Public Board of Directors

Schedule	Thursday, 1 Nov 2018 9:00 — 12:00 GMT
Venue	CRH - Large Training Room
Organiser	Amber Fox

Agenda

1. Welcome and Introductions:

Jo Machon – Presenting a patient story

Presented by Philip Lewer

2. Apologies for absence:-

Lesley Hill

Presented by Philip Lewer

3. Declarations of Interest

4. Minutes of the previous meeting held on 6 September 2018

Presented by Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

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

PRESENT

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

IN ATTENDANCE

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

OBSERVERS

Paul Butterworth	Public Elected Governor
Sian Grbin	Staff Elected Governor

120/18 WELCOME AND INTRODUCTIONS

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

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

121/18 APOLOGIES FOR ABSENCE

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

122/18 DECLARATIONS OF INTEREST

Alastair Graham and the Executive Director of Workforce and Organisational Development and the Managing Director for CHS declared an interest in the Calderdale and Huddersfield

Solutions update (item 139/18).

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

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

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

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

124/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

The action log was updated and amended accordingly.

125/18 CHAIR'S REPORT

Annual General Meeting Minutes

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

Council of Governors Elections

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

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

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

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

126/18 CHIEF EXECUTIVE'S REPORT

Response to the Secretary of State

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

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

The Director of Transformation and Partnerships drew attention to the Public Calderdale and Kirklees Joint Health Scrutiny Committee taking place on 7 September where there will be representation from all respondents regarding the proposals, including NHS England and

NHS Improvement. The Director of Transformation and Partnerships and the Executive Medical Director will be in attendance. Officers of both councils have also been invited to attend in reference to the Council's response. In addition the Trust continues to engage with stakeholders and Local Medical Committees.

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

127/18 PATIENT/STAFF STORY

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

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

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

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

The Board formally thanked Katie Berry for sharing her story.

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

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

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

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

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

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

Risk 6903 Estates/Resus, HRI - Alastair Graham asked if the mechanical ventilation can take

place in advance of October 2019. The Managing Director for CHS explained the ventilation can't take place without the full refurbishment. Alternative options are being explored for resuscitation by the Managing Director for CHS and Associate Director of Urgent Care. A paper will be brought to WEB in a few weeks' time to determine the capital. The date for completion will be next Summer.

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

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

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

129/18 WINTER PLAN 2018-19

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

Winter Plan 2018-19 Presentation.pptx

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

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

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

130/18 RESILIENCE & SECURITY MANAGEMENT FINAL REPORT

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

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 case of MRSA so far, 5 in total last year, this is a single case with little that could've been done to prevent
- C.difficile figure is higher than last year and breaching targets, the rolling 12 months doesn't show a drop in c.diff and all have been sporadic cases and are not linked
- MSSA bacteremia has reduced to 2 cases opposed to 10 at this point last year
- CPE is a new MRSA gram negative bacteria which is resistant to all antibiotics and common in certain parts of the country, there are concerns of CPE increasing and all patients are been screened from high level areas
- Ongoing problems with isolating patients in a timely fashion due to wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling

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

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

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

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

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

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

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

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

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

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

134/18 GOVERNANCE REPORT

a. Constitutional Changes

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

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

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

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

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

b. Deputy Chair / SINED Appointment

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

The Freedom to Speak Up Guardian was picked up as part of the CQC report for this role to not be a Non-Executive Director in terms of visibility; therefore, the Director of Workforce and Organisational Development has developed a job description and will appoint into this role. This Freedom to Speak Up Guardian will network with the Freedom to Speak Up ambassadors across the Trust.

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

c. Use of Trust Seal

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

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

d. Board Workplan

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

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

135/18 QUALITY & PERFORMANCE REPORT – JULY 2018

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

The key highlights from the report were:

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

- Infection Control figures for MRSA and preventable c.diff will be up to date next report due to being late reported for June

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

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

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

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

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

136/18 **DATA QUALITY ASSESSMENT**

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

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

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

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

137/18 **ANNUAL FIRE REPORT**

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

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

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

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

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

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

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

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

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

138/18 **MONTH 4 FINANCIAL SUMMARY**

The Director of Finance presented the highlight summary.

- The year to date deficit is £16.51m, in line with the plan submitted to NHSI
- Clinical income is below plan by £0.68m. The Aligned Incentive Contract (AIC) is now protecting the income position by £0.56m in the year to date (£0.51m at Month 3), see Appendix 1 for detail
- CIP achieved in the year to date is £3.54m against a plan of £3.78m, a £0.24m shortfall
- Agency expenditure remains £0.13m beneath the agency trajectory set by NHSI
- Current position is heavily reliant on releasing reserves, need to improve income trajectory
- The forecast is to achieve the planned £43.1m deficit; this relies upon full delivery of the £18m CIP plan including high risk schemes, there are significant risks in the Cost Improvement Programme (CIP)
- The Aligned Incentive Contract (AIC) protection remains at Trust level but has not extended significantly in-month; however, the differential position by division has moved considerably. Surgery division is now being adversely impacted by the AIC whilst Medical division position includes £0.60m additional income under the AIC than the operational position

would justify
- The risk of delivering the finance position is currently rated at a 12, this is being reviewed.
- Recovery plans have been requested from all Divisions, this does not provide full assurance

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

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

139/18 CALDERDALE AND HUDDERSFIELD SOLUTIONS UPDATE

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

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

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

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

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

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

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

The key points were highlighted:

- As at 31st March 2018, 338 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 331 on 31st March 2017)
- In the 2017/18 revalidation year (1st April 2017 – 31st March 2018) 49 non-training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 20 non-training grade medical staff in 2016/2017
- Based on headcount, 94.7% of non-training grade appraisals were completed and submitted in the appraisal year (93.5% in 2015/2016)
- 5.2% of non-training grade medical staff were not required to complete an appraisal

(due to recently joining the Trust, maternity leave, recent return from secondment etc.), this compares to 5.5% in 2015/2016
- Overall a good performance compared to peers

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

141/18 WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT

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

The key areas highlighted from the report were:

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

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

Action: Executive Director of Workforce and Organisational Development

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

142/18 QUALITY OF APPRAISALS

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

The key points highlighted were:

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

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

Paul Butterworth raised discussions taken place at Quality Committee in that staff are still receiving increments when they haven't received their appraisal. Paul asked if there is a plan in place to ensure staff only receive increments once they have undertaken essential training and a quality appraisal. The Executive Director of Workforce and Organisational Development agreed to discuss with Linda Patterson.

Action: Executive Director of Workforce and Organisational Development

DRAFT

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

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

a. Audit & Risk Committee – minutes from meeting 11.7.18

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

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

b. Quality Committee – minutes from meeting 2.7.18 & 30.7.18

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

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

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

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

d. Charitable Funds Committee – minutes from meeting 28.8.18

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

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

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

f. Workforce Committee - minutes from meeting 10.07.18

The minutes of the previous Workforce Committee were received.

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

DATE AND TIME OF NEXT MEETING

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

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

DRAFT

5. Action Log and Matters Arising

- Fire Risk Assessment

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 6 September 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED AT BOD MEETING	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
6.9.18 142/18	**QUALITY OF APPRAISALS** To discuss incremental pay when staff have not undertaken a quality appraisal and essential training with Linda Patterson.	SD		November 2018		
6.9.18 141/18	**WORKFORCE RACE EQUALITY STANDARD (WRES)** Work with Board members to champion WRES actions and extend invites to the Disability and LGBT Forum.	SD		November 2018		
6.9.18 137/18	**FIRE RISK ASSESSMENTS** A summary of the Fire Risk Assessments audit to be received at Board to understand if there are any issues that the Board need to address.	LH	Fire Risk Assessments are included in the papers under Matters Arising.	November 2018		
5.7.18 117/18	**RECONFIGURATION UPDATE** Further review of the impact of the recent interim medical services reconfiguration to be brought back to Board in 3 months.	HB	On the agenda.	November 2018		
5.7.18 111/18	**LEARNING FROM DEATHS – QUARTERLY REPORT** Update to be provided on initial screening reviews (ISR) and increasing this from 25-30% to 75-80%	DB	**Update 6.9.18:** Ongoing struggle to engage Medical colleagues to become more involved. The delivery of initial screening reviews (ISR) is being reviewed across the Trust, led by Sal Uka. The broad process is being converted so that doctors will complete mortality reviews for their own specialty, rather than their own patients, which will be similar to the national process. The position is better than it is currently reported due to a delay in reporting.	September 2018		6.9.18

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 6 September 2018/ APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED AT BOD MEETING	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
5.7.18 110/18	**HIGH LEVEL RISK REGISTER** Decision to reduce the EPR financial risk to be reviewed. The wording for the longer term financial sustainability risk (#7278) as it refers to the control total. **Complete**	GB / F&P Committee	Andy Nelson was not in attendance at the Finance and Performance meeting; therefore, the EPR risk was not discussed.	November 2018		
7.12.17 183/17	**PATIENT STORY** The COO advised that at the end of the quarter she would bring a paper to Board updating on winter planning arrangements and conversations with partners.	HB	A winter plan presentation was presented to BOD on 6.9.19. A more detailed paper will be received at the next BOD in November once it has been through A&E Delivery Board.	November ~~September~~ 2018		
7.12.17 197/17	**UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES** The Chief Executive advised that a piece of work was underway looking at staff experience of appraisals would be brought to a future BOD meeting.	SD	A paper was brought to BOD on 6.9.18.	September 2018		6.9.18
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT** Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed to investigate this further.	DA	David Anderson contacted the National Guardian Office to enquire if they have any information on alternative routes for Raising Concerns. Received information via attendance at the Regional Meeting of Guardians where we have had presentations from different approaches in different Trusts. Set up a Raising Concerns, Insight and Analysis group in so much as they recognise that using the FSUG is only one way to raise concerns and Staff members may choose to approach a chaplain, discuss a worry within Occupational Health Team, reflect a concern in staff survey, or indeed raise a concern during a staff grievance investigation. There may be concerns not escalated by Staff but	~~July~~ September 2018		6.9.18

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED AT BOD MEETING	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			come to light through a patient complaint or included by a patient on a Friend and Family test. The purpose of the above Insight and Analysis group is to triangulate the above different sources of concerns. Barry Mortimer and David Anderson have done a 'Go See' to this Trust. This confirms the approach that the Trust have taken in so much that creating a culture where staff feel safe to raise concerns is paramount and via the route they prefer, while continuing to improve and make the Freedom to Speak Up processes more visible and accessible.			
1.3.18 44/19	**BOARD SKILLS AND COMPETENCIES** Arrangements were being made to prepare a Board Development Programme and utilise some of the intelligence from this exercise, along with strategic issues in its development and would be brought back to the Board in the near future.	OW/PL/ SD/VP	Workshop held with the Board of Directors on Thursday 28 June 2018 – development plan to be brought to Board in November.	November ~~September~~ 2018		
5.4.18 57/18	**HIGH LEVEL RISK REGISTER** It was agreed Audit and Risk Committee would monitor the risk to business continuity should a power outage or cyber-attack occur.	MG / RH	The Audit and Risk Committee discussed cyber risks at the last meeting and will pick up this action.	September 2018		6.9.18
5.4.18 62/18	**DATA QUALITY ASSURANCE** Receive the outcome of the NHSI Data Quality Assessment and associated recommendations.	HB	A paper was brought to BOD on 6.9.18.	September 2018		6.9.18

Calderdale and Huddersfield NHS
NHS Foundation Trust

PAPER TITLE: Fire Risk Assessment Update	**REPORTING AUTHOR:** Chris Davies (Fire Safety Manager / Head of Estates) Keith Rawnsley (Fire Safety Adviser)
DATE OF MEETING: 1st November 2018	**SPONSORING DIRECTOR:** Lesley Hill
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To Note

PREVIOUS FORUMS: N/A

EXECUTIVE SUMMARY:

The report describes the fire risk assessment process and status for Calderdale and Huddersfield NHS Foundation Trust (CHFT) in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

Calderdale & Huddersfield Solutions Ltd (CHS) employ an independent Authorising Engineer (AE(Fire)) Jonathan Harrison GIFireE, FRACS to undertake Fire Risk Assessments and the annual audit. CHS also provide a site based Fire Officer / Adviser, Keith Rawnsley. Johnathan and Keith are former Fire Service auditors. Johnathan is a Certificated Fire Risk Assessor, third party certification managed by Warrington Fire, UKAS accredited.

The initial risk assessment process in 2013/14 picked up many issues and non-conformities, highlighted by the West Yorkshire Fire & Rescue Service the organisation was asked to improve.

The initial position in 2013 started from a line of no suitable and sufficient fire risk assessments. In 2018 the positon is much stronger, the table below indicates which areas now have assessments.

Huddersfield Royal Infirmary

A+E	A+E X-Ray	Acre House	Birth Centre
Boiler House	CCU	Cleaning Services	Corridor 3
Corridor 4	Corridor 5	Corridor 6	Corridor 7
CT	DATS	Day Surgery	Dermatology
Discharge Lounge	EBME	Endoscopy	Haematology
ICU	Laundry	Kitchens	L+D
Max Fax	Medical Records	Mortuary	MRI
Orthopaedic OPD	Pathology	Paediatric OPD	Staff Res
Pharmacy	Phlebotomy	Plant and Ducts	PMU
Surgical Directorate	Surgical OPD	PAU	Surgical OPD
Theatres	Trust Offices	Ward 1	Ward 2
Ward 3	Ward 4	Ward 6	Ward 7
Ward 7	Ward 9	Ward 10	Ward 11
Ward 12	Ward 15	Ward 17	Ward 18
Ward 19	Ward 20	Ward 21	Ward 22
X-Ray			

Calderdale Royal Hospital

A+E	Assis Conception	Cardiology	Birth Centre
Chapel	CCU	Chest Clinic	Children's Centre
Day Surgery	Diabetes	Discharge Lounge	Dermatology
Eye Clinic	ENT	Endoscopy	General Office
ICU	IT	ICU	L+D
LDRP	Medical Records	Mortuary	MRI
Orthopaedic OPD	Pathology	Paediatric OPD	Macmillan
Pharmacy	Phlebotomy	Pain Clinic	SCBU
Surgical Office	Surgical Secretaries	Diag imaging	Orthopaedic OPD
Theatres	Trust Offices	SPA	Neruo Phys
Ward 1D	Ward 2AB	Ward 2 CD	Ward 3
Ward 4 D	Ward 4 B	Ward 5	Ward 6
Ward 7	Ward 8	Ward 9	Ward

Community Premises

Acre Mill	Allan House
Beechwood	Brighouse
Broad Street	Horne Street
Princess Royal	Salterhebble
Saville Court	St Johns

CRH assessments have also been carried out for Engie and ISS in the areas they have control of. On an annual basis the AE(Fire) also conducts a compartmentation audit on the means of escape across the whole site.

In addition to the Fire Risk Assessments the Trust is reducing risks by alternative methods:

- All staff receive annual fire safety training.
- A fire warden occupying each ward/department
- The fire alarm system is as close as possible to L1 standard to give early warning.
- Training the fire wardens to prevent the fire from starting in the first place.
- Staff on the ground giving new starters to the area they work in initial and immediate induction.
- Ensuring all staff are aware of the actions they need to take if they discover or suspect a fire.
- Each member of staff understands the different type of evacuation.
- Making advice and information available to all staff, either by department visits or making it available on the Trust Intranet site.

The AE(Fire) commenced the audit process in 2017 re-assessing the areas listed in the tables. There will be some additional areas as well as some disappearing. The new assessment documents also include an exec summary at the front of the document as a full evacuation procedure. The final round of visits is now taking place; the final assessments will be submitted in October 2018 for upload.

FINANCIAL IMPLICATIONS OF THIS REPORT: N/A

RECOMMENDATION:

WEB are asked to:

- Note the contents of the paper

APPENDIX ATTACHED: N/A

6. Chairman's Report

Presented by Philip Lewer

7. Chief Executive’s Report

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

Presented by Owen Williams

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday 1 November 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding - Attached is the final version of the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors - approved on 6 September 2018	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The System Leadership Executive (SLE) agreed a small number of amendments to the MoU text that had resulted from feedback from Board discussions. SLE agreed that these amendments were not sufficiently material to require further re-approval.

Please find attached the amended final draft, which incorporates these amendments.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to note the final amended West Yorkshire and Harrogate Memorandum of Understanding.

Appendix

Attachment:

181002 WYH MoU Final Draft.pdf

West Yorkshire and Harrogate
Health and Care Partnership

Memorandum of Understanding

F I N A L
D R A F T

October 2018

DRAFT

Contents

Foreword

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

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

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

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

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

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

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

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

1. Parties to the Memorandum

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

Local Authorities

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

NHS Commissioners

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

NHS Service Providers

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

- South West Yorkshire Partnership NHS Foundation Trust1
- Tees, Esk, and Wear Valleys NHS Foundation Trust1
- Yorkshire Ambulance Service NHS Trust[1]

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other National Bodies

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

Other Partners

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

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

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

Definitions and Interpretation

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

Term

1.5. This Memorandum shall commence on the date of signature of the Partners. It shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. It shall thereafter be subject to an annual review of the

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

arrangements by the Partnership Board.

Local Government role within the partnership

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

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

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

Partners in Local Places

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

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

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

2. Introduction and context

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

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

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

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

Purpose

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

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

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

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

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

2.8. The Memorandum should be read in conjunction with the Partnership Plan, published in November 2016, the Next Steps (February 2018) [3] and the six local Place plans across West Yorkshire and Harrogate.

Developing new collaborative relationships

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

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

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

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

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

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

[3] https://www.wyhpartnership.co.uk/meetings-and-publications/publications

Promoting Integration and Collaboration

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

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

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

3. How we work together in West Yorkshire and Harrogate

Our vision

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

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

Overarching leadership principles for our partnership

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

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

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

Our shared values and behaviours

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

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

Partnership objectives

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

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

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

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

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

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

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

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

Delivery improvement

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

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

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

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

4. Partnership Governance

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

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

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

Partnership Board

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

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

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

System Leadership Executive

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

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

Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

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

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

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

West Yorkshire and Harrogate programme governance

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

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

Other governance arrangements between Partners

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

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

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

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

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

West Yorkshire Association of Acute Trusts Committee in Common

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

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

West Yorkshire Mental Health Services Collaborative

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

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

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

Local council leadership

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

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

health and care partnership;

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

Clinical Forum

4.23. Clinical leadership is central to all of the work we do. Clinical leadership reflecting both primary and secondary care, is built into each of our work programmes and governance groups, and our Clinical Forum provides formal clinical advice to all of our programmes.

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

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

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

Local Place Based Partnerships

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

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

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

5. Mutual accountability framework

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

Current statutory requirements

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

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

A new model of mutual accountability

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

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

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

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

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

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

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

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

Taking action

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

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

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

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

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

The role of Places in accountability

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

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

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

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

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

Implementation of agreed strategic actions

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

National NHS Bodies oversight and escalation

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

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

6. Decision-Making and Resolving Disagreements

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

Collective Decisions

6.2. There will be three levels of decision making:

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

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

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

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

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

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

Dispute resolution

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

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

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

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

6.10. The key stages of the dispute resolution process are

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

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

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

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

7. Financial Framework

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

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

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

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

Living within our means and management of risk

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

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

NHS Contracting principles

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

Allocation of Transformation Funds

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

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

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

Allocation of ICS capital

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

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

Allocation of Provider and Commissioner Incentive Funding

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

8. National and regional support

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

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

9. Variations

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

10. Charges and liabilities

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

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

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

11. Information Sharing

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

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

12. Confidential Information

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

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

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

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

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

13. Additional Partners

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

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

14. Signatures

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

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

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

[INSERT SIGNATURE PAGES AFTER THIS]

Schedule 1 - Definitions and Interpretation

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

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

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

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

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

Glossary of terms and acronyms

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

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

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

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

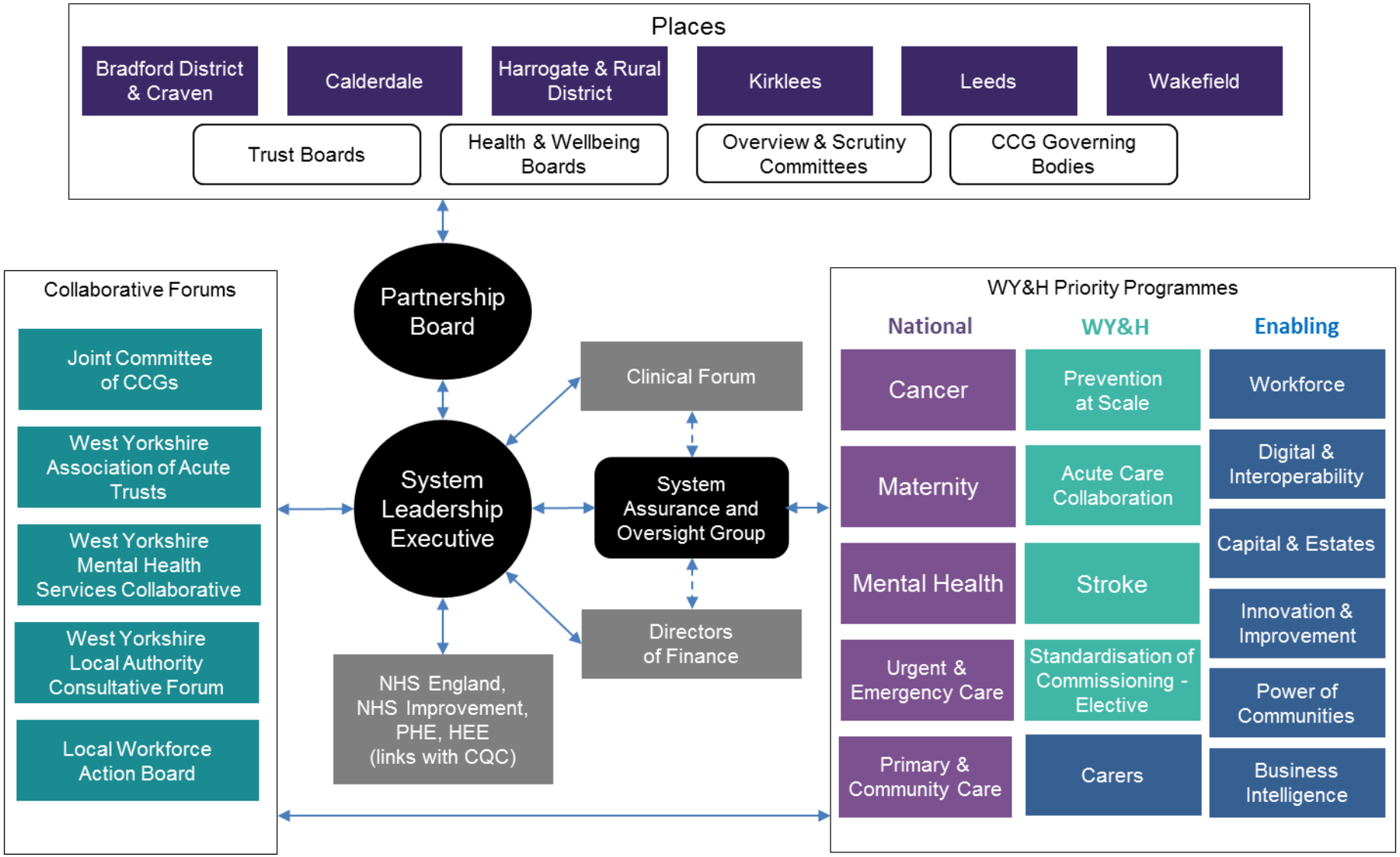
Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association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

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers[4]	Councils	NHSE and NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financial framework – financial risk management	✓	✓		✓		
Financial framework – Allocation of capital and transformation funds	✓	✓	✓	✓		
National and regional support	✓	✓	✓	✓		

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

Annex 2 – Schematic of Governance and Accountability Arrangements



Annex 3 - Terms of Reference

Part 1: Partnership Board

Part 2: System Leadership Executive

Part 3: System Oversight and Assurance Group

Part 4: Clinical Forum

8. Patient/Staff Story & Quarterly Quality Report (Q2)

Outpatients patient story presented by Jo Machon

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday 1 November 2018	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: Quality Report Q2 2018/19 - To provide an assurance to Board members regarding work to improve quality of services and present quality data for Q2 2018/19.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee 29 October 2018	
Governance Requirements: Relates to patients receiving high quality and safe care	
Sustainability Implications: None	

Executive Summary

Summary:

Presentation and paper on quality improvement across the Trust as at Q2 2018/19, including CQUINS.

Main Body

Purpose:

Presentation of highlights of covering key work being undertaken to improve quality across the Trust by CQC domain with a more detailed quality report included.

Background/Overview:

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

The Issue:

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A presentation on the key quality data as at Q2 2018/19 will be provided at the Board meeting.

The report summarises the information shared with the Board on quality over the last three months.

Information on the 2018/19 quality account priorities of deteriorating patients, patient flow and end of life care at quarter 2 is also included within the enclosed quality report.

Next Steps:

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

The next formal update on quality at the end of Q2 will be presented to the Board.

Recommendations:

The Board is asked to note the quality reporting for the first three months of 2018/19, quality data as at quarter 2 2018/19 and the update on the three quality account priorities.

Appendix

Attachment:

Narrative Quality Report Q2 2018 19 Board.pdf

BOARD	
PAPER TITLE: QUALITY REPORT for Quarter 2, 2018/19	**REPORTING AUTHORS:** Andrea McCourt, Head of Governance and Risk
DATE OF MEETING: Thursday 1 Novemberr 2018	**SPONSORING DIRECTOR:** Jackie Murphy - Chief Nurse
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: None	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY

This paper summarises:

- **i.** assurances on quality that have been presented to the Board of Directors between July and September 2018
- **ii.** an update on the three quality account priorities for 2018/19 for quarter 2.
- **iii.** a presentation on quality indicators as at quarter 2, 2018/19

1. Quality reports to the Board:

During the three month period July to September 2018 three reports relating to quality were presented to the Board which included an update on the electronic record in maternity and how this has helped investigations, learning from deaths and the benefits of the flu vaccine.

1.1 Maternity EPR

On 5 July 2018 the Board received a presentation from the Head of Midwifery about how the maternity electronic patient record, (EPR), the K2 Athena system, had supported complex investigations / serious incidents, comparing these pre and post the maternity EPR and noting the benefits of the real audit trail and story of the care provided by the system.

1.2 Learning from Deaths

A report on the quarterly learning from deaths for Q4 of 2017/18 was shared with Board members at its meeting on 5 July, together with a video on end of life care. The report highlighted learning themes from reviews to improve the quality of care including timely senior medical review, appropriate control of symptoms, communication, earlier recognition of deterioration and the dying phase and better fluid management.

There was also discussion on how the Trust is now a positive outlier for HSMR.

1.3 Flu Campaign

At the Board meeting on 6 September 2018 a patient story from a staff member, was shared, who had received her flu immunisation last year and subsequently became very ill and felt the vaccine had prevented her from developing more severe symptoms. The Board noted the Trust work on the flu campaign, successfully led by occupational health with support from nursing colleagues and the film should help with the 2018/19 flu campaign.

2. Update on 2018/19 Quality Account Priorities, Quarter 2

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

2.1 Care of the Acutely Ill Patient

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

The Deteriorating Patient Group has had a refresh witha new terms of reference and membership agreed. The focus remains on the recognition of, response to and prevention of deterioration in patients. Patients (over the age of 16) with NEWS (National Early Warning Score) of 5 or more are within the scope of this project.

Recognition is dependent on timely and high quality physiological observations to formulate the patient's NEWS. An audit was performed across the Trust on19 July 2018 and 150 sets of observations were observed by a range of clinical colleagues. The audit showed that approximately 80% of observations were performed by HCAs and students/apprentices. Furthermore assessment of respiratory rate was felt to be inaccurate in 60% and the pulse was only felt in 30%. 25% of observations were not on time. The data has been shared with senior nursing colleagues and discussions are underway to address how to improve the quality of observations performed and appropriate escalation.

As a Trust we have agreed to pilot new competencies for level 1 enhanced care for non-HDU/Critical Care areas. It is anticipated that will not commence until Q4 or possibly Q1 (2019-20). In maternity there are active plans to deliver the Maternal Acute Illness Management (MAIM) course to all midwives to improve the recognition of and response to deterioration in pregnant women. The NEWS2 task and finish group continues to collaborate with our EPR partner Bradford Teaching Hospitals Foundation Trust and capital funding has been agreed to fund the essential work within Nervecentre to support this. Plans have been agreed to deliver Trust-wide training in Q3 and an anticipated to 'go-live' in Q4. Finally, performance around observations on time has remained approximately 70% over Q2 although as we will need to monitor this as we move into Q3 and as the Trust encounters winter pressures.

Response is dependent on whether the patient's NEWS of 5 or more triggers in or out of normal working hours. In-hours escalation is to ward based teams whereas out of hours this occurs through HOOP. Although a previous audit suggested the need to refine processes the focus over Q2 has been on recognition of deterioration in patients as described above. Sepsis remains 'out of scope' of this group however there are pending discussions to align the two groups. Finally, it is anticipated that with the implementation of NEWS2 that there might be an increase in patients with NEWS 5 or more escalated for a response/review.

Prevention of (further) deterioration in patients is reliant on ongoing recognition of patients who are unwell. Safety Huddles are in place across patient areas at CHFT and plans are being developed to support this with highly visible ward view screens on wall mounted flat screen televisions. The ward

view, where patient identifiable data has been hidden, will display a number of patient alerts including raised NEWS. The ward view screens are being piloted on both AMU's and HRI ward 6 albeit depending on the actual availability of flat screen televisions on which to project. Wards will have the choice to display preconfigured EPR views of either the 'doctor's worklist' or the 'discharge worklist'. Ultimately it would be better to have an agreed ward view list but this will not be possible for over twelve months given other EPR change requests.

2.2 Patient Flow – Improving timely and safe discharge

Why we chose this

As we know there is a considerable evidence base for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, both in terms of safety, experience and the needs for the patients when they are finally discharged as patients can significantly decondition during long stays in hospital. Safe and timely discharge planning for all patients is an essential part of their overall plan of care and treatment and should always start on admission.

Good patient flow and transfer of care across the health and social care system is now widely recognised as a key indicator of how the system is working in collaboration and the agenda for the system Transfer of Care Group and A&E Delivery Board has a clear focus on safer patient flow and discharge.

Improvement work

SAFER Patient Flow Programme

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

- **Introduction of Criteria led Discharge**
  This work is being led by the clinical teams and focuses on specific clinical pathways to ensure a consistent approach.

- **Trusted Assessor- reablement pathway**
  The Discharge coordinators are now assessing and referring into the reablement service with a quality control process built into the process. This has reduced delays and improved social care capacity to focus on patients who need a social care assessment.

- **Trusted Assessor- Nursing & Residential homes**
  We have introduced a Senior Nurse into the discharge team who has developed a strong relationship with local nursing home managers who now trust her to assess patients on their behalf. This has reduced the delay often experienced waiting for nursing home managers to attend the hospital to assess patients.

- **Home First Team**
  This team of senior nurses and therapist have been brought together to support ward staff, educate, track and challenge treatment plans to ensure that every day in hospital adds value for the patient, staff focus on trying to get the patient home as soon as possible and ensuring that we are providing patients with a good quality, safe and timely discharge plan.

- **Standardised MDT**
  The lead therapist for the SAFER Programme is working closely with the elderly care team to develop a standardised approach to MDTs.

- **Choice and Recovery Beds**
  We have a shared vision with colleagues from partner organisations for patients who are medically fit and require high nursing needs within a 24 hour facility on discharge are transferred to have their assessments and choose their preferred nursing home from a community facility rather than the hospital. This reduces risks of hospital acquired infections/falls, promotes opportunities for independence for patients and reduced deconditioning.

- **Enhanced Reablement**
  This is a community development to provide an enhanced rehabilitation and support service for patients who would have historically had the therapy whilst in hospital.

- **Introduction of a twice weekly Multidisciplinary Accelerated Discharge Event (MADE) Room** (meeting with partner organisations – further details below).

How are we doing?

		Current Week - 01/10/2018	Current Week - 24/09/2018	Current Week - 17/09/2018	Current Week - 10/09/2018	Current Week - 03/09/2018	Current Week - 27/08/2018
Stranded Patients length of stay of seven or more days		292	283	321	319	302	312
Calderdale Royal		99	92	118	117	104	105
Huddersfield Royal		193	191	203	202	198	207
Patients length of stay of 21 or more days		107	119	116	119	104	107
Calderdale Royal		38	48	41	46	45	37
Huddersfield Royal		69	71	75	73	59	70
Patients>50 Days Trust		23	22	24	26	25	26
Calderdale Royal		13	12	10	8	7	8
Huddersfield Royal		10	10	14	18	18	18
Patients>100 Days Trust		0	1	0	3	2	2
Calderdale Royal		0	0	0	0	0	1
Huddersfield Royal		0	1	0	3	2	1

- Overall we seen a reduction in the medically stable patients within the hospital as patients are being discharged safely sooner and this is evidenced through no increase in readmissions. With the focus of 'home first' we have also seen a reduction in patients being discharged into nursing homes for 24 hour care.

MADE Room

The MADE Room was developed following learning from the MADE event which was held on 12 April 2018 in CHFT with partners.

Twice weekly colleagues from partner organisations meet with the aim of reducing any delays in the discharge pathway, expediting discharge and supporting the ward teams with any particular challenges they faced with and reducing the number of patients stranded (in hospital 7 days and

over) and those with the longest length of stay (21 days and over) Attendees are senior decision makers with an escalation to Directors if required. NHS England has now set each organisation a target to reduce their long stay patients by 25% in quarter 4 with the aim to create capacity during the winter months.

THIS has developed a data source and view through Knowledge Portal to support teams to understand the detail and specialities where the improvement work needs to be focused.

As of October 2018 there has been a gradual improvement.

CHFT Target & Actual

Division		19 Aug 18	26 Aug 18	02 Sept 18	09 Sept 18	16 Sept 18	24 Sept 18	01 Oct 2018
Surgical	Last 91 days	24	23	23	23	26	26	24
	Target	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Medical	Last 91 days	96	92	92	87	84	85	84
	Target	**79**	**79**	**79**	**79**	**79**	**79**	**79**
FSS	Last 91 days	0	0	0	0	1	0	0
	Target	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total	Last 91 days	120	116	115	110	110	111	108
	Target	**104**	**104**	**104**	**104**	**104**	**104**	**104**

2.3. End of Life

Why we chose this

Improving end of life care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die, when their death is expected, it is vital that they receive appropriate end of life care.

The Trust is looking to sensitively establish that during these times a patients relatives felt that the needs of their loved one were meet in a compassionate and appropriate way.

Improvement work - Bereavement Survey
The bereavement survey is part of the Trust Learning from Deaths (LfD) programme. This programme supports a quality improvement plan relating to death and dying primarily for improved patient and family/carer experience and patient outcomes.

Each year, CHFT currently takes part in an annual bereavement survey, whereby Next of Kin (NOK) for deaths occurring in the month of May are sent a survey to comment on their experiences. Of the 90 surveys sent, the trust has a 30% response rate –i.e 27 forms being returned which is a small number when you considering that the Trust has 1500+ deaths a year.

In order to gather more meaningful feedback to both highlight the areas of excellent care and some areas that we can improve on, a 6 month pilot audit is being undertaken on our four stroke wards at CRH. The NOK of patients who have died from January to June 2018 will receive a bereavement survey 3 months after death. They will also receive a bereavement card a couple of weeks after the death of their loved one, which has been designed to offer support and inform them of the upcoming survey.

Below is what is written in the card:

On behalf of Ward XXX at CHFT we would like to offer our sincere condolences to you and your

family following the recent death of your loved one.

In a few weeks' time we will send you a bereavement questionnaire. We would truly appreciate your feedback as this will help us in the future.

If you would prefer not to receive this questionnaire please send the enclosed form in the prepaid envelope. Our thoughts are with you at this difficult time.

