- We recommend that the terms of reference for the Infant Feeding Advisory group are refreshed to consider how best the group sustains the Baby Friendly standards, monitors outcomes and continues to progress the service.

In addition, we suggest the following to further enhance this high-quality submission:

- The project lead has provided training for the managers which clearly meets their needs, going forward and thinking about succession planning, it might be useful for one of the band 7s to attend the Achieving Sustainability workshop to explore new materials that can be shared within the Trust.

Theme 2 - Culture

Overview of documents submitted:

- Submission form
- Summary of training figures
- Curriculum e-learning
- Curriculum day 2
- Infant Feeding workbook
- Breastfeeding Practice Guide
- Staff evaluations – qualitative
- Tongue Tie clinic award
- RCM award
- GEM – Go the Extra Mile Award
- Facebook group – Calderdale and Huddersfield Better Births
- Calderdale Baby Café qualitative feedback from mothers
- Calderdale Peer support Network qualitative feedback
- Friends and Family results and comments

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 2: Culture					
There is support for ongoing staff learning	✓				
There are mechanisms in place to support a positive culture, such as staff recognition schemes, mechanisms for staff to feedback concerns	✓				
Systems to enable parents' and families' feedback to be heard and acted upon.	✓				
Staff survey responses	✓				

Staff culture audit

40.25% of staff (157/390) completed the Baby Friendly staff culture audit.

Staff responses to question 1, (How valued is Baby Friendly within your service?), gained a borderline pass (79.62%), however, most staff feel motivated to implement the Baby Friendly standards, most or some of the time (98.09%). It is encouraging that 84.71% of staff feel they can raise concerns about how the service provides Baby Friendly care. If concerns are raised, 80.89% of staff (borderline pass) feel that positive action would then be taken. Qualitative

feedback on this question, identified that budget and resourcing impacts on how feedback is actioned, with some staff expressing variance in how it would be received *'depends on who I spoke to'* and unsure about how it would be viewed.

Whilst over 90% of staff agreed that there were mechanisms for their voices to be heard, less staff (73.89% probably and 22.93% maybe) thought their ideas would be listened to. Qualitative feedback included comments such as;
'many forums to raise concerns but feels like there is little done to improve them', 'other staff and myself have suggested improvements but they were not implemented, or we were told they have tried that before but it didn't work.
More work therefore needs to be done to ensure that if staff voice concerns, that when asked, they then report they would be listened to.

There is clearly a culture of kindness towards women and families, further work could be done to ensure that that there is a culture of kindness between staff of all grades, this question achieved a borderline pass (79.62%).

16 staff gave further qualitative feedback, including;
'The Baby Friendly 'way' of working feels well embedded in our organisation. We have Champions in areas to offer on- going support as well as experienced IFA's. Staff certainly go the extra mile to support parents with their feeding choices.'

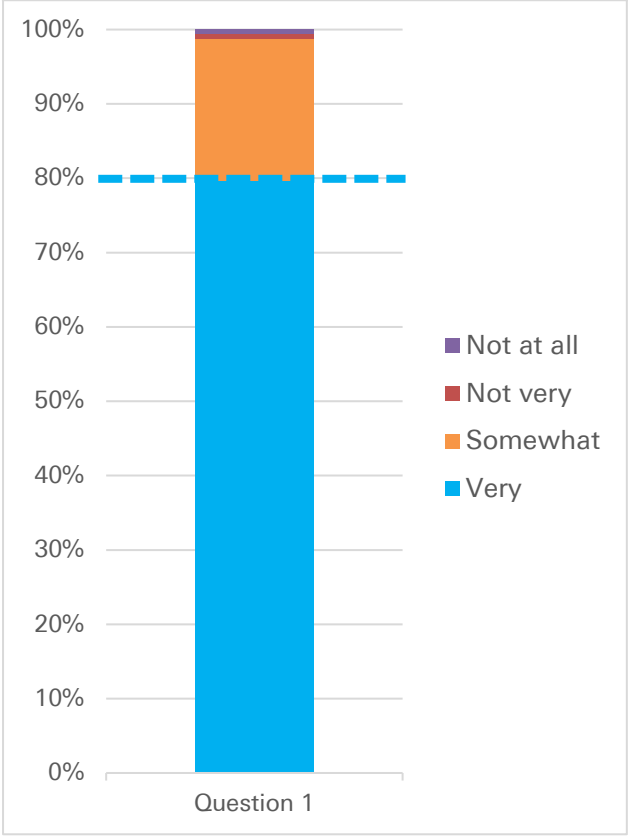
'Morale is at an all-time low at the moment. There is a lack of team working across all areas. Negative feedback is the only feedback given which causes individuals to feel unmotivated'

'As a neonatal nurse it would be easier and more beneficial to families on maternity and on the neonatal unit if midwives and neonatal staff worked closer together to understand more about each other's infant feeding guidelines'

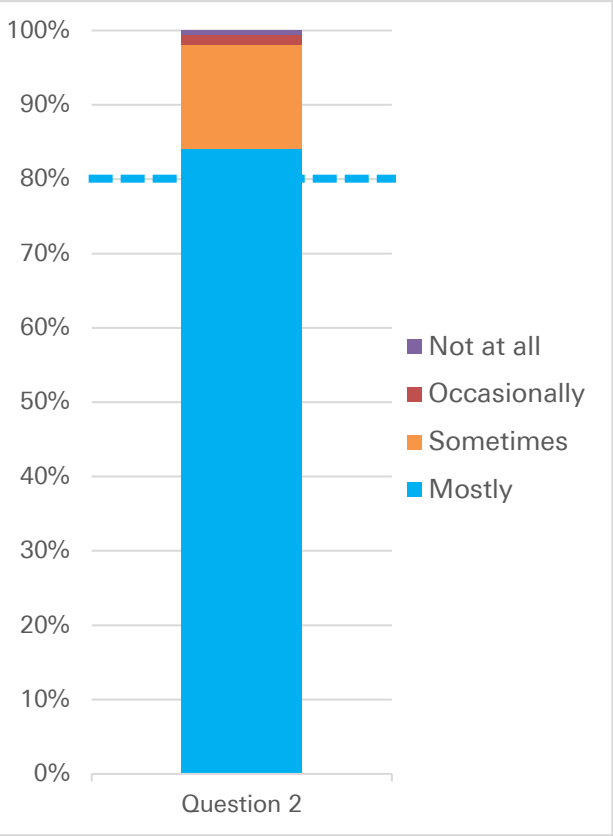
'I do feel that the Baby Friendly standards are part of our normal routine practice.'

Question	Response (N = 157)		Standard
1. How valued is Baby Friendly within your service?	Very valued	79.62%	80% Very valued
	Somewhat valued	19.11%	
	Not very valued	0.64%	
	Not at all valued	0.64%	
2. How motivated do you feel to implement the Baby Friendly standards?	Most of the time	84.08%	80% Most of the time
	Some of the time	14.01%	
	Occasionally	1.27%	
	Not at all	0.64%	
3. Do you feel there is an opportunity for you to raise concerns about how the service provides Baby Friendly care?	Yes	84.71%	80% Yes
	No	15.29%	
4. If you raised concerns, do you think that positive action would be taken?	Probably	80.89%	80% Probably
	Maybe	17.83%	
	Unlikely	1.27%	
5. If you had ideas about how to further improve care for parents and babies, is there a way in which you can voice your ideas?	Yes	93.63%	80% Yes
	No	6.37%	
6. If you voiced ideas, do you think you would be listened to?	Probably	73.89%	80% Probably
	Maybe	22.93%	
	Unlikely	3.18%	
7. Do you feel that there is a culture of kindness between staff of all grades?	Nearly all the time	35.03%	80% Nearly/Most
	Most of the time	44.59%	
	Some of the time	17.20%	
	Occasionally or not at all	3.18%	
8. Do you feel that there is a culture of kindness towards women and families?	Nearly all the time	71.34%	80% Nearly/Most
	Most of the time	27.39%	
	Some of the time	0.64%	
	Occasionally or not at all	0.64%	

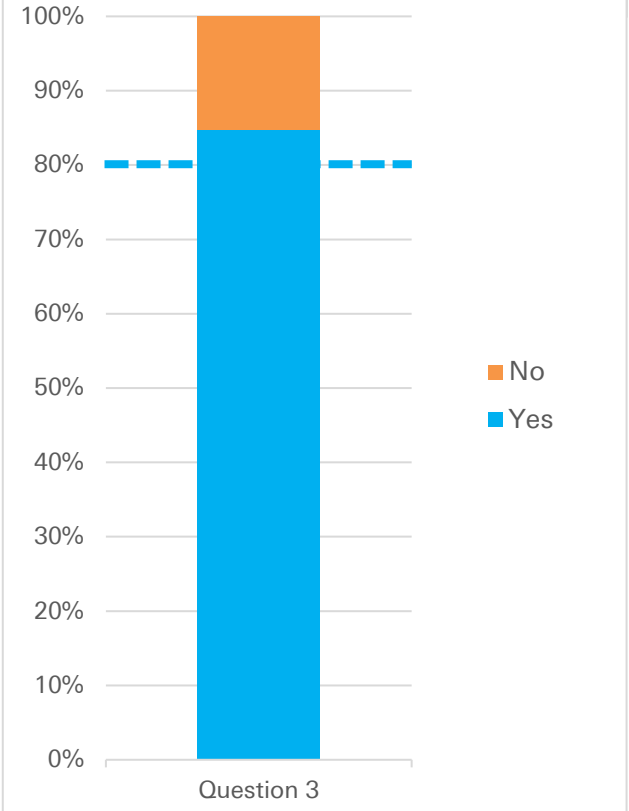
1. How valued is Baby Friendly within your service?



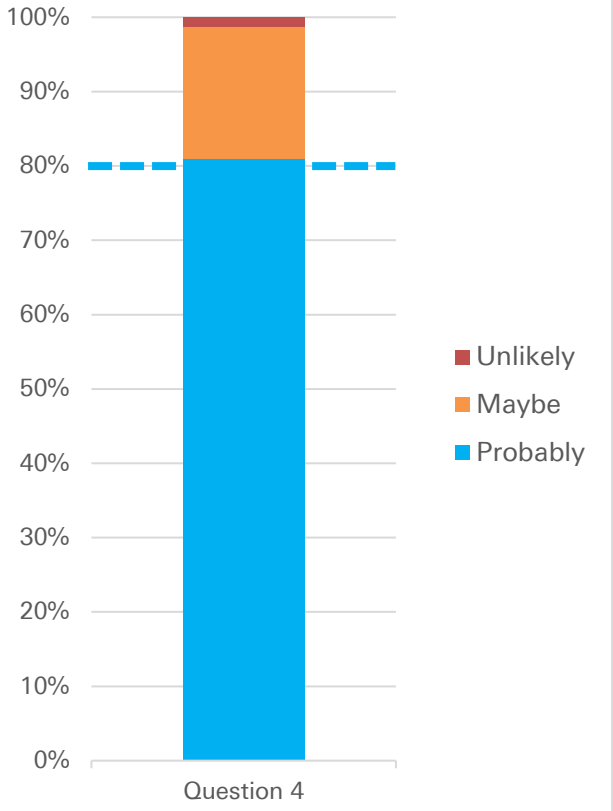
2. How motivated do you feel to implement the Baby Friendly standards?



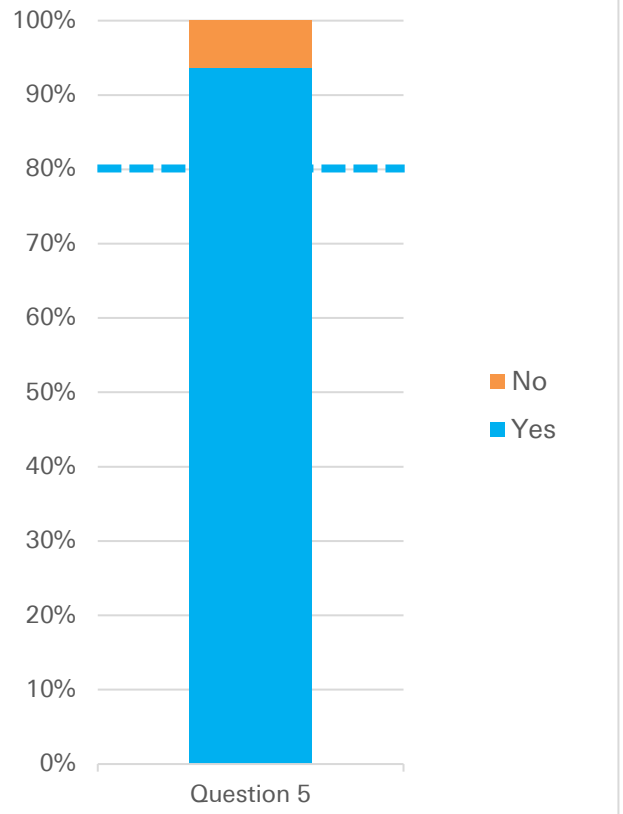
3. Do you feel there is an opportunity for you to raise concerns about how the service provides Baby Friendly care?



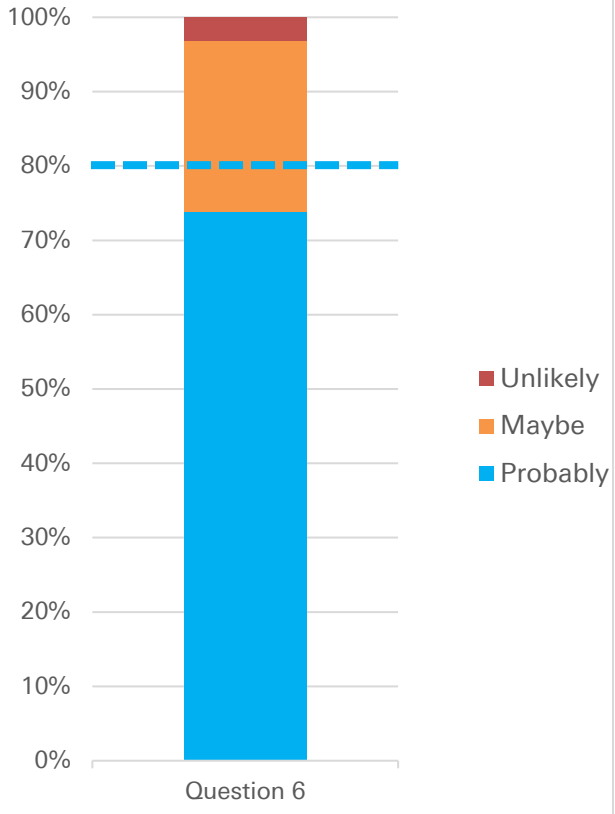
4. If you raised concerns, do you think that positive action would be taken?



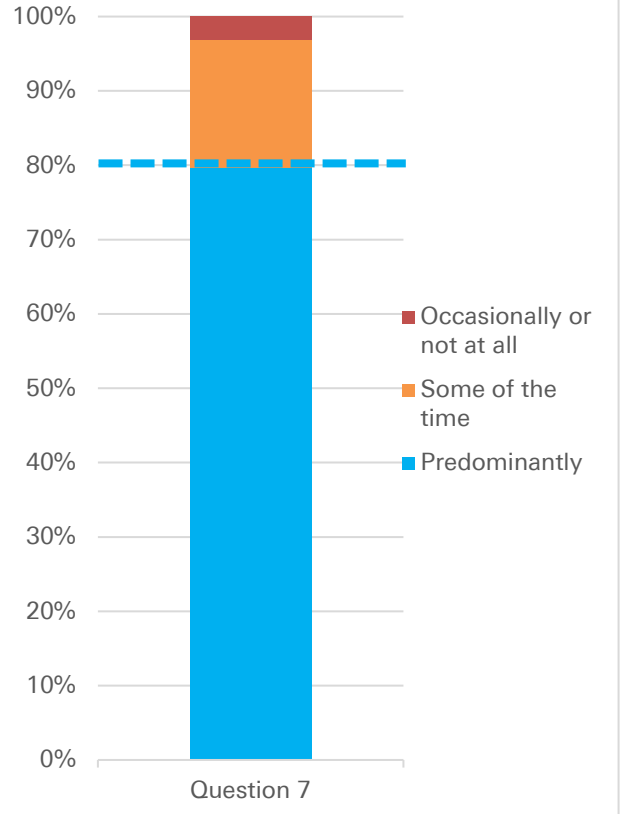
5. Is there a way in which you can voice your ideas?



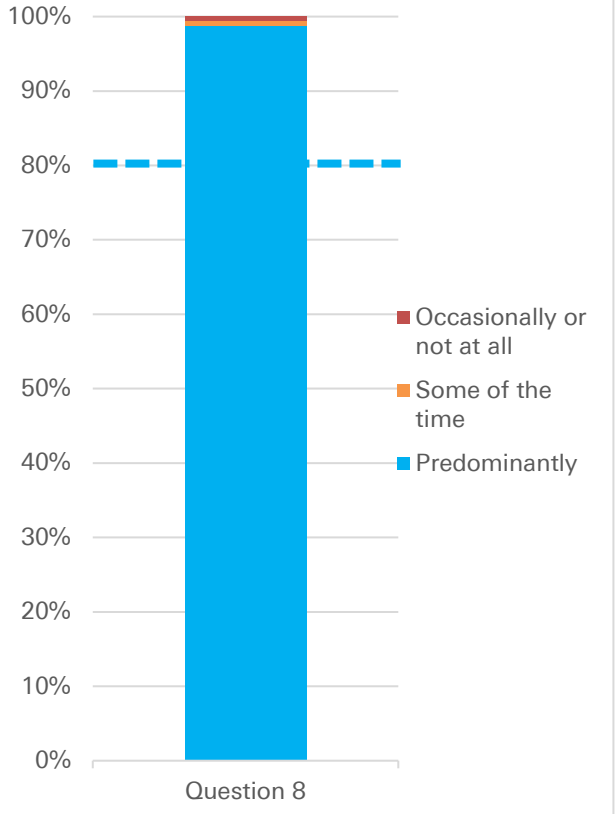
6. If you voiced ideas, do you think you would be listened to?



7. Do you feel that there is a culture of kindness between staff of all grades?



8. Do you feel that there is a culture of kindness towards women and families?



Feedback from parents

Criterion	Result	Standard required
Mothers reported that staff were kind and considerate	**Results from December 2018 re-assessment* All of the time 88% Mostly 12% Sometimes N/A Not at all N/A	80% All of the time

We found that the following is working well:

- Families report a culture of kindness which is recognised by staff in their feedback. The Friends and Families test is positive and there are very few complaints regarding infant feeding.
- The Infant Feeding Team are supported by 'breastfeeding champions' which means that feedback from clinical practice is efficient and proactive.
- Managers have several schemes in place to elicit feedback from staff including Walkabouts, making tea for staff, staff survey and a new initiative based on the AEquip supervision model supporting resilience in staff and providing active listening – a toolkit provides mechanisms for feedback and action planning.
- The staff education programme is well established, ongoing and responsive to changes. The Infant Feeding Team are supported to remain up to date. They are a 'go to' resource for staff with any queries in relation to infant feeding.
- The peer support training programme and support is excellent and very well evaluated by staff and mothers.

We found the following that needs to be addressed:

- More work needs to be done to ensure that if staff voice concerns, that when asked, they then report they would be listened to (Question 6, 73.89%).

We recommend the following:

- Considering how the three borderline areas identified in the staff survey can be improved.

In addition, we suggest the following to further enhance this high-quality submission:

- Staff training is well organised and regularly updated by the project lead, and recent Audit following the re-assessment in December 2018, and audit updates March 2019, demonstrate that the service has met the standards. Going forward, *we suggest* that for succession planning, the band 7 infant feeding team leads consider updating their knowledge and skills to refresh the current curriculum, workbook and practice skills guidance. It may be that attendance at the updated Train the Trainer programme would help this goal.

Theme 3 - Monitoring

- **Overview of documents submitted:**
- Submission form
- Baby Friendly audit results for requirements at reassessment
- Perinatal Mortality and Morbidity meeting agenda
- Maternity Dashboard
- Governance structures
- Action Log and plan

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 3: Monitoring					
Baby Friendly audits are carried out regularly according to service needs	✓				
All relevant data is available and is accessed	✓				
Data is analysed effectively and collectively to give an overall picture	✓				
Action plans are developed in response to findings	✓				
Relevant data is routinely reported to the leadership team	✓				
Relevant data is routinely reported to Unicef UK	✓				

We found that the following is working well:

- Initiation data is collected efficiently and reported via the maternity dashboard. Baby Friendly audit cycles are embedded into the maternity system and continue to inform action planning and improvements in the service.
- A Red Flag system is used to identify women/babies that require urgent care and support, evaluation of this process is good.
- Complaints are dealt with efficiently via the Datixweb system, there have been very few over that last 2-3 years and when they do occur the service is very responsive, and complaints are handled well.

We recommend the following:

- We recommend continued development of data collection methods with review from relevant groups to determine the effectiveness**.**

In addition, we suggest the following to further enhance this high-quality submission:

- Two comprehensive and informative evaluation reports of the Breastfeeding Cafes in Calderdale and Huddersfield have been written by the Infant Feeding Leads, the reports are excellent and demonstrate some detailed analysis and monitoring of services. *We suggest* that some of this information is used to demonstrate changes in breastfeeding rates and analyse action planning for how the service can be developed and that this information is shared with senior colleagues.
- Moving forward as a Gold service, you will be expected to report annually to Unicef UK about progress, to include improved outcomes

Theme 4 - Progression

Overview of documents submitted:

- Submission form
- Calderdale Baby Café evaluation report 2002-2017
- Huddersfield Baby Café report 2017
- Frenulotomy clinic template and evaluations
- Peer support Q1-4 evaluation, action plans and code of Conduct
- NICE audit check list of Donor Breast Milk bank
- Antenatal colostrum harvesting care plan
- Web link to CQC report 2018

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 4: Progression					
The service demonstrates innovation and progress	✓				
There is evidence of improved outcomes	✓				
There is evidence of integrated working.	✓				

We found that the following is working well:

- Calderdale and Huddersfield have implemented many successful and innovative innovations over many years, including; an excellent peer support programme which includes, face to face, Facebook, text and phone support and peer welcome and support in the post-natal wards, the service provides evidence of integrated working and close links to health visiting services.
- The Frenulotomy services is excellent and there is a clear referral pathway.
- The Donor Milk Bank is established and meets NICE guidelines
- More recently antenatal colostrum harvesting is popular and is supporting breastfeeding initiation and sustainability, particularly where the mother may have complex needs.

We recommend the following:

- In order to progress and develop the service further we recommend that the service utilises the evaluation documents already in place and further develops some more analytical evaluation of how services could be progressed to support those mothers who do not start to breastfeed or stop breastfeeding before they want to. For example; qualitative feedback of the Breastfeeding Cafes is excellent; do you know what happens

to those mothers who don't access further support or come to the Café once and then don't return, how many babies receive donor breast milk, what are the gaps, the antenatal colostrum harvesting innovation is excellent, could you develop an evaluation tool to monitor success and identify areas for improvement etc.

- Some of the innovations detailed in the submission have been recently planned and implementation has just begun. We therefore further recommend effective evaluation of the newer innovations so that their impact on both qualitative and quantitative outcomes is assessed.

In addition, we suggest the following to further enhance this high-quality submission:

- Staff suggested that they had ideas to improve the service in relation to the Baby Friendly but that they were not always enacted, how could you progress the service to ensure that all staff feel involved in taking the service forward.

Summary of what is *required* before you can progress to the Gold Award

Actions that are ***required*** are mandatory if the criteria for the Gold Award are to be met in full. If any requirements are made, these are listed below.
The Designation Committee will be asked to consider what additional evidence is required. Further requirements may be made in the future in relation to any changes made, and in light of practice found or current research evidence.

1. An action plan or description of strategies that will be taken to make sure that staff feel that any concerns raised in relation to the implementation of Baby Friendly or ideas put forward around improving care will be considered.
2. The above to be confirmed by staff survey 12 months after the Gold award is made.

Summary of recommendations

Recommendations are made when we believe the actions will further enhance either the ability of the service to maintain core Baby Friendly standards, or will address any weaker areas in the plans for sustaining and progressing Baby Friendly within the organisation. In some cases implementation (or not) of these recommendations is likely to make a significant difference to sustainability and thus to the ability of the facility to maintain and progress the Baby Friendly standards.
The recommendations made by the assessment team are listed in this report. Further recommendations may be made in the future in relation to any changes made, and in light of practice found or current research evidence. Actions taken to address the recommendations will be considered at the time of the first annual review.

1. We recommend that a further organogram is developed to explain how those who have an impact on the Baby Friendly standards report to each other, how they receive information and how information is disseminated, with more explicit detail of who reports to who – this should include the project lead.
2. We recommend that the terms of reference for the Infant Feeding Advisory group are refreshed to consider how best the group sustains the Baby Friendly standards and monitors outcomes and that this group formalises the action plan for progress.
3. We recommend that consideration is given to how the three borderline areas identified in the staff survey can be improved.
4. We recommend continued development of data collection methods with review from relevant groups to determine effectiveness.
5. We further recommend effective evaluation of the newer innovations so that their impact on both qualitative and quantitative outcomes is assessed.
6. Moving forward as a Gold service, you will be expected to report annually to Unicef UK about progress, to include improved outcomes.

What happens next?

- Please send written acknowledgement to the recommendations in this report and any actions you will take to bfi@unicef.org.uk by **10 July 2019.**
- Plans should be made for the first annual review in **April 2020.** Moving forward an annual review of documents and data will be carried out to establish that Baby Friendly standards have been maintained and progressed. We will inform you by letter of the timescale and expectations related to this.
- Gold services are expected to agree to a Service Level Agreement. This will accompany the report and once returned, the award will be confirmed.

Mother sample - Maternity

All mothers were randomly selected for interview:

Data from re-accreditation December 2018, including updated audit data from recommendations March 2019

Number of mothers interviewed:	**54**
Breastfeeding	32
Formula feeding	16
With a baby on the neonatal unit	6

Standard 1 – Antenatal care

Criterion	Result	Standard required
Mothers who confirmed that they had the opportunity for a discussion about feeding their baby	90%	80%
Mothers who confirmed that they had the opportunity for a discussion about the importance of developing a relationship with their unborn baby and that the conversation met their needs	81%	80%

Standard 2 – Care at birth

Criterion		Result	Standard required
Care at birth (breastfeeding mothers)	Mothers who confirmed that they were able to have skin contact for at least one hour and support to offer the first feed in skin contact	96%	80%
Care at birth (formula feeding mothers)	Mothers who confirmed that they were able to have skin contact for at least one hour and support to offer the first feed in skin contact	86%	80%

Skin contact on the neonatal unit	Mothers who confirmed that they had been able to hold their baby in skin to skin contact	83%	80%

Standard 3 – Getting breastfeeding off to a good start

Criterion		Result	Standard required
Positioning and attachment	Mothers who confirmed that they were supported with learning how to position and attach their baby	100%	80%
Hand expression	Mothers who confirmed that staff offered to show them how to hand express	83%	80%
Responsive feeding	Mothers who confirmed that they understood baby led feeding and how to recognise feeding cues	96%	80%
	Mothers who confirmed that they understood responsive feeding	86%	80%
Recognise effective feeding	Mothers who confirmed that they were aware of how to recognise effective feeding	87%	80%
Ongoing support information	Mothers who confirmed that they were aware of support available and how to access this	100%	80%
Breastfeeding assessments	Breastfeeding assessments were carried out	88%	80%
Initiating expressing for mothers with a baby on the neonatal unit	Mothers who confirmed that they had been encouraged to express as soon as possible after the birth	83%	80%
	Mothers who confirmed that they received effective support to express	100%	80%

Standard 4 – Informed decisions regarding the introduction of food or fluids other than breast milk

Criterion		Result	Standard required
Maximising breastmilk	Mothers who confirmed that their baby had received a supplement Informed maternal decision or clinical indication	3	N/A
	Mothers who confirmed that their baby had received a supplement **Not** informed maternal decision or clinical indication, or care could have been improved	1	0
Formula feeding mothers	Mothers who confirmed that they had been supported with learning about making up feeds	100%	80%
	Mothers who confirmed that they had been supported with responsive bottle feeding	91% March 2019	80%

Standard 5 – Close and loving relationships

Criterion	Result	Standard required
Mothers who confirmed that they had received information about the importance of close and loving relationships	91% March 2019	80%
Mothers confirmed that they were not separated from their baby	100%	80%

Overall

Overall care from the maternity service	% of mothers
Very happy with care – no complaints or comments	86%
Fairly happy or neutral	14%
Unhappy with care overall	N/A
Mothers report staff to be kind and considerate	**% of mothers**
All of the time	88%
Mostly	12%

Background information

Baby Friendly accreditation history	Re-assessment with Calderdale and Huddersfield NHS Foudnation Trust December 2018 with recommendations due May 2019. First accredited as Baby Friendly in February 2002. Re-accredited again in April 2004 , May 2007, October 2011 and April 2015
Births per year	5,361
Facilities	Two Units: Huddersfield Birth Centre, Ante-natal Clinic, Community Midwifery Service. Calderdale: Birth Centre, Antenatal clinic, Community Midwifery Service,Maternity Assessment unit, Labour ward, Antenatal / Postnatal ward, Level 2 Neonatal unit with 24 cots including three intensive care cots.
Local demographics	Mixed socio-economic population from the towns of Halifax and Huddersfield and surrounding area.

8. 1 Year Strategy on a Page year ending 2020

To Approve

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Strategy on a Page Year Ending 2020
Author:	Anna Basford, Director of Transformation & Partnerships
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report

This attached report provides the Trust's Five year plan on a page and the annual strategic objectives for the year ending 2020.

Key Points to Note

The attached report describes the Trust's annual strategic objectives for the year ending 2020. Progress to deliver these will be reported at quarterly intervals to the Trust Board.

EQIA – Equality Impact Assessment

The 5-year strategic plan on a page and annual objectives aim to address the needs of the whole population, including those who experience disadvantage to help improve access, experience and clinical outcomes for all. Some objectives included in the strategy have been subject to detailed QIA and EQIA processes. However, it should be noted that as plans are progressed to deliver the strategy there will need to be QIA and EQIA for each objective.

Recommendation

The Board is asked to receive and **APPROVE** the annual strategic objectives.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

5 Year Strategy

Five Year Responses and Year Ending 2020 Objectives

5 Year Strategy

Our Vision	***Together we will deliver outstanding compassionate care to the communities we serve***			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Our patients and the public will be involved in their treatment and we will use their feedback to develop services for the future	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape and size with the capability and capacity to deliver safe, high quality services.	We will have implemented the five year plan
	We will have commenced implementation of an agreed re-configuration of integrated hospital and community services	We will be compliant with NHS Improvement standards	We will be widely recognised as an employer of choice through growing our own and attracting talented people to join our team.	We will be financially sustainable with the ability to invest for the future
	We will meet all relevant 7 day working standards and our SHMI will be 100 or less	We will consistently achieve all national and local patient performance targets	Engaging with our people and involving them in decisions that affect the Trust will be the norm.	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust interoperable electronic patient record which is used by patients and clinicians alike	We will be fully compliant with health and safety standards		

Year Ending 2020

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

9. Care Quality Commission (CQC) Update

To Note

Presented by Jackie Murphy

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	CQC Update
Author:	Shelley Rochford, CQC Compliance Manager
Previous Forums:	None
Actions Requested: To note	
Purpose of the Report	
This paper provides an update on the delivery of the Trust's response to the CQC report, future improvement work, preparation for our next CQC inspection and CQC engagement activities.	
Key Points to Note	
The Board of Directors are asked to be aware of the on going improvement work, preparation for our next CQC inspection as recommended by the CQC Response Group and approved by the Trust Quality Committee.	
EQIA – Equality Impact Assessment	
N/A	
Recommendation	
The Board of Directors is requested to: 1. Be aware of the actions that are not progressing. 2. Be aware on continued improvement work. 3. Note activities to prepare for the next CQC inspection.	

Calderdale and Huddersfield
NHS Foundation Trust

UPDATE CARE QUALITY COMMISSION (CQC) INSPECTION RESPONSE AND PREPARATION

BOARD OF DIRECTORS

4 JULY 2019

1. Background

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

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

The Trust achieved:

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

CQC identified:

- 9 'must do' actions.
- 54 'should do' actions.

Following the inspection improvement action plans were developed and a process for monitoring progress via a schedule of core service updates to the CQC Response Group was implemented.

The CQC Response Group reports to the Quality Committee on a monthly basis.

All improvement actions were scheduled to be embedded by 31 March 2019.

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

By 31 March 2019, evidence received by the CQC Response Group confirmed that 49 actions (4/9 'must do' and 45/54 'should do') had been completed and embedded in the relevant core service areas. This recommendation was supported by the April 2019 Quality Committee.

2 actions remain incomplete and papers sponsored by the Chief Operating Officer are due to be presented at WEB in July for further consideration of the quality and financial impact of the CQC actions. Both actions are on the Trust risk register and the CQC relationship team are kept fully briefed on progress and trust quality and safety monitoring across these areas:

- Must Do 8 (CRH): The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.
- Should Do 9 (HRI & CRH): The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.

Further progress has been made to embed outstanding 'must do' and 'should do' since 31 March 2019 and by 30th June 2019 evidence received by the CQC Response Group confirmed that 54

actions (7/9 ‘must do’ and 47/54 ‘should do’) had been completed and embedded in relevant core service areas.

9 actions (2 ‘must do’ and 7 ‘should’) are not yet embedded and these are areas of specific focus for the CQC Response Group. Progress is monitored on a monthly basis via the 2019 - 2020 Exceptions CQC Action Plan and the CQC Response Group.

3. Towards Outstanding - Preparation for Next CQC Inspection

The Trust ambition is to achieve an overall rating of ‘outstanding’ at our next inspection.

There are five key areas of focus for preparatory activities:

a. Sharing Learning - Quality Summit, Sharing Learning Improving Care Summit and Networking

A Quality Summit facilitated by Creative Connections was held on 18 April 2019. Colleagues from commissioning, partner organisations, the CQC and the trust joined together in a series of metavisioning exercises which took a creative approach to how we can work together to achieve our ambition of providing outstanding, compassionate care to the communities we serve and our colleagues.

Colleagues from a variety of core services also provided poster presentations for the Quality Summit to celebrate and share their achievements; excellent feedback was received from all attendees.

A Sharing Learning Improving Care Summit is planned for 24 October 2019. The purpose of this Summit is to learn from each other, our stakeholders and subject matter experts about how we can make improvements in our approaches to learning from each other so that we can improve care. The event will be opportunity to showcase how we are using digital technologies to support change and make care safer.

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

b. CHFT CQC ‘Health Check’ Process

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

- Review the associated inspection framework.
- Review the last CHFT report (for the associated core service).

- Review reports from other trusts.
- Complete the assessment documentation.
- Review the appropriate characteristics of ratings – working towards good / outstanding.

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

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

c. External Body Accreditation and Invited Service Reviews

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

The CQC Team play an integral role in facilitating any ISR or Accreditation reviews and are working with core services and Divisions to identify relevant and recognised accreditation and quality assurance schemes and provide a risk based assessment to the Executive Team about prioritisation and cost.

d. Peer Review

A programme of internal and external peer reviews has begun. The purpose is to revisit CQC actions and test out whether actions are embedded and consistently showing evidence of sustained improvement, as well as assessing services against the CQC 5 domains and relevant regulatory requirements and standards.

The Peer Reviews closely mirror CQCs approach to inspections and will assess service quality against regulatory standards. A range of evidence is collated through focus groups, review of documentation, observations and review of systems. A written summary report is provided to the service management post review.

The Peer Review program has been agreed by the CQC Response Group and includes:

June	Ward Based Medicine Review (Complete)
July	Nutrition and Hydration
August	Gynaecology
September	Mental health
October	Workforce and Organistaional Development

e. Provider Information Request (PIR)

The PIR has been updated with work ongoing to ensure learning and improvement since the last inspection is shared widely across the trust and with partners.

4. Review by CQC

In line with the new CQC strategy, scheduled engagement meetings have taken place between the trust and the CQC in March and May 2019. The next planned relationship meeting is in October 2019.

The CQC relationship manager spent a day visiting critical care in HRI and CRH and visits are planned for community and Emergency Department during Q2.

In addition, the CQC have attended the following trust meetings:

- Quality Committee June 2019
- Patient Safety Group May 2019

Arrangements are in place for CQC to attend further meetings:

- Meeting to review trust NHS Resolution Maternity Incentive Scheme July 2019
- Patient Experience Group (tbc)
- Risk and Compliance Group October 2019

5. Conclusion

The Board of Directors is asked to:

1. Be aware of the actions that are not progressing

2. Be aware on continued improvement work

3. Note activities to prepare for the next CQC inspection

10. Director of Infection Prevention Control Annual Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Annual Director of Infection Prevention and Control (DIPC) Report
Author:	Jean Robinson, Lead Infection Prevention and Control Nurse David Birkenhead, Executive Medical Director
Previous Forums:	None
Actions Requested: To approve	
Purpose of the Report	
To provide the Board with a report on the healthcare associated infections (HAI) performance 2018/19.	
Key Points to Note	
None	
EQIA – Equality Impact Assessment	
N/A	
Recommendation	
The Board is asked to receive and **APPROVE** the annual report on the position of healthcare associated infections.	

Calderdale and Huddersfield
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2018-19

Executive Summary

The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (DH, 2015).

This report details the activities of the Infection Prevention and Control Team (IPCT) during the period of April 2018 to March 2019. The Director of Infection Prevention and Control (DIPC) who is also the Executive Medical Director leads the IPCT and reports directly to the Chief Executive.

The first 2 quarters of 2018/19 were challenging for the Trust against national objectives for Meticillin Resistant Staphylococcus *aureus* (MRSA) bloodstream infections and *Clostridium difficile* toxin positive infection (CDI). The Trust performance at the end of the year reported 2 MRSA bloodstream infections against a target of zero preventable infections, and 18 CDI cases against an objective ceiling of 20 cases.

The Trust complies with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and the Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed HCAI programme of work and audit for 2018/19 that includes the 10 criteria identified in the code.

Key points:

- There were 2 trust apportioned Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 18 trust apportioned *Clostridium difficile* toxin (CDI) positive cases this year against a ceiling target of 20. All were subject to a Root Cause Analyses (RCA) – 5 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
- A cluster of Clostridium *difficile* infections on one ward was managed as an outbreak.
- There were 16 CHFT attributed Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias which is a decrease from 22 in 2017/18.
- The trust reported 52 *Escherichia coli* bacteraemias which is an increase on 2017/18 performance of 49. Analysis of all cases has not demonstrated a common underlying cause. *E. coli* bloodstream infection is the focus of collaborative work across the healthcare economy, due to the fact that >80% of these infections develop in the community.

- There was a cluster of patients colonised or infected with Cabapenamase producing Enterobacteriacea (CPE) which was reported and investigated as a serious incident via the trusts risk management processes
- 381 patients were diagnosed with influenza compared to 420 in 2017/18. The point of care test for influenza was introduced in December which assisted in isolating patients promptly and preventing cross infection.
- There were 5 wards affected (either closed or restricted) with viral gastroenteritis, resulting in a total of 106 bed days lost in comparison to 318 bed days lost during 2017/18.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of compliance with the Hand Hygiene Policy for the year was 89%.
- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust intranet and internet sites. Eight policies have been approved at Executive Board during 2018/19.

Contents

1. Infection Control Arrangements

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

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

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

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

The Director of Infection Prevention and Control (DIPC) has presented the Trust Board with the following agenda items on IPC during 2018/19:

- The annual DIPC report 2018/19 – endorsed.
- Quarterly DIPC reports – endorsed.
- Quarterly Infection Control Committee minutes highlighting outbreaks and areas of concern and providing assurance around infection control practice across the organisation.
- Monthly Trust MRSA bacteraemia trajectory progress and areas of concern.
- Monthly Trust Clostridium *difficile* trajectory progress and areas of concern.
- Monthly Trust MSSA and E-coli bacteraemia figures.
- A narrative of any underperformance against target indicators is provided in the integrated board report, detailing actions being taken to mitigate risks and to support improvement to deliver against targets. .

Infection Prevention and Control representation at relevant groups

The IPC team supports the Trust to provide infection and prevention advice and ensure liaison between the IPCT and key groups, by providing representation at the following:

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

- Urinary Catheter Steering Group
- Sisters Meetings
- Nursing and Midwifery Committee
- Nursing and Midwifery Practice Group
- Water Management and Air quality Group
- CHS Estates & facilities Operational Committee
- Matrons Forum
- Health & Safety Committee
- Patient Safety Group
- Decontamination Committee

Infection Control Budget 2018/19

The Infection Control Team has a budget of £524,792.00 per annum, of this £5,097.00 is for non-pay including licensing of ICNet surveillance IT system which has just completed phase 1 of an upgrade with phase 2 scheduled for 2019/20, training expenses and other non-pay items. The Matron Lead is both the budget holder and budget manager. Excess costs associated with outbreaks are funded separately from within the Trust.

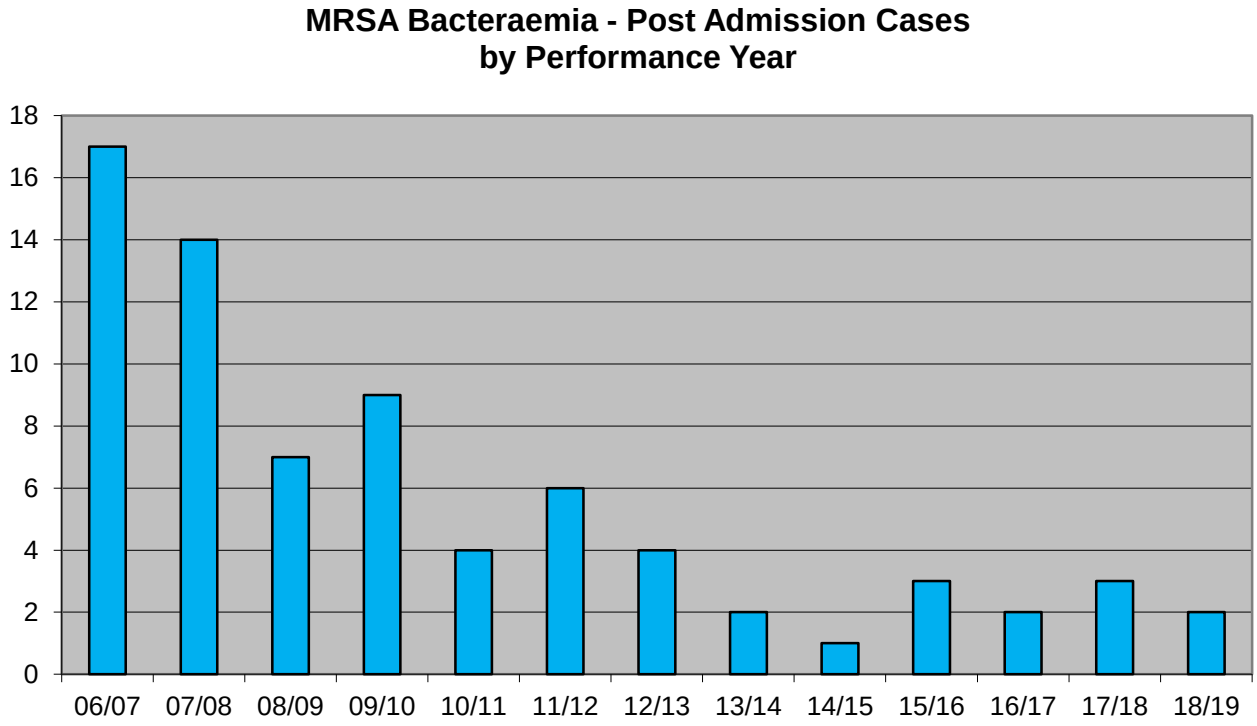
2. Mandatory reporting of Healthcare Associated Infections (HCAI)

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

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

Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

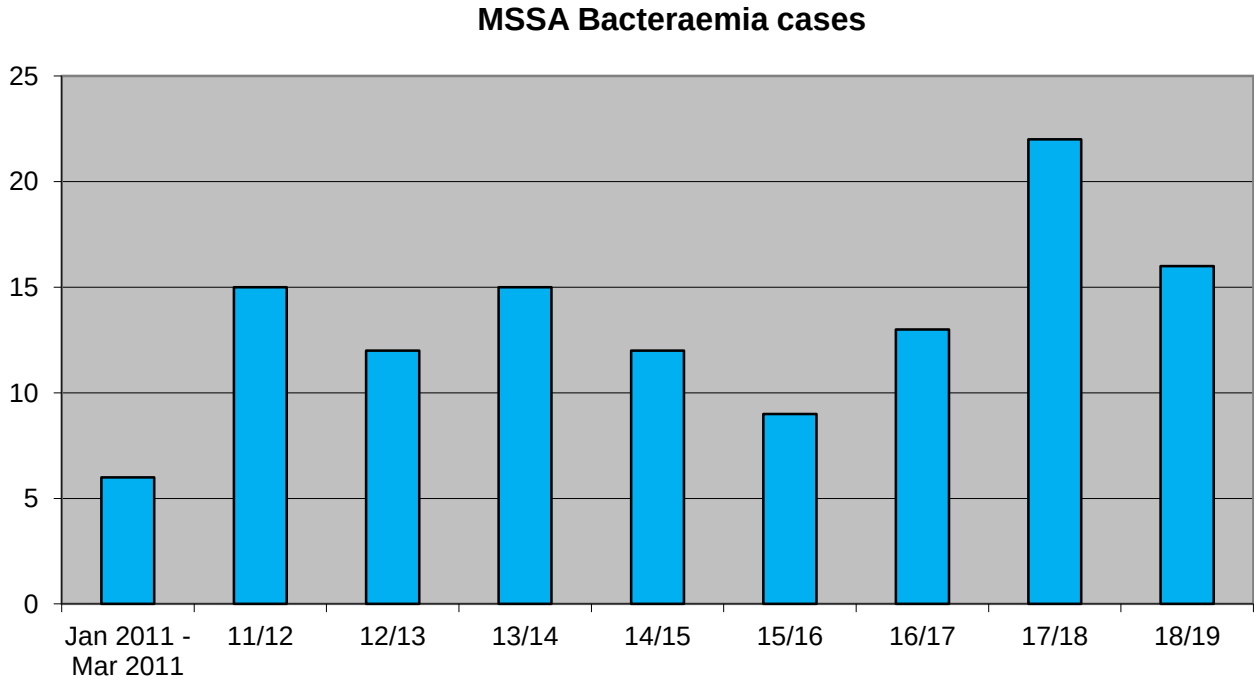
The total number of Trust-apportioned MRSA bacteraemia (blood stream infection) cases for the 2018/19 was 2 against a ceiling of zero, which is a reduction from 5 cases in 2017/18. The Trust ensures that all these have a Post Infection Review (PIR) to identify if there were any lapses in care to aid prevention of further cases.