As of June 18 there has been 25 surveys sent out with 9 returned (36%). On the bereavement survey there is a sentence at the bottom to encourage relatives to add their name and number if they would like us to contact them about the care their loved one received – we have had 5 out of the 9 that have responded. It has been a positive experience being able to talk with bereaved relatives to find out what we do well and areas to improve. The feedback on the whole so far has been positive with some areas we could improve in a quick timeframe, such as more chairs.

The last feedback forms will be sent out at the end of September with the hope of collating the data by the end of 2018.

The role of the trial is to ascertain whether it would be possible to send out bereavement cards and surveys for all deaths within the Trust to ensure we are truly gaining a representative sample of experiences within our Trust. We would also like to be able to add a number on the bereavement card for relatives to ring to offer support which is something we are currently working through.

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

3. Quarter 2 2018/19 Quality presentation
The attached presentation provides key points relating to quality indicators during quarter 2, 2018/19.

FINANCIAL IMPLICATIONS OF THIS REPORT:
None

RECOMMENDATION
The Quality Committee is asked to note the quality reporting for quarter 2, 2018/19 as at 22 October 2018 and the update on the three quality account priorities and that this report will be presented to the Board at its meeting on 1 November 2018.

APPENDIX ATTACHED
Yes – Appendix - Quarter 2 2018/19 quarterly quality presentation

9. Board Assurance Framework

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday 1 November 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: Board Assurance Framework - The Board Assurance Framework has been updated and is attached for review.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Audit & Risk Committee	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The Board Assurance Framework is presented for review and approval by the Board.

Main Body

Purpose:

The Board Assurance Framework has been updated and is attached for review and approval by the Board.

Background/Overview:

-

The Issue:

Following feedback from Non-Executives, some initial work by Internal Audit, feedback from Audit and Risk Committee there has also been some work on the board assurance process. This has resulted in the development of a standard operating procedure, which was reviewed by the Audit and Risk Committee and is attached here for information. The process set out in the procedure will be built in to the work plans for each committee and the Board.

Next Steps:

Over the next two months further work will be undertaken on the BAF including:
- Work to re-structure the BAF so that it is clearer in relation to the sources and strength of assurances; monitoring of the risk ratings; clarity on progress and effectiveness of actions.
- Further review of the High Level Risk Register and the BAF to see how they can be more closely aligned.
- Inclusion of the Risk Appetite following the approval by the Board at this meeting.
- Work to review the overall governance structure to be clear on lines of assurance and accountability – particularly in relation to Quality Governance. This work is due to complete in November and will be shared with the Audit and Risk Committee and Quality Committee in January.

In addition, a report is awaited from Internal Audit on the comparison of BAFs across over 20 organisations and some recommendations on the future structure of Board Assurance. Any learning from this report will be built into the BAF.

A workshop is planned for the new year to look at risks and risk management and it is proposed that we use the questions within the BAF standard operating procedure to inform this discussion.

Recommendations:

The Board is asked to approve the Board Assurance Framework.

Appendix

Attachment:

BAF Process and Standard Operating Procedure V1.2.pdf

Calderdale and Huddersfield NHS Foundation Trust

Board Assurance Framework Process

and

Standard Operating Procedure

Version: 1.2

Summary:	This document describes the integrated governance and internal controls processes within CHFT and the Board Assurance Framework processes by which the Board and the management of the Trust receives its assurance they are operating effectively. It takes account of Department of Health and other best practice guidance which are listed at the end of this document.	
Keywords	Board assurance framework, governance, system of internal control, risk management	
Target Audience:	All Staff employed by Calderdale and Huddersfield NHS Foundation Trust	
Next Review Date:		
Approved and ratified by:	Audit and Risk Committee	Date: 17 October 2018
Date issued:		
Author:	Victoria Pickles, Company Secretary	

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
10.10.18	Victoria Pickles	1.1		Original
23.10.18	Victoria Pickles	1.2		Amends following Audit and Risk Committee: - Make reference to the Risk Strategy - Reference to the Board

Reviewers/contributors

Name	Position	Version Reviewed & Date
Victoria Pickles	Company Secretary	

Contents

Board Assurance Framework Process and Standing Operating Procedure

1. Introduction

1.1 Calderdale and Huddersfield NHS Foundation Trust (CHFT) Board must be able to assure itself that the organisation is operating effectively and meeting its strategic objectives. CHFT does this through its governance structures and internal management controls and by providing assurance which demonstrates these controls are operating as they should and objectives are being met.

1.2 As a Foundation Trust it is a requirement for all NHS Chief Executives to sign an Annual Governance Statement as part of the statutory accounts and annual report which provides public assurances about the effectiveness of the organisation's system of internal control.

1.3 Internal Audit will also assess the effectiveness of controls in place and provide an annual opinion to support the Annual Governance Statement. This will entail reviewing the way in which the Board has identified its objectives, risks, controls and sources of assurance and assessed the value of assurance obtained.

1.4 It is ultimately the Board who requires assurance that the organisation is operating effectively. However, assurance must be provided at all levels, within both corporate and clinical services, of effective integrated governance and the effectiveness internal controls so that onward assurance can be provided to the Trust Board.

2. Purpose

2.1 This document describes the integrated governance and internal control processes within CHFT and the way the Board and the management of the Trust receives its assurance they are operating effectively. It takes account of Department of Health and other best practice guidance which are listed at the end of this document and sits alongside the Trust's Risk Management Strategy and Policy.

2.2 Board Assurance Framework is used by the Trust as:

- A strategic but comprehensive method for the effective and focused management of the principal risks to meeting an organisation's objectives as well as providing evidence to support the Annual Governance Statement
- A document to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.

3. Definitions

Definitions of the terms used throughout this document:

3.1 *Governance* - the management systems, processes and behaviours by which the Trust leads, directs and controls its functions to achieve its organisational objectives, safety and quality and the way in which it relates to patients and carers, the wider community and partner organisations.

3.2 *Integrated Governance* - the streamlined pulling together of intelligence of the competing pressures on the Trust and its staff, advisors, systems, and processes which enables the Trust to avoid the handling of issues in management silos.

3.3 *Board Assurance Framework (BAF)* - enables the Board to: identify and understand the principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are needed, action plans are in place and are being delivered, and; provide an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place (Risk Rating)

3.4 *High Level Risk Register* - enables the Board to: identify and understand the risks (internal and external) that are critical to the success and continuation of the organisation; agree acceptable levels of strategic risk and approve the actions required to mitigate risks to this level; monitor assurance mitigating actions are being taken and risks are being appropriately managed.

3.5 *Risk Appetite* - The levels and types of risk the organisation is prepared to accept in pursuance of its objectives. This informs all planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks.

3.6 *Internal Controls* - The policies, procedures, practices and organisational structures put in place by the Trust to mitigate risks relating to the achievement of objectives. Gaps in the control framework should be identified and listed with actions to close.

3.7 *Assurance Measures* – Methods of measuring the effectiveness of controls in place, for example; monitoring incidents related to the risk, peer reviews or Monitor compliance, internal and external audits, regulator reviews, etc.

3.8 *Gaps in Assurance Measures* - Where there are inadequate assurance measures or assurance measures are limited and cannot provide full assurance that controls are effectively mitigating the risk. Gaps should be identified and listed with actions to close.

3.9 *Risk Scoring /rating* - A process by which risks are graded/ scored based on the impact of their occurrence and the likelihood of their occurrence

The table below is used by CHFT for the purposes of determining scores for a risk's impact and likelihood. This table is further augmented by the Trust's Risk Matrix, which provides more specific interpretation of impact scoring. This can be found in the Trust Risk Management Strategy and Policy, and in the Board Risk Appetite Statement. To derive the risk's rating, the two scores are multiplied together.

Risk Scoring				
Impact			**Likelihood**	
5	**Catastrophic**	An effect upon the objective that renders it unachievable.	**5**	Almost certain (> 80%)
4	**Major**	Significant effect upon the objective, thus making it extremely difficult/costly to achieve.	**4**	Likely (60%-80%)
3	**Moderate**	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	**3**	Possible (40%-60%)
2	**Minor**	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/cost.	**2**	Unlikely (20%-40%)
1	**Negligible**	Insignificant effect upon achievement of the objective	**1**	Rare (< 20%)

4. The role of the Board Assurance Framework

4.1 The role of the BAF is to provide evidence and structure to support effective management of risk within the organisation. The BAF provides evidence to support the Annual Governance Statement.

4.2 The BAF identifies which of the Trust's strategic objectives are at risk of not being delivered. At the same time, it provides positive assurance where risks are being managed effectively and objectives are being delivered. This allows the Board to determine where to make most efficient use of their resources and address the issues identified in order to deliver the Trust's strategic objectives.

4.3 The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviewers; these are supplemented by internal sources such as clinical audit, internal management representations, performance management and self-assessment reports.

4.4 The BAF template will be continuously adapted in line with Trust risk maturity development and risk system development improvements.

The Board Assurance Framework achieves the following:

- Draws together reporting on strategic risks identified in the Plan on a Page, key Board level assurances and controls, gaps in assurances and controls, key performance
  targets and corporate enabling projects
- Provides high level reporting to the Board to indicate where there are gaps in controls and assurances and how these impact on the risk to achieving that objective

5. Regulatory and good practice requirements for Trust Board Assurance

5.1 The Trust Board will use the BAF as a dynamic tool to drive the board agenda through the following activities:-

- At least three times a year scrutiny via Audit and Risk Committee.
- The Board will review the full Board Assurance Framework at least three times a year.
- The format may vary but the framework must include:
  - Trust objectives
  - Strategic risks
  - Key controls
  - Sources of assurance
  - Gaps in control/ assurance, and action plans for addressing gaps
  - A full review of strategic objectives annually

6. Trust Risk Appetite Statement

6.1 The Trust recognises it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the trust realise its aims. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed acceptable from time to time by the Board and, by extension, external inspectors/regulators and relevant legislation.

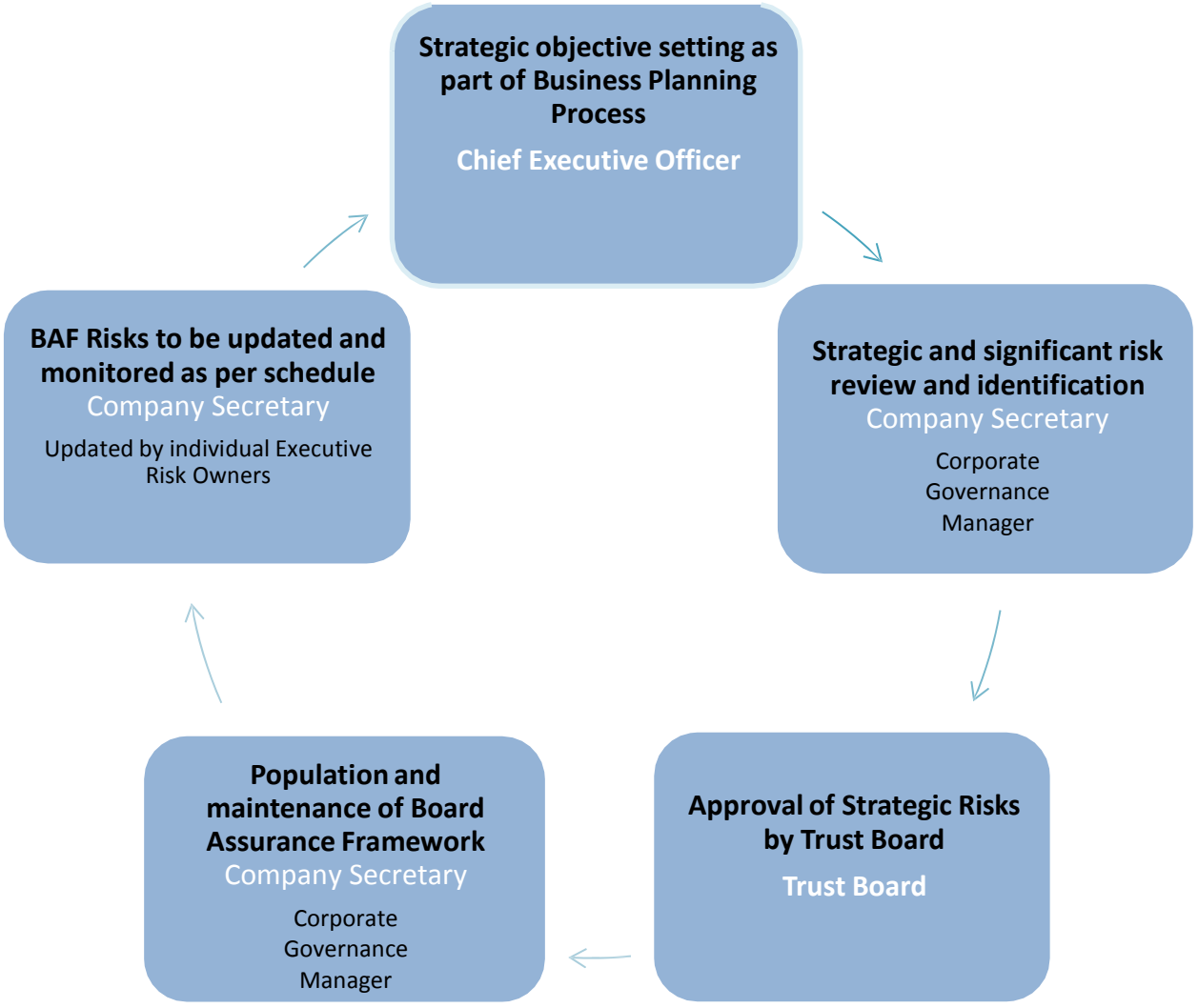
6.2 Methods of controlling risks must be balanced in order to support innovation and the imaginative use of resources when it is to achieve substantial benefit. In addition, the trust may accept some high risks because of the cost of controlling them. As a general principle the Trust has a low tolerance for, and will therefore seek to control, all risks which have the potential to:

- Cause harm to patients, staff, visitors, contractors and other stakeholders;
- Endanger the reputation of the trust;
- Have severe financial consequences which could jeopardise the trust's viability;
- Jeopardise the trust's ability to carry out its normal operational activities;
- Threaten the trust's compliance with law and regulation.

Further information can be found within the Trust's Board Risk Appetite Statement, separate to this document.

7. Trust Assurance Process and Infrastructure

The annual cycle of the Board Assurance process is shown below.



7.1 The key components of the assurance process are as follows and are shown diagrammatically below:

7.2 **Step 1 – Strategic Objectives:**

The first step in designing the assurance process is for the Board to identify its strategic objectives, e.g. clinical, financial, workforce, commercial and other objectives, focusing on those which are crucial to the achievement of its aims and values. Objective setting and review in Calderdale and Huddersfield is aligned to the annual business planning cycle and takes place in Quarters 3 and 4 (October to March) each year.

7.3 **Step 2 – Strategic Risks:**

These are risks which threaten the achievement of the Trust's objectives. Strategic risks should be identified through Board workshops and seminars where the strategic objectives that these risks relate to are identified and debated.

As part of the identification of strategic risks the level and type of risk the Trust is prepared to accept, or its appetite, should also be reviewed.

7.4 **Step 3 – Key Controls:**

These are the management systems and processes the Trust has place to manage its strategic risks. Controls will be scrutinised internally and externally e.g. by independent reviewers, which includes internal auditors, CQC and external audit in conjunction with clinicians and other specialists where necessary.

Key controls will also be mapped to the strategic risks. When assessments are made about controls, consideration will be given not only to the design but also their effectiveness in light of the governance and risk management framework within which they will operate. Guidance on testing controls can be found as **Appendix 1**

Examples of controls in place at Calderdale and Huddersfield include:

- Staff Training Programmes
- IT systems and management information (e.g. EPR; ESR etc.)
- Policy and procedure guidance
- Board, Sub Committee and Management Committee structure (**Appendix 3**)
- Leadership infrastructure
- Trust-wide and Operational Risk Registers
- Strategies, for example; Risk Management, Workforce, etc.
- Incident reporting and management arrangements

7.5 **Step 4 – Assurance on Controls:**

The Board must then gain assurance about the effectiveness of the controls in place to manage the principal risks. They not only need to ensure that controls are in place and effective, but to make use of the work of external reviewers and ensure that the control framework is proportionate to the associated risk. A system that provides good coordination and evaluation of the work of the auditors, inspectors and reviewers will bring increased benefits to both the Trust and the review bodies. It will help minimise the burden on the Trust by reducing overlap and allow potential gaps in assurance to be identified and addressed.

Examples of sources assurances in Calderdale and Huddersfield include:

- Reports e.g. Board, management, incident
- Up to date policy documentation, approved by relevant committees
- Clinical audit programmes, internal and external audit.
- External assessment e.g. CQC, HSE, NHSI inspection
- Regulator and commissioner compliance reviews
- Patient and staff feedback
- Comparative data, statistics, benchmarking

A gap in assurance is deemed to exist where there is failure to gain evidence that controls are effective. Any gaps in either controls or assurance will be identified in the BAF, along with actions, action owners and timescales for implementation.

Scrutiny of assurance

During the course of its business members of the Board should continually ask questions to assess the strength of the internal controls and assurances being presented. Guidance on robust scrutiny on controls assurance, assurance data and triangulation detailing assurance questions for the board to ask can be found within **Appendix 1.**

7.6 **Step 5 Board Report & Actions:**

The BAF provides a framework for identifying which of the Trust's objectives is at risk because of inadequacies in controls or where the Trust has insufficient assurance about those controls. At the same time it provides structured assurances about risks which are being managed effectively and objectives that are on track to be delivered.

This allows the Board to determine where to make best use of its resources and address the issues identified in the delivery of strategic objectives.

8. Assurance Roles and Responsibilities

8.1 **Trust Board**

- Ensuring the Trust has sound and comprehensive governance and assurance arrangements in place that guarantee the resources vested in the Trust are appropriately managed and deployed, key risks identified and managed and the Trust fulfils its accountability requirements and delivers its strategic objectives
- Ensuring the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe care taking account of patient, user and carer experience
- Using the Board Assurance Framework to drive the board agenda
- Assuring itself that an efficient risk management approach is in operation within the organisation

- Effective use of external and internal audit to provide assurance in internal controls (including clinical audit)
- Scrutinising the Annual Governance Statement and the Statement on Internal Control contained within it to ensure that the assertions within it are supported by a substantial body of compelling evidence
- Ensuring that controls and processes are reviewed and tested to ensure that they continue to be effective in dealing with risks as they change and evolve.

8.3 **Audit and Risk Committee**

- Responsible for scrutinising Trust systems for internal control and risk management:
  - ensures the provision and maintenance of an effective system of risk identification and associated controls, reporting and governance
  - maintains an oversight of the Trusts general risk management structures, processes and responsibilities, including the production and issues of any financial risk and control-related disclosure statements or reports (e.g. Annual Accounts, Annual Governance Statement)
  - reviews the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effective management of principal risks

This will lead to improvements in key controls to manage its risks and gain assurances where required. It will also provide opportunities to improve the effectiveness of management and will provide evidence to support the annual Governance Statement.

8.4 **Risk and Compliance Group**

- Responsible for reviewing the content of the Board Assurance Framework and high level risk register prior to reporting to the Trust Board and subcommittees
- Review the current gaps in controls, gaps in assurances, and associated actions to ensure actions are implemented fully and within the stated timescales.

8.5 **Board Committees**

- An overview of the Trust Board Committee and Management Forum structures are provided as **Appendix 3.**
- Principle scrutiny and assurance responsibilities are provided as **Appendix 4.**

8.6 **Chief Executive**

- Ensuring the organisation has a sound framework of controls and systems of risk management and governance in place to enable the organisation to deliver its strategic objectives
- Ensuring the Executive Team provides reports to the board in relation to delivery of the strategic objectives and operates within the management controls/ risk management systems

8.7 **All Executive Directors**

- Ensuring they and their directorates operate within the organisational management controls and risk management systems, policies and procedures of the Trust
- Presenting to the Board accurate, clear and timely information regarding the delivery of the Trusts strategic objectives and portfolio areas

8.8 **Non-Executive Directors**

- Satisfy themselves that management controls and systems of risk management and governance are sound and are used effectively

8.9 **Company Secretary**

- Overall responsibility and accountability for the Board Assurance Framework and associated processes, and ensuring these are fit for purpose.
- Proposing the organisational assurance process and infrastructure for Board approval and monitoring and reporting upon its effectiveness.

8.10 **Director of Nursing**

- Ensuring the Trust has a sound and effective clinical risk management process in place and that it is being operated effectively.
- Ensuring the provision and maintenance of an effective system of quality and clinical risk identification and associated controls, reporting and governance.
- To maintain an oversight of the Trusts clinical and quality risk management structures, processes and responsibilities, including the production and issues of any clinical risk and control-related disclosure statements or reports (e.g. Annual Quality Report and Quality Account).

8.10 **Corporate Governance Manager**

- Coordinates the Executive review / population and update of BAF risks
- Document preparation for Committee and Board presentation and scrutiny

9 Monitoring and review of the Board Assurance Framework

9.1 The Board, through the Audit and Risk Committee, must evaluate the quality and robustness of the Board Assurance Framework Process and Board Assurance Framework on a regular basis and to ensure arrangements are in place to keep it updated in the light of evidence from Board Reports, internal and external reviews and organisational achievements.

Calderdale and Huddersfield will achieve this through:

- Annual review of the Board Assurance Framework and supporting Process documentation by Internal Audit as part of the Internal Audit Programme.
- Annual review of the Strategic Risks identified within the Board Assurance Framework, and associated supporting controls and assurance sources following agreement or review of the strategic objectives.
- Reviewing the assurance process and BAF if new best governance/assurance guidance is issued or annually otherwise.
- Annual review of the Risk Management Strategy and processes supporting the Board Assurance Framework to ensure it continues to be fit for purpose and that effective scrutiny and challenge continues to occur.

10. Annual Board Assurance Schedule

10.1 The Trusts annual board assurance schedule will be as follows:

Action	Executive Lead	Management Lead	Date
Strategic objective setting to be undertaken as part of the annual business planning cycle	Trust Chief Executive Officer	Chief Operating Officer	Quarters 3 and 4 (October to March each year)
Strategic and significant risk review and identification to be undertaken as part of business planning process	Trust Chief Executive Officer	Company Secretary	Quarter 4 (March each year)
Approval of Strategic Risks	Trust Chief Executive Officer	N/A	End April each year
Population of Board Assurance Framework	Company Secretary	Corporate Governance Manager with relevant risk owners	Quarter 1 April and May each year
BAF Risks to be updated in line with the Trust Risk Management Policy	Company Secretary	Corporate Governance Manager with relevant risk owners	Monthly / as required
Sections of the Board Assurance Framework to be monitored by relevant Board committees and Executive Board to ensure risk management of the delivery of the strategic objectives	Board Committee Chairs	Presented by Lead Executive and or nominated Senior Manager Timetable scheduled by Company Secretary and Lead Executives	Prior to scheduled Audit, Assurance and Risk Committee
Risk and Compliance Group to review full Board Assurance Framework a minimum of three times a year prior to presentation to Audit and Risk Committee	Company Secretary	Corporate Governance Manager with relevant risk owners	
Presentation to Audit and Risk Committee	Company Secretary	Presented by Lead Executive and or nominated Senior Manager	
Presentation to Trust Board a minimum of three times a year	Company Secretary	Timetable scheduled annually by Company Secretary and Lead Executives Corporate Governance Manager	Following Audit and Risk Committee. To include presentation at year end; March.

11. References:

- The ICSA Health Service Governance Handbook (2016)
- Integrated Governance Handbook (Department of Health, 2006)
- Audit Committee Handbook (HM Treasury, March 2007)
- The Intelligent Board (Dr Foster Intelligence, February 2009)
- Taking it on Trust: A review of how boards of NHS trusts and foundation trusts get their assurance (Audit Commission, April 2009)
- A simple Rules Guide for the NHA Board Assurance Frameworks (Good Governance Institute March 2009)
- Code of Governance for NHS Foundation Trusts (Monitor, March 2010)
- The Healthy NHS Board: Principals for Good Governance (2010)
- The Foundations of Good Governance: A compendium of best practice (Foundation Trust Network & Beachcrofts, October 2011)

Appendix 1*:* Guidance on testing controls, Assurance Sources, Scrutiny and Questions to Ask

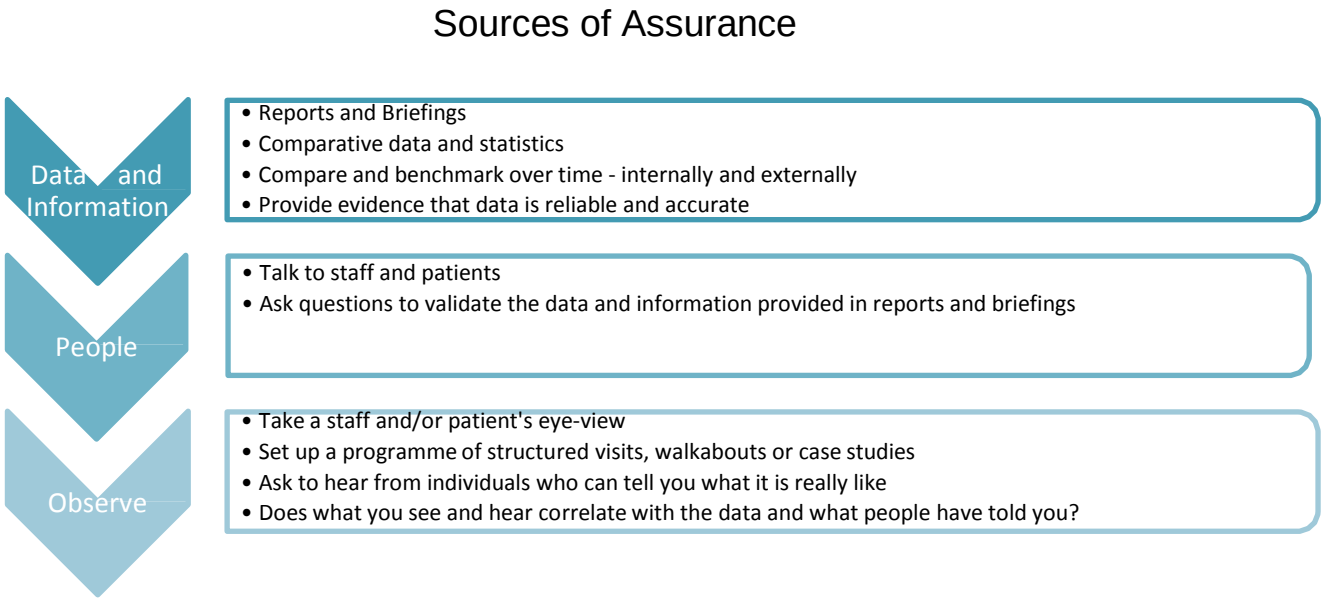
1. Testing the Controls

- Prior to presenting reports and information about key controls to the Board, Executive Directors and senior managers of the Trust must satisfy themselves the arrangements in place are robust and will enable reasonable assurance to be provided.

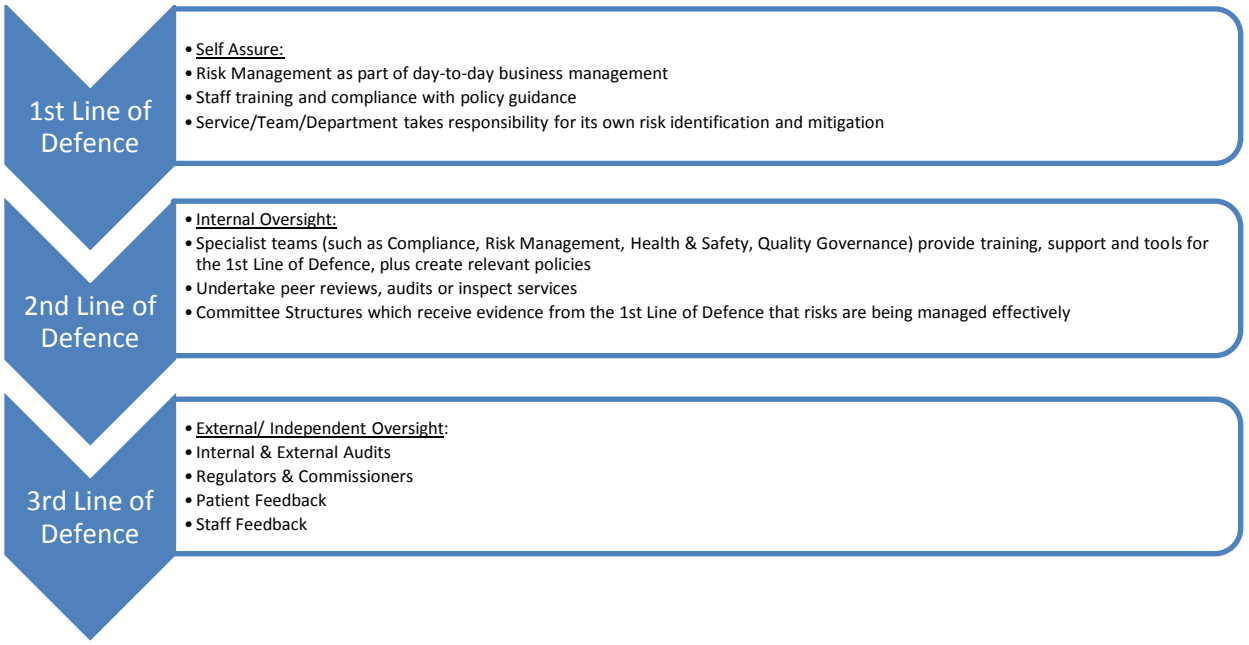
- **Appendix 2** provides an overview of the Trusts model to support the corporate and clinical governance processes and infrastructures, performance and delivery, and risk management arrangements. It also provides a series of assurance- tests in the form of questions managers must be able to answer in their reports.

- The Trust Divisional performance reports each month will provide an indication of the level of risk within each Service in relation to quality and safety issues such as medication, infection control, CQC registration, etc.

  Example Sources and levels of Assurance:



Strength of assurance: "Three Lines of Defence"



2. Assurance Triangulation

- It is considered best practice (The foundations of good governance: a compendium of good practice (FTN/ Beachcrofts, 2011)) for organisations to adopt a triangulation approach to gain their assurance; this consists of looking for three distinct sources of information and comparing them. If those three sources coincide then reasonable assurance can be taken.

  – *Data & Information* – formal board and sub-committee reports and briefings. These will provide comparative information to show performance against other similar organisations and within the Trust over time. Dashboards / traffic light / heat map and other representations may be used. Performance which falls outside acceptable (and Board defined) parameters will be accompanied by an exception report and actions tracked and reported to the Board. The Board should seek evidence of the quality and reliability of data presented in reports e.g. that it is accurate.

  – *People* – the Board should talk to relevant managers and frontline staff who can add insight into data and information presented.

  – *Observation* – taking a patients-eye view such as a Board programme of site and service visits, participation in internal inspections, structured walkabout programs and requesting reports include patient case studies or request to hear from individual patients at Board meetings.

- The BAF requires the Trust to consider the effectiveness of each control during the process of gaining assurance. The Board will take all reasonable steps to ensure it looks at the right data, and verifies the data by talking to the right staff and verifies both through direct observations of patient care and treatment. Through this process the Board will ensure it gains all of the three key assurance levels of self-assurance, internal oversight, and external / independent assurance.

3. Questions for the Board to ask to assess the effectiveness of the assurance process and infrastructure, key controls and assurances presented

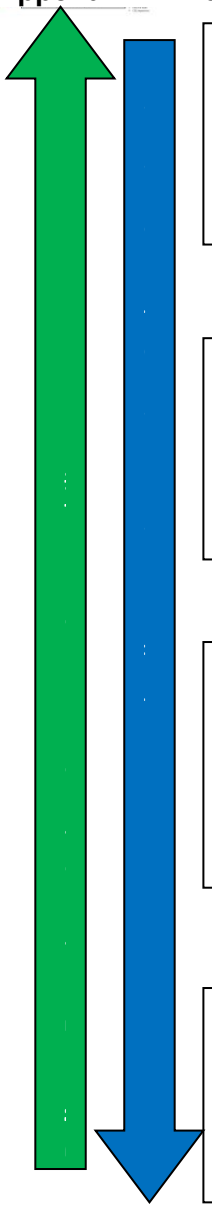
Based on: *Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance (Audit Commission, 2009)*

Strategic Aims and Objectives
1. How clear are we about what the trust is trying to achieve?
2. What strategic aims and objectives have we set out for the trust?
3. Are strategic aims and objectives clearly defined?
4. How do we provide leadership to the staff delivering the objectives that we have set?
5. What process do we have in place for translating the objectives into the contribution expected from divisions, care groups and frontline staff and how will their performance will be monitored?
Governance Structures
6. Are the governance structures clear and straightforward with minimal overlap?
7. How well do we understand our governance structures and how do we think current governance arrangements could be improved?
Board Meetings
10. Is our board agenda dynamic and focused on the right things: the strategy and its implementation?
11. How much time do we spend on strategic issues at board meetings?
12. To what extent do we have the right information prepared for board meetings to allow us to monitor this?
13. Have we considered and acted on the Trust's Insight Report?
14. Are board meetings managed effectively?
15. What improvements could be made to ensure that we operate as a team?
16. Do we have trust and respect between executive and non-executive directors?
Board Operation and Skills
17. What skills do we need as a board?
18. To what extent do we have the right skills as a board?
19. How clear are we about what the role of the chair and non-executive directors should be?
20. Do we delegate responsibilities effectively and appropriately?
Strategic Risks
21. How can we be sure that we have identified all of our strategic risks?
22. Are we monitoring strategic risks properly and what level of independent scrutiny or constructive challenge from within the organisation is there?
23. How timely and relevant is the performance information that we use to monitor risks?
24. What reports do we receive that provides evidence of the effectiveness of risk management and progress in achieving strategic objectives?
Management and Monitoring of Risk
25. How do we provide leadership on risk management?
26. Do we monitor the trust's main operational risks?
27. How can we be sure that the risk management processes in place will avoid operational risks becoming strategic risks?
Risk Measurement
28. How clear are we about our risk appetite?
29. Do we quantify risk appropriately?
30. Do we have an accountability framework for the trust that sets out the level of risk that is

expected to be managed at each level of the trust?
31. Have we devolved risk management sufficiently and how can we be sure that it is embedded within operational processes and that there is ownership of risk?
Risk Culture
32. Do we understand what risk culture we are trying to embed?
33. Do we know what a good risk culture looks and feels like?
34. How and when do we communicate our risk culture?
Use of Internal Audit
35. How are we using the internal audit function to obtain assurance on internal controls?
36. Is the scope and level of investment in internal audit appropriate?
37. How are we maximising the assurances we can gain from internal audit and do internal audit staff have the right skills and experience?
38. Are we making best use of other independent sources of assurance?
Compliance
39. Do we need to establish or increase investment in a separate compliance function to ensure operations comply with laws, rules, regulatory requirements and our policies?
Use of Clinical Audit
40. Is the clinical audit function used appropriately? 41. Is the clinical audit function systematic and focused on our own risks as well as on nationally identified issues?
42. Are the results of clinical audit work regularly reported to the board through the assurance framework?
43. Does clinical audit give us a comprehensive view of the quality of clinical services across the trust's portfolio?
Sources of Assurance
44. What are our potential sources of assurance?
45. Do we use assurances appropriately, balancing them across the risk profile of the trust?
46. How have we satisfied ourselves that assurances are not skewed towards big and topical projects and that we keep our eye on the ball more widely?
47. How do we systematically test and evaluate the sources of assurance?
Board Sub-Committees
48. Where have we set out the roles and responsibilities of sub-committees to the board and do we receive full and appropriate reports from them?
49. Specifically, how will the audit committee programme enable it to meet the board's expectations?
50. Do all non-executive directors have the opportunity to communicate with those on the sub- committees?
Self-declarations
51. How do we ensure that the statement on internal control is robust and consistent with other declarations and self-certifications?
52. Would our self-declarations stand up to rigorous external scrutiny?
Data Quality – culture and responsibilities
53. Is there a corporate framework in place for the management and accountability of data quality?
54. Is there a commitment to secure a culture of data quality throughout the organisation?
55. How have we made clear the responsibility for data quality governance and accountability at all levels of the organisation?
56. Do our clinicians understand the purpose and use of the data collected?

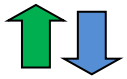
Data quality – policies and training
57. What policies or procedures are in place to secure the quality of the data used for reporting?
58. What policies and guidance on data quality do we have? Are they appropriate?
59. What policies or procedures are in place to secure the quality of the data used as part of the normal business activity of the organisation?
60. How has the trust ensured that staff have the knowledge, competencies and capacity in relation to data quality?
61. What kind of training is made available on data quality issues?
Use of data
62. What arrangements are there to ensure that data supporting reported information are actively used in the decision-making process?
63. Are data subject to a system of internal control and validation?
Data quality assurance
64. What arrangements are there to ensure that data supporting reported information are actively used in the decision-making process?
65. Are data subject to a system of internal control and validation?
66. What controls do we have to ensure that the quality of data used for decision making is good enough?
67. Is the quantity and timeliness of information we receive for board meetings adequate?
68. How do our board reports explain the assurance process for the data contained in them?
69. Do our board reports clearly highlight any issues with data quality?

Appendix 2 - Trust Assurance Process & Infrastructure



Board

- Agrees organizational strategic objectives
- Reviews and monitors performance and delivery of objectives
- Identifies and receives **assurance** that strategic risks are being managed via the **Board Assurance Framework (BAF)** and **High Level Risk Register**
- Receives ongoing **assurance** that controls are in place, comprehensive and effective reported through the **Board Assurance Framework**

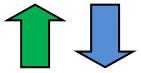


Risk and Compliance Group

- Establishes **internal controls** (structures and systems) to deliver strategic objectives
- Scrutinises strategic risks to delivery via the BAF and monitors performance
- Review of the Trust risk register and other escalated operational risk
- Receives **assurance** and provides **assurance** to the Board

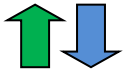
Board Sub-Committees

- Receives and scrutinizes **assurance** and provides onward **assurance** to Board
- Monitors risk management systems and processes to ensure working effectively



Clinical Divisions and Corporate Directorates

- Work within structures and systems designed to support delivery of objectives **(internal control)**
- Set local objectives (linked to strategic objectives)
- Managers and measures local performance and provides assurance of delivery
- Manages risks via the risk register



Clinical teams / frontline staff

- Work within structures and systems designed to support delivery of objectives **(internal control)**
- Provide assurance of delivery of objectives
- Identify and manage risks and escalate where appropriate

Examples of internal control

- IT systems, e.g. EPR, Athena, e-rostering
- Board and sub-committee structures
- Strategies e.g. risk strategy
- Business plans, delivery plans, action plans
- Incident management
- Policies and procedures
- Staff training programmes

Examples of Assurance

- Finance reports
- Staff surveys
- Patient feedback
- KPIs
- Quality, safety and risk reports
- Performance reports
- Internal and External Audit
- CQC and NHS I inspections / reviews

Appendix 3 – Board, Sub-Committee and Management Committee Structure

TO BE INSERTED

Appendix 4 - Action and Responsibility Guide

Role	Risk Owner/ Accountable Executive	Chair of Responsible Committees, Groups or Fora	Action Owner	Corporate Governance Manager
Responsibilities	1. Overall accountability for management and mitigation of Risk. 2. Reporting to Board on progress and changes to the BAF and offer expert corporate and clinical advice to Board. 3. Ensure that strategic and clinical risks are reported via appropriate routes and gaps in assurance highlighted.	1. Scrutiny and assurance of: • Controls in place • Assurances in place and whether they give positive or negative assurance • Gaps in controls or assurance • Actions to close gaps and mitigate risk 2. Ensuring effective systems are in place to identify, monitor and mitigate risks. 3. Providing assurance to Board or Sub Board Committees (as per Trust Committee structure – Appendix 3)	1. Identification and regular update of: • Controls in place • Assurances in place and whether they give positive or negative assurance • Gaps in controls or assurance • Actions to close gaps and mitigate risk 2. Informing update of Risk Assessment 3. Reporting to relevant Committee, Group or Forum (as stated against each Risk)	1. Creation and maintenance of the BAF documentation. 2. Co-coordinating updates to the BAF and ensuring appropriate sign off process of updates. 3. Document preparation for Committee and Board presentation and scrutiny 4. Maintenance of Policies, Procedures and Statement of Purpose documents.
Regularity of Review	Bi-monthly review of BAF with Corporate Governance Manager Report to Board twice per year and year end.	As per meeting Cyclical Agenda	Bi-monthly update with Corporate Governance Manager	Bi-monthly review of BAF with Action owner/Risk Owner Report to Trust Executive Group, then Audit and Risk, Committee followed by Board for approval of BAF three times per year.

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2018

Contents:

compassionate care

BOARD RISK APPETITE STATEMENT - APPROVED OCTOBER 2016

Risk Category	This means	Risk Appetite level	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial / 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**
Commerical	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality innovation and improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**

REF	RISK DESCRIPTION	Current score	Lead	Link to RR	Risk Appetite
Transforming and improving patient care					
01/17	Risk that the Trust will not secure agreement to implement the proposals set out in the Full Business Case resulting in poor quality of care and impacting on workforce resilience.	**20 =**	AB		Seek / Significant
02/17	Risk of non-delivery of the WYAAT programme as part of the wider West Yorkshire STP due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'.	**12=**	OW		Seek / Significant
03/17	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	**8 ↓**	DB		Cautious / Moderate
04/17	Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions	**6 ↓**	JM		Cautious / Moderate
05/17	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.	**15 =**	MG		Seek / Significant
Keeping the base safe					
06/17	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	**15 =**	JM		Minimal / Low
07/17	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action	**15 =**	OW		Cautious / Moderate
08/17	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	**12 ↓**	HB		Cautious / Moderate
09/17	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.	**20 =**	GB		Minimal / Low
A workforce fit for the future					
10/17	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.	**20 =**	BB / DB		Minimal / Low
11/17	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	**12 =**	SD		Seek / Significant
12/17	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms	**12 =**	SD		Seek / Significant
Financial sustainability					
13/17	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	**25 =**	GB		Open / High
14/17	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	GB		Open / High

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)				9. Estate fit for purpose =	13. Financial delivery =
Likely (4)					1. Full Business Case = 10. Staffing levels =
Possible (3)		3. Seven day services	12. Staff engagement	8. National and local targets = 6. Compliance with quality standards 11. Clinical leadership =	5. EPR = 7. Compliance with NHS Improvement =
Unlikely (2)			4. Public involvement		2. WYAAT =
Rare (1)					

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
1.17	Board of Directors	Director of Transformation and Partnerships	**Risk** Risk that the Trust will not secure agreement to implement the proposals set out in the response to the Secretary of State resulting in poor quality of care and impacting on workforce resilience. **Impact** - Delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance; Compliance with Paediatric Standards; Compliance with Critical Care Standards; Speciality level review in Medicine - Unable to meeting 7 day standards - Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums) - Potential loss of service to other areas	• Participation in Hospital Services Board by key senior staff. 20/1/16 CCGs made the decision to commence public consultation on the future configuration of hospital services. • CCGs and NHS England representatives included in roundtable discussion with NHS I • There is an agreed consensus between the CCGs and the Trust on the preferred clinical model.This has been reviewed and endorsed by Yorkshire and Humber Clinical Senate. • NHS I support for development of Business Case and timetable for decision making received from NHS I / NHS E • ED business continuity plan developed • Additional consultant posts agreed for ED • Interim actions to mitigate known clinical risks • Nurse led service managing Paediatrics • Critical care still being managed on both sites • Frequent hospital to hospital transfers to ensure access to correct specialties	First line Vanguard work in Calderdale showing an impact Second line Board reviewed Third line Capital bid selected as highest priority by WY&H ICS QRM meeting with NHS I and roundtable meeting tracks progress Reconfiguration included within WYSTP	• Difficulty in recruiting Consultants, Middle Grade and longer term locums • Estate limitations inhibit the present way of working • Consultant rotas cannot always be filled to sustain services on both sites • High use of locums	• Awaiting decision on Capital by DH • Awaiting decision on whether JR will proceed. • Ongoing maintenance issues with HRI to clarified through Six Facet Survey due Q4.	**Initial** 5x5 = 25	**Current** 4x5 = 20	**Target** 3x5 = 15

Action	**Timescales**	**Lead**
Further work on financial case	October 2018	AB
Communications and engagement plan to be agreed across CHFT / CCGs / NHSE / NHS I	November 2018	VP

Links to risk register:
Risk 6131 - large scale service change

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** Initial	Current	Target
2.17	Board of Directors	Chief Executive	**Risk** Risk of non-delivery of the WYAAT programme as part of the wider West Yorkshire STP due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'. **Impact** - Reputational impact - Inability to realise benefits of partnership working - Regulatory impact related to single oversight framework requirements - Potential loss of services	• Full participation in WYAAT - Chair post currently held by CHFT • Key senior individuals engaged in programmes of work and leading on aspects of support work including governance and communications . • Joint EPR implementation with Bradford Teaching Hospitals Trust	First line WYAAT minutes and programmes of work reported to Board WYAAT Programme Director attendance at WEB • Programme Director's report to be developed and routinely received by Trust Board Second line Governance arrangements approved by the Board Third line Reconfiguration included within WYSTP	• Programme of work and reporting timescales still to be finalised • Vascular proposal still to be finalised	• Competing priorities within the Trust impacting on ability to fully engage.	2x5 = 10	2x5 = 10	1x5 = 5

Action	**Timescales**	**Lead**
Scan4Safety business case to come to the Board	December 2018	MG
Vascular business case to come to the Board	December 2018	AB

Links to risk register:
Risk 6131 - large scale service change

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE									
Ref & Date added	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
3.17	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Working group set up and workshop held with senior colleagues to develop plan • Perfect week learning shared • Governance systems and performance indicators in place • Part of the West Yorkshire early implementers	First line Improvement in performance against some key indicators including pre 12 o'clock discharge and reduction in outliers Second line Integrated Board report Benchmarked against four key Keogh standards - Benchmark well Paper received at WEB 18/10/18 Single Oversight Framework. metric measured against the three standards Third line Independent review of mortality cases by Professor Mohammed Visit from NHS Improvement Medical Director gave positive feedback		• Scope for futher implementation limited without service reconfiguration or additional investment	**Initial** 5x3 = 15	**Current** 3x2= 8	**Target** 2x2 = 4
Action					**Timescales**			**Lead**	

Links to risk register:
No corporate (>15) risks

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
4.17	Quality Committee	Executive Director of Nursing	**Risk** Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions **Impact** - Non delivery of improvements in services - Risk of legal challenge - Reputational impact	• Joint working with CCGs • Working with HealthWatch on key areas of interest / concern • Patient Experience Group in place • Engagement champions in place across the Trust • Engagement toolkit been developed	First line Public involvement and engagement included in Patient Experience Group Areas of good practice identified within the Trust Second line Governor included in Patient Experience Group Patient Experience Group reporting to Quality Committee Engagement work completed in relation to proposed Medical Service reconfiguration Third line Annual reporting to CCGs CQC rating of Good.			**3x4 = 12**	**2x3= 6**	**1x4 = 4**
Action								**Lead**		
Links to risk register: No risks on the risk register >15										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
5.17	Finance and Performance Committee	Managing Director of Digital Health	**Risk** 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. **Impact** - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• Modernisation Programme Management and Governance structure to manage the ongoing implementation EPR system within the Trust-wide IT Modernisation Programme. • Operational Delivery Board in place with cross divisional representation • Business as Usual structure in place • Transformation Board reporting • Operational Delivery Board in place with cross divisional representation	First line Operational Board reporting Digital open days held Digital Boards in place at divisional level Second line Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee Third line Improvement as part of QRM reporting arrangements	• Number of issues following implementation still to be addressed • Business as usual structure doesn't include development structure •Further work to be done on benefits realisation to ensure embedded across the Trust linked to wider work on benefits realisaton	• Lack of capital funding for developments	**3x5 = 15**	**3x5 = 15**	**2x5 = 5**

Action	**Timescales**	**Lead**
Work on benefts realisation being developed as part of annual planning arrangements	Mar-19	GB / MG

Links to risk register:
Risk 7049 - EPR Financial risk

TRUST GOAL: 2 KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
6.17	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale	• Quality governance arrangements revised and strengthened • Revised SI investigation and escalation process in place • Strengthened risk management arrangements • Risk and Compliance Group overseeing implementation of actions and preparation plans for well led inspection • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures and introduction of ward assurance tool. • Board to ward programme in place • Process in place for policy review and approval • New ward assurance tool being developed and rolled out.	<u>First line</u> Staffing levels reported to WEB Clinical audit plan reviewed Assessment of compliance with NICE guidance Improvement in HSMR & SHMI Vacancy and agency use reporting Improvement in staff sickness absence <u>Second line</u> Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee DIPC report to Board <u>Third line</u> CQC rating of Good Quality Account reviewed by External Auditors and stakeholder bodies Well Led Governance review Independent assurance on clinical audit strategy Ongoing relationship with arms length regulatory bodies Independent Service Reviews and accreditations	• Consistent mandatory and essential training compliance • Operational and financial priorities impacting on capacity and ability to maintain consistent quality of care - • Standard of serious incident investigations needs further improvement • Estate issues identified • Scale of change and pace impacting on staff morale and engagement	• CQC assessed the Trust as Good except for Safe domain which was rated as requires improvement • National Clinical Advisory Team recommendations not fully addressed • Staff FFT and staff survey (2017) responses show decline • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements	3x5 = 15	3x4= 12	2x5 = 10

Action	**Timescales**	**Lead**
Ward assurance tool to be finalised	December 2018	JM
Roll out of Allocate for Medical and Therapy staff	March 2019	CP
CQC action plan to be delivered	March 2019	JM

Links to risk register:
Risk 6345 - Staffing risk, nursing and medical
Risk 6658

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** Initial	Current	Target
7.17	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• QRM meeting with NHS I • Corporate compliance register in place • Review of monthly NHS I bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • 5 Year strategic plan completed and formally adopted by the CCGs as part of the pre-consultation business case • Well Led Governance review completed • Use of Resources inspection completed	First line Clear PMO reporting from Divisions Second line Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee Well Led Governance review report to Board Board approval of 5 Year Strategic Plan Third line Quarterly PRM with NHS Improvement Round table meetings being held with CCGs, NHS England and NHS Improvement CCG acceptance of 5 Year Strategic Plan	• Performance against STF standards • Challenging financial position	• Performance against key targets • Use of Resources rating of requires improvement	5x5 = 25	3x5 = 15	2x5 = 10
Action					**Timescales**			**Lead**		
UoR action plan to be implemented					Mar-19			AB / JM		
Links to risk register: Risk 4706 - Financial plans Risk 6693 - Agency cap										

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
8.17	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Impact** - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders - STF withheld and financial issues	• Strengthened performance monitoring and management arrangements • Bed modelling work and additional investment made in to bed capacity • New patient flow programme • CQUINS compliance monitored by Quality directorate • Bronze, silver and gold command arrangements and escalation process • System-wide gold commanders meeting in place • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Head of Performance in place • Assistant Director for SAFER appointed	First line Weekly performance review with divisions. Divisional board and PSQB reviews of performance with executive attendance Activity reporting discussed at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Second line Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff Third line Urgent Care and Planned Care Boards and System Resilience group	• System responsiveness • Pressures impacting on delivery of key targets • Achievement of 4 hour emergency care standard requires micro-management. • Inability to retain enough middle grades		Initial 4x4 = 16	Current 3x4 = 12	Target 2x5 = 10
Action					**Timescales**			**Lead**		
					Ongoing			HB		
Links to risk register: Risk 6658 - Patient flow										

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	Current	Target
9.17	Quality Committee	Executive Director of Finance	**Risk** Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care **Impact** - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• System for regular assessment of Divisional and Corporate compliance • Policies and procedures in place • Quality Governance assurance structure revised • Estates element included in development of 5 Year Strategic plan • Close management of service contracts to ensure planned maintenance activity has been performed • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Development of Planned Preventive Maintenance (PPM) Programme • Audit of medical devices by independent assessor to identify any further actions needed • Health Technical Memorandum (HTM) structure in place including external Authorsing Engineers (AE's) who independantly audit Estates against statutory guidance. • Authorising engineer for fire • Partnership agreement with fire authorities	First line CQC compliance reported in Quarterly Quality and Divisional Board reports Weekly strategic CQC meetings Second line Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices Monitor review of PFI arrangements Assurance provided by AE's following audits against Estates statutory requirements SLAs in place with CHS CHS governance in place Third line PLACE assessments CQC Compliance report Assurance received from Environment Agency regarding healthcare waste implementation plans Progress made on DoH Premises Assurance Model (PAMs) to illustrate to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe. HSE review of water management Assessment by local operational Fire and Rescue teams	• Capital funding significantly scaled back which has impacted on ability to deliver estates schemes • Ongoing issues around Medical Devices to be addresses	• Issues identified with estate requiring urgent work • New six facet survey currently being undertaken • Mandatory training figures remain below plan for health and safety	4x4 = 16	5x4= 20	2x4 = 8

Action	**Timescales**	**Lead**
Six facet survey to be completed and reported	Jan-19	CHS

Links to risk register:
Risk 6903 - Estates / ICU risk, HRI
Tisk 5806 - Urgent estate schemes not undertaken

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
10.17	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff	• Weekly nurse staffing escalation reports • Ongoing multifacted recruitment programme in place, including international recruitment; • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • ED business continuity plan in place; • Vacancy Control Panel in place; • E-roster system in place. •Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place. • Risk assessments in place • Nursing recruitment and retention strategy in place	First line Staffing levels, training and education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IBR shows slight decrease in sickness levels, and reduction in agency spend Bi-annual review of ward nursing levels Weekly meeting on agency spend Number of PA posts recruited to Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs embedded in Integrated Board Report. PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues	Current hotspots are: Emergency Care; Radiology; ; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; Recruitment and retention strategy for medical and therapy staffing required Continued spend onmedical locums and agency remains challenging. Multi-professional e-roster yet to be rolled out	• Need to embed workforce plan	4x4 = 16	4x5 = 20	3x3 = 9
Action					**Timescales**			**Lead**		
New allocate system to be fully implemented for medics and therapies					Jan-19			CP		
Links to risk register: Risk 6345 - overall staffing risk Risk 2827 - Over reliance on middle grade doctors in A&E										

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
11.17	Quality Committee	Executive Medical Director	**Risk** 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 **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Devolved clinical structure • Work together get results programme in place • Positive feedback from Junior doctors on medical training • Performance appraisal based around behaviours • Coaching circles process • All CIP schemes have clinical lead • Development of new roles across professional groups • Good revalidation compliance • Performance Management Framework agreed including job description for clinical leads. • Development of medical director's office • Development programme being rolled out - first cohorts completed	<u>First line</u> Established escalation framework to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead particpation in star chamber approach Job planning framework approved Recruitment to key roles across the Trust <u>Second line</u> Integrated Board Report Revalidation report to board <u>Third line</u> IIP Accreditation Feedback from Royal Colleges Junior doctor GMC questionnaire feedback	• OD Strategy to be developed	• Acquire independent assessment of clinical leadership arrangements	**4x4 = 16**	**3x4 =12**	**3x3 = 9**
Action					**Timescales**			**Lead**		
OD strategy to be developed					February 2019			SD		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
12.17	Well Led Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Leadership visibility increasing and impact of EPR work • Quarterly staff FFT in place • Work together get results programme in place • 'Ask Owen' being responded to • Good evidence of colleague engagement in OBC / FBC development • Celebrating success annual awards • Staff survey action plan • Health and wellbeing strategy • Implemented star award recognition scheme • Board to ward programme in place • LGBTQ network in place • BME network in place and well attended • Tea trolley rounds taking place across the TRust • Colleague engagement calendar in place	<u>First line</u> Divisional leadership approach CQC preparation for self assessment shows some areas reporting GOOD in well led domain Significant number of actions delivered against action plan Good involvement in Annual Planning Days Improving absence position Introdcued tea trolley rounds <u>Second line</u> Integrated Board report shows sickness absence slightly improved CQC Mock inspection feedback from focus groups <u>Third line</u> Staff FFT / staff survey provides some positive feedback IIP accrediation - Bronze award CQC rating of Good	• Further work required to develop engagement section of OD strategy	• Staff FFT response rate along with number of staff who would recommend the Trust as a place to work • Still a number of well led indicators on the IBR showing red • Awaiting feedback from IIP report	**3x4 = 12**	**3x3 = 9**	**1x4 = 4**
Action					**Timescales**			**Lead**		
Colleague engagement plan being rolled out.					Awaiting clarity on timescale			JE		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING
13.17	Finance and Performance Committee	Executive Director of Finance	**Risk** 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. **Impact** - financial sustainability - loss of STF - increased regultory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Financial recovery and cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process • Detailed income and activity contract monitoring • Bottom-up forecasting process • Star chamber process to support CIP schemes off track • Quality directorate overview of progress against delivery of CQUIN • Authorisation processes for agency spend • Standing Financial Instructions set authorisation limits • Detailed recovery plan in place including non-pay review, tightening of vacancy control panel process, controls around additional hours. • Clear communications plan around financial pressures	First line Divisional Board performance reports Achieving agency target Second line Turnaround Executive Reports NHS I scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting Third line Monthly return to NHS I QRM meeting with NHS I AIC in place NHS I review of CIP arrangements NHS I review of agency usage	• Temporary staffing remains a cost pressure • Remain gap between activity and plan • Additional cost pressures resulting from clinical waste position and building work	• Spending levels still high • High risk CIP still to be delivered • Use of Resources rating of requires improvement	Initial: 4x4 = 16 Current: 5x5=25 Target: 1x4=4

Action	Timescales	Lead
Ongoing monitoring of financial position through F&P and Board	Ongoing	GB
Reporting to Turnaround Exective on progress with CIP	ongoing	AB

Links to risk register:
Risk 6967 - Non-delivery of financial plan
Risk 7049 - EPR Financial risk

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
14.17	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Small contingency remains in place to cover any further changes.	First line Reporting through WEB on capital prioritisation Second line Turnaround Executive Reports Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Third line Monthly return to NHS I QRM meeting with NHS I	Year to date capital spend is below plan. Internally generated funds will only support capital expenditure of £7.38M around half of the amount committed for 2018/19. In the context of the state of the HRI estate; the requirements around MRI and the number of schemes pushed back from 2017/18 there is a risk of overspending.		4x5 = 20	4x3 = 12	3x4=12

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through F&P and Board	Ongoing	GB

Links to risk register:
Risk 7062 - Capital programme

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CSU	Commisisoning Support Unit
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
PRM	Progress review meeting (with NHS Improvement)
PSQB	Patient Safety and Quality Board
SI	Serious incident
SHMI	Summary hospital-level mortality indicator
SOC	Strategic Outline Case
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
WYSTP	West Yorkshire Sustainability and Transformation Plan

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
BB	Brendan Brown, Director of Nursing
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Director of Finance
HB	Helen Barker, Associate Director of Operations
JC	Juliette Cosgrove, Assistant Director of Quality
MG	Mandy Griffin, Managing Director of Digital Health
LH	Lesley Hill, Executive Director of Planning, Estates and Facilities
RM	Ruth Mason, Associate Director of Engagement and Inclusion
VP	Victoria Pickles, Company Secretary
CP	Cornelle Parker, Deputy Medical Director
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
OW	Owen Williams, Chief Executive
ALL	All board members

10. High Level Risk Register

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday 1 November 2018	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: High Level Risk Register - To present the high level risks on the Trust Risk Register as at 24 October 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The draft high level risk register has been reviewed by members of the Risk and Compliance Group at a meeting on 22 October 2018.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

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

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

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

The Issue:

The attached paper includes:

i. Identification of the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks. This paper refers to a summary of the Trust risk profile as at 24 October 2018.

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

iii. Details of movement during October 2018

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

7324, risk score of 20, Integrated Facilities Management - risk of healthcare waste not being collected on a daily basis

7240, risk score of 16, risk of expenditure being above planned levels for the Surgery and Anaesthetics division

7309, risk score of 16, Corporate division, CHFT use of Nerve Centre Technology to record observation is being updated in January 2019 and there is a risk that the integration with EPR will not be completed within the timeframe

7315, risk score of 15, Family and Specialist Services division, risk of delay to patient care, diagnosis and treatment caused by insufficient outpatient appointments

7619, risk score of 16, not achieving the 2018/19 financial plan

Next Steps:

Minor rewording to risks 7324, healthcare waste and 7169, 2018/19 financial plan will take place.
It is likely that risk 7318, the building structural risk at HRI, will be reviewed in November given that the required works to make the stone cladding safe have been completed.

Work is on going to review the leads for estates risks which will be presented to the Risk and Compliance Group in November 2018.

To note that the high level risk register will be presented at all public meetings of the Board, i.e. every two months.

Potential new risks for the high level risk register will be discussed on a monthly basis at the Risk and Compliance Group.

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

HLRR (1) pdf 24 October 2018.pdf

High Level Risk Register Board Summary – October 2018

Risks at 24th October 2018

TOP RISKS

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

7278 (25) Longer term financial sustainability risk
7234 (20) Healthcare waste collection
6903 (20): Estates/Resus risk, HRI
7271 (20) HRI ICU collective infrastructure risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk

The Trust risk appetite is included below.

NEW RISKS

7324 Score (20) Integrated Facilities Management
Risk of healthcare waste not being collected on a daily basis
Minor rewording to the risk is being undertaken

7240 Score (16) Surgery and Anaesthetics
Risk of expenditure being above planned levels for the division

7309 Score (16) Corporate
CHFT use of Nerve Centre Technology to record observations requires updating by January 2019 and there is a risk that the integration with EPR will not be completed within the timeframe

7315 Score (15) Family Services Division
Risk of delay to patient care, diagnosis and treatment caused insufficient outpatient appointments

7169 Score (16) Corporate
2018/19 financial plan risk
Minor rewording to the risk is being undertaken

RISKS WITH INCREASED/REDUCED SCORE

None

October 2018 –SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 24/10/2018

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	May 18	June 18	July 18	Aug 18	Sept 18	Oct 18
10/17	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
06/17	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing (JM)	=16	=16	=16	=16	=16	=16
09/17	5806	Keeping the base safe	Urgent estate work not completed	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
09/17	6903	Keeping the base safe	Resuscitation HRI Estates risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
05/17	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
10/17	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
06/17	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
10/17	6949	Keeping the base safe	Blood transfusion service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
05/17	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Medical Director (DB)	=16	=16	=16	=16	=16	=16
	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)	=16	=16	=16	=16	=16	=16
11/17	7248	Keeping the base safe	Mandatory Training	Director of Workforce and OD (SD)	!16	=16	=16	=16	=16	=16
09/17	7271	Keeping the base safe	ICU Huddersfield – collective infrastructure risk from 12 individual risks	Director of Finance (GB)		**!20**	=20	=20	=20	=20
	7280	Keeping the base safe	Unnecessary repeat specimen collection by not following EPR procedures	Director of Operations of FSS (RA)			!15	=15	=15	=15
	7251	Keeping the base safe	Ophthalmology equipment risk	Divisional Director of SAS (WA)				!15	=15	=15
	6299	Keeping the base safe	Medical Devices maintenance risk	Director of Finance (GB)	**=12**	**=12**	=12	=12	!16	=16
	7318	Keeping the base safe	Building structural risk	Director of Finance (GB)					!15	=16
	7273	Keeping the base safe	Opti flow medical device risk	Divisional Director, Med (AV)					**!15**	=15
	7324	Keeping the base safe	Healthcare Waste risk	Director of Finance (GB)						**!20**
	7315	Keeping the base safe	Outpatient appointment capacity risk	Director of Operations of FSS (RA)						**!15**
	7309	Keeping the base safe	NEWS2 implementation risk	Director of Nursing (JM)						**!16**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	May 18	June 18	July 18	Aug 18	Sept 18	Oct 18
INANCE RISKS										
	6895	Financial Sustainability	Finance IT systems	Director of Finance (GB)	=16	=16	=16	=16	=16	=16
13/17	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)		!25	=25	=25	=25	=25
	7169	Financial Sustainability	Financial plan risk	Director of Finance (GB)						**!16**
	7240	Financial Sustainability	Divisional expenditure risk	Divisional Director of SAS (WA)						**!16**
Performance and Regulation Risks										
	None									
10/17	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20
10/17	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20

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

TRUST RISK PROFILE AS AT 24/10//2018

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation =7280 Unnecessary repeat specimen collection = 7251 Ophthalmology risk =7273 Optiflow medical device risk !7315 Outpatient appointment capacity riskk	= 6345 Nurse Staffing = 7078 Medical Staffing = 7271 ICU infrastructure ! 7324 Healthcare waste	=7278 Financial sustainability
Likely (4)				=5862 Risk of falls with harm =7132 Patient scores in ED =7223 Digital IT systems risk =7248 Mandatory training =6895 Finance core function =6299 Medical Devices maintenance risk !7240 Expenditure Risk !7309 NEWS2 implementation risk !7169 Financial plan risk	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 HRI Resus estates risk
Possible (3)					= 6011 Blood transfusion process = 5747 Vascular /interventional radiology service = 6949 Blood transfusion service = 7818 Building condition Risk
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

Risk Category	This means	Risk Level Appetite	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**

Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	

High Level Risk Register October 2018
(15 or over) Board of Directors 1.11.18.

NHS
The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Action Plans	Further Actions	Review	Target	RC	Exec Dir	Lead
Very High	7278	Corporate	Finance and Procurement	Trustwide Finance	Jun-2018	Active	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £43.1m (£19.9m variance from the 18/19 control total). This includes loss of access to £14.2m Provider Sustainability Funding (PSF). The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raises concerns regarding going concern and value for money. The Trust does not currently have an agreed plan to return to in year balance or surplus.	Working with partner organisations across WYAAT and STP to identify system savings and opportunities Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Development of Business Case for reconfiguration Development of 25 year financial plans in support of Business Case Finance and Performance Committee in place to monitor performance and steer necessary actions Aligned Incentive contract with two main commissioners. On-going dialogue with NHS Improvement	Pressures on capacity planning due to external factors. Competing STP priorities for resources Progression of transformations plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors The Trust does not currently have an agreed plan to return to in year balance or surplus.	25 5 x 5	25 5 x 5	20 5 x 4		Long term Financial plan continues to be developed in conjunction with regulators and department of health.	Oct-2018	Mar-2019	FPC	Gary Boothby	Philippa Russell
Very High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16 4 x 4	20 4 x 5	9 3 x 3		October 2018 Applicants from the International recruitment trip to the Philippines continue to progress (119 offers were made in country, since March 2017, with on-going training and tests underway), 8 Nurses have started with the Trust in 2018, with a further 5 starting in September and 68 still engaged in the recruitment process. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued and is progressing with offers during July 2018. Application numbers are low and divisions are discussing a new approach advertising by specialty with targeted recruitment support. 53 newly qualified nurses started with the Trust on 19 September. Advertising is continuing to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT. 49 nurses were interviewed at the recruitment fair held on 13 October and 49 offers were made. Offer letters will be sent next week. An assessment day for trainee nursing associates took place on 22 September with interviews at the University of Huddersfield on 16 October. 26 verbal offers were made and offers to be sent week commencing 22	Jul-2018	Dec-2018	WF	Jackie Murphy, Jason Eddleston	Paul Casson/Rachael Pierce

							staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)							October. 4 new Physician Associates will join the team on 22 October and a further 6 are under offer expected to start in November.							
Very High	6903	Integrated Facilities Management	Estates	Estates Department	Dec-2016	Active	Keeping the base safe	Resus - There is a collective risk in regards to Resus from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: Ventilation - potential danger to staff and patients from nitrous oxide due to the lack of background air changes resulting in harm . (The Trust has been advised by their external independent Authorising Engineer to install mechanical ventilation to the RESUS area to mitigate the risk.) Electrical Resilience – lack of support infrastructure/ Medical IT i.e. UPS/IPS to ensure continuity of power supply in the event of a power outage resulting in harm to patients Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases Medical Engineering Risk - 4 Dameca Anaesthetic Machines - failure due to end of useful life resulting in unplanned disruptions/ harm to patients Operational Safety – the current space within each bed bay does not meet the minimum required space for operational safety	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of RESUS, currently this is not achievable due to Capital budget constraints. Refurbishment requires decant for around 6 months, Operational Plans & activity currently do not permit this length of decant.	20 5 x 4	20 5 x 4	0 0 x 0		September 18 Update - Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. Estates services have commissioned a feasibility study to develop a modular unit at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. October 18 Update - Discussions are continuing to progress regarding the refurbishment of the RESUS area at HRI. High level cost estimates are due this month to develop a modular unit at HRI. Meanwhile, Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Nov-2018	Oct-2019	RC	Gary Boothby	Chris Davies

							resulting in harm to patients and staff Compliance / Statute Law – All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law resulting in prosecution												
Very High	7271	Integrated Facilities Management	Estates	Estates Department	Jun-2018	Active	Keeping the base safe	Intensive care unit (ICU) HRI - There is a collective risk in regards to the ICU from individual (12) risks listed below due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. Individual Risks as Follows: • Ventilation – Imminent failure of the ventilation system due to end of useful life resulting in potential danger to staff and patients • Electrical Resilience –UPS/IPS power failure resulting in harm to patients from no functioning equipment • Flooring – causing trips/falls and infection control hazards for staff and patients • Electrical Infrastructure - failure of infrastructure • Plumbing infrastructure - failure with resulting infection hazards for staff and patients • Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases • Building Fabric - infections & failure due to moisture ingress within the plaster/concrete within ICU resulting in poor environmental conditions. • Compliance / Statute Law – Compliance / Statute Law – Failure of equipment or infrastructure could result in HSE intervention	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime. Authorising Engineers / Independent Advisors cover this area when conducting their annual audit. Resulting recommendations are actioned following a risk assessment process.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU, currently this is not achievable due to patient flow and Capital budget constraints.	20 5 x 4	20 5 x 4	0 0 x 0		September18 Update - Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. New discussions on how to maintain the Ponta Beams are taking place with the maintenance provider Draeger. October18 Update - Ponta beam medical gas hose replacement scheme business case due to go to CMG for request for funding.	Nov-2018	Sep-2020	DB	Gary Boothby	Chris Davies

Very High	5806	Integrated Facilities Management	Estates	Estates Department	May-2015	Active	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks identified within the Estates Risk Register being: • 7220 Flooring: cracked, torn, blown flooring screed and vinyl resulting in possible slips, trips, falls • 6734 Pipework: Potential of water borne diseases due to the corrosion of services pipe work • 6735 Structural: if more openings are made through the structure it will make the building unstable. • 6736 Air Handling Units: non-compliance, & increased infection risk to both patients and staff • 6737 Windows: all elevations of the Hospital require replacing, prone to leeks and very drafty • 6739 Roofs: water ingress through roofs resulting in decanting services, wards and departments. • 6761 Ward Upgrade Programmes: Compliance with regulatory standards - Health & Social Care Act • 6762 Day Surgery: Non-compliance with relevant HTM standards • 6763 Environmental Condition: failure to bring areas of the Hospital to a condition B level • 6766 Road Surfaces: South Drive and Tennis Court car park in need of repairs potential for injury to public • 6767 Staff Residences: Properties not statutory compliant for accommodation in regard to fire and utilities. • 6769 Electrics: Statutory compliance to reduce the risk of electric shock and damage to equipment • 6770 Plantroom: Statutory and physical condition of the plant room to H & S regulations • 6332 Asbestos: risk of	The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. Each of the risks above has an entry on the risk register and details actions for managing the risk.Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	6 3 x 2		September 18 Update - Ward flooring replacement complete on Ward 3 and Ward 11. Ward 15 is now 50% complete. Main entrance Infrastructure now in progress and is due to complete in Ocotber. Work progressing on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient. October 18 Update - Ward flooring replacement complete on Ward 3, Ward 11 and Ward 15 Main entrance Infrastructure progressing and is due to complete in October. Work progressing on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient.	Nov-2018	Feb-2019	RC	Gary Boothby	Paul Gilling / Chris Davies

							industrial disease to staff, patients and general public • 6771 Emergency Lighting: Statutory compliance in order to provide adequate emergency lighting • 5963 Equality Act: non-compliance with the Equality Act 2010 due to a inadequate physical access • 6764 Fire Detection: aged fire detection could lead to inadequate fire detection. • 6860 Electrical 3rd substation HV supply only 1 meter apart • 5511 Fire Compartmentation: inadequate fire compartmentation in ceilings; risers and ducts. • 6897 BMS heating controls failure will result no control over heating or air condition throughout the hospital • 6997 Structural Cladding - Loose Portland Stone creating a hazard • 5630 Poor condition of the WCs in HRI's public areas • 6848 Water Safety: non-compliance to statutory law across HRI due to the ageing infrastructure											
Very High	2827	Medical	Emergency Care	Accident & Emergency	Apr-2011	Active	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention Inability of School of EM to allocated trainees.	20 4 x 5	20 5 x 4	12 4 x 3		September 2018 update 5HSTs and 3 ST3's in post as well as 1FY3 working on the MG rota. 2 further Locum MG doctors converted to Bank contracts October 2018 update 2 long term agency locum middle grade doctors have withdrawn their services due to changes in pay process/rates. Apparent reduced availability of short term agency locums. Unsure if this is due to reduced pool of available doctors as a result of national squeeze on agency pay rates.	Dec-2018	Mar-2019	WEB	David Birkenhead	Dr Mark Davies