Meticillin-sensitive Staphylococcus aureus

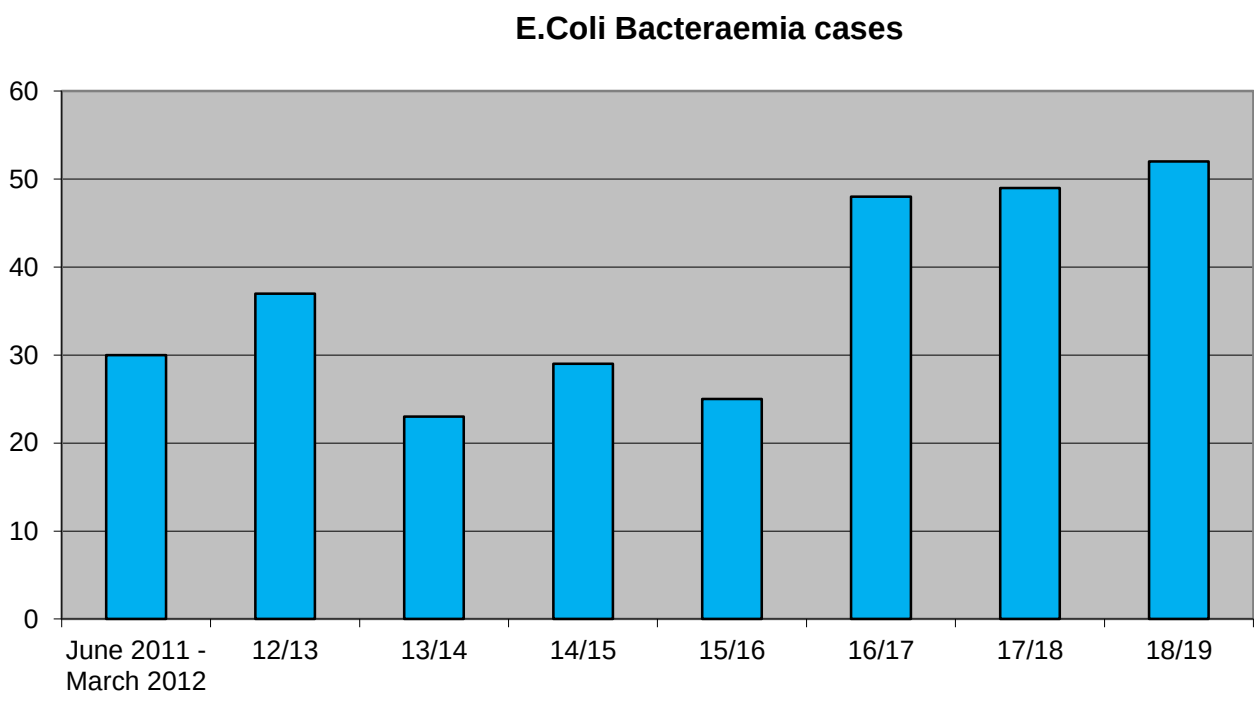
MSSA (Meticillin-sensitive *Staphylococcus aureus)* bloodstream infections are reported nationally although there are no mandated reduction targets set. 16 Trust apportioned cases were reported during 2018/19, compared to 22 in 2017/18. A review of these cases has been completed with recommendations included in the Trust's Infection Control Action plan.

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



E.coli Bloodstream Infections

There is no national set target for the reduction of *E.coli* bloodstream infections for acute care providers at present. There were a total of 52 cases in 2018/19, compared to 49 in 2017/18. There is a healthcare economy wide action plan which is being led by Kirklees CCG to reduce *E. coli* bloodstream infections, with a particular focus on urinary catheter care. Actions to support the reduction of *E. coli* bloodstream infections will be incorporated in the HCAI (healthcare associated infection) action plan for 2018/19. New guidance is due to be published within the next couple of months to aid organisations on how to achieve reductions, with the date for a 50% reduction being extended to 2024.



Clostridium *difficile* Infections

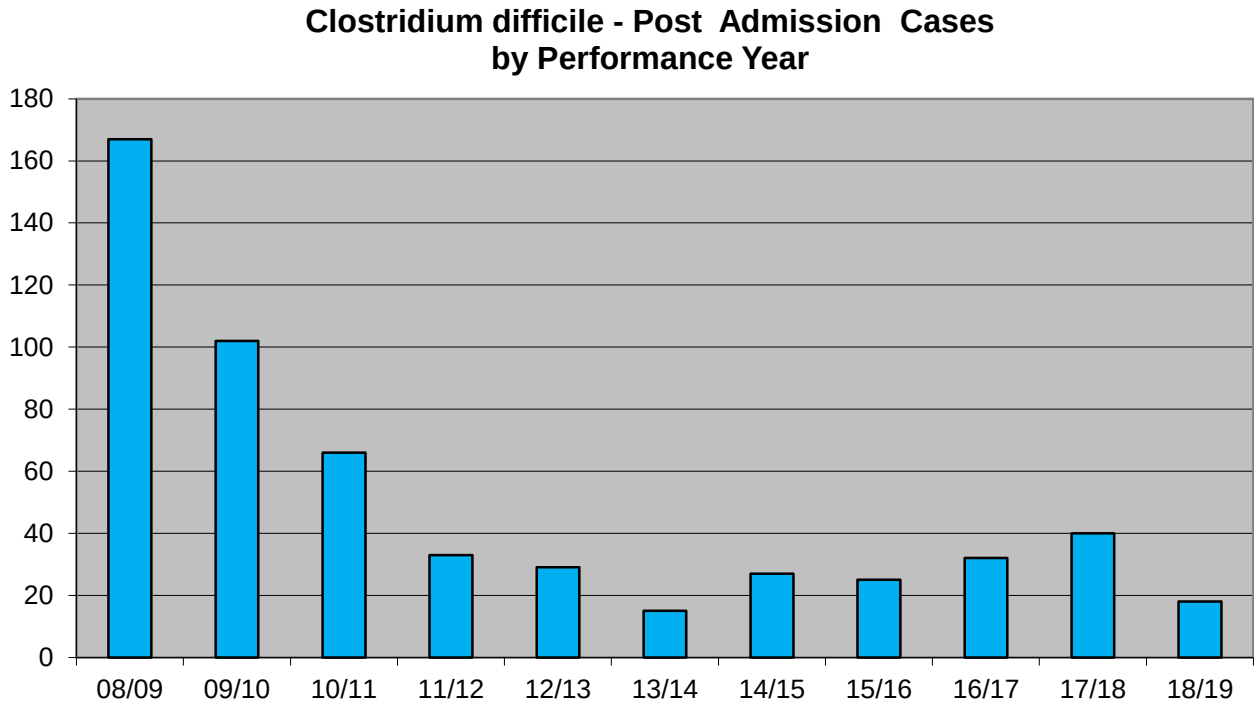
The target set for the Trust in 2018-19 was a ceiling of 20 cases: At the year end, we had 18 cases in total demonstrating a >50% reduction in cases from 2017/18. This is a commendable achievement, with two key initiatives contributing to this reduction:-

- Antimicrobial guidelines for over 65yrs were revised to increase the use of narrow spectrum antibiotics and those associated with a low risk of C.difficile.
- Deep clean and HPV (hydrogen peroxide vapour) cleaning of high risk wards. This has been approved again for the forthcoming year and a plan has been developed to support its implementation.

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

- Gaps in completion of the Bristol Stool Chart and assessing patient bowel habits

- Delays 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 have been reviewed.



3. Serious Incidents and Outbreaks

The following incidents occurred in 2018/19 related to infection prevention and control.

- A cluster of Carbapenemese-producing enterobacteriaceae (CPE) on an elderly care ward (HRI ward 20): In August there were five linked cases of colonisations (4 of which were reported as having the same strain by DNA fingerprinting). This was reported and was managed as an outbreak. The actions included: - closing the ward, a deep clean of the environment using HPV, and an enhanced CPE screening protocol was offered to all other patients. Following these interventions, no further cases of CPE were identified on the ward.

- Pertussis (whooping cough): In September 2018 a non-clinical staff member was found to have whooping cough whilst she had been working at CHFT. There were no in-patient

exposures. Contact tracing was undertaken and contacts were followed up by Occupational health.

- Clostridium *difficile* During October 2018, two toxin positive patients were identified on the same ward. Both cases were proven to be identical using DNA fingerprinting techniques indicating that cross transmission had occurred. The ward was closed and the environment thoroughly decontaminated using HPV.
- Tuberculosis: There have been seven in-patient exposure TB incidents that have required contact tracing during. Staff contacts were referred to occupational health; patient contacts were traced and followed up according to Trust policy.

- Influenza: - December 2018 to March 2019 there were 380 confirmed cases of Influenza, the majority of cases were Influenza A. There were no reported hospital-acquired cases or outbreaks. The Trust introduced a of 'point of care' test in both Emergency Department (ED) in January. This test enables rapid results (within 20 mins) at the point of patient admission compared to the laboratory test which can take several hours. Over 400 tests were done and the clinical feedback was that it aided patient management and flow. However there were some logistical lessons learnt which will help in improving the process this year.

- Chickenpox: There were two incidents of in-patient chickenpox exposure this year. Contact tracing and risk assessment were undertaken in line with Trust policy.

- Measles: In May a patient who attended the ED was found to have measles, contract tracing was undertaken and risk assessment of exposed patients completed. Staff contacts were followed up by Occupational health.

4. Preventing Healthcare Associated Infections – Divisional reports

Surgical Division:-

The year-end position for the division assigned Clostridium *difficile* cases is 4, which is an improvement on last year. Only one of these cases was found to be avoidable following the RCA meeting. There have been no MRSA bacteraemias.

The division has participated in the trust wide HPV programme and continues to try and reduce clutter in wards and departments. This has been challenging due to the increase in clinical equipment across clinical areas and Matrons have participated in a number of walk rounds to identify storage solutions. Teams have been supported in procurement discussions to ensure that stock levels are kept at a manageable level to support this.

The Division has worked with pharmacy teams to adopt the changes to antibiotic prescribing. The initial change to the use of Gentamicin did result in an increase in clinical incidents mostly relating

to prescribing and taking of levels. These did not result in harm to patients and the Divisional Director has worked with pharmacy colleagues to improve practice with improving results.

Frontline Ownership Audits (FLO) audits continue to address environmental issues with most areas scoring Green or Amber FLOs this year above 90%. Performance against key indicators in this area is good with no areas closed in surgery due to outbreaks.

Hand hygiene surveillance has been above 98% across the division. The divisional team continue to promote an open culture regarding audits and to ensure that staff are empowered at all levels to challenge poor practice. Divisional teams have participated in the hand wash roadshow with recommendations addressed through the divisional action plan.

Performance against the WHO checklist compliance has remained at 98% or above across all areas throughout 2018/19. As part of ongoing improvement work the division is currently exploring opportunities for Go Sees and peer review to provide assurance regarding data capture.

The main area of concern from an environmental perspective has been Main theatres at HRI which has seen deterioration in cleaning standards and clutter. The team have worked with cleaning services to improve basic cleaning standards in the department. A theatre specific FLO has been designed and is currently being tested. Standards in CRH main theatre have been sustained following the improvement work undertaken in 2017/18 and many of the checklists and standard operating procedures have been implemented at HRI.

Improvements in practice around aseptic non-touch technique (ANTT) and hand hygiene in operating services have been sustained this year. The priority for 19/20 has been identified to continue to try and improve compliance with PVC insertion recording in EPR. This has been a challenge as theatre teams currently use paper, EPR and Bluespier systems. This will be supported by increased surveillance by the service leads that now have clinical sessions booked into their working week and perform regular spot checks and audits. The teams in operating services have fully embraced a proactive approach to developing a safety culture that ensures environmental standards are maintained.

Work is ongoing to ensure compliance with ANTT training. The year-end position overall within the division was 93.61% compliance with nursing staff at 96.59% and medical staff trained at 82.81% which is a slight increase from last year which ended at 77.81%. The medical staff training and compliance continues to be a priority for 2019 / 20. Work started towards the year end to increase the number of ANTT assessors in line with changes to reassessment process. Clinical Directors are engaged and supporting this agenda.

Endoscopy services were re accredited by the Joint Advisory Group (JAG) with outstanding feedback regarding their decontamination practice and standards. The endoscopy team are developing an advanced HCA role at Band 4 to take on more decontamination responsibilities following further training.

The surgical procedures unit has relocated to Day Surgery at HRI which has reduced this environmental risk in the division.

Outstanding IPC risks are associated with estates issues which are being closely monitored by the leads with appropriate escalation and support into the division. A new risk has emerged at the end of Q4 regarding decontamination as there is currently no Decontamination manager in post. This has been escalated to the executive team and mitigations have been put in place to manage which will be identified on the risk register.

The division has prioritised its division specific actions to add into the trust wide action plan for 2019/20. These are:

- Engagement with catheter improvement and UTI work
- Documentation of PVCs in theatres
- Quality assurance of FLO audits and embedding new process – theatres revised process and Matron and Band 7 inspection. With more of a focus at DMT and PSQB on any recurrent issues that require escalation or action
- Identify lead and actions to progress SSI agenda.

The action plan will be monitored through the Divisional PSQB with work progressed through the Quality Improvement group and other relevant clinical forums.

Medical Division:-

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

There have been 2 MRSA bloodstream infections over the past year in the medical division a key area for learning was the accurate labelling of specimens, and correct usage of antibiotics
Current elective admission compliance is 98.7%; current acute compliance is 92.9% with a target of at least 95%.

The Trust Clostridium *difficile* ceiling for 2018/19 was 20 for the trust with the Medical Division having 14 cases in total.

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

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

- The division had an outbreak of C. difficile on one ward within the medical division (involving five patients). This was managed as an outbreak and lessons learnt were shared throughout the division and the Trust. The ward has had no further issues with regard to infection control.

Work continues to improve compliance with the above issues within the Division.

There have been minimal outbreaks of Norovirus on both sites throughout the winter period.
There have been continued challenges to comply with side room isolation requirements for all our patients however proactive management from wards and teams have worked hard to minimise risks for our patients.

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

The division has had a high number of influenza cases on both sites, in line with the national average. The trust has used point of care testing to enable a speedy positive diagnosis, to ensure that patients are isolated promptly if they required admission.

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

Wards and departments continue to audit hand hygiene compliance and staff are encouraged to report actual practice so that any problems can be identified. Ward staff have been asked to focus on the World Health Organisation (WHO) '5 moments' of hand hygiene when monitoring compliance.

Families and Specialist Services division:-

Families and Specialist Services Division have maintained a good performance in 2018/19. The divisional action plan reflects the priority areas and the strategies in place in preventing HCAI's the current focus is compliance and trainers for ANTT.
Within the last 12 months there was 1 case of HAI Methicillin–resistant staphylococcus (MRSA) and 2 cases of E-coli infections but no cases of Clostridium difficile(C-diff). The Infection control clinical lead links have been instrumental in keeping the base safe, with regular updates and feedback to individual teams. The nursing and midwifery leaders have focussed on compliance with all mandatory training including all aspects of Infection prevention that are discussed at the weekly confirm and challenge meetings. The FLO audits show compliance of 94.4% and hand hygiene at 99.9% over the last 12 months and we continue to use 'fresh eyes' when Matrons complete FLO's in

colleagues areas when requested. We continue to target specific groups that are low in compliance at every opportunity including training sessions on audit days.

In maternity services the campaign to vaccinate pregnant women against influenza has had another successful year for 2018/19. Calderdale have the 6th highest uptake of women accessing the FLU Vaccination in the UK at 55.5% with Kirklees in 51st position at 45.1%. The public health midwife is conducting a virtual visit to Worchester who achieved 69% and were 1st in the country.

In Calderdale and Huddersfield the Trust aimed to:

- Improve patient safety by increasing the uptake of flu immunisation by pregnant women.
- Offer immunisation at a time/place convenient to the woman including CRH/HRI hospitals or at her own GP surgery/local pharmacy.
- Provide training and updates for midwives and MSW/HCA to promote and deliver the maternity flu campaign.

Data for flu vaccines given by CHFT is shown in table 1 with comparison to 2017/18.

Table 1

2017/18	Cald	Hudds	Total	**2018/19**	Cald	Hudds	Total
October	20	62	82	October	17	31	48
November	20	24	44	November	17	13	30
December	11	11	22	December	4	5	9
January	9	2	11	January	5	1	6
Total	60	99	**159**	Total	43	50	**93**

Number of pregnant women having a flu vaccine at CHFT

The percentage uptake of flu vaccine by pregnant women from 1.10.18 to 31.1.19 across the Local Maternity System is shown in table 2 with comparison to national, regional and the previous year. Statistics were retrieved from Public Health England online.

Table 2

CCG	**2017/18**	**2018/19**
Calderdale	56.1%	55.5%
Harrogate	54.1%	55.2%
Bradford City	49.8%	52.1%
Greater Huddersfield	53.9%	51.7%
Leeds N	53.9%	)
Leeds S & E	50%	) 47.6%
Leeds W	52.9%	)
Wakefield	46.4%	45.4%
North Kirklees	46.7%	45.1%
Airedale	45.2%	43.2%
Bradford Districts	44.5%	42.5%

Yorkshire & Humber	51.6%	46.9%
England	45.3%	43.7%

Table 2 Flu vaccine uptake in pregnant women – WY & H LMS

There has been a small decline nationally in flu vaccine uptake by pregnant women, despite this uptake in both Calderdale and Greater Huddersfield is above the national and regional average. Calderdale has achieved the highest uptake regionally for the 3rd consecutive year, as a result of the combined efforts of CHFT community midwives, antenatal clinic CRH and local GP Surgeries.

Maternity services have implemented a Wound management working group in collaboration with the tissue viability specialist nurse to improve/prevent wound and perineal infections, with the aim to standardise practice with best evidence and national guidance in the following areas as currently there is inconsistency in practice.

1. Episiotomy /tears
2. C – section management
3. Pre –operatively to reduce SSI and wound dehiscence
4. Post operatively – ensure correct dressing and wound care pathway
5. Reduce SSI and wound dehiscence
6. To explore Incision management for ladies at risk of wound dehiscence following C section

In the last 12 months all the inpatient areas for Gynaecology, Children, Neonatal unit, and maternity services were exemplar assessed and accredited silver, demonstrating a range of quality metrics that provide assurance and compliance.

Community division:-

The Community Division have developed the Divisional Infection Control Performance Dashboard over the last year. The dashboard is progressing with in-depth work continuing around data sourcing to ensure an accurate report on the Community position.

Nursing teams within the division have moved into 5 hubs across 5 localities in Calderdale during the last 12 months. FLO audits for these hubs have been reviewed and a robust plan for audit is well described in the division this incorporates peer reviews with a 'fresh eyes' approach to ensure rigorous audits.

The divisional action plan describes the priority areas and the strategies in place for preventing HCAI's. These include the upgrading of some clinic rooms and sluice facilities in some Community bases.

Training compliance for 2018/19 training compliance with ANTT was 97.54%: this compares with the Trust overall compliance of 94.12%. The IPC training compliance with 'beyond the basics' was 95.6% in Community. The division has a targeted approach to staff that are not compliant.

Community nursing teams have been involved in responding to two infectious outbreaks in Calderdale care homes over the last 12 months. As a result of these outbreaks the division are involved in a multi-agency exercise in June 2019 to look at logistical responses from Public health, CCG and the Community division to ensure a coordinated response.

Occupational Health

Influenza – staff immunisation campaign 2018-19

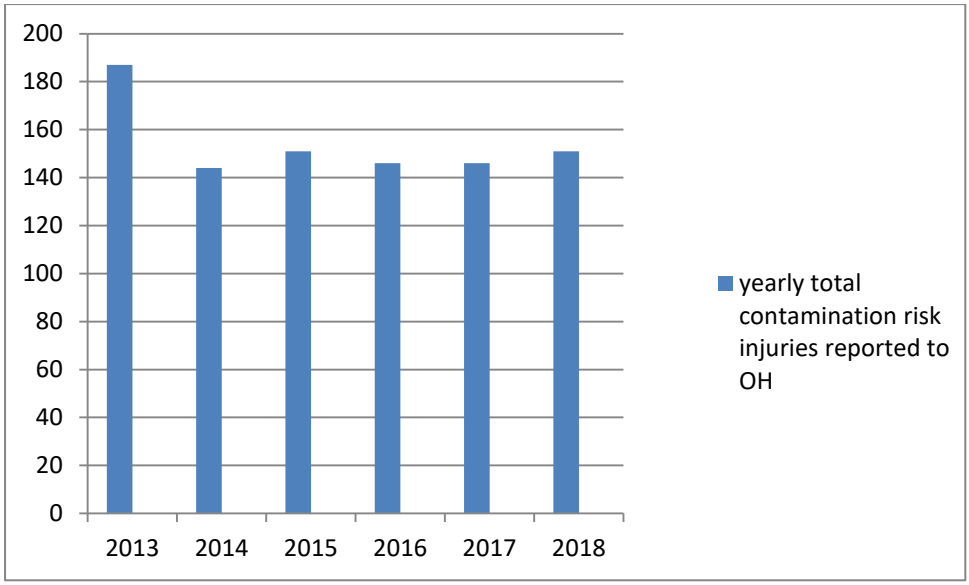
This was the third year that a CQUIN had been attached to the uptake of frontline healthcare workers of the annual flu vaccine. The target uptake was 75% of frontline healthcare workers to have had their flu vaccine by 28th February 2019. There was also a requirement for the Trust to collect and report to the Department of Health (DOH) on the number and reasons for vaccines being declined by staff.
A high profile campaign was launched in October 2018, building on our experiences of past campaigns, and drawing on information from staff engagement events. Additional incentives and prizes were offered, and over 100 peer immunisers trained to be able to offer the vaccines in nearby workplaces on and off site reaching most staff around the clock. Data collection was digitalised with support from the Web team who build a bespoke app to collect immunisation uptake linked to the ESR and anonymised decline information from staff and immunisers. Key reasons for non-immunisation were concerns over vaccine side effects, a belief that the vaccine was ineffective and that it was a matter of personal choice.

The final uptake of frontline healthcare workers reported to the Department of Health was 75.5%; this is an increase in the uptake from the previous year by 5%.

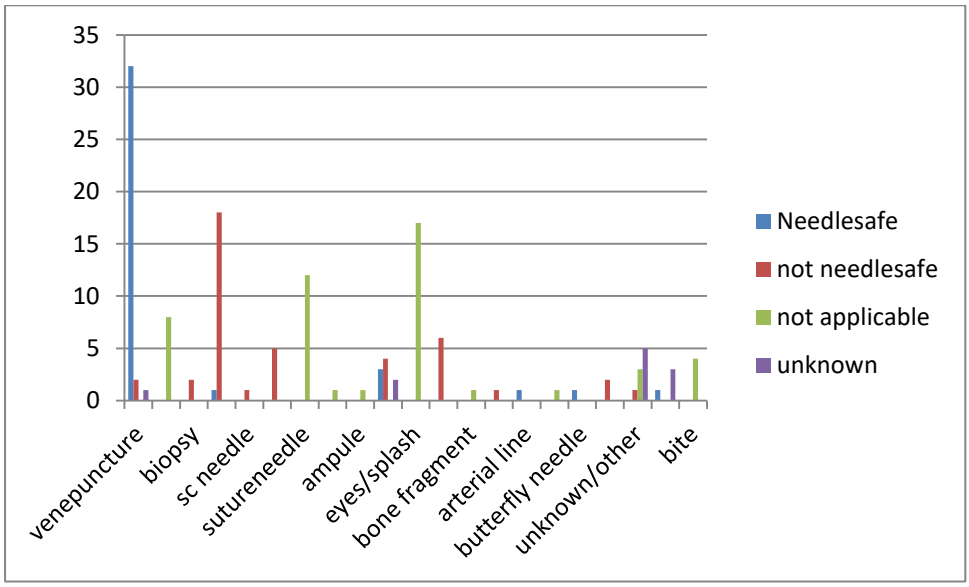
The influenza steering group is developing the plans for the season 2019-20 which will press forward with a target of 80% by 28th February 2020 in accordance with the national CQUIN, however will be planning for a rapid immunisation of the majority of staff during October 2019.

Contamination Risk Injuries to staff

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



The type of reported injuries was recorded with the injury recipient's description as to the "sharp-safety "of the item logged where applicable. In some cases where the use of a safety device was noted, the injury occurred during the clinical procedure and before the device could be activated, mostly during venepuncture as a patient flinches for example.



During 2018 there were 3 cases of possible exposure to a source patient who had Hepatitis B, three exposures to Hepatitis C and one to HIV where PEP was commenced but stopped after 5 days as the donor viral load was undetectable. In all cases routine follow on screening was pursued. There have been no cases of healthcare worker infection acquisition identified in follow up screening.

A sharps injury sub group of the health and safety committee has been formed to investigate apparent trends or significant incidents relating to these incidents. An audit in the surgical division and in Emergency departments was undertaken with an awareness raising value as theses were areas where higher numbers of injuries were reported. The use of patient's own insulin kits has also

been identified as a factor, and work ongoing to influence prescribing of needle safe devices to patients.

Staff Hepatitis B immunisation

Due to international supply constraints of Hepatitis B vaccines, the staff immunisation campaign was suspended in August 2017 on the guidance of the Department of Health. This resulted in staff commencing in post without immunisation to Hepatitis B, or with primary immunisation programmes suspended. Vaccine supply has gradually increased and immunisation of healthcare workers recommenced in October 2018 on employment, with a plan in progress to catch up on these missed vaccines within a priority framework.

There was one reported exposure risk incidents involving an unimmunised staff due to the unavailability of vaccine.

BCG immunisation

There has been an international shortage of BCG vaccine resulting in its unavailability and suspension of healthcare worker immunisation. The BCG vaccine has recently been resupplied, and updated chapter of the green book (infectious diseases) published in August 2018 recommends a risk assessed approach to the immunisation of some healthcare workers.

The Occupational Health service has continued to screen new healthcare workers for TB infectivity risks throughout this period, and is due to recommence immunisation of healthcare workers in higher risk areas, with a review of staff currently in post in identified areas to ensure a catch up of any who have moved to these areas without appropriate BCG immunisation.

5. Antimicrobial Prescribing

Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) CQUIN 2018/9

Owing to the increasing global threat associated with antimicrobial resistance, the CQUIN relating to antimicrobial use continued in the year 2018/19. This continued to involve the Sepsis Collaborative and the Antimicrobial Management Team (AMT) working closely together. These groups bring together multidisciplinary representation from microbiology, infection prevention & control, and pharmacy, with the medical, surgical and FSS divisions, health informatics and primary care. The Collaborative meets monthly and the monthly Antimicrobial team (AMT) meetings feed into the above.

CQUIN Part 2c: Assessment of a clinical antibiotic review

Prescriptions Reviewed at 24-72 hours	2018-9	Target
Q1	95.60%	**25%**
Q2	63.60%	**50%**
Q3	85.3%	**75%**
Q4	81.25%	**90%**

Targets were met for quarters 1-3. Targets were not met for quarter 4. The results from quarter 4 are to be fed back to the relevant clinicians. A review code ".abrv" has been created in EPR and promoted for use throughout the trust to facilitate antimicrobial review and documentation thereof.

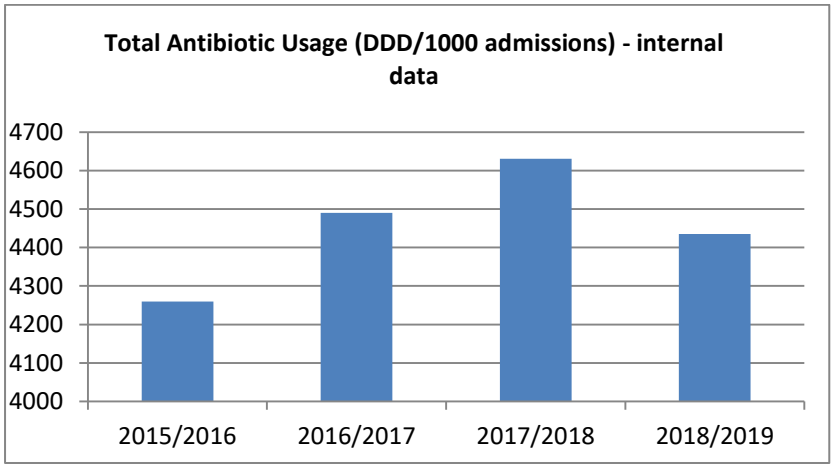
CQUIN Part 2d: ANTIBIOTIC REDUCTION per 1000 admissions

Summary of the latest results published by Public Health England:

	Target for 18/19	Q3 PHE results
a) ALL Antibiotics	4108.94	**4373** **(four quarter rolling)**
b) Carbapenems	65.18	**45.2** **(four quarter rolling)**
c) AWaRe (%)	45.45	**45.1%**

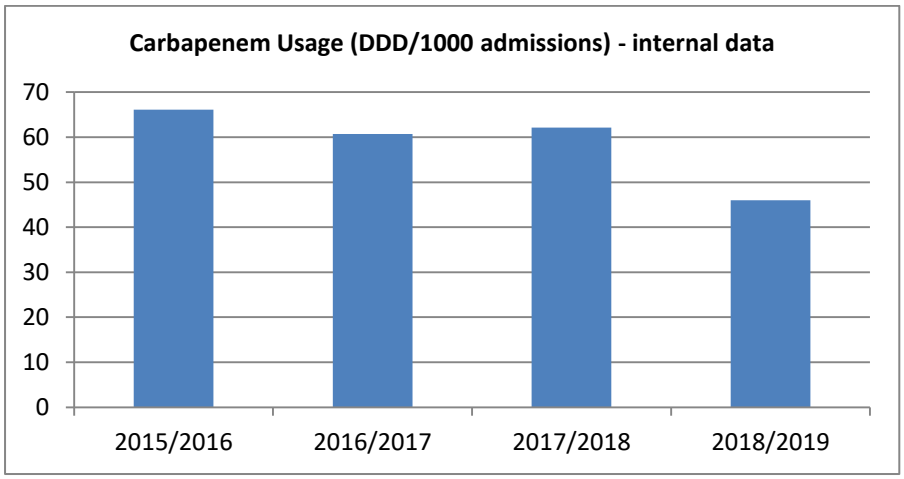
a) Reduction of 1% or more in Total Antibiotic consumption against the baseline year 2016.

Although we have not managed to meet the 1% reduction below the 2016 baseline year, there has been a promising decrease in antibiotic consumption in 2018/19 compared to 2017/18.



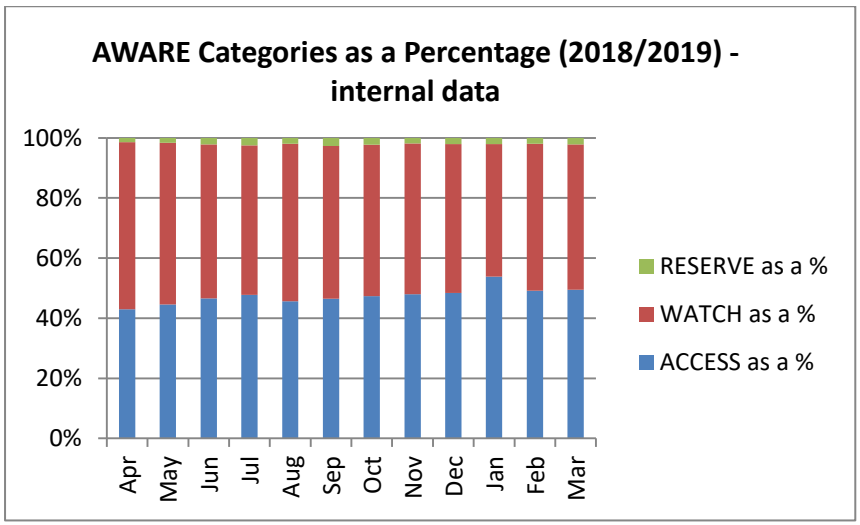
b) Reduction of 1% or more in Carbapenem consumption against the baseline 2016.

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



c). ***Increase by 3% the proportion of antibiotic usage (for both in-patients and out-patients) within the Access group of the AWaRe category against the 2016 baseline.***

This was new element to the CQUIN for 2018/19 and we have amended various antibiotic guidelines to reduce our use of broad spectrum antibiotics and replace them with narrower spectrum antibiotics.



Key changes were made to guidelines in June 2018 and December 2018 and an increase in the percentage use of the ACCESS category antibiotics has been seen following these. Quarter 4 data from PHE has yet to be released but we are hopeful to meet the target.

Antibiotic Prescribing Guidelines:
Since May 2015 all adult antibiotic prescribing guidelines have been updated and approved by the Medicines Management Committee (MMC) and are available on the Trust Intranet site. Significant changes have been made as mentioned above in June and December 2018 to introduce the use of narrower spectrum antibiotics, mainly Benzylpenicillin and Gentamicin, and to reduce our use of the broad spectrum antibiotic Co-amoxiclav.

Antimicrobial Ward Rounds
The Consultant Microbiologists continue to carry out regular antibiotic ward rounds (ICU, Vascular, Haematology, Oncology & Care of the Elderly on HRI 20). In addition, review of broad-spectrum antibiotics such as carbapenems, complex patients, and those on prolonged courses of intravenous antibiotics are prioritised.

Outpatient Parenteral Antibiotic Therapy (OPAT) antibiotics:
An OPAT service is provided for Kirklees and Calderdale patients for up to 12 antibiotic administrations per day in each community area. A multi-disciplinary health economy-wide group has continued to meet regularly. Patients benefit from a weekly "virtual" review by a multi-disciplinary team led by a Consultant Microbiologist.
The tables below show the OPAT data.

Kirklees data April 18 – March 19

Total Referrals	351
Bed days saved	3058
Admissions avoided	122

Calderdale data April 18 – Jan 19

Total Referrals	189
Bed days saved	1696
Admissions avoided	105

Education and Training

Education and Training is provided in a number of ways and aimed at different professional groups including Medical staff (Trust-wide Junior Doctor Inductions, CHFT anaesthetic registrar teaching, FY1 education sessions, Regional specialty trainee sessions, Physician Associate education, Grand rounds, Trust-wide consultant mandatory training & Clinical audit meetings), multi-disciplinary events (Infection Control Link Practitioners Workshops & Laboratory staff education), the pharmacy team and to our potential future staff (third and fifth year medical students & final year nursing students).

A medicines management newsletter was written and distributed to staff promoting safe Gentamicin prescribing and administration and there have been multiple teaching sessions to the junior doctors on Gentamicin following guideline changes in 2018.

The AMT continue to contribute relevant topical pieces to the junior doctor newsletter.

Following completion of RCPath's Science Communication Training, one AMT member provided infection training to ~180 primary school pupils. The sessions included basics on "bugs", transmission and discussions around antimicrobials & vaccines.

Southwest Yorkshire area-prescribing committee (APC) antimicrobial subgroup

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

Key Challenges in 2018-9:

The widespread introduction of Gentamicin into core antimicrobial guidelines was challenging. This agent has a narrow therapeutic range, involves more monitoring and dose adjustment than other antibiotics and has significantly increased the work load of junior doctors, pharmacists and the Hospital Out Of hours Programme team in high usage areas.

Antimicrobial Pharmacist – there was a gap in full time cover as one post holder (0.5wte) was on maternity leave for a proportion of the year, and the other left the role in February.

Future Challenges

The new Antimicrobial Resistance CQUIN for 2019/20 focuses on the following two areas:

a) Lower Urinary Tract Infections in Older People: Achieving 90% of antibiotic prescriptions for lower UTI in older people (in accordance with NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance) in terms of diagnosis and treatment.

b) Antibiotic Prophylaxis in colorectal surgery: Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery at single dose and prescribed in accordance to local antibiotic guidelines.

The AMT will need to work closely with clinical teams, to ensure prompt feedback to prescribers and engagement at all levels. Appropriate amendments to guidance and practice will be required to achieve these targets.

The AMT will continue to support clinical, nursing and pharmacy colleagues to ensure gentamicin is correctly prescribed and monitored within the trust.

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

6. Decontamination

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

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

In 01-01 and 01-06 DH will be retaining the Essential Quality Requirements and Best Practice format, this maintains their alignment with HTM 01-05 and the requirement of 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' which requires that "decontamination policy should demonstrate that it complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice".

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

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

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

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

BBraun Sterilog Yorkshire Limited is recognised as having validated processes and as such is fully compliant against all guidelines as detailed via the National Decontamination programme where

independent verification by the British Standards Institute (BSI) confirms compliance by a six-monthly review audit and certificated accordingly.

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

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

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

Reviews currently underway.

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

Endoscopy

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

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

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

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

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

Additionally, further independent monitoring carried out in November 2018 by the Joint Advisory Group (JAG) which is recognised as a pathway of quality improvement, where acceptable standards for endoscopy units are continually met, and assurance that endoscopy training and quality are consistently achieved and therefore the patient experience and outcomes are of the standard expected.

The planned project to replace the equipment associated with decontamination i.e. Automated Endoscope Reprocessors, (AER's), Reverse Osmosis water treatment plants (RO) and Drying Cabinets was completed in September 2018

ENT

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

Decontamination Committee

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

The aim of the Committee is to undertake the development of high quality decontamination processes, policy and procedures to ensure that a safe, properly managed and effective

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

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

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

- Endoscopy / ENT Reusable Medical Devices via the Trusts independent Authorised Engineer Decontamination AE(D)
- BBraun Sterilog via British Standards Institute in recognition of MDD 93/42 EEC Annex V, section 3.2 under article 12
- Laundry in recognition of HSG(95)18 / CFPP 01-04and EN14065
- PPM regimes associated with hard FM services
- Pharmacy Manufacturing Unit compliance

7. Cleaning Services

The provision of cleaning services at HRI, Broad Street Plaza and Beechwood Community Health Centre is delivered by Calderdale and Huddersfield Solutions Ltd (CHS) and an outsourced service under the PFI (Private Finance Initiative) agreement by ISS Facilities Healthcare Services at CRH and OCS cleaning services at Acre Mill outpatients HRI.

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

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

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

Performance management systems are in place with key performance indicators produced on a monthly basis in line with the national specification for cleanliness. The monthly scores are

provided by Service Performance and displayed on each wards public facing board at the entrance to the ward and on the infection control notice board within outpatient departments.

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

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

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

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

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

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

Two members of cleaning services gained a BICSc licence to practice allowing them to deliver and assess BICSc training to all members of cleaning services. This will ensure a consistent method of cleaning is delivered to all areas at HRI. The aim is to have 50% of the workforce fully trained before the end of 2019.

HRI cleaning services were audited in April 2017 against the Cleaning Industry Management Standards (CIMS) as their quality management system. CIMS is the first consensus based management standard that outlines the primary characteristics of a successful quality cleaning organisation. HRI achieved the accreditation with honours and is due the next assessment in July 2019

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

A piece of work is ongoing to look at the workforce model at HRI, which on completion will determine how much resource is required on both clinical and non-clinical areas. This piece of work is likely to be completed by early summer

8. Estates

In Sept 2018 the Estates, Facilities and Procurement service jointly developed a CHFT Wholly Owned Subsidiary providing Integrated Facilities Management. Calderdale and Huddersfield Solutions Ltd (CHS) employ around 450 colleagues to deliver a comprehensive Estates, Facilities and Procurement service to all properties owned by the Trust. CHS work closely with the Trust delivering the Capital Programme improving the estate, environment and addressing compliance; improvement works include:

- Refurbished the Main Entrance toilets together with the lower ground and Basement both male and female.
- Following the replacement of the mixer taps on all wards and department the balancing of the domestic hot water system started including removal of low use risers.
- Replaced the flooring on wards 3, 11 and 15 including minor decoration.
- Continual replacement of degraded pipework.
- Complete replacement of a cold room in the main kitchen stores for better temperature control and storage of food.
- A number of obsolete building management panels were replaced to allow better control of heating, ventilation and cooling.

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

- Emergency lighting
- Fire detection
- Roof repairs
- Air handling units
- Fire doors.
- Emergency Structural investigations and repairs
- Work was completed to replace the water for injection system at PMU (HPS) including a dedicated steam boiler and new gas meter.

- The server for the security cameras was replaced and upgraded to allow high definition CCTV cameras to be connected to the system.

- Continuation of the Fire compartmentation throughout HRI, to reduce the spread of fire risk.

Estates maintenance:-

The estates team continue to work through HTM action plans following independent compliance audits for engineering services in 2018/19 to ensure compliance with DH requirements the estates department are committed to replacing/upgrading services to ensure the very highest quality is delivered to patients and staff.

The Water and Air management/safety group ensure scrutiny and clinical governance arrangements are in place for both systems. The Capital programme further progressed the quality and assurance around water safety with the completion of the tap replacement scheme and system balancing. The HRI site now has up-to-date water system schematics again ensuring a quality management structure is in place.

Any concerns raised in the Water and Air management/safety group are subsequently escalated to the Patient Safety & Quality Committee and Infection Control Committee. Water and air Management is controlled and delivered via a written control scheme/Estates Management plan administered by the Authorising Engineer/External Consultant Microbiologist. There were no water safety / air quality incidents escalated in FY 18/19.

Patient-led Assessments of the Care Environmental (PLACE)

Patient-led assessments of the care environment (PLACE) is the system used for assessing the quality of the hospital environment and replaced Patient Environment Action Team (PEAT) inspections in April 2013. The annual PLACE assessments put patient views at the centre of the assessment process using information gathered directly from patient assessors to report how well a hospital is performing focusing entirely on the care environment. The PLACE assessments teams are made up of membership councilors, governors, volunteers and staff and results are reported publicly to help drive improvements in the care environment and show how hospitals are performing nationally; in 2018 the teams consisted of at least 50% non-staff members for each site.

In 2018 both HRI and CRH achieved positive results with improvements at CRH from the previous year both on environment and cleanliness:-

CRH	
Condition/Maintenance	96.58%
Cleanliness	99.59%
HRI	
Condition/Maintenance	94.25%
Cleanliness	98.31%

Infection Prevention and Control Audit Programme:-

The audit programme for 2018/19 was completed and all action points were shared with the divisions for follow-up. This programme included:

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

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

The hand hygiene road show carried out in September across the Trust enabled the Infection Control Team to deliver education to staff of all levels across the multidisciplinary team and to audit compliance with bare below the elbow. It also gave staff the opportunity to use an ultraviolet light box which highlights areas of the hand that are missed during hand decontamination so that staff can improve their technique, staff were advised to consult the Hand Hygiene policy to look at diagrams and instructions on handwashing techniques that would ensure the whole hand was decontaminated during hand washing / hand gelling.

Agar plates were used in some areas for staff to check what was growing on their hands after being in contact with their environment. Many had been using computers and had touched door handles before placing their finger tips on the agar.

In addition, during the visits an audit of compliance with 'bare below the elbow' was undertaken and a staff survey exploring hand health was completed.

The IPC team assessed 640 staff throughout the organisation during the hand wash road show. The overall compliance was 89%: which is an increase from 85% on last year, it remains an improvement on the previous years and will remain a focus of Infection Prevention monitoring and intervention in 2019.

9. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2018/19:

Section A	Infection Control Arrangements Policy
Section E	Major Outbreak Policy
Section J	Multi-resistant Organism Policy
Section K	Isolation Policy
Section O	TSE Policy
Section Q	CPE Policy
Section R	Specimen Collection Policy
Section U	MERS-CoV Policy

10. Education and training

A blended learning approach continues with the provision of both face to face and e-learning for clinical staff.

The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Bite size and bespoke training sessions are provided as and when required. In Addition education is provided on a one to one basis during routine clinical visits by the IPCNs and in response to patient specific clinical enquiries from wards and departments.

The IPCT also support Aseptic Non Touch Technique (ANTT) training, supporting compliance and safety metrics and zero harm; the Trust overall compliance at the end of March 2019 reported 94% compared to 90% in March 2018.

Comprehensive Infection prevention training for the Junior Dr induction day, including the assessment of ANTT.

Throughout 2018/19, the IPCT teaching sessions consistently score 'good' or 'excellent' in feedback from participants. The IPCT keeps update to date with current national policies and guidance and attending any relevant study days or conferences.

11. Conclusion

The trust continues to provide proactive infection Control and prevention strategies across the trust and complies with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and associated Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed HCAI programme of work and audit for 2018/19 that includes the 10 criteria identified in the code.

- There were 2 trust apportioned Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 18 trust apportioned *Clostridium difficile* toxin (CDT) positive cases this year against a ceiling target of 20. All were subject to Root Cause Analyses (RCA) – 5 were identified as potentially avoidable owing to 'lapses in care' identified at RCA. Lapses in care principally related to antibiotic prescribing out with policy, poor documentation, substandard cleaning of both patient equipment and the patient environment. Areas for improvement feed into the Trust and Divisional HCAI action plans.
- There were 16 Trust attributed Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, which is an improvement on the previous year of 22 cases.
- The trust reported 52 E.coli bacteraemia infections demonstrating an increase on last year's performance of 49. Analysis of all cases has not demonstrated a common underlying cause. Collaborative work within the health economy during the year was not delivered due to staffing issues within our community partners.
- Clostridium *difficile* outbreaks occurred on ward 20 and ward 6 HRI these have been investigated as an SI.
- 380 Influenza cases were identified this year in comparison to 420 during 2017/18.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of hand hygiene compliance for the year was 99%.
- The Trust participated in mandatory 3 month orthopaedic surgical site infection surveillance (SSIS), and extended this to six months for some procedures with post discharge surveillance.

- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust Intranet and Internet sites. Eight policies have been approved at Executive Board during 2018/19.

Appendix 1:

Link to the Infection Prevention & Control Arrangements Policy:

http://www.cht.nhs.uk/services/clinical-services/infection-prevention-and-control/infection-control-policies/

Appendix 2:

Terms of Reference for the ICC

Terms of Reference	
Committee Name	**Infection Prevention & Control Committee**
Chairperson	Infection Prevention & Control Doctor
Date	June 2015
Version	2
Receives reports/minutes from:	Occupational Health Decontamination Manager Divisions: Surgery;Medical;FSS;Community;Estates & Facilities PHE CCGs
Meeting and attendance frequency:	Minimum four times per year.
Definition of Quorum	Eight members (five of which are not members of the IPCTeam), including senior member of Infection Control Team and divisional representation
Membership	Current list available from IPC secretary
Core membership:	All members expected to attend every meeting or send appropriate representative in their absence.
Associate Membership:	Must attend on an adhoc basis dependent on the agenda

Scope of responsibilities (duties): See below

Infection Prevention and control is a high priority within CHFT, in order to ensure adherence and maintenance of standards as set out by the CQC and the Health and Social Care Act 2008.