Very High	7078	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3		October 2018 All new doctors in training that were due to commence in October 2018 have started without delay as scheduled. The joint BMJ advert was published Saturday 6 October. It has created some interest from applicants who have been in touch to discuss the posts available with the relevant Clinical Director. The BMJ Careers Fair will be attended 19 and 20 October by clinical representatives from each division who will be able to talk about CHFT and what is good about working here. This is the first time that the Trust has attended a careers event for qualified Medical and Dental staff. It is a way to increase networks and promote the Trust as a great place to work. Nursing colleagues have been attending and promoting recruitment fairs for a number of years so this may become 'Business as Usual' in the future, at relevant targeted events. The Medical HR team are trying to create a support group for our overseas doctors who have recently relocated from overseas to join us here at CHFT. Whilst it is informal it is intended to learn about the challenges that our new doctors face when moving to the UK so that we can try to improve their experience and improve retention.	Nov 2018	Jan-2019	WF	David Birkenhead	Pauline North
High	7132	Medical	Emergency Care	Accident & Emergency	Nov-2017	Active	Keeping the base safe	The Trust EPR system whilst having the facility to record NEWS and PAWS assessments, it does not have the facility to calculate the score unless all fields are filled. This is not always clinically appropriate. There is a risk to patient safety due to EPR system not automatically calculating and recording the score. This provides the potential for non recording, miscalculation and non detection of deterioration of patients. A number of clinical incidents have identified failure to detect deterioration as a contributing factor	All staff informed to document PAWS and NEWS as a clinical note with PAWS and NEWS in the title and laminated charts put up in the cubicles in the department. All staff have been made aware of the change. SOP and training has been provided. Above audited as part of monthly documentation audit.	Clinical staff not routinely looking at PAWS and NEWS and relying on individual judgement of vital signs recorded.	16 4 x 4	16 4 x 4	2 1 x 2	Regular documentation spot checks by lead nurses. Medical staff to evidence use of early warning scores in their clinical decision making. Issue escalated to A Morris and J Murphy to establish if PAWS and NEWS can be on the front page of the ED clinical summary.	September 2018: Still awaiting nerve centre meeting. Documentation audits are showing improved results in recording NEWS and PAWS in the notes. October 2018 Still awaiting to hear from nerve centre. Also PAWS and NEWS audits still being reviewed.	Nov -2018	Nov-2018	PSQB	David Birkenhead	Louise Croxall
High	7223	Corporate	THIS	THIS -Operational	Mar-2018	Active	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital	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	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 4 x 4	16 4 x 4	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend	August 2018 : No further update or change to score - Awaiting confirmation from E&F around the remedial Power/UPS following the outage in June. September 2018: As above, no further update. October 2018 - The CHS works to move back to resilient power feeds at HRI is now planned for November 2018. This will go some way to mitigating the overall risk. BCP plans are in the process of being tested within divisions with emergency planning. Still work to do to close the gaps in controls.	Nov -2018	March 2019	RC	Mandy Griffin	Rob Birkett

								infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	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					(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).						
High	7248	Corporate	Workforce & Organisational Development	Workforce Development	Apr-2018	Active	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts. Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our 9 mandatory training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 mandatory subjects alongside the 41 essential skills. This approach strengthens the importance of completing the essential skills designated to specific roles and by combing the two areas into one enhances the Trusts' requirement to reach 96% across all the training offerings.	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16	16	4			September 2018 A paper went to EB on 6 September which explored the option of excluding quarter 4 as a period in which Essential Safety Training could be completed, this is to avoid training during the winter period. Due to the number of people whose training expires in quarter 4 this was decided as not a viable option. It was highlighted at board that a focus on the training must take place and therefore the HRBP's are meeting with the mandatory training lead to put together a recovery plan. October 2018 A paper went to the Workforce Committee meeting on the 8 October giving a detailed 3 year recovery plan for all 50 EST subjects. A weekly compliance update to EB will commence on 25 October 2018.	Aug-2018	Mar-2019	WF	Suzanne Dunkley	Ruth Mason
											x 4	x 4	x 1							

High	6299	Integrated Facilities Management	Estates	Estates Department	May-2015	Active	Keeping the base safe	Patient Safety Risk Risk of high risk medical devices (patient monitoring infusion devices, incubators, phototherapy equipment) due to lack of routine maintenance, staffing capacity and systems in Medical Engineering, resulting in potential patient harm and inability to meet CQC requirements for medical devices.	Maintenance prioritised based on categorisation / risk analysis of medical devices Tight control of management of service contracts to ensure planned preventative maintenance (PPM) activity performed. PPM programme being developed. Progress monitored by Health & Safety Committee ensuring recruitment issues, database, risk analysis of devices is progressing. Also being monitored by the CQC Steering Group Recruitment of administrator and 1 Medical Engineer	1. PPM Programme development ongoing. 2. Complete review Medical Device database to ensure accuracy on medical devices needing maintenance. 3. Lack of information on what proportion of equipment has accurate recording of location on medical devices database 4. Medical Devices Assessor final report and action plan not yet received, meaning further actions required not yet known 5. Newly recruited Medical Engineer not yet in post. Completed	15 5 x 3	16 4 x 4	5 5 x 1		August 2018 - Peer review complete, High risk PPMs still not on target, agency staff commencing August 2018 to catch up on PPMs. Interviewing Chief Medical Engineer on 5th September. Short to long term plan drafted as a business case. October 2018 - PPM KPIs beginning to increase slowly, Chief Medical Engineer interview unsuccessful on 5th September. Short to long term plan drafted as a business case	Nov-2018	Dec-2018	PSQB	Gary Boothby	M Coughlan
High	5862	Medical	All Directorates Medical	All Departments/Wards Medical	Aug-2013	Active	Keeping the base safe	We have a risk of harm due to vulnerable patients who are more likely to fall due to the unfamiliar hospital environment. The impact is high levels of fractures, head injuries all causing increased length of stay with associated issues	Falls management policy Safety Huddles Falls bundles Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment Enhanced care team and assessment process Safety rails assessment Falls champions	Insufficient uptake of education and training of nursing staff, particularly in equipment. On occasion staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. Failure to use preventative equipment appropriately. Low levels of staff training. Failure to implement preventative care. Limited amount of falls prevention equipment. Increased acuity and dependency of patients Lack of access to falls prevention training for agency staff.	12 4 x 3	16 4 x 4	9 3 x 3		September 2018 risk rating reviewed and remains unchanged. increase in harm falls in August - no pattern as yet - overall number of falls decreased in month. Falls collaborative work continues with concentrated efforts on ward 8. Falls action plan completed and actions ongoing October 2018. Risk reviewed and remains unchanged 4 harm falls in Division. Review undertaken of 9 completed harm fall investigations YTD to review identified actions and trends.Actions from these investigations are not consistently being embedding in practice therefore focused Divisional approach has been identified around three keys areas: Training ESR on Falls prevention(September 91.51% Divisional)to achieve 90% compliance on all ward areas by Jan 2019. Improved compliance in completion of initial falls assessment and documentation standards(September 37.9% Divisional)monitored though ward assurance and aim to achieve 75% by end December 2018. Treatment and care delivery -Safety huddle implementation on all medical wards to include falls risk and review falls prevention interventions.	Nov -2018	Nov-2018	PSQB	Jackie Murphy	Helen Hodgson

High	6895	Corporate	Finance and Procurement	Corporate Finance	Dec-2016	Active	Keeping the base safe	Risk of Inability to fulfil core functions of the Finance and Procurement department, i.e. Internal and external financial reporting; business partnering with Divisional management teams; transactional functions of paying suppliers, raising invoices and placing orders for goods and services; cash management; adherence to procurement legislation. Due to IT Systems failure of financial ledger, fixed asset register, costing system or procurement systems. Resulting in failure to meet statutory deadlines; ensure good governance of the organisation with regard to the financial position and outlook; maintain cash flow to suppliers and staff; maintain supply of goods and services essential to operational performance and safety; comply with procurement legislation leading to legal challenge.	The majority of the Trust's key Finance and Procurement systems are outsourced to a third party and contractual arrangements exist for continuity of service and resilience. In case of failure, the department would revert to saved records and manual systems supported by generic Office software. Further action is being taken as follows: 1. Address additional short term resource requirements in Accounts Payable - additional resource in place supported off site by systems supplier NEP, local resource being prioritised from within wider finance team and additional temporary local resource to be in place from June. 2. Escalation of outstanding issues with system provider, NEP - including site visit and regular senior communication between parties 3. Systems optimisation project to create action plan including engagement and communications roll out - detailed action plan with sub projects, key milestones and KPIs. Fortnightly meeting to ensure oversight. 4. Continued focus on cash management actions through cash committee and divisional cascade	In December 2017, the Trust's key finance ledger system and procurement ordering system went through an upgrade with the existing supplier, North East Patches (NEP). The system changeover adversely affected functionality in a number of areas. Many of the initial issues have been resolved but the residual system issues cause potential operational risk to the Trust's ability to maintain supply of goods and services essential to operational performance and safety. The key issues are: - the slower speed of processing invoices for payment which has generated a backlog of outstanding invoices, compounded by the additional volume of queries into the department that this is generating - the ineffectiveness of the system in automatically recognising VAT status, requiring manual intervention. - the lack of a system automated reminder to the requisitioners of goods within the Trust meaning that receipting is not being completed in a timely manner to allow for payment to be made - these issues are compounded by the Trust's ongoing challenges of cash availability meaning that payments are having to be prioritised (See Risk ref 6968)	8 4 x 2	16 4 x 4	8 4 x 2		October update: 1. Additional temporary resource is in place in Accounts Payable, with further capacity being sought in addition to off-site processing support to address invoice backlog. A number of material cash amounts were received in July which supported the Trust's ability to catch up on payment timescales and reduce the additional pressure brought about through creditors chasing payment 2. Regular communication remains in place at a Senior level with the system supplier. A number of issues impacting system effectiveness have been alleviated by a system update applied at the end of August. 3. Systems optimisation plan, 'Silver Lining Project' progressed with some improvements now in place and others in train. A key action to close is the implementation of agency pre-approval through the Allocate system which requires wider operational involvement. 4. A 'Go See' knowledge exchange has been set up with York Teaching Hospitals who are in a similar position. A number of meetings have been held including CHFT, York and system suppliers NEP and Oracle to further escalate issues for resolution. The next meeting is scheduled with Oracle for 30 October. 5. Raising of cash awareness on-going. 6. A VAT review has been carried out by EY, the Trust's VAT advisors in order to ensure that the NHS COS VAT reclaim position is robust. 7. Conversations are being held with colleagues across the West Yorkshire Association of Acute Trusts to share learning and with a view to potential joint escalation of shared issues. 8. A full report has been prepared for Executive Board in October to outline the position and actions taken.	Nov -2018	Dec-2018	FC	Gary Boothby	Kirsty Archer
High	7318	Integrated Facilities	Estates	Estates Department	Sep-2018	Active	Keeping the base safe	There is a risk to life and building due to the very poor fixing condition of the Stone Cladding on Ward block 1 West Elevation resulting in falling Stone debris. Highlighted by an external structural engineer for immediate response / action.	The RMO block has been evacuated and the area cordoned off from staff / public access.	There is no immediate physical method of restraining the stones to prevent them from detaching from the building.	15 5 x 3	15 5 x 3	0 5 x 0	A cantilever scaffold system is currently being designed to restrain the stones effectively mitigating the risk of falling debris.	Repair / survey the stone cladding across the whole west elevation. September 2018 - R&C Group, agreed to add to High Level Risk Register October18 CHS commissioned structural engineers have considered all options to make safe the stone cladding. High level access / MEWP and fixings considered as safest option. Possible start date 3rd October.	Nov-2018	Nov-2018	HSC	Lesley Hill	Chris Davies
High	7280	Family & Specialist Services	Pathology	Blood sciences	Jun-2018	Active	Keeping the base safe	Risk of: unnecessary repeat specimen collections (same EPR order) or rejected Specimens (incorrect EPR order used) Caused by: Failure to follow procedures in EPR at point of specimen collection. (not clicking collected) Resulting in: increased patient harm through repeat specimen collections and subsequent	1.Ward patients- the lab phones and requests new order to be sent down (samples processed) 2.Out patients- if there is a location sticker the lab will phone and find out if bloods required- if so new order with barcodes requested by lab (samples processed)	1. Not all ward staff have been trained correctly to order tests in EPR (see also 3 below) 2.Current lab procedures for allowing the labelling of samples without the need for disclaimer form is outwith the minimum data set policy and is facilitating the problem 3. Staff are not clicking collect once they have ordered and collected specimen- this results in order remaining live in EPR.	15 3 x 5	15 3 x 5	3 3 x 1	1. Lab to liaise with EPR trainers 2. comms re use of disclaimer form to be sent out by lab. 4. cerner do not have resolution to outstanding worklists- international problem. Lab to continue to monitor situation 5. Lab to develop system for logging rejected requests in APEX- EPR	Update September 2018. Support has been provided by the lab and the lab will continue to collect data to feedback. Consideration required as to where the ownership of the risk now needs to be. Discussed in PSQB and to take to EPR/Risk management Update September 2018- Training continues no new incidents in month. Update 02. October 2018 The path team with EPR trainers are	Nov-2018	Dec-2018	PSQB	Rob Aitchison	Karen Mitchell

								delays in patient care		(see also 1 above) 4.High volumes of outstanding orders in the system 5. Lab do not have an effective system in place for logging rejected specimens in APEX or feeding back to users (Lab IT system)- lack of awareness by service users of the number of specimens being rejected or collected incorrectly 6. Additional tests are being routinely added to phlebotomy lists 7. OP phlebotomy requests are being processed without appropriate requests - use of duplicates of request forms				lab staff to be trained to mark as collected those requests where barcode has been used and results issued 6. Lab IT to liaise with EPR team to restrict addition of requests onto the phlebotomy list 7.Comms to clinicians around end-date for lab accepting inappropriate requests from out patients.(feedback directly to clinicians on each incorrectly requested test in interim)	continuing to roll-out training in click-collected. The next phase will be to concentrate on MAU cross site, provide advice and request that the risk of re-bleeding patients is added to relevant risk registers. Once the risk of re-bleeding patients is transferred to the other relevant risk registers the actual pathology risk can be amended to reflect the cost/time pressures and re-scored.					
High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20	4	x 5	15	3	x 5	6	3	x 2	Establish clinical documentation group	September 2018 New Chief Nurse Information Officer and Chief Clinical Information Officer in post. Key objective is to re-instate the Clinical Records Group Ward assurance tool being tested in Surgery and Medicine with a view to full implementation by October 2018. Community version also being tested. October 2018 Chief Clinical Information Officer in post from 15th October - to recommence Clinical Records Group. Meeting between CNIO and CCIO to be arranged to recommence these. Ward Assurance Tool now on Knowledge Portal and being used by clinical staff - results under review. Digital Health Team in the process of working on a model ward, exploring areas of poor documentation and developing training plans to improve quality of documentation between all users of the system.	Nov-2018	Nov-2018	WEB	Jackie Murphy	Carole Gregson/Graham Walsh
High	7273	Medical	All Directorates Medical	All Departments/Wards Medical	Jun-2018	Active	Keeping the base safe	There are 20 Optiflow devices used throughout the trust for critically ill patients. They deliver humidified high flow oxygen and air via a nasal cannula. These are older than their life expectancy (9 years old against an expectancy of 5 years) their expiry date is the end of 2019. Two of the machines have not been repairable and have been condemned. These machines were all purchased at the same time so there is a a risk that other machines will continue to break and become unrepairable before the end of 2019. We have no other comparable machines to use on the wards, therefore this will put critically ill patients at increased risk of death and will mean an increased demand on the intensive care units.	This work sits under the Trust NIV and O2 group and updates are reported there. We are currently repairing the machines where possible, however certain pieces of the machine cannot be repaired and so far 2 machines have been condemned. There is a quote available to replace the machines (as per below). To manage the drop in machines we have had to move machines between sites. The demand has been mapped last Oct and Nov in snap shot audits The greatest demand on any given day (to three sigma points from mean) at CRH is 10, lowest 0, mean 4, and HRI most 8, lowest 0, mean 3. The number of machines being repaired at any one time was 0-5. This explains why at times machines are	There is no direct replacement for the Optiflow because the supplier no longer sells them. We have gone through a procurement exercise to find options for their replacement and we have then asked staff to submit their opinion on these options. The preferred machine of choice is the Air VO2 and is from the same suppler as the current Optiflows -Fisher Paykel The switch to this new machine will increase the consumable costs. (increase in cost from £35885.94 to £46,100.14 annually, 65% of this is medical division and 35% surgical division). The machines will be swapped free of charge.	15	3	x 5	15	3	x 5	1	1	x 1	There has been a business case completed It is captured on the risk register It was discussed at the Compliance and Risk meeting on the 18/9/18 where it was asked for the risk register to have more detail and for it be taken to the Capital Management contingency funding meeting by Paul Cornish	updated 20/9/18 Switch consumables to Fisher Paykel (increase in cost from £35885.94 to £46,100.14 annually, 65% of this is medical division and 35% surgical division) and get kit for free. Need to decide when to change machines and plan staff training to coincide. Decide is it possible to switch one site this financial year and risk not being able to move machines cross-site if demand spikes. October 2018 Capital Management meeting agreed to the swap of Optiflows with AirVO2 devices. The clinical risk remains until we can ensure the process has commenced.	Oct-2018	Dec-2018	PSQB	Nick Scriven	Heather Moffat

									required to be moved between sites.	These devices need an agreed storage area at each site where more careful tracking can be completed. This is also required if we buy the AirVO2's as they have a longer cleaning time of just under 1 hour.									
High	6949	Family & Specialist Services	Pathology	Blood sciences	Mar-2017	Active	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas. 2. Staff rotas changed to a block pattern for night shifts. 3. All substantive vacancies are being advertised and gaps backfilled with locum staffing. 4. Staff development plan in place for training Biomedical Scientists 5. Existing business continuity plan in place	1 & 2. Substantive Biomedical Scientists are working additional shifts on a voluntary basis with no obligation to provide cover and over a sustained period of time with no imminent resolution. 3. Delay in recruiting locums due to impact of Flexible workforce procedures. 4. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments. 5. Business continuity plan has not had a recent test with relevant stakeholders - further work required to establish contingency plan if rota was unfilled at any point in time.	10 5 x 2	15 5 x 3	5 5 x 1	3. Understand blockers to the recruitment process and determine options to expedite the process. 5. Organise a test for Business continuity plan with relevant stakeholders	July 2018 - Risk presented at PRM 4/7/18. Department to prepare 3R report and meeting with senior managers to look for options to mitigate risk earlier than 2020 August 2018- no change 04-September 2018 - Training continues and two more staff due to join the 24/7 rota in October - 27/08/2018 October 2018 Training still progressing. Lab currently looking into all options to reduce timescales for the training.	Nov-2018	May-2019	DB	Rob Aitchison	Hayley Baker
High	6011	Family & Specialist Services	Pathology	Blood sciences	May-2014	Active	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust). - Solution identified and purchased - currently for implementation from August 2018. This solution will mitigate the current risk in full.	Lack of electronic system Lack of duplicate sampling Training compliance not at 100%	15 5 x 3	15 5 x 3	3 3 x 1		August 2018- Bloodtrack implementation ongoing in line with plan 4th September 2018 go live for Haemanetics project stages 1 & 2 place on Thursday 30th august and monday 3rd . Assessment of residual risk to be undertaken by managers during september October 2018. No change since last review. Date planned mid-october to re-assess risk	Nov-2018	Dec-2018	PSQB	Julie O'Riordan	Sarah Ramsden and Alison Milner

High	5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist 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 2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response.	August &September 2018 Locum in place until 12th October. Continuing to pursue possible recruitment of substantive consultant. October 2018 update - Locum now in place until 9th November. Longer term support from LTHFT agreed in principle, detail still being decided.	Novt -2018	Mar-2019	DB	Rob Aitchison	Sarah Clenton
High	7251	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2018	Active	Keeping the base safe	There is a risk to patients receiving a poor experience and possible delay 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. This is resulting in a slower patient flow through clinics due to the increase time taken per scan. The machine can "crash" leading to inability to perform scans and access historical results for progression of eye conditions to determine diagnosis, treatment and management plans. The OCT machine' 16TB storage limit cannot be overcome by additional storage space – this is a physical limit set by the software used by Optovue/Haag-Streit (which is dated). Storage file structures cannot be altered to get round this for similar reasons.	Increase use of the Heidelberg OCT machine on Floor 2 to spread demand for scans during clinics but requires patients to travel between 2 floors during their visit.	The OCT server ran out of space last August, linked the server to the Trusts Storage Area Network and backed up and restored the archive so it is kept on the Trusts larger area however this only gave the system 6TB more space, even though we have a lot more available to allocate, the limitation is 16TB per volume. Optovue are unable to use a 2nd Archive to keep us going and the system is obsolete in this regard. Recent performance review identifies the need for a new infrastructure otherwise the machines will not function beyond January 2019 due to server storage reached, this will impact on patient care as unable to receive these diagnostic scans to monitor progression of their eye disease. For this reason the risk has been increased to 15 (high) CHFT-OCT servers warranty expires within the next financial year(28/03/2019), backing up the system for 12TB costs the Trust about £10-15k a year in licensing alone, a new server would be at least £10k.	9 x 3	15 x 5	0 0 x 0		October 2018 We are down to 2 possible solutions for immediate issue of storage running out: 1. Modify the EXISTING server – Make existing OCT image archive the “secondary” archive, and add a new “primary archive”. Both archives would remain accessible so scans can be compared quantitatively. Both archives would be backed up. This is dependent on the plan for backup of the 2 archives (which is different from existing backup of single archive using Trust backup storage) being viable. James Ledgard has a meeting on 15th w/ relevant company that do the software to confirm this. If viable, should be able to go ahead and build as per plan. Some IT support from THIS likely required. Optovue will not be involved in support as they state this is an internal IT issue. 2. If the above is not viable, there is no other solution immediately available that involves live backup of data AND continued use of the current OCT archive as a “secondary” archive. Further storage is possible to put into place without backup (which we do not recommend for obvious reasons), OR we lose the ability to access data gathered over the last 10 years (for clinical analysis) in favour of having somewhere to at least continue saving new scan data (again, not recommended at this stage). The long term solution remains replacement of all OCT infrastructure to resolve issues with: 1. Storage. 2. Slowdown of scanning patients (can take 20 mins currently, versus 5 mins normally) – causing clinic delays, or not being able to scan patients at all (possible clinical risk). 3. Slowdown of reviewing and processing scans (can take 5-10 mins currently, versus 1-2 mins or less normally) at end user level.	Novt-2018	Jan-2019	PSQB	Will Ainslie	Louise Corp
								NEW RISKS											

Very High	7324	Integrated Facilities Management	All Directorates	All departments	Sep-2018	Active	Keeping the base safe	There is a risk that healthcare waste including infectious clinical waste, cytotoxic waste, sharps, anatomical waste and medicinal waste will not be collected from the Trust on a daily basis as currently occurs. Due to the failure of the current healthcare waste contractor, Healthcare Environmental Group (HEG) being unable to satisfy the Environment Agency and NHS England that they can safely deal with the waste that is treated or transferred at their facility in Normanton, West Yorkshire that provides a service for the Yorkshire and Humber NHS Clinical Waste Consortium. NHS England have informed the consortium that this facility will shut on 23rd Sept 2019. Resulting in emergency measures being put in place by NHS England to keep waste on site for 2 weeks in bulk storage before collection. NHS England have said that they will be responsible for bulk collection but given no further details. These emergency measures are likely to be in place until early 2019. This will require waste to be removed from the yellow wheelie bins that are currently used on site and transported to Normanton. Portering and ISS staff will be required to remove waste bags from bins before placing this in bulk storage shipping containers. The Impact of these emergency measures will be to increase the infection control risks to staff, produce increased manual handling risks, provide challenges regarding bin washing and return to wards, add financial pressures in terms of overtime or bank staff payments, require risk assessments regarding site access to remove the bulk waste. As the healthcare waste market only has two major contractors (HEG being one) there is no immediate solution to this issue and a strategy needs to be put in place that will be sustainable for several months.	Clinical waste and other healthcare waste such as offensive waste from wards, departments and community settings is currently placed in 360 litre or 770 litre yellow wheelie bins by Trust or ISS staff and these bins are transported to the Healthcare Waste facility in Normanton where the bins are cleaned and the same number returned each collection. The waste is therefore correctly segregated and manual handling risks are minimised. As the bins should be cleaned before returning, infection control risks are minimised. Waste at the hospital sites is collected six times a week meaning that only limited storage space is required. Waste is consigned in line with legislative requirements and a record of tonnages is kept.	The number of yellow wheelie bins on site is limited and fixed so removal off site using these containers is impossible. They will be used within wards and departments with the waste having to be manually removed for bulk storage. Secure storage space is limited so secure storage will need to be procured and sited. Infection control procedures will need to be updated. Extra manual handling procedures will need to be put in place	20 4 x 5	20 4 x 5	12 3 x 4	Implementing business continuity plan Calderdale and Huddersfield Solutions, Estates General Manager and is coordinating an action plan	Speaking to other waste contractors has been embargoed by NHS England due to commercial sensitivity, after this point	Dec-2018		DB	Gary Boothby	Don Mackenzie

High	7309	Corporate	Corporate Nursing	Workforce and Clinical Development	Aug-2018	Active	Keeping the base safe	This is a works issue with Bradford CHFT use Nerve Centre Technology to record and escalate patients physiological observation. Using the National Early Warning Score (NEWS). The NEWS is being updated to NEWS2. All organisation are required to change to News2 by January 2019 to comply with the NPSA alert circulated in April 2018. There is a risk that the integration between NC and EPR will not be complete within the timeframe. This is due to the delay in building the NEWs2 chart within EPR. As we are in partnership with Bradford with EPR,the Impact for CHFT is that Bradford will want to go live with News2 as soon as the new chart is built within EPR CHFT will require time to work on the interface between EPR & NC Within the NEWs2 chart build Bradford are requesting a hard stop alert for escalation of News of 5 or above. It is unknown if this will affect in the interface /integration with NC This would be detrimental to Patient Safety within CHFT.	The IPROC for the News2 App within NC was signed off yesterday. I have emailed NC and asked them to look out for the order. Nerve centre have agreed to prioritise CHFT for the NEWS2 update above Trusts Timeline for the work is 8 weeks EPR colleagues are in contact with Nerve centre and Cerna to understand work required for interface	Inability to bring forward the timeline of 1st January 2019 as we are in partnership with Bradford and there is a CCG issue which means Bradford will go live irrespective of our position Building of the NEWs2 chart in EPR is underway - we do not know at the moment how long this will take. We cannot start any testing of the News2 App with EPR until the chart in EPR is built. Work required for integration/interface of NC and EPR not identified as yet	16 x 4	16 x 4	6 3 x 2		Our Servers need updating to V5 NC will do this free of charge and we are liaising with them to get this done within the next 10days. We have updated servers before. This will require a short period of downtime 24.10.18 NEWs2 meeting with Bradford yesterday and SF (Bradford) and I will keep in contact and we will agree a launch date when we know where we are with the EPR build. I explained that from a CHFT point of view we would not be going live until we had the interface with NC/EPR.	Sep-2018	Jan 2019	EPR	Jackie Murphy	Catherine Briggs
Very High	7169	Corporate	Finance		Jan-2018	Active	Financial sustainability	Risk of not achieving the 2018/19 Financial Plan: The Trust has planned a deficit of £43.1m. There is a risk that the Trust fails to achieve its financial plans for 2018/19 due to: - £18m (4.5% efficiency) Cost Improvement Plan challenge is not fully delivered - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - shortfall in income recovery	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Controls around use of agency staffing have been strengthened. Aligned Incentive contract with two main commissioners. Approval process for new investments through Commercial Investment Strategy Committee	Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges - including impact of external pressures Volume of agency breaches remain comparatively high and a higher value for each breach.	25 x 5	16 x 4	9 3 x 3		The year to date and forecast deficit are both currently in line with the plan, although the year to date position has relies on the release of £1.00m of contingency reserves and a positive timing difference on the Winter Reserve to offset overspends in both pay and non pay. Unless the run rate improves, a financial pressure will emerge in Months 7-12 as contingencies are now exhausted. The forecast assumes full achievement of £18m CIP target, of which £5.48m is high risk and also relies on an additional recovery requirement with a total value of £1.66m. Agency expenditure is slightly below the NHS Improvement ceiling. The forecast remains below the ceiling, but achieving this position through the winter months relies on the delivery of some challenging savings targets. The risk of loss of income has been largely mitigated by agreement of an Aligned Incentive Contract (AIC) with the two main commissioners, although any out of area activity remains on a payment by results basis and any costs incurred as a result of overtrading against the AIC would not be covered by additional income generation.	Nov -2018	Mar-2019	FPC	Gary Boothby	Philippa Russell

High	7315	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2018	Active	Keeping the base safe	Risk of delay to patient care, diagnosis and treatment caused insufficient outpatient appointment capacity to meet current demands resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and possible claims. Currently there are in excess of 8,000 patients awaiting appointments. circa 2,000 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 6,000 follow up patients that have all exceeded the appointment due date. Please refer to following individual risks: 4050 6078 6079 7199 7202	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3		Actions as per individual risks named above. Monitored at PSQB and Directorate Board Support from Clinical Divisions and Performance Board to address backlog and meet current demands.	Nov-2018	Apr-2019	PSQB	Rob Aitchison	Katharine Fletcher
High	7240	Surgery & Anaesthetics	All Directorates S&A	All Departments/Wards S&A	Apr-2018	Active	Financial sustainability	Risk of expenditure being above planned levels for the Division Caused by lack of budgetary controls, usage of agency and locum to support gaps in capacity to achieve contracted activity or higher than planned costs to maintain appropriate staffing levels relating to patient safety and quality or identification of pressures not evident within the planning process. . With a Consequence of non achievement of the Divisions planned contribution impacting on the Trusts ability to deliver its 18/19 I & E plan and remain a viable sustainable organisation	Pressures experienced in 17/18 have been incorporated and supported within the pressures funding approved for 18/19 Monthly budget holder meetings Monthly DMT, Divisional Board and Surgery PRM meeting to review performance Bi Monthly Directorate PRM to review performance Weekly Medical agency confirm and challenge meetings Bi weekly nursing agency confirm and challenge meetings Weekly CIP directorate meetings to ensure schemes are on track	Head & Neck General Manager Vacancy	9 3 x 3	16 4 x 4	9 3 x 3	Following the detailed forecast review at month 5 the potential deficit could be circa £2m. The risk register score is therefore recommended to be a 16. Actions to recover are focused around Release of workforce capacity including bank, agency and WLI - Executive decision awaited with regard to agency Opportunities for out of area activity - a number of Trusts and specialities have indicated they require capacity to deliver on performance targets. Where existing capacity can be used to facilitate this it may bring additional income at marginal cost Performance and productivity Medical job plan review Vacancy freeze Enhanced non pay governance	Appointment to GM post	Nov-2018	Mar-2019	DB	Mr Ainslie	Joanne Hardcastle

11. Risk Appetite Statement

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday 1 November 2018	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: Risk Appetite - The refreshed Trust risk appetite is presented for approval.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board workshop 25 May 2018	
Governance Requirements: All - the risk appetite ensures the Trust has a clear framework within which it considers risk management against an agreed risk appetite statement.	
Sustainability Implications: None	

Executive Summary

Summary:

The Trust's risk appetite statement is presented to the Board of Directors for approval, defining the element and type of risk that the Trust is willing to consider in pursuit of delivery against it's strategic objectives.

Main Body

Purpose:

A risk appetite supports well-managed risk taking, recognising that innovation and opportunities to improve services requires risks taking, as long as those risk can be well managed.

The current guidance in the NHS on risk appetite was developed by the Good Governance Institute. The Trust's risk appetite, in line with other NHS organisations, follows their framework.

Background/Overview:

This is the second risk appetite statement that the Board of Directors will consider, the last being approved in November 2016.

Since the financial crash of 2008, increasingly organisations are using risk appetites as a fundamental part of effective corporate governance. Auditors of NHS services are increasingly advocating the use of a risk appetite in public services in the NHS, a reflection of a more mature risk management system within an organisation.

Public sector guidance on risk appetite , the Orange Book from the Treasury, has been in place since 2004.

The Issue:

An organisation’s risk appetite is defined as the amount and type of risk that the organisation is willing to take in the pursuit of it’s strategic objectives. The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved and communicating expectations for risk taking to managers.

The risk appetite statement has been reviewed and refreshed at a workshop with Board members in May 2018 July, where its practical use was also discussed. The risk appetite was confirmed, with one new risk relating to partnership agreed and developed by the Director of Transformation and Partnerships.

Next Steps:

Following Board approval, the risk appetite should be a key reference document in discussions regarding the risks on the Board Assurance Framework and risk register, ensuring these are in line with the Trust's risk appetite.

The risk appetite will be presented to the Board of Directors for approval on an annual basis, or sooner if circumstances require.

Recommendations:

The Board of Directors is asked to approve the risk appetite statement.

Appendix

Attachment:

Risk appetite october 2018.pdf

CHFT RISK APPETITE October 2018

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

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

*For definitions of risk level and risk appetite see next page which details Good Governance Institute definitions

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

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

12. Winter Plan

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday 1 November 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Winter Plan 2018-19 - The Board is asked to approve the Winter Plan 2018-19	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board: September 2018 and Urgent Care Board: September 2018	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations. The winter period is normally defined as being from early November to late March, with specific emphasis on the 'Critical Period' early December to the end of January.

The plan has been developed with Clinical Directors across CHFT along with Operational colleagues taking the learning from 2017/18 and using the framework required by NHSI & NHSE. The plan has been shared with the local AEDB and complements system plans and is anticipated to provide safe services based on anticipated demand and those actions taken by other providers.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Winter Plan 2018-19

Appendix

Attachment:

Winter Plan 2018-19.pdf

Review Date: June 2019
Review Lead: Director for Urgent Care

Calderdale and Huddersfield NHS
NHS Foundation Trust

Winter Plan 2018/19

Document Summary Table			
Unique Identifier Number			
Status	Final		
Version	2		
Implementation Date	November 2018		
Current/Last Review Dates	October 2017		
Next Formal Review	June 2019		
Author	Director of Urgent Care		
Where available	Preparing for Emergencies Section of the Trust Intranet.		
Target audience	Executive Directors, On-call General Managers, Directors on-call, Duty Matrons, Senior ward & department staff, CHS.		
Ratifying Committees			
Weekly Executive Board			September 2018
Consultation Committees			
Committee Name		**Committee Chair**	**Date**
Board of Directors			
A&E Delivery Board		Matt Walsh	

Does this document map to other Regulator requirements?	
Care Quality Commission	Outcomes 4B, 6D, 10E and 14A

Document Version Control	
V1	Updated for Winter 2018
V2	Updated following internal Urgent Care Board – 2 October 2018
V3	Winter Schemes

Contents

Appendices

Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The winter period is normally defined as being from early November to late March with specific emphasis on the 'Critical Period' early December to the end of January. However NHS England expectations of Trusts to implement improvements as described below do not and cannot be achieved if just focused on planning through the winter but must be the focus throughout the year.