Remit

- To ensure that Calderdale and Huddersfield NHS Foundation Trust provides a safe environment, in terms of infection risk and within the sphere of current knowledge, for patients, staff and visitors.

- To oversee the organisation and development of infection prevention and control services across the Trust, including surveillance, education and audit.

Accountability

- To the Trust Board.

Function of the Committee

a) Advice and Reports
   - To advise the DIPC on all matters concerning Infection Prevention and Control within the Trust.
   - To advise and support the Infection Prevention and Control Team.
   - To act as a referral centre for infection prevention and control advice within the Trust.
   - To support the DIPC to produce an Annual Report to the Trust Board.

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

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

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

e) Outbreak/incident Management
   - To discuss and review all matters relating to outbreaks of infection in Trust premises and makes recommendations to address shortcoming and avoid recurrences.

- To draw to the attention of the chief Executive and Trust Board, any serious problems or hazards relating to infection control.

f) Collaboration and Partnerships

- To work closely with the Clinical Commissioning Groups.

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

Composition of the Infection Prevention and Control Committee

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

The Members of the Infection Control Committee

Infection Prevention and Control Doctor (Chair)
Medical Director & Director of Prevention and Control of Infection
Assistant Director of Infection Prevention and Control
Consultant Microbiologists
Lead Infection Prevention and Control Nurse
Senior Infection Prevention and Control Nurse
Head of Infection Prevention & Control, Calderdale Council
Senior Community Infection Prevention and Control Nurse, Kirklees Council
Consultant in Communicable Disease Control, Public Health England
Senior Nurse, Occupational Health
Lead Nurse - Medicine
Lead Nurse - Surgery and Anaesthetics
Lead Consultant - CWF
Lead Nurse - CWF
Associate Director - Estates and Facilities
ISS Manager, Calderdale Royal Hospital
Cofely Manager, Calderdale Royal Hospital
Decontamination Manager
Non-Executive Director
Other members may be co-opted as appropriate, e.g.

- Catering manager
- TB Nurse

Minutes

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

11. Freedom to Speak Up Annual Report

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Freedom to Speak Up Annual Report
Author:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Board of Directors 1 February 2018

Actions Requested:
To note

Purpose of the Report

This paper provides an update regarding the Trusts 'Freedom to Speak Up' (FTSU) activity since the last Board paper in February 2018.

Key Points to Note

It is a statutory requirement that the board is required to receive and review FTSU activity on an annual basis. The board paper covers the period 1 March 2018 – 21 June 2019.

The paper is presented in a restructured format to ensure compliance with the – "Guidance for Boards on FTSU in NHS trusts and NHS foundation trusts" published by the National FTSU Guardians Office and NHS Improvement in May 2018.

EQIA – Equality Impact Assessment

The Freedom to Speak up policy and associated procedures takes into consideration the nine protected characteristics and promotes inclusivity in the workplace.

The Freedom to Speak up action plan ensures opportunities for promoting equality, diversity and inclusion are maximised by having regular discussions with BAME, LGBQT and Colleague Disability Action Groups to explore the impact these 'speaking up' channels have on these respective equality groups.

Whilst this policy identifies specific areas which should be raised under whistleblowing, it does encourage all staff to raise any concerns they have, and this should encourage people to speak out about any inequalities they have experienced.

Recommendation

The Board is asked to **NOTE** the contents of this report.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

4 JULY 2019

FREEDOM TO SPEAK UP ANNUAL REPORT

1. PURPOSE

This paper provides an update regarding the Trusts 'Freedom to Speak Up' (FTSU) activity since the last Board paper in February 2018.

It is a statutory requirement that the board is required to receive and review FTSU activity on an annual basis. The board paper covers the period 1 March 2018 – 21 June 2019.

The paper is presented in a restructured format to ensure compliance with the – "Guidance for Boards on FTSU in NHS trusts and NHS foundation trusts" published by the National FTSU Guardians Office and NHS Improvement in May 2018.

2. INTRODUCTION

The intent of the FTSU model is that in time it will be acknowledge, respected and embraced by all at CHFT. The aim of this report is to provide assurance to the Board of Directors (BoD), that the Trusts FTSU channel is robust, fair, healthy, responsive and that any learning points are acted on, shared and focused on continual improvement.

In 2018 the National Guardians Office and NHS Improvement published guidance for Boards. To ensure we comply with 'best practice' the guidance is adhered to. This report has been structured to provide information concerning the following:

Section 1 - The assessment of issues
Section 2 - Potential patient safety or workers experience issues
Section 3 - Action taken to improve FTSU culture
Section 4 - Learning and improvement
Section 5 – Recommendations

3. CONCERNS REPORTED IN 2018/2019

Section 1 - The Assessment of Issues

The table below states the number and types of cases being dealt with by the Guardian and the FTSU ambassador volunteers since the first concern being raised:-

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
Apr – June 2018	2	0	2	1
July – Sept 2018	3	0	1	2
Oct – Dec 2018	4	3	1	2
2018 Total	9	3	4	5

Albeit a very small sample of data, in 2018, colleagues in roles such as Nurses and Allied Healthcare professionals were more likely to speak up than others.

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
Jan – Mar 2019	9	7	2	0
Apr – 22 June 2019	18	5	4	2
2019 Total	27	9	6	2
Overall Total	36	12	10	7

Since 2019 there has been much more diversity in colleagues raising their concerns from porters, clerical assistants, practice managers, theatre orderlies, nurses and apprentices.

The Trust has developed its own on-line system for staff to register and record their concerns. An accessible FTSU portal was introduced in October 2018. This portal can be accessed via the intranet at home or in work. The portal intranet button is shaded in green in order that it is easily identifiable. There is an option to raise concerns anonymously via the portal. The portal is easy to use and allows colleagues to provide as much or as little information as they require to share. The Guardian then picks up the concern and ensures the FTSU process is activated.

Upon introduction of the portal there has been an increase in concerns being raised. This is likely as a result of the communications campaign, the increase in FTSU ambassadors and the introduction of the portal.

Upon appointment of the new Guardian, concerns have increased 100% with the anonymous concerns reducing by 50% compared to the previous quarter.

Section 2 – Potential patient safety or workers experience issues

Each concern raised has been treated with respect and care, with regular confidential communication with the colleague who has raised their concern and confidential discussions with the leaders responsible for the particular department where the concern has been highlighted. Some investigations have found that there are necessary actions that need to be undertaken to improve patient, care, quality or safety. The Guardian will ensure these concerns are followed up to ensure those lessons learned are implemented and embedded.

The Guardian intends to triangulate learning and data through relevant management meetings, to identify opportunities to learn and improve. This activity will be implemented in September 2019.

Section 3 - Action taken to improve FTSU culture

Specific work has been conducted over the past year to improve FTSU culture, specifically concerning visibility of the FTSU ambassadors. There are 26 ambassadors across the Trust. Increasing the visibility of the FTSU concept within all services and increasing accessibility. Our volunteer ambassadors hold a number of different roles in the organisation as well as being spread across the Trust footprint/geography.

The Guardian and the ambassadors' pictures have been promoted through CHFT weekly, twitter, screensavers and have a section on the intranet, with the aim of creating a more personal connection with Freedom to Speak up.

Promotional posters not only emphasise the role of the FTSU ambassador team, but the role and responsibility of everyone in the organisation, which is consistent with NHSI recommendations published in May 2018.

The FTSU Guardian is present at each corporate induction, Trust conferences ie wellbeing and attends management meetings to promote listen, learn, no blame. The intention is for FTSU ambassadors to take on this responsibility in the future.

A FTSU portal was introduced in October 2018. This portal can be accessed via the intranet at home or in work. The portal intranet button is shaded in green in order that it is easily identifiable. There is an option to raise your concern anonymously via the portal. The portal is accessible, easy to use and allows you to provide as much or as little information you require to share. The Guardian then picks up the concern and ensures the FTSU process is activated (ie the colleague is contacted) within 48 hours.

Findings from the CQC inspection in 2018 highlighted that to be a Guardian, a certain level of independence from the board is required. In response, budget was approved to recruit a Freedom to Speak up Guardian/Equality, Diversity & Inclusion Manager. The appointment of the Guardian came into effect 25 March 2019 and since then due to efforts increasing communication and visibility of what the Guardian is there do to, concerns have started to increase.

The CHFT BAME steering group highlighted it may be beneficial to create a 'Talk in Confidence' group to encourage Black & Minority Ethnic (BAME) colleagues to speak to other BAME colleagues to share their experiences.

The Guardian held an ambassador workshop to open debate regards to the skills, knowledge and capability of ambassadors and understand what they need to be a 'Speaking up Ambassador'. The workshop highlighted the need for additional, accessible resources regarding the role and signposting, which is all held on the ambassador section on the Freedom to Speak up section of the intranet.

The Trust has implemented a range of 'speak up channels' ie:

- Ask Owen – 'you can ask the chief executive anything' - Almost 100 questions have been responded to. Questions come from all divisions and most staff groups, from HCAs to consultants. They are wide-ranging and cover various topics affecting both staff and patients. They include: uniform provision, training, shuttle bus service provision and car parking. Some suggested improvements for patients such as introducing a water fountain for physiotherapy patients in the hospital gym.
- Staff Survey
- Datix – incident reporting
- Talk in Confidence

The plan is that these speaking up channels complement one another and work together in partnership with FTSU to drive continuous improvement and positive change.

Section 4 - Learning and Improvement

Since the new Guardian has been appointed there has been a diverse range of concerns raised from patient appointment letter issues, colleagues feeling they don't fit in within the team, the way a certain doctor in a department speaks with their patients to porter establishment in A&E, information governance and labelling of medicines.

Each concern has been fairly investigated, each concern has highlighted lessons that can be learnt and action plans to implement those lessons learnt have been developed. The Guardian going

forward intends to implement a follow up process 4 weeks after the concern has been closed, to ensure we are delivering on our promises.

There are no clear themes coming from the concerns relating to concerns being raised, concerns in neither one particular department nor one particular grade. Themes will be closely monitored.

Section 5 – Recommendations

It is appreciated that there is a lot of work to do in order to ensure that 'everyone' in the Trust is fully aware of the context behind FTSU, who the FTSU team are and the FTSU process.

The work described in the paper regarding enhanced communication campaigns, increased ambassador recruitment and also the implementation of the FTSU intranet portal provides a strong foundation for embedding the FTSU principles in the Trust. The efficacy of these increased efforts appears to be contributing to a rising use of FTSU which is being monitored.

Within the next 6 months recommendations are:-

- Enhance communication and visibility of the FTSU team
- Provide additional support/material for the FTSU team
- Ensure FTSU and the EDI agenda work together to ensure the process is inclusive and that barriers around 'speaking up' are removed for under represented groups
- More information added to the FTSU intranet pages
- Sharing case studies, lessons learnt, actions taken, improvements made
- FTSU guardian is to work with the Medical Director and Guardian of Safe Working Hours in order to enhance the support for junior doctors
- The Guardian has received feedback that colleagues would feel more comfortable approaching an ambassador if they were grades 2, 3, 4. The Guardian will be working with 'front line colleagues to promote the FTSU ambassador role to hopefully enhance the ambassador pool at this level
- The development of an FTSU Long Term Plan - in line with the NHS Improvement recommendation for a Trust wide FTSU strategy including a review of the FTSU policy (this work will be done in partnership with the Trust's trade unions)
- The FTSU team to deliver 'Listen & Learn Surgeries'
- Continue to submit quarterly data to the NGO
- Continue to be part of the Regional FTSU team

Next 12 Months

- The FTSU team will aim to support all student nurses, trainee nursing associates and trainee AHPs who gain placements within the Trust, ensuring they are fully aware of FTSU processes and routes to raise concerns
- Develop an FTSU report in December 2019 for CHFT colleagues which will share case studies, what improvements have been implemented as a result of the FTSU channels being utilised and how the listen and learn culture is making a difference in the Trust
- Ensure that learning from FTSU is incorporated into developing patient safety processes.
- Work together with the Ask Owen/Datix team to enhance the 'speaking up' channels
- Analysis of NGO case studies and recommendations identified are discussed within the FTSU team and recommendations for action will be taken as a result of these discussions

4. CONCLUSION

The Board of Directors is asked to note the content of this report.

Nikki Hosty, FTSU Guardian
21 June 2019
Appendix 1

FTSU National Statistics – 2018 data

A total of 7087 cases provide an average of 30 cases per Trust (based on 234 Trusts).

Trust Type	Total	Average per trust type
Acute	2941	30
Acute Specialist	259	15
Ambulance	181	18
Combined Acute and Community	1662	43
Combined mental health / LD / community	1015	34
Community	480	28
Mental Health / LD	549	24
Total	7087	30

Size comparisons are provided in terms of Trust reporting in the NGO report and are provided below.

Trust size	Number of cases	Average per Trust
Small (up to 5,000 staff)	3088	25
Medium (5,000-10,000 staff)	2960	35
Large (10,000 + staff)	1039	38
Total	7087	

Comparison between Trust CQC ratings:

Within the annual data report, the NGO provided a comparison for reporting of concerns against CQC rating; high level results are demonstrated in the table below. The NGO found that there was no correlation between trust rating and number of FTSU cases, however have explained that they intend to continue to monitor this.

Trust Rating	Number of cases	Average per Trust
Outstanding	626	39
Good	3057	28
Requires improvement	3103	32
Inadequate	297	37
No published rating	4	4
Total	7087	

The NGO data report for this period is that 6 Trusts did not record any cases of speaking up throughout the year. These are:

- Black Country Partnership NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- London North West Healthcare NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- Walsall Healthcare NHS Trust

In the annual data report the NGO have stated that they have raised this point with regulators and requested that they take appropriate action to support these Trusts.

Who is speaking up?

Profession	2018/19 - % recorded cases
Nurses	31%
Allied Health Professionals	13%
Administrative / Clerical workers	16%
Healthcare Assistants	7%
Doctors	6%
Other*	11%
Corporate Service Staff	5%
Cleaning/catering/maintenance/ancillary staff	5%
Midwives	3%
Board members	<0.5%
Dentists	<0.5%

*includes health visitors, psychologists, psychotherapists and anonymous reports.

Potential patient safety or workers experience issues

Within national reporting, the NGO have demonstrated that more issues are raised through FTSU concerning staff experience than patient safety;

Theme or experience	% reported Nationally
% of Patient Safety Concerns	2266 (32%)
% of Bullying / Harassment Concerns	3206 (45%)
% reported anonymously	1254 (18%)
% who reported perceived detriment	361 (5%)

Between 1 April 2017 and 31 March 2018 national FTSU reporting demonstrated:

- 7087 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions in Trusts and FT's.
- 2266 of these cases included an element of patient safety / quality of care.
- 3206 included elements of bullying and harassment.
- 361 related to incidents where the person speaking up may have suffered some form of detriment.
- 1254 cases were raised anonymously.

Feedback

Given your experience would you speak up again	
Answer	**% reported Nationally**
% stated 'Yes'	2077 (87%)
% stated 'No'	84 (4%)
% stated 'maybe'	108 (5%)
% stated 'don't know'	114 (5%)

Case review

In the past year, five case reviews in total have been conducted in: Southport and Ormskirk, Northern Lincolnshire and Goole Hospital, Derbyshire Community Trust and Nottinghamshire Healthcare NHS Foundation Trust. A further case review pertaining to the Royal Cornwall Hospital is due to be published shortly.

Each case review can be found upon the NGO website which is hosted by the CQC.

The case review published since the previous CHFT Board report is at Nottinghamshire Healthcare NHS foundation Trust. The NGO's review makes 13 recommendations for how Nottingham Healthcare NHS Foundation Trust to improve how it can support its staff.

The CHFT FTSU Guardian will ensure going forward as part of the FTSU Approach that NGO case reviews are discussed with the FTSU team and discussions will be held in respect of what learnings/actions our Trust can take on board.

The National Guardians Office recommendations will be integrated into both the CHFT FTSU Long Term Plan and EDI Approach.

12. High Level Risk Register

To Approve

Presented by Jackie Murphy

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Andrea McCourt, Head of Governance and Risk
Previous Forums:	The high level risk register has been reviewed by members of the Risk and Compliance Group at meetings on 7 May and 10 June 2019.

Actions Requested:
To approve

Purpose of the Report

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 as at 21 June 2019.

Key Points to Note

Movement on the high level risk register since it was presented to the Board in May is summarised in the attached paper. In brief 5 new risks have been added to the high level risk register, which are:

Risk 7454, a Radiology staffing risk has been added by the Family and Specialist Services Division scored at 20.

Risk 7062, a Corporate risk (Finance) on the capital programme has been added at a risk score of 16.

Risk 6493, a Corporate risk (Quality) re: complaints management and quality and performance has been added at a risk score of 15.

Risk 7474, a Trustwide risk relating to medical devices has been added at a risk score of 15.

Risk 7251, a Surgery and Anaesthetics risk relating to the Optovue OCT machines has been re-added at a score of 15.

Further detail on each risk is given in the enclosed paper.

There are no risks with reduced or increased scores and 2 risks have been closed due to progress in mitigating the risks, with detail given in the paper.

These are:

- 7396 - risk of inadvertent connection to air
- 7132 - Emergency Department NEWS score risk

There remains ongoing discussions regarding the score of the new medical device risk, risk 7474 and staffing risks 7078 (medical staffing) and 6345 (nurse staffing), the latter two due to mitigation of the risks.

Any changes on these scores will be reported to the Board at its meeting in September 2019.

EQIA – Equality Impact Assessment

No significant impact.

Recommendation

Board members are requested to:

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

High Level Risk Register Board Summary – July 2019

Risks at 21st June 2019

TOP RISKS

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

7278 (25) Longer term financial sustainability risk
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
7454 (20): Radiology Staffing Risk !

The Trust risk appetite is included below.

NEW RISKS

7454 Score (20) FSS

Radiology staffing risk

This risk relates to Radiology service provision due to a reduction in consultant capacity resulting in gaps in some specialist areas, a reduction in overall general capacity and the potential for breaching national targets.

7062 Score (16) Capital Programme

Risk that the Trust will have insufficient funding available to complete its planned capital programme. This risk was added following discussion at the Finance and Performance Committee in June 2019 following discussion of a paper on the capital progamme.

6493 Score (15) Corporate Quality

Complaints Management - Quality and Performance Risk

This risk is that the Trust does not respond in a timely way to complaints and breaches NHS Complaints Regulations 2009 due to complaints responses not being investigated and drafted within agreed timescales, staff not recording all complaints investigations on Datix and not updating complainants in a timely way, resulting in dissatisfaction for complainants due to poor communication, delays in responses, poor performance on complaints responsiveness identified within the integrated performance report, reputational damage, increasing number of complaints referred to the Ombudsman

7474 (Score 15) Trustwide

Equipment failure from Medical Devices

This risk relates to out of service medical devices being in circulation and use across CHFT due to the lack of assurance that the Trust asset register is comprehensive resulting in potential patient harm.

7251 (Score 15) SAS

Optovue OCT (Ocular Coherence Tomography) machines risk

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

This risk has been on the high level risk register previously, in September 2018 when it was added at a score of 15 and was reduced in February 2019 to 12 as the OCT image archive storage was temporarily upgraded to give the department space until the OCT infrastructure is replaced. The score increased to 15 in May 2019 due to the OCT machine failing and 8 patients had to be cancelled 30/4/2019 and ongoing problems with the OCTs taking 45 mins to perform and save.

RISKS WITH REDUCED SCORE

None

CLOSED RISKS

7396 (Score 15) Risk of inadvertent connection to air

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

This risk can now be closed as the risk has assurance all airflowmeter have been completely removed from clinical areas and all areas are permanently capped (other than Paeds) or fitted with semi permanent caps. The trust had purchased electric nebulisers

New risks will be added to the risk register for the Paediatric caps and the Air/Oxygen training

7132 (Score 16) Emergency Department NEWS score risk

There is a risk to patient safety due to EPR system not automatically calculating and recording the score.

Since NEWS 2 has been implemented there have been no incidents - the NEWS score now calculates on EPR.

June 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 14/06/2019

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Jan 19	Feb 19	Mar 19	April 19	May 19	June 19
Quality and Safety Risks										
10/19	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
09/19	5806	Keeping the base safe	Urgent estate work not completed	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
05/19	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
10/19	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
08/19	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)	=16	=16	=16	=16	=16	=16
11/19	7248	Keeping the base safe	Mandatory Training	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
05/19	7338	Keeping the base safe	EPR Risk	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
06/19	7315	Keeping the base safe	Out patient appointments capacity risk	Director of Operations, FSS (RA)	=15	=15	=15	=15	=15	=15
06/19	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (JM)	!15	=15	=15	=15	=15	=15
06/19	3793	Keeping the base safe	Opthalmology follow up appointment capacity risk	Divisional Director of SAS (WA)	!16	=16	=16	=16	=16	=16
05/19	7345	Keeping the base safe	Referral to the District Nursing Service	Director of Nursing (JM)				!16	=16	=16
09/19	7414	Keeping the base safe	Buidling safety risk	Director of Finance (GB)				!15	=15	=15
10/19	7413	Keeping the base safe	Fire compartmentation at HRI	Director of Finance (GB)				!15	=15	=15
13/19	7253	Keeping the base safe	Paediatric staffing Risk	Director of Operations, FSS (GH)					!15	=15
08/19	**6493**	**Keeping the base safe**	**Complaints Quality and performance Risk**	**Director of Nursing (JM)**					**!15**	**=15**
10/19	7454	Keeping the base safe	Radiology staffing risk	Director of Operations, FSS (GH)					!15	↑ 20
06/19	**7474**	**Keeping the base safe**	**Medical Devices Risk**	**Director of Finance (GB)**						**!15**
06/19	**7251**	**Keeping the base safe**	**Optovue OCT (Ocular Coherence Tomography) machines risk**	**Divisional Director of SAS (WA)**						**!15**

FINANCE RISKS										
10/19	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
10/19	**7062**	**Financial sustainability**	**Funding of capital programme**	**Director of Finance (GB)**						**!20**

WORKKFORCE RISKS										
10/19	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20
10/19	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (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

Board Assurance Framework risks referenced above.

05/19	*Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's EPR due to lack of optimisation of the system.*
06/19	*Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.*
08/19	*Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.*
09/19	*Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.*
10/19	*Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.*
11/19	*Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future*
13/19	*Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention*

TRUST RISK PROFILE AS AT 21/06/2019

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation =7253 Paediatric staffing ! 6493 Complaint management ! 7251 Optovue OCT Risk	= 6345 Nurse Staffing = 7078 Medical Staffing ↑7454 Radiology staffing	=7278 Financial sustainability
Likely (4)				=7223 Digital IT systems risk =7248 Mandatory training =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity =7345 District Nurse Referral Risk ! 7062 Capital programme	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed =7315 Appointment Risk
Possible (3)					= 5747 Vascular /interventional radiology service =7338 EPR =7413 Fire compartmentation HRI =7414 Building safety risk !7474 Medical Devices Risk
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may	**SEEK**	**SIGNIFICANT**

	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.		
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, Risks 15 or > as at 21 June 2019
Board Meeting 4 July 2019
Quality Committee 1 July 2019

June 2019

The Health Informatics Service
Informing Healthcare

Risk No	Div	Dir	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
7278	Corporate	Finance and Procurement	Trustwide Finance	Jun-2018	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £37.99m (as per the NHS Improvement 19/20 control total). Acceptance of this control total gives the Trust access to £6.15m MRET funding, £7.33m Provider Sustainability Funding (PSF) and £14.81m Financial Recovery Funding (FRF), reducing the planned deficit to £9.71m. The receipt of PSF and FRF are dependant on achievement of the control total. The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raised 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. No additional revenue costs have been included for the development of the Reconfiguration Business Case.	25 5 x 5	25 5 x 5	20 5 x 4	Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case for reconfiguration due for submission in April. Capital plan for 19/20 includes £4m relating to reconfiguration and the development of the Business Case: £3m for HRI and £1m for Fees. Stretching CIP target of £11m (3%) for 19/20 reflects the fact that the Trust needs to find greater efficiencies than the baseline incorporated within Tariff as part of its journey towards financial sustainability. The target is in excess of the minimum expected of 1.6% (1.1% national efficiency factor plus 0.5% additional requirement for Trust's in deficit).	Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case for reconfiguration due for submission in April. 2019/20 Financial plan has been submitted to NHS Improvement and the Trust has submitted a plan that accepted the Trust's allocated control total of £37.99m. This will allow the organisation to access non-recurrent MRET funding of £6.13m, Provider Sustainability Funding (PSF) of £7.33m and Financial Recovery Funding (FRF) of £14.81m reducing the overall planned deficit to £9.71m.	July -2019	Mar-2020		FPC	Gary Boothby	Philippa Russell
7062	Corporate	Finance and Procurement	Corporate Finance	Sep-2017	Financial sustainability	Risk that the Trust will have insufficient funding available to complete its planned capital programme	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.	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. No additional revenue costs have been included for the development of the Reconfiguration Business Case.	20 5 x 4	16 4 x 4	6 3 x 2	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.	Capital Plan has been reduced to £20.20m, but this is still £12m more than internally generated: • £3m agreed PDC funding for National Pathology Exchange (confirmed as approved) and Energy Efficiency scheme (awaiting final confirmation) • £5m emergency capital bid to fund MRI £3m and Cladding £2m, yet to be approved, (assumed as Loan funding) • £4m of the £197m SOC case – provisional split of £3m for HRI and £1m for fees (assumed as Loan funding) • Internally generated relies on sale proceeds from Acre House and Glen Acre House at £1.7m (net) Since the initial plan submission the internally generated capital funding has been reassessed based on asset revaluation and has had to be constrained by £1.4m, significantly reducing the contingency allowed down to £0.3m. The external capital funding is not secured at this stage and the likelihood given an oversubscription of capital resources nationally is that the Trust will be asked to further reduce its plans. In this context it was proposed that the risk is increased to 16 (Likelihood 4 x Impact 4). Confirmed by Finance & Performance Committee on 31.05.19.	Jul-2019	Mar-2020		FPC	Gary Boothby	Philippa Russell

2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	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	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	Limited Contingency available. Uncertainty regarding long term capital planning while FBC is awaiting approval. The Trust has planned capital expenditure for 19/20 of 20.2m, £12m more than available internally generated capital funds of £9.33m. Only a very small contingency of £0.3m is included. Some elements of the Capital plan are reliant on securing external funding through a combination of Public Dividend Capital and capital loans.	20 4 x 5	20 5 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	**May / June 2019** Rotas have been reviewed and planned for implementation in August. Further ST3 (specialty trainee) level trust doctor posts have been shortlisted. Discussions ongoing with another agency locum regarding transfer to Bank	July 2019	Aug-2019		WEB	David Birkenhead	Dr Mark Davies
5806	Calderdale and Huddersfield Solutions	Estates	Estates Department	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks identified within the Estates Risk Register being: • 7220 Flooring: cracked, torn, blown flooring screed and vinyl resulting in possible slips, trips, falls • 6734 Pipework: Potential of water borne diseases due to the corrosion of services pipe work • 6735 Structural: if more openings are made through the structure it will make the building unstable. • 6736 Air Handling Units: non-compliance, & increased infection risk to both patients and staff • 6737 Windows: all elevations of the Hospital require replacing, prone to leeks and very drafty • 6739 Roofs: water ingress through roofs resulting in decanting services, wards and departments. • 6761 Ward Upgrade Programmes: Compliance with regulatory standards - Health & Social Care Act • 6762 Day Surgery: Non-compliance with relevant HTM	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 risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	12 3 x 4	• Monitoring of the estate structural and infrastructure through annual report • Ongoing programme of works	**JUNE 2019** Work has now commenced on developing the Estates Strategy for Huddersfield Royal Infirmary. This work stream will use the 6-facet survey and external consultancy to develop the strategy. Capital work continues to progress with live schemes on fire safety, pipework and critical infrastructure.	Jul-2019	Mar-2020		RC	Gary Boothby	Paul Gilling / Chris Davies

						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													
6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in:	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - staff redeployment where possible - nursing retention strategy	Low numbers of applications to nursing posts across grades and specialities	16 4 x 4	20 4 x 5	9 3 x 3	• Recruitment including international recruitment of Nurses • Nursing associate role development • Developing nursing retention strategy • Use of flexible workforce	**JUNE 2019** **Utilising the safe care tool effectively to address risk in real time and ensure appropriate skill mix to care for patients** Risk score being reviewing by senior nurse managers. April 2019 update Applicants from the Philippines continue to progress (119 offers were made in country, since March 2017, with on-going training and tests underway), 15 Nurses have started with the Trust, 4 are currently going through the visa process and 61 still engaged in the recruitment process. From the nursing associate role is adverted in	July 2019	July-2019		WF	Jackie Murphy, Suzanne Dunkley	Rachael Pierce

						- 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	- flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - Active recruitment activity, including international recruitment - Introduction of new roles e.g. Nurse associate						January, 4 offers are being progressed by recruitment with 1 starting in April. Hard Truths report presented to January 2019 Trust Board.						
7078	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Oct-2017	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	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	• Monitored by Medical Workforce Group • Active recruitment including international	**JUNE 2019** An appointment has been made for a Consultant in Emergency Medicine following the AAC 4 June 2019. A second applicant was unable to attend due to personal reasons but is still interested in joining CHFT and a new date is being identified to interview this candidate. The Medical HR team have now received the names of all the new doctors in training that will commence in post in August. A number of trainees have already been cleared to commence in post in August and the majority of work schedules have been sent ahead of the national deadline. Rota reviews have been undertaken and some changes have been adopted following feedback from the trainees working the actual rota. New rotas will begin in August 2019 for Trainees in medicine at FY1, FY2 and CT1 and CT2 level. Additionally, new rotas have been introduced in Obstetrics and Gynaecology and Trauma and Orthopaedic Surgery. ESR reports have shown that the number of medical and dental vacancies has reduced from a total of 72 FTE in June 2018 to a total of 53 FTE in June 2019. The Fixed Term Consultant in Interventional Radiology commences in post in June 2019. He will be shadowing the current Interventional Radiologist initially as part of his induction to the Trust and the UK.	July-2019	Sep-2019		WF	David Birkenhead	Pauline North
7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in consultant capacity resulting in gaps in some specialist areas, a reduction in overall general capacity and the potential for breaching national targets.	- Agency locum cover. - NHS Locum cover. - Additional support from external providers. - Short term support from adjacent Trust. - Head and neck: Additional support from external providers and short term support from adjacent Trust. - Lung and chest: Additional support from external providers and temporary change to job plans. - IR: Agency locum cover. - Neuro: Additional support from external providers and temporary change to job plans.	Vacancies in: - Head and neck: No vetting or requests Monday, Tuesday and Thursday. No on-site cover Monday, Tuesday and Thursday. - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap during annual leave/other leave of one remaining Consultant. - Breast: Reduced capacity and no capacity during annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave.	15 3 x 5	20 4 x 5	0 0 x 0	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all areas. - Actively seeking two radiology overseas fellows. - Successfully recruited one head and neck Radiologist (due to start July 2019). - Successfully recruited one IR Radiologist (due to start June 2019). - NHS locum position offered to one breast Radiologist.	**JUNE 2019** IR radiologist commenced 10th June 2019 (as NHS locum, fixed term) but existing substantive leaves the organisation on the 28th June Breast radiologist accepted NHS locum fixed term contract (12 months) and is due to start on the 19th August 2019.	July-2019			PSQB	Gill Harries	Sarah Clenton

							- General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Impact on the general on-call rota.									
7223	Corporate	THIS	THIS -Operational	Mar-2018	Keeping the base safe	Risk of inability to access all clinical and corporate digital systems due to the lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc.) Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in inability to effectively treat patients and deliver compassionate care, not achieving regulatory targets and loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc.) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 x 4	16 x 4	8 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).	April 19 Awaiting Divisional/Trust testing of BCPs. Conversations underway with Divisional colleagues. **JUNE 2019** TTE Carried out around EPR on the 11th of June. This raised some further concerns around how prepared clinical areas are for any downtime. There is an planned downtime in early July (10th) where these plans will be tested again and this risk can be reassessed - No change in the current score.	July-2019	Oct-2019		RC	Mandy Griffin	Rob Birkett
7248	Corporate	Organisational	Workforce Development	Apr-2018	Developing our	Risk that not all colleagues will complete their designated essential safety training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts. The proposal has been agreed for 2019/2020. Impact: - Colleagues practice without a basic, or higher	All electronic e-learning training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on	None	16 x 4	16 x 4	4 x 1	January 2019 Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support. Additional training dates have been added for safeguarding and MCA/DoLS level 3. There are sufficient places to train ALL staff	**JUNE 2019** The work identified above is continuing but the completion date has been put back to the end of July 2019. This is due to some technical issues identified in the process - the Workforce BI Team have raised these with the ESR Functional Advisor and IBM. Additional DSA classroom sessions have been attended to raise compliance in this subject.	July-2019	Mar-2020		WF	Suzanne Dunkley	Claire Wilson

						depending on role/service, understanding of our essential safety training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 essential safety training subjects alongside the 29 role specific essential skills training. This approach strengthens the importance of completing the essential skills designated to specific roles and by combining the two areas into one enhances the Trust's requirement to reach 95% across all the competency offerings. Risk:- There have been issues with ESR and the consequences of not being able to undertake e-learning. ESR was down for 15 days from 31 December 2018 - 14 January 2019. Impact:- Employees have been unable to access ESR to undertake e-learning and in turn affects our ability to reach and maintain 95% compliance.	performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.					who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.							
3793	Surgery & Anaesthetics	Head and Neck	Ophthalmology	May-2017	Keeping the base safe	Risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 3 x 2	16 4 x 4	3 1 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) Appointment made, anticipated start date July 2019 - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	April 2019 - Corneal Consultant appointed - prioritisation of holding list patients over New referrals - triaging of all referrals to minimise incorrect out patient appts **MAY/JUNE 2019** No change	July-2019	Dec-2019		DB	Will Ainslie	Pnt Laloe

7345	Community	Community Nursing	District Nursing / Matrons	Oct-2018	Transforming and improving	Patient Safety Risk - There is a risk of patients with a nursing need not being referred on discharge to the District Nursing service. Due to lack of referral facility on EPR and the discontinuation of the PASWEB referral pathway prior to the implementation of EPR. Resulting in patients not receiving district nursing care deteriorating at home and being re admitted to hospital.	Wards have been advised to contact the DN teams via telephone to make referrals on discharge. Community Division to work with the other division to test out if this process is being followed and understood. Community Division are reporting incidents of non referral on to Datix to enable monitoring	System has not yet been tested	16 x 4	16 x 4	2 1 x 2	Directory of Community services circulated to wards and departments Ward staff encouraged to refer to District nurse via telephone E referral option being scoped Wards and discharge coordinators encouraged to invite District nurse to MDT	April 2019 Update from Digital Board. E Referral is now with the IT build team. Proposed go live date is end of June/July 2019 **JUNE 2019** Final demonstration of e referral form taking place on 21 June and testing implementation of e referral form with wards 12,17 and frailty service on 1 July 2019	July -2019	Jul-2019		PSC	Liz Morley	Caroline Lane
6829	Family & Specialist Services	Pharmacy	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 and January 19 EL (97) 52 external audit which reported 3 major deficiencies limiting its capacity to make parenteral products, resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be implemented before October 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition, update the product catalogue, and from May 2020 - outsource radiopharmacy (buy in MDVs of radioisotopes)	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	15 3 x 5	16 4 x 4	3 3 x 1	Agreed Action Plan October 18 to reduce capacity at HRI ADU i - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit. Delays in project have delayed the temporary closing of the CRH unit to October 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in. Target 100% by Aug 19. Phasing in of ready to use chemo batches also underway.	**JUNE 19** Aseptics progress reported at June Divisional PRM. Aseptic Staffing in new model reviewed to ensure meet the required QA standards. Financial costs have increased from original feasibility study. Project has been delayed due to procurement process issues initially and more recently due to extra estates works (air extractors/ planning permission). New target date for opening June 2020. Aseptics managers continue to work on EL audit action plan to ensure necessary quality standards are reached.	Jul-2019	Jun-2020		DB	Jackie Murphy	Elisabeth Street
7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Keeping the base safe	HRI There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete	Number of Areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard.	**June 2019** 1) A number of fire risk assessment have been carried out at CRH on Wards 1, 2, 3 and 4. 2) 90% Sockets completed at HRI & message to be communicated Trust wide relating to the reason for the additional sockets (LOWs) 3) Toaster replacement at HRI complete 4) Fire Risk Assessment programme being explored with CHS and Fire Safety AE 5) WOD providing support to identify those who have received fire warden training across CHFT	July-2019	Dec-2019		FC	gary boothby	Alison Wilson

							• Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher						to cross reference with Departments **May 2019** CRH - New sockets are being installed to charge LOWs to help keep the corridors clearer. HRI - Compartmentation survey to assess 60 minute commenced 3th May, additional sockets for LOWs - 50% complete, toasters are 50% complete CHFT Fire Training - Medical & Surgical divisions have booked 15 extra Fire Warden training sessions, ISS have booked 2, Community have booked 1, with possibly more to follow. Sessions are in addition to the "planned fire warden training" sessions already advertised. These courses all have Fire Extinguisher training. A risk has been identified relating to Fire Risk Assessment programme for CRH which is being progressed with CHS who are responsible for delivering the service.						
7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors and staff.	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	**JUNE 2019**. Report provided from engineer regarding cladding and option appraisal to be presented to Capital Management Group. Costs between £7 & £14m April 2019 - remedial works taken place on very high risk areas. Feasibility study being carried out on remaining panels (1515) on all elevations to agree a way forward. Option appraisal expected with CHS by end April 19/beginning May 19 which will be presented to CHFT.	July 2019	Dec-2019		FC	Gary Boothby	Alison ~Wilson
7474	Trustwide	All Divisions	All Departments/Wards	May-2019	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and use across CHFT due to the lack of assurance of the Trust Asset Register being up to date including equipment which has been gifted or bought without CHS involvement resulting in potential patient harm. CHS Risk 7438 –(Rating 20) - There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, resulting in potential patient harm CHS Risk 7438 –(Rating 20)	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.	Failure to manage, maintain and service medical devices.	5 5 x 1	15 5 x 3	1 1 x 1	March 2019 CHS to prioritise High Risk devices in the first instance, then progress to Medium and Low. Push out a list of High Risk Devices to departmental leads, IOT expedite the identification and testing process. In the first week since this risk was identified, 10% have been identified and serviced, CHS have identified a number of other devices that have been done but are awaiting update and some that are due to be disposed of or have already been sent for repair. As CHS have moved into a new month the number has risen again as more equipment goes out of date. 2019/04/15-Update- Numbers are falling slowly • High risk (728 to 691), • Medium risk (2617 to 2621),	**JUNE UPDATES** **June 2019** A number of devices have been identified as not managed on eQuip and not maintained these items include Beds, Hoists, Chairs and other devices, these are now being added to eQuip and service and maintenance is being arranged. **May 2019** High Risk numbers continue to fall High risk (592 to 574), Medium risk fell (2612 to 2488), Low risk fell (1987 to 1824), a total of (5195 to 4886). More High risk are to be tackled next week during theatre audit, SLA provide to tackle all outstanding work and visits to be published to ensure greater attendance, however recently an in use anesthetic device was identified as faulty during maintenance programmed due to this risk. The device was overdue service by in excess of 3 years, this has now been rectified awaiting department to raise Datex.	July-2019	October 2019		RC	Jackie Murphy	Robert Ross

						CHFT Risk 7474 (Rating 20)						• Low risk (1973 to 1918), a total of (5318 to 5230) Considering that the number increases daily as more equipment goes out of date CHS consider this as significant progress especially with respect to High risk devices. Locating devices has proven to be a problem in most areas. May 2019 Update Locating devices has proven to be a problem in most areas. 2019/05/09-Update-Numbers are falling slowly for High risk (691 to 643), Medium risk rising (2621 to 2635), Low risk rising (1918 to 1956), a total of (5230 to 5234) the number has risen slightly due to the time taken to complete high risk work taking longer as it is generally more complex equipment and the time put aside to investigate and locate equipment. There are another 324 maintenance events planned this month as well as the extra work to catch up we have recruited to a vacant post, which will aid in reducing the amount of high risk and employed a member of flexible workforce to assist with the low risk work. 2019/05/17-Update-High Risk numbers continue to fall High risk (643 to 592), Medium risk fell (2635 to 2612), Low risk rising (1956 to 1987), a total of (5234 to 5195) 2019/05/21-Update Contract meeting held with SLA provider Mid York's now in agreement with them to complete outstanding work, problem identified individuals within CHFT retaining un-serviceable medical devices within community(this will be stopping have instructed Mid York's to remove devices), a forecast of dates for servicing will be pushed out to community. Feedback on good progress has reduced the likelihood from 4 to 3. (28th May 2019) As agreed by DoN (J Murphy) and DoF.							

5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1wte substantive consultant in post - Ad-hoc locums supporting the service - Continue to try to recruit to vacant posts	- Failure to secure long term locum support. - Lack of clarity on regional commissioning arrangements relating to vascular services	16 x 4	15 x 3	6 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response	**JUNE 2019** NHS locum in post for 12 months commenced June, undertaking a period of orientation into the UK. Substantive consultant left 21 June 2019, Working to secure a second agency locum for 2/3 months. Ongoing discussions with agency re:locum on-call, Leeds and Bradford regarding on-call cover. **April 2019 update** -substantive consultant in post -ad-hoc locums supporting the service as no cover agreed with Leeds or Bradford - NHS locum for 12 months due to start in June 2019 - regional reconfiguration project will establish longer term solution although no definite timescales to date.	July 2019	October - 2019		DB	Gill Harries	Sarah Clenton
7315	Family & Specialist Services	Appointment and Records	Appointments Service	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 11,000 patients awaiting appointments. circa 3500 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 8,000 follow up patients that have all exceeded the appointment due date. Please refer to following individual risks: 4050 6078 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 x 5	15 x 5	6 x 3	Monitoring of appointment backlog at Performance Meetings Validation of Holding List and Appointment Slot Issues List SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level	**JUNE 2019** New patient ASI's remain high. All specialities instructed to clear long waiters over six months by the beginning of July. Will look at managing ASI's on ERS to ensure we are working from an up to date position. SOP being developed between appointments and divisions. ASI presentation given at WEB. F/up patients exceeding there to be seen by date continues to reduce now at 5014. Continue to discuss with divisions and ensure all capacity is used to best effect.	Jul-2019	Jul-2019		PSQB	Gill Harries	Katharine Fletcher
7338	Corporate	Corporate Nursing	Workforce and Clinical Development	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	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	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'.	15 x 5	15 x 5	8 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.	**JUNE 2019** 1. Computer tags now available with a plan to distribute over the next week to all areas with PC's and laptops on wheels. 2. Figures currently 40,178. 3. Update requested from Trust Architect - unable to provide a time frame for completion. Requested assistance from other Trusts with a similar issue to provide assistance. 4. BTHFT have made minimal progress on this. No clear direction as to how they will resolve.	Jul-2019	Sep-2019		NA	Jackie Murphy	Carol Gregson/Graham Walsh

						records.	given and user guide supplied. Escalated to Data Quality Team Escalated to EPR Operation Group	No automatic prompt advising that the entry only viewable to the author.									
7251	Surgery & Anaesthetics	Head and Neck	Ophthalmology	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.	- 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) - commenced in post 13/5/19 - patients who have had their apt cancelled due to slow running of the machines have been re-booked within a week following validation from Macular Consultant Lead - should additional capacity be required to ensure patient safety this will be provided.	- 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 reporting them on Datix.	**JUNE 2019** 3/6/19 - Agreed at Risk and Compliance 10/6/19 - Clinical systems Specialist - removed anti-virus to see if this improved machine performance, check network speed to the OCT machines on the network and the servers that control the application, looked at the operating system on the OCT machines to see if any errors or improvements that could support performance. 9:30am and 2pm - seem to be peak times for drop in performance of OCT machines. The impact - machines running better for a few weeks. 7/6/19 - OCT machines running slow - 4 patients had to be cancelled Software very old, OCT system not fit for purpose and the throughput of activity within current clinics. PLAN - Install new OCT infrastructure - new OCT machines purchased and arrived on site, training to be undertaken by all staff (post grad 13/6), awaiting new computers, licenses and Imagenet software to arrive then installation will commence across the 2 sites, designing infrastructure for server networking to ensure OCT scan can be taken and linked across sites and future proofing the demand on this system (waiting for Heidelberg to present server solution ideas to fit infrastructure - expected by 14/6/19). Need to consider live testing period to ensure working properly and continuation of being able review past OCT scan for comparison. Risk likely to be resolved by end of August 19. Haag Streit contacted - suggested we have a software upgrade - done	Jul-2019	Aug-2019		PSQB	Will Ainslie	Louise Corp
7253	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Apr-2018	Keeping the base safe	Quality and Safety and Service Delivery Risk There is a risk that due to 5 WTE gaps in the 11 person Tier 2 medical staffing rota, that over the next 6 months delivery of safe care for the Paediatric and Neonatal unit may be compromised. This shortfall is likely to result in inadequate service provision for local children, young people and their families, reliance on bank and agency staff and individual's resilience both at tier 2 and Consultant level. This shortfall will impact on the Consultant workforce who may be required to cover service critical tier 2 gaps which will in turn impact on OPD activity, financial stability and individual's resilience.	Escalate and update Divisional Board and PSQB Re-worded and increased risk score Feb 2019 Actively manage roster Discussed at weekly Divisional workforce meeting out to advert for trust grade doctors Utilise ANNP workforce Out to advert for bank posts Manage sickness and maternity leave as per policy and guidance	Insufficient workforce to cover gaps	9 3 x 3	15 3 x 5	4 2 x 2	Recruitment of Trust grade doctor secure bank doctors utilise speciality doctor review rota - *removing the twilight shift from the rota following consultation with the trainees	**JUNE 2019** A further Doctor has left the programme before the end of contract to return to Pakistan with Family this has created further challenges with delivering a compliant safe rota - 6 week agency locum secured which will support gap cover. Continue to monitor at weekly Agency spend meeting. Current allocation for August is identifying 4 WTE gaps at Tier 2 level. Reviewing further solution eg employment of Specialty doctor to be part of Rota on a more permanent contract.	Jul-2019	Oct-2019		PSQB	Gill Harries	Gill harries /Eilean Crosbie

6493	Corporate	Corporate Quality	Governance and Risk Quality	Nov-2015	Keeping the base safe	Complaints Management - quality and performance risk Risk that the Trust does not respond in a timely way to complaints and breaches NHS Complaints Regulations 2009 due to complaints responses not being investigated and drafted within agreed timescales, staff not recording all complaints investigations on Datix and not updating complainants in a timely way, resulting in dissatisfaction for complainants due to poor communication, delays in responses, poor performance on complaints responsiveness identified within the integrated performance report, reputational damage, increasing number of complaints referred to the Ombudsman	Complaints response letter and report template introduced in line with PHSO clinical standard. Divisional Directors or Assistant Director of Nursing reviewing complaints in before sending to complaints team for review. . Complaints Policy details process for managing all complaints including cross divisional complaints. Quality assurance process in division and central team to ensure complaint is responded to appropriately. Escalation process of 10% complaints by division overdue highlighted to Director of Nursing. Complaints Investigation training reiterates key timescales and investigator responsibilities. complaints improvements within Governance and Risk action plan.	Medical division complaints position continues to be challenging - to be addressed through performance route also following lack of assurance to Quality Committee on 30 July 2018 re: sustained improvements. Quarterly meetings with senior complaints team and Assistant Directors of Nursing to be introduced. Investigators not routinely contacting complainants within 7 days. Quality of responses received variable Further WEB report on complaints and tracking of individual cases for September 2018	12 3 x 4	15 3 x 5	4 2 x 2	Continue to monitor overdue complaints via weekly tracker and revise risk score and actions required if improved position is not sustained. Position escalated to Chief Nurse and Chief Operating Officer and discussed with divisional teams through PRM route. External review of complaints completed by Chief Executive.	**June 2019** - Chief Executive presenting findings of deep dive into compliant handling at CHFT across all Divisions and Corporate meetings. Chief Executive is reinforcing to all colleagues his accountability and responsibility for improvement. Improvement to be assessed through 1/4rly Serious Incident Review Group. New improvement 'dashboard' developed which focuses on patient and staff experience as well as timeliness, upgrading from concern to complaint and proportion of complaints reopened. Complaint Policy being revised in line with patient and colleague feedback and national standards. Learning Lessons from Complaints work extended to include learning around process as well as care and care outcomes May 2019 - discussed at Risk and Compliance Group and agreed April 2019 Update Complaint performance has deteriorated in month. Chief Executive now leading inquiry and investigation work to understand improvement actions. Risk rating increased.	July 2019	August -2019		QC	Jackie Murphy	Anne-Marie Henshaw
6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group - lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment.	20 4 x 5	15 3 x 5	6 3 x 2	Establish clinical documentation group	**JUNE 2019** Further work required around Digital Champions requested by the Board - liaising with Leeds as they do use Digital Champions - arranging a go see. Through the Clinical Records Group and audit tool is being produced to look at the Clinical Record for data that cannot be extracted from the system to further reassure regarding the clinical record.	Jul-2019	Sep-2019		WEB	Jackie Murphy	Carol Gregson/Graham Walsh

13. Care of the Acutely Ill Patient Programme - Closing Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Care of the Acutely Ill Patient (CAIP) Programme - Closing Report
Author:	Dr Sal Uka, Associate Medical Director Dr David Birkenhead, Executive Medical Director
Previous Forums:	None.

Actions Requested:
To approve

Purpose of the Report

The paper updates the Board on the position regarding the progress and achievements made through the CAIP programme in particular the Trust's mortality measures. The report summarises this ahead of the new Clinical Improvement Group described below.

Key Points to Note

- The overall aim of the CAIP programme was to deliver a sustained improvement in mortality. Hospital standardised mortality ratio (HSMR) remains a positive outlier and summary hospital-level mortality indicator (SHMI) within the as expected range.
- This improvement has been supported by a robust mortality review programme and implementation of the learning from deaths policy.
- The six themes identified within the CAIP programme will continue albeit under a refreshed reporting and governance structure either through the Mortality Surveillance, Patient Safety or the new Clinical Improvement Groups.
- The Clinical Outcome Group will cease to meet and will be replaced by the Clinical Improvement Group.
- The aim of the Clinical Improvement Group will be to support and monitor a wider range of clinical quality improvement within the Trust.
- The Clinical Improvement Group will also host the implementation of the Trust's quality improvement strategy.

EQIA – Equality Impact Assessment

The specific work on Frailty continues to have a beneficial impact on the outcomes and experience of older patients. As the Clinical Improvement Group is established there may be opportunity for specific clinical quality improvement for patients within certain groups but the care of the acutely ill patient programme was not developed with this intention.

Recommendation

Board of Directors are asked to:
1. Acknowledge the progress and achievements made through the CAIP programme
2. Acknowledge the end of the CAIP programme and Clinical Outcomes Group
3. Support the new Clinical Improvement Group as described above.

Closing report from the Care of the Acutely Ill Patient (CAIP) Programme to the Board of Directors – 4 July 2019

Background

The Care of the Acutely Ill Patient (CAIP) Programme was developed with the overall aim to reduce mortality and improve the quality of care provided to our patients. The programme has, more recently, focussed on:

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

Programme governance arrangements have been:

- Monthly reporting into the Clinical Outcomes Group
- Quarterly reporting into the Quality Committee

Update on progress

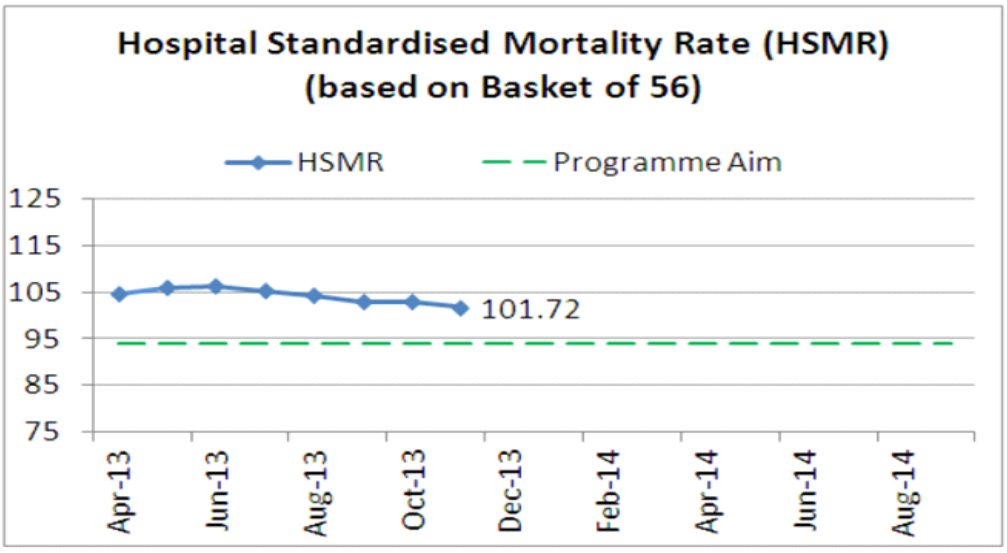
Investigating causes of mortality and learning from findings

The aim of the reducing mortality theme was to see the standardised mortality ratios, HSMR and SHMI move into the 'as expected' ranges.

At the start of the work CHFT's hospital standardised mortality rate (HSMR) was:

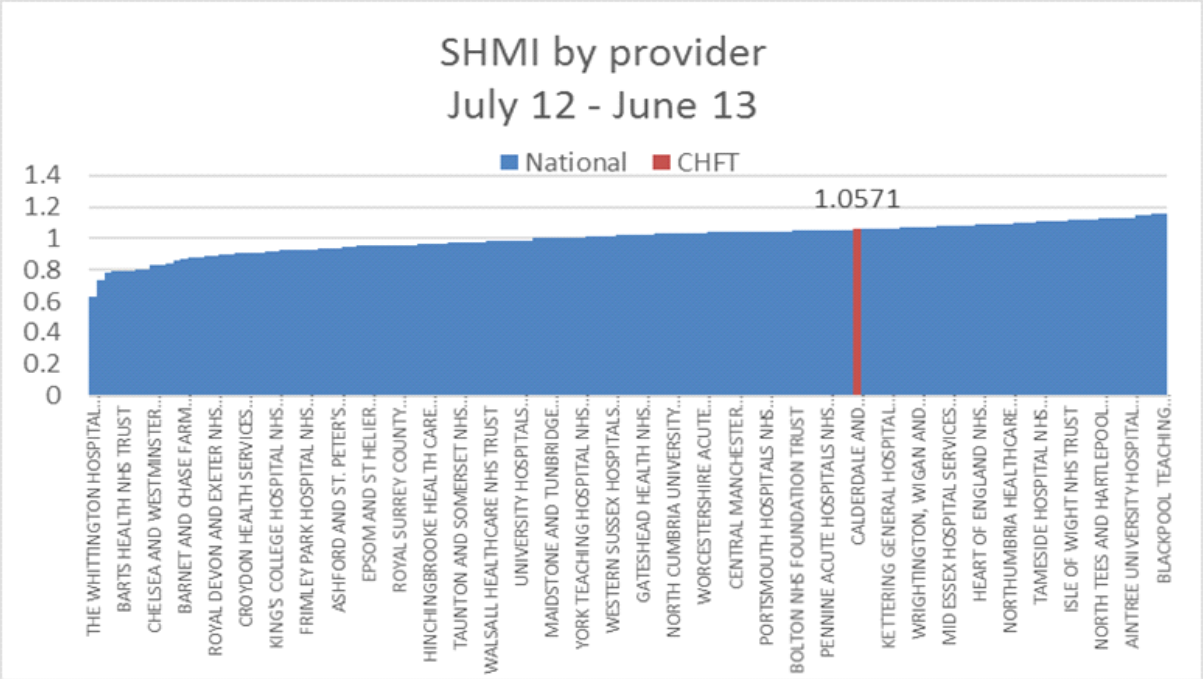
Data released on 5th February 2014 reported a rolling 12 month HSMR score of 101.7 for the time period of December 2012 to November 2013 as shown on the chart below.

HSMR data is published retrospectively; as such no more recent data is available.



At the start of the work, Calderdale and Huddersfield NHS Foundation Trust's summary hospital-level mortality indicator (SHMI) was:

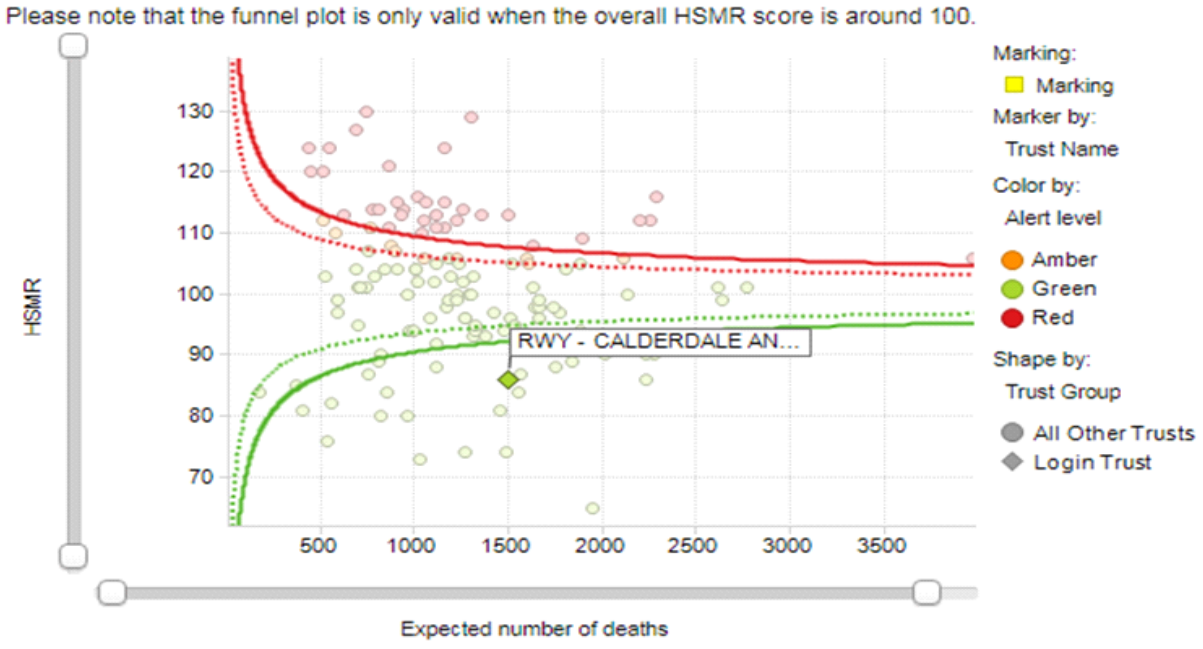
Data released on the 29th January 2014 reporting a rolling 12-month SHMI score of 106:



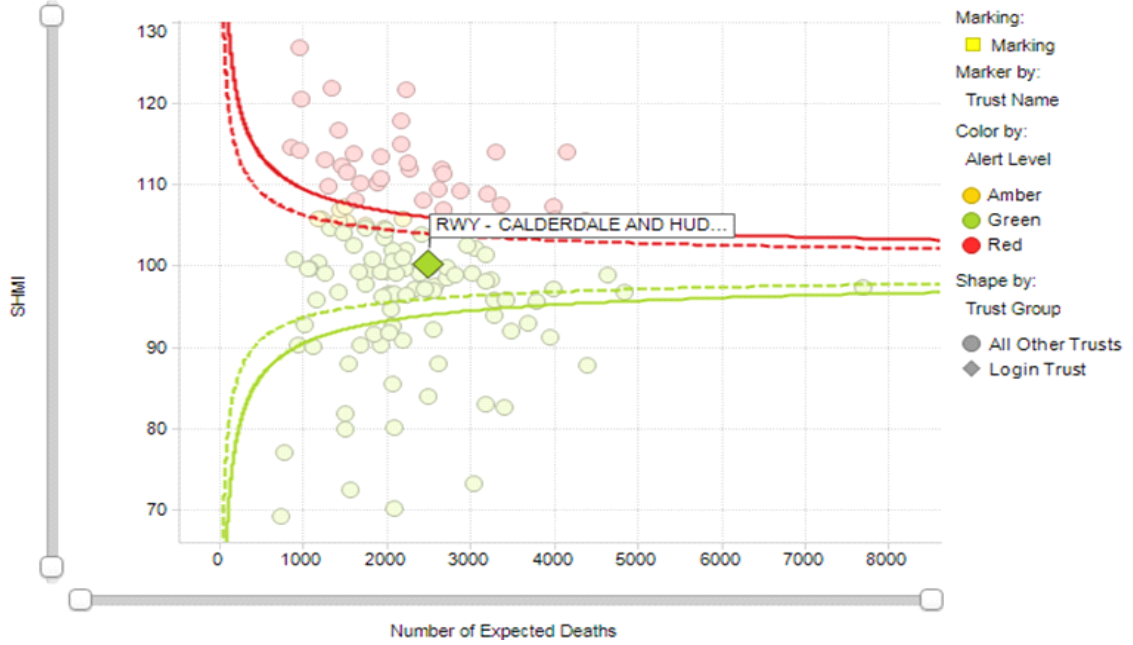
Since the start of the work there has been significant improvement in these measures as the programmes unpinning the CAIP programme delivered on their aims.

At the end of the programme, HSMR is 86 for the most recent 12 months April 18 – Mar 19 and is now performing in the 'better than expected', category.

SHMI is 100 and is performing in the 'as expected category' for the most recent release October 2017 to September 18:



Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.



June 2019 position – Standardised online Initial Screening Review (ISR) tool is available to all specialities to review deaths. The online tool feeds into the Knowledge Portal enabling anyone with access to review the overview of the ISRs. Approx. 30% of all adult inpatient hospital deaths are currently reviewed by specialities. Each speciality reviews their mortalities at their monthly Mortality & Morbidity meetings.

Community Services in Calderdale have developed a review system based on the trust's ISR tool to review deaths that occur within 30 days of discharge for patients in receipt of CHFT community services post discharge. Our colleagues at Locala use a similar tool for deaths in the Kirklees area.

Deaths that are identified as having poor or very poor care through the ISR process are escalated for a Structured Judgement Review (SJR) along with Learning Disability deaths, Elective Surgery deaths, SHMI/HSMR outliers or alerts as agreed by the Mortality Surveillance Group (MSG), deaths associated with complaints, serious incidents or claims and those deaths that have been referred for Coroner's inquests. The trust's SJR process is in line with the National Mortality Case Record Review Programme.

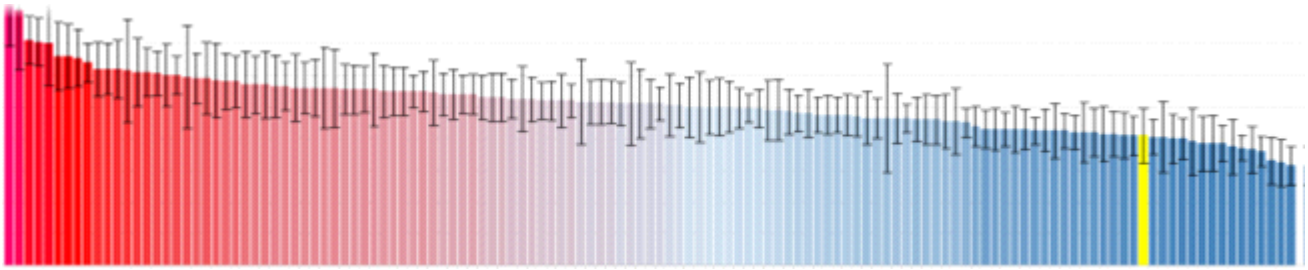
An overview of the reviews is reported in the Mortality Surveillance Group on a monthly basis and to the Board of Directors on a quarterly basis.

Reliability in clinical care (sepsis)

There is well established multi-disciplinary sepsis collaborative with WTGR and QI to make improvements with patient safety, quality and experience. The purpose of the collaborative group is move forward with a work plan to improve outcomes for patients who are either admitted with or develop Sepsis during their inpatient stay.

Sepsis HSMR

The most recent available 12 months HSMR figures show that as a Trust CHFT's HSMR is at 82.19for the period April 2018 –March2019 which has been steady for the last few months. The screenshot on the right shows CHFT's HSMR position compared with other trusts for Sepsis, we are ranked 18th out of 132 Trusts.



Ongoing plan:
1.Working with the Digital Health team to progress with the Trust having the technology in place to Link Lactate results from POC testing to EPR. AP assured the group that this was being explored.
2.Sepsis bundle improvements – focus on ensuring Blood cultures are completed for all patients.
3. Sepsis bundle improvements – Improving fluid balance. It was noted that the Nutrition and Hydration group were also looking at this.
4. Sepsis bundle improvements – Improving issues around the administration of Gentamicin.
5.Learning from incidents to be shared quarterly and added to the Collaborative agenda.
6.Paediatrics to develop a separate sepsis dashboard.

Early recognition and treatment of deteriorating patients

The Deteriorating Patient Group, chaired by Associate Medical Director Dr Sal Uka, has maintained focussed on the recognition of, response to and prevention of deterioration of patients in hospital. It builds on the initial implementation of Nervecentre with electronic recording of patients' observations and auto-escalation. Following the introduction of Nervecentre there was a definite improvement in the percentage of patients with an raised NEWS who subsequently died. Nervecentre also provides an electronic platform for the Trust's out of hours system known as HOOP. This was a significant landmark transformation for CHFT and identified as an exemplar by NHSI. HOOP has undoubtedly contributed to the identification and treatment of patients who deteriorate specifically out of hours.

The Deteriorating Patient Group will continue to meet under a refreshed leadership (Deputy Medical Director) and will build on plans to ensure timely escalation of deteriorating patients aligned to well documented plans within the medical record. There will also be a refresh of HOOP through a WTGR approach and potential alignment with the Critical Care Outreach Team.

End of Life Care (EOLC)

Up until September 2018 CHFT didn't routinely provide any bereavement support to families and carers of patients that had died within CHFT. Since then, the Marigold café, bereavement cards and new bags for families to take their loved one's belongings in have been developed. Within the last 2 years the Trust has also developed end of life care companions and champions. All these improvements are to try and ensure high quality, compassionate, consistent care for our EOLC patients and their families. The Marigold is now the symbol synonymous with end of life care and bereavement care within the Trust. EOLC has a clear reporting structure through the EOLC steering group which reports quarterly to the Clinical Improvement Group (CIG).

Bereavement Survey

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

In order to gather more feedback to both highlight the areas of excellent care and areas that we can improve on, a 6-month pilot audit was undertaken on our four stroke wards at CRH. Prior to sending the survey, a bereavement card was sent to offer support and inform them of the upcoming survey. The response rate was 49% and the findings from the bereavement survey are going to be fed back through the Stroke meetings highlighting both the areas of excellence and areas for improvement. The Stroke wards are continuing to send out the bereavement cards.

Bereavement Cards

Up until this year the Trust didn't routinely send out bereavement cards to families, apart from in areas such as ICU. A bereavement card has now been developed with input from our bereaved relatives and colleagues. This card, with a Marigold on, is sent out across the Surgical Division wards 1-2 weeks after death. The card lets the families know we are thinking of them and also offers a phone number for relatives to ring if they have unanswered questions or need support. The plan is for bereavement cards to be sent out Trust wide by the end of 2019.

Bereavement café - The Marigold cafe

The Chaplaincy department alongside the end of life care facilitator have developed - The marigold café, a bereavement café which started on the 7th September 2018. It runs the first Friday of every month on each hospital sites. This is open to anyone who has suffered bereavement. Attendance has been slow to start but we are now seeing a gradual increase in attendance every month.

End of Life Care Companions

The companions are again a new service started in the past 2 years to sit alongside patients at the end of life, either if they have no family or their families need a break. 20 companions have been trained to support our dying patients, their families and the ward teams. The plan is to try and increase the wards use of the Companions - we have added the information about the companions to the essential training to ensure all ward areas are aware of this service.

Horizon Group

This is a collaborative group which includes CHFT, Calderdale Council, the Council of Mosques and Overgate Hospice. We work together to support our BAME community. The group has undertaken a lot of work with the South Asian community in Calderdale. Recently an event was held at the Sikh Temple in Huddersfield. The future plans are to continue to support our communities.

DNACPR

Compliance around DNCAPR review dates and discussion date are now being reported directly from EPR, compliance has dropped slightly in relation to this whole sample approach. It has been noted that discussions are documented in the notes, but the corresponding box not ticked on the form. A bite size learning has been communicated around this to try and improve compliance. This will be reported through the CIG meeting.

Integrated Care of the Dying Document (ICODD)

Completion rates for the Integrated Care of the Dying Document (ICODD) continue to be below Trust aspirations. The improvement work for this includes, EOLC/ICODD training was agreed at WEB to be part of essential skills training. In the coming weeks this learning package will become part of ESR with front line staff having to complete training every 3 years. There is also a joint EPR build with Bradford to incorporate the Integrated Care of the Dying Document onto EPR, this has now been made an urgent priority and again is reported through CIG. There is also ongoing work to improve recognition of the end of life with

education and training and using tools like the Supportive and Palliative Care indicators (SPICT) tool.

Caring for frail patients

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

There has been an investment into the frailty service from the winter monies 2018/2019, which has allowed the frailty service to recruit an additional geriatrician, nurses, ACPs, therapists, Physician Associates, pharmacist and a Band 4 nurse. This investment has enabled the frailty team to avoid a further 100 admissions a month in comparison to last December with a further 194 new referrals seen a month.

There has been a further investment for 2019/2020 into the frailty service to enable:

- Same day emergency care unit for frailty patients. This will ensure frail patients come straight into the unit rather than being cared for in a busy emergency department where there will be a MDT approach and wraparound of their health and social care as soon as they arrive. This will then enable GP referrals to come to the unit rather than be admitted to the Acute floor.
- Frailty one stop clinics in the community once a week in both localities to review patients being diagnosed with frailty and starting to decline with a full comprehensive geriatric assessment. This will stop patients presenting in crisis with more signposting to help frail patients live well for longer at home. This will be an MDT approach with health and social care.
- Advanced care planning Facilitator to bring together planning future care of frail and non-frail patients. At present, very few patients are offered an Advanced care plan with no option for patients to have a voice in their end of life care. This role will help train and educate all staff to make advance care planning everyone's business
- The proactive care of older people for surgical patients will commence in September delivering a frailty service across surgery.

Work is ongoing to develop key performance indicators for frailty.

Clinical Coding

The aim of the Clinical Coding theme was to ensure that the clinical coding accurately reflected patient diagnosis and co-morbidities in terms of specificity, completeness, accuracy and relevancy. This was to be achieved by ensuring clear clinical documentation in the clinical systems used for coding and a high standard of coding accuracy to provide a true reflection of our inpatient population. At the start of the work CHFT's clinical coding KPI's were below the national average and there was minimal communication between the coding and clinical teams as well as no training for clinical teams on coding and documentation.

Since the start of the work there has been significant improvement in communication between the coding team and clinical teams through engagement and training sessions including sessions for FY1's and other clinical appointments. The Trust now has 3 consultants with clinical coding as an additional responsibility as well as an Associate Medical Director with responsibility for clinical coding. This has meant a much greater understanding regards requirements in the clinical documentation to improve clinical coding KPI's. All 3 coding KPI's have improved from below the national average and during the last

quarter of 18/19 all achieved the national upper quartile. A Knowledge Portal model has been developed which allows performance to be monitored for coding KPI's at various levels including Trust, Division and treatment function. The model also allows monitoring by diagnosis and co-morbidities. The roll out of the EPR has provided important benefits to coding completeness and accuracy in terms of the documentation of Specialist Palliative Care (SPC) which has meant more accurate capture of SPC input into patient care. To ensure a high level of coding accuracy there has been investment into the coding workforce to provide a structure that meets CHFT coding needs for the future and make sure coders are adequately trained and regularly audited as well as retaining staff as much as possible.

Moving forward the plan will be to build on the progress made so far to address documentation and data quality issues in EPR and continue to work towards consistently achieving the national upper quartile targets for each of the clinical coding KPI's. The Clinical Coding Improvement Action Plan for 2018-20 which was signed off at the Digital Health Forum in September 2018 will provide the structure for the work over the next 18 months. The action plan includes actions relating to improving data quality, documentation quality, education/engagement and ease of use within source clinical systems. This work will be progressed and managed via the Clinical Coding Improvement Steering Group and Mortality Surveillance Group. The structure of the coding team will also continue to be regularly reviewed to ensure it continues to meet CHFT's needs.

Recommendations to the Board of Directors

The Board of Directors is requested to:

1. Acknowledge the progress and achievements outlined within this report especially with regards to mortality.
2. Support the development of a new Clinical Improvement Group to support and drive clinical quality improvement within the Trust.
3. Acknowledge the end of the Clinical Outcomes Group and the care of the acutely ill patient programme.

14. Guardian of Safe Working Hours Annual Q1 Report - Dr Anu Rajgopal

To Note

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Annual Report of the Guardian of Safe Working Hours
Author:	Anu Rajgopal
Previous Forums:	None

Actions Requested:
To note

Purpose of the Report

In this report, the Trust Board will be updated on issues relating to safe working hours of doctors in training. The periods of cover are the financial year of April 2018 to March 2019 as well as Q1 of this year (April -June 2019).

Key Points to Note

The following areas are to be considered:

- Temporal distribution of exception reports (ERs) each month
- Trends in grade of trainee who submit reports
- Departments which submit the most reports
- Trainee perception of either work load or educational issues
- Typical outcomes for the trainee
- Immediate safety concerns
- Work schedule reviews
- Rota Gaps and locum booking data
- Main issues and actions taken to resolve them

EQIA – Equality Impact Assessment

Recommendation

The Board is requested to receive and **NOTE** this report.

Annual and Q1 report: (1st April 2018 to 26th June 2019)

Guardian of safe working hours (GOSWH), CHFT

Purpose of the report

In this report, the Trust board will be updated on issues relating to safe working hours of doctors in training. The periods of cover are the financial year of April 2018 to March 2019 as well as Q1 of this year (April -June 2019).
The following areas are to be considered:

- Temporal distribution of exception reports (ERs) each month
- Trends in grade of trainee who submit reports
- Departments which submit the most reports
- Trainee perception of either work load or educational issues
- Typical outcomes for the trainee
- Immediate safety concerns
- Work schedule reviews
- Rota Gaps and locum booking data
- Main issues and actions taken to resolve them

Executive summary

All our junior doctor rotas are compliant with the 2016 terms & conditions of service (TCS). However, there are significant registrar level gaps, especially in paediatrics, obstetrics, emergency and general medicine. These are generally covered only out of hours by locums leading to significant pressures during working hours and come at a financial cost to the Trust. Tracking real-time rota compliance can be difficult and a few work schedule reviews have been requested this year.

The trust has been using Allocate to provide exception reporting software since August 2017. All junior doctors, educational and clinical supervisors have access to this and guidance is given at junior doctor inductions and via emails and also available on the Trust intranet. Over the last year, there has been an improvement in proportion of ERs that are completed in a timely manner which is indicative of a clearer process for ER reporting and provision of administrative support to the GOSWH. However, some ERs remain pending despite repeated reminders. Some of these have been discussed and agreed with the trainee but not closed on Allocate. The Allocate software does not enable sign off by the GOSWH as did the previous DRS software.

Over a third of our trainee doctors have used the exception reporting system last year. There was an increase in exception reports seen over Q2 which reflects the new F1 doctors joining the Trust and is mirrored from the trend last year. Majority of these relate to working hour rather than educational matters.. There has been a shift in ERs reported per speciality, with now an approximately equal split between medicine and surgery. There is also an increasing trend of ERs reported by higher trainees (14% versus 2% of total ERs last year). In obstetrics, these are mostly related to work pressure and missed educational opportunities.

The first ever CHFT junior doctor awards were held in May 2019 with awards given to doctors in training across 6 categories and one supervisor award. This was really well supported by our executive team and was a huge success with positive feedback from trainees and supervisors.

High level data (CHFT)

Total number of doctors in training on the 2016 TCS	**230**
Total number of GP trainees for whom CHFT is the lead employer	**34**
Number of SAS doctors on the 2016 TCS	**One**

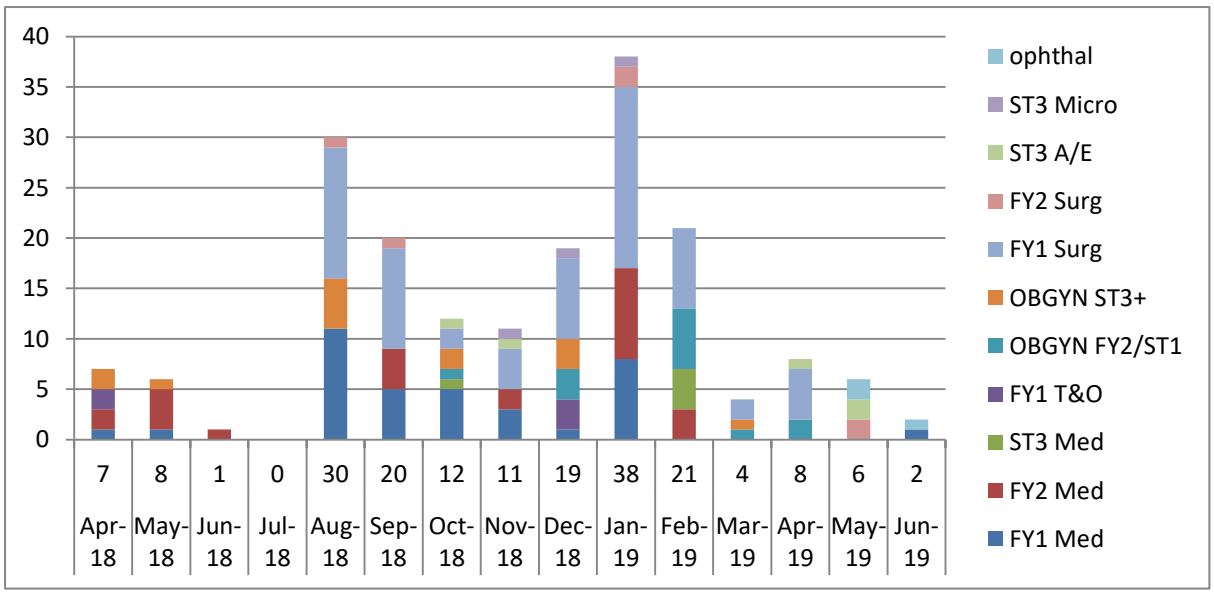
a) Exception reports (1st April 2018- 26th June 2019)

There have been a total of 187 exception reports (ERs) from 77 junior doctors representing one third of all doctors on the 2016 TCS.

Since August 2018, the Trust has also been the lead employer for 3GPSTs in GP practices who have access to me as their GOSWH. There is a plan to move newly recruited Trust doctors and those renewing their contracts at CHFT to the 2016 TCS. These doctors will have access to the exception reporting system and GOSWH.

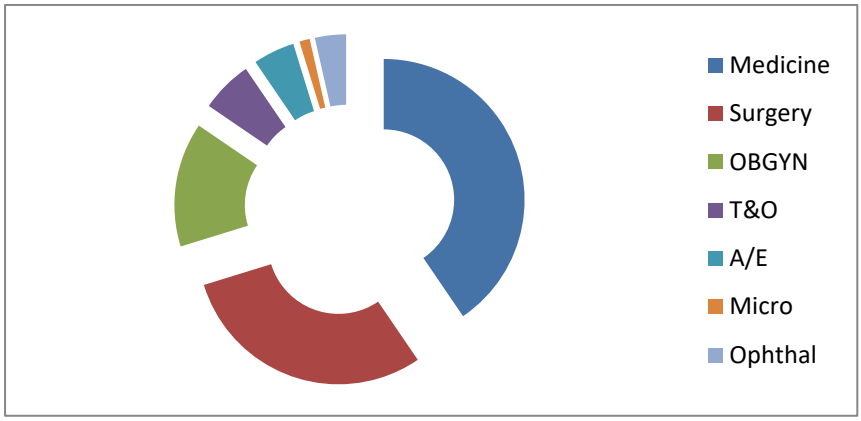
- **Number of exceptions and junior doctor grades submitting them**

There is a spike seen with increased exceptions reported soon after the new FY1 induction in July and then during the early year reflecting a busy period in the hospital.



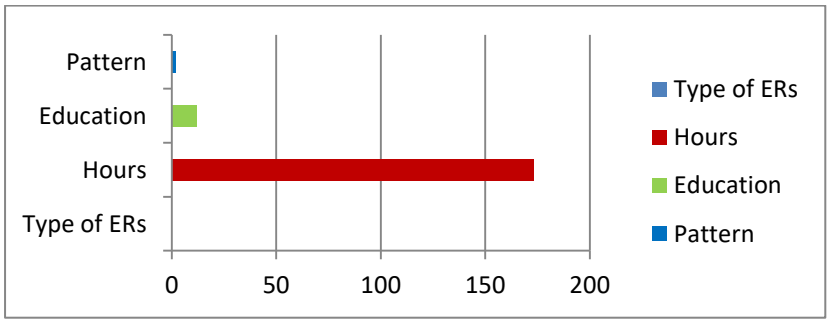
Majority of ERs (83%) were submitted by foundation trainees (FY1/2) with a peak in the months following their induction and a second peak over the busy winter period. There has been an increase in ERs submitted from senior trainees (ST3+) this year, majority of which were related to missed educational opportunities in obstetrics.

- The ERs were across a range of specialities as shown below.



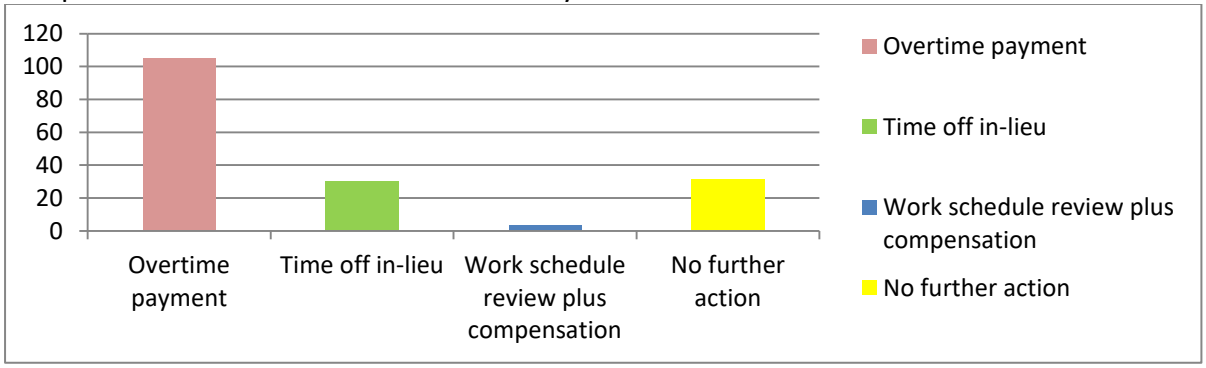
- **Type of exception**

Over 90% were due to an increase in working hours suggesting that overworking is common and is an element of reporting that doctors are more comfortable with. It is likely that the ER system is not appropriate for reporting lack of rest and natural breaks and poor access to education and training opportunities. Positively, ERs have been presented by multiple specialties. ERs reported due to educational concerns were mainly from the FY2/GPST and ST3+ rotas, i.e. from speciality and senior trainees.



- **Outcome**

Over 90% of ERs have been completed. The ones that are pending are mainly in medicine and obstetrics & gynaecology. Majority have been resolved with overtime payment but at present there is no tracking mechanism to ensure that time off in lieu or monetary compensation has been received in a timely manner



- **Immediate safety concerns**

One ER was reported as an immediate safety concern as the junior doctor had to stay late after a night shift in order to complete a coroner's report leading to a decrease in the rest period before the next shift. This was escalated to the consultant on-call and the trainee was given extra time off in lieu.

b) Work schedule reviews (WSRs)

There have been a few work schedule reviews requested by me following a series of exception reports or requested by the trainees themselves.

In Q1 (2018) a group work schedule review was requested in gastroenterology as the junior doctors reported a trend of often working beyond their rostered hours. This was successfully resolved within the division in a timely manner leading to a decrease in ERs from that area.

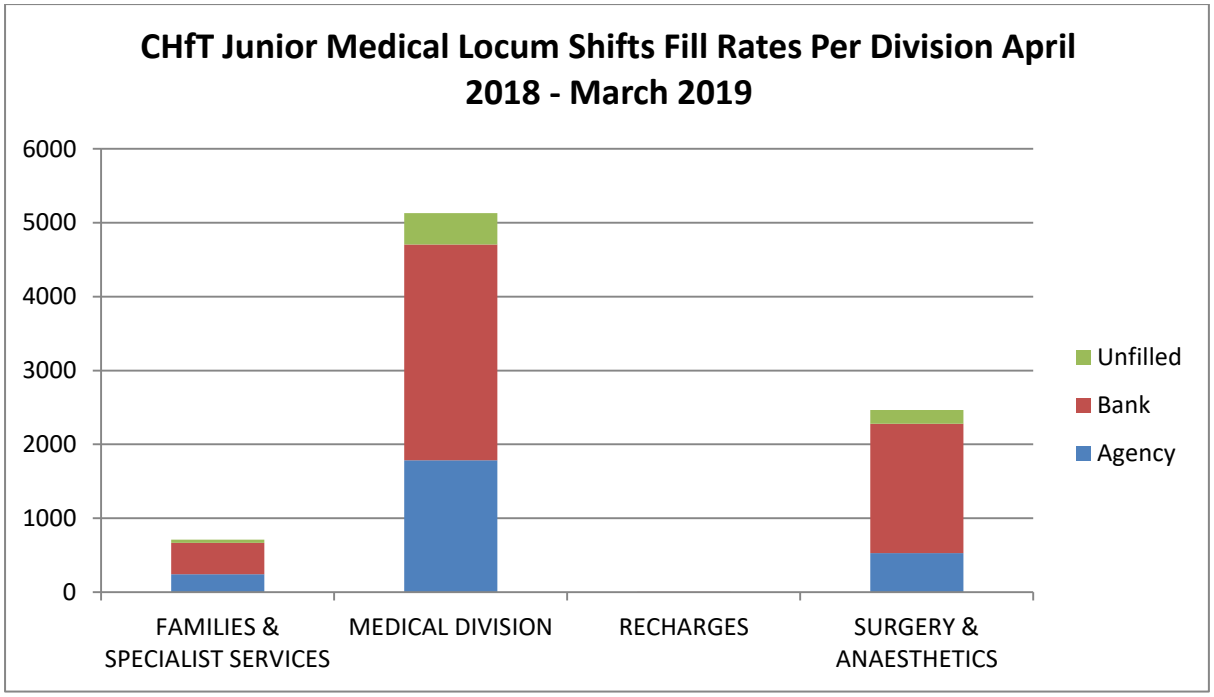
A less than full time trainee (LTFT) in urology had requested a work schedule review prior to her starting the rotation. There were delays in reaching an agreed schedule and the matter was escalated to the GOSWH in Q4. With engagement from the CD and rota co-ordinators, this was eventually resolved with positive feedback from the trainee.

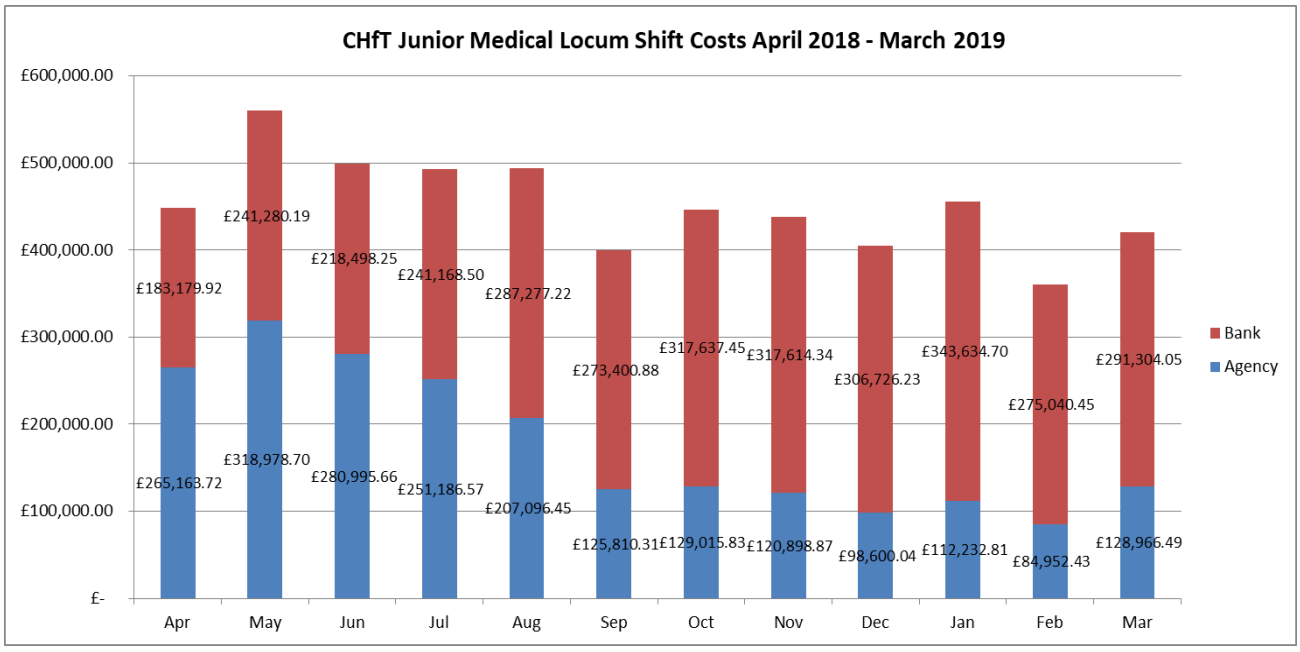
An ST3+ trainee in Trauma & Orthopaedics (T&O) had requested a WSR in Q3 (2018) which has only been resolved this month. The trainee has since left the organisation and will be receiving some back payment as a result of the review. Following this, the ST3+ rota in T&O has been reviewed and resolved with majority support from the affected trainee doctors. I have escalated the delay in the process to the relevant clinical director. Recently, the FY2's have requested a review as well as their attendance at trauma meetings is not captured on their work schedules. This is currently ongoing and may impact on the new trainees joining in August 2019

c) Rota Gaps

Grade	Dept	Number of Gaps	Reason for gap	Cover arrangements	Vacancy period	Any anticipated concerns
CT	UGI surgery	1	Deanery	Daytime & on-calls filled by Internal bank.	Feb 19 - Aug 19	
CT	Vascular	1	Trust	On-calls only filled	April 18 - ongoing	on-going trust gap
GPST	ENT	50%	LTFT Deanery	On-calls only filled – Bank & Agency	April 18 - April19	
SAS	ENT	1	Trust	Bank & Agency	April 18 - ongoing	on-going trust gap
SAS	ENT	1	Trust	Bank & Agency	April 18 - ongoing	on-going trust gap
SAS	Urol	1	Trust	On-calls only - Bank & Agency	April 18 - ongoing	on-going trust gap
ST3+	Urol	1	Deanery	On-calls only - Bank & Agency.	April 18 - Oct 19	
GPST	A&E	3	Deanery gaps	Locums	April 18-Aug 18	
CT1-2	A&E	1	Deanery gap	Locums	April 18-Aug 18	
ST3+	A&E	5.5	Deanery gaps(mat leave /LTFT)	Locums/trust doctors	Aug 18-Aug 19	
GPST	A&E	1.5	Deanery gap/0.5 due to LTFT	Locums/ACPs 1 covered by MTI	Aug 18-Aug 19	
CST + Trust grade junior	Ortho	7 (1 CST + 5 trust grade)	Deanery + Trust vacancies	bank + agency locums	CST Feb 18-Aug 18 Ongoing Trust grade vacancies	One CST 5 trust gaps from Feb 19
FY2	OBGYN	1	Deanery gap	Bank and agency for on calls	Aug-Dec 18 April-Aug 19	
GPST	OBGYN	3	Deanery/mat leave/LTFT	Bank and agency for on calls	Feb18-Aug18	
GPST	OBGYN	50%	LTFT	Bank and agency for on calls	Jan 18-ongoing	
ST3+	OBGYN	2.5	Deanery/mat leave/LTFT	2 gaps covered by MTIs from Dec 18/bank and agency for on calls	Aug 18-Jan 19	
ST4+	Paediatrics	2	Deanery gap	Bank and agency for on calls/ANNPs covering some daytime as Reg	Aug 18-Feb 19	3.5 ST4+ gaps from Feb 19
CMT	Gen Med	2	Deanery gap	Trust doctor for on calls	Apr 18-Aug-18	
FY2	Gen Med	3	Deanery gap	Trust doctor for on calls	Apr 18-Aug-18	
FY1	Gen Med	1	Deanery gap	Trust doctor for on calls	Apr 18-Aug-18	
GPST	Gen Med	2	Deanery gap	no on-calls	Aug 18-Feb 19	
GPST banded	Gen Med	3	Deanery gap	Trust doctor for on calls	Aug 18-Feb 19	
Registrar	Gen Med	4	Deanery gap	trust doctors appointed plus bank and agency	Aug -18-Apr 19	1 due to commence mat leave, 1 exempt from on-calls, 2 delayed starters and 2 due to return from mat leave in Feb 2019

d) Locum bookings





Compared to the previous year, the number of unfilled shifts has decreased which is a good trend and contributes to the well-being of our junior doctors. Bank shifts have increased relative to agency locums which is also a positive trend. Better tracking of doctors hours is required when doing bank shifts as it is likely that locum hours will cause breaches in working time if done in addition to normal working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation.