Purpose

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter response
- To provide a framework for the development of other plans
- To provide the basis for agreement and working with other partners & organisations
- To provide reference material for use in the Trust
- To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Reducing Delayed Transfer of Care
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning
- Planning for Peaks in demand over weekends and Bank Holidays.

1. Definitions

Import - The monthly report on take up of influenza vaccination in staff.

Organisational resilience - The ability to adapt and respond to disruptions to deliver organisationally-agreed critical activities

Sitrep - A daily report to NHSE which highlights pressures in Trusts' capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November until the end of March 2019.
THIS will support the reporting of the Sitrep on a daily basis and the Associate Director of Urgent care or deputy will complete the sign off, a rota will be created.

2. Duties (roles and responsibilities)

Chief Operating Officer

- Reportable officer at executive level for Winter Planning
- Will represent Trust on the A&E Delivery Board

Director of Urgent Care

- Chair the Winter Planning Group
- Represent the Trust on the Joint Surge and Escalation Teleconferences
- Compile a situation report for the Joint Surge and Escalation Teleconferences
- Cascade the situation report from the Joint Surge and Escalation Teleconferences / Update the winter planning group and divisional leads of the situation across the local healthcare system
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period
- Ensure that contingency plans that are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Winter Plan aligns with those across the local health & social care system.
- Lead in partnership with the Deputy Chief Nurse and Clinical Director for Emergency Medicine CHFT's Winter Room

Divisional Directors

- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis
- Ensure collaboration across Divisions to ensure compliance with Patient First principles
- Ensure each Division has robust arrangements for escalation and any associate operational and tactical or Winter Room Meetings

Deputy Chief Nurse

- Lead in partnership the Winter Room

Winter Planning Group (Division Winter Leads)

- Ensure that appropriate plans are in place to manage an increase in activity through the winter period within the division
- Ensure that divisional plans are joined up across the organisation
- Ensure that contingency plans are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases.

- Ensure that key staff groups are aware of the risks and response arrangements for winter

CHS, Clinical Site Commanders and Night Matrons

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements
- Contact alternative transport providers if required

CHS

- Ensure that there is sufficient supplies of salt/grit for clearing car parks, pathways and roads on site
- Liaise with contractors to arrange access to 4X4 vehicles for transport services if required
- Ensure that additional staff accommodation is available if required
- Cascade weather updates throughout the year including winter.

3. The Trust's Winter Strategy

The winter plan is based on the following strategic aims;

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs
- To work collaboratively with other health and social care providers to effectively manage capacity
- To assess risks to continued service provision and put plans in place to mitigate those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm
- To ensure patients do not wait in any part of the system unless clinically appropriate
- To ensure learning from Winter 2017/18 is incorporated into 2018/19 Winter Plan.

4. Winter planning arrangements

The Trust Operational Lead for winter planning is the Director of Urgent Care in collaboration with the Divisional Senior Management Teams.

The A&E Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity over the winter period. The CHFT Winter Planning Group reports to the A&E Delivery Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

The trust has established an internal Urgent Care Board with membership of all Clinical Directors, this group contributed to and signed off the Trusts Winter plan and associated new schemes a summary of which is in the following table:

CHFT Winter Schemes				
CHFT				
Work stream	**Project Number**	**Project Description**	**KPI's**	**Current known Impact of Scheme**
Frailty	1	Step change capacity of frailty team to support delivery 7/7 for admission avoidance and short LOS and inreach into surgical specialties to reduce stranded and superstranded volumes	Non elective admissions; readmissions following frailty assessment; bed occupancy; 7day access; ECS. Stranded & Superstranded	Reduction in avoidable admissions and readmissions; reduction in bed occupancy by 3%: reduction in superstranded and starnded patient numbers and LOS
Enhanced Paed Consultant Cover 5-9pm 7/7	2	Deployment of additional senior decision maker at CRH for Paediatrics	Paeditaric Breaches, Non elective admissions	Identified following review of Winter 17/18. High volume of Paediatric attendances in evening. Significant vo,lume of paediatric breachs
Phlebotomy	3	Enhanced afternoon Cover	Junior Doctor feedback	Known to directly support junior doctors from direct feedback from 17/18 winter review. Also supports reduced LOS but less tangible to evidence
Transfer Team	4	Deployment of team to manage the transfer of patients from AED to their admitting ward	Reduction in AED breaches by reducing exit block, releases ward nurses to deliver direct care, improved patient experience. Improved staff experience	Strong feedback from winter 187/18 review thast would have improve flow and experience
Management Support for Central Ops	5	Provide additional management support to Central Ops team to improve pace of improvements and provide greater resilience theugh winter were increased 7/7 cover required	Flow and Safer programme	Supports reduction in site variation and provide support to froint line teams in the delivery of winter plans.
Flu testing	6	Point of Care testing in AED for Flu to reduce demand for isolation facilities and enable increased out of hours service	Side room demand, confirmed Flu statistics	Timely flu testing, side room demand, improved patient flow
Weekend Pharmacy enhancement	7	Increase pharmacy technician and prescribing capacity at weekends, secures rapid medicines reconcilliation and supports timely discharge with correct medications. Will also support roll out of Community Pharmacy offer	Medicines reconcilliation, Evening and Monday bottlenecks, readmissions	Review of Winter 17/18 highlighted benefits when out of hours specific experstise in place. Supported junior medical staff in the out of hours period providing more timely interventions with patients and supported overall flow
Private Ambulance	8	Increased responsiveness to discharge and cross site transfer in addition to YAS crews and ability to manage this locally	LOS, patient experience; flow	At times of pressure curent capacity unable to manage all discharges and trabnsfers with urgent cases taking priority. Imoact is exit block from AED which then culminates in ambulance handover breaches so vicious circle
Clinical Coaches	9	Depolyment of senior clinical coaches (Home First team) to support patient pathways reducing LOS and accelerating discharge includng expertise in directory of services and D2A	DTOC; TOC; LOS, ECS, superstranded and stranded	Idenrified from MADE event as a requirement to support local teams with the confidence to accelerate patients pathways and facilitate timely discharge
GP Lens	10	Placement of GPs in critical parts of the system to observe and provide evidence of potential changes to flow	To be developed from the work	Paper presented to AEDB
Rapid Support Fund	11	Fund to be deployed across out of hospital to support timley discharge including, local handiman, cleaning services etc	Reduction in discharge delays, reduced stranded and superstranded	Already known that patients waiting in hospital whilst funding is secured for odd jobs, house cleaning etc
CardioRespiratory Inreach Community Nursing 1	12	Evening and weekend inreach which is an extension to current inreach capacity to support more timely discharge & better support ward staff with complex patients	LOS,patient experience, evening and weekend flow	Current service provision supports LOS reduction but is not available 7days so in particular will help with evening pressures and Monday surge
CardioRespiratory Increach Community Nursing 2	13	As above howwever need to secure basic inreach for core hours before releasing cash for additional to Locala	LOS, patient experience; flow	MADE events evidence delays to discharge and therefore increaed LOS due to fractured pathways and lack of inreach further exascerbated out of hours.

These schemes will be described in more detail through this document

5. Command, control and coordination

During the period 1 November – 29 February, a daily SitRep (Mon-Fri) will be completed for submitting to NHS England by the Health Informatics Service. The Monday SitRep will include details from the preceding weekend. SitReps will be signed off by the Director of Urgent Care/Director of Operations/Deputy Chief Nurse after high level validation with fully validated data submitted daily. Arrangements will be confirmed to ensure that there is adequate cover in case of absence.
A **Winter Room** will be introduced from the beginning of December, led by the Director of Urgent care, Deputy Chief Nurse and Clinical Director of Emergency Medicine. This will be a more robust coordination of the command and control of the operational sites, escalation and actions needed to provide assurance of increased resilience during surge and escalation.

6. The National Escalation Framework

4 Hour Emergency Care Standard Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An Emergency Department (ED) could be experiencing isolated difficulties but the rest of the system is coping well for example there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system, community beds, community services and social care are experiencing high pressures due to a lack of capacity.

Escalation Triggers at Each Level

Local A&E Delivery Boards should align their existing systems to the escalation triggers and terminology used below, and adds to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.**

Local A&E Delivery Boards should be able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.
National terminology (OPEL) has now been adopted and has been used within the Trust throughout 2018.

To ascertain the OPEL status of acute hospitals within Yorkshire, YAS contacts each acute trust. CHFT's Clinical Site Commanders will be contacted by Yorkshire Ambulance Service twice daily either by phone or email firstly at 09:00 each morning and secondly in the afternoon for the new national escalation level (OPEL) status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report.

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Figure 1

OPEL-Winter command and control arrangements (internal)

Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

The three hourly Patient Flow Hospital Meetings chaired by the Clinical Site Commanders involving the patient Flow Team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational actions using a standard operating procedure and escalation policy to manage capacity issues. The level (OPEL) at which the hospitals are working within will be determined at these meetings. The Director of Urgent Care will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

The Director of Urgent Care for Calderdale and Huddersfield Foundation Trust is responsible for representing the Trust at the Calderdale, Kirklees and Wakefield Joint Surge and Escalation meetings where situation reports are shared and healthcare system-wide actions to manage demand and capacity are determined.

Each division and department is responsible for the successful implementation of their escalation plans. In the event that significant pressures are identified the Director of Urgent Care or the Divisional Directors of Operations will decide to implement the Trust Emergency Management Arrangements Strategic (Gold) and Tactical (Silver) and Operational (Bronze).

7. Workforce

Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services over the 7 day period. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover an arrangement especially over the Xmas and New Year period and to ensure annual leave is managed appropriately over this period. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last minute absences will be actioned by on-call, out of hours teams

For Xmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by the 3rd December 2018.

Vaccination

The target for Trust staff to have had the flu vaccine for this year for Calderdale and Huddersfield the ambition is to achieve 100%of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, 'myth busting' and league tables of performance have been advertised on the intranet. Additional groups of staff have been trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.

8. Strengthened Operational Management

Daily support for patient flow from the Clinical Divisions is already in place, additional senior support is provided by the Director of Urgent Care or a Director of Operations as point of escalation and chair of the critical 12pm Patient Flow Meeting. From the beginning of December 2018 until the end of January 2018 there will be a weekly Winter Room introduced that will increase its frequency depending on OPEL to ensure any surge in activity above expected levels are acted upon immediately and provide additional assurance that good control and command is in place.

Throughout the New Year period and for the full month of January the on call a manager will remain on site until 10pm each evening and there will be an additional Manager on site into the OOHs period.

If OPEL 3 is determined through the Winter Room or daily Patient Flow Meetings escalation will be sent out via a digital platform to Clinical colleagues to ensure greater awareness of the escalating position.

Lead Nurse-Patient Flow

Each hospital site will have increased presence of the lead nurses for Patient Flow through the winter period. They will ensure the patient flow meetings will be coordinated in a SMART way, ensuring the Urgent Care Actions Cards are being operationalised daily in collaboration with the divisional clinical and management teams.

Clinical Site Commander

The Clinical Site Commander will effectively manage the Trusts bed capacity, ensuring the patient's journey is safe and their experience is good. They will be the point of escalation if surge is being experienced.

Winter Transport Support Vehicles

We will develop and hold a register of staff and appropriate volunteers that have access to 4x4 vehicles and who can provide assistance with transporting staff to work and home during times when roads are impassable due to adverse weather conditions.

Divisional Operational Winter Teams

There will be a Divisional manager and Matron who will be the leads for winter to support the patient's journey, ensuring safe effective admissions, transfers and discharge. They will attend the Winter Room Meetings

"On call/site manager of the day"& Support Manager

There is an on call manager designated on site daily and an additional support manager working on the opposite acute site.

Duty Matron

There will be a duty matron on site daily.

Reducing Admissions

Ambulatory Care in medicine and Medical Admission avoidance will be available on each hospital site to prevent avoidable medical admissions. Surgical Ambulatory will be available on the HRI site with dedicated additional surgical registrars on specific days over the x-mas and New Year period.

Reducing Delayed

SAFER Patient Flow Transformational Programme is supporting initiatives throughout 2018 to improve flow, prevent avoidable admissions, reduce LOS and improve timely discharges.
Working with senior members of CHFT partner organisations will attend a twice weekly MADE Room (Multi-disciplinary discharge event) from September 2018 which will increase to three times a week over the winter period. The aim is to reduce the number of patients who are medically fit for discharge remaining in hospital, support the reduction in those patients with the longest length of stay and manage those complex discharge pathways in a timely, proactive way, making decisions that more junior staff are unable.

Transfer Team

There will be a transfer team working alongside the Clinical Site Commanders to provide a smooth, timely transfer from ED to the assessment areas and assessment areas to wards. The nursing handover will be completed once the patient arrives on the ward (exclusion criteria in place). This will prevent delays and improve the patients' experience.

Home First Team

A team of senior nurses and therapist are working together with our elderly care clinical teams to support early discharge planning and prevent delays and track and expedite clinical pathways,

Pharmacy

Ward based ATOs will be targeted to high turnover areas to assist with transferring medicines.

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

Enhanced weekend pharmacy service Oct-March to provide additional staff to manage dispensing workload and timely supply of medicines for discharge. To include a limited clinical service and availability of pharmacist prescriber on the Acute Medical Unit at CRH and MAU/short stay at HRI.

Pharmacy Prescribers will provide an enhanced service over weekends.

9. Divisional Winter Plans

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, tracking assumptions against their business plans and understanding the impact transformational work is having.

Medical Divisional Plans

The Medical Division will have completed the new medical staffing rotas for consultants and these will be in place at the beginning of October 2018. These rotas will see an introduction of more specialist weekend reviews. All wards will have a daily ward round. The Medical Division has developed specific plans to provide escalation capacity to meet the expected increased demand on inpatient capacity. With the improvements seen in reducing the longest lengths of stay within the hospital these plans will be operationalised **only** if a surge in activity described in figure 1 impact on operational performance and patient safety. Ward 4 will be the winter escalation ward on the HRI and will be open until the end of March 2019. There is already a substantive workforce in place to cover this ward area as well as the associated infrastructure.

The division will stand down several meetings within the month of January 2019, these will be directorate confirm and support meetings and directorate board meetings. Annual leave will be monitored and planned through an annual leave planning meeting to ensure that cover is appropriate throughout the winter months. This meeting will take place in September 2018. All staff will not complete mandatory training through the month of January, so that they have available capacity to robustly cover ward areas and patient flow issues.

An extra locum consultant will be in place for the month of January to cover medical outliers and extra capacity where required.
The division will hold an 11am huddle to look at any delays in discharge and areas of concern, present at these meetings will be GMs, matrons and the ADN.

Acute Medical Care

Hot clinics:

Diabetes & Endocrine: 7 day service now in place reducing admissions and length of stay for diabetic patients.

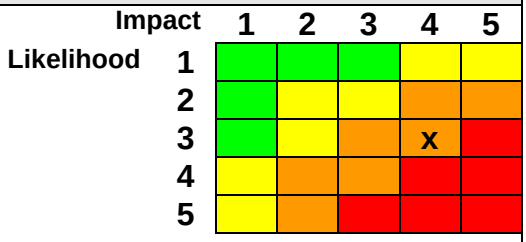
Acute Medical Unit/General Medicine*:* This will be delivered from the Ambulatory Assessment Unit (AAU) on a daily basis by the Acute Medical team. AAU will be extended to provide ambulatory care until 10pm daily on each hospital site Monday to Friday. The referrals from ED will go through a designated acute consultant Monday-Friday 9-5pm. GP referrals will continue in the usual way.
If unexpected surge occurs the ambulatory care unit at CRH will be used for escalation capacity, when this is required the area will have a maximum of 8 inpatients. Patients will be allocated into this area when it assessed that this function is required at the 11am medical division huddle. The consultant on the acute floor at 5pm will then highlight the patients that are suitable to be transferred into this area for an overnight stay.
An acute medical floor will be developed at the HRI site with a collocated frailty/short stay ward.

Care of the Elderly*:* This will be delivered by the Care of the Elderly team who will be on a speciality rota covering the service 7 days a week

There will be a significant extension of frailty services across the Huddersfield Royal Infirmary site. The service will run from 8am-8pm Monday to Sunday and be in place by December 2018. There will be 3 frailty nurses based in ED at HRI daily with increased OT/PT in the team. There will be a frailty Advanced Clinical Practitioner in place to help support the frailty consultant in the ED but also support the ward frailty patients. There will be a frailty nurse based on MAU and a frailty nurse based on SAU.

GP referrals for frailty will commence in December 2018, these patients will be referred via telephone with advice or asked to come to ambulatory for assessment.

Surge in Non-Elective Demand

Overview		
Impact		
• Unpredicted increase activity in ED's, SAUs and MAUs- follow triggers described in the EDs escalation plan • Increase in bed occupancy across the Trust • Increased pressure on community healthcare services to support discharges above predicted • Potential of the need to outlie patients into another speciality. • Greater potential for inpatient outbreaks of infection and outbreaks in nursing homes preventing discharges		
Proactive strategy- Actioned by the Director of Operations		
• Identify flexible beds that can be opened in the short term to support increased admissions and staffing requirements • Trigger escalation- OPEL		
Reactive strategy		
• Use of winter strategy & plan- Winter Room in place • Implement the joint surge and escalation plan- Strategic and Tactical and operational • Activate business continuity plans and escalation plans • Increase inpatient capacity by opening flexible beds as described in divisional plans		
Trigger	**Received by**	**Immediate action**
ED reporting of increased activity	Emergency department matron/manager	• Reallocate junior medical/nursing staff to support the Emergency Department • Establish additional trauma lists as required • Review the availability of trauma surgery equipment • Move from elective beds to trauma as demand dictates • Use of flexible capacity- short term • Surge & Escalation plan actions to be followed • Monitor impact via Winter Room • Review actions and impact from the twice weekly MADE
YAS reporting of increased activity	Emergency department. Patient flow team	
Low temperatures Met Office - proactive	Emergency Planning Officer	• Prepare for increased attendance by patients in the at-risk groups
Community nursing workload	General Manager – Adult Community Nursing	• Review community case load to prioritise at risk patients • Trigger business continuity plans
Assess bed capacity issues in line with regional plan	Director Of Operations	• Implement the escalation policy. • Implement joint partner surge & escalation plan • If required initiate System Tactical Call.
Requirement to expedite discharge	Clinical Site Commander Discharge	• Liaise with YAS to agree priority order for patient movement. • Initiate spot purchasing agreements via LAs • Start discharges with medicines to follow. (Use

	Matron/Discharge Team.	of taxis of transportation of medicines post discharge.) • Use of day rooms and discharge lounges to facilitate expedite discharge. • Discharge thresholds to be challenged.

Figure 1

Escalation Capacity

Division	Escalation Capacity	Trigger & Action	Lead
Medicine	8 escalation beds are planned, using the ambulatory area on the acute flor at CRH	Triggered through the Winter Room Meetings using demand management data/daily predicted discharges after all other admission avoidance has been exhausted. **Risk assessments must be completed.** Daily tracking will be in place and Senior Divisional Team will monitor winter demand. A robust nurse staffing plan will be developed and signed off by the Deputy Chief Nurse. Plan to flex these beds as required (overnight).	Winter Room -Divisional Manager/Matron/Clinical Site Commander. Director of Operations Associate Directors of Nursing

Figure 2

Emergency Department

The Emergency Department (ED) will have;

• Surge triggers developed for ED Consultants that will be implemented to extend the working hours of the consultant until midnight.
• Additional assessment capacity has been created, adjacent to the ED to ensure **all** ambulance and ambulatory major's patients even at

times of surge are seen within 15 minutes through EDIT/WEDIT. This will be managed by the ED team but supported through triggers and escalation (described in the Surge & Escalation Plan) by the hospital matrons providing the required staff.

- Daily analysis of 'reasons for breaches' will be completed and weekly meeting will be chaired by the Emergency Medicine Directorate where a root cause analysis of breaches will be shared with divisional directorate teams and solutions/actions will be agreed to prevent recurrence
- Daily representation at Patient Flow Meetings with consultant attendance at critical pressure points. Actions fed back to the department and two-way communication in place.
- Robust internal Escalation Plans are in place to manage surges in demand and ensure there is a zero tolerance to 12 hour trolley waits.
- In order to improve communication between AMU, ED and site management team, the ED team will strengthen communication via patient flow team by providing an ED update at each Patient Flow Meeting.
- Daily huddle held with coordinators from ED. MAU/AMU, SAU to discuss 'what went well' the day before, with the ethos of 'working together to get results'
- Planned increased medical staffing over the X-mas and New Year period as mitigation against the expected increase in demand especially over the out of hours period .
- The Senior Lead Nurse B7 for each department will be supernumery
- The Frailty Team will work closely with the ED team to ensure all opportunities to support avoidable admissions are taken.
- Urgent Care Action Cards are in place to prevent exit block within ED and any patient waiting on hospital corridors.

Surgical Divisional Plans

The Surgical Division has developed plans to be able to respond to increased non-elective demand, planning to reduce elective activity in Q4, Day Case surgery will be conducted on both sites and also Cancer surgery, Clinically Urgent and time critical cases.

- With the elective plan now being delivered over a 9 month period certain staff groups may be able to be released through quarter 4. This will enable Anaesthetists to provide additional support to patients in the resuscitation area in ED, theatre nurses may also be able to support other ward and departments if they are not required to work in theatre areas
- In addition to current planned trauma lists(19)additional increases in demand will be delivered by following the Trauma Surge Pathway (Appendix 6)

- Additional trauma theatre capacity will be established before and after the Bank Holidays
- Trauma list provision will continue, as normal on the Bank Holiday days.
- Current medical workforce on SAU will be increased with an additional middle grade to minimise impact on patient flow. Improved timely access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre.
- Increased Frailty team input and extended hours to provide support on the SAU to support/expedite discharge

Elective Orthopaedic activity

The surgical division will continue to deliver elective inpatient orthopaedic surgery as planned through the winter period.

From January 2 the Surgical Division will introduce additional Laparoscopy Cholecystectomy lists when an Upper GI Surgeon is on CEPOD week. This will improve the scheduling of acute/emergency patients with cholecystitis based on clinical urgency, over and above the CEPOD list. This will improve length of stay for these patients, prevent readmission and improve patient experience.

The Division have progressively moved more work to day-case this year, thereby further reducing the risk of elective cancellations.

Central Operations (COT)

Lead Nurses for the COT will provide cross site cover into the Patient Flow Team over the x-mas and New Year period

Discharge Coordinators

- A daily huddle will be introduced to focus resource of the team when triggers on any specific pending delays occur this must be without reducing the robust management of the complex discharges. Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service.
- A process for linking GP practices with MDTs will be introduced to ensure primary care support for complex discharges.
- Weekly ‘stranded patient’ meeting will be in place to prevent any clinical delays.

Patient Flow Team

- There will a Digital Operations centre developed on each acute hospital site to be the hub for all Patient Flow Meetings and as required for escalation meetings using learning from EPR go live.
- The Winter Room will be in place twice weekly with cross Divisional colleagues chaired by the Director of Urgent Care/Deputy Chief Nurse/Clinical Director of Emergency Medicine, share information on divisional issues/risks affecting patients flowing through the hospital in a safe and effective way. To then agree solutions and implement supplemental actions to address these.
- A cross divisional QIA Panel will be in place to review all x-mas and New Year rosters. Panel consisting of Deputy Chief Nurse and the Associate Directors of Nursing for each division. A daily Nurse Staffing Assurance Panel will then be in place to monitor.
- Introduction of an Internal Transfer team to aid timely transfer between ED, assessment units and wards.
- An additional transport service will be available managed through the Clinical Site Commanders to support discharge and inter-hospital transfers.

Discharge Planning

- Implement the 8 High Impact Changes to improving Patient flow and discharge.
- Twice weekly MADE Room triggering into three times a week if required with Director level attendance from partner organisations at this point.
- Increased task management will be in place each afternoon from January-March 2019

Family & Specialist Services

Paediatrics

- During the winter period the Matron for the service continues to undertake a daily situation report and will risk assess situations regarding staffing and activity on the Paediatric ward, to support and underpin this there is an Escalation Plan in place (Appendix 2)
- Continued support to the paediatric stream in the Emergency Departments (ED) with Paediatric Nurse Practitioners during surge in both EDs and planned at Huddersfield Royal Infirmary (Appendix 3).
- The Paediatric ward operates on a workforce model that accounts for surge during the winter period which strengthens nurse staffing and leadership during the winter period with the plan to have a senior Nurse Band 6 and 7 working clinically across all shifts.
- From a medical prospective the following actions will be taken between Nov and Feb to support winter pressures
    a. The Consultant scheduled for ward 18 HRI will cover in the morning and will if appropriate to undertake a virtual round of ward 18

patients by phone utilising EPR this will ensure they are available to help on the ward round on the ward 3 CRH – to improve flow and timely discharge at times of peak activity..

b. For the winter period to relocate safeguarding medicals back to CRH outpatients. To ensure that if the consultant has no scheduled medicals, they will be on site and can be deployed to support flow on the children's ward
c. To consider utilising APNPs and ANNP's to support gaps on the medical rotas, especially twilights and nights.
d. To utilise the winter locum consultant additional PA to cover twilight shifts which is peak time for patients attending ED and the assessment unit

Maternity

- Escalation Plan (Appendix 4)

Diagnostics

- There will be daily attendance in the Patient Flow meetings of Operational management from FSS to support flow, support prioritisation of diagnostics during increased demand.

Radiology

- There will be a central contact point for in-hours escalation of specific issues – contact details will be made available to flow teams in advance of the winter period.
- A second on-call system for the Emergency Department X-ray will enable extra capacity OOH during periods of exceptional demand throughout the winter period (Nov to Mar), triggers will be agreed with the ED team.

Gynaecology

During the winter period the activity theatre plan has been planned to ensure the surge in medical winter emergency activity is supported.

In addition prior to transferring to ward 4C the patient must be assessed against essential criteria as outlined below (appendix4)

Community Division

CHFT Community Division accesses on-call support via the Trust on-call rota.

The community division manager will be the first point of contact for Community staff and staff escalating a concern about responsiveness of community services out-of-

hours and the on- call divisional manager will escalate to the Trust on-call manager and on-call Director for support if the situation cannot be managed locally.

On-call staff can be accessed by contacting Calderdale switchboard on **01422 357171.** All staff are made aware of the route to access on-call staff.

Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:-**

- District Nursing priority one patients
- Blocked catheters
- Administration of medications including IV therapy
- Support for discharge out of hospital
- Palliative Care
- Crisis Intervention Team
- Intermediate Care bed base
- IV Therapy priority one patients
- Palliative care priority one patients
- Gateway to Care
- Quest Matron support to Care Homes
- Community Respiratory Service
- Community Heart Failure Service

Community Services Available

Gateway to Care

The service supports the co-ordination of intermediate care services and prevention of hospital admissions. The service accepts patient referrals from GPs, community clinicians, Social Workers and patients.

Referral should be made to Gateway to Care for the following services:-

- Crisis Intervention Team
- Community Rehabilitation Team including Stroke early Supported Discharge Team, Falls Prevention Team
- Intermediate Care Beds
- Heatherstones

Hours of Operation	8.45am-5.30pm Monday to Thursday and 8.45am-5.00pm Friday
Contact Details	01422 393000

Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases i.e.

Brackenbed View (32 beds) or Ferney Lea (12 beds) and Heatherstones (12 apartments)

The Service Aims to:-

- Promote a faster recovery from illness
- Prevent unnecessary presentation and admission to an acute hospital bed
- Prevent premature and unnecessary admission to long term care
- Maintain independence as long as possible

Service Criteria:

- Service user/patient must be over 18 years of age
- Medically stable
- A resident of Calderdale or Registered with a Calderdale GP
- Consent to rehabilitation

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Muir Botterill
Contact Details	07810290657 (for IMC Beds)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and level of care required to enable them to cope long term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 8.00am – 9.45pm 7 day service
Lead Manager	June Warman
Contact Details	01422 392229

Reablement

The reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8.00am-9.00pm, 7 day service
Lead Manager	Tracey Proctor
Contact Details	07748 797896

Reablement Team	Allocator	Contact number
Lower Valley	Julia Green	01484 728943
Upper Valley	Stephanie Brooks	01422 264640
Central	Jo-Anne Rice	01422 383584

Enhanced Reablement

The Enhanced Reablement service provides early supported discharge for patients requiring a period of rehabilitation supported by therapists but who could manage in their own home

Reablement is offered for up to 4 visits a day for up to a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual

Hours of Operation	8am – 4pm
Lead Manager	Clare Folan
Contact Details	07879447218

Crisis Intervention Team

Crisis Intervention Team will provide support to someone in crisis in their own home for up to 72 hours. For example if someone is struggling in their own home after a

fall, or discharge from hospital where packages of care cannot start immediately. They also assess suitability for intermediate care beds. They are a responsive service and will assess within 2 hours for urgent referrals and 24-48 hours for routine referrals.

The team consists of nurses and a physiotherapist who undertakes assessments and set care plans. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care.

Hours of Operation Assessors	8.00am–7.00pm 7 days a week
Reablement Service Work	8.00am-9.00pm 7 days a week
Lead Nurse	Susan Johnson
Contact Details	01422 307333/07917 106263

End of Life Out-of-Hours Crisis Team

This is collaboration between Overgate Hospice, Marie Curie and CHFT. This small team provide crisis support to people out of hours who are near the end of their life. The Specialist Palliative Nurse supports the person with symptom control, physical and emotional support and works with a Marie Curie Support Worker. They provide support to the person, carers and families.

Hours of Operation	7 day service
Lead Nurse	Abbie Thompson
Contact Details (9am-5pm Mon-Fri)	01422 310874
Contact Details (Out-of-Hours)	07917 106263 Out-of-Hours Service/ 01422 379151

OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals
- Commissioned for 12 administrations a day
- Compatible drugs need to be administered within 30 minutes

Hours of Operation	7 day/24 hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7 day/24 hour service
Contact Details Core Hours (8am-6pm)	07917 106263
Contact Details Evening/Night (6pm-8am)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT have established a multi-disciplinary team consisting of Community Matrons, pharmacist, therapist and consultant Geriatrician who caseload residents in all Residential and Nursing Homes in Calderdale. This scheme's main role is to reduce the number of calls made to General Practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the Care Homes.

The team have a responsive function to the Care Homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education.

The pharmacist role has greatly helped with reviewing patient medication, reduction in poly- pharmacy and education and training of care home staff.

Hours of Operation	9am-6pm, 7 days a week
Lead	Liz Morley
Contact Details	07917 086450

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	8.30am-4.30pm, Mon-Fri
Lead	Andrea Beevers

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health Centre	Beverley Jessop Sarah Howden	07795 252396 07901 518171
Lower Valley	Church Lane Surgery Rastrick	Rachel Clegg/ Sheila Kalanovic Mandy Kazmieski	07795 801112 07795 825037 07795 825084
South Halifax	Stainland	Andrea Beevers Jenny Dyson	07795 825139 MAT LEAVE
North Halifax	Beechwood	Julie Norris Victoria Smith	07770 734748 07584 522297
Halifax Central	Lister Lane	Sheryl McGinn/Louise Watson	07769 365247 07717 347547

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Continence	7.00am-4.30pm Mon-Fri	Sharon Holroyd	01422 252086
Respiratory	8.30am-4.30pm 7 days/Week	Sue Scriven	01422 307328
Heart Failure **Cardiac Rehab**	9.30am-5.30pm Mon-Fri 7.30am-4.30pm Mon-Fri	Ian Ormerod Caroline Lane	07500 553892 01422 224260/ 07713 739144
Parkinson's	9.00am-5.00pm Mon-Fri	Paula Roberts	01484 712515
TB	9.00am-5.00pm Mon-Fri	Mary Hardcastle Dale Richardson	07824 343770 07795 825070 01422 307307
Lymphoedema	9.00am-5.00pm Mon-Fri	Sarah Wilson	01422 350755

Respiratory Team

During the winter period the Respiratory team will increase their working hours until 8pm and double capacity at the weekend to have 2 members of staff instead of one. This will enable the team to provide further focus upon key services offered to reduce pressures on the hospital

- ESD – facilitating patients going home as soon as possible with support from the respiratory team 7 days a week
- Admission avoidance from ED 7 days a week, 9am-8pm
- Crisis management for community patients via the SPA. Direct telephone access for patients 7 days a week
- Admission avoidance from the community 7 days a week

Hours of Operation	8.30am-4.30pm 7 days a week
Lead Nurse	Sue Scriven
Contact Details	01422 835193

Cardiac Rehabilitation Services

There will be increased capacity by a further 30 hours which will support extended working hours Monday – Thursday supporting the Cath Lab until 6pm. This will allow the team to facilitate earlier discharges. When the Cath Lab sessions are scheduled for Saturdays this will be mirrored by the team facilitating patient flow. In focusing upon facilitating earlier discharges this would also allow the team to offer Cardiac rehab at the weekend which could reduce readmissions.

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Sally Grose
Contact Details	01422 358146

Elective Orthopaedic Rehabilitation

The EOR service facilitates a smooth discharge home from the orthopaedic unit at Calderdale Royal Hospital. Most people are medically fit and safely mobile enough to return home within a few days following joint surgery to replace a hip or knee. Rehabilitation is started on the ward by EOR and continues following discharge home. EOR assess, advise and offer treatment, enabling a timely recovery and return to independence. This includes an exercise programme to gain improvement with walking, both indoors and out. Any equipment previously supplied is assessed to ensure it is still appropriate and if required, new equipment is provided.

Hours of Operation	8.00am-4.00pm, 7 day service
Lead Manager	Sophie Box
Contact Details	01422 223554

Outpatient Physiotherapy

The role of the Out-Patient Physiotherapy service is to help people aged 13 and over manage their pain and dysfunction as a result of a musculoskeletal condition and injury. We also give advice and education to prevent risk of further injury and to help people enjoy a more full and healthy life.

Hours of Operation	7.15am-7.30pm dependent on site Mon - Fri

Community Falls Service

The Falls Prevention Team is part of the Support and Independence Team who assess and advise people over the age of 50 who have had a fall or who are worried about their balance and frightened of falling. The team raise public awareness of falls and how to prevent them, identify older people who are at risk of falling using a simple five question screening tool, undertake detailed falls risk screening and refer patients to appropriate services to help, manage the risk of falling, provide education and advice to older people including advice on physical activity, diet, footwear and environmental hazards. The team provide strength and balance groups in local settings and /or tailored exercises in older people's homes.

Hours of Operation	8.30am-5.00pm, 5 day service
Lead Therapist	Claire Folan
Contact Details	07879 447218

Senior Managers in Community Division

Senior manager contact details are as follows:-

Name	**Role**	**Work mobile**
Andrea Dauris	Director of Operations	07920 251715
Nicola Ventress	Assistant Director of Finance/ Deputy Director of Operations	07765 306617
Liz Morley	Associate Director of Nursing	07747 630989
Debbie Wolfe	Head of Therapies and Service Manager for OP Physio, MSK, Podiatry, Orthotics, Speech and Language Therapy, Dietetics Children's Therapies	07825 902363

Caroline Lane	Matron for Community Nursing	07713739144
Mandy Gibbons-Phelan	Matron for Specialist Nursing	07795 825137

Transportation and 4X4 Vehicles in Severe Weather

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. The Estates Department have access to a 4X4 vehicle. The Hospital Transport Service can also arrange to hire 4X4 vehicles through their vehicle contractor, Arrow.

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale Royal Hospital patients based at the Community Support Centre, Salterhebble.

Loan Stores Hours of Operation	8.00am-4.30pm Monday-Friday 8.00am-12.00pm Saturday
Lead Manager	Andrew Mould
Contact Details	01422 306725

Escalation plans and business continuity plans

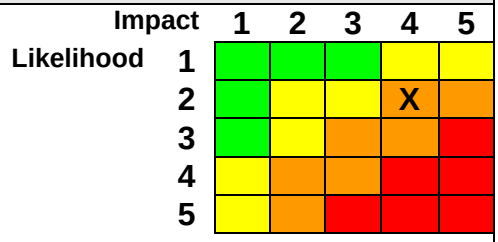
There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet, the ED and Paediatric escalation plan will be included in the On Call Managers Pack.