Further analysis of speciality areas that are requiring high volume locum hours is required and consideration for more innovative ways of working should be considered. Stretching the existing workforce to plug rota gaps has detrimental effects on both staff wellbeing and patient safety.

e) A summary of issues arising and actions taken to resolve these

i. Rota gaps

Medicine: Gaps at the registrar grade. Recently, these gaps have been successfully recruited into by Trust doctor grades. There are 2 MTIs on the registrar rota as well.

OBGYN: Mainly registrar level gaps and anticipated 1.5 gap at the SHO level (due to a LTFT and Deanery gap). The 2 MTIs are continuing on the registrar rota. One may help with the SHO rota as well.

Paediatrics: There are 3.5 Registrar level gaps (mat leave and LTFT) till October 2019. There is a Trust ST3 currently on the SHO grade who could move to the registrar rota. There may be a need to recruit a Trust doctor.

Emergency Medicine (A&E): Registrar level gaps persist, some covered by long-term bank staff. From August 2019, the A/E rota will be split into 3 tiers (rather than the current 2) which will help in attaining minimal levels of staffing across the grades. They also have four advanced nurse practitioners (ACPs), some of who are on the junior trainee rota, one MTI and one permanent Trust grade to fill these gaps.

ii. Work-schedule reviews

Orthopaedics: Following a 24-hour shift the registrars were attending the post-trauma meeting and ward-rounds. This was not reflected on their work schedules. The matter was escalated to me and medical HR have now drafted a new compliant rota with input from the directorate and agreed to by the trainees. Any extra work will be compensated and the trainee who raised this issue will be receiving back pay.

iii. FY1 rota review

The FY1s in medicine had requested a review of their rota after highlighting perceived inequalities in their rostering especially their weekend working hours. This was escalated to the BMA and our Trust chief executive. Following a series of meetings between the junior doctors and the clinical director, a senior manager from medical HR, GOSWH and the chief executive with a detailed look at their rota, the matter was settled amicably with the junior doctors accepting their rota as an equitable one.

iv. Medicine FY1 weekend working

A few ERs had flagged up very busy on-call shifts on weekends. Going forward, the rota has been revised with extra weekend day-time cover provided and a more equitable distribution of weekend on-call.

v. Increase in ERs from microbiology

We have had 3 exception reports in Q4 from microbiology as a result of a breach in the stipulated 5 hours of continuous rest between the hours of 22.00 and 7.00. Trust-wide communication from the clinical lead in February 2019 stipulated that microbiology calls only from registrars and above will be accepted after 22.00 hours unless acutely deteriorating patient. There have been no further ERs since.

vi. Timeliness of ER completion

The main struggle is following up exception reports and ensuring that they are completed in a timely manner. We have drafted a process of follow-up by the GOSWH and the medical HR team, with the issue being escalated to the relevant clinical director if not resolved within 14 days (See Appendix A). Non-familiarity with the Allocate software is also causing delays in completing these ERs.
I have sent guidance on exception reporting and using the Allocate system to supervisors and had face to face sessions at various departmental meetings.

vii. Feedback from the junior doctors survey CHFT (July 2018)

One of the anaesthetic FY2s had collated responses from 39 junior doctors which highlighted a lack of knowledge around exception reporting and using the Allocate software in a third of the doctors surveyed. Since then, ER guidance has been communicated via emails, there have been face-to-face sessions at the FY1 teaching days, a GOSWH intranet page has been set up and information was disseminated in the trainee newsletter. The GOSWH also does 'walk-abouts' which encourages direct discussion and information sharing with the junior doctors.

viii. Timeliness of paid compensation following an ER outcome

Payment for work in different directorates is authorised by different managers and clinical directors. The process is unclear and the claim forms may differ. This leads to a delay in the trainees getting their overtime payment. Moreover, data around compensation payment as a result of ERs cannot be collected specifically.
We have designed a specific claim form for ERs (Appendix B) and will be drafting a unified process across divisions.

f) Junior Doctors Forum

Attendance at this remains low however those in attendance were well engaged. We have not had any attendance from the BMA or the LNC representative this last year. The meeting is now held at lunchtime following trainee feedback and lunch is provided. We regularly

have FY1, FY2 and GP trainee representation. Any GOSWH message around exception reporting is disseminated by the trainee representatives via individual whatsapp groups in addition to emails. In general, the junior doctors are engaged on multiple levels through social events and educational opportunities. The JDF representatives played a key role in planning our inaugural junior doctors' awards function. A catering & retail survey has been emailed to all doctors in training in May 2019. Results are awaited.

g) Fines

The total amount in the GOSWH fund remains at £ 2191.59. No fines have been imposed in the last year. This reflects the work of the medical staffing team and the rota coordinators who have created compliant rotas and enable junior doctors to avoid shifts that will breach safe working limits. However it also reflects that there is no robust system for identifying breaches as the system is dependent on the doctors to report breaches in their TCS
There may be a fine following the T & O registrar work schedule review: this is currently being calculated.

h) "CHFTs Got Medical Talent Awards"

We held the inaugural Junior Doctors' award ceremony- "CHFT's got Medical Talent!" on the 9th of May 2019. The event was co-hosted by the Head of workforce and development and the Associate medical director and opened and closed by our Trust chief executive.
In all, there were 70 nominations for junior doctors in five categories from their colleagues across the board. The evening was well attended and received great feedback from our trainees and their supervisors.

Summary and recommendations

All our trainee doctors, some of our Trust doctors and GP trainees for who we are the lead employer organisation are now on the 2016 contract. Given the varying specialities which report on Allocate, I am assured that majority of our trainees are engaging well with the process of exception reporting, however further work needs to be done to improve the time frames set for their resolution. Registrar-level rota gaps continue to be an issue in A/E, paediatrics, obstetrics and medicine. The departments are working closely with flexible workforce to explore a variety of solutions, including recruiting more Trust doctors, MTI trainees, FY3 doctors and other clinical staff groups like physician associates and advanced nurse practitioners. Most rota gaps are covered only out of hours by locums, leading to an increased pressure on junior doctors during working hours. This also carries a significant financial cost. Work is ongoing in the trust to move to e-rostering which will help identify rota gaps and vacancies in a timely fashion.

The board is requested to receive and note this report.

Anu Rajgopal

Guardian of safe working hours

June 2019

Appendix A

Exception Reporting Procedure

All exception reports must be resolved within 14 days of receipt

Below outlines the process to be followed for overdue exception reports

Stage 1- Day 1

An exception report is received

HRA to log on the Exception report spreadsheet and email the named supervisor

Send guidance for exception reporting to Supervisor and trainee doctor

"Dr (INSERT NAME) has raised an exception report which should be completed within 14 working days"

Stage 2 - Day 7

An exception report is overdue (not closed)

HRA to email the supervisor and copy the GOSWH:

"Further to the previous email sent on [INSERT DATE] regarding an exception report raised by {Dr INSERT NAME], I am emailing to inform you that it is still showing as an unresolved exception report. Please resolve and close ASAP (definitely within the next 7 days)"

Stage 3 - Day 14

An exception report is overdue (not closed)

HRA to email the Supervisor, copy the Clinical Director and the GOSWH with the following email:

"Further to my previous emails I am writing to inform you that the exception report for [Dr INSERT NAME], is still showing as an unresolved. This issue has now been escalated to your Clinical Director"

If an 'immediate risk/ safety concern' is received this must also be sent to the Clinical Director and Director of medical education at Stage 1/ Day 1.

15. Integrated Performance Report – May 2019

To Note

Presented by Helen Barker

Date of Meeting:	4th July 2019
Meeting:	Board of Directors
Title of report:	Quality and Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsor:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee, Quality Committee

Actions Requested:

- To note

Purpose of the Report

To provide the Executive Board with the performance position for the month of May 2019.

Key Points to Note

May's Performance Score is 73% and the Trust has 4 green domains for the first time. **SAFE** continues to be green although 3 of the 4 maternity targets were missed. The **CARING** domain remains amber with FFT A%E response rate dropping further in month alongside Community would recommend. **EFFECTIVE** domain is green back to green although #NoF missed target again. The **RESPONSIVE** domain has improved to 67% as RTT incompletes achieved target although stroke indicators are underperforming and the 6 weeks Diagnostics target was missed again. **WORKFORCE** is still green with sickness levels at their lowest position. Only Infection Control EST remains below 90% alongside appraisals for medical staff. Within **EFFICIENCY** & **FINANCE** the domain is now green.

EQIA – Equality Impact Assessment

N/A

Recommendation

The Board of Directors is asked to note the contents of the report and the overall performance score for May.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

May 2019

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

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

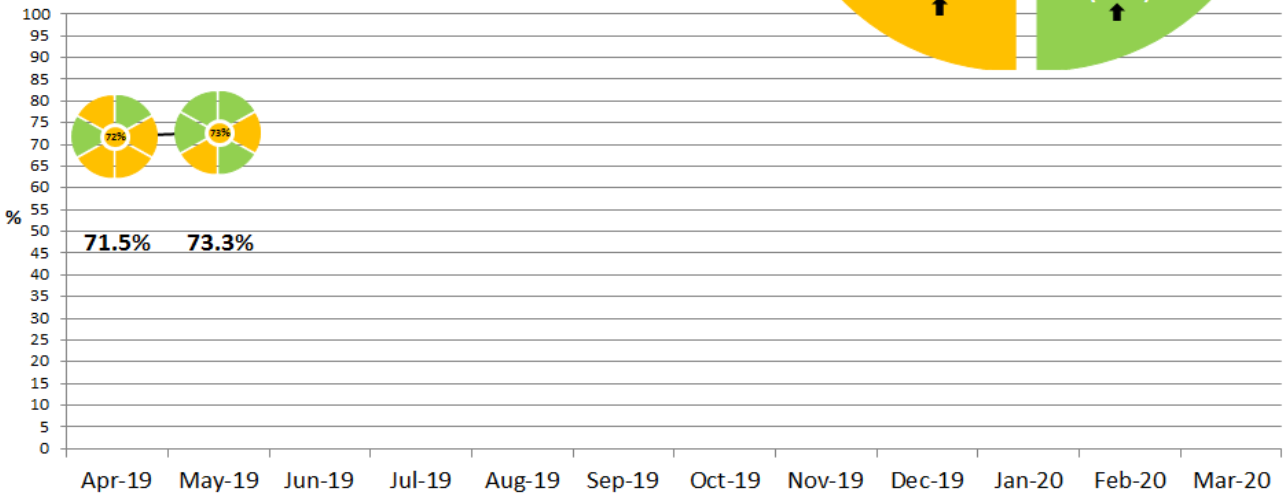
There have been minor reductions in performance in the EFFECTIVE domain in April due to more challenging coding targets being introduced.

Performance Summary

May

RAG Movement

May's Performance Score is 73% and the Trust has 4 green domains for the first time. SAFE continues to be green although 3 of the 4 maternity targets were missed. The CARING domain remains amber with FFT A%E response rate dropping further in month alongside Community would recommend. EFFECTIVE domain is green back to green although #NoF missed target again. The RESPONSIVE domain has improved to 67% as RTT incompletes achieved target although stroke indicators are underperforming and the 6 weeks Diagnostics target was missed again. WORKFORCE is still green with sickness levels at their lowest position. Only Infection Control EST remains below 90% alongside appraisals for medical staff. Within EFFICIENCY & FINANCE the domain is now green.



SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT OP
FFT IP FFT Maternity	FFT A&E FFT Community
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Key Indicators

	18/19	Apr-19	May-19	YTD	Annual Target	Monthly Target
SAFE						
Never Events	4	0	0	**0**	0	
CARING						
% Complaints closed within target timeframe	42.00%	29.0%	**38.0%**	**35.0%**	100%	
Friends & Family Test (IP Survey) - Response Rate	36.39%	34.35%	**36.50%**	**35.44%**	>=24.5%	
Friends & Family Test (IP Survey) - % would recommend the Service	97.46%	97.29%	**97.56%**	**97.43%**	>=96.7%	
Friends and Family Test Outpatient - Response Rate	10.75%	7.93%	**9.25%**	**8.60%**	>=4.7%	
Friends and Family Test Outpatients Survey - % would recommend the Service	90.92%	91.13%	**90.36%**	**90.71%**	>=96.2%	
Friends and Family Test A & E Survey - Response Rate	13.03%	11.56%	**11.48%**	**11.56%**	>=11.7%	
Friends and Family Test A & E Survey - % would recommend the Service	83.80%	83.88%	**84.79%**	**83.88%**	>=87.2%	
Friends & Family Test (Maternity Survey) - Response Rate	36.51%	30.84%	**41.78%**	**24.08%**	>=20.8%	
Friends & Family Test (Maternity) - % would recommend the Service	98.64%	100.00%	**99.19%**	**99.52%**	>=97.3%	
Friends and Family Test Community - Response Rate	4.91%	3.38%	**5.74%**	**4.59%**	>=3.2%	
Friends and Family Test Community Survey - % would recommend the Service	94.64%	96.69%	**95.48%**	**95.91%**	>=96.7%	
EFFECTIVE						
Number of MRSA Bacteraemias – Trust assigned	2	1	**0**	**1**	0	
Preventable number of Clostridium Difficile Cases	5	0	**0**	**0**	40	3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.25			**100.25**	<=100	
Hospital Standardised Mortality Rate (1 yr Rolling Data)	84.51			**85.82**	<=100	
RESPONSIVE						
Emergency Care Standard 4 hours	91.29%	90.19%	**92.30%**	**91.24%**	>=95%	
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	64.00%	46.55%	**50.88%**	**48.70%**	>=90%	
% Incomplete Pathways <18 Weeks	92.05%	91.79%	**92.15%**	**92.15%**	>=92%	
Two Week Wait From Referral to Date First Seen	98.46%	96.57%	**96.82%**	**96.69%**	>=93%	
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.56%	98.34%	**94.05%**	**96.28%**	>=93%	
31 Days From Diagnosis to First Treatment	99.63%	100.00%	**99.35%**	**99.68%**	>=96%	
31 Day Subsequent Surgery Treatment	99.04%	100.00%	**100.00%**	**100.00%**	>=94%	
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	**100.00%**	**100.00%**	>=98%	
38 Day Referral to Tertiary	52.42%	31.58%	**25.00%**	**29.63%**	>=85%	
62 Day GP Referral to Treatment	88.37%	88.51%	**91.14%**	**89.76%**	>=85%	
62 Day Referral From Screening to Treatment	94.42%	91.30%	**95.65%**	**93.48%**	>=90%	
WORKFORCE						
Sickness Absence rate (%) - Rolling 12m	3.69%	3.67%	*	-	4%	
Long Term Sickness Absence rate (%) -Rolling 12m	2.39%	2.37%	*	-	2.5%	
Short Term Sickness Absence rate (%) -Rolling 12m	1.30%	1.29%	*	-	1.5%	
Overall Essential Safety Compliance	94.45%	93.18%	93.40%	-	90%	
Appraisal (1 Year Refresher) - Non-Medical Staff		16.52%	50.88%	-	95%	
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	92.85%	87.23%	86.89%	-	95%	
FINANCE						
I&E: Surplus / (Deficit) Var £m	0.01	**0.01**	**0.01**	**0.01**		

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Overall Sickness absence - Sickness rolling 12 month total (3.67%) is at its lowest position since September 2018.	% Diagnostic Waiting List Within 6 Weeks - target missed in 6 out of last 7 months due to a cohort of requests which had not been entered onto the system; existing staffing capacity constraints impacting on speed of recovery. In addition staffing issues in Neurophysiology are causing some breaches.	ECHO - ICS outsourcing company have started working at CHFT and provided adhoc capacity in May. We are exploring additional weekend lists with ICS to increase their capacity. CHFT staff are also performing extra weekend lists through June/July to maximise the number of scans available. Mid Yorks have offered alternative Saturday lists to support our service. Neurophysiology Staff in post are running additional sessions, we have several jobs going out to adverts and we are putting in a new rota to manage the capacity against the demand. Two outsourcing companies have offered capacity - we are putting together a costed recovery plan.
All key cancer targets achieved for 7th month running.	Stroke targets - % Stroke patients spending 90% of their stay on a stroke unit is at 77.19% but still below the 90% target, scoring an SSNAP D score in May. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival was 50.88% against the 90% target, scoring a SSNAP E score in May. There were also a number of thrombolysis breaches.	MADE events are being held to review the length of stay and provide challenge to the teams to ensure discharge planning is starting as soon as possible. This is to reduce the number of delayed discharges and thus improve the flow across the unit . Fortnightly task and finish groups still continue to standardise pathways/ MDT protocols and are expected to be fully implemented by the end of June. Matron and GM are checking patients daily to provide assurance that there will be a continued increase in the percentage of patients admitted directly to an acute ward. Escalation measures are now in place for the ward staff to contact the Matron if there is no available bed for an admission.

Executive Summary

The report covers the period from May 2018 to allow comparison with historic performance. However the key messages and targets relate to May 2019 for the financial year 2019/20.

Domain	Area
Safe (75%)	• **% New Harm Free Care** is below the 98% target for May at 97.88%. Increases have been seen in the number of Low Harm Falls and New UTI Infections. There are improvement collaboratives in place for all harms reported through the Safety Thermometer tool.
Caring (65%)	• **Complaints closed within timeframe** - Of the complaints closed in May, 38% (22/58) were closed within target timeframe. The Chief Executive has presented the findings of the deep dive into complaints to WEB and a range of multidisciplinary meetings across the Trust, with further meetings planned for June and July. Divisional and Corporate teams continue to work together to make improvements in the quality and timeliness of investigations and responses. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance remains at 91% against the 95.7% target. Outpatients as a whole continues to undergo a transformational programme of work, the FFT metrics are being monitored throughout the period to assess changes in patient satisfaction levels. The action plan is being worked through and an improved performance is expected by Q3. • **Friends and Family Test A & E Survey - Response Rate**. Lowest performance since May 2018. The patient experience lead, lead nurse and CDU sister are doing some focused work to try and improve the response rate. • **Friends and Family Test A & E Survey - % would recommend the service**. Performance is at 85%. The patient experience leads continue to work on addressing the key themes and areas to focus improvement. • **Friends and Family Test Community Survey - % would recommend the service**. Performance has fallen to 95.48%. A review of the comments associated to any negative scores show all but one were related to the immunisation team – with young people indicating that the injections hurt / don't like injections. A recommended form of words has been sent to the Immunisation team to help children understand that the FFT question is about the care of the nurse, not the actual injection. • **% Dementia patients screened following emergency admission aged 75 and over** - performance has dipped to 57.3% and is still below the 90% target. Multi-disciplinary, dementia screening quality improvement programme continues to work across all clinical areas to improve the proportion of screens fully completed and recorded. A Benchmarking exercise will be undertaken to assess how the Trust compares to other Cerner Trusts and this will contribute to a deep dive report scheduled with WEB in Q2.
Effective (83%)	• **% Sign and Symptom as a Primary Diagnosis** - Performance in month is at 8.64% against a target of 8.3% which is a significant improvement from the April performance. The 2 year Clinical Coding Action plan has been signed off and aims to address the key issues affecting the quality of the coding primarily the quality of the documentation within EPR and data quality. • **% Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - performance improved to at 81% in May but is still below the 85% target. The division experienced surges in complex limb trauma and volumes of Paediatrics during May which has challenged prioritisation and therefore elective activity was cancelled and additional trauma capacity put in place.

Background Context

In the latest quarter SSNAP results (January – March 2019) we scored an A for the second time putting us in the top 20 percent of Trusts delivering excellence in stroke care.

ED have introduced a greatix scheme where staff can email when they see outstanding practise or someone going the extra mile. These compliments will be shared with staff and will allow us to learn from all the great practise we do.

Within Medicine staffing is still a huge challenge across the ED directorate. There are 6 vacancies at the HRI site but 6 NQNs are due to start in September. A number of vacancies have been filled in the last month. The directorate is struggling to fill a lot of vacant shifts and July and August are showing a lot of gaps across the roster. There has also been an impact in stopping overtime for shifts and only releasing to bank in the first instance. The Respiratory wards and Acute floor at HRI remain the other high risk areas, however recruitment to the Respiratory vacancies continues to be successful and the number of vacancies are falling accordingly.

Following the closure of ward 4 staff were redeployed at the Huddersfield site, which has had a positive impact on the acute floor staffing.

Ward 17 and 6C have received a second silver accreditation which means achieving a gold exemplar ward accreditation. The Acute Floor at Calderdale has been shortlisted in 2 categories of the HSJ Patient Safety awards. Safety on the unit has improved as the number 1 priority with demonstrable reduction in falls, hospital acquired pressure sores and medication errors, reduction in complaints along with the additional benefits of much better staff recruitment and retention.

Executive Summary

The report covers the period from May 2018 to allow comparison with historic performance. However the key messages and targets relate to May 2019 for the financial year 2019/20.

Domain	Area
Responsive (67%)	• **Emergency Care Standard 4 hours** - improved to 92.3% in May, (93.33% all types) - one of the biggest challenges is around workforce and we are completing focused work with the nursing teams on training and development. The double consultant cover from 11:00am commenced in May and we are in the process of recruiting to the triage post and developing streaming pathways to support this service. With the new Frailty investment, we are working cross directorate with the Acute directorate to develop the same day emergency care unit. The number of over 8 and 10 hour waits reduced by 50% from the April position as this was supported by improved flow through both hospital sites. • **Stroke targets** - % Stroke patients spending 90% of their stay on a stroke unit is at 77.19% but still below the 90% target, scoring an SSNAP D score in May. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival was 50.88% against the 90% target, scoring a SSNAP E score in May. There were also a number of thrombolysis breaches. MADE events are being held to review the length of stay and provide challenge to the teams to ensure discharge planning is starting as soon as possible. This is to reduce the number of delayed discharges and thus improve the flow across the unit. Fortnightly task and finish groups still continue to standardise pathways/ MDT protocols and are expected to be fully implemented by the end of June. • **% Last Minute Cancellations to Elective Surgery** - Increase to 1.16% highest in 12 months. This was due to Theatre staff short notice sickness alongside vacancies and planned sickness absence which created an increase in on day cancellations. There was also some cancellations as part of the Trauma surge SOP (to create capacity for #NoF and other trauma patients). • **% Diagnostic Waiting List Within 6 Weeks** - target missed in 6 out of last 7 months. ECHO - ICS outsourcing company have started working at CHFT and provided adhoc capacity in May. We are exploring additional weekend lists with ICS to increase their capacity. CHFT staff are also performing extra weekend lists through June/July to maximise the number of scans available. Mid Yorks have offered alternative Saturday lists to support our service. Neurophysiology - Staff in post are running additional sessions, we have several jobs going out to adverts and we are putting in a new rota to manage the capacity against the demand. Two outsourcing companies have offered capacity - we are putting together a costed recovery plan. • **38 Day Referral to Tertiary** - performance was 25% in May. Recovery plans are in place. • **Appointment Slot Issues on Choose & Book** - performance has improved to 35%. Action plans in place including Specialty Level Plans, Advice & Guidance, Reviewing of Referrals, Development of Straight to Test Services and DNA management. CAS has had a significant impact in the specialties where it has been implemented. Plans to introduce to a wider number of specialties.
Workforce (85%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total (3.67%) is at its lowest position since September 2018. RTWI performance continues to perform well at 76% but is below the 90% target. • **Essential Safety Training** - overall at 93.4% with only Infection Control below 90%.
Finance (75%)	• **Finance**: **Year to Date Summary** The year to date deficit is £4.58m, a £0.01m favourable variance from plan. • There is some pressure year to date due to lower than planned commercial income and expenditure on utilities, maintenance contracts and clinical waste. • These pressures have been offset in the reported position by lower than planned pay expenditure. • Clinical contract income performance is below plan by £1.03m. The Aligned Incentive Contract (AIC) protects the income position by £0.89m in the year to date leaving a residual pressure of £0.14m. This under-performance is being investigated and is potentially a concern from a performance perspective. • CIP achieved year to date is £1.30m, £0.06m more than planned. • Agency expenditure year to date is £1.36m, £0.82m below the planned level. **Key Variances** • Clinical contract income is not far below plan overall but only after £0.89m protection offered by the Aligned Incentive Contract and indicating the lower than planned activity levels across all points of delivery. • In the main the clinical divisions are showing favourable variances to plan, reflective of lower expenditure linked to lower activity levels across Divisions; and vacancy levels in Community. Medicine division has some expenditure pressure from additional beds being open in the early part of the year. • Non-clinical areas are experiencing pressure with lower than planned income generation for the Health Informatics Service and higher than planned cross charge for services from CHS including utilities, clinical waste and maintenance contracts. • There is a favourable variance on Medical staffing expenditure of £0.13m, with lower than planned activity in some specialties resulting in a reduction in the requirement for agency / bank premium. • Nursing pay expenditure is also lower than planned with a further reduction in both agency usage and average price. **Forecast** • At this early stage of the year the Trust is forecasting to achieve the planned £9.7m deficit with the assistance of the full allocation of conditional funding available as a result of accepting the 2019/20 Control Total, (a £37.99m deficit). • Conditional funding consists of three separate funds: Marginal Rate Emergency Tariff (MRET) funding (conditional on acceptance of Control Total but not on achievement of plan), Provider Sustainability Funding and the Financial Recovery Fund, both of which are conditional on the achievement of the quarterly plan. • There is a balance of risk and opportunity at this stage which is being monitored. Calls against the Trust's £1m contingency reserve will be considered through the Commercial Investment Strategy Committee.

Background Context

In Community there have been no category 3 or 4 pressure ulcers demonstrating excellent patient care.

Key challenges continue to be around workforce - with vacancies and sickness. Strategies both short term and long term are being developed to improve the position. The impact is being seen specifically across Therapy services and the OoHs team.

In FSS the Radiologist vacancy still continues to be a pressure. Work continues to offer Radiology support to front line services whilst pursuing a number of short and long term solutions. There is a discussion under way with Leeds regarding Interventional Radiology and Mid York's for support for Head and Neck.

A number of visits and inspections have been undertaken within the Division:
Fertility services have had a HEFA inspection from Leeds with initial feedback being positive.
Diabetes Peer review - had a disappointing outcome with 2 serious concerns - initial action plan has been drawn up and a WTGR event is planned with team to agree a way forward and a robust plan to address concerns.

NHS Resolution work is coming to a conclusion with the Majority of KPI's met.

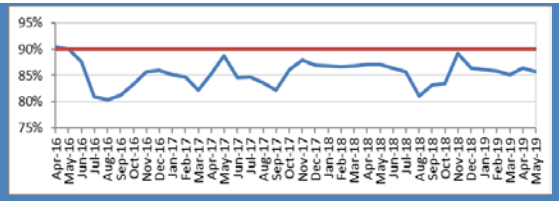
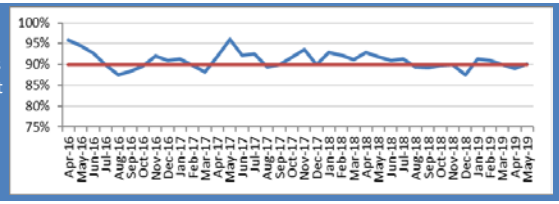
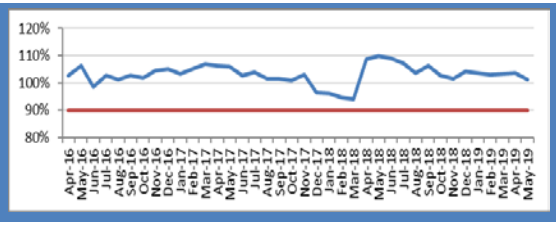
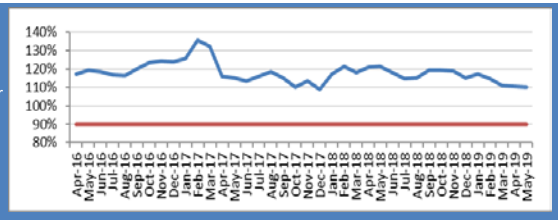
in May a spike in the follow up OPD DNA rate was recorded. This is currently being investigated further and appropriate mitigating actions will be taken.

Within Surgery the divisional team is still without a Head Nurse/Theatre Matron which is contributing to a reduction in complaint response capacity (interviews 20th June). The Theatre Scheduler post started on 3rd June and Project Manager commences in post on 8th July – should have impact on theatre utilisation, late starts and list compilation. Activity has been impacted by a reduction in WLI due to Pension challenges across specialties that are reliant on non-contracted spend to deliver capacity (General/Colorectal Surgery and Ophthalmology in particular). Short/long term sickness has had additional impact upon the already challenged Ophthalmology capacity, although improvements in holding list and ASIs has started to impact due to micromanaging of slots and maximising any free capacity.

Upper GI has long term sickness which has impacted upon ASI position and DC/IP capacity. Endoscopy activity increased due to ASI reduction in Gastroenterology, creating 7 day demand and increased costs (income is within Medicine).

Gastroenterology ASIs have seen a further reduction. In the last four months the ASI has reduced from 650 to 199, this is ahead of the trajectory of 400 in June. The biggest impact on the ASI numbers is the Clinical Assessment Service (CAS).

Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	85.64% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 4 44.8% - Ward 15 74.5% - Ward 7a/d 74.7 - Ward 12 69.8% - ward 17 69.8%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy and closure of ward 4 HRI. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	90.13% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - Ward 4 46.8% - Ward 17 73.4%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to a level of vacancy and the closure of ward 4 HRI in month. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	101.36% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - Ward 4 52.5% - ICU 57% - LDRP 63.5% - NICU 72.7%	The low HCA fill rates in May2019 are attributed to a level of HCA sickness within the FSS division and the closure of ward 4 within medicine. 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.	110.15% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - Ward 4 45.2%	Low HCA fill rates on ward 4 HRI as the ward closed in month.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT						Care Hours Per Patient Day						
		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	GENERAL MEDICINE	2,977.17	2,864.00	2,309.83	2,376.00	96.2%	102.9%	2,520.00	2,438.00	2,046.00	2,195.00	96.7%	107.3%	10.5	10.6		0	24	3.43	2.81	87.8%
HRI ACUTE FLOOR	GENERAL MEDICINE	3,236.33	2,928.67	2,693.00	2,675.50	90.5%	99.4%	2,725.50	2,539.50	2,046.00	2,123.00	93.2%	103.8%	10.8	10.3		5	31			81.0%
WARD 4	GENERAL MEDICINE	887.20	397.37	1,168.50	613.50	44.8%	52.5%	682.00	319.00	682.00	308.00	46.8%	45.2%	33.9	16.2		1	1	4.78	-1.32	72.4%
WARD 5	GERIATRIC MEDICINE	1,666.80	1,327.13	1,152.33	1,548.23	79.6%	134.4%	1,023.00	1,023.00	1,023.00	1,551.00	100.0%	151.6%	5.5	6.2		0	9	1.15	-0.52	57.8%
WARD 15	GENERAL SURGERY	1,870.30	1,399.17	1,568.50	2,018.17	74.8%	128.7%	1,364.50	1,311.50	1,364.00	1,584.00	96.1%	116.1%	6.4	6.6		1	11	2.15	-2.32	73.0%
RESPIRATORY FLOOR	GENERAL MEDICINE	3,628.67	3,079.25	2,427.58	2,503.42	84.9%	103.1%	2,717.00	2,380.00	1,023.00	1,281.00	87.6%	125.2%	6.9	6.5		1	6	12.25	-1.95	50.4%
WARD 6	GENERAL MEDICINE	1,494.08	1,172.08	930.42	1,106.08	78.4%	118.9%	1,023.00	1,010.17	1,022.02	1,023.02	98.7%	100.1%	5.6	5.4		0	0			71.6%
WARD 6C	GENERAL MEDICINE	1,097.83	936.17	763.00	742.25	85.3%	97.3%	671.00	682.00	341.00	341.00	101.6%	100.0%	5.3	5.0		1	3	1.88	-1.83	67.0%
WARD 6AB	GENERAL MEDICINE	1,432.73	1,124.73	1,111.50	1,491.17	78.5%	134.2%	1,023.00	1,078.00	1,023.00	1,279.50	105.4%	125.1%	5.5	5.9		1	11	1.54	3.41	50.4%
WARD CCU	GENERAL MEDICINE	1,499.17	1,374.25	373.50	373.50	91.7%	100.0%	1,023.00	1,023.00	0.00	11.00	100.0%	-	8.9	8.6		0	2	1.08	0.13	72.9%
WARD 7AD	STROKE MEDICINE	1,733.33	1,295.18	1,576.83	1,286.50	74.7%	81.6%	1,023.00	847.00	1,023.00	814.00	82.8%	79.6%	10.1	8.0		1	1	1.97	4.52	65.3%
WARD 7BC	STROKE MEDICINE	2,607.33	2,061.55	1,721.67	1,781.17	79.1%	103.5%	2,046.00	1,620.00	682.00	1,093.50	79.2%	160.3%	10.7	9.9		0	2	3.65	-8.90	69.7%
WARD 12	MEDICAL ONCOLOGY	1,656.58	1,156.58	754.00	1,126.75	69.8%	149.4%	1,023.00	935.00	341.00	429.00	91.4%	125.8%	6.2	5.9		1	2	1.26	-2.35	51.7%
WARD 17	GASTROENTEROLOGY	2,255.00	1,575.00	1,320.67	1,062.00	69.8%	80.4%	1,364.00	1,001.00	682.00	792.00	73.4%	116.1%	6.3	5.0		0	3	8.80	-3.97	49.8%
WARD 20	GERIATRIC MEDICINE	1,784.33	1,558.42	1,542.33	1,777.00	87.3%	115.2%	1,364.00	1,245.00	1,364.00	1,452.50	91.3%	106.5%	6.8	6.8		2	8	3.89	-2.76	71.3%
WARD 21	TRAUMA & ORTHOPAEDICS	1,648.83	1,456.58	1,512.17	1,438.00	88.3%	95.1%	1,069.50	954.50	1,069.50	1,046.50	89.2%	97.8%	8.9	8.2		3	4	6.46	-1.29	70.8%
ICU	CRITICAL CARE MEDICINE	4,301.50	4,066.25	793.50	453.25	94.5%	57.1%	4,266.50	3,623.75	0.00	0.00	84.9%	-	38.4	33.4		2	2	3.93	0.20	75.9%
WARD 3	GENERAL SURGERY	1,045.67	1,000.33	589.00	568.17	95.7%	96.5%	713.00	713.00	529.00	540.50	100.0%	102.2%	6.5	6.3		1	6	0.00	0.37	67.4%
WARD 8A	TRAUMA & ORTHOPAEDICS	1,038.25	768.08	747.50	703.00	74.0%	94.0%	713.00	563.50	356.50	356.50	79.0%	100.0%	9.7	8.1		0	1			63.7%
WARD 8D	ENT	981.00	924.00	589.00	570.00	94.2%	96.8%	713.00	713.00	172.50	178.00	100.0%	103.2%	6.7	6.5		0	0	1.76	-0.85	65.6%
WARD 10	GENERAL SURGERY	1,441.00	1,232.83	874.00	1,082.77	85.6%	123.9%	1,069.50	896.50	713.00	943.00	83.8%	132.3%	7.1	7.2		0	0	7.02	2.18	56.1%
WARD 11	CARDIOLOGY	1,777.67	1,640.12	1,114.77	1,079.38	92.3%	96.8%	1,241.00	1,064.00	713.00	873.00	85.7%	122.4%	6.5	6.3		3	2	6.02	-0.71	66.3%
WARD 19	TRAUMA & ORTHOPAEDICS	1,717.67	1,416.08	1,178.00	1,394.00	82.4%	118.3%	1,069.50	1,057.67	1,069.50	1,437.00	98.9%	134.4%	7.4	7.8		1	5	3.66	1.98	75.2%
WARD 22	UROLOGY	1,259.58	1,190.67	1,103.17	1,096.67	94.5%	99.4%	713.00	690.00	713.00	724.50	96.8%	101.6%	6.0	5.9		0	1	1.27	0.72	51.0%
SAU HRI	GENERAL SURGERY	1,771.83	1,605.33	878.00	915.67	90.6%	104.3%	1,652.75	1,505.25	356.50	423.50	91.1%	118.8%	10.0	9.5		0	4			68.5%
WARD LDRP	OBSTETRICS	4,111.00	3,530.17	934.83	593.83	85.9%	63.5%	3,879.00	3,405.50	713.00	679.50	87.8%	95.3%	25.2	21.5		0	0			33.8%
WARD NICU	PAEDIATRICS	2,340.00	2,021.25	775.75	564.25	86.4%	72.7%	2,139.00	1,782.50	713.00	621.00	83.3%	87.1%	12.2	10.2		0	0	3.15	1.47	42.6%
WARD 3ABCD	PAEDIATRICS	3,649.90	3,447.25	750.00	799.50	94.4%	106.6%	3,629.00	3,466.50	356.50	391.00	95.5%	109.7%	11.3	10.9		0	0	0.47	1.82	20.2%
WARD 4ABD	OBSTETRICS	2,415.33	2,229.42	713.00	703.00	92.3%	98.6%	1,777.75	1,713.50	713.00	719.00	96.4%	100.8%	5.7	5.5		0	0	2.72	4.26	43.4%
WARD 4C	GYNAECOLOGY	1,394.42	1,225.75	384.50	377.00	87.9%	98.0%	713.00	713.00	356.50	350.75	100.0%	98.4%	9.3	8.7		0	1	1.02	0.52	75.4%
TRUST		**60,720.52**	**52003.67**	**34350.85**	**34819.7**	**85.64%**	**101.36%**	**46950.5**	**42314.3**	**23206.52**	**25561.3**	**90.13%**	**110.15%**	**8.5**	**8.0**						

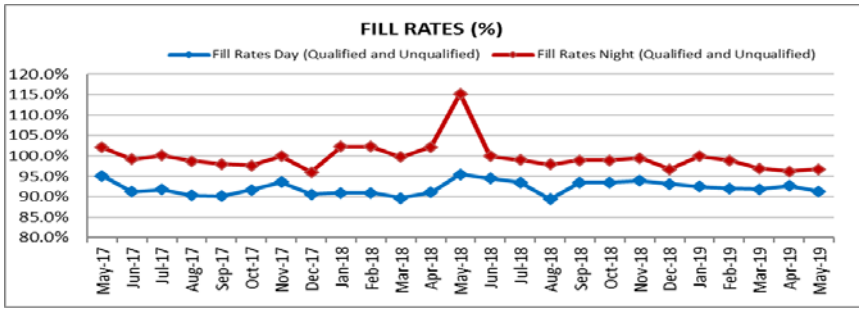
Hard Truths: Safe Staffing Levels (3)

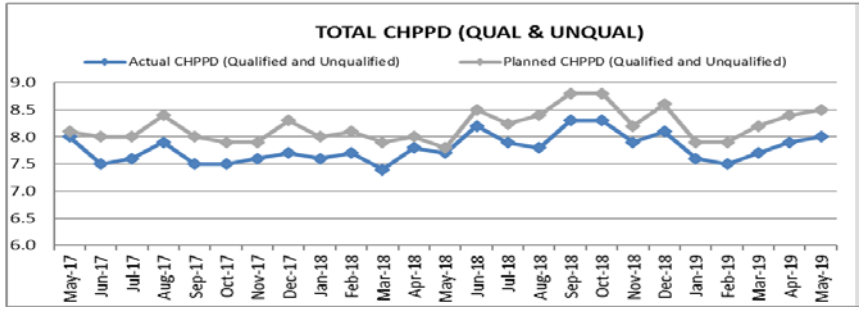
Care Hours per Patient Day

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

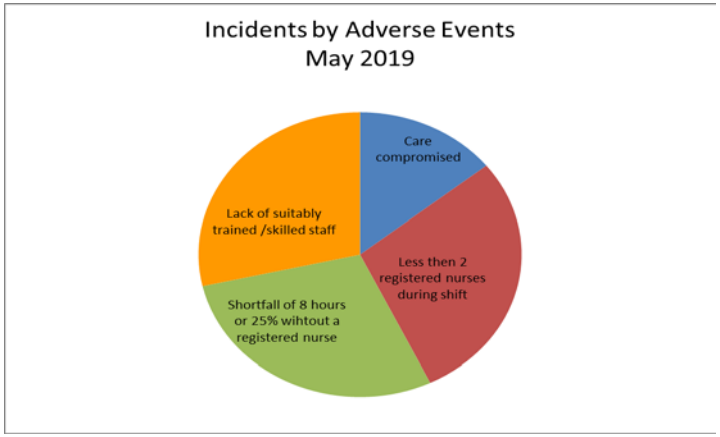
	Mar-19	Apr-19	May-19
Fill Rates Day (Qualified and Unqualified)	91.8%	92.6%	91.3%
Fill Rates Night (Qualified and Unqualified)	96.9%	96.2%	96.7%
Planned CHPPD (Qualified and Unqualified)	8.2	8.4	8.5
Actual CHPPD (Qualified and Unqualified)	7.7	7.9	8.0

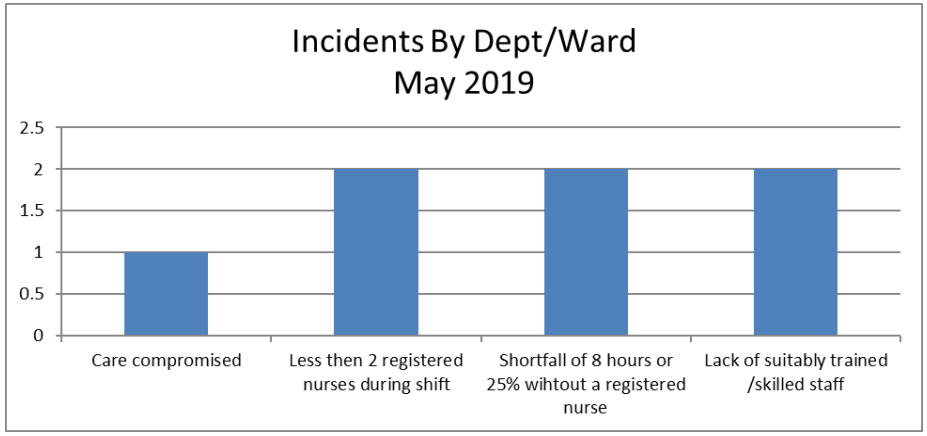
A review of April 2019 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 22 clinical areas of the 30 reviewed having CHPPD less than planned. 6 areas' reported CHPPD slightly in excess of those planned and 2 areas having CHPPD as planned. Arears with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and reviewed monthly through the Nursing workforce strategy group.
There were **7 Trust Wide Red shifts** declared in May **2019.**
No datix's reported in May 2019 have resulted in patient harm.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.
2. Monthly recruitment initiatives continue.
3. Applications from international recruitment projects are progressing well and the first 25 nurses have arrived in Trust, with a further 4 planned for deployment in late June 2019
4. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 6 NA who started in post in April 2017. A further 43 trainees are on programme and will graduate in 2020. The programme will next run in June 2019 with 17 recruits.
6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment & retention of the graduate workforce.
7. A new module of E roster called safe care has been introduced across the clinical divisions. Benefits will include, better reporting of red flag event and, real-time data of staffing position against acuity.

CQUINS - Key messages

Area	Reality	Response	Result
Overall	There is a new CQUIN Scheme in place for 19/20	April's data requirements are being worked through and performance will be updated for all indicators at the end of Q1	

CQUIN - Key Measures

	Services in Scope	Indicator Name		Target	Apr-19	May-19	Jun-19	Q1	Jul-19	Aug-19	Sep-19	Q2	Oct-19	Nov-19	Dec-19	Q3	Jan-20	Feb-20	Mar-20	Q4
Prevention of Ill Health	Acute	CCG1: Antimicrobial Resistance	CCG1a: Antimicrobial resitance - Lower urinary tract infections in older people	90%	Data available at quarter end			-												
			CCG1b: Antimicrobial resistance - Antibiotic prophylaxis in colorectal surgery	90%	Data available at quarter end			-												
	Acute & Community	CCG2: Staff Flu Vaccinations	CCG2: Staff Flu Vaccinations	80%	Data collection starts 1st September 2019				Data collection starts 1st September 2019											
	Acute & Community	CCG3: Alcohol and Tobacco	CCG3a: Alcohol and Tobacco - Screening	80%	Data available at quarter end			**TBC**												
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice	90%	Data available at quarter end			**TBC**												
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice	90%	Data available at quarter end			**TBC**												
Patient Safety	Acute & Community	CCG7: Three high impact actions to prevent Hospital Falls	CCG7: Three high impact actions to prevent Hospital Falls	80%	Data available at quarter end			**TBC**												
	Community	CCG8: PICC lines secured using a SecurAcath device	CCG8: PICC lines secured using a SecurAcath device	85%	Data available at quarter end			**TBC**												
Best Practice Pathways	Acute with type 1 emergency department	CCG11: Same Day Emergency Care	CCG11a: SDEC - Pulmonary Embolus	75%	Data available at quarter end			**TBC**												
			CCG11b: SDEC - Tachycardia with Atrial Fibrillation	75%	Data available at quarter end			**TBC**												
			CCG11c: SDEC - Community Acquired Pneumonia	75%	Data available at quarter end			**TBC**												

16. Transformation Programme Board Terms of Reference

To Approve

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Transformation Programme Board Terms of Reference
Author:	Anna Basford, Director of Transformation & Partnerships
Previous Forums:	The draft terms of reference were discussed at the meeting of the Estates Sustainability Committee held on 17th June 2019. Comments from members of the Committee have been incorporated.
Actions Requested: To approve	
Purpose of the Report	
To describe the terms of reference of the Transformation Programme Board that will be established as a Standing Committee of the Trust Board to oversee the development and delivery of complex transformation programmes in the Trust and provide assurance on these matters to the Trust Board.	
Key Points to Note	
The responsibilities of the Transformation Programme Board includes establishing key milestones for the reconfiguration of services and to monitor progress against them ensuring that service delivery plans are based on new ways of working including the optimised use of digital technology.	
EQIA – Equality Impact Assessment	
The terms of reference of the Transformation Programme Board includes responsibility for monitoring the Equality and Quality Impact Assessment and Data Protection Impact Assessment of the Transformation Programme.	
Recommendation	
The Board is asked to **APPROVE** the draft Transformation Programme Board Terms of Reference.	

TRANSFORMATION PROGRAMME BOARD TERMS OF REFERENCE

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Transformation Programme Board. The Transformation Programme Board has no executive powers, other than those specifically delegated in these Terms of Reference. The governance structure is at appendix 1.

2. Authority

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

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

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

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

3. Purpose

3.1. The purpose of the Transformation Programme Board is to oversee the development and delivery of complex transformation programmes in the Trust, and to provide assurance on these matters to the Trust.

3.2. The responsibilities of the Transformation Programme Board include:

- To monitor key milestones for the reconfiguration of services ensuring that service delivery plans are based on new ways of working including the optimised use of digital technology.
- To monitor the key milestones for the capital investment and estate development at Huddersfield Royal Infirmary and Calderdale Royal Hospital to enable service reconfiguration.

- To ensure the Trust has secured through appropriate commercial arrangements an effective supply chain with the necessary specialist skills and capacity to deliver the reconfiguration of services and associated estate development.

- To ensure that the Programme produces viable and affordable business cases that are supported by local CCGs and the West Yorkshire Health and Care Partnership and approved by NHSE&I, DHSC and HM Treasury. This includes the Strategic Outline Case, the Outline Business Case and the Full Business Case.

- To ensure that the risks associated with the Transformation Programme are managed appropriately.

- To ensure that benefits realisation associated with the Transformation Programme are managed appropriately.

- To monitor the Equality and Quality Impact Assessment and Data Protection Impact Assessment of the Transformation Programme.

- To ensure the Trust continues to engage and involve local people, key stakeholders and the Joint Health Scrutiny Committee in the Transformation Programme.

4. Duties

4.1 The Programme Board will approve and manage the programme plan and sign off the key outputs and decisions at each stage of the programme. This includes:

- patient and staff communications and engagement;
- procurement and commercial processes and decisions;
- review of all the key deliverables and the activities required to deliver them;
- the activities required to validate the quality of the deliverables;
- the resources and time needed for all activities and any need for people with specific capabilities and competencies;
- the dependencies between activities and any associated constraints when activities will occur;
- the points at which progress will be monitored, controlled and reviewed;
- the provision of regular reports, updates and assurance to CHFT Board, NHSE&I and Treasury;
- maintenance of a detailed risk register and mitigation of risk factors affecting the successful delivery of the project;
- maintenance of a benefits realisation register and monitoring of delivery;

- considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required;
- review of serious issues, which have reached threshold level;
- brokering relationships with stakeholders within and outside the project to maintain positive support for the programme;
- maintaining awareness of the broader strategic perspective advising the SRO on how it may affect the project;
- approving the design brief, appointment of external consultant team and approving the programme of work and the critical path.

5. Membership and attendance

5.1. The Transformation Programme Board shall consist of the following members:

- Three Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee. (The Trust Board may also choose to appoint an independent Lay Chair.)
- Chief Executive / Senior Responsible Officer (SRO)
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Director of Workforce and Organisational Development
- Director of Finance
- Director of Transformation and Partnerships (Programme Director)
- Managing Director - Digital Health
- Managing Director – Calderdale and Huddersfield Solutions

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

- Transformation Programme Manager
- Transformation Programme Administrator (notes)
- Associate Director of Finance

5.3. Other attendees may be co-opted or requested to attend as considered appropriate and may include external advisors.

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

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

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

6. Administration

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

- in consultation with the Chair develop and maintain the reporting schedule to the Committee;
- collation of papers and drafting of the agenda for agreement by the Chair of the Committee;
- taking the minutes and keeping a record of matters arising and issues to be carried forward;
- advising the group of scheduled agenda items;
- agreeing the action schedule with the Chair and ensuring circulation ;
- maintaining a record of attendance.

7. Frequency of meetings

7.1. The Committee will meet bi-monthly. Additional meetings may be scheduled if required in relation to the Transformation Programme of work and timelines.

8. Reporting

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

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

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

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

8.5. In considering reporting to the Trust Board, the Transformation Programme Board will consider Guidance for Reserving Matters to a Private Session of the Board of Directors

9. Review

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

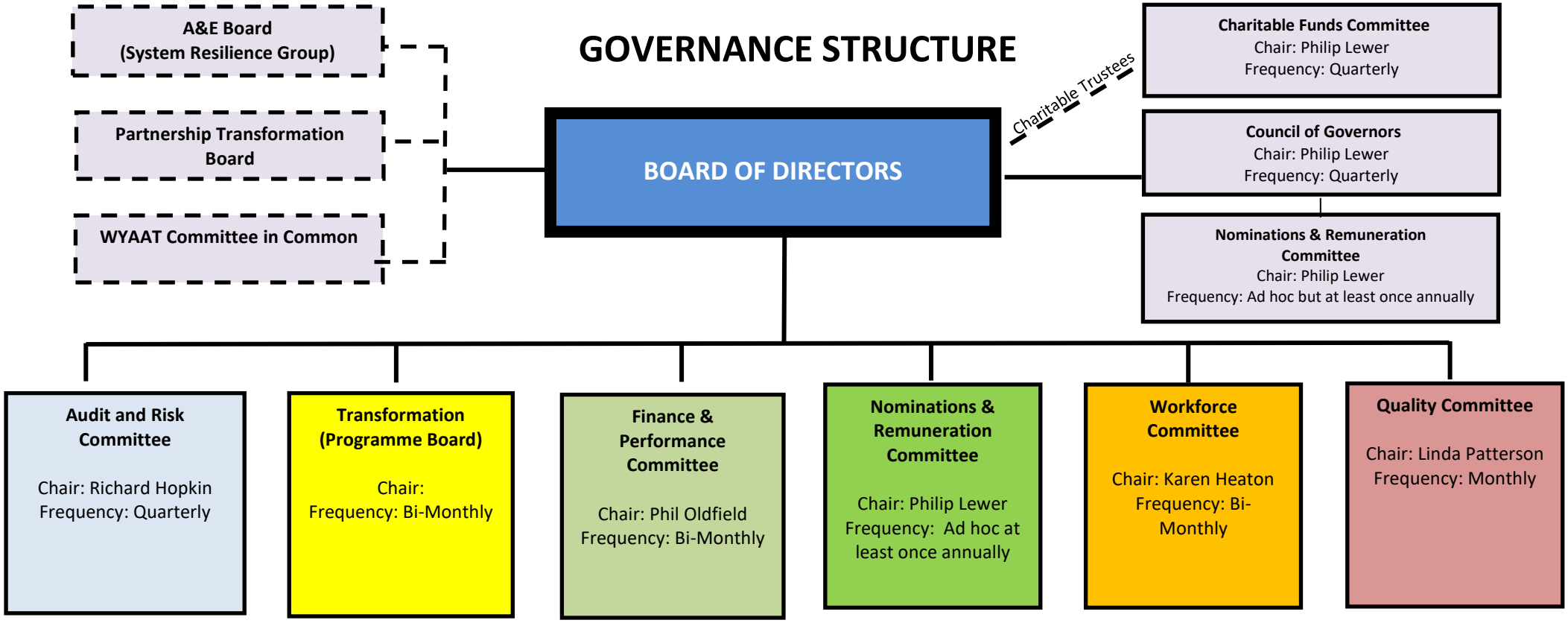
9.2. The terms of reference of the Committee shall be reviewed by the Trust Board of Directors at least annually.

10. Monitoring effectiveness

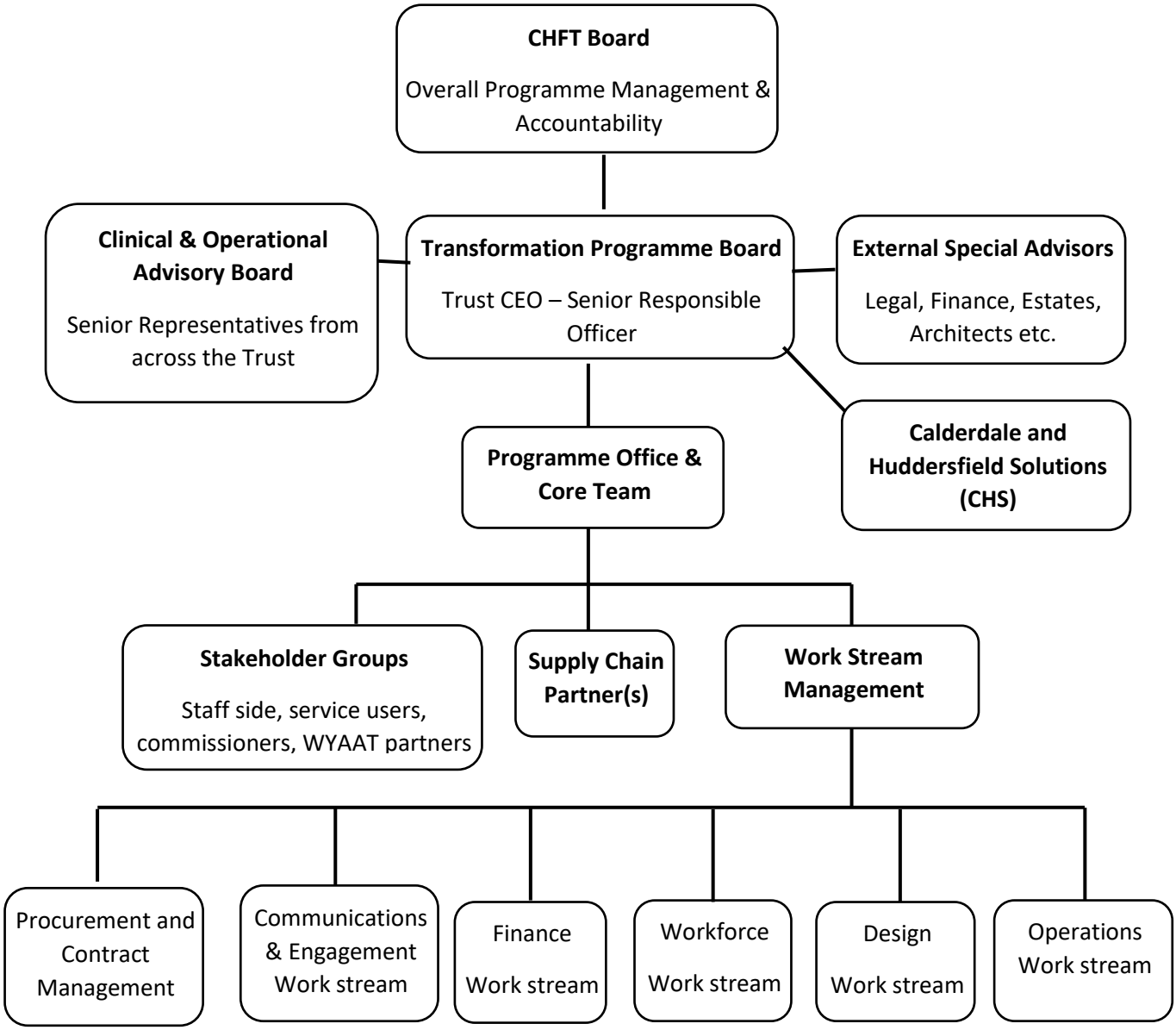
10.1. In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following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

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

Appendix 1


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
Transformation (Programme Board)
Chair:
Frequency: Bi-Monthly
Finance & Performance Committee
Chair: Phil Oldfield
Frequency: Bi-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

Transformation Programme Structures



Note – Calderdale and Huddersfield Solutions Ltd (CHS) is a wholly owned subsidiary of the Trust that provides a full range of estate and facilities services to the Trust. CHS formal governance accountability to the Trust Board is through the Finance and Performance Committee. CHS will provide the Trust with in-house estates and facilities advice in relation to the programme of reconfiguration and this is reflected in the Transformation Programme Board governance structure shown.

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

• Finance and Performance Committee – minutes from meeting held 31 May 2019

• Quality Committee – minutes from meeting held 1 April, 29 April 2019 and 3 June 2019

• Workforce Committee - minutes from meeting held 17 May 2019

• Charitable Funds Committee – minutes from meeting held 22 May 2019

To Note

Presented by Phil Oldfield, Linda Patterson, Karen Heaton and Philip Lewer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 31 May 2019, 9.30am – 12.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnership
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive

IN ATTENDANCE

Mel Addy	Director of Operations – Surgical Division (For Item 089/19 only)
Sian Grbin	Governor
Philip Lewer	Chair of the Trust
Philippa Russell	Assistant Director of Finance
Betty Sewell	PA (Minutes)

ITEM

083/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

084/19 APOLOGIES FOR ABSENCE

Apologies were noted for Kirsty Archer and Stuart Baron

085/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

086/19 MINUTES OF THE MEETING HELD 26 APRIL 2019

The Draft Minutes of the meeting held 26 April 2019 were approved subject to several minor amendments.

087/19 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as appropriate.

Matters Arising

009/19: Use of Resources – this will be updated at the next meeting regarding conversations with NHSI – **GB, 28 June 2019**

076/19: Medical Division Reconfiguration – RH asked HB for an update regarding the frailty service and possible cover 24/7. HB confirmed that there were three elements surrounding frailty, one was in establishing clinics, one was expansion to the current frailty service in terms of developing a frailty assessment area and thirdly an overnight frailty service. Even though all three have a good evidence base we do not have the funds for them all. It was noted that we have supported the establishment of clinics and the frailty assessment area, and the first component starts in July. As part of the wider system of emergency care, one of the priority workstreams is frailty and we are

looking to see if there could be any assistance from the system to invest in the overnight element.

056/19: Marvellous March – This item has been deferred to next month to ensure the Committee see a balanced view – **HB, 28 June 2019**

FINANCE & PERFORMANCE

088/19 INTEGRATED PERFORMANCE REPORT

The Director of Operations reported that April was a challenge and to help avoid some issues recurring, particularly around Emergency Care. Next year, irrespective of where Easter lands, Winter Planning will be kept in place during April 2020. However, we did secure the agreed trajectory with NHSI of 90%. Easter was a pressure point in terms of flow and following some learning from this we planned differently for the May Bank Holidays and we are slightly under 92.6% (Type 1 only). Our focus is still on HRI A&E.

Cancer – all standards delivered apart from Day 38. It was noted that we have a significant number of patients delayed to treatment with a cohort of patients who are over 62 days without diagnosis and we had 4 patients who were over 104 days still without a treatment plan. Some of these patients have very complex pathways and are being tracked, however, the lesson learnt is that even though a patient has been referred to one of the tertiary centres they should be progressed within our tracking. Long waiters are being closely managed, however, it was acknowledged that Day 38 is a real challenge.

Fast-Track Referrals – continue to increase, as at last week we had 1250 patients who had had a fast-track referral. This is increasing month on month and our ability to respond is a challenge and is compounding on our Appointment Slot Issues (ASIs).

Capacity – there is a particular challenge on the 2 week wait. We have vacancies in Radiology for Breast Radiologists which in turn has caused 40 breaches on our 2 week wait, this also gives us a further pressure on Day 62.

It was noted that a Head & Neck Radiologist is due to commence in July and we have ad-hoc cover from Mid-Yorks. From a lung perspective we do not have any cover for annual leave. A Diagnostics Board has since been established with the Clinical Director to try to get to a position of reporting around diagnostic performance and demand and we are working with our clinical teams to identify a reporting structure.

It was also noted that several Work Together Get Results (WTGR) sessions have taken place with Radiology and Diagnostics colleagues, it was felt that requests for further resource and equipment have not been listened to by the organisation. Restricted working and their ability to sub-specialise along with reduced teaching time have also been called out as reasons for the lack of retention of our Radiologists. The direct engagement events have taken place to try to identify how we can support Radiology and be pro-active, however, it was also noted that the performance from our Radiologists to achieve our cancer targets has been quite remarkable and was acknowledged.

ACTION: The significant risks for the Trust, not just for cancer but for most of our services were recognised by the Committee. It was agreed to receive a paper at the next meeting summarising an action plan for the sustainability and the risk – **HB, 28 June 2019**

RTT – The March performance had been a challenge and lessons learnt had not been taken into April and the target for Incomplete Pathways failed for the first time. Looking at May, each specialty has been in escalation with clear focus on confirmation of RTT timed pathways with clear milestones, reduction in first outpatient appointment waiting times and clearing the backlog on the ASI list. Key themes from validation are being reviewed with focus on fixing issues at source and refocusing operational capacity on RTT improvement. Questions are being asked to gain reassurance around data quality and resource is being investigated to ensure the right skill set is in place.

Weekly meetings are taking place with General Managers and DoOps and the link with regard to the ASI backlog is recognised, this backlog should be clear by August.

The Committee asked for a planned proposal to address these issues including what finance will be required to resource realistic capacity/capability.

It was suggested that 'Priorities/Resource' should be discussed/presented to the wider Board.

ACTION: To feedback with a timeline to get RTT back on track at the next meeting – **HB, 28 June 2019**

It was noted that next month's WEB will hold a deep-dive on RTT.

Stroke – the decrease in the stroke target reflects pressures in April with a combination of capacity reduction, a peak in demand and the ownership of model changes. Discussions have been held with the Stroke team and agreement has been reached to ensure there is always a stroke bed available. The one element of Stroke which we haven't got underneath is Thrombolysis and a review of what is driving this is being undertaken.
Complaints – a deep-dive has been undertaken and results have been presented to colleagues, it was agreed that this will come to this forum next month.

ACTION: To bring the Complaints presentation to the next meeting – **OW, 28 June 2019**

Stranded/Super-stranded – the target was for a 25% reduction, we actually achieved a 35% reduction, the only Trust in the region to achieve. Nationally the drive is around a 21-day length of stay, the expectation is for every organisation on every ward to have a multi-disciplinary accelerated discharge event every week.

In terms of May, it was noted that ASI is significant, there was a presentation at WEB yesterday which will come back to this Committee.

Finally, the Committee were advised that there will be a Re-admission Summit next week based on the Get It Right First Time (GIRFT) data.

RH sighted the Committee that regarding data quality, there was a point picked up by KPMG at year-end and the test of the I&E indicator which found that 3 out of 25 failed and therefore they could not be assured at that point in time in hitting the 4 hour deadline, this will go back to Audit & Risk Committee in July to receive assurance.

RH raised a question regarding the lack of resource in Respiratory and asked if this is being addressed, it was confirmed that issues are being addressed.

The Committee **NOTED** the report for April.

089/19 THEATRE PRODUCITIVTY/UTILISATION WORK

Mel Addy, Divisional Director of Operations – Surgical Division presented an update to the Committee detailing the findings of the 2018 NHSBN Theatres Benchmarking. It was noted that Theatre Utilisation has been a focus for the Division for many years, however, there has been a targeted fresh approach this year to deliver the same work for less cost.

As part of this fresh approach, Will Ainslie worked with Health Informatics to produce an App through the Knowledge Portal. This can evidence, in real-time and with live data, the late starts, touch time on patients, turnaround time and any unused time. This information is available for each specialty and each consultant and as part of this a WTGR session has taken place with 6 representatives from each area who came together to share their experience.

The good progress was noted and as a data-rich organisation it was felt that there is an opportunity to improve Theatre Utilisation further through engagement and having further informed discussions. A question was asked regarding the dissemination of this information and MA explained that each Clinical Director has shared individual group data about their specialty and this information, in turn, is shared through the theatre teams.

The presentation also listed the opportunities under consideration and the detail of the delivery of efficiency savings. In 2019/20 there is a further saving of £569k forecasted based on the new approach, a Project Manager is due to start in July and a Theatre Scheduler is due to start in the coming week, this is to ensure an independent view of the theatre times are accurate. Both positions are temporary.

A question was asked regarding staffing and fallow lists, MA described scenarios which assured the Committee that their time is used to complete their essential safety training, fill short-term notice sickness and to cover vacancies.

MA concluded by confirming that a follow up session will take place with the theatre teams in 3 months' time to work through this process.

GB agreed that this is a really important piece of work but to put context to the last slide regarding efficiency, we are doing less volume of work (activity) for the same cost. It was noted there are several factors around this such as recruitment issues within Ophthalmology and that this is the trend locally. OW challenged this view and questioned that this is not just around headcount but the unpredictability of the unplanned element. MA described that this week two elective lists have been cancelled due to unplanned trauma cases, however, some days this is not an issue.

PL commented that he was re-assured regarding the debate and challenge about this subject and that reviewing data not individual consultants was refreshing.

In terms of clinical variation, it was noted that this is the strand through GIRFT which is being reiterated but it was stressed that outcomes are important and unless a consultant is an outlier and the outcomes are good then this should be accepted. Within the GIRFT programme there is a real opportunity for clinical engagement.

The Committee thanked MA for the very interesting presentation and agreed that the Committee would like to receive a review of next steps in 6 months' time, looking at where are we now, what we have done and what are the lessons learnt.

ACTION: To receive a further review of Theatre Utilisation in 6 months – **MA/WA, 29/11/19**

090/19 MONTH 02 FINANCE REPORT

The Director of Finance reported that the year to date deficit is £3.28m, in line with plan. It was noted that agency spend was lower than plan and maintenance expenditure was higher than plan, this risk of items previously not being maintained has been flagged through the Joint Liaison Committee. CIP is on plan and Cash is in a stronger position in terms of aged debt. It was also noted that the high planned deficit position at Month 1 is mainly due to the phasing of conditional funding which is back-ended. In addition, the planned payment for the Agenda for Change pay awards has also been made.

In relation to Cash, RH asked a question regarding debt collection, specifically relating to PMU, Locala and Overseas Visitors and the availability of day to day resource. GB accepted the challenge and assured the Committee that the Cash Committee has been recognised by NHSI and external organisations are approaching us to replicate our model. The assigning of accounts to an Assistant Director Finance is working well and is making good progress. However, in relation to PMU there are a significant number of invoices being raised and the cost of resource to chase payments needs to be off-set. It was acknowledged that PMU need to be engaged to find resource to chase debts and that we still have a challenge with the system.

It was noted that regarding Locala, this debt has now been paid and in relation to Overseas and private work, on the whole payment is being asked for in advance. Aged debt is not written-off too quickly as payments are still received many months after treatment.

In the short-term the Committee will review the Cash Committee minutes to monitor continued improvement.

The Committee **RECEIVED** and **NOTED** the report.

091/19 2019/20 TRUST FINANCE RISK

The Director of Finance presented a paper which proposed a change to our Risk Scores.

The following Risk Ratings were discussed in detail and the following scores were agreed: -

- The Cash and in-year I&E Risk remains at 12.
- The Capital risk increases to a score of 16 to reflect the latest position.

- The longer term financial stability risk remains at 25 – subject to a change in the narrative to suggest that we are currently progressing a business case.

The Committee **NOTED** the paper.

092/19 REFERENCE COSTS PRE-SUBMISSION REPORT

The Director of Finance shared a paper with the Committee which described the current governance process in place for the submission to NHS I of our Reference Costs and Patient Level Cost Submission for 2018/19.
The Final Submission will be presented to the F&P Committee prior to submission.

The Committee **NOTED** the report.

093/19 WYAAT – COMMITTEE IN COMMON FINANCIAL REPORTING 2018/19 YEAR-END POSITION

The Director of Finance presented a paper which provided the Committee with the year-end position across WYAAT, prior to audit, compared with plans. It showed the position with and without Provider Sustainability Funding (PSF). It was noted that all organisations delivered a pre-PSF better position than their forecast at Qtr. 3, with the exception of CHFT. It was also noted that despite Mid-Yorks., missing their Control Total because they had accepted it, they still got their bonus. It was agreed that CHFT are gaining the reputation of delivering what we say we will deliver and that we still did the right thing in not accepting our Control Total.

The Committee **NOTED** the contents of the report for information only.

STRATEGIC ITEMS

094/19 CIP UPDATE

The Director of Partnerships & Transformation reported the current CIP position as follows: -

- 2019/20 CIP requirement is £11m with £10.2m at GW2
- £800k is at scoping GW1 – agreed timelines will be taken to Turnaround Executive (TE)
- Headroom is being factored in to mitigate any slippage
- Move to a full £11m recurrent to minimise impact for next year
- Pipeline schemes will be updated at Monday's TE.

GOVERNANCE

095/19 DRAFT MINUTES FROM SUB-COMMITTEES

- Draft Cash Committee held 11 April 2019
- Draft Capital Management Group held 14 April 2019.

The Minutes were **RECEIVED** and **NOTED** by the Committee.

096/19 FINANCE & PERFORMANCE SELF-ASSESSMENT REPORT

The Chair asked for comments following the findings from the responses from the Self-Assessment questionnaire. It was noted that it was generally positive in terms of

the views of the Committee and the balance between the Finance and Performance elements of the Committee are being addressed. Discussions took place regarding the timing of the papers and it was agreed that the setting of the meetings for 2020/21 will be reviewed to allow papers to be available at least 7 days prior to the meeting.

ACTION: To review the meeting dates for 2020/21 – **GB/BS**
ACTION: To provide a verbal update for the next meeting regarding the balance of Finance and Performance and how this will be addressed going forward– **PO, 28/6/19**

In terms of the responses to question (3.6) "The Board challenges and understands the reporting form this Committee" it was suggested that the Chair should discuss with the Board.

097/19 WORK PLAN

The Work Plan will be updated accordingly following today's discussions.

The Committee **NOTED** the Work Plan.

098/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following for cascading to the Board:

- Theatre Utilisation - good discussions
- IPR – Radiology / RTT Pathways / Complaints / Project Resource
- Finance – on plan, noted the non-pay and maintenance spend
- Finance Risks – proposed the increase to 16 for the Capital Risk, Sustainability to hold at 25
- CIP – on plan
- Reference Costs – noted the process, to come back for recommendation for approval

099/19 REVIEW OF MEETING

The Committee agreed that the Theatre Utilisation presentation and the issues raised within the IPR regarding Radiology and RTT had led to interesting discussion and debate.

100/19 ANY OTHER BUSINESS

There were no additional items raised.

DATE AND TIME OF NEXT MEETING:
FRIDAY 28 June 2019, 9.30am – 12.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 1 April 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

060/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce and Development
Karen Heaton **(KH)**	Non-Executive Director
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public Governor
Jackie Murphy **(JMy)**	Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Ayesha Marshall **(AM)**	Lead Tissue Viability Nurse **(item 065/19)**
Elisabeth Street **(ES)**	Clinical Director of Pharmacy **(items 070/19)**

061/19 APOLOGIES

Dr Anne-Marie Henshaw	Assistant Director for Quality and Safety
Lindsay Rudge	Deputy Director of Nursing

062/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

063/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 4 March 2019 were approved as a correct record.

064/19 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

Clinical Audit Comparisons

Following the presentation of the Trust's Clinical Audit Programme by Mr Neeraj Bhasin (Associate Medical Director) at the last Quality Committee meeting on 4 March 2019, the Committee suggested that comparisons with other Trust's audits would be useful. Slides from the Healthcare Quality Improvement Partnership (HQIP) website were tabled showing CHFT's benchmarking position against other Trusts for the following audits: maternal, newborn and infant clinical outcome review programme, bowel cancer audit, lung cancer audit, paediatric diabetes audit, national vascular registry, emergency laparotomy audit and hip fracture audit. The blood glucose diabetes control (HbA1c) on the paediatric diabetes audit was showing as an outlier, and the FSS division were asked to review the data and provide an update on what is being done as part of their next Patient Safety and Quality Board reports on 3 June 2019.

Action: FSS division to provide an update, as part of their quarter 4 Patient Safety and Quality Board report, regarding outliers on the paediatric diabetes audit.

065/19 PRESSURE ULCER UPDATE

Ayesha Marshall (Lead Tissue Viability Nurse) was in attendance to provide an update from the pressure ulcer collaborative:

- When comparing quarter 2 with quarter 3, there has been a reduction of category 2 and 3 pressure ulcers, an increase of category 4 (total 1), and an increase of hospital-acquired unstageable pressure ulcers (0 to 6) which are yet to be evaluated to resolved or unresolved.
- The Community division shows increase in all categories of pressure ulcers
- Category 2 pressure ulcers and moisture lesions are not seen by tissue viability, these should be managed in the area; however a number of category 2 will be moisture lesions, due to inaccurate categorisation.
- Data cleanse for unstageable pressure ulcers continues

Key issues identified were that:
- Communication is improving with the embedding of safety huddles to highlight risks
- Electronic Patient Record documentation gaps are highlighted in orange panel meetings
- Pressure ulcer categorisation remains challenging, with bite-sized learning provided and training to improve accuracy and validation.

Comparison data of pressure ulcers between July to September 2018 and October to January 2019 were provided. One serious incident investigation is ongoing in relation to a hospital acquired category 4 Plaster of Paris incident.

Areas of progress include:
- The implementation of a decision support tool to justify and evidence rationale of when to raise an adult safeguarding concern and the implementation of the pressure ulcer safety huddle (PUSH) tool for rapid review within 48 hours
- Datix reporting clearer and more specific, with causal omissions included to identify thematic trends which include risk assessment, communication, and skin assessment.
- Competency-based training programme is well attended by nurses and Allied Health Professionals (AHPs)
- CRH Acute Medical Floor now with 70 pressure ulcer-free days

Recommendations from the pressure ulcer collaborative were to ensure that causal factors are recorded on Datix so that themes and trends can be more easily identified; that moisture lesions, which can develop into pressure ulcers, are reported on Datix; to continue to build a competent workforce; to work with training strategy group to ensure learning from incidents is reinforced, and to support business case to reduce the increase in category 2 and above pressure ulcers.

Discussion on the decision support tool and the pressure ulcer safety huddle (PUSH) tool, which is awaiting approval from the Nursing and Midwifery Committee, took place. Further discussion took place on the increase of pressure ulcers and the recording of pressure ulcers. Patients may belong to care homes, but due to CHFT staff providing care for those patients, those pressure ulcers are recorded as CHFT. It was stated that it is commendable that the Trust record all pressure ulcers, however, this will adversely affect the number of pressure ulcers recorded against the Trust. It was suggested that a footnote is placed in the report to explain the reason for the increase due to patients from care homes being included in the figures.

OUTCOME: The Quality Committee received and commended the content of the report.

066/19 INTERNAL AUDITS – DEATH CERTIFICATION

Dr David Birkenhead (Medical Director) provided an update on the death certification task and finish group action plan (appendix D), following discussion on the internal audit recommendations at the Quality Committee meeting on 4 February 2019. In response to the

Trust audit from August 2018, the action plan was agreed to meet the recommendations made. All actions are currently being progressed and the Committee requested an update in six months' time

Action: Further update to be provided from the task and finish group in six months' time – Monday, 4 November 2019

067/19 SCHWARTZ ROUNDS

Jason Eddleston (Deputy Director of Workforce and Development) was in attendance to provide an update on progress with Schwartz Rounds (appendix E).

Following the introduction of Schwartz Rounds at the Quality Committee meeting on 29 October 2018, two rounds have been held to date, the first on 24 January 2019 at Huddersfield Royal Infirmary with the topic *'A patient I will never forget'*, and the second on 22 March 2019 at Calderdale Royal Hospital with the theme *'The day I made a difference'*.

Both rounds were extremely well-received, with a total of 37 colleagues attending the two sessions. Feedback collated from the sessions was fairly positive, and there is some work to do regarding communicating what the Schwartz rounds are, and ensuring that doctors in training have an opportunity to attend. It is proposed that six Schwartz round sessions will be held each year.

The Rounds are part of the Trust's health and wellbeing agenda and is a safe space within a supportive group where colleagues are given the opportunity to express their feelings/concerns on what it is like to work at CHFT.

Further information on Schwartz Rounds can be found on the CHFT intranet page, as well as a research paper done by The Kings Fund and the Point of Care Foundation website.

OUTCOME: The Quality Committee received and noted the content of the report.

068/19 CARE QUALITY COMMISSION (CQC) UPDATE

Jackie Murphy (Chief Nurse) provided an update on the delivery of the Trust's response to the CQC report (appendix F).

All actions were due to be completed and embedded by 31 March 2019, however, some must-do actions have not progressed sufficiently enough to change the BRAG (Blue, Red, Amber, Green) rating. These include:

- MD 2 - Equipment and consumables checks *(current rating GREEN)*
- MD 4 - Environmental audit, cleanliness, infection control *(current rating AMBER)*
- MD 5 - Appropriate fridge temperatures (HRI & CRH) *(current rating GREEN)*
- MD 8 - Medical staffing (CRH) *(current rating RED)*

The movements of the should-do actions were also detailed in the report, as well as the should-do actions which have not yet been embedded. These include:

- SD 6 - Training in relation to mental capacity act and deprivation of liberty safeguards (HRI & CRH) *(current rating GREEN)*
- SD 9 – Medical staffing *(current rating RED)*
- SD 10 - Children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced *(current rating AMBER)*
- SD 21 - Monitor transfer rates from Huddersfield Birth centre to the Calderdale site, and review why rates appear high compared to national averages *(current rating GREEN)*
- SD 28 - Arrangements in place to monitor when band five staff are in charge of ward 18 without the advanced paediatric nurse practitioner (APNP) being present *(current rating GREEN)*

- SD 37 - Opportunity to improve exists particularly in regards to agency staffing *(current rating GREEN)*
- SD 38 – Trust to improve identification of recurrent opportunities for savings and productivity in line with five year recovery plan *(current rating GREEN)*
- SD 39 – Trust to ensure it delivers the return in investment and maximises realisation of the benefits of the innovative technologies *(current rating AMBER)*
- SD 40 – Trust to ensure it has robust systems of measurement in place to track investments and enable timely decision making about their effectiveness *(current rating AMBER)*

It is proposed that the 2018 CQC Action Plan is closed as of 31 March 2019, and the 14 actions that have not met the embedded deadline will be transferred onto a new 2019-2020 CQC Action and Improvement Plan. Revised embedded dates will be discussed and agreed at the next CQC Response Group on 15 April 2019.

All closed and embedded actions will continue to be monitored within divisions as part of the health checks and as part of a CQC Peer Review Programme which is being developed by the Assistant Director of Quality & Safety and the CQC Compliance Manager. The CQC Peer Review Program will provide ongoing assurance that actions continue to remain embedded. The programme will also ensure any must-do and should-do actions that are transferable to other divisions are monitored in preparation for the 2019 CQC inspection.

A Quality Summit will take place at Huddersfield Royal Infirmary on Thursday, 18 April 2019, with attendees including representatives from the Trust Executive Team and Senior Divisional management teams as well as external bodies such as CQC, NHS Improvement, Clinical Commissioning Groups, local council and NHS trusts.

Action: For CQC response group to provide review of all actions from the improvement plan in 6 months' time

OUTCOME: The Quality Committee received and noted the content of the report.

069/19 SERIOUS INCIDENT REPORT

Andrea McCourt (Company Secretary) reported on the serious incident report (Appendix G), summarising incidents reported to commissioners in January and February 2019.

Five incidents were reported in total:

- Three in January 2019:
  - Two never events relating to oxygen connected to air
  - One neonatal death investigated by the Healthcare Safety Investigation Branch (HSIB)

- Two in February 2019:
  - One category four pressure ulcer
  - One delay in recognition of sepsis

The Healthcare Safety Investigation Branch (HSIB) began investigating maternity cases in the region since December 2018. The criteria for referral to HSIB are intrapartum stillbirth, early neonatal death or severe brain injury diagnosed within the first 7 days of life. The HSIB are expected to take longer than 60 days to investigate, and the Clinical Commissioning Groups are recording these as taking 6 months to investigate. The serious incident panel, when considering these cases, is also identifying immediate actions for consideration in the divisions to address any identified concerns early to help reduce risk.

There were also five completed serious incident recommendations and learning reports included in the update, which have been shared within the organisation.

Discussion ensued on the very clear and succinct summaries and it was stated that the learning reports are now being used in team meetings.

OUTCOME: The Quality Committee received and noted the content of the report.

070/19 MEDICATION SAFETY AND COMPLIANCE REPORT

Elisabeth Street (Clinical Director for Pharmacy) was in attendance to provide an update on key points from the Medication Safety and Compliance Group meetings in February and March 2019 (appendix H):

- *Syringe drivers* - As part of the required reduction in capacity in aseptic service due to the reconfiguration of services, from February 2019, pharmacy now no longer supply prefilled syringe drivers to wards. Communication was completed to wards / clinical areas informing them of this change. No issues have so far been raised.
- *Assurance of safe medication storage:*
  - *Annual medication storage audit* - This was due to be completed by December 2018 and still awaiting 10 outstanding audits. Once these have been received, pharmacy will collate responses to produce a Trustwide dashboard showing compliance.
  - *Pharmacy safe storage of medication audit* – the spot check audit took has been implemented by pharmacy staff and completion has now occurred on several ward areas and results have been shared with ward managers. The tool is proving useful in terms of reminding clinical staff of the required standards of medication handling and storage.
- *Ambient fridge temperature monitoring* – The Trust currently do not routinely monitor ambient temperatures for rooms / wards were medications are stored (with the exception of those medicines stored in fridges and those medicines stored within pharmacy). The risk of non-compliance with ambient temperature monitoring is recorded on the risk register (ID 7358) and currently scoring 9.
- *Safe storage of waste medication* - A new bin option for improved security has been sourced; unfortunately there has been a delay in the trial of this bin due to a change of the Trust waste lead. Communication is being issued to ward staff that medication waste bins must be kept securely (in a locked room or cupboard) and that packaging and leaflets from medication boxes (after first removing patient identifiable information) does not require disposing of in the medication waste stream.
- *Controlled drug assurance* – an external controlled drug report has been completed and the report and action plan are being monitored at the controlled drug sub-group. There are several areas of non-compliance highlighted. Six areas were audited (three at HRI and three at CRH). The results have been shared with ward managers.
- *Never event – oxygen / air* - A requirement, as per the Health memorandum for medical gases, states that the Trust should have a trained designated nurse / medical officers on site at all times to ensure that if any emergencies occur, a nominated / trained member of staff at the Trust has a clear understanding of medical gases / clinical risk, and is able to make informed decisions if medical gas supplies need to be turned off. Dates for training have been provided and the senior nursing team is to coordinate this training for those staff nominated to undertake it.
- *Antimicrobial stewardship* – Due to an increase in Datix incidents due to incorrect prescribing and monitoring of gentamicin, a change in the antibiotic prescribing policy has been made. The antimicrobial stewardship team have reviewed these incidents and developed an action plan to support prescribers with the safe use of this drug. The pharmacy team will have a gap in antimicrobial pharmacist cover from June / July due to one postholder recently leaving the Trust and one postholder with impending maternity leave. Actions have been taken to minimise this risk.

Discussion ensued on the annual medication storage audit and the 10 outstanding audits, which LS stated that the Associate Directors of Nursing have agreed to pick up. Further discussion took place regarding checks of other drugs and whether there were any near misses. JMy and LS agreed to take this forward.

Action: LS and JMy to provide progress report on controlled drugs, fridge temperatures and annual medication storage audit in three months' time – Monday, 29 July 2019

OUTCOME: The Quality Committee received and noted the content of the report.

071/19 HEALTH AND SAFETY REPORT

A summary report from the Health and Safety Committee meeting held on 19 February 2019 was provided (Appendix I). Jackie Murphy (Chief Nurse), who was in attendance at the meeting, gave an update:

- *Action plan* - A detailed review of the action plan took place where it was noted a number of long-standing recurring actions were present. The Chair requested these were progressed with more specific actions and timescales, and it was challenged that some of the actions were now closed.
- *Transfer of patients on oxygen* - Nursing colleagues were invited to present the outcome of the "Transfer of Patients on Oxygen policy" as there were concerns this was not fully implemented. Further actions are being progressed via Dr Nicholas Scriven (Consultant in Acute Medicine) with the Oxygen policy to ensure consistency between both policies.
- *Community Premises* – the Community division raised concerns from recent infection control inspections which highlighted a risk with clinical activity being provided in non-compliant rooms / premises. The risk was added to Community division's risk register and the provision of treatments in alternative premises was being considered. The division will present next steps at the next meeting.
- *Shuttle Bus* - Questions were raised regarding transporting of staff and patients on the shuttle bus and the ratios between both. Calderdale and Huddersfield Solutions (CHS) were invited to the next meeting to discuss further.
- *Healthcare Waste* - Intermediate controls remained in place for the safe management of healthcare waste following the collapse of the Healthcare Environment Services (HES) contract. Discussions are taking place with the West Yorkshire Association of Acute Trusts (WYAAT) and other partners for national debate.
- *Delivery Yard* - A risk relating to the potential of vehicle / pedestrian collision in the CRH delivery yard area was highlighted. The risk was discussed following similar incidents being reported nationally that resulted in serious injuries and fatalities followed by Health and Safety Executive (HSE) prosecutions. The HSE reminded employers of the need to separate vehicles and pedestrians who use the same area. The Committee are risk assessing the situation and are making immediate recommendations to improve safety in this area.

Discussion ensued on the governance of the Health and Safety Committee and it was stated that the governance structure is being reviewed at the Audit and Risk Committee.

OUTCOME: The Quality Committee received and noted the content of the report.

072/19 CLINICAL OUTCOMES GROUP REPORT

Dr David Birkenhead (Medical Director) reported on the update from the Clinical Outcomes Group meetings from 21 January, 18 February and 18 March 2019 (appendix J):

- *Frailty* - The new enhanced frailty service is now nearly fully recruited into, and has given all front-end services a robust frailty service over the winter period. This enabled the frailty team to avoid a further 100 admissions a month in comparison to last December with a further 194 new referrals seen a month. There is now an acute floor with 22 frailty beds under the care of a geriatrician and the frailty team. The service is currently available 12 hours a day, seven days a week but an aspiration for the future is for it to be available overnight.
- *Sepsis* - The Trust is still in a good position in regards to the Hospital Standardised Mortality Ratio for Sepsis. CHFT is also on track with the Commissioning for Quality Indicator (CQUIN) and this has been achieved for quarter 3. Sepsis will be reported into

the Clinical Outcomes Group on a quarterly basis in future.

- *Nasogastric tube* – the latest training compliance is 72.4% and a dashboard has been commissioned from the Health Informatics Service (THIS) to monitor nutrition metrics.
- *Clinical coding* – three coding key performance indicators (KPIs) have been achieved since November 2018 and the Trust is performing in the upper quartile nationally. Digital information and outcomes are being looked at to drive improvement.

Discussion ensued on the commendable frailty service and the achievement of avoiding a further 100 admissions per month.

OUTCOME: The Quality Committee received and noted the content of the report.

073/19 QUALITY AND PERFORMANCE REPORT

February's performance score has improved by four percentage points to 73%, the best performance this financial year. The safe domain has improved to green at 79%, although there was a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and a category 4 pressure ulcer. The caring domain has improved to 74%, with both Community Friends and Family Test indicators achieving target. The effective domain is green for the fourth consecutive month. The responsive domain has improved to 71% achieving all key cancer targets for the fourth consecutive month and three out of four stroke targets, however the six-week diagnostics target was missed for the third time in four months. In workforce, there has been an improvement in eight of the nine essential safety training (EST) areas with only fire safety showing a small decline. Within efficiency and finance, there have been a number of improvements in the efficiency targets alongside cost improvement plans, which have improved to green in month, meaning the domain is now green for the first time this year.

The performance summary wheel now has three green segments in efficiency and finance, safe and effective. There are still issues within the safe domain in regard to Friends and Family Test and closed complaints within timeframe, however, Owen Williams (Chief Executive) has this on his agenda and will present a deep dive to the Weekly Executive Board on 30 May 2019.

Discussion ensued on whether complaints responses are improving, as there were nine re-opened complaints in February 2019. It was stated that not as many complaints are being received regarding the care of patients. The Chair pointed out that a review was carried out in October 2018 of re-opened complaints, and due to there being no national benchmarks, it was agreed that a baseline of around 10% will be taken in order to see whether re-opened complaints cases can be reduced. It was also stated that the Quality Accounts report (appendix L) also details complaints which are upheld.

OUTCOME: The Quality Committee received and noted the content of the report

074/19 QUALITY ACCOUNT (DRAFT)

Andrea McCourt (Company Secretary) presented appendix L which outlines the Trust's 2018/2019 quality account. The report details improvements that have been made to services in the past year and where and how the Trust will improve patient care in the coming year.

The quality account was developed in line with the national guidance from NHS Improvement on quality accounts reporting arrangements 2018/19. The additional information that Trusts have been asked to include are:

- A statement on progress in implementing the priority clinical standards for seven day hospital services as assessed by the *Seven Day Hospital Services Board Assurance Framework*
- Details of ways in which staff can speak up, how feedback is given and how Trusts

ensure that staff who speak up do not suffer detriment, and
- A consolidated annual report on rota gaps for doctors and dentists and plans for improvement to reduce these gaps
- Information on learning from deaths, requested in 2017/18, has become part of the routine report of the quality account.

Governors were asked to select three quality priorities from a list of six for 2019/20 and chose Emergency department; deteriorating patients and mental health. Full details on why the priorities were chosen are included in appendix L2.

The report will be forwarded to stakeholders and auditors for comment on 4 April 2019, therefore any comments on the content of the report will need to be forwarded to Andrea McCourt by Wednesday, 3 April 2019. The complete report will then be submitted to the Trust Board in May 2019.

OUTCOME: The Quality Committee received and noted the content of the report

075/19 ANY OTHER BUSINESS

There was no other business.

076/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- Issues from medication and safety group
- Good story from Frailty service.

077/19 EVALUATION OF MEETING

What went well…….
- Reports very clear, and good executive summaries provided

Even better if……..
- There were fewer pages of reports.

078/19 QUALITY COMMITTEE EFFECTIVENESS

As part of an end of year governance review, a self-assessment review is forwarded to Committee members to complete. The self-assessment is designed to gauge the Committee's effectiveness by taking the views from members across a number of themes.

A copy of the self-assessment and terms of reference were attached (appendix M) for completion no later than Tuesday, 9 April 2019 in order for an overall report to be submitted to the Board of Directors in May 2019.