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of Consultants that are off at any one time over this period.

10. Severe Winter Weather

Overview	
Business Impact	
• Absence of staff because they cannot get to work • Difficulty for staff and patients to travel around and between sites • Difficulty for community staff to access patients homes • Increase in minor injuries from slips, trips and falls • Reduced patient transport service • Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities • Difficulty for suppliers to get supplies to hospital	
Proactive strategy	
• Adverse winter weather plan in place and reviewed. • Weather forecasts and gritting information published on the local authority websites. • Stockpile of salt/grit for car parks and access ways to Hospital sites. • Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes. • Yorkshire Ambulance Service winter plan. • Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work. • Community staff advised to work to nearest location to their homes	
Reactive strategy	
• Implement flexible working arrangements where possible (adult community nursing) • Implement the joint surge and escalation plan • Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible). • Provide accommodation for essential staff who cannot get home from work • Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)	

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Estates/Associate Director of Urgent Care	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges • The Calderdale & Huddersfield Solutions have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Commander	
Significant number of out-patient DNA	Outpatient manager	
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

Cold Weather Alerts

Alert trigger	Trust Actions
OPEL 1 Winter Preparedness	• Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness • Plan for a winter surge in demand for services • Identify those at risk on your caseload
OPEL 2 Alert and readiness (60% risk of severe weather)	• Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity plans • Identify those most at risk • Check client's room temperature when visiting
OPEL 3 Severe Weather Action	• Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that staff can help and advise clients • Signpost clients to appropriate benefits • Maintain business continuity

OPEL 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days	• Activate emergency management arrangements • Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that the hospital sites are kept clear and accessible • Maintain business continuity

Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at –

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating “gritter twitter” this winter which gives real time information on the council’s response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to open. The link to twitter is can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

Managing absence

The Trust Adverse Winter Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential have difficulty getting to work and there are no alternate travel options including car sharing or public transport it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

Useful contact information

Organisation	Contact Name	Telephone / Email
4X4 Response	24hr call out number	Available in patient flow office
British Red Cross		
Calderdale Council Highways		01422 288002
		OOH 01422 288000
Calderdale Council Emergency Planning Team		01422 393134
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council Highways		01484 414818
St John Ambulance		
	24hr pager	Via switchboard

11. Seasonal influenza

Overview						
Business Impact						
• Absence of staff due to influenza illness	**Impact**	**1**	**2**	**3**	**4**	**5**

• Spread of the virus to staff due to ineffective use of personal protective equipment • Lack of available supplies of personal protective equipment • Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas • Lack of available side rooms to isolate infectious patients • Lack of available capacity on intensive care units to treat flu patients with serious illness • Closure of ward areas and loss of bed days due to outbreaks of infection • Increased monitoring and reporting requirements for flu-related activity	**Likelihood** 

Proactive strategy

• Immunise staff for seasonal flu
• Community staff continue support people to stay at home
• Restate the risks and infection control requirements for managing flu patients
• Key messages reinforced by community staff
• Purchase additional supplies of face masks, gowns and goggles
• Create and manage a stockpile of FFP3 masks
• Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in A&E, ICU, Respiratory and MAU)
• Near patient testing in A&E for patients with suspected seasonal flu

Reactive strategy

• Promote key flu messages for patients (if you've got flu, stay at home)
• Follow standard infection control precautions for managing flu patients
• Reassign or redeploy staff in high-risk groups as appropriate
• Implement the joint surge and escalation plan
• Implement the escalation plan for critical care if required

Trigger	Received by	Immediate action
DH reporting - proactive	DIPC	• Alert forwarded by email rule to Director of Operations, Chief Nurse, Director of Infection Prevention and Control. • Staff in the Emergency Departments and out patient departments will remind relevant patients to have their flu jabs if they have not already done so. • Implement management of flu arrangements.
Surge in flu related activity	ED matron/CD	
Surge in flu admissions	Infection control team	

Infection Control

There will be near patient testing provided in the Emergency Department (ED) for patients with suspected seasonal flu. Patients that require admission with suspected or confirmed influenza should be nursed in a side room with the door closed. A respiratory isolation sign should be displayed (further information on isolation of patients is available in the isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area.

Some members of staff will be at greater risk from flu because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols.

Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, gowns and eye protection will be established on each site. The stockpile will be managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks, gowns and eye protection are only required by staff performing cough inducing procedures for patients with suspected or confirmed influenza. FFP3 respirators must be used as an alternative to a surgical face mask when performing the following procedures.

- intubation and related procedures, e.g. manual ventilation and ET tube suctioning
- cardiopulmonary resuscitation
- bronchoscopy
- surgery and post-mortem procedures in which high-speed devices are used.

Staff performing these types of procedures will include ED medical staff, Anaesthetists and Intensivists, respiratory physicians, medical physicians, physiotherapists (chest) and some nursing staff in ICU, respiratory and MAU. Other wards and departments should not routinely stock these masks.

FFP3 masks are held on wards 1, 6, 11, 18, ICU, SAU, Emergency Department at HRI; wards 2AB, MAU, 3, 5, ICU and Emergency Department at CRH); A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.
A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.

Fit Testing For FFP3 Masks

Prior to using a face mask respirator the user must first test that an air-tight seal can be attained. Face masks come in various shape sizes so users can determine the most effective.

There are fit test kits on all ward areas within the Trust. Fit test kits will be used to fit test initially. It is the responsibility of leads in each of the areas identified to fit test their staff, that perform aerosolizing procedures, and to record the type of mask that they require. For those staff that have been fit tested need adding onto the equipment training database to ensure an accurate training record is maintained.

Where a member or staff does not successfully fit test with the mask in the central stock areas (wards 1, 5, 6, 18, ICU, SAU, Emergency Departments at HRI; wards 2AB, MAU, 3, CCU, ICU and Emergency Department at CRH); or a reusable mask held by the ward or department, each management team must put in place appropriate risk mitigation measures to protect the member of staff from contracting the flu virus at work. This may involve:

- Purchasing an alternative model of mask (if available)
- Reassigning to an alternative task
- Redeploying to a different area where they will not be required to perform aerosolising procedures with flu patients

FFP3 portable hood systems have been purchased for use in the emergency departments on both sites. Training is being undertaken in both ED's in the use of the FFP3 hood systems.

Critical Care Escalation Plan

The Local Critical Care Network has developed a critical care network escalation plan that includes triggers and escalation levels (see appendix 2). The Trust Critical Care Escalation Plan details the arrangements for increasing level 3 capacity in the event of a surge in demand.

12. Christmas and New Year Bank Holidays

Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on callpack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the

Christmas and Bank Holiday period will be again available for the on call teams over the Christmas and New Year period.

Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

Communications

The communications team will issue media statements during winter to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

Training and Implementation of the Winter Plan

The winter planning group is overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by;

- Involvement of leads from each division in winter planning group
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news;
- Publication of related documents on the Preparing for Emergencies section of the staff intranet;
- Publication of the plan on the Trust intranet; and,
- Winter Plan briefings for Managers, Directors, Matrons, Ward/department sisters from October 2018.
- To improve capability and resilience in CHFT senior management/clinical teams there will be a number of Table top exercises to test surge and escalation, the winter plan and major incident plans.

Equality Impact Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement service policies and measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Monitoring Compliance with this procedural document

The winter planning group is responsible for the successful implementation and monitoring of the winter plan. The winter planning group will continue monitor the plan (October 2018 to March 2018) to review its effectiveness and update the document where appropriate.

Associated Documents/Further Reading- Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use.

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge policy/Transfer of Care policy

There are also some whole system plans that will be implemented as appropriate:

g. Joint Surge and Escalation & Winter Plan

Appendix 1: Criteria and SOP for open and referral to flexible capacity

Checklist on opening additional beds.docm

Paediatric Escalation Plan, Advanced Paediatric Nurse Practitioner Escalation Plan and Maternity Escalation Policy

Appendices 2, 3, 4, 5 & 6

2

2016__Feb__-_Paediatric_Escalation_-_v3

3

2016__Sept__-_APNP_escalation_process

4

Escalation Policy (Maternity).pdf

5

180829 2018-19 Calderdale and Greate

6

HRI trauma surge pathway.docx

13. Gosport Report

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday 1 November 2018	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: GOSPORT REPORT: Assurance re: clinical governance systems - This report responds to specific questions asked by NHS Improvement about patient safety and openness following the report into deaths at Gosport War Memorial Hospital.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee 3 September 2018 - report presented to Quality Committee with embedded documents to support the assessment, many of which had previously been presented to the Board.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report provides information and assurance regarding the effectiveness of clinical governance systems across the Trust. It responds to specific questions asked by NHS Improvement about patient safety and openness following the report into deaths at Gosport War Memorial Hospital. Assurance is given on six of the eight areas, with two areas requiring further work.

Main Body

Purpose:

The Trust has reviewed all eight areas of assurance on the effectiveness of clinical governance systems identified by NHS Improvement - these eight areas being:

1. Working practices on particular ward areas – “the way we do it around here”. Is it within agreed norms?
2. Response to patient/ relative concerns – collation of repeated themes/ clinician/ clinical area
3. Response to staff concerns/ whistleblowers/ Freedom to Speak Up guardians
4. Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and MHPS investigation if indicated
5. Medical appraisal; 360 feedback
6. Accuracy of death certification/ understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding)/ learning from deaths - Structured judgement reviews
7. Controlled Drug use and scrutiny of high usage areas
8. Meaningful audits on the standard of care

Assurance is given in the report for six of the eight areas regarding the effectiveness of clinical governance systems in response to the Gosport report, with two areas identified as needing ongoing work to be fully assured that systems are effective. These two areas are responding to staff concerns, (area 3) and controlled drugs (area 7).

Background/Overview:

The Gosport report published in June 2018 highlighted concerns about patient safety and openness at Gosport War Memorial Hospital between 1987 and 2001 which led to shortened lives of patients. 456 people died following prescribing of opioids which were made “without medical justification”, with potentially up to another 200 patients affected.

Whilst the report relates to care provided up to 27 years ago the Gosport report prompts all Trusts to consider the effectiveness of their clinical governance arrangements, reviewing eight areas of assurance identified by NHS Improvement.

The enclosed report provides a summary position (reality) against each of eight areas of assurance raised by NHS Improvement with a RAG rating. Where further work has been identified from the Gosport review this is stated in the response column.

The report provides detailed information and evidence in relation to each of the eight areas of assurance being sought by NHS Improvement.

The Issue:

The Gosport report published in June 2018 highlighted concerns about patient safety and openness at Gosport War Memorial Hospital between 1987 and 2001 which led to shortened lives of patients. 456 people died following prescribing of opioids which were made “without medical justification”, with potentially up to another 200 patients affected. The report describes how concerns from staff and families were ignored and

a range of agencies involved did not work together.

The inquiry found:

• A disregard for human life
• An institutionalised regime of prescribing and administering dangerous doses of medication.

The report can be found at:

https://www.gosportpanel.independent.gov.uk/panel-report/

Whilst the report relates to care provided up to 27 years ago and there have been many changes to the governance and regulatory landscape over this time, the Gosport report prompts all Trusts to consider the effectiveness of their clinical governance arrangements, and in particular :

• Has or could a similar event happen today in the organisation ?
• Are there any further changes needed ?

This paper and report outlines the Trust position in relation to eight areas of assurance NHS Improvement has asked Trusts to consider. The approach taken to assessing assurance has been to discuss each area with the key lead and to review the evidence, to allow a judgement to be made whether “all is well”.

The Gosport report recommends that all Trusts cease to use Graesby ambulatory syringe drivers.On 28 June 2018 NHS Improvement wrote to all NHS Trusts seeking assurance that none of the old style Graesby ambulatory syringe drivers, that worked by measuring millimetres of syringe length, were still in use. These rapidly dispensed opiates into a patient’s bloodstream. The Director of Nursing responded to NHS Improvement confirming that the Trust does not use the Graesby syringe drivers.

Next Steps:

Freedom to Speak Up Process
There is ongoing work to deliver the identified CQC action relating to improving the effectiveness of Freedom to Speak Up processes, including policy review, communications strategy and confirmation of new Guardian. Further details are given in the report. .

Controlled Drugs
A controlled drugs (CD) sub group has been established as a sub group of the Medication Safety and Compliance Group.

A report on syringe driver usage from EPR has been requested by Pharmacy.

A meeting with the Chief Pharmacist and senior nurses is planned. The Chief Pharmacist recently attended a national controlled drugs conference which discussed the Gosport report and the importance of assurance that guidelines are followed and good practice delivered.

There is currently no system within the Trust to monitor unusual patterns of opioid prescribing practice. A tool, AIDOS, has been tested and identified one spike on ward 6, however the tool requires funding of £5k and VAT.

Other actions locally include training with pharmacists to ensure they are confident in palliative care prescribing and have a clear understanding of anticipatory medicines, streamlining audits of controlled drugs and re-focussing these to review appropriate clinical use.

Recommendations:

The Board is requested to note the contents of this report which provides assurance regarding internal governance arrangements in response to the Gosport report, noting further work is underway in relation to responding to concerns from staff and controlled drugs.

Appendix

Attachment:

B papers for Board 1 11 18 - Gosport report word final 23 10 18 to supplement B papers.pdf

Board	
PAPER TITLE: GOSPORT REPORT: Assurance re: clinical governance systems	**REPORTING AUTHOR:** Andrea McCourt, Head of Governance and Risk
DATE OF MEETING: Thursday 1 November 2018	**SPONSORING DIRECTOR:** Jackie Murphy, Director of Nursing
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care	**ACTIONS REQUESTED:** • For information / assurance
PREVIOUS FORUMS: Quality Committee 3 September 2018	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link: http://nww.cht.nhs.uk/index.php?id=12474**	

This report provides information and assurance regarding the effectiveness of clinical governance systems across the Trust. It responds to specific questions asked by NHS Improvement about patient safety and openness following the report into deaths at Gosport War Memorial Hospital. Assurance is given on six of the eight areas, with two areas requiring further work.

1. RESULT, REALITY, RESPONSE

1.1 RESULT

The result we are seeking is to ensure that the Trust has effective clinical governance systems in place in relation to the eight areas of assurance requested by NHS Improvement following the Gosport report to ensure that a similar situation could not occur within the Trust. These eight areas are:

1. Working practices on particular ward areas – "the way we do it around here". Is it within agreed norms?
2. Response to patient/ relative concerns – collation of repeated themes/ clinician/ clinical area
3. Response to staff concerns/ whistleblowers/ Freedom to Speak Up guardians
4. Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and MHPS investigation if indicated
5. Medical appraisal; 360 feedback
6. Accuracy of death certification/ understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding)/ learning from deaths - Structured judgement reviews
7. Controlled Drug use and scrutiny of high usage areas
8. Meaningful audits on the standard of care

1.2 REALITY

1.2.1. Governance and regulatory changes since the events in Gosport:

The landscape of governance and regulation has shifted since the events in Gosport up to 27 years ago. The key changes in regulation and governance are described below:

- **Clinical Governance Structures**
  Clinical governance was introduced as a concept into the NHS in the mid 1990s and is the system through which the Trust is accountable for continually improving the quality of services and safeguarding high standards of care. The Trust has a governance structure in place to ensure effective clinical governance, with the Quality Committee and Audit and Risk Committee being the key Board Committees with responsibility for clinical governance.

- **Care Quality Commission** (CQC) was established in 2009 to provide independent assurance on the quality and safety of care provided to patients across health and social care.

  The Trust has received a "good" overall rating from the CQC following a well-led inspection by the CQC in April 2018.

- **NHS Never Event and Patient Safety Incident Framework**

  The Trust has systems and processes in place to work within the national framework for reporting patient safety incidents and never events. One never event was declared in 2017/18, and 58 serious incidents were reported and fully investigated in 2017/18. None of these serious incidents related to controlled drugs.

- **Complaints legislation** revised in 2009, CQC regulation 16 introduced to ensure people can make a complaint about their care and treatment in 2014

- **Duty of Candour** – a legal duty was introduced by the CQC, regulation 20, in 2014, to inform patients and families when there have been problems with care which have caused harm – this was a recommendation from the Francis report into failings at the Mid Staffordshire Foundation Trust. The Trust has a Being Open /Duty of Candour policy and monitors compliance with duty of candour through monthly performance reports to Board.

- **Healthcare Services Investigation Branch** – is an independent team of experience investigators established in 2017, to investigate safety incidents across the whole healthcare system.

- **Controlled drugs accountable officer (CDAO**) – this role was introduced as statutory requirement by the 2007 Health Act, following the Shipman report. The role has increased the focus on safe use and secure handling of controlled drugs. The Trust's Chief Pharmacist is the CDAO.

  Assurance of safe use of opioid medications has developed over the past 20 years. Professional responsibilities of pharmacists include validation of prescribed medication to ensure that medicine choice, dose and route of administration are appropriate. In 2014 the role of Medication Safety Officer was introduced nationally to improve reporting of medication errors and learning from these.

- **Maintaining High Professional Standards** – in 2005 the Department of Health introduced new arrangements for handling issues about medical staff performance. NCAS, the National Clinical Assessment Service, supports Trusts in resolving concerns about professional practice.

- **Revalidation** processes were introduced nationally to demonstrate fitness to practise to renew professional registration. Medical revalidation for doctors was introduced in 2012, for nurses and midwives in 2016. The Trust has an appointed Responsible Officer (RO) for doctors and the RO is responsible for local revalidation arrangements. Further detail on Trust revalidation processes is given in Appendix 2.

- **Freedom to Speak Up** – again a recommendation following the Francis report and "Freedom to Speak Up" review in 2015, the Freedom to speak up: raising concerns policy for the NHS was introduced to develop a more open and supportive culture that encourages staff to raise any issues of patient care quality or safety. Further details on this are given at Appendix 2.

- **Learning from Deaths** guidance – this provides a framework for NHS Trusts to identify, report, investigate and learn from deaths in care and new national requirements were introduced in 2017. The Trust has been investigating selected deaths since 2014 to learn from these. Further detail on current arrangements for learning from deaths is given in Appendix 2.

- **Medical Examiners** – as part of reform of death certification processes, from April 2019 medical examiners will scrutinise every death, checking every death certificate issued by treating doctors for accuracy and compliance, with Coroner notification obligations

1.2.2. Trust - Reality – External Assurance

Many external organisations provide an independent perspective of the Trust and a number of these are referred to in Appendix 2 where relevant to the area of assurance.

As noted above the CQC provides independent assurance on the quality and safety of care provided to patients. The outcome of the recent CQC well-led inspection, which took place in April 2018, led to the Trust being given an overall Trust rating of "good" by the CQC. A summary of the key findings is given below, with the comment on an open culture being particularly pertinent to this review:

Calderdale and Huddersfield NHS Foundation Trust

We've been inspected and rated by CQC as...

Good

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jun 2018	Good ↑ Jun 2018	Good ↔ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018

The Trust has developed an action plan to respond to the recommendations from the 2018 inspection and progress with the delivery of these is monitored by the CQC and through divisional governance arrangements.

1.2.3. Trust - Reality – Internal Assurance

Use of Graesby Ambulatory Syringe Drivers
The Gosport report recommends that all Trusts cease to use Graesby ambulatory syringe drivers.

On 28 June 2018 NHS Improvement wrote to all NHS Trusts seeking assurance that none of the old style Graesby ambulatory syringe drivers, that worked by measuring millimetres of syringe length, were still in use. These rapidly dispensed opiates into a patient's bloodstream.

The Director of Nursing responded to NHS Improvement confirming that the Trust does not use the Graesby syringe drivers and uses McKinleyT34 syringe drivers. This was based on a check by the medical devices team that CHFT do not have any of the Graseby MS16/MS26 syringe drivers in circulation according to their database. These were replaced in 2011, including community based ones, with the CME Medical T34 syringe driver. This followed an NPSA rapid response report from 2010 to end the use of old style MS16/MS26 syringe drives and move to using ambulatory syringe drivers with additional safety features.

Appendix 1 provides a RAG rating for each of the 8 areas that assurance is being sought. This is summarised in the table below. Assurance is provided for six of the eight areas, with two of the eight areas, responding to staff concerns (3) and controlled drugs (7) requiring further work / assurance before a significant assurance rating can be given.

Appendix 2 provides detailed evidence to support the assurance rating for each of the eight areas.

No.	Area	NHS Improvement assurance area
1	**Culture of Care**	Working practices on particular ward areas – "the way we do it around here". Is it within agreed norms?
2	**Responding to Concerns**	Response to patient/ relative concerns – collation of repeated themes/ clinician/ clinical area
3	**Responding to Concerns**	Response to staff concerns/ whistleblowers/ Freedom to Speak Up guardians

4	**Managing Doctors**	Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and MHPS (maintaining high professional standards) investigation if indicated
5	**Managing Doctors**	Medical appraisal; 360 feedback
6	**Mortality Review / Death Certification**	Accuracy of death certification/ understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding)/ learning from deaths - Structured judgement reviews
7	**Controlled Drugs**	Controlled Drug use and scrutiny of high usage areas
8	**Review of Care**	Meaningful audits on the standard of care

Ratings are based on the following:

Green: significant assurance that there is a good system of internal control operating effectively
Amber – limited assurance that some elements of the system of internal control are operating, improvements are required

1.3 RESPONSE
The following actions are being taken following this internal assurance review:

Internal Audit
Internal audit was commissioned to:

- review case notes of 20 patients, including and whether the individualised care of the dying process (ICODD) is adhered to ensuring opioids are administered at the correct dosage in line with the Medicines Code (section 11/13). The internal audit reference for this end of life review is CH/07/2019 Gosport Review

- review of death certification, CH/08/2019.

Draft reports of these audits have been received, with limited assurance opinions given for both reports. The reports and recommendations are currently being reviewed by the Director of Nursing and colleagues. Following agreement of the reports, progress in delivering recommendations will be monitored internally, by the End of Life Group and the Deputy Director of Nursing for the end of life audit (CH/07/2019) and by the Associate Medical Director for the death certification report (CH/08/2019).

Freedom to Speak Up Process
There is ongoing work to deliver the identified CQC action relating to improving the effectiveness of Freedom to Speak Up processes, including policy review, communications strategy and confirmation of new Guardian. Further details are given in Appendix 2.

Controlled Drugs
A controlled drugs (CD) sub group has been established as a sub group of the Medication Safety and Compliance Group.

A report on syringe driver usage from EPR has been requested by Pharmacy.

A meeting with the Chief Pharmacist and senior nurses is planned. The Chief Pharmacist recently attended a national controlled drugs conference which discussed the Gosport report and the importance of assurance that guidelines are followed and good practice delivered.

There is currently no system within the Trust to monitor unusual patterns of opioid prescribing practice. A tool, AIDOS, has been tested and identified one spike on ward 6, however the tool requires funding of £5k and VAT.

Other actions locally include training with pharmacists to ensure they are confident in palliative care prescribing and have a clear understanding of anticipatory medicines, streamlining audits of controlled drugs and re-focussing these to review appropriate clinical use.

APPENDICES

Appendix 1 provides a summary position (reality) against each of the questions raised with a RAG rating. Where further work has been identified from the Gosport review this is stated in the response column.

Appendix 2 provides detailed information and evidence in relation to each of the eight areas of assurance being sought by NHS Improvement.

Appendix 1 Summary – RAG rating on areas of assurance in response to the Gosport Report

No.	NHS Improvement – assurance area	Reality – Level of assurance Further detail on each area is given below.	Response	Result
1	**Working practices on particular ward areas – "the way we do it around here". Is it within agreed norms?**	CQC rating of good following well –led inspection in April 2018. This noted strong focus on patient safety and Trust vision and pillars of behaviour widely understood. Trust vision and values Go See / patient safety walkarounds Ward assurance processes Non-medical prescribing governance Clinical supervision and revalidation Clinical audit Risk Management Systems Investors in People Silver Standard accreditation	Ongoing assurance processes are embedded throughout the Trust	Early identification of any quality and safety issues on wards are addressed through clinical governance arrangements
2	**Response to patient/ relative concerns – collation of repeated themes/ clinician/ clinical area**	Ward and department methods for feedback Accessible Patient Advice and Complaints Service Reports on complaints and PALS to Patient Experience Group and annual complaints report to Quality Committee. Friends and family test is the primary method of feedback on in patient and day cases reported monthly within IPR 100% duty of candour for orange and red incidents.	Ongoing responses to concerns and feedback in line with existing policies and processes	Patients / relatives concerns are reviewed and acted on
3	**Response to staff concerns/ whistleblowers/ Freedom to Speak Up guardians**	Multiple routes for staff to raise concerns in addition to usual line management arrangements: - Freedom to Speak Up Guardian, ambassadors, policy and online reporting tool, with annual report to Board - Staffing and workforce forums - Divisional "go see" visits and ward to Board visits / walkarounds - "Ask Owen" intranet facility for staff to raise questions - Open culture noted by CQC at inspection in April 2018 - Incident reporting system for staff to report any patient safety incidents with Incident Reporting Policy describing investigation processes.	Should do action (SD2) from CQC re: improving effectiveness of Freedom to Speak Up process Confirmation of appointment of new Guardian. Approval of revised Freedom to Speak Up Policy Communication re: Freedom to Speak Up Framework	Staff know how to raise concerns and when raised these are listened to, taken seriously, investigated and responded to appropriately

4	**Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and MHPS (maintaining high professional standards) investigation if indicated**	Medical Director is Responsible Officer (RO) for non training grades and has HR and dedicated legal services resource For training grade doctors RO is the Post Graduate Dean, Health Education England, for locums agency is RO. Revalidation and Appraisal Panel's role to ensure compliance with RO regulations. Annual organisational audit to NHS England on responding to concerns and revalidation Process for exclusion with reporting to Board and NHS England Remediation Policy for medical staff not in training grades. Process for actions arising from serious incident reports re: concerns about doctors highlighted to RO for appropriate action, e.g. referral to General Medical Council	Deputy Medical Director and Associate Medical Director to attend NCAS case investigator training	Robust processes to manage concerns about a doctor in place
5	**Medical appraisal; 360 feedback**	NHS England review of appraisal process in 2015 was positive. Responsible Officer and clinical lead for appraisal and revalidation in place Appraisal Policy Revalidation and Appraisal Panel External assurance from NHS England in response to annual organisational audit on revalidation with appraisal uptake > 90% in 2017/18	Continuation of existing appraisal processes and systems	Assurance that doctors are fit to practise and identify learning needs.

6	**Accuracy of death certification/ understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding)/ learning from deaths - Structured judgement reviews**	Learning from Deaths Policy with review processes which focus on quality of care. The initial screening review includes a check on whether the cause of death is accurate and requests information on what it should be if not correct. Death certification guidance in place. Mortality Surveillance Group provides assurance on mortality to Board via Quality Committee. Quarterly Board report on Learning from Deaths Following improvement work, measures of mortality, HSMR, SHMI have consistently improved and the Trust is within expected ranges for mortality. Improvement actions underway on death certification process following Learning from Deaths summit. CQC review of mortality review process confirmed the arrangements in place. Medical Examiner role to be introduced in April 2019 as part of reforms to death certification processes.	Internal audit has been commissioned to review whether 20 death certificates have been completed in line with Trust Policy and guidance to assess the quality of death certification. Death certification action plan for work with junior doctors on legality of what to include when writing cause of death on death certificates. Lead Dr Uka, Associate Medical Director	Robust processes to identify any mortality outlier triggers.

7	**Controlled Drug use and scrutiny of high usage areas**	MS16/MS26 syringe drivers not used in Trust since 2011. Suite of Medicine Code Policies in place governing prescribing and administration including Medicine Code 7 (prescribing drugs) and 13 on controlled drugs. 97% compliance with NICE guidance 46 for controlled drugs. EPR system gives order sentence for anticipatory medication to support prescribing of correct doses in line with guidelines. Controlled Drugs Accountable Officer, Chief Pharmacist, responsible for monitoring the safe use and management of controlled drugs in the Trust. Pharmacy staff are key members of multi-disciplinary teams, validate prescribed medications and would alert to any inappropriate prescribing practice. Designated Medication Safety Officer whose role is to improve medication error incident reporting and learning.. Recent review of governance arrangements for medicines management. Systems in place for effective monitoring and assessment of controlled drugs via Medication, Safety and Compliance Group, which reviews medicines incidents reported on Datix and would identify and act on any abnormal prescribing practice. Collaborative work underway nationally by all England Chief Pharmacists, e.g. on standardised benchmarking reports.	Report on syringe driver usage by ward for May, June, July 2018 requested to identify if any unexpected usage. Internal audit commissioned to undertake a review to assess if opiates are administered in accordance with the Medicine's Code and that the ICODD (care of the dying) process is complied with at the Trust. Report expected end of September 2018. End of life draft report recommendations being reviewed and progressed. Controlled Drugs sub group of Medication, Safety and Compliance Group being established in September 2018 Steer awaited from all England Pharmacists on how national assurance is given on CD usage	Assurance that medicines management governance is effective and will identify / prevent any inappropriate use or abuse of medicines, including controlled drugs.

8	**Meaningful audits on the standard of care**	Participation in national and local clinical audit into standards of care. Clinical Effectiveness and Audit Group with clinical lead. End of Life Care Group provides leadership for end of life care End of life care is a quality account priority for 2018/19 and is reported on to Board and Quality Committee. Evidence from our participation in the national audits of dying patients over the past 6 years has revealed an average diamorphine equivalent dose of 10mg over 24 hours. This is minuscule (a thirtieth of the dose given in Gosport at time) and will not hasten someone's death. ICODD audit undertaken February 2018 of 10 patients in hospital on ICODD, included review of symptoms of control – no concerns re: inappropriate use of opioids 2016 End of Life Care national audit – extensive documentation of prescribing of specific drugs for prn and regular use	Internal audit review of ICODD to ensure opioids administered at correct dosage in line with Medicines Code and quality of completion of death certificate. Limited assurance given in draft report and recommendations being followed up by End of Life Group. 2018 bi-annual end of life care national audit underway (completion of data submission October 2018)	Audits are meaningful and use to improve care where needed.

Ratings are based on the following:

Green: significant assurance that there is a good system of internal control operating effectively
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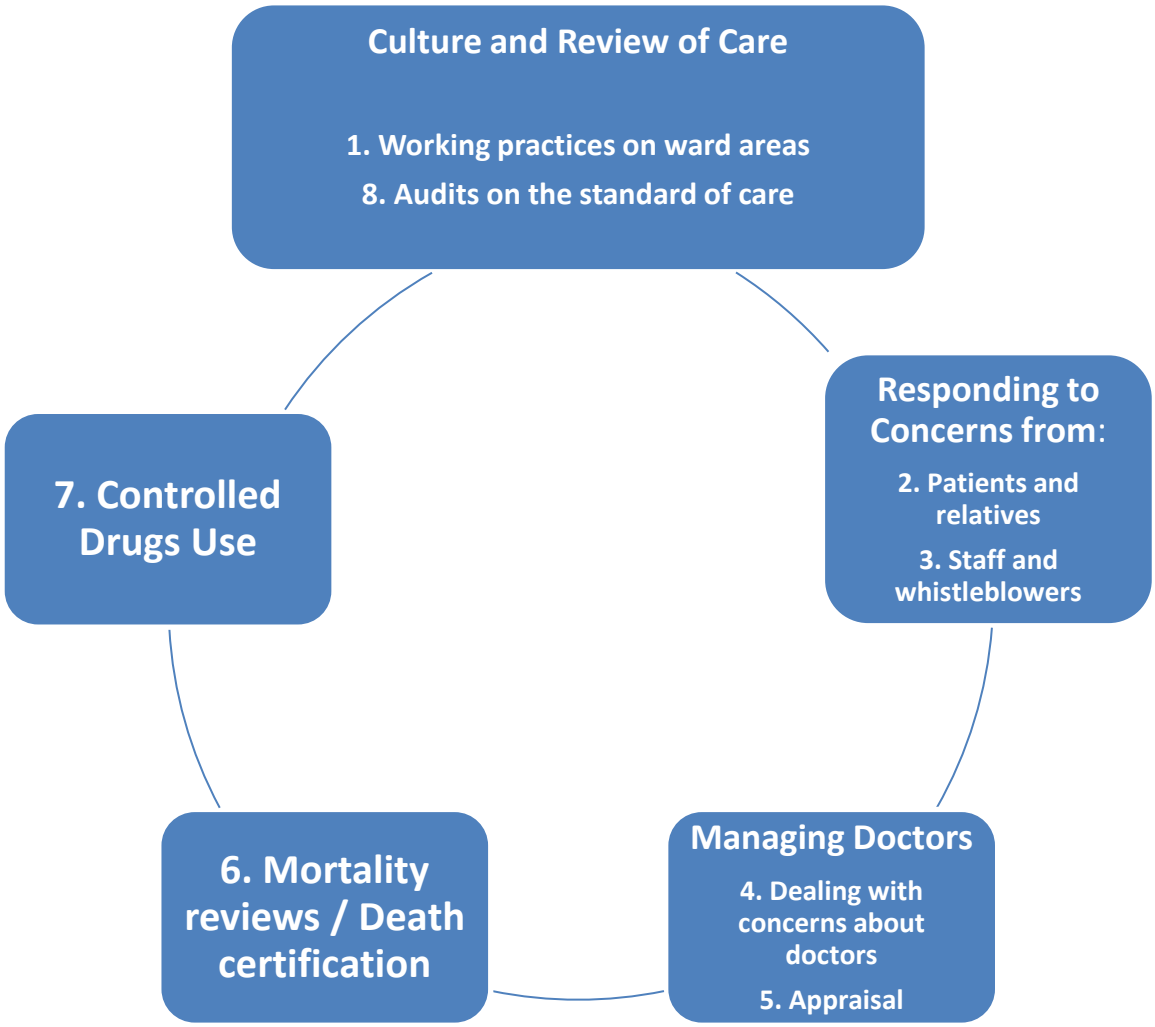
6 of the 8 areas have been assessed as green and two of the areas have been assessed as amber: Freedom to Speak Up and Controlled Drugs. This is because further assurance or ongoing work needs to be completed to give significant assurance. This is detailed below

Appendix 2: Assurance relating to the 8 areas for review identified by NHS Improvement following the Gosport report from June 2018

Link to the Gosport report: https://www.gosportpanel.independent.gov.uk/panel-report/



SUMMARY

This report provides detailed information and evidence in relation to each of the eight areas of assurance being sought by NHS Improvement in response to the Gosport report. Each area has been RAG rated and two of the eight areas, responding to staff concerns (3) and controlled drugs (7) require further work / assurance before a significant assurance rating can be given.

No.	Area	NHS Improvement assurance area
1	**Culture of Care**	Working practices on particular ward areas – "the way we do it around here". Is it within agreed norms?
2	**Responding to Concerns**	Response to patient/ relative concerns – collation of repeated themes/ clinician/ clinical area
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1. **Working Practices on ward areas – are these within agreed norms ?**

The Gosport report said:

…members of the nursing team were the first to draw attention to problems with the pattern of prescribing and the administration of drugs through syringe drivers…nurses continued to administer the drugs for many years though the pattern of deaths would have been familiar to them…the nursing staff had a responsibility to intervene and challenge the prevailing practice on the wards.

Nursing care: "lack of patient-centred care", poor record-keeping and monitoring of patients, "poor understanding of pain management" and a lack of sensitive end of life care that took patients' and families' needs or concerns into account.

The shortcomings in nursing care extended to passive and inappropriate responses to the needs of patients, particularly at key times such as at hospital admission.

not all patients prescribed diapmorphine were in pain, …no other forms of milder painkiller appeared to be considered

Internal Assurance

- **Trust Vision and Values** – the Trust's vision is to deliver compassionate care and has four pillars of behaviour to deliver this which means that staff:

- Put the patient first
- "Go See" to test and challenge assumptions
- Work together to get results
- Do the must do's

- **Assurances on working practices on wards**

There are multiple ways of working that ensure information on how staff work is collected and reviewed. These include, amongst others.

- A ward to Board programme where go see visits from directors to ward areas take place and a divisional programme of "go see" visits which provide an early warning of any quality issues

- Exemplar ward accreditation process which provides a strategic vision for nursing that promotes consistency and standardisation within ward teams and departments

across the Trust, providing a clear framework that brings together quality, safety, service improvement and patient experience. There is an accreditation process, for example ward 18, elderly care at HRI which achieved silver standard accreditation in June 2018. The following areas are reviewed as part of the accreditation process

1. Organisation and Management of the Clinical Area
2. Safeguarding Patients
3. Pain Management
4. Dementia/Delirium
5. Patient Safety
6. Environmental Safety
7. Nutrition and Hydration
8. End of Life Care
9. Medicines Management
10. Person Centred Care
11. Pressure Ulcers
12. Elimination
13. Communication
14. Infection Control

- Ward assurance process where compliance is measured against 12 indicators on a monthly basis, including medicine management.
- Ward handbooks detailing ward routines
- Safety huddles on wards
- Nursing forums – eg ward managers forum, matrons forum
- Register of non-medical prescribers and appraisal process including regular audit of prescribing
- Prescribing audits on missed doses reported to Medication, Safety and Compliance Group
- Clinical supervision Policy - ward managers having supervisory time within workforce models to provide clinical supervision, used as a tool to support revalidation for all Registered Nurses and Midwives, clinical educator posts, preceptorship and mentorship are integral to practice.
- Revalidation process
- Incident reporting system – the Trust is an average reporter of incidents compared to other acute Trusts
- Risk register processes which have been reviewed and deemed to have significant assurance by internal auditors
- Governance structure – including divisional and directorate Patient Quality and Safety Boards, Patient Safety Group, Medication and Safety Compliance Group, Risk and Compliance Group, Quality Committee
- Clinical audit programme and participation in local and national audits to improve patient outcomes
- Patient stories shared at Board and other governance meetings
- Staff Management Partnership Forum

External Assurance

CQC Well-Led Inspection 2018

The Trust received a CQC rating of good following the well-led inspection in April 2018. The report states:

"there were effective governance and quality monitoring processes across most of the services we inspected. Key risks were identified and escalated effectively. "

"There was an open and friendly culture across the trust with a strong focus on patient safety. The trust vision and the four 'pillars' of behaviours were widely understood by staff across the trust. Most staff felt supported and spoke positively about working for the trust and within their teams."

The report also noted:

- patients spoke positively about the care they received
- executive and non-executive directors undertook a scheduled programme of walkabouts and reported these back at Board meetings
- staff understood the process for reporting incidents, which were investigated and learning was shared
- the Trust participated in local and national audits to improve patient outcomes
- Friends and family test feedback was positive.

Of the improvement actions identified by the CQC there are two specifically relevant to the eight areas that NHS Improvement has asked the Trust to review following the Gosport report. These are:

- must do action 3, regarding the Trust ensuring that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs

- should do action to improve the effectiveness of the Freedom to Speak Up process

The progress with these actions is being monitored by the CQC response group.

Investors in People (IIP) Silver accreditation – a 2018 IIP review is currently underway. The report below details the results of the assessment in August 2016 which provided silver level accreditation. This looks at people management and measures nine indicators including leading and inspiring people, living the organisation's values and behaviours and empowering and involving people.

Staff Survey – the annual staff survey results from the 2017 survey undertaken by the Picker Institute were presented to the Workforce Committee in March 2018. The Trust level of response to the survey was similar to the average response rate to other acute Trusts. The findings are given in the paper below presented to the Workforce Committee which sets out the Trust response to the survey. It should be noted that the survey was undertaken in September 2017, whilst the EPR system introduced in May 2017 was still being embedded.

Invited Services Reviews

The Trust has requested services reviews and identified and delivered actions following these reviews – recent examples include stroke, elderly care and respiratory services.

Quality Improvement
The Trust works with established quality improvement bodies, such as the Yorkshire and Humber Improvement Academy and is a member of NHS Quest, a network of NHS trusts which focusses on improving quality and safety.

2. **Response to patient/ relatives concerns – collation of repeated themes/ clinician/ clinical area**

The Gosport report said:

> *When the relatives complained about their care they were consistently let down by authority. When there was effective challenge from the families the documents reveal a pattern of response that even then did not focus on their concerns or effectively address them.*

> *Patronising attitudes of staff towards families, records of conversations often brief, cursory and dismissive*

> *..there was an underlying attitude that families were marginalised by professional staff. Instead of listening to families objectively….there was a tendency to dismiss them as troublemakers.*

Internal Assurance

- **Wards and departments** use a variety of methods to encourage patient feedback, e.g. direct contact through rounding by the ward managers and matrons, debriefs, guest books and graffiti boards. The Trust is keen to demonstrate to service users that their feedback matters and that staff are committed to acting on it. All wards and departments have a public facing information board, where changes introduced (often in response to FFT feedback) are displayed, these are often simple things, but are important to enhance the patient experience. Opportunistic engagement is also carried out to gather service user opinions to support improvements the teams are taking forwards.

- **PRASE (Patient Reporting and Action for a Safe Environment)**
  The Trust has worked with the Yorkshire & Humber Improvement Academy using the PRASE survey, which uses the patient voice to improve patient safety. Surveys are conducted by trained volunteers at ward level. This approach enables patients to provide anonymised feedback (positive and negative) on the safety and quality of care experienced during their ward stay. The questions are linked to the following eight safety domains: communication and teamwork, organisation and care planning, access to resources, the ward environment, information flow, staff roles and responsibilities, staff training and delays.

- **Friends and Family test (FFT) is** a key source for feedback of patient concerns A range of methods are used to engage patients with this initiative: postcards, text messaging and web based solutions. The Trust is keen to demonstrate to service users that their feedback matters and that staff are committed to acting on it. All wards and departments have a public facing information board, where changes

introduced (often in response to FFT feedback) are displayed, these are often simple things, but are important to enhance the patient experience.

- **A Patient Advice and Complaints Service** is in place which is publicised throughout Trust, and on the website, with a drop in service available (part time) at HRI. When complaints are made families are offered meeting with clinicians to raise their concern in full and discuss these. Patients or carer needing support with making a complaint are directed to advocacy services to assist them.

  All complaints are reviewed by a senior divisional manager and reviewed and signed by a Director. In 2018 a survey of complainants to assess their satisfaction with the complaints service was introduced and results will be analysed and shared with colleagues to undertake any improvements needed.

  Opportunities are taken to learn from complaints and PALs concerns and implement changes that will reduce the likelihood of recurrence. The complaints policy details how complaints are managed and quarterly reports are presented to the Patient Experience Group (see below).

  Patients also provide feedback through NHS choices and Care Opinion, these are reviewed and where a more detailed response is required, the patient is asked to contact the PALs office. The Trust Facebook page and Twitter account are monitored and opportunities taken to act on real time feedback where possible

- **Being Open / Duty of candour policy** is in place and there are plans to strengthen family liaison support where patients / relatives would find this useful when serious incidents are being investigated. There is 100% compliance with duty of candour for serious incidents notification to patients / relatives. The policy has been recently reviewed and e-learning to support this is in the process of being developed.

- **A Patient Experience and Caring Group** (PEG) is in place reporting to the Quality Committee, which monitors the Trust's compliance and benchmarking against key patient experience and related quality indicators. Complaints reports are presented on a quarterly basis. The Patient Experience and Caring Group promotes experience based co-design as an approach to develop and improve services in partnership with service users.

- **Trust Surveys -** End of Life – a bereavement survey actively seeks out families views on care provided and share the findings of the questionnaire. The 2016 survey looked at confidence in Trust staff, listening to worries and concerns and symptom control. (2016 findings). A quality account priority for 2018/19 for experience focuses on bereavement survey on four stroke wards.

External Assurance

National surveys

The Trust analyses feedback from national surveys, such as the Inpatient Survey, Emergency Department Survey and Children and Young People Survey, Maternity Survey, Cancer Patient Experience Survey to identify any areas where scores are worse than average and further actions needed with progress monitored through internal governance arrangements and reported through Divisional reports to the patient experience and caring group.

CQC Inspection 2018

The report from the April 2018 CQC well-led inspection showed:

"*staff involved patients those close to them in decisions about their care and treatment"*

"friends and family test feedback was positive across the core services we inspected"

"complaints were investigated and shared with staff to aid their learning"

3 Response to staff concerns/ whistleblowers/ Freedom to Speak Up guardians

The Gosport report said:

> *The documents show that the nurses raised clear concerns in 1991, but these were ignored. From the perspective of 2018, it is hard to understand how such serious matters could be so easily discounted,*

> *Failure to heed the nurses' warnings meant that for many years there was no effective challenge to what was happening at the hospital*

> *Raising the concerns in the first place was a brave act given the culture at the hospital. There is evidence in the documents that the nurses felt ostracised as a result*

Internal Assurance
Trust staff are encouraged to raise issues internally, with multiple routes available to staff to raise concerns including line managers, appraisal and appraisal revalidation (for medical and nursing staff), return to work interviews, clinical supervision and clinical audit.

Routes for staff to raise concerns other than via line managers include:

Divisional / Board to ward "go see" visits / walkarounds
Staff Partnership Forums
Medical Director, Director of Nursing forums
Incident reporting
Freedom to Speak Up Policy and framework
Ask Owen intranet site - which allows staff to ask questions or raise concerns with Chief Executive
Direct contact by staff with prescribed bodies , eg CQC,

Freedom to Speak Up

- **Freedom to Speak Up Policy and Framework** – The Trust's Freedom to Speak Up policy is undergoing a substantial revision which includes the introduction of an on line reporting tool for staff to report their concerns direct to the Guardian. Consultation on the revised policy will take place including consultation with line managers, staff forum, Medical and Dental Pay and Conditions Committee (MADPACC). The revised policy is expected to be reviewed for approval by WEB in late October / early November 2018.

- Recently established support network of **Freedom to Speak Up Champions/Ambassadors** to help signpost staff to sources of advice/help and training sessions are being held 20 September and 15 November 2018. Work is planned with the Communications team to publicise the ambassador role.

- **A Freedom to Speak Up on line reporting tool** is being developed in-house which will enable staff to raise issues either from work or home directly with the Freedom to Speak Up Guardian. This is expected to be ready to launch by September 2018.

- **Non Executive Freedom To Speak Up Guardian** in place, proposal for future arrangements being discussed by WEB in late August 2018 due to end of tenure

- **Communications strategy** to publicise the work on Freedom to Speak Up once revised policy approved and new guardian in post.

External Assurance:

CQC inspection and report 2018

The CQC described the Trust as having an open and positive culture. The CQC report following the well-led inspection in April 2018 identified that no concerns had been raised in 2017 through the Freedom to Speak Up process and whilst staff felt able to raise concerns through other routes, the Freedom to Speak Up process needed embedding further across the organisation.

The Trust has developed a plan to deliver the CQC Should do action 2 reagrding Freedom to Speak Up which was: The trust should improve the effectiveness of the Freedom to Speak up process. Actions for this are being progressed as identified above and progress will be monitored via the CQC response group.

4. Effectively dealing with concerns about a doctor through the Responsible Officer decision making forum and Maintaining High Professional Standards (MHPS) investigation if indicated

There are no specific quotes from the Gosport report in relation to this area of assurance. The Gosport report provides detail on the GMC professional regulatory process, noting the GMC's function is to protect the public by regulating the fitness to practise of registered medical practitioners.

The report states that it was wrong for NHS bodies to exclusively rely on professional regulatory bodies in Gosport. The summary describes an exclusive focus on an individual rogue doctor (influenced by the arrest of Shipman in 1998) rather than on systemic problems, which hindered a wider investigation being undertaken.

The following information describes the Trust processes for dealing with concerns about a doctor which the Medical Director has confirmed are robust.

Responsible Officer
Dr Birkenhead as Medical Director is the Trust Responsible Officer (RO) for non training grades. As RO he is supported in this by a senior HR manager and dedicated legal services resource.

For training grade doctors RO is the Post Graduate Dean, Health Education England and their polices for support of doctors and dentists in training experiencing difficulties apply. The RO responsibility for locums sits with agencies.

Governance / Responsible Officer Decision Making Forums

- A **Revalidation and Appraisal Panel** is in place and meets quarterly which reports to the Workforce Committee and Board. The terms of reference include ensuring that the Trust acts in accordance with its obligations as a designated body {as defined in The Medical Profession (Responsible Officers) regulations 2010}.

Policies and Procedures

- A **Procedure for Handling Concerns regarding Medical and Dental Staff Conduct and Capability** is in place. This details the roles of the Medical Director, Case Manager and Designated Board member and states when it is mandatory to consult with the National Clinical Assessment Services (NCAS). It also describes the reporting process to Board on exclusions.

- **Remediation Policy for medical staff not in training grades**.

  This policy provides a clear, formal framework to apply in order to address issues of remediation.

- **Serious Incident Investigations** - actions arising from serious incident reports re: concerns about doctors are highlighted to the Responsible Officer for appropriate action, e.g. consideration of referral to General Medical Council.

External Assurance

A **2017-18 Annual organisational audit** was completed for NHS England as part of the Framework for Quality Assurance for Responsible Officers (RO) and Revalidation (FQA). This annual audit was introduced in 2017 and first submitted for 2016 – 17.

The audit is completed by all ROs to demonstrate the effectiveness of the systems the RO oversees for recommendations to the GMC on doctors' fitness to practise, arrangements for medical appraisal and responding to concerns. The most recent report is for 2017-18.

NHS England sent a comparator report based on this on 27 July 2018 which will be presented to the Board in September 2018.

The RO meets regularly with the GMC employment liaison advisor to discuss cases.

5. Medical appraisal / 360degree feedback

There are no specific quotes from the Gosport report regarding medical appraisal which has been introduced into the NHS in more recent years.

Revalidation and appraisal processes provide assurance that doctors are up to date and fit to practise and has been a requirement of retaining a GMC licence since 2012 for doctors in clinical practice. The process enables early identification of doctors whose practice needs attention.

The Responsible Officer recommends a doctor for revalidation if they have engaged with the appraisal process, demonstrated they are up to date and fit to practise and if there are no outstanding investigations into their performance.

Internal Assurance

Governance arrangements for medical appraisal
The Trust's Responsible Officer (RO), Dr Birkenhead, Medical Director is accountable for appraisal systems. The Trust has an effective system in place for medical appraisal and the RO is supported in this by a Consultant, Dr Ankarath, who is the designated revalidation and appraisal clinical lead, as well as by the Revalidation and Appraisal Panel (see section 4 for details of this).

The Trust **Appraisal Policy for Non Training Grade Doctors** is given below.

Medical appraisal for non –training grade medical staff (consultants, associate specialists, staff grades, specialty doctors, trust grades, clinical assistants and hospital practitioners) differs from appraisal in other settings due to its link with external professional regulation and revalidation.

The Trust has 63 non training grade medical staff appraisers who renew their training every 5 years and attend 2 top up training sessions every 3 years in line with the Appraisal Policy. The clinical lead has a quality assurance process for appraisals and reviews approximately 10% appraisals submitted. The Appraisal Policy details the process for managing non – engagement in appraisal, Section 15(6). There is also a Remediation Policy in place, enclosed in section 4.

Information on incidents and complaints is fed into the appraisal process.

The Trust has a **Revalidation and Appraisal panel** dealing with concerns about doctors. The panel is responsible for the quality and assurance of the revalidation assessment of all medical staff within the Trust and for ensuring that appropriate governance arrangements are in place to support medical revalidation. This panel provides reports to Board on revalidation.

The Responsible Officer, RO, liaises regularly with the GMC employment liaison advisor and discusses any cases as needed. In 2017/18 the Trust made 5 deferrals for revalidation (5 year cycle) – these were doctors new to the organisation who did not have enough evidence from previous employer for a recommendation.

External Assurance

NHS England

In October 2015 the Medical Director invited NHS England to review Trust appraisal processes and a positive report was provided.

The Trust submitted the 2017-18 annual organisational audit on revalidation to NHS England NHS England has deemed the Trust appraisal rate to be sufficient however the Trust voluntarily submits quarterly reports on revalidation to NHS England.

The Trust participates in quarterly RO regional meetings.

CQC

In 2018 the CQC reviewed medical staff appraisals in urgent and emergency care, critical care, maternity and children's and young peoples services and their findings were positive.

6. **Accuracy of death certification/ understanding why there is a mortality outlier trigger (and subsequently checking the quality of care rather than simply attributing to coding)/ learning from deaths - Structured judgement reviews**

There was a doubling of the death rate at Gosport between 1992 and 1998, which mirrored the hospital's use of opiate medication on the rehabilitation wards. The excess deaths were not picked up by the Trust governance systems.

The Gosport report also raised concerns about death certification and noted:

> *The most notable feature on immediately examining the death certificate was the frequent occurrence of bronchopneumonia as a cause of death …….(a poorly defined infection of the lungs and small airways)…..without a clear cause and in the absence of clinical signs it would be an inappropriate cause of death to certify……*

> *…… in a quarter of patients who died there was no other certified cause leading to death…….(there was a) lack of clinical findings that would point to this diagnosis*

Internal Assurance

A **Mortality Surveillance Group** is in place chaired by the Medical Director which provides assurance on mortality and reports to the Clinical Outcomes Group and Quality Committee. Certain specialties, including stroke, undertake a more detailed review and report on these reviews to the Mortality Surveillance Group.

The Board receives quarterly report on **learning from deaths** - most recent report from July 2018 provided a summary position for 2017/18. 2017/18 found 8% poor care and 0.25% very poor care.

Learning from Death Policy is in place describing process and governance arrangements for mortality reviews. The reviewer forms are being updated based on comments from the Royal College of Pathologists to remove the section relating to avoidability and focus on quality of care and themes. – the revised Learning from Deaths Policy incorporating this will be presented to the Board in November 2018. .

Initial Screening Reviews - Quality of care is assessed via initial screening reviews (ISR) as part of the Learning from Deaths policy. Any cases where the review identifies care as poor or very poor triggers a structured judgement review which provides a more in depth review of quality of care. The ISR form includes a check on whether cause of death is correct.

Structured Judgement Reviews - The structured judgement review form includes an assessment of problems with medication. Any cases where there is strong evidence of avoidability or a death was definitely avoidable are reported as red incidents and assessed by the Director serious incident panel as to whether it should be reported and investigated as a serious incident.

A **Learning from Deaths panel** meets every two months to review themes from structured judgement reviews, and agrees the process for feedback and learning.

A **Learning from Deaths Summit** was held on 12 July 2018 – one group focussed on reviewing death certification processes and identified a number of actions to improve this, with Dr Uka, Associate Medical Director is responsible for delivery of these actions. The death certification process is largely undertaken by junior doctors and training is needed on the appropriateness of content and use of acronyms. Death certification reforms are underway nationally, and from April 2019 a medical examiner will scrutinise the medical certificate cause of death.

Mortality Measures
Measures of mortality, HSMR and SHMI, have consistently improved over the years due to a number of quality improvement initiatives. Current mortality figures based on the most available data are given below, with the Trust being a positive outlier for HSMR:

SHMI = 98.89 April 2017 – March 2018
HSMR = 83.56 July 2017 – June 2018

External Assurance

Internal Audit
Internal audit was commissioned to undertake a review of 20 death certificates, 10 on patients on the care of the dying pathway (ICODD) and 10 on patients who were not on the ICODD. The results of this review, which gives a limited assurance opinion, are currently being considered. Work is planned to improve the timeliness and accurate completion of death certificates.

CQC
The CQC, during its inspection in April 2018 reviewed the Trust mortality review programme and confirmed the Trust position on mortality measures. The CQC report details their overview of the mortality review process and comments on evidence of learning from the death of patients, the learning from deaths' policy, the mortality surveillance group overseeing the mortality review process and sharing learning and reports about mortality regularly submitted to the Trust Board.

In describing the initial screening review and structure judgement reviews the CQC noted in their report:

"A total of 73 deaths have been escalated for SJR since April 2017, of these 70 had been completed. We reviewed a selection of mortality investigation reports, initial screening reviews and structured judgement review during the inspection and these were completed appropriately."

The CQC also reviewed mortality in Urgent and Emergency Care, critical care, maternity and children's and young people's services.

7. Controlled Drug use and scrutiny of high usage areas

The Gosport report **f**indings relating to the prescribing and administering of drugs were as follows:

- 1. Opioid usage without appropriate clinical indication
- 2. Anticipatory prescribing with a wide range of doses
- 3. Continuous opioid usage for patients admitted for rehabilitation or respite care
- 4. Continuous opioids started at inappropriately high doses
- 5. Opioids combined with other drugs in high doses
- 6. Few patients survived long after starting continuous opioids
- 7. Prescription and administration of drugs contravened guidelines
- 8. Occurrence and certification of deaths.

The report said:

……456 patients died where medication – opioids - had been prescribed and administered without appropriate clinical justification

…..opioids were prescribed with a wide range of dosage in a practice described as "anticipatory prescribing" ……the range of dosage was completely contrary to national and local guidance, and ignored national and local guidelines ……

… Over half of patients were given a combination of three drugs via a syringe driver: diamorphine, midazolam and hyoscine…the majority of patients given the combination died on the same day or the next day

Internal Assurance

Medicines Management Governance

- **Compliance with NICE guidelines** for Controlled Drugs (CDs): safe use and management

  97% compliance with NICE NG 46: controlled drugs: safe use and management. Actions are around risk assessment destruction / disposal of CDs.

- **Policies:** Medicines Code, specifically Medicines Code 13 (Controlled Drugs) and 7 (Prescribing) policies are in place.

- **Pharmacists are bound by professional standards.** Pharmacists act as medication safety advocates for patients and validate prescribed medication to ensure that medicine choice, dose and route of administration are appropriate, with knowledge of the patient's medication history and concurrent condition.

- The **Chief Pharmacist is the Controlled Drugs Accountable Officer**. The Trust has not used the old style syringe drivers since 2011 and uses McKinley T34 syringe drivers. The Chief Pharmacist (interim) has commissioned a report on syringe driver usage for 3 months (May, June, July 2018) which will review what strength syringe drivers are being prescribed and for which ward locations. This will be reported to the Medication Safety Group.

- The **Medication Safety and Compliance Group** is the forum for reporting on the management of CDs. The terms of reference, reviewed in July 2018, are given below. At the most recent meeting it was agreed that a task and finish sub group of the Medication, Safety and Compliance Group be established to review controlled drugs, risks and embed best practice in all clinical areas. The lead for this is the Assistant Director for Quality and Safety and the CD sub group met for the first time during September and confirmed it's remit.
- **CD stock lists** - areas using controlled drugs (CDs) have an agreed stock list, which was reviewed in July 2018. High strength diamorphine (30mg) is only kept as stock item on ward 12 which is appropriate. Clinical checks take place by pharmacists for any non stock items requested prior to supplying these.

- **CD checks** - monthly ward manager CD checks and pharmacy checks on CD stocks take place, six monthly or more frequently depending on risk assessment (ED departments now being checked quarterly due to recent improvements). A dashboard is being developed which will be presented to CD sub group and Medication Safety and Compliance Group.

- **Electronic Patient Record system (EPR)**
  With electronic prescribing in EPR there is a clear audit trail of prescribing and as noted above a report on syringe driver usage has been requested.

  EPR includes the following which support staff to prescribe correct doses:
  :
    - order sentences with specified doses eg for anticipatory prescribing – this does not prevent selection of high doses
    - 'when required doses' – dose too close alert eg if 4 hourly prescription is given after 2 hours (though can be overridden and this may be appropriate)

- **Incident Reporting system and Medication Safety Officer role –** all CD Datix incidents reported by staff on Datix are reported to the Chief Pharmacist / Controlled Drugs Accountable Officer and Medication Safety Officer and are investigated as appropriate and reviewed at Medication Safety Group.

  The Chief Pharmacist confirms there have been no reported concerns about inappropriate consumption of CDs and intentional inappropriate prescribing. Nothing has been reported that suggests prescribing of high dose opioids which indicate malicious intent.

  There have been no serious incidents regarding controlled drugs.

An example of a recent incident, reported in August 2018, shows that staff are alert to and reporting controlled drugs medication incidents. D:160270 was an incident reported querying the introduction of use of opioids and syringe driver for a patient. Following review by a pharmacist and Consultant the medication and use of the syringe driver were stopped.

External Assurance

Regional / National
There is ongoing work at a national level by Chief Pharmacists in England and the Royal Pharmaceutical Society to review how assurance can be given on CD usage; this is expected to be confirmed in October 2018.

The Trust is a member of the Yorkshire and Humber controlled drugs **Local Intelligence Network (LIN)** which meets quarterly to share information on controlled drugs.
There has been some initial regional benchmarking on controlled drugs findings which is being validated. Early findings show that CHFT is:

- a higher than average users of fentanyl – though further investigation has identified this is largely due to use in critical care and may reflect different practice across the region (tbc).

- regionally a lower than average users of flumazenil, ketamine, midazolam, morphine

- regionally a high user of opioids generally – this includes codeine/ dihydrocodeine w

There is no information available at present on diamorphine, oxycodone and alfentanil.

CQC
The 2018 CQC inspection report confirmed that controlled drugs were managed appropriately in critical care, maternity and children's and young people's services.

The CQC identified the need for strengthened arrangements for medicines management and controlled drugs in ED and the Trust has a must do action, MD3, on systems and processes for safe storage, security, recording and administration of medicines including CDs. Dedicated pharmacy medicine checks including controlled drugs and sustained processes for the communication of issues identified to staff have been introduced in ED. Progress with this CQC action is being monitored by the CQC response group.

Internal Audit An internal audit review has also been commissioned to provide assurance to the Trust that it is actively managing the storage and security of medicines in clinical areas in accordance with Medicine Code 11.

8. Meaningful audits on the standard of care

The Gosport report does not comment specifically on audit, though notes that there were missing records which hindered investigations.

Clinical audit is a quality improvement tool which can provide assurance and identify gaps and is used to assurance and improve the quality of services delivered.

Internal Assurance

The Trust participates in national and local audits and has a clinical audit programme. The Clinical Effectiveness and Audit Group oversees the clinical audit programme. The group is chaired by an Associate Medical Director and reports to the Clinical Outcomes Group and the Quality Committee.

Local audit includes:

- Mortality reviews
- Monthly Crash calls audited for appropriateness of intervention
- Monthly do not attempt cardio pulmonary resuscitation (DNACPR) audit
- Quarterly review of complaints arising from an admission that ended in death or a death up to 30 days after discharge
- Hospital Specialist Palliative Care Team (SPCT) patient experience audit.
- Training Needs analysis
- Preferred Place of death audit
- National service evaluation of bereaved relatives' satisfaction with patients' end of life care 2016 using FAMCARE 2 tool
- Yorkshire Cancer Network Peer Review Dec 2016 – Case Note Audit

Bereavement surveys – views of bereaved relatives are sought by questionnaires and a pilot is underway to get more meaningful feedback. Experience during end of life care is one of the Trust's 2018/19 quality account priorities.

Each year, CHFT currently takes part in an annual bereavement survey, whereby Next of Kin (NOK) for deaths occurring in the month of May are sent a survey to comment on their experiences. Of the 90 surveys sent, the trust has a 30% response rate –i.e 27 forms being returned which is a small number when you considering that the Trust has 1500+ deaths a year.

Pilot - In order to gather more meaningful feedback to both highlight the areas of excellent care and some areas that we can improve on, a 6 month pilot audit is being undertaken on our four stroke wards at CRH. The NOK of patients who have died from January to June 2018 will receive a bereavement survey 3 months after death. They will also receive a bereavement card a couple of weeks after the death of their loved one, which has been designed to offer support and inform them of the upcoming survey.

On the bereavement survey there is a sentence at the bottom to encourage relatives to add their name and number if they would like us to contact them about the care their loved one received – we have had 5 out of the 9 that have responded. It has been a positive experience being able to talk with bereaved relatives to find out what we do well and areas to improve. The feedback on the whole so far has been positive with some areas we could improve in a quick timeframe, such as more chairs.

The role of the trial is to ascertain whether it would be possible to send out bereavement cards and surveys for all deaths within the Trust to ensure we are truly gaining a representative sample of experiences within our Trust.

End of Life Care Group – this group, which reports to the Clinical Outcomes Group, provides leadership on end of life care. There is a programme of audit currently in place which includes national audits and also local audits which informs the end of life care dashboard. The Consultant in Palliative Medicine has confirmed that evidence from our participation in the national audits of dying patients over the past 6 years has revealed an average diamorphine equivalent dose of 10mg over 24 hours. This is deemed to be minuscule and will not hasten someone's death. An annual report from the group for 2017/18 is presented to the Clinical Outcomes Group.

The Consultant in Palliative Medicine undertook a small qualitative audit in February 2018 of ten patients in hospital on the car of the dying pathway (ICODD), which included review of symptoms of control. This is enclosed:

Building on this audit, in response to the Gosport report the Director of Nursing commissioned Internal Audit to review these deaths to ensure opioids are administered at the correct dosage in line with the Medicines Code (Section 11/13) and also review death certificates for a further ten non ICODD deaths as well as .

The objective of the review was to provide assurance to management and the Board that the Trust's Individualised Care of the Dying Patient Document (ICODD) process is adhered to, ensuring any opioids are administered in line with Trust's guidance on prescribing anticipatory drugs. A draft of the report has been received, with a limited assurance opinion, and is currently being reviewed by the Director of Nursing.

External Assurance

National audit

The Trust participates in a national care of the dying audit for hospital - bi annually and also sends out an annual bereavement questionnaire

The Trust is currently submitting data to the 2018 end of life national audit.

The Trust also participated in the national quality end of life care (FAMCARE) audit which aims to see how well the Trust cares for patients referred to palliative care services.

CQC

The CQC report from 2018 stated:

"the trust participated in local and national audits to improve patients outcomes. Audit results were used to benchmark and compare with other trust s locally and nationally. "

14. CQC Report

Presented by Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Stephanie Jones, PA to Director of Nursing
Date: Thursday 1 November 2018	**Sponsoring Director:** Jackie Murphy, Interim Chief Nurse
Title and brief summary: CHFT CARE QUALITY COMMISSION (CQC) INSPECTION - This paper provides an update on the delivery of the Trust's response to the CQC report. The plan is based on the 23 must do and 40 should do actions detailed in the CQC report which was published on 20th June 2018. The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology. The Board of Directors are asked to approve the movements in the plan as recommended by the CQC Response Group and approved by the Trust Quality Committee.	
Action required: Approve	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: None	
Governance Requirements: NA	
Sustainability Implications: None	

Executive Summary

Summary:

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

The plan is based on the 23 must do and 40 should do actions detailed in the CQC report which was published on 20th June 2018.

The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology.

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

Main Body

Purpose:

As above

Background/Overview:

As above

The Issue:

NA

Next Steps:

The Quality Committee are requested to:

1. Support the process for managing the actions (detailed in section1)

2. Approve the movements in the plan (detailed in section 2) from September 2018 as recommended by CQC Response Group and approved by the Trust Quality Committee.

3. Support the revised completion dates (section 3) for the actions currently not delivering against the plan.

4. Be aware of the actions that are not progressing

Recommendations:

As per next steps

Appendix

Attachment:

Combined CQC Report and Action Plan Oct 2018.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Board of Directors

PAPER TITLE: CHFT CARE QUALITY COMMISSION (CQC) INSPECTION	**REPORTING AUTHOR:** Alison Lodge
DATE OF MEETING: November 2018	**SPONSORING DIRECTOR:** Jackie Murphy
STRATEGIC DIRECTION – AREA: Keeping the base safe Transforming and improving patient care	**ACTIONS REQUESTED:** To approve
PREVIOUS FORUMS: None	
EXECUTIVE SUMMARY: This paper provides an update on the delivery of the Trust's response to the CQC report. The plan is based on the 23 must do and 40 should do actions detailed in the CQC report which was published on 20th June 2018. The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology. The Board of Directors are asked to approve the movements in the plan as recommended by the CQC Response Group and approved by the Trust Quality Committee.	
FINANCIAL IMPLICATIONS OF THIS REPORT: None	
RECOMMENDATION: The Quality Committee are requested to: 1. Support the process for managing the actions (detailed in section1) 2. Approve the movements in the plan (detailed in section 2) from September 2018 as recommended by CQC Response Group and approved by the Trust Quality Committee. 3. Support the revised completion dates (section 3) for the actions currently not delivering against the plan. 4. Be aware of the actions that are not progressing	
APPENDIX ATTACHED: None	

CHFT Care Quality Commission (CQC) update October 2018

1. Context / Background

Following the publication of the Trust CQC action plan on 20th June 2018, a detailed plan was developed for all of the must and should do actions and governance arrangements were agreed.

This paper presents the current position with the plan, which is made up of 23 must do and 40 should do actions and details the movement against the target dates using BRAG rating.

The CQC Response Group have supported the recommendation that the Community In Patient actions are all treated as 'should do' actions as the service that was inspected is no longer in operation. These actions are being used to review other community core services, predominantly through a peer review process. These account for 14 of the must do actions.

The revised totals are therefore 9 must do actions and 54 should do actions.

The monitoring of should do actions is being delivered through a schedule of core service updates:

Core service current position (should do actions)

	Update due	Red	Amber	Green	Blue	Not rated	Total
Critical Care	Sep-18			5	1		6
Urgent and Emergency Care	Sep-18	1	4				5
Community	Oct-18		9	7		3	19
Corporate including (UoR)	Oct-18		9				9
Maternity	Nov-18		7	1			8
Children and Young People	Nov-18		5	2			7

Must do actions are being reviewed based on their dates for expected completion:

Current position must do actions

Rating	Must do actions
Delivered and sustained	0
Action complete	2
On track to deliver	4
No progress / Not progressing to plan	3
Total	**9**

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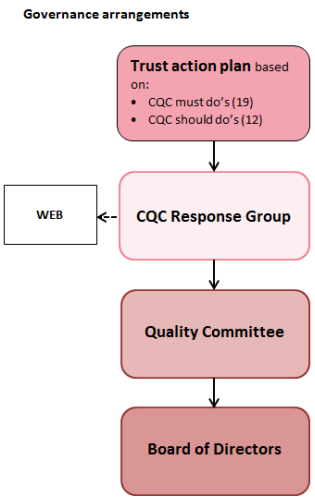


2. Must do action Plan – movements

The plan was considered and challenged at the CQC Response Group on 27th September 2018 and the Group agreed to recommend the following BRAG rating movements in the plan:

MD3	Medicines management (Urgent & emergency care)	BRAG rating from **Amber** to **Green**
MD9	Prescription charts (Critical care)	BRAG rating from **Amber** to **Green**

3. Must do actions currently not achieving the 'actions complete dates - proposed new target timescales

Two actions have not met the deadline for completion of the actions (MD6, MD7). The CQC Response Group meeting on the 27th September considered the reasons for the delays and proposed the following extensions to the deadlines and recommended the further actions to be taken:

MD6	Ligature room (Urgent & emergency care)	**Issue:** Room at CRH complete, some final tweaks required, HRI still requires work on the door **Further actions:** Request definite date for completion (delay at HRI is preventing the cubical being used at all) ***Recommendation: Move action deadline from 31.8.18 to 31.10.18*** ***BRAG rating remain amber***
MD7	Ligature risks (Urgent & emergency care)	**Issue:** Walkround in the departments not yet undertaken, needs input from Estates colleagues **Further actions:** CRH walkround scheduled w/c 1.10.18, HRI walkround to be scheduled ASAP ***Recommendation: Move action deadline from 31.8.18 to 31.10.18*** ***BRAG rating moved from red to amber***

4. Actions rated as no progress

MD8	Medical staffing (CRH)(Critical care)	**Issue:** Not delivering in line with GPICS standard at CRH as consultants have other areas of responsibility when on call (this was also the position at the time of the previous inspection). **Reason for no progress:** Ability to deliver against this standard is dependent on centralisation of acute services. It is on the risk register (score of 8), the team monitor for any incidents / near misses – none reported.
SD9	Medical staffing (Urgent and emergency care)	**Issue:** Consultant cover does not meet the Royal College of Emergency Medicine guidance for consultant presence of 16 hours per day **Reason for no progress:** Compliance with guidance cannot be achieved whilst there are 2 units on 2 sites. The inability to recruit sufficient middle grades and consultants is on the high level risk register

The Board of Directors are requested to approve the recommendations made by the CQC Response Group and approved by the Trust Quality Committee:

- to support the processes for managing the plan detailed in section 1
- to move the BRAG ratings for the actions listed under section 2,
- support the revised completion dates detailed in section 3
- be aware of the actions with no progress in section 4.

5. Monitoring arrangements

Monitoring of the plan follows the governance arrangements described below:

Governance arrangements

CQC Response Group:	Oversee the delivery of the plan, monitor progress, sign off actions, agree submission of sustained position to the Trust Quality Committee (must and should do actions)
Trust Quality Committee:	Provide assurance to the Board that the plan is achieving the expected impact and give final sign off for sustained actions.
WEB:	Receive a monthly report ahead of the Quality Committee, in order to be informed of any emerging concerns and agree any actions required by WEB.
Divisional PSQBs:	Oversee the delivery of the core service plans; escalate to Divisional performance meetings by exception any impacts on performance requiring Executive support, provide progress updates to the CQC Response Group.

Calderdale and Huddersfield NHS Foundation Trust

CQC Domain	Core Service Area	Action reference MD (must do) SD (should do)	Recommendation	Associated regulation (It is possible that the recommendation could be a breach of more than 1 recommendation - the one of most impact has been selected)	Trust Response		Measurable outcome expected following implementation of recommendation	Expected Date of Completion of Actions	Date of Sustained Improvement of Outcome (Embedded)	Director Responsible	Implementing Officer	BRAG status
					Action taken to date	Further action (if required)						
Well led	Corporate	MD 1	• The trust must improve its financial performance to ensure services are sustainable in the future.	Regulation 17: Good Governance	• Clinical strategy is being developed to inform and shape future planning. • Aligned Incentive Contract (AIC) agreed with two main commissioners to facilitate transformational change and costs out. Programme of internal engagement and ideas generation. Supported by joint ownership and system wide governance processes through System Recovery Group (SRG). • Response being developed to Secretary of State feedback on reconfiguration proposal. This proposal will seek to address longer term return to financial sustainability. • Strong CIP and financial governance process embedded and acknowledged in Use of Resources assessment.	• Finalisation of strategy and link to planning for 2019/20 onwards. • Delivery against SRG transformation schemes and development of joint governance processes to maturity in support of this. • Ongoing liaison with NHSI with regards to next steps on reconfiguration plans. • Analysis work in conjunction with NHSI to gain greater understanding of premium costs being incurred through current configuration, demand and mix of services	• Clarity on next steps on reconfiguration and timescales to deliver financial sustainability.	31.3.19 (Achievements against plan)	3-5 year plan (to incorporate reconfiguration)	Director of Finance	Deputy Director of Finance	In-progress
Safe	Urgent and Emergency Care	MD 2	**HRI & CRH:** The trust must ensure they have robust systems for checking equipment and consumables and identifying and disposing of expired items.	Regulation 12: Safe care and treatment	• The senior ED management team have reviewed and updated all departmental checklists • The ED team have highlighted the importance of completing all checks to all staff - Spot checks completed by the Matron • Ad-hoc spot checks undertaken each week by lead nurses and matron to ensure checks are being performed and actions required undertaken. • Where omissions are identified, the shift leader is required to provide a written statement to account for the circumstances • Staff to complete DATIX forms when checking is not carried out due to the unit being busy / full • Peer assessment carried out by Divisional Associate Director of Nursing and Pharmacy colleagues. • Trust ward assurance tools (e.g. exemplar audit) also include these elements	• Monthly reports to assess whether checks have been carried out as planned and any issues that have arisen - monthly for 3 months, then quarterly if being conducted as planned. • Review performance monthly as an agenda item at the ED Quality Improvement Board (run chart to show comparative performance) and include in highlight reports to Divisional PSQB • Full review of Nursing and Housekeeping provision in the ED.	• ED regular daily and weekly checks occur as planned and required actions undertaken. • Monthly reports show positive compliance • Adequate staffing, both clinical and non-clinical to ensure essential safety and house keeping functions undertaken while maintaining patient care an safety	30.9.18	31.12.19	Divisional Director - Medicine	Associate Director of Nursing - Medicine	In-progress
Safe	Urgent and Emergency Care	MD 3	**HRI & CRH:** The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.	Regulation 12: Safe care and treatment	• The ED team have developed a new clear SOP for the management of medicines with pharmacy. • Introduced dedicated pharmacy medicine checks including controlled drugs and sustained processes for the communication of issues identified to staff. • Introduced formal notification processes to all staff identifying re: expectations of medicines management standards regarding administration of controlled drugs . This includes performance management as required. • Provide individual feedback to staff where standards are not complied with. • New 5 Must-do checklists introduced including Fridge temperature monitoring to re-enforce required daily checking. • Pharmacy ATO's monitoring expiry dates of all ED drugs. • Trust ward assurance tools (e.g. exemplar audit) also include these elements	• Follow up to ensure all staff are following the SOP • Clinical Director and Matron have personal oversight of the safety checks and will ensure action is taken as required • Review position monthly for 3 months, then quarterly if being conducted as planned. • Review performance monthly as an agenda item at the ED Quality Improvement Board (run chart to show comparative performance) and include in highlight reports to Divisional PSQB	• Appropriate safety checks carried daily and actioned as required. • All pharmacy stock within date • Clear, appropriate Controlled Drug recording in line with legal requirements • Staff escalate issues immediately to action • Monthly reports show positive compliance	31.8.18	31.11.18	Divisional Director - Medicine	Associate Director of Nursing - Medicine	Complete
Safe	Urgent and Emergency Care	MD 4	**HRI & CRH:** The trust must ensure that they meet environmental audit targets for cleanliness or infection control.	Regulation 12: Safe care and treatment	• The ED team have established an ongoing programme of review and work for the environmental issues at HRI with estates colleagues. • Progress of environmental issues/work is tracked and monitored via established action plan of estates work and monthly meeting to monitor progress against actions • The ED have undertaken a review of storage facilities and stock levels at CRH. They have now changed to twice weekly top-up which has reduced stock levels required. • Regular weekly and monthly audits continued - isolation of infected patients has been 100% for the year so far. 5)Policies in place to isolate and use minors if an outbreak of infected patients attend. Policy reiterated to the team. • Peer assessment carried out by Divisional Associate Director of Nursing and Infection control colleagues. • Trust ward assurance tools (e.g. exemplar audit) also include these elements • Combined Audits (ICPA), provide a further independent review	• Quotes requested for estates work to storage areas to improve compliance. • Complete review of cleaning provision at HRI. • Review performance monthly as an agenda item at the ED Quality Improvement Board (run chart to show comparative performance) and include in highlight reports to Divisional PSQB	• Action plan progress • Completion of estates work to storage areas to improve compliance • Option appraisal document following the review of cleaning provision at HRI • Monthly reports show positive compliance	30.9.18	31.12.18	Divisional Director - Medicine	Associate Director of Nursing - Medicine	In-progress

CQC Domain	Core Service Area	Action reference MD (must do) SD (should do)	Recommendation	Associated regulation (It is possible that the recommendation could be a breach of more than 1 recommendation - the one of most impact has been selected)	Trust Response		Measurable outcome expected following implementation of recommendation	Expected Date of Completion of Actions	Date of Sustained Improvement of Outcome (Embedded)	Director Responsible	Implementing Officer	BRAG status
					Action taken to date	Further action (if required)						
Safe	Urgent and Emergency Care	MD 5	**HRI & CRH:** The trust must ensure that deviations to appropriate fridge temperatures are escalated in line with internal policies.	Regulation 12: Safe care and treatment	Covered in MD3	Covered in MD3	As MD3 plus: • All Fridges are monitored daily by ward staff as per Trust guidelines. Any out of range temperatures are managed according to Trust guidelines.	30.9.18	31.12.18	Divisional Director - Medicine	Associate Director of Nursing - Medicine	In-progress
Safe	Urgent and Emergency Care	MD 6	**HRI & CRH:** The trust must ensure there is a suitable ligature room to accommodate patients presenting with mental ill-health.	Regulation 12: Safe care and treatment	• Ligature free room at CRH is now complete	• Work due to start at HRI on 23/7/18. • SOP to be developed for use of the room. • Progress reported through Emergency Care Directorate Board and concerns escalated to Divisional Management Board	• Compliance with guidance for ligature free provision • Completion of estate work	~~31.8.18~~ 31.10.18	30.11.18	Divisional Director - Medicine	Divisional Director of Operations - Medicine	no progress / not progressing to plan
Safe	Urgent and Emergency Care	MD 7	**HRI & CRH:** The provider must remove ligature risks identified in key areas of the department.	Regulation 12: Safe care and treatment	• Ligature free room at CRH is now complete	• Review of ligature risks elsewhere within the ED to be undertaken with Estates team • Progress reported through Emergency Care Directorate Board and concerns escalated to Divisional Management Board	• Compliance with guidance for ligature free provision • Completion of estate work	~~31.8.18~~ 31.10.18	30.11.18	Divisional Director - Medicine	Divisional Director of Operations - Medicine	no progress / not progressing to plan
Safe	Critical Care	MD 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.	Regulation 18: Staffing	• Huddersfield site is compliant however Calderdale out of hour's commitment still requires consultants covering Critical Care to cover other areas of responsibility. • Plan still in place with workforce model to separate the rotas to ensure compliance however currently unable to enact: - Recruitment remains challenging with 3 failed attempts to recruit over the last 9 months. - Out of hours cover currently being supported with internal locums. • Once acute services are configured onto the CRH site, with 1 large ICU/HDU on that site, the rotas will be revised and hopefully with improved recruitment will facilitate the required CQC compliance	• Divisional Director discussed with COO. Paper to be tabled at WEB (date yet to be agreed) regarding current situation, risks etc. and request that support is given to current way of working until one unit is operational. • Regular review of incident/near miss reporting.	• Compliant rotas would be the measurable outcome but will not be realised while 2 units on 2 sites	Once centralisation of acute services occurs	Once centralisation of acute services occurs	Divisional Director - Surgery	Divisional Director of Operations - Surgery	no progress / not progressing to plan
Safe	Critical Care	MD 9 *(Should do HRI)*	**CRH &HRI :** The trust must ensure paper prescription charts are fully completed ensuring second signatures and batch numbers are recorded. ***Recorded as a 'should do' action in the HRI report***	Regulation 17: Good Governance	• Audit undertaken on CRH in June 2018 to measure compliance with BN recording and second signature. • Safety Brief utilised to instruct staff as to the importance and essential nature of compliance with Medicine code 12 - specifically to record BN and second signatures.	• Critical Care Nursing Staff to be issued with the Medicine Code 12 - Preparation And Administration Of Medicines. All Staff to sign that they have read and understood the document. • Learning from CQC feedback poster to be actioned by end July 18. Audit to be undertaken before (completed 4/7/18) and after sign sheet completed. All staff informed of requirement in the daily safety brief.	• Audit to be undertaken monthly until fully compliant with requirement.	31.8.18	31.12.18	Divisional Director - Surgery	Associate Director of Nursing - Surgery	Complete

15. Learning from Deaths - Quarter 3 Report

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday 1 November 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Learning from Deaths Report - The Board are asked to approve the contents of the Learning from Deaths report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

The Board are asked to approve the contents of the Learning from Deaths report.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

LfD Oct 2018 SU.pdf

Initial screening (first level) reviews

In the last 12 months, there have been a 1,654 deaths, of these, 513 (31%) have been reviewed using the initial screening tool. The quality of care was assessed as excellent in 31% (161), good in 43% (219), adequate in 17% (86), poor in 6% (31) and very poor care in 0.2% (1) of cases reviewed. Poor or very poor care has triggered further investigation using the structured judgement review process.

The table below shows the number of cases reviewed each month.

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug
Total deaths	138	119	129	121	138	171	193	172	158	130	117	116	96	113
Total reviewed	25	14	33	38	35	65	55	58	38	33	47	40	25	41
% reviewed	25	12	25	31	26	38	29	34	24	25	40	35	26	36

Online ISR Tool

The online screening tool is being modified to simplify the questions and also to include speciality specific questions. This is almost ready to go live and anticipated it will be in use next month.

Future of Initial Screening Reviews

Despite implementing a robust process to allocate all deaths for an ISR along with offers of training and support at best we have only reviewed approximately 30% of all deaths. However, it was noted that uptake we significantly better in specialties who had agreed to review their own deaths. To date specialty reviews have been occurring in General Surgery, Orthopaedics, Stroke, Gastro, ED, Maternity and Children. From Q4 onwards specialty specific reviews will also take place in:

- Critical Care
- Respiratory
- Cardiology
- Oncology
- Haematology
- Acute Medicine
- Elderly
- Calderdale Community (Kirklees Community in discussion with Locala)

This process whilst not screening all deaths will provide an initial review of more than 50% of all CHFT deaths. For great assurance there will be random sampling of each specialty directed to a Structured Judgement Review on a rolling monthly basis.

Structured Judgement (second level) Reviews

In the last 12 months, 79 deaths have been escalated for a SJR. The table below shows the reason for escalation for a SJR and the number completed.

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	total
Escalated from ISR	2	8	1	3	2	0	2	2	0	0	1	0	21
Complaint	0	1	1	3	3	1	5	2	2	0	0	0	18
SI process	4	2	0	1	0	0	0	1	0	1	0	0	9
Elective	0	1	0	1	0	0	0	2	0	1	1	1	7
LD	0	1	0	0	1	2	1	0	0	0	3	0	8
Other	0	0	9	0	3	0	0	0	1	0	0	3	16
Total Requested	6	13	11	8	9	3	8	7	3	2	5	4	79

Analysis of the learning themes

Thematic analysis has been performed on SJR's performed between August 2017 and July 2018 by Dr Mansoor Ali and Carole Hallam.

The top 5 themes of good practice were:

1. Overall good quality of care in approximately 85% of cases reviewed
2. Evidence of good junior doctor decision making
3. Good pre and post procedural care
4. Excellent specialist palliative care in-reach
5. Timely and appropriate in-reach into ED when required.

The top 5 themes for improvement are:

1. Communication between healthcare professionals, the patient and family/carers
2. Documentation especially of communication, diagnoses and cause of death
3. Timely senior review
4. Timely escalation or decision making not to escalate
5. Recognition of the dying phase and use of the ICODD.

Serious Incidents Assurance

Since April 2017, 22 deaths have been reported on Datix. Of these 22 deaths, there have been 16 requests from the Serious Incident Panel for the case to have a Structured Judgement review. The outcomes of these are as follows

- 4 completed SI red incidents
- 1 SI de-logged following the Coroner's report
- 7 investigated as orange incidents at Divisional level
- 2 downgraded to yellow incidents and closed
- 2 downgraded to green incidents and closed

None of the above cases downgraded to yellow or green met the criteria for orange level investigation with avoidability concerns following SJR.

The SJR process has resulted in two cases being reported as red incidents due to an assessment of 'strong evidence of avoidability', a further 3 cases have been reported orange incidents due to assessment of 'probably avoidable' and one case reported due to an assessment of poor care. The outcomes of these cases are:

- 1 SI investigation completed
- 1 SI investigation still in progress

- 4 orange incidents
  - 1 continued to be investigated as an orange incident
  - 2 downgraded by the division to green and closed
  - 1 downgraded by the division to yellow and closed

3 cases that were downgraded to yellow and green by the division and closed have been escalated to the Senior Risk Manager for assurance that these have been fully investigated.

LfD Policy

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

Learning from Death Summit

The first LfD Summit was held on July 12th with over 70 delegates attending. The event was supported by Chris Pointon, husband of the late Kate Granger, who shared his 'hello… my name is' story. In addition attendees shared the reality of the themes under the LfD Umbrella and contributed to the response to achieve the result for each theme.

Future Plans and Sharing Learning

- Revise pathway for bereaved family/carers to raise any concerns in line with
- Disseminate learning across the Trust – by video linked to Trust news, Intranet, PSQB and audit meetings
- Action planning at Trust and Divisional level for Quality Improvement
- Implementation of new ISR process.

16. Quality & Performance Report – September 2018

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday 1 November 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - The Board is asked to approve the contents of the report and note the overall performance score for September.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board: Thursday 25th October 2018	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

September's Performance Score has improved by 2 percentage points to 67%. The SAFE domain has deteriorated to amber as there has been a never event in Medicine. The CARING domain's performance has improved as A&E FFT would recommend has gone from red to amber in-month. EFFECTIVE is now green with improvements in child mortality and MSSAs. The RESPONSIVE domain has improved but remains amber with cancer 62 days screening missing target but better performance in the Stroke targets. In WORKFORCE all 9 EST areas have deteriorated again in-month. Within EFFICIENCY & FINANCE Agency usage has improved in-month whereas I&E: Surplus / (Deficit) has deteriorated.

Please note that the full report now contains the West Yorkshire extract from the Integrated Operational Report published in September by NHS England as an appendix. This benchmarks key indicators locally and nationally

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

Integrated Performance Report - Sept 18.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

September 2018

Report Produced by : The Health Informatics Service
Data Source : various data sources syndication by VISTA

Performance Summary

To Note

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

% of Initial Screening Reviews (Mortality) has been removed as an indicator and this has improved performance by 0.4 percentage points month on month.

We are in the process of refining the initial screening mortality review process. We will move away from % of mortality reviews complete e.g. not aiming to performance manage this. The focus of mortality reviews should be QI which is where clinical teams will focus. Once established the new process will see approximately 50% of all deaths being reviewed.

Board are provided with a quarterly update as part of the LfD report. We will maintain oversight on this and support the QI needed to make a difference.

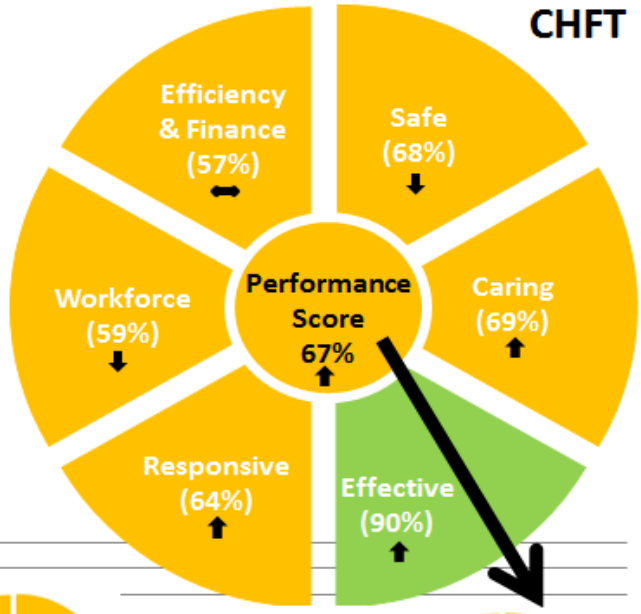
For Friends and Family Test A & E Survey - % would recommend the Service – the threshold for Amber has reduced and this has improved performance in some instances by up to 1 percentage point.

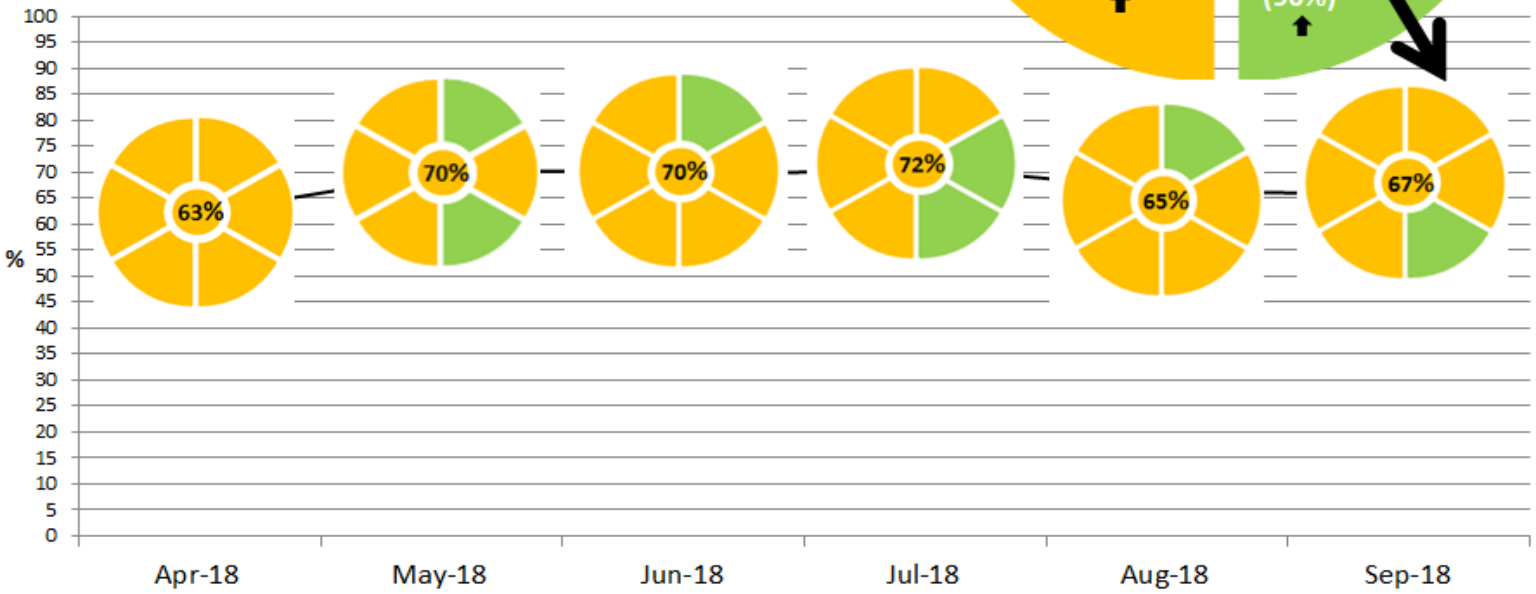
Performance Summary

September

RAG Movement

September's Performance Score has improved by 2 percentage points to 67%. The SAFE domain has deteriorated to amber as there has been a never event in Medicine. The CARING domain's performance has improved as A&E FFT would recommend has gone from red to amber in-month. EFFECTIVE is now green with improvements in child mortality and MSSAs. The RESPONSIVE domain has improved but remains amber with cancer 62 days screening missing target but better performance in the Stroke targets. In WORKFORCE all 9 EST areas have deteriorated again in-month. Within EFFICIENCY & FINANCE Agency usage has improved in-month whereas I&E: Surplus / (Deficit) has deteriorated.





SINGLE OVERSIGHT FRAMEWORK

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

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

Key Indicators

	17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD	Annual Target	Monthly Target
SAFE										
Never Events	1	0	0	0	0	0	1	1	0	0
CARING										
% Complaints closed within target timeframe	48.70%	37.00%	44.00%	30.00%	31.00%	33.00%	53.00%	37.00%	95%	95%
Friends & Family Test (IP Survey) - Response Rate	31.40%	39.97%	39.75%	38.83%	36.47%	37.83%	34.93%	37.96%	>=25.9% /24.5% from June 18	
Friends & Family Test (IP Survey) - % would recommend the Service	96.90%	96.78%	97.98%	97.38%	97.42%	97.65%	97.70%	97.48%	>=96.3% / 96.7% from June 18	
Friends and Family Test Outpatient - Response Rate	10.10%	11.30%	10.45%	11.43%	11.40%	11.32%	11.61%	11.24%	>=5.3% / 4.7% from June 18	
Friends and Family Test Outpatients Survey - % would recommend the Service	89.70%	90.66%	90.99%	90.40%	90.79%	90.82%	90.96%	90.77%	>=95.7% / 96.2% from June 18	
Friends and Family Test A & E Survey - Response Rate	10.20%	10.74%	9.55%	12.85%	15.25%	14.53%	13.10%	12.69%	>=13.3% / 11.7% from June 18	
Friends and Family Test A & E Survey - % would recommend the Service	85.00%	84.65%	86.35%	84.28%	84.30%	82.15%	84.75%	84.28%	>=86.5% / 87.2% from June 18	
Friends & Family Test (Maternity Survey) - Response Rate	41.00%	33.20%	34.80%	34.80%	33.70%	35.59%	36.35%	34.78%	>=22.0% / >=20.8% from June 18	
Friends & Family Test (Maternity) - % would recommend the Service	97.60%	98.00%	98.90%	98.20%	98.36%	98.09%	99.05%	98.46%	>=97% / 97.3% from June 18	
Friends and Family Test Community - Response Rate	6.50%	3.60%	6.30%	4.20%	4.40%	4.66%	6.50%	4.98%	>=3.4% / >=3.5% from June 18	
Friends and Family Test Community Survey - % would recommend the Service	90.00%	93.90%	92.60%	92.00%	97.40%	94.06%	92.89%	93.67%	>=96.2% / >=96.6% from June 18	
EFFECTIVE										
Number of MRSA Bacteraemias – Trust assigned	5	0	0	1	0	0	0	1	0	0
Preventable number of Clostridium Difficile Cases	8	3	1	1	0	0	0	5	<=20	< = 2
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.98							98.98	<=100	100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	82.47							83.56	<=100	100
RESPONSIVE										
Emergency Care Standard 4 hours	90.61%	91.52%	93.23%	94.78%	92.37%	91.15%	89.63%	92.15%	>=95%	95%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	60.36%	58.00%	53.49%	68.63%	54.00%	59.02%	70.21%	60.40%	>=90%	90%
% Incomplete Pathways <18 Weeks	93.75%	93.77%	93.32%	94.05%	93.99%	93.18%	93.00%	93.00%	>=92%	92%
Two Week Wait From Referral to Date First Seen	94.09%	95.63%	98.78%	98.61%	98.82%	97.67%	98.71%	98.08%	>=93%	93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.88%	95.48%	95.28%	98.94%	95.24%	100.00%	100.00%	97.41%	>=93%	93%
31 Days From Diagnosis to First Treatment	99.83%	100.00%	99.37%	99.41%	100.00%	100.00%	100.00%	99.79%	>=96%	96%
31 Day Subsequent Surgery Treatment	99.26%	100.00%	100.00%	100.00%	97.22%	100.00%	100.00%	99.33%	>=94%	94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	>=98%	98%
38 Day Referral to Tertiary	45.49%	47.62%	40.00%	50.00%	50.00%	44.44%	40.00%	45.75%	>=85%	85%
62 Day GP Referral to Treatment	88.67%	90.66%	92.35%	83.98%	87.72%	83.67%	88.17%	87.58%	>=85%	85%
62 Day Referral From Screening to Treatment	94.87%	81.82%	91.67%	100.00%	100.00%	100.00%	83.33%	93.94%	>=90%	90%
WORKFORCE										
Sickness Absence rate (%) - Rolling 12m	4.10%	4.10%	4.07%	4.04%	4.01%	3.97%	*	-	4%	4%
Long Term Sickness Absence rate (%) -Rolling 12m	2.55%	2.54%	2.53%	2.51%	2.48%	2.45%	*	-	2.7%	2.7%
Short Term Sickness Absence rate (%) -Rolling 12m	1.55%	1.56%	1.53%	1.53%	1.53%	1.52%	*	-	1.3%	1.3%
Overall Essential Safety Compliance		95.00%	94.40%	93.96%	93.84%	91.56%	90.12%	-	95%	95%
Appraisal (1 Year Refresher) - Non-Medical Staff - Rolling 12m	93.50%	15.43%	62.67%	96.65%	96.74%	95.74%	95.76%	-	95%	95%
Appraisal (1 Year Refresher) - Medical Staff - Rolling 12m	69.88%	99.75%	99.70%	98.65%	96.59%	97.21%	97.42%	-	95%	95%
FINANCE										
I&E: Surplus / (Deficit) Var £m	-7.97	0.01	0.00	0.00	0.01	0.26	-0.02	0.25		

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
% PPH ≥ 1500ml - all deliveries - at 2.2% lowest rate since March.	Never Event - In ED a Paediatric patient was transferred to the ward and attached to air rather than Oxygen.	As an immediate response to this the division has re-inforced in the department that student nurses do not transfer patients to wards. Also removed all air ports when not in use in the department. This action has been re-inforced and monitored throughout the Division in line with NPSA alert. The incident is under investigation currently.
Sickness Absence rate (%) - rolling 12 months - finally below 4%.	Essential Safety Training compliance has fallen again in-month in each of the 9 EST areas.	A 'Deep Dive' into EST was held in September with Divisions asked to provide recovery plans at Workforce Committee on 8th October. All Divisions now have a robust EST Action Plan to drive up compliance across all EST elements.
% Complaints closed within target timeframe - at 55% best position since March.		

Executive Summary

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

Area	Domain
Safe	• **Number of Incidents with Harm** - YTD position suggests large increase on 2017/18 although higher number is due to better reporting. An assurance report comparing our practice and possible further work to the first acute sector report on wrong implants (one of the Never Event Categories) went to the Serious Incident Review Group in September. The Trust can learn from other Trusts across the country to try to prevent making similar errors. The Trust has started to monitor the reports of the Health Service Investigation Branch (HSIB) for learning from investigations. • **Never Event** - first one since October 2017. This related to the use of air instead of oxygen. This was noted and quickly rectified resulting in no long term harm.
Caring	• **Complaints closed within timeframe** - Of the 40 complaints closed in September , 53% (21/40) of these were closed within target timeframe, best performance this year. The number of overdue complaints was 25/109 (23%) at the end of September; compared to 15/100 (15%) at the end of August. Medicine division has now implemented the recommendations of the deep dive and employed additional administrative support for 3 months. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still under 91% which is below 95.7% target. The matrons and area managers are working with staff so that they engage with patients to promote the survey and therefore receive valuable feedback. Discussions have been had as to how best to enhance the waiting environment and ensure patients know their options with regards to claiming back parking charges if they experience long delays. Outpatients as a whole are currently undergoing a transformational programme of work, the FFT metrics are being monitored throughout the period to assess changes in patient satisfaction levels. • **Friends and Family Test A & E Survey - % would recommend the service**. Performance has improved slightly to 84.75% in month. Plans are in place to tackle the main themes. • **Friends and Family Test Community Survey - % would recommend the Service**. Performance has fallen again to 92.89% against 96.6% target. In reviewing the national comparators CHFT Community Division is performing well nationally. An FFT deep dive has been presented to WEB. • **% Dementia patients following emergency admission aged 75 and over** - current performance at 28.21% has deteriorated and is still some distance from 90% target. CNIO and CCIO will be leading on digital update. Nurse Consultant and Head of the Acute Frailty Service providing professional leadership with Matrons and clinical team and tracking on a weekly basis. Workplan will be reviewed at the end of November. EPR access issues mean that at present only doctors can update the assessment.
Effective	• **#Neck of Femur** - performance improved to 80.85% in September but still struggling to achieve and maintain 85% target. Patients who breach their 36 hours to theatre target will now undergo an RCA to ensure a robust process is in place for learning. The directorate team will be reporting findings back to the Exec sponsors.

Background Context

All divisions continue to plan a response to the CQC action plan following the recent 'Good' CQC inspection making progress on must do's.

Divisions are also actively working on a management plan for Winter and have also started preparing for the annual planning sessions in October and November.

Within Medicine and Surgery vacancies/gaps in the management teams have continued which has stretched capacity but most posts are now recruited to with start dates imminent.

There continues to be issues with vacancies in several key specialties that require capacity to deliver elective capacity and on-call which is driving continued use of agency consultants where available. For some specialties locum cover has not been secured and alternative options to reduce activity and demand are being worked through.

The ward decant programme for flooring is nearing completion with nurse staffing moving back to normal levels.

A reduction in the Cardiology bed base (8 beds) started in September as part of releasing post-reconfiguration benefits.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** - at 89.63% in September, (91.11% all types) - lowest performance since March. Reviewing the junior doctor staffing rota including the training schedule and the internal process for filling gaps. Also reviewing ACP staffing plan and a trajectory of what gaps will be filled on the doctors' rota by when and requirements needed to move to a 7 day 16 hour consultant led service. • **% Stroke patients Thrombolysed within 1 hour** - last 2 months only around 40% against 55% target compared to usual 80% plus achievement. All patients who receive thrombolysis have a case review to consider delays and where they were avoidable. • **38 Day Referral to Tertiary** - 40% for September. All 7 day pathways to be in place by the end of October which will inform a step change. • **62 Day Referral from Screening to Treatment** - just missed the 90% target at 83.3% for September. First time missed since April. This equated to 0.5 breaches and impacts heavily as the numbers treated are low. The breach patient was complex as the diagnosis needed clarifying at Leeds melanoma MDT. There was a 14 day wait for Leeds MDT discussion and the patient was then referred back to Pinderfields for surgery. • **Appointment Slot Issues on Choose & Book** - improved to 28% in-month. Capacity issues within Oral Surgery and Ophthalmology. Ophthalmology prioritising vacant slots for patients on pending lists alongside vacant consultant posts.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Sickness is now achieving the overall sickness target of 4% over a rolling 12 month period. RTWI performance has improved in month but is still below target and is still being addressed at monthly PRM sessions. • **Essential Safety Training** compliance has fallen again in-month in each of the 9 EST areas. A 'Deep Dive' into EST was held in September with Divisions asked to provide recovery plans at Workforce Committee on 8th October. All Divisions now have a robust EST Action Plan to drive up compliance across all EST elements.
Finance	• **Finance**: **Year to Date Summary** The year to date deficit is £24.31m, a £0.25m favourable variance from plan. • The variance reflects the Department of Health pay announcement on Medical Staff pay which confirmed that pay awards would be implemented in October and not backdated as assumed in the plan. **Aside from this the position is in line with plan.** • Clinical contract income performance is below plan by £1.88m. The Aligned Incentive Contract (AIC) protects the income position by £1.65m in the year to date leaving a residual pressure of £0.23m. However, a proportion of this income protection (£0.82m) is as a result of CIP plans and management decisions where there is a corresponding reduction in cost. When these elements are adjusted for, the impact is reduced to £0.83m. • CIP achieved in the year to date is £6.05m against a plan of £6.51m, a £0.46m pressure. • Divisional budgets (excluding Calderdale & Huddersfield Solutions) are now overspent by £1.00m year to date. This pressure has been mitigated by the release of all of the Trust's contingency reserves in the year to date a total of £1.00m. In addition the winter element of the reserve has been released in the short term to offset the shortfall on CIP and will need to be reinstated as CIP is achieved per the re-profiled forecast. • Agency expenditure is £0.03m below the agency trajectory set by NHSI, despite last month's prior period adjustment. **Key Variances** • Medical staffing expenditure continues above plan in both Surgery and FSS with a year to date adverse variance to plan at Trust level of £1.60m. However, against the agency trajectory there was a significant improvement in month, with **Medical Agency dropping below the planned level in month for the first time this year.** • **Nursing pay expenditure reduced in month**, with a reduction in both agency and bank expenditure. Year to date the adverse expenditure variance has reduced to £0.21m (excluding the impact of pay awards which is funded as income). **Forecast** • The forecast is to achieve the planned £43.1m deficit; this relies upon full delivery of the £18m CIP plan including high risk schemes. • The underlying position is driving an additional recovery requirement with a total value of £1.66m. £0.68m of recovery actions have been agreed and incorporated within Divisional forecasts. A further £0.96m of recovery plans are being scoped against a recovery requirement of £0.98m.

Background Context

Within the Community division the move out of St Johns has now been completed and teams are now settling into their new bases. Further estates rationalisation is planned which has raised concerns from some GP Practices. Responses will be coordinated by CHFT and Calderdale CCG so that the approach is consistent with the approach described in Calderdale Care.

Maternity services saw one of their busiest months of the year - the service continues to manage higher than planned vacancies and maternity leave in keeping the service safe.

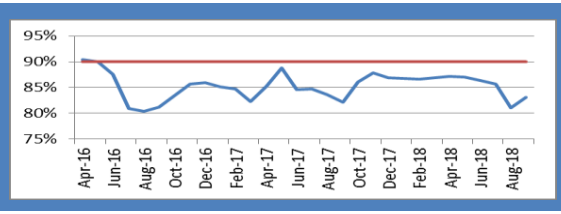