The results of the self-assessment will be reviewed by the Chair and secretary in order to recommend any further actions.

079/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix N) was accepted.

NEXT MEETING

Monday, 29 April 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 29 April 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

080/19 WELCOME AND INTRODUCTIONS

Present

Karen Heaton **(KH)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Dr Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Vicky Thersby **(VT)**	Head of Safeguarding **(item 088/19)**
Dr Sal Uka **(SU)**	Associate Medical Director

081/19 APOLOGIES

Jason Eddleston	Deputy Director of Workforce and Development
Jackie Murphy	Chief Nurse
Dr Linda Patterson	Non-Executive Director

082/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

083/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 1 April 2019 were approved as a correct record.

084/19 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

085/19 PATIENT SAFETY GROUP REPORT

Dr Anne-Marie Henshaw (Assistant Director of Quality and Safety) presented the quarterly update (appendix C) from the patient safety group meetings held between February and April 2019, highlighting issues to be escalated to the Quality Committee:

- Hospital Transfusion Committee (HTC)
  The Patient Safety Group raised concerns regarding issues the HTC reported on, particularly in relation to:
  - *Incidents* – there was an increase in the number of Serious Hazards of Transfusion (SHOT) reportable incidents. 12 serious incidents were reported in 2018, compared to eight reported in 2017. SHOT benchmarking figures published in November 2018 also showed the Trust ranking 11th out of 14 regionally, for anti-D incidents. Assurance has been requested from the Patient Safety Group on an action plan on how to address this.
  - *Attendance* – a number of HTC meetings had to be cancelled due to the number of apologies received. Other issues relating to attendance also include representation from divisions. Ideally, the Committee needs an anaesthetist, obstetrician, surgeon and a paediatrician in attendance. A possible candidate to chair the committee was

requested, as the chair should be a 'user' not a haematologist (previously the case), in order to potentially reach more colleagues. A new chair has is now in place and the membership of the Committee has been invigorated, an update from which is due to be provided at the Patient Safety Group in May.

- Patient Safety Alerts
  The patient safety alerts were formerly managed via the Clinical Effectiveness and Audit Group (CEAG), however, given the clinical presence and engagement at the Patient Safety Group, it was felt that this would be the best forum for the alerts to be managed. A tremendous amount of work has since taken place with the alerts, including a review the central database where the alerts are recorded. Work has been planned to audit and test the practice of embeddedness of alerts which have been declared fully compliant. Audits will be completed during the April 2019 - March 2020 financial year.

- Medical Devices
  An update from medical devices highlighted a significant amount of out of date high-risk medical device equipment in use. Divisions were asked to ensure that they are managing medical devices within their areas and that 'before use' checks are carried out by users. The main issue was that the asset register of devices was not as robust as it could have been, however, tremendous progress to identify and service out of date medical devices has taken place.

  Discussion took place on the backlog of servicing outdated medical devices and the timeframe for remedying the build-up. It is felt that this may take up to six months, with a priority on all high-risk equipment. A risk has also been placed on the risk register scoring 20; however, there have not been any incidents in relation to this risk. It was suggested that Robert Ross (Chief Medical Engineer) attends the Quality Committee to explain the process, and that annual reviews may need to be planned over time in order to address the backlog. It was stated that an internal audit will take place later in the year.

OUTCOME: The Quality Committee received and commended the content of the report.

086/19 SERIOUS INCIDENT REPORT

Andrea McCourt (Company Secretary) presented the serious incident report (appendix D), summarising the new serious incidents and the completed serious incident reports submitted to commissioners in March 2019.

The two serious incidents reported were in relation to sepsis and a neonatal death. The details of both incidents were provided in detail within the report.

The completed serious incident investigation case summary report relating to a cardiac patient (which was subsequently de-escalated by the commissioners upon review of the report) was also provided, and the learning from this incident has been shared within the organisation.

Discussion followed on how the learning is disseminated, and this was stated as via the intranet, the Patient Safety and Quality Board meetings, the Quality Committee and the Serious Incident Review Group were each division has the opportunity to share a report. There are also a number of different routes that each report is shared, as listed on the bottom of each case summary. A learning event will also be taking place later in the year for learning to be shared.

OUTCOME: The Quality Committee received and noted the content of the report.

087/19 HIGH LEVEL RISK REGISTER

Andrea McCourt (Company Secretary) reported on the high level risk register (appendix E), as at 23 April 2019, which included:

- Five top risks
  - 7278: longer-term financial sustainability risk
  - 2827: over-reliance on locum middle-grade doctors in the emergency department
  - 5806: urgent estates schemes not undertaken
  - 6345: nurse staffing risk
  - 7078: medical staffing risk

- One new risk
  - 7253: paediatric and neonatal staffing risk

- Four risks with a reduced score
  - 7169: in-year finance and financial plan *(reduced from 16 to 12)*
  - 5862: falls risk *(reduced from 16 to 12)*
  - 7240: surgical and anaesthetics financial risk 2018/2019 *(reduced from 20 to 9)*
  - 7280: unnecessary repeat specimen collection risk *(reduced from 15 to 12)*

- One closed risk – 6011: blood track system

Two risks have been removed from the high level risk register (risks 6903 and 7271) relating to the estate at the Huddersfield Royal Infirmary. These risks are now being managed on the Calderdale and Huddersfield Solutions risk register. The operational impacts of the two risks have been identified and added to divisional risk registers for management.

Discussion followed on the new risk (7253) and what is taking place to mitigate the risk and the impact it has on bank and agency staff. It was stated that attempts are being made to recruit to posts, including from overseas, however, bank and agency staff have to be used until there is a new allocation of trainees. There is a shortfall of five posts, which is also combined with sickness at consultant level; however, colleagues are going above and beyond to provide cover.

The report also included a copy of the detailed high level risk register.

OUTCOME: The Quality Committee received and noted the content of the report.

088/19 SAFEGUARDING COMMITTEE ANNUAL REPORT

Vicky Thersby (Head of Safeguarding) was in attendance to present the sixth annual safeguarding children and adults report 2018/2019, providing an overview of the national and local safeguarding and areas of practice across the Trust.

- *Governance arrangements* - All statutory posts for safeguarding adults and children are in place and have been throughout the year. The designated nurse for Children Looked After (CLA) (Calderdale) retired in June 2018 and as part of new arrangements supported by Public Health and the Clinical Commissioning Group, the functioning and arrangements of the CLA team in Calderdale was reviewed. The previously commissioned designated role is now absorbed into the designated role for safeguarding children of which is part of the Clinical Commissioning Group governance arrangements.

- *Adult safeguarding*
  - Incidents – 884 incidents were recorded in 2018-19 compared to 882 reported in 2017-18, an increase of two incidents this year. Of the 884 incidents, 482 related to quality of care issues and are reviewed and investigated by the safeguarding team and divisions

  - Referrals – there were 279 referrals made by the Trust in 2018-19 compared to 168 made in 2017-18, an increase of 66%, which shows an increased awareness and how to report. There was a 37% reduction in referrals made against the Trust from 197 in 2018-19 to 123 in 2017-18
  - Adult Intercollegiate Document - this has been published which puts adult safeguarding training on a statutory footing, and will be reviewed and implemented this year.

- *Safeguarding week* – this will be held between the 24th and 29th June 2019 and the theme of '*listen to me and help keep me safe'*

- *Pressure ulcer* – the tissue viability team continues to work with safeguarding to ensure all category 3 / 4 and unstageable pressure ulcers are reviewed from a safeguarding perspective. A decision tool to justify and evidence rationale for referral to Gateway to Care was approved by the Safeguarding Committee and is being shared with external organisations.

- *Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)* – there has been a decrease in the number of urgent and standard DoLS applications due to level of awareness of the MCA and a significantly improved quality of DoLS submitted.

- *Mental Capacity (amendment) Bill* – the amendment bill, now in Parliament, is awaiting agreement and royal ascent. Changes to the bill will be that hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the hospital manager). Staff will need to be trained and aware of what the new Liberty Protection Safeguards constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP).

- *Mental Health* - The Mental Health Act 1983 was reviewed in 2018 and the final report, published in December 2018, is being monitored and reported via the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) mental health act committee. The process for use within the Trust has been reviewed and agreed with SWYPFT Mental Health Liaison Team to ensure robust oversight of all Section 5(2), Section 2 and Section 3 detentions at CHFT.

- *Safeguarding mental health and midwifery* – this was not part of last year's report, and CHFT continue to work in partnership with SWYPFT and Locala to provide care for pregnant women who have mental health concerns

- *Safeguarding children* - Level 3 children's training has been updated in line with Working Together 2018 statutory guidance, and the Intercollegiate Document published in 2019 provides a clear framework that identifies the competencies required for all health-care staff. This requires reviewing this year.

- *Contextual safeguarding* – this identifies and responds to harm and abuse posed to young people outside their home, and the safeguarding team are involved with the Kirklees Strategic and Operational Contextual Safeguarding Group. Calderdale are yet to contribute.

- *Child sexual exploitation (CSE)* – The Trust has an identified CSE lead

- *Female Genital Mutilation (FGM)* – The Trust has an identified FGM lead and the FGM Information Sharing System (FGM-IS) has been successfully embedded within maternity since November 2018 with a new process of adding a flag to the record of a female child born to a survivor of FGM. This has also been backdated to 2015 when the data collection commented. This system will generate a flag onto the record if a child or young person attends who is at risk of FGM.

- *Domestic abuse*
  - The named professional for safeguarding adult's remit has expanded and is the named lead for domestic abuse.
  - A new campaign to promote Claire's law (also known as the Domestic Abuse Disclosure Scheme) was launched in January 2019 to encourage the public to use their 'right to ask' if they are worried that a partner or ex-partner may have a history of domestic abuse. CHFT supported in promoting this campaign.
  - The Trust has been awarded the West Yorkshire Domestic Abuse Quality Mark; awarded when there is consistent and high quality service provision to women, children and men affected by domestic abuse. CHFT have now been awarded this at level 2 (safety, good practice, routine and triggered enquiry and policies) for three years.
  - There has been a reduction in the number of referrals by maternity services to Multi-Agency Risk Assessment Centres (MARAC) in Kirklees and the domestic abuse hub in Calderdale. A deep dive into this is currently being commissioned along with an audit.

- *Children Looked After (CLA) Team* - It was reported that a separate reports for both Calderdale and Kirklees will be presented in further detail to the Board of Directors and submitted to the Quality Committee, with information about progress against priorities and new priorities for 2019-20.

- *Training* – overall safeguarding compliance has improved from 91.2% to 93.63%

- *Serious case reviews, serious adult reviews and domestic homicide reviews* - The Trust participates fully in both the Serious Case Review process for children and the Serious Adult Review process. The Trust also works in partnership with Community Safety Partnerships in relation to the Domestic Homicide review process, which may include representation and participation by the Trust. We receive requests from both local authority areas and local authorities out of this area.

- *External reviews*
  - There are four outstanding actions that relate to Kirklees Children's and Children Looked After CQC Inspection from January 2018.
  - Ofsted inspected Calderdale Metropolitan Borough Council in November 2018 and the overall effectiveness was rated as 'good'.
  - Ofsted Special Educational Needs and Disability (SEND) inspection which took place in March 2019 will have a report due to be published in May 2019.
  - Ofsted have continued to monitor progress since the Kirklees Ofsted inspection in 2016 and a re-inspection is likely shortly in Kirklees.

- *Safeguarding boards and changes* - The Safeguarding team support the multi-agency partnership working with the Safeguarding Children and Adults Boards for Kirklees and Calderdale.

Discussion took place on several points from the report, including the Children Looked After report - it was stated that the reason why this is a separate report is due to the reporting to the local authority. The outstanding actions from the Children's and Children Looked After CQC inspection were raised. The Committee was asked where the actions are escalated, and it was stated that they are with the Safeguarding Committee. There are now only two outstanding actions and an exception report can be submitted to the Quality Committee. The Mental Capacity (amendment) bill was passed last week and now awaiting royal ascent. It was stated that a detailed report to the Board of Directors will be produced as the Bill and Codes of Practice develop. The Chair reported on the positive work included in the report.

OUTCOME: The Quality Committee received and noted the content of the detailed report and approved the priorities for next year.

089/19 PATIENT EXPERIENCE AND CARING GROUP

Lindsay Rudge (Deputy Director of Nursing) presented appendix G, provided an update from the Patient Experience and Caring Group meetings from February and March 2019:

- Learning disability update including:
  - *the 'Treat me well' campaign* – The Trust are in the first phase of this campaign which aims to transform how the NHS treat patients with a learning disability in hospital
  - *dementia café (butterfly lounge)* – this opened in February 2018, with the café open each Wednesday and supported by Age UK and run by the Prevention of Delirium (POD) team. This is also part of the Trust's dementia strategy to develop a dementia-friendly environment such as communal dining, relatives bringing in personal possessions and familiar items, and wearing clothes rather than nightwear during the day.
  - *Surveys* – the Patient Reporting and Action for a Safe Environment (PRASE) survey is being reviewed to recognise if this is the most effective means of capturing structured feedback
  - *Changing facilities* – there is a risk regarding suitable locations for changing facilities and safe spaces on both the Huddersfield Royal Infirmary and Calderdale Royal Hospital sites. This is on the risk register and is being considered in line with any new builds or reconfiguration of services.

- Divisional updates:
  - *Families and Specialist Services (FSS) division*
    - The Trust are currently part of the national 'Mat Neo' Improvement Programme and were chosen to present nationally in at the launch of the Wave 3 Trusts event in March 2019
    - The Trust have been re-accredited with the World Health Organisation (WHO) / United Nations Children's Fund (UNICEF) Baby Friendly award and assessed as outstanding.
  - *Medical division*
    - The Trust was awarded a score of 'A' from the Sentinel Stroke National Audit Programme (SSNAP) for the last quarter. This is only the second time it has been achieved since SSNAP was introduced eight years ago.
  - *Estates and facilities*
    - Several wards on both sites received 'silver' exemplar team accreditation - a local assurance audit involving a review of quality and care metrics, including patient feedback.
    - The removal of specific fans (due to an infection control risk of not being able to clean properly) is being reviewed locally from a patient experience point of view, recognising the reliance on fans last summer during the heatwave. It is assured that all specific fans are on the correct cleaning schedule.

A copy of the minutes from the Patient Experience and Caring Group meetings from February and March 2019 were also included in the report.

A Committee member praised the patient experience, care and wonderful understanding received from colleagues to family and wished for this to be noted.

OUTCOME: The Quality Committee received and noted the content of the report.

090/19 QUALITY AND PERFORMANCE REPORT

Appendix H provided a summary of March's performance score peaking again at just over 73%. The safe domain remains green and has further improved. The caring domain has improved to green; the effective domain remains green for the fifth consecutive month, although fractured neck of femur missed the target this month; the responsive domain has

deteriorated slightly to 67%, however all key cancer targets were achieved for the fifth consecutive month. Workforce has improved by 10 percentage points to 67%, with better performance in all nine essential safety training areas and appraisals for medical staff. In finance, there was deterioration in income and expenditure surplus and cost improvement plans, although for the full year, all key indicators were green, and efficiency maintained its green performance.

Safe - it was stated that the harm-free care target remains to consistently achieve 98% (new), however this has not been realised this month. Key learning messages from the pressure ulcer collaborative will be implemented and work has been commissioned to validate data and monitor ward assurance standards in documentation.

Caring

- Friends and Family Test (outpatients) – it was stated that this will continue to be challenging as existing themes remain to be car parking, timeliness of appointments and outpatient clinic wait times.
- Dementia - There has been a huge focus on dementia screening and there are some solutions through the Electronic Patient Record that could further improve performance.
- Complaints - as the Trust continues to close complaints, the amount re-opened has fallen to five, in comparison to 12 in January 2019. Owen Williams (Chief Executive) continues to meet with colleagues involved in complaint management to identify areas for improvement.

Effective – Fractured neck of femur process has not been delivered on, and divisions have been asked to review. It was stated that this is a challenging metric for the NHS to consistently achieve; however, there has not been any harm to patients.

OUTCOME: The Quality Committee received and noted the content of the report

091/19 ANY OTHER BUSINESS

There was no other business.

092/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- Safeguarding annual report received
- High level risk register received with one new risk which is being mitigated
- Patient Safety Group report received
- Serious Incident report received
- Patient Experience report received with positive updates
- Quality and Performance report received and reference to complaints and the red indicators will be made at the Board meeting

093/19 EVALUATION OF MEETING

What went well…….

- Good chairing

Even better if……..

- There was nothing to report.

094/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix I) was accepted.

It was suggested that a story from each division is received each month, highlighting good work on quality improvement.
Clarify

NEXT MEETING

Monday, 3 June 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

Patient Safety and Quality Board Q4 reporting and CQC in attendance

QUALITY COMMITTEE

Monday, 3 June 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

095/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Karen Heaton **(KH)**	Non-Executive Director
Dr Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public Governor
Jackie Murphy **(JMy)**	Chief Nurse
Lindsay Rudge **(LR)**	Deputy Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Andrea Dauris **(AD)**	Associate Director of Nursing – Community Healthcare
Ruth Dixon **(RD)**	CQC Inspection Manager **(observing)**
Maggie Metcalfe **(MM)**	Associate Director of Nursing – Medical Division
Joanne Middleton **(JMidd)**	Associate Director of Nursing – Surgical Division
Dr Julie O'Riordan **(JOR)**	Divisional Director – FSS Division
Maxine Travis **(MT)**	Senior Risk Manager
Jayne Woodhead **(JW)**	Clinical Manager for District Nurses - Community Healthcare Service **(observing)**

096/19 APOLOGIES

Jason Eddleston	Deputy Director of Workforce and Development

097/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

098/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 29 April 2019 were approved as a correct record.

099/19 ACTION LOG AND MATTERS ARISING

The action log can be found at appendix B at the end of the minutes.

100/19 SERIOUS INCIDENT REPORT – GOVERNANCE OF ACTIONS

Maxine Travis (Senior Risk Manager) was in attendance to present appendix C, updating on the outstanding actions from completed serious incidents up to 31 March 2019.

The position as at 14 May 2019 was summarised and data compared from the last report in February 2019. The medical division had a total of 97 outstanding actions from serious incidents, of which 75 were overdue. The 97 individual actions were linked to 22 serious incident investigations. 22 actions were closed in the last quarter (01/01/2019 to 31/03/2019).

The surgical division had a total of eight outstanding actions from serious incidents of which eight were overdue. The eight individual actions were linked to one serious incident investigation. Eight actions were closed in the last quarter.

The community division had seven outstanding actions, all of which were outstanding. These related to three serious incident investigations. Two actions were closed in the last quarter.

The families and specialist services division had a total of 36 outstanding actions from serious incidents, of which 24 were overdue. The 36 individual actions were linked to eight serious incident investigations. 22 actions were closed in the last quarter.

The levels of risk presented by the outstanding actions are being reviewed by the Risk team, and the risk profile will be assessed and agreed in consultation with divisions. The report demonstrates that actions arising from serious incident investigations are being actively implemented by divisions with evidence collated to verify their delivery.

Future reports will provide a more detailed view of outstanding actions, and will be individually risk rated, with more qualitative information to support assessment and prioritisation of risk mitigation. The Committee also asked whether themes from incidents could be reviewed, and it was stated that this action could be addressed and included in the next report.

OUTCOME: The Quality Committee received and noted the content of the report.

101/19 CLINICAL OUTCOMES GROUP REPORT

Dr David Birkenhead (Medical Director) presented appendix D summarising the key points for escalation from the Clinical Outcomes Group meetings held on Monday 15 April 2019 and Monday, 20 May 2019.

- *Fluid balance* – challenges with documentation of fluid balance are known, and one solution is to interface into the Electronic Patient Record, and for hand-held devices to be used. Assistance is being sought from the Lead Quality Nurse
- *Paediatrics diabetes audit* – CHFT was previously recorded as an outlier with HbA1c (haemoglobin A1c – average blood glucose levels) and has worked hard to address this. Improvement work continues, however, the audit data was confirmed to relate to the level of HbA1c and not the number of patients that have been checked. The audit published in the 2018 no longer reports the Trust as an outlier.
- *End of life care* - Do not attempt cardiac pulmonary resuscitation (DNACPR) compliance remains consistent. The build of the Integrated Care of the Dying document (ICODD) onto the Electronic Patient Record has been taken back to the Change Board as there is no implementation date as yet. The National Audit of Care at the End of Life (NACEL) has found that CHFT was below average on all metrics compared to the national scores. A Work Together to Get Results (WTGR) session arranged for 30 April 2019 was well-attended and supported by colleagues both internal and external, with a stimulus to improve end of life care.
- *Clinical Improvement Group Proposal* - The proposed work plan and terms of reference for the Clinical Improvement Group (CIG) were shared. The CIG will replace the Clinical Outcomes Group, and focus on improvement. The work plan will be fluid to allow for quality improvement projects starting and ending and to move between different groups.

The Chair enquired as to whether the work done by Dr Sal Uka (Associate Medical Director) regarding learning from death is interfaced with end of life care. It was stated that the learning from death links into the end of life care group.

OUTCOME: The Quality Committee received and noted the content of the report.

102/19 MEDICAL DIVISION QUARTER 4 PATIENT SAFETY AND QUALITY BOARD REPORT

Maggie Metcalfe (Associate Director of Nursing) presented appendix E, summarising:

- Quality and safety issues
  - *Pressure ulcers* – the Tissue Viability team recently introduced a PUSH (Pressure Ulcer Scale for Healing) tool - a rapid assessment of pressure ulcers category 3 and 4 - which is completed within 48 hours of the incident being reported, and identifies immediate learning and ensures appropriate interventions are in place. This has been well-received by colleagues.
  - *Nurse staffing* – there are vacancies for Registered Nurses on the acute floor at HRI and the respiratory floor at CRH
  - *Dementia screening* – compliance is improving with a daily report being produced on where dementia screens are needed.
  - *National Early Warning Score (NEWS) 2* – since the launch, auto-calculation is being monitored. There have been a few occasions where this was not happening immediately.

- Improvement work
  - Work is ongoing with Workforce and Organisational Development to triangulate patient experience with staff experience - Maggie Metcalfe and Suzanne Dunkley (Director of Workforce and Organisational Development) are doing extended tea and listening events.
  - In future, the division will hold meetings six weeks in advance of a bank holiday to plan for staffing
  - New processes in place to ensure yellow and green incidents progress and closed in a timely manner.

- Exceptions for the Quality Committee
  - Information requested by the Quality Committee for the Patient Safety and Quality Board to discuss the controlled drugs audit position has not yet taken place, as the PSQB meeting in March was not quorate and did not take place. This item was also on the agenda for the Controlled Drugs sub-group meeting on Friday 3 May 2019, and an update will be given in the quarter 1 (2019 / 2020) PSQB report.

- Positives / successes from division
  - Dr Huw Masson (Emergency Department Consultant) devised a template for learning from all red and orange incidents and these were shared at safety huddles.
  - The Integrated Medical Specialties directorate have embedded 2-hour turns on the stroke wards following two recent hospital-acquired category 3 pressure ulcers. No further category 3 pressure ulcers have been reported following implementation.
  - The Acute Floor at Calderdale was shortlisted in two categories of the Health Service Journal (HSJ) Patient Safety awards. Finals are to be held in July 2019.

Discussion ensued on:

- Other divisions being encouraged to learn from the medical division in regard to the PUSH tool.
- Discharge incidents.
  Action: Outputs from increase in incident discharges between quarters 3 and 4 to be included in the next quarterly report.
- Non-compliant clinical guidelines – it there is a risk against non-compliance, that it is included in the report.
- Complaints – why there was an increase of six complaints in this quarter compared to

previous months. The Chair stated that Owen Williams (Chief Executive) provided an impassioned response to the Weekly Executive Board's clear and specific action on complaints, and is planning on reporting his findings at the next Quality Committee, and to request that he is held to account for complaints.

- Issue with documentation of discharge times when patients leave the emergency department. The Chair stated that an audit has been done on this, and the findings will need to be reported to the Quality Committee.
  Action: Findings from audit on emergency department discharge times to be presented at the next meeting.

OUTCOME: The Quality Committee received and noted the content of the detailed and comprehensive divisional quarterly report.

103/19 SURGERY AND ANAESTHETICS DIVISION QUARTER 4 PATIENT SAFETY AND QUALITY BOARD REPORT

Joanne Middleton (Associate Director of Nursing) presented appendix F, summarising:

- Quality and safety issues:
  - The division reviewed its approach to controlled drug audits, and the management of controlled drugs have been addressed through the Quality Improvement meeting. Spot checks across most wards and departments have been positive, and the main area of concern regarding medicines management has been HRI main theatres. An improvement plan is in place which is being supported by pharmacy colleagues, and improvements following the peer review are also being noted.
  - Infection prevention and control performance maintained compliance. The switch to gentamicin (antibiotic) did result in an increased number of prescribing incidents which are being managed by the Divisional Director. No harm or orange incidents have been reported regarding gentamicin.
  - An increase in harm-free falls was noted in February, however, analysis did not identify any concerns, and the usual pattern has resumed.
  - Reduction in open orange incidents following targeted work and support from the Clinical Governance Support Manager. The length of time to complete investigation has improved significantly.

- Issues for future improvement work
  - The head and neck directorate continue to work towards a number of quality assurance programmes including:
    - Audiology – IQIPS (Improving Quality in Physiological Services) – which is a rigorous set of standards to ensure a safe and effective service is provided and that the experience for the patient is continually improving
    - Ophthalmology – Patient standards for ophthalmology services in respect of RNIB (Royal National Institute for the Blind) and UKOA (United Kingdom Ophthalmology Alliance)
  - The orthopaedic team have been undertaking virtual fracture clinics to review appropriate patients virtually. Positive feedback was received from patients involved, and the team are currently working through how this model can be supported going forward.
  - The divisional quality improvement (QI) meeting continues to meet twice monthly and the senior nursing team are focusing on improvements to ward assurance with a particular focus on elimination and completion of fluid balance charts.

- Fractured neck of femur performance continues to be a challenge during periods of trauma surge and the team have been asked to develop a sustainable plan. The reasons for the decrease in performance were thought to be staffing, however, some of it relates to complexity. The division have been asked to provide an update for their Performance Review Meeting, which will be submitted to this Committee in August.

- Exceptions for the Quality Committee

  - Critical care has continued to work through the must-do and should-do actions following the CQC (Care Quality Commission) visit. Good progress has been made against most elements, and the outstanding action regarding medical staffing requires further work on the options appraisal prior to sign-off.

  - The Clinical Director for critical care is undertaking a review of the standards for critical care post-discharge. The review will also explore out of hours options.

- Review of meetings

  - A work together to get results (WTGR) session was held during quarter 4 for the Patient Safety and Quality Board meeting, the results of which have been amazing. The chair for each meeting is rotated and the division are mirroring the way that the medical division reports in and out of Patient Safety and Quality Board meetings, which is working well.

  - The weekly Orange Panel continues to be well supported with good engagement from Clinical Directors and attendance from the surgical team.

Discussion ensued on infection control and to be cognisant of Meticillin-resistant Staphylococcus aureus (MRSA) screening in the division, which has gone down. Equipment risks were also discussed and it was asked whether there have been any incidents in relation to these. It was stated that there have been no incidents in relation to equipment risks. The Medical Director commented on the Joint Advisory Group accreditation and 23-hour knee replacement pilots which started in quarter 4.

OUTCOME: The Quality Committee received and noted the content of the detailed and comprehensive divisional quarterly report.

104/19 COMMUNITY HEALTHCARE QUARTER 4 PATIENT SAFETY AND QUALITY BOARD REPORT

Andrea Dauris (Associate Director of Nursing) presented appendix G, summarising:

- Quality and safety issues
  - The impact of vacancies in some areas continues to challenge the teams.
  - Infection Prevention and Control inspections identified issues relating to some premises where community teams provide clinics.

- Issues for future improvement work
  - *Quality and safe discharges* - the division intend to carry out a piece of improvement work alongside colleagues in the hospital to improve the quality and safety of discharges.
  - *E-referral* – The development of an e-referral system into community services in Calderdale will ensure equitable referral processes across the patch and standardise the process to promote safe and quality discharges. This is on the risk register with a score of 16.
  - *Nursing Competencies* – The division are developing a range of nursing competencies to develop the skills of their healthcare assistants.
  - Six Community division staff members are booked on to cohort 1 of the Trust's new Work Together 2 Improve (WT2i) training scheme.

- Exceptions for quality committee:

  A decision was made to incorporate Central Operations into the newly integrated Community Healthcare. This was a welcomed development and represents the beginning of a significant journey with service integration.

OUTCOME: The Quality Committee received and noted the content of the detailed and comprehensive divisional quarterly report.

105/19 FAMILIES AND SPECIALIST SERVICES QUARTER 4 PATIENT SAFETY AND QUALITY BOARD REPORT

Dr Julie O'Riordan (Divisional Director) presented appendix H, summarising:

- Quality and safety issues
  - Paediatric staffing – There are five junior doctor gaps on an 11-person rota following changeover in February 2019. Remedial action is being taken.
  - Healthcare Safety Investigation Branch (HSIB) – The Trust currently has five cases under investigation, and now awaiting reports.
  - Appointment letters – there was a noted 2% increase in the outpatient directorate of first appointment did not attend (DNA) rates and the number of patients who not received a paper or electronic appointment letter.
  - Women's directorate is working with theatres to review and improve the gynaecology theatre lists
  - Radiology vacancies at consultant level are impacting acute capacity and multi-disciplinary team cover. Remedial actions taken include increased outsourcing of radiology reporting and working with Mid-Yorkshire hospitals to provide support for head and neck and lung services. A head and neck consultant will be starting in post in July 2019 and an NHS locum interventional radiologist will be in post next week. Work is ongoing with clinical fellows from overseas and will hopefully have one or two colleagues from September.
  - Pharmacy – awaiting analysis of 4-week audit data for all gentamicin prescriptions, and undertaking a 2-week trial of gentamicin huddles to provide timely and individual feedback to doctors.

- Issues for future improvement work
  - In the next scope of ATHENA work, there is the opportunity to include an electronic customised growth chart, which will reduce the risk of human error when plotting on a paper centile chart.
  - Northern Pathology Imaging Co-operative (NPIC) Digital Pathology – final contract agreed and circulated for sign-off. CRH could be used as a possible pilot site.
  - New primary and acute care systems (PACS) had successful "go-live" on 28 April 2019. CHFT are early in the phasing and will be able to view other hospital images and improve how we work together.
  - Mat Neo - CHFT presented the neonatal aspect of the project at the national launch of wave 3 Trusts in March 2019, which was positive and well-received.

Discussion ensued on the reduced junior doctor placements, and it was stated that the posts are vacant for a number of reasons, including maternity leave, part-time working, transfers to other deaneries, etc.) which have all impacted at the same time.

OUTCOME: The Quality Committee received and noted the content of the detailed and comprehensive divisional quarterly report.

106/19 EXTERNAL AGENCY VISITS

Dr Anne-Marie Henshaw (Assistant Director of Quality and Safety) reported on appendix I, a bi-annual report setting out external visits and accreditation which took place during quarters 3 and 4 of 2018 / 2019. The report also highlights focussed work which took place to improve the quality of the divisional compliance registers which are reported through divisional Patient Safety and Quality Board meetings and the Risk and Compliance Group.

11 external agency visits, inspections and accreditations took place during quarter 3 and quarter 4 of 2018 / 2019:

- *Imaging Services Accreditation Scheme (ISAS)* – Accreditation awarded, no outstanding actions;
- *United Kingdom Accreditation Service (UKAS) ISO 15189 Cellular Pathology* – Action plan completed and evidence cleared by UKAS;
- *UNICEF UK Baby Friendly Initiative (BFI) Accreditation* – Awarded;
- *UNICEF UK Baby Friendly Initiative (BFI) Accreditation GOLD Award* – Awarded;
- *Audit of Aseptic Services* – Action plan received;
- *Microbiology UKAS ISO 15189* – Action plan in place and progress being monitored by Pathology Governance Board;
- *Trust Human Tissue Act (HTA) inspection* - Action plan in place and progress being monitored by Pathology Governance Board;
- *Getting It Right First Time (GIRFT) – Radiology Deep Dive & department tour* – Awaiting report
- *Blood Sciences UKAS 15189* – All actions cleared;
- *CQC & OFSTED special education needs & disability (SEND) inspection* – Report received and now action planning;
- *Respiratory Services – Invited Service Review* - All actions complete.

Results from the NHS cervical screening programme were presented at the gynaecology forum this week; the CQC / Special educational needs and / or disabilities (SEND) report was received into the organisation last week. A number of incomplete actions have an associated risk register entry listed against them, and work is ongoing to progress these actions.

Progress is being made on five external agency visits, inspections and accreditation visits planned for quarter 1 of 2019 / 2020:

- *National accreditation process for Occupational Health Services in public and private sectors;*
- *Diabetes Peer Review - Royal College of Paediatrics and Child Health (RCPCH);*
- *HFEA inspection by the primary centre care Manchester, Leeds & Sheffield Yorkshire Fertility;*
- *Gynaecology Oncology - Quality Surveillance programme;*
- *CHKS Children's Services 1st surveillance visit.*

Work continues to promote the External Agency Visits, Inspections and Accreditations Policy to ensure colleagues are fully supported to prepare for and manage visits.

A second report regarding horizon scanning and other accreditation visits which the Trust may want to participate in will be taken to the Weekly Executive Board in July, which will also be submitted to this Committee.

Discussion ensued on the improvement work which needs to continue once accreditation has been achieved, and a better way of sharing the positive work. It was suggested that once a service has undergone a visit / review / accreditation, that they should be invited to the Quality Committee to present their achievement and tremendous amount of work.

The work undertaken by divisional teams on compliance registers was also noted. Compliance registers have been revised and updated and now used at Patient Safety and Quality Board and directorate board meetings.

OUTCOME: The Quality Committee received and noted the content of the report.

107/19 QUALITY AND PERFORMANCE REPORT

Jackie Murphy (Chief Nurse) presented appendix J and the key points from the April 2019 report.

April's performance score was 72%. The safe domain was green, but there were two category 4 pressure ulcers (community and intensive care), with root cause analyses and learning coming from those. The caring domain is now amber as the emergency department's Friends and Family Test response rate fell in month. The effective domain was green for the sixth consecutive month, although there was one meticillin-resistant staphylococcus aureus (MRSA) and Fractured Neck of Femur missed the target again. The deep clean programme is continuing. The responsive domain deteriorated to 61% with the referral to treatment (RTT) incomplete target being missed for the first time, alongside poor performance in two of the stroke indicators, and the 6-week diagnostics target missed again. Within the workforce domain, short-term sickness was green. Infection control and data security essential skills training both dipped below 90%, as well as appraisals for medical staff. Within efficiency and finance, the financial element of the domain was green.

OUTCOME: The Quality Committee received and noted the content of the report

108/19 MENTAL HEALTH STRATEGY

Lindsay Rudge (Deputy Chief Nurse) reported that the three year mental health strategy, which is being developed in line with the Trust strategy and aligns to the Treat as One document, will be submitted to the Weekly Executive Board, and be brought to the next Quality Committee meeting in July.
Action: Mental health strategy to be received next month

109/19 DIVISIONAL PATIENT SAFETY AND QUALITY BOARD TERMS OF REFERENCES

Five copies of the divisional Patient Safety and Quality Board meeting terms of references (appendix K) were circulated for ratification.

Changes were made to the membership and change of name to the Community Healthcare division terms of reference. The other four terms of reference (surgical division, medical division, families and specialist services (Diagnostic and therapeutic services and children and women's services)) were submitted for annual ratification.

OUTCOME: All terms of reference were approved.

110/19 INFECTION CONTROL COMMITTEE MINUTES

Dr David Birkenhead (Medical Director) presented appendix L, summarising items discussed at the infection control committee meeting on 25 April 2019.

- Flu update
  - The CQUIN (Commissioning for Quality and Innovation) target (75%) was met at 75.5%.
  - 106 immunisers trained
  - 2019 / 2020 CQUIN target will be 80% and will continue to report non-vaccinated staff. The strategy for next year was taken to the Executive Board in May.

- Deep clean programme – the plan for the deep clean is underway for this year, starting in June 2019.

Discussion ensued on the issue of cross-infection with portable fans in health and social care facilities. It was reported that the Trust will be compliant with the guidance published in April 2019, as fans can be decontaminated, and will not be placed in patient areas.

111/19 ANY OTHER BUSINESS

There was no other business.

112/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- The development of serious incidents action planning
- Complaints – Owen Williams to attend Quality Committee next month
- Proposal of the use of hand-held devices to improve compliance with documentation of fluid balance charts
- Progress made on Mental Health strategy, which will be presented at next month's meeting.
- The good quality and presentation of the divisional Patient Safety and Quality Board reports received from each division.

113/19 EVALUATION OF MEETING

What went well……

- Patient Safety and Quality Board reports very helpful
- Meeting finished ahead of time
- Observers to the meeting fed back that it was really positive to hear discussion on patients and challenges made and very useful to hear issues that take place in other divisions.

114/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix M) was accepted.

Andrea McCourt (Company Secretary) stated that quarterly report was inadvertently missed from the work plan, and will be submitted to the next meeting on 29 July 2019.

The Chair asked whether an update on Schwarz rounds should be brought to this meeting on a regular, and it was stated that it could be part of the patient story section as a topic at the public Board meetings.

The Chair reported that divisional good stories (an item on the work plan), can be submitted through the Patient Safety and Quality Board reports on a quarterly basis. Divisions are welcome to invite any team to the Quality Committee meeting to present their achievements.

Presentation of results from external visits / accreditations to be added to the work plan.

NEXT MEETING

Monday, 1 July 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on FRIDAY 17 May, 2.00pm – 4.30pm, CE Office, Trust Offices, CRH/Discussion Room 1, Learning & Development Centre, HRI

PRESENT:

Helen Barker	(HB)	Chief Operating Officer
David Birkenhead	(DB)	Medical Director
Alexis Brown	(AB)	Human Resources Business Partner
Andrea Dauris	(AD)	Director of Operations, Community
Suzanne Dunkley	(SD)	Executive Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Leigh-Anne Hardwick	(LH)	Human Resources Business Partner
Karen Heaton	(KH)	Non-Executive Director (Chair)
Nikki Hosty	(NH)	Freedom to Speak up Guardian / EDI Manager
Diane Marshall	(DM)	Human Resources Business Partner
Ruth Mason	(RM)	Associate Director of Organisational Development
Adam Matthews	(AM)	Workforce BI Manager – Analytical Lead
Andy Nelson	(AN)	Non-Executive Director
Jackie Robinson	(JR)	Human Resources Business Partner
Alison Schofield	(AS)	Lead Governor
Sharon Senior	(SS)	Staff Side Representative
Claire Wilson	(CW)	Assistant Director of Human Resources

IN ATTENDANCE:

Mel Addy	(MA)	Director of Operations, S&A
Laurie Beckett	(LB)	Workforce BI Manager - Appraisal & Essential Safety Training Lead
Gill Harries	(GH)	Director of Operations, FSS
Lucy Jesson	(LG)	General Manager, Emergency Care Network
Lindsay Rudge	(LR)	Deputy Director of Nursing

18/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

19/19 **APOLOGIES FOR ABSENCE:**

Will Ainsley, Divisional Director, S&A
Gary Boothby, Director of Finance
Azizen Khan, Assistant Director of Human Resources
Jackie Murphy, Chief Nurse
Charlotte North, Assistant Director of Human Resources
Julie O'Riordan Divisional Director, FSS

20/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

23/19 **MINUTES OF MEETING HELD ON 8 OCTOBER 2018:**

The minutes of the WC meeting held on 11 February 2019 were approved as a correct record.

The minutes of the meeting held on 8 April 2019 to review the Quality and Performance Report were also approved as a correct record.

22/19 **MATTERS ARISING**

(i) Unplanned Turnover Position

The report had been circulated with papers to the Committee meeting.

CW provided an overview of the Trust's position during the period 1 April 2018 to 31 March 2019. During this period unplanned turnover is reported at 7.9% (480 leavers). 354 unplanned leavers are deemed as potentially preventable (preventable leavers classed as those giving a leaving reason of Voluntary Resignation). Top voluntary reasons for leaving are reported as relocation and work life balance. The Committee asked for further information of where people are going when they leave the Trust.

ACTION: Identify destination on leaving **(CW)**

OUTCOME: The Committee **RECEIVED** and **NOTED** the content of the report.

(ii) EST – Plan on a Page

The report had been circulated with papers to the Committee meeting.

CW reported that a 3Rs exercise had been undertaken to produce an action plan to deliver a compliance rate of 90% across both Essential Safety Training and Essential Skills Training (role specific) for 2019/2020. EST compliance continues to be reported weekly to the Executive Board.

It was noted the Trust attained the second highest compliance rate of 5 Trusts which participated in a recent benchmarking review by Audit Yorkshire.

AN queried the link between pay progression and EST. It was confirmed both EST and appraisal have to be up to date for pay progression to be actioned. The Pay Progression policy has been live for two years however there is now a strong drive to make colleagues more aware of the policy and understand its implications. A communications message has been circulated and colleague drop-in sessions have been taking place. It was reported the sessions have gone well with colleagues accepting this as a 'must do'.

OUTCOME: The Committee **RECEIVED** and **NOTED** the content of the report.

23/19 **ACTION LOG (items due this month)**

The action log was reviewed and updated accordingly.

16/19: The Committee noted the work to develop the job matching standard operating procedure is progressing. The item will not be brought back to the Committee.

68/18: NH advised the Equality, Diversity and Inclusion (ED&I) Strategy and action plan will be shared with the October 2019 Committee meeting. KH requested that NH provide an update on progress at the next Committee meeting.

ACTION: Provide a short presentation updating work on the ED&I strategy and action plan at the August 2019 Committee meeting **(NH).**

24/19 **DEEP DIVE: 2018 NATIONAL STAFF SURVEY RESULTS**

RM introduced a presentation setting out the response to the Trust's 2018 National Staff Survey results.

The survey results identified particular areas which require focus, these included service teams (Central Operations, Head and Neck, Emergency Care, Pathology, HPS, Critical

Care, Radiology, Orthopaedics and Operating Services), Health Care Assistants (HCAs), effectiveness of appraisals and colleagues with a disability. A high level action plan has been developed in response to the feedback in these groupings.

Service Teams

Survey results have been shared within divisions and were discussed at the 8 April 2019 Hot House event. Divisional areas of action are identified below. In addition, directorate specific actions plans have been developed and these were presented to the Committee by the HR Business Partners.

Surgery and Anaesthetics:-

- AskSAS email account created
- Know your senior team photos updated on intranet and ward areas
- Annual engagement calendar
- Senior management team (SMT) walkrounds/tea trolleys
- Listening events

Family and Specialist Services:-

- Update of divisional structure chart
- FSS intranet pages to be updated
- Newsletter/Virtual notice board
- May Divisional board WTGR session to finalise full action plan
- Further SMT walk rounds/tea trolleys
- Scoping - what support do our leaders need to lead

Medicine:-

- SMT led staff engagement meetings arranged for each directorate during May
- SMT programme of ward visits in place for 19/20
- Listening event to be arranged for divisional management team
- Directorate led staff engagement meetings with range of staff groups

Community:-

- Members of SMT to attend team meetings in May/June
- Initial nursing workforce planning meeting held on 9 May 2019
- Update of Divisional intranet page and reintroduction of Virtual Notice Board.
- Programme of engagement regarding Workforce wellbeing commencing May 2018

Healthcare Assistants

LR presented the actions in response to the concerns raised by HCAs:-

- WTGR sessions arranged to engage with colleagues to further explore concerns.
- Deployment of colleagues to be examined
- Colleague development
- Deep dive into key workforce workforce data

Effectiveness of Appraisals

LB presented the activities undertaken to enable an effective appraisal:-

- Intranet section dedicated to Appraisal Season
- Self-assessment tool for appraisees
- Appraiser training sessions delivered throughout Appraisal Season
- Manager checklist
- Updated four pillars – added expected ‘behaviours’
- Guidance, tips and advice available on the intranet
- ‘Interim Review Form’ created to reassess objectives/development opportunities 6 months after initial appraisal
- Information stands held at CRH and HRI during Appraisal Season

AN asked what happens at the end of the appraisal season. LB confirmed an evaluation

questionnaire is being developed and will be issued to all colleagues post 30 June to test the quality of the appraisal interaction.

It was noted the updated 4 pillars posters can be accessed via the intranet and will soon be available from the printers.

Colleagues with a Disability

NH presented the progress in response to colleagues with a disability feeling less engaged than others.

- Plans in place to establish a disability network/forum as part of the Trust's Equality, Diversity & Inclusion Strategy
- Work to review policies in relation to assessing whether colleagues with a disability are disadvantaged/not taken into account. Upon the work being undertaken, discussions will take place with the Inclusion Advisory Group when established
- WTGR for colleagues with a disability

NH advised the Trust's first Inclusion Advisory Group will meet on 13 June 2019.

KH asked if everyone declares their disability. It was noted there has been 100% increase in numbers of colleagues who have updated their ESR record and now consider themselves to have a disability. NH is positive about the activities making a difference to colleagues.

RM summarised the presentation highlighting that local engagement and actions, a health and wellbeing programme and management and leadership programmes will enhance colleague's experience of working at CHFT.

HB advised the next annual planning event will focus on leadership. In addition, there is a focus on 'celebrating the positives', colleagues are encouraged to speak up about good news stories.

The Committee noted the next (2019) NHS Staff Survey will commence in Autumn 2019.

The Committee was satisfied with the activities taking place and thanked those involved.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the actions.

25/19 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) MARCH 2019**

The report had been circulated with papers to the Committee meeting.

AM provided an overview of main points of the report:-

- The Workforce domain improved from 56.7% in February 2019 to 67.2% in March 2019. This is due to improvements in EST and Medical Appraisals. The revised targets for 2019/20 would see the Trust's current performance at 87.9% and would move the Workforce Domain to 'Green' for the first time.

- Staff in Post decreased by 27.22 FTE (15 Headcount), which, despite a reduction of 4 FTE Establishment, led to an increase in vacancies (23.22 FTE).

- Turnover improved slightly to 8.81% from 8.90% in February 2019. This is 2.53% improvement from the same point in 2018 and the lowest turnover recorded on ESR since March 2014. The Committee noted the highest turnover is within the Healthcare Scientists staff group at 11.37%. Turnover with Medical & Dental continues to decrease, currently at 7.78%.

- The rolling 12 month sickness absence position improved again to 3.74% from 3.76% in January 2019. This is the lowest rolling sickness absence rate recorded on ESR.

- EST overall compliance improved to 94.45%, just under the 95% stretch target.

- Appraisal compliance for medical colleagues increased to 92.85% in March 2019, from 85.22% in February 2019.

The Committee recognised the significant improvements and expressed huge thanks to all who support this work.

KH commented on the number of administrative and clerical vacancies. Vacancies are still being held in Divisions with regard to the voice recognition project. A vacancy deep dive report will be shared with the Executive Board on 20 June 2019.

KH asked who is recorded in the capability category. The current data identifies both formal and informal sickness absence. The data can be shown separately in future. AS asked if there is any flexibility towards colleagues with a disability. JB advised the wording in the attendance management policy is being looked at so that it has emphasis on supportive conversations with colleagues.

KH referenced the high turnover figure within the healthcare scientist staff group. CW explained this is a small staff group which does skew the figures however the position is closely monitored.

AN asked where CHFT benchmarks against workforce metrics. It was confirmed that the workforce report provides benchmarking data on sickness and absence. AM will check to see if benchmarking data for turnover is available to include routinely in the report.

ACTIONS: Separate out formal and informal data for the capability category **(CW/AM)**. Identify if benchmarking data for turnover is available **(AM)**.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

26/19 **RISK REGISTER – WORKFORCE RISKS**

The report had been circulated with papers to the Committee meeting.

JE advised there are currently 3 high level workforce risks with a score above 15; medical staffing, nurse staffing and EST compliance. AN asked if there was a national benchmark in terms of medical staff. DB advised the risk aspect had improved.

The Committee noted that Therapy staffing and EU exit are recorded as a risk but not at high level score.

ACTION: Review risk score for medical staffing risk and nursing staffing risk **(DB/SD/JE).**

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

27/19 **FIRE SAFETY TRAINING**

The Committee had been previously advised alternative methods for the delivery of fire safety training were being pursued, this was approved at the April 2019 Board of Directors. CW confirmed progress is on plan and that a training needs analysis is currently being undertaken. A progress update would be provided at a future Committee meeting.

ACTION: To provide a progress update at a future Committee meeting **(CW).**

OUTCOME: The Committee **NOTED** the refreshed approach to fire safety training.

28/19 **QUARTERLY ESCALATION FROM PRMS:-**

INFECTION CONTROL TRAINING

DB reported the compliance rate is being closely monitored.

DB stated there had been instances of colleagues completing the training but not being able to record it on ESR. SD confirmed she and Owen Williams had met with the ESR Programme Director who had volunteered to work with the Trust regarding usability. Colleagues are asked to contact the Business Intelligence team if they are unable to record their training. SD commented that compliance rates show a declining position. DB confirmed that compliance is reported at Infection Performance Board and individual colleagues are identified if their infection control training is not completed. It was noted that compliance rates are issued to Directorates on a weekly basis by HR Business Partners.

ACTIONS: Work with Central ESR Team colleagues in relation to ESR functionality and enhancements **(Mark Bushby/Laurie Beckett).**

OUTCOME: The Committee **RECEIVED** and **NOTED** the response.

29/19 **CQC POST INSPECTION ACTION PLAN**

The report had been circulated with papers to the Committee meeting.

The CQC post Inspection Action plan has now been closed as agreed at the CQC Response Group in April 2019. The two outstanding workforce actions ('Must Do' 8 and 'Should Do' 9) have been added to the 2019-20 CQC Exception Action Plan. SD advised there will be a focus on SD9 (Emergency Medicine) at the June 2019 Medical PRM.

ACTION: Provide current and up to date action plan **(LR).**

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

30/19 **OD STRATEGY (THE CUPBOARD) UPDATE**

RM confirmed The Cupboard launched on 17 April 2019. So far it has had 866 hits through the intranet. The opening animation has had 1297 views. The colleague engagement calendar and health and wellbeing recipe cards have been the most viewed areas. The Cupboard will continue to be monitored and 'stocked up' as needed. Extending links into external stakeholders is also being considered. KH requested to receive regular updates on The Cupboard's growth.

OUTCOME: The Committee **SUPPORTED** The Cupboard.

31/19 **WORKFORCE COMMITTEE SELF-ASSESSMENT**

The report had been circulated with papers to the Committee meeting.

As part of an end of year governance review, a Committee self-assessment review is forwarded to members to complete. The self-assessment is designed to gauge the Committee's effectiveness by taking the views from members across a number of themes. The results of the self-assessment had been shared with members.

It was noted that the self-assessment questions were generic and therefore not all relevant to the Workforce Committee. Discussion followed regarding the various Board Committees and HB acknowledged that each Committee operates differently and advised she is working with both the Trust's Company Secretary and Chief Nurse to look at inconsistencies, duplication and ensuring positive escalation to the Board.

The self-assessment responses were positive and well received by the Committee. It was noted that Committee attendance had improved although was disappointed that only nine members out of 31 completed the assessment. AS commented that it was a well-attended meeting and it was noted the Committee has a large membership with both Board and Divisional input.

KH welcomed all feedback on the meeting, wanting to know what had gone well and what not so well. The Committee agreed to the introduction of a standard agenda item which would provide feedback on the meeting.

Action: Add standing agenda item 'evaluation of meeting' **(TR).**

OUTCOME: The Committee **RECEIVED** and **NOTED** the Committee's effectiveness.

32/19 **REVIEW OF TERMS OF REFERENCE**

It was agreed to defer this item until the review of Board sub-committees had been undertaken.

33/19 **ANY OTHER BUSINESS**

There were no items to discuss.

34/19 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

There were no matters for escalation.

35/19 **DATE AND TIME OF NEXT MEETING:**

7 June 2019 Review Quality & Performance Report – Workforce, 1.15pm–1.45pm, MR1, Learning Centre, HRI
7 June 2019 Hot House, 2pm–4pm, Discussion Rooms 1 & 3, Learning Centre, HRI

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Wednesday, 22 May 2019

Present: Philip Lewer, Gary Boothby, David Birkenhead
Linda Patterson, Sheila Taylor

In attendance: Emma Kovaleski, Asif Ameen, Carol Harrison, Lyn Walsh (minutes)
Apologies: Jackie Murphy, Phil Oldfield

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Minutes of the last meeting
The minutes of the last meeting held on 27 February 2019 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.

3. Action Log
Matters arising ~ not covered on this agenda due August 2019. Risk register and strategy are also due August 2019. Todmorden premium cost is on today's agenda. Funds overview is on today's agenda. Fund holder review is due August 2019.

4. Terms of Reference review
The terms were reviewed by the Committee with the following amendments agreed.

The Membership council representative is to be changed to Council of Governors.
Emma Kovaleski (Fundraising Manager) and Asif Ameen (ADD Service Planning) are to be added to in attendance.

5. Draft Annual Report & Accounts 2018-19
Carol Harrison presented the Annual Reports and Accounts 2018/19 to the committee for further review and comment subject to being audited.

Gary Boothby commented that income had increased from the previous year due to legacies being received, can the accounts information be used to raise awareness and be included in the marketing for promotion of the charity and celebrate the success.

6 Todmorden Health Centre (Premium)
Gary Boothby presented the paper which had been discussed at a previous meeting. A lengthy discussion was had as to how services at both Todmorden and the Holme Valley fitted into the overall strategy of the Trust. It was felt that this should be part of the work being done by the Outpatient Transformation Group Sheila Taylor suggested engagement from the local community. It was agreed that this be added to the next Board workshop as the Outpatient Transformation is on the agenda.

Some members of the Committee were not comfortable that this recommendation for funding was completely of a charitable nature. Emma Kovaleski explained that all charitable proposals should be considered against the following tests, the public perception test, patients benefit test and the additionality test.

There was discussion about what a good outcome would look like if the recommendation was agreed, baseline data had been gathered but timing of starting the proposal was also felt to be an issue.

The Committee agreed to support the IT equipment purchase £847 so digital clinics could be supported and trailed. The other premium cost is to be revisited at the August meeting.

7. Funds of the Charity – an overview
Carol Harrison presented the paper it was well received and all agreed that it provided the Committee with useful information in particular that it highlighted that the smaller funds were generating 56% of all expenditure. Thanks were given to Carol.

Linda Patterson questioned if all staff were aware of funds and how to access them. Carol Harrison explained that awareness was mixed and it is all linked in to raising the profile of the charity going forward.

Gary Boothby gave an example of a Manager who had asked for revenue expenditure authoring which would have taken them over budget, where there was a charitable fund that could be accessed as the expenditure could be considered as charitable.

8. Reserves to General purpose fund
Carol Harrison presented the paper which detailed the current balances in reserves and general purpose funds for the Committee to decide whether to release funds from the former to the latter.

As the investments had seen a gain in year it was decided that £120k would be released to general purpose funds from the £266k reserve.

Gary Boothby highlighted that if there were investment losses the decision would have been not to release the reserves. He explained that there still needed to be

two out of three signatures from the Committee for authorised expenditure on general purpose funds.

9. Minutes from Staff Lottery Committee held on 12 March 2019
These were noted.

10. Any other business

Philip Lewer introduced Emma Kovaleski the new Fund Raising Manager.
Emma said how delighted she was to be here as there was so much potential good will and enthusiasm at the Trust.

Emma explained how she has started general scoping work looking at what income is currently spent on, defining the potential in the medium and long term how to engage staff and the community, support patients and visitors.

How does the Trust position itself and some benchmarking against the NHS Association of Charities and other Trusts? SWOT analysis which Emma agreed to share outside of the meeting. Looking at the Charities compliance with GDPR how information is stored. Looking at what budget is required for resources such as buckets tea shirts, leaflets templates harlequin system.

Begin to review upcoming events be part of induction days and engage with staff, access data base for the 8000 members of the membership council.

Philip Lewer updated that Stephen Duncan from Healthy Minds had been in touch to ask for help on a project but due to time scales it wasn't possible for the Charity to help, he suggested that Emma contact Stephen and arrange a meeting. Carol to invite him to the next meeting.

11. Date and time of next meeting
The next meeting will be on Friday, 23 August 2019 at 2.00pm-3.30pm in Meeting Room 4, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
22 May 2019
Action Log - 2019/20

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Brand launch and promotion of Charitable Funds.	**PL/GB**	Aug-19	ongoing
Risk Register & Strategy update	28.08.18	Papers are updated await further approval when fundraiser appointed.	**GB/TBC**	Aug-19	ongoing
Todmorden premium cost	29.11.18	Bring a proposal where there may be a request of use of charitable funds to support either continued activity at Todmorden which costs a premium to deliver or for digital technology investment to allow the local service to continue and expand. Linked to the review of what activity takes place at Todmorden Jackie Murphy would support discussions and survey with patients to understand their preferences for Todmorden activity. This may be included within any request for funds but the overall review of Todmorden should be addressed elsewhere. Revisit at August 2019 meeting.	**GB / JM**	Aug-19	ongoing
AOB	22.05.19	Contact Healthy Minds (S Duncan) invite to next meeting.	**EK/ CH**	Aug-19	
AOB	27.02.19	Fund holder post to bring review of options to consolidate smaller accounts alongside merits of both options	**EK**	Aug-19	

18. Governance Report

a) Update to the Scheme of Delegation

b) Board Workplan 2019/20

c) Board meeting dates 2019/20

d) Use of Trust Seal

e) Council of Governor Election Results

To Approve

Presented by Amber Fox

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Governance Report - July 2019
Author:	Andrea McCourt, Head of Governance and Risk
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report

This report brings together a number of governance items for review and approval by the Board in July 2019.

Key Points to Note

a. Scheme of Delegation

Following the scheme of delegation review at the Board meeting on 2 May 2019, it is confirmed that within the detailed scheme of delegation, authority for the review of fire precautions is deleg ated to the Chief Operating Officer. The Board are asked to **NOTE** this update.

b. Board Workplan 2019/20

The current January 2020 Board date is Thursday 2 January 2020. It is proposed to amend this date to Thursday 9 January 2020.

The Board work plan for 2019/20 has been updated with minor amendments and is presented to the Board for review at (Appendix 1). The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and **NOTE** the work plan and **APPROVE** the revised date for the January 2020 Board meeting.

c. Board meeting dates 2020/21 proposal

The attached is a proposal of the future Board of Directors meetings from April 2020 up to March 2021 at Appendix 2. The Board of Directors meetings will continue to take place bi-monthly, on the first Thursday of the month and on alternating sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital. The Board are asked to **APPROVE** the proposal of future Board dates.

d. Use of Trust Seal

There have been two documents sealed since the last report to the Board in March 2019, these are available at Appendix 3. The Board are asked to **NOTE** the use of the Trust seal in the last quarter.

e. Governor Elections

Elections for two staff governors and five public governors are being held and the outcome of these, together with the announcement of a new partnership governor for Calderdale and Huddersfield Solutions Ltd., will be announced at the Annual General Meeting on 17 July 2019. The Board are asked to **NOTE** the update on the 2019 governor elections.

EQIA – Equality Impact Assessment

No impact identified.

Recommendation

The Board is asked to:

- **NOTE** the update to the Scheme of Delegation
- **NOTE** the Board Workplan for 2019/20 and **APPROVE** the revised Board meeting date for January 2020
- **APPROVE** the proposal for future Board meeting dates 2020/21
- **NOTE** the use of the Trust Seal
- **NOTE** the process underway for the Governor elections.

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

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

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

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

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

Calderdale and Huddersfield
NHS Foundation Trust

Appendix 2

Public Board of Directors Meetings Dates Proposal for 2020/2021

Date	Time	Location
Thursday 7 May 2020	9:00 – 12:30 pm	Huddersfield Royal Infirmary
Thursday 2 July 2020	9:00 – 12:30 pm	Calderdale Royal Hospital
Thursday 3 September 2020	9:00 – 12:30 pm	Huddersfield Royal Infirmary
Thursday 5 November 2020	9:00 – 12:30 pm	Calderdale Royal Hospital
Thursday 14 January 2021	9:00 – 12:30 pm	Huddersfield Royal Infirmary
Thursday 4 March 2021	9:00 – 12:30 pm	Calderdale Royal Hospital

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
2-19	12.4.19	12.4.19	The Guarantor set out in Schedule A and Shawbrook Bank Limited Deed of Guarantee Calderdale and Huddersfield NHS Foundation Trust is the guarantor and Calderdale and Huddersfield Solutions Ltd is the guarantee company. Schedule B, the guaranteed contract, is for the lease of goods.	NAME: Andrea McCourt TITLE: Company Secretary NAME: Jackie Murphy TITLE: Chief Nurse

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
3-19	29.04.19	29.04.19	The Amendment Agreement of the Pennine Property Partnership LLP Remove of Lesley Hill and David Anderson from the Partnership Board.	NAME: Philip Lewer  TITLE: Chair

19. 6 Facet Survey

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	6 Facet survey 2019
Author:	Gary Boothby, Executive Director of Finance
Previous Forums:	Estates Sustainability Committee 17th June 2019

Actions Requested:
To note

Purpose of the Report

The report provides a summary of the 2019 6 facet survey report and describes how this information is being used to support the development of the estate strategy for HRI.

Key Points to Note

A 6 Facet Survey is a method used that allows estate condition categories to be allocated to properties on a facet by facet basis together with a summary of the remedial costs to bring each facet up to a safe and sound condition. A number of surveys have taken place over the years in relation to HRI and these have been used to inform the CHFT reconfiguration strategy.

The 2019 survey has identified a backlog maintenance cost of £84m. The summary provides more detail on the specific challenges for HRI.

The data provided within the 6 facet survey is being used to inform the development of an overall Estates Strategy for HRI with the key and immediate focus being on developing a strategy that will address the high priority areas. External technical support has been commissioned to support this work and the proposed investment plan for Huddersfield Royal Infirmary will be completed by October 2019. This will inform the detailed plan for the use of the £20m capital funding that DHSC has announced is available for investment at HRI.

EQIA – Equality Impact Assessment

The report highlights challenges for the HRI estate including its functionality and accessibility. Issues are raised that will be considered in the HRI estate strategy being developed.

Recommendation

The Board is asked to **NOTE** the findings of the 2019 6 facet survey report and the planned timescales to develop the estate strategy for HRI.

Huddersfield Royal Infirmary 6 Facet Survey 2019

Integrated Facilities Management

Working in partnership with Calderdale and Huddersfield NHS Foundation Trust

Executive summary

A 6 Facet Survey is a method used that allows estate condition categories to be allocated to properties on a facet by facet basis together with a summary of the remedial costs to bring each facet up to a safe and sound condition.

In 2013 a 6-facet survey of Huddersfield Royal Infirmary (HRI) was undertaken by the NIFES Consulting Group. The 2013 survey was updated by Lendlease in 2015 and identified a backlog maintenance cost at HRI of £92m, applying inflationary uplifts for the intervening period from 2015 -19 this represents a backlog maintenance cost at HRI in 2019 of £95m.

In 2019 the Trust commissioned White Young Green (WYG) to undertake a new 6 facet survey to provide an up to date assessment of the condition and risks associated with the HRI estate. The 2019 survey has identified a backlog maintenance cost of £84m (a summary of the cost is included in section 2 of this paper).

The backlog maintenance cost includes preliminary costs, fees, contingency and VAT however it excludes the cost of enabling work that would be required to remove asbestos. Asbestos is a significant issue across HRI and is present in many areas and in the vertical risers that carry pipework and electrical services between the different floors of the hospital. Removal of asbestos would require areas of the hospital to be decanted and patient services moved to temporary accommodation.

There has been an £11m reduction in backlog maintenance cost at HRI in the period 2013 to 2019 (£95m reduced to £84m). This is partly due to technical differences in the market rates and allowances used in the two surveys, however it is also associated with investment of circa £32m at HRI during the same period (on schemes such as external façade improvement; pipework replacements; fire door replacements; air handling units; water compliance; emergency lighting, the opening of Acre Mills for outpatient services, and; fire compliance).

Priority areas within the current £84m backlog cost have been identified based on the risk rating as described in section 3. WYG identified two high-risk backlog maintenance items: missing guard rail to link corridor roof and fire doors, both in the Theatre Block. These priority areas are being addressed as necessary with the remedial action further described in section 3.

Significant backlog maintenance for the main building at HRI currently stands at £14.5m. Issues with the electrical and mechanical infrastructure are evident throughout the hospital, in particular 1960's wiring and distribution boards (electrical panels). Existing mechanical ventilation requires urgent upgrades and / or replacement. Other key priority areas include the external building fabric (corrosive ties to cladding panels), fire doors to circulation areas and passenger lifts.

The data provided within the 6 facet survey is being used to inform the development of an overall Estates Strategy for HRI with the key and immediate focus being on developing a strategy that will address the high priority areas. External technical support has been commissioned to support this work and the proposed investment plan for Huddersfield Royal Infirmary will be completed by October 2019. This will inform the detailed plan for the use of the £20m capital funding that DHSC has announced is available for investment at HRI.

1. Introduction

Calderdale and Huddersfield NHS Foundation Trust runs the two main hospitals in Huddersfield and Halifax – Huddersfield Royal Infirmary and Calderdale Royal Hospital - and provides outreach services in the local communities.

Huddersfield Royal Infirmary (HRI) is located about two miles from Huddersfield town centre. It has a gross floor area of 67,493m2 across a site with land area of 16.77 acres. The hospital offers a full range of day case and outpatient services, an accident and emergency department, and critical care. It provides emergency surgery, planned complex surgery and emergency paediatric surgery for the people of Greater Huddersfield and Calderdale. It also provides diagnostic services including magnetic resonance imaging (MRI). Inpatient medical services are provide at HRI. There are approximately 420 beds at HRI.

6 Facet Survey

The 6 Facet Survey forms the ‘core’ estates information required by HBN 00-08 (NHS Estate Code). It is regarded as the ‘minimum data set’ of information necessary on which to base informed decisions about the future of an estate. It provides a good baseline of information for an Estates Strategy, assists with property transfers and is consistent with the updated NHS Premises Assurance Model (PAM), ERIC Returns, and the Carter and Naylor Reviews.

The 6 Facet Survey comprises of six separate surveys and reviews, which are carried out by separate specialised facet survey teams and auditors, each experienced in their own field.

The resultant 6 Facet Survey allows Condition Categories to be allocated to properties on a facet by facet basis together with a summary of remedial costs to bring each facet up to a safe and sound condition.

The 6 facets are:

- Facet 1 - Physical Condition Survey (Fabric and M&E)

- Facet 2 - Functional Suitability Review
- Facet 3 - Quality Audit
- Facet 4 - Space Utilisation Audit
- Facet 5 - Statutory Compliance Audit (incl. Fire)
- Facet 6 - Environmental Management Audit

The most recent 6 facet survey at Huddersfield Royal Infirmary is dated March 2019 and was carried out by White Young Green (WYG).

2. Cost Information

Fig.1.0 below provides a summary of the cost estimates provided by WYG and findings of independent review of the rates and budget allowances which was carried out by Lendlease. The cost review was based on high level budget estimates, approximate rates and included several assumptions where there was limited information.

The total cost following the review, including allowance for contractor's preliminaries, fees, contingency and VAT is estimated at £84,616,078.86.

		6 Facet Survey Completed by WYG	6 Facet Survey adjusted for arithmetical amendments etc.	Lendlease review	
Item	Description	Total	Total	Total	Difference
1	Physical Condition	£27,552,601.41	£27,403,894.73	£24,689,725.79	-£2,862,875.62
2	Functional Suitability	£15,416,250.00	£15,466,250.00	£15,239,750.00	-£176,500.00
3	Quality	£1,000,000.00	£1,000,000.00	£1,000,000.00	£0.00
4	Space Utilisation	£861,250.00	£861,250.00	£844,500.00	-£16,750.00
5	Statutory Compliance	£5,362,250.00	£4,552,250.00	£4,502,250.00	-£860,000.00
6	Environmental Management	not priced	not priced	N/A	
	Total	**£50,192,351.41**	**£49,283,644.73**	**£46,276,225.79**	**-£3,916,125.62**
		Difference:	**-£908,706.68**		
	Preliminaries @ 15%			£6,941,433.87	
	Works Cost Total			**£53,217,659.66**	
	Fees @ 15%			£7,982,648.95	
	Contingency @ 20%			£10,643,531.93	
	Sub-Total			**£71,843,840.54**	
	Inflation			Excluded	
	Sub-Total			**£71,843,840.54**	
	VAT (Excluding fees)			£12,772,238.32	
	VAT Recovery			Excluded	
	Total			**£84,616,078.86**	

Figure 1.0. Shift Statement following analysis by Lendlease

It should be noted that asbestos removal costs are excluded from the 6 Facet Survey therefore the costs are expected to be higher than the circa £85m estimated above.

The above figures have also been analysed against the previous 6 Facet Survey undertaken by Nifes in 2013. Bottom line back log maintenance costs of the Nifes 2013 and WYG 2019 survey was £39,424.286.13 and

£50,192,351.41 respectively.

We have identified number of reasons for the increase by £10,768,065.28 such as:

- Functional Suitability decreased in value from 2013 to 2019 due to OPD moving to the new Acre Mill complex, ward upgrades and ward moves.
- Statutory Compliance increased due Fire Safety issues relating to compartmentation.
- Physical Condition increased due to the issues with the External Fabric (cladding) associated with damage and corrosion of fixing ties.

In 2015, Lendlease have undertaken the review of the 6 Facet survey completed by Nifes. The Lendlease reviews 2015 and 2019 are £92,398,118.86 and £84,616,078.86 respectively. Key reasons for the decrease by -£7,782,040.00 include:

- number of Nifes allowances appearing to be below market rate and number of WYG allowances appearing higher than market rates and/or historical data from HRI site.
- errors made in Facet 5, Statutory Compliance resulting in reduction of cost by £840K
- number of allowances which Lendlease were unable to review due to limited information and no rates or quantities provided
- the differences between findings of the two 6 facet surveys

3. Findings of the survey, risk ratings and priority

Each element of the report is assessed in terms of likelihood and consequence. Fig.2.0 below demonstrates the basis of risk assessment. The risk matrix used to calculate the risk scoring and the score range are as shown below. Significant Risk backlog is scored at 11-16 and high risk at 17-25.

SCORE RANGE	RISK RANKING
1–6	LOW
7–10	MODERATE
11–16	SIGNIFICANT
17–25	HIGH

			PROBABILITY OF FAILURE				
		Rating	1	2	3	4	5
		Failure descriptors	RARE	UNLIKELY	POSSIBLE	LIKELY	CERTAIN
			None or minimal remedial action required and/or new/recent upgrade. Estimated time to failure may be circa > 10 yrs	Normal wear and tear. Sound, operationally safe and exhibits only minor deterioration. Estimated time to failure may be circa < 10 yrs	Reasonable physical damage/ deterioration. Reassignment of life may be acceptable based on technical tests or residual robustness. Estimated time to failure may be circa < five yrs	Major physical damage/ deterioration. Failure apparent/ assessed as imminent or unacceptable built environment. Not appropriate to reassign life. Estimated time to failure may be circa < one yr	Failure occurred. Unacceptable built environment. Not appropriate to reassign life. Estimated time to failure may be circa < six months
			Fire/statutory Complies with mandatory fire safety requirements and statutory safety legislation.	**Fire/statutory** Complies with mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature	**Fire/statutory** Known contravention of one or more requirements – which falls short of "B".	**Fire/statutory** Dangerously below "B"	**Fire/statutory** Dangerously below "B"
	SEVERITY		**Health & safety**	**Environment**	**Business**	**Operational/ building/ engineering element**	
	Rating	**Descriptor**					
POTENTIAL CONSEQUENCES	1	INSIGNIFICANT	No injury/breach of guidance/ procedures	No or minimal impact breach of guidance/ procedures.	Unlikely cause of complaint. Litigation remote. Minimal reputation loss/ limited awareness within organisation.	Minimal or no impact. Minimal or no disruption.	1	2	3	4	5
	2	MINOR	Minor injury/ill health (first aid or self-treatment). Breach of legal requirement.	Breach of legal requirement.	Possible complaint Litigation unlikely Loss of reputation (widespread internal awareness).	Localised impact. Disruption to normal services.	2	4	6	8	10
	3	MODERATE	Moderate injury/ill health statutory obligations. Improvement notice issued.	Single breach of legal requirement. Improvement notice issued.	Possible complaint. Possible litigation. Loss of reputation. National paper reporting.	Moderate impact. Moderate disruption to normal services.	3	6	9	12	15
	4	MAJOR	Major/significant injury or long-term incapacity/disablement. Prohibition notice issued.	Multiple breach of legal requirement. Prohibition notice issued.	Litigation expected. Loss of reputation National reporting.	Major/significant impact. Severe disruption to normal services.	4	8	12	16	20
	5	CATASTROPHIC	Fatality and/or permanent incapacity/ disability. Prosecution.	Multiple breach of legal requirement. Prosecution.	Litigation certain. National adverse publicity	Critical impact. Service closure.	5	10	15	20	25

Figure 2.0 Risk Matrix

3.1 Facet 1: Physical Condition

The physical condition of the estate is assessed on three elements; the internal and external building fabric, mechanical systems and electrical systems. The current position stands at a backlog maintenance figure of £24,689,725. This includes several properties around the main site including the Old Nurses Residences, Saville Court etc.

High Risk Backlog Maintenance

Two items have been identified by WYG as high-risk backlog maintenance associated with the main building.

1. Theatre Block link corridor roof guard. WYG stated in their comments that there are “Missing guard rails / barrier to link corridor roof”. Estates are aware of the location and of the historic non-compliant

edge protection down one side. There is no immediate action required as the roof is never accessed.

2. Theatre Block Fire Doors. WYG stated in their comments that “Fire doors are considered to be beyond economical repair” These doors will be prioritised in this year’s capital scheme for Fire Safety. The works are due to commence imminently.

Significant Backlog Maintenance

Significant backlog maintenance currently stands at £14,588,598.98 for the main building at HRI. Issues with the electrical and mechanical infrastructure are evident throughout the hospital, in particular 1960’s wiring and distribution boards (electrical panels). Existing mechanical ventilation requires urgent upgrades and / or replacement.

Some of the key areas of significant risks are:

3.1.1 Cladding (site wide) Approx. £5,649,000.00

Cladding on all elevations of the main site was identified as a significant backlog maintenance issue. WYG have referred to the independent structural report which *“identified corrosion of ties to cladding panels.”*

3.1.2 Electrical Systems (Distribution, wiring, boards, luminaires) Approx. £3,690,633.33

The survey identified a large amount of ailing electrical infrastructure across the HRI site. The main areas of concern are Ward Block 1 and 2.

Comments were:

- Distribution Boards (Electrical Panels) are at end of life/poor condition and require replacement.
- Majority of electrical wiring observed to be original (1963) with some replacements made.
- UPS (battery backup) serving 15 rack server cabinet require replacing
- Distribution Boards; (Electrical Panels) (Predominantly Dorman Smith & Bussmann DB's) are at end of life. Distribution boards are currently in operational condition; however the internal component condition is unknown.

3.1.3 Mechanical Systems (Pipework, pumps, insulation)

Approx. £1,486,298.46

The survey identified significant issues with heating installation (pipework) which requires replacement.

Main areas of concern are:

- Ward Block 1
- Ward Block 2
- Block 3 (Old OPD)
- Main Entrance

3.1.4 Ventilation (Cooling systems, split chillers, plant)

Approx. £294,385.82

Existing ventilation air handling units (AHU) require replacing / upgrading urgently in:

- Day Theatre 3
- Recovery
- Theatre Office
- Day Theatre 1 & 2
- Main Theatre Recover
- Main Theatre General
- Main Theatre 6
- Vascular

All the above are approaching their end of life and will require replacement or refurbishment within the next 5 years in order to bring it to a good condition.

3.1.5 Internal Doors (Hardwood circulation doors)

Approx. £404,300.00

Many fire doors across the whole site require replacement as a priority, WYG stated that:

- Original fire door are nearing end of service life and have some damage which could limit the potential of the door should it be required in an emergency
- Replacement and repairs to fire doors throughout block
- Fire doors have undergone significant damage that could reduce their performance when required in an emergency scenario.
- Fire doors - binding to frames, missing ironmongery, damaged leaves, aged leaking hinges, missing smoke seals, missing door closers

- Allowance for the full replacement of fire doors where sticking, binding, damaged aged and generally worn

3.1.6 Lifts (Passenger Lifts) Approx. £1,236,000.00

A number of passenger lifts require replacing / upgrading, mainly in Ward Block 2.

WYG commented: "*Asset approaching end of life and lifecycle replacement/refurbishment should be considered.*"

3.2 Facet 2: Functional Suitability Review

Functional suitability is assessed on three elements; internal space relationships, support facilities and location. The overall cost was calculated at £15,239,700. A number of significant support facilities were identified such as inadequate toilets and disabled provision.
Several observations were made on the current layout and design of the hospital, for example access and suitability of support facilities and walking distances, particularly in ward block 2 were assessed as poor.
WYG added: "nothing but a total rebuild, or relocation will suffice as improvements are either impractical or too expensive to be tenable".

3.3 Facet 3: Quality Audit

Quality is assessed on three elements; amenity, comfort and design. Two significant areas of concern were identified, both describing the Renal Medical Offices (RMO).

WYG in their comments stated that "*The Block is currently running at near to full capacity.*" WYG recommended cost to address the issues with office capacity is £1,000,000. This cost is to provide additional admin space.

3.4 Facet 4: Space Utilisation

Space Utilisation is assessed on a series of judgements made on the intensity of use i.e. the number of people using it and the frequency with which they use it.

The current position in terms of utilisation stands at £844,500.00. Each area is assessed on likelihood and possible consequence and subsequently awarded a priority-based risk score. Significant risk associated with space utilisation has been assessed at £231,500.00. This includes:

- No WCs on ground floor – Pathology Annex

- Lack of natural light. Some areas are dark and unwelcoming, for example Block 3 Entrance
- Redecoration required.
- Multiple requirements for new seating, decor and refurb on corridors 1-7
- Phlebotomy department suffers from excess temperatures and would benefit from solar shading and improved ventilation
- Poor lighting and lack of natural light. Complaints of headaches due to poor lighting and/or ventilation. Requests for skylight from staff.
- Multiple complaints noted regarding lack of temperature control. Too hot in summer, too cold in winter.

3.5 Facet 5: Statutory Compliance

Statutory Compliance Audit (including Fire) - Fire, health and safety are assessed on the property's compliance to statutory legislation.

3.5.1 Fire Safety

Fire safety covers elements such as compartmentation, fire doors, and support services etc., calculated at £3,420,250.00. The areas with the most backlog maintenance are Ward Blocks 01 & 02 with £745,800 and £988,800 respectively. Block 3 (Old OPD & ED) collectively at £500,000 of backlog maintenance.

3.5.2 Mechanical & Electrical (M&E) Compliance

The Department of Health provide mandatory guidance documents, Health Technical Memorandums (HTM) on how to comply with Mechanical & Electrical legislation in healthcare environments. Evidence and documentation is controlled by the Estates department, WYG found little to no concerns regarding M&E compliance subsequently resulting in zero cost.

3.5.3 Accessibility

Accessibility looks at our level of compliance against the Disability Discrimination Act 1995. This relates to access into the building and circulation spaces around the hospital site. The current backlog stands at £4,502,250.00

3.5.4 Asbestos

Asbestos is not costed within this survey. There are many areas throughout the hospital which are assumed to contain Asbestos Containing Material.

3.6 Facet 6: Environmental Management Audit

Environmental management is assessed on the overall efficiency of the property, with energy being a critical factor. Energy Performance is an important factor in determining the overall efficiency of the hospital. This appraisal follows the NHS Estate departments energy code (Encode) as a relevant performance indicator.

The calculated energy performance for the site has been derived from the utility bills dated April 2017 – March 2018 received from the estate team at Huddersfield Royal Infirmary. The energy performance results are shown in the table below:

Energy Consumed 2017/2018						
HRI Site	Heated Volume Approx (m^3)	Kilowatt Hours			Giga Joules	GJ/100m^3
		Electricity[1]	Gas[2]	Total		
Whole Site	174,536	7,861,974	19,238,997	27,100,971	97,563	61
Main Building	143,356	7,675,982	17,917,865	25,593,847	92,138	64
Acre Mills + PMU	24,890	160,790	1,148,399	1,309,189	4,713	47
Staff Residence	Not Included in analysis due to buildings being vacant during 2017/2018					

Table 3.0: Results of energy performance for HRI during 2017/2018

The energy performance calculated of the whole site is 61GJ/100m3; NHS Estatecode benchmarking data states that this falls within the condition B rating and signifies an average level of energy performance for a large acute hospital.

4. Conclusion

The total backlog maintenance cost including allowance for contractor's preliminaries, fees, contingency and VAT is estimated at £84,616,078.86.

The Trust is currently developing a strategy to address the high priority areas. Data provided within the 6 facet survey will also inform and drive development

[1] Utility Sheet: electricity consumption 2017-18 v1 30-4-18
[2] Utility Sheet: gas usage and cost 2017-18 ERIC

of the overall Estates Strategy for HRI. Assistance will be provided by an independent consultancy company with a range of experience in Healthcare Planning, Strategic Development and Master Planning.

The significant back log maintenance issues will be prioritised immediately within the current capital plan as permittable by the budget. Consideration is also being given to disposing of the satellite properties around the main sites.

5. Appendices:

Appendix 1 - Lendlease Review

Appendix 2 - WYG 6 Facet Survey

20. Month 2 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	Month 2 Financial Summary
Author:	Gary Boothby, Executive Director of Finance
Previous Forums:	Turnaround Executive

Actions Requested:
To note

Purpose of the Report

To provide the Board with the month 2 financial summary.

Key Points to Note

Year to Date Summary

- The year to date deficit is £4.58m in line with the plan.
- The CIP delivered in the year to Month 2 is £1.25m slightly ahead of a planned £1.20m
- There is an underspend of £0.82m against the budgeted agency trajectory, offset somewhat by other pay spend. The overall operational pay position is underspent by £0.53m.
- Clinical contract income is in line with plan overall but only after £0.89m protection offered by the Aligned Incentive Contract (see detail below) and indicating the lower than planned activity levels across all points of delivery.
- In the main the clinical divisions are showing favourable variances to plan, reflective of lower expenditure linked to lower activity levels across Divisions; and vacancy levels in Community. Medicine division has some expenditure pressure from additional beds being open in the early part of the year.
- Non clinical areas are experiencing pressure with the THIS position being driven by lower than planned income generation. A higher than planned cross charge for services from CHS including utilities is being held centrally by the Trust (Technical Accounting and Reserves). Further work is ongoing to investigate.

Division	Reported Position YTD - Month 2		
	Plan	Actual	Variance
	£'000	£'000	£'000
Corporate	(7,158)	(7,105)	53
FSS	(1,002)	(985)	17
THIS	380	206	(174)
Medicine	5,907	5,811	(96)
Surgery	2,130	2,418	288
Community	182	346	165
PMU	508	603	95
Divisional Operating Position	**946**	**1,293**	**347**
CHS Ltd	18	1	(17)
Technical Accounting & Reserves	(5,558)	(5,874)	(316)
Total Trust Surplus / (Deficit)	**(4,594)**	**(4,580)**	**14**

Clinical contract income

The overall position is £0.1m below contract in the year to date and this can be further described as follows:

- The Aligned Incentive Contract (AIC) activity is driving income that is £0.52m below the contract in-month (split £0.38m CCCG and £0.14m GHCCG), bringing the YTD position to £0.89m below contract level (split £0.46m CCCG and £0.43m GHCCG) with income protected back to contract level.
- The remaining non-AIC contracts are £0.1m below contract in-month and therefore impacting on the Trust's I&E position. This brings the YTD position to £0.14m below contract.
- The non-AIC in-month position is solely driven by North Kirklees which is £0.12m below plan in month – this is across all points of delivery and is a material shift from the position in April.

Forecast

At this very early stage, the year-end forecast at divisional and Trust level is to achieve the planned £9.7m deficit. Achievement is reliant the delivery of the full £11m of CIP. There is a balance of risk and opportunity at this stage which is being monitored. Calls against the Trust's £1m contingency reserve will be considered through the Commercial Investment Strategy Committee.

EQIA – Equality Impact Assessment

None

Recommendation

The Board is asked to **NOTE** the Month 2 Financial Summary.

21. Calderdale and Huddersfield Solutions Verbal Update

To Note

Presented by Gary Boothby

22. GDPR Assurance Compliance Report

To Note

Presented by Mandy Griffin

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 4 July 2019
Meeting:	Board of Directors
Title:	General Data Protection Regulations and Data Protection Act 2018 update
Author:	Mandy Griffin, Managing Director, Digital Health
Previous Forums:	None

Actions Requested:
To note

Purpose of the Report

The General Data Protection Regulation (GDPR) and a new Data Protection Act 2018 (DPA 2018) were the biggest change in data protection laws for 20 years when it came into effect in May 2018. These changes were created due to the technical advances and the widespread availability of personal information; new technology brings new threats. These changes obviously have an impact on the Trust, in the way we manage information and the way we support patients, service users and staff. The Information Governance Team and Data Protection Officer developed an implementation plan based on the ICO steps and guidance to compliance and this report provides an update with regards to progress and issues which need to be considered.

Key Points to Note

A key provision of the DPA 2018 is the principle of 'accountability'. Organisations (Data Controllers) must be able to demonstrate compliance with the DPA 2018 and GDPR principles and that they have appropriate technical and organisational measures in place. The Trust has demonstrated compliance through (not limited to):

- Data Security and Protection Toolkit Compliance
- Updated policies to bring in line with new legislation
- Significant review of the Information Asset Register (ERAMBA)
- Formation of the Governance, Risk and Compliance Group
- Changes made to the legal basis for the processing of information
- Changes to the way consent is being requested
- Requirement to notify the ICO of breaches within 72 hours with increased fines for failure to comply
- Updated fair processing notices
- Introduction of a Data Protection Officer (DPO)
- Changes to timescales for subject access requests
- Awareness raising through, one2one training and Trust wide communications
- Data Protection Impact Assessment (DPIA)

The Organisation has continued with significant areas of work including development to ensure that systems and processes are in place to meet the DPA 2018 requirements as well as communicating what it means for staff and patients.

The Trust has areas of good practice and work is ongoing to achieve compliance with technology and best practice. However, overall the Board of Directors should feel assured that the organisation has made significant progress in achieving compliance.
EQIA – Equality Impact Assessment
No impact identified.
Recommendation
The Board is invited to **RECEIVE** and **NOTE** the new Data Protection requirements and the management actions being taken to ensure compliance with the Data Protection Act 2018 and General Data Protection Regulation.

Calderdale and Huddersfield
NHS Foundation Trust

General Data Protection Regulations and Data Protection Act 2018 update
Board of Directors 4th July 2019

1. Purpose

This report provides an update to the Board of Directors on compliance of the Data Protection Act 2018 (DPA 2018) and the General Data Protection Regulation (GDPR). The GDPR was approved in 2016 and has become directly applicable as law in the UK on 25 May 2018. The now current Data Protection Act 2018, fills in the gaps of the GDPR, addressing areas in which flexibility and derogations are permitted. Achievement of compliance with the regulation is overseen by the Data Protection Officer.

It is important to note that the GDPR and DPA 2018 is an evolution of the Data Protection Act 1998 (which the Organisation historically complied with) and is aimed at raising IG standards within all industries across the EU. The Organisation has maintained high levels of IG for many years with assurance provided through the achievement of Level 2 compliance with the IG Toolkit. The journey to GDPR compliance is therefore evolutionary rather than revolutionary as it is in some other sectors. However, the Information Commissioners Officer (ICO), as the regulator, can impose high penalties for non-compliance of up to €20m for serious breaches.

2. Background

Compliance

A key provision of the GDPR and DPA 2018 is the principle of 'accountability'. Organisations (Data Controllers) must be able to demonstrate compliance with the DPA 2018 and GDPR principles and that they have appropriate technical and organisational measures in place. The Trust has demonstrated compliance through (but not limited to):

- Data Security and Protection Toolkit Compliance
- Updated policies to bring in line with new legislation
- Significant review of the Information Asset Register (ERAMBA)
- Formation of the Governance, Risk and Compliance Group
- Changes made to the legal basis for the processing of information
- Changes to the way consent is being requested
- Requirement to notify the ICO of breaches within 72 hours with increased fines for failure to comply
- Data Protection Impact Assessment (DPIA)
- Updated fair processing notices/privacy notices for staff and service users
- Introduction of a Data Protection Officer (DPO)
- Changes to timescales for subject access requests
- Awareness raising through, one2one training and Trust wide communications

Awareness & Communication

The DPO and IG Service has engaged with Divisions to raise awareness of DPA 2018 and GDPR, these have proven effective as a major mechanism for raising awareness and communicating information in addition The IG Team undertook a successful initial awareness campaign through our intranet and internet pages.

The areas below described the work on-going in order to meet full compliance,

Information You Hold

Status: DPA 2018 and GDPR requires that each organisation must understand what information is held and how it is used and shared. Within the Trust this is managed through the following:

1. Information Asset Register - A comprehensive Information asset register (ERAMBA) has been developed and reviewed; work continues with various Divisions to capture business assets and associated data flows.

2. Information Sharing Protocols (ISPs) The ISP has been reviewed to comply with DPA/GDPR and new templates are currently in use.

3. Data Flow Mapping - Flow mapping will be a continuous process and the Trust will use the Eramba database to map processes.

Communicating Privacy Information / Fair Processing

Status: Each organisation must inform people what it does with their information, it's security arrangements and their rights around this information.

1. Privacy Notices – The Trust privacy notice was written in May 2018 and has been maintained and updated over the last 12 months by the IG service and Web Development Team.

2. Subject Access Requests – The Access to Health Records department has reviewed its processes and information for the public. Documentation has been amended.

3. Policies and Procedures – All IG related Policies have been amended to ensure compliance with changing legislation.

Legal Basis for Processing

Status: Legislation provides the ability for the NHS to collect, use and share information by using different legal conditions without reliance on consent. The trust consistently uses the conditions below to legitimise our sharing for direct care purposes

1. Conditions for processing information -
For processing 'Personal data':
– Article 6(1)(e) – Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller
For processing 'Special category data':
– Article 9(2)(h) – Processing is necessary for the purposes of preventative or occupational medicine, for assessing the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or management of health or social care systems and services on the basis of Union or Member State law or a contract with a health professional

These conditions are detailed on our privacy notice which is on CHFT/THIS websites so that patients can see it or be signposted

2. Consent - The issue of consent has caused significant confusion when discussing GDPR in many sectors. Many interpretations were that, as the rules for gaining consent were being tightened by GDPR, then measures would have to be put in place to more explicitly gain patient consent when processing their data. However, this is only the case where consent is used as the legal basis for data processing.

Data Breaches

Status: DPA 2018 and GDPR provides an instruction to report serious data breaches with 72 hours of identification.

1. Policies & Procedures - The Trust is now using the ICO and NHS Digitals reporting assessment matrix.
2. Datix Risk Management - Work has been undertaken with the Datix team to better reflect IG incident categorisation.

Data Protection by Design

Status: Each (new) system digital or otherwise must include security and protection of data at its instigation and design stages.

1. Data Protection Impact Assessments (DPIA) are being undertaken; a register has been created.

Data Protection Officer

Status: Each organisation must nominate a Data Protection Officer.

1. Data Protection Officer (DPO) The Trust has appointed its Data Protection Officer

International Transfers

Status: Each organisation must identify, and control data transferred outside the "safe zone" of the EEA.
1. Transfers of PCD to other countries - It has been identified that the Trust sends (in the main) radiology images to other countries (Australia, South Africa) out of normal hours. These flows have been assessed and graded as 'safe' or safe with caveats.

4. Next Steps

The Trust made good progress in readiness for 25th May understanding that not all threats would be mitigated and that not requirements will be implemented. Many objectives are "green" and some actions will continue to be implemented throughout the next year. Overall, it is believed that the Trust is in a robust position and can provide a high-level assurance regarding its compliance with GDPR and Data Protection Act.
Whilst there is no real concern at this stage that the organisation is not meeting its requirements under the updated legislation, there is a moderate risk that the consequences of non-compliance would be a breach in our statutory duty with the risk of enforcement action and monetary penalties.

Therefore, the risk of non-compliance is included on the Organisations Risk Register to ensure monitoring of progress.

5. Recommendation

The Board is invited to receive and note the new Data Protection requirements and the management actions being taken for compliance to the General Data Protection Regulation and Data Protection Act 2018.

23. Date and time of next meeting

Thursday 5 September 2019, 9:00 am

Venue: Boardroom, Huddersfield Royal Infirmary

To Approve

Presented by Philip Lewer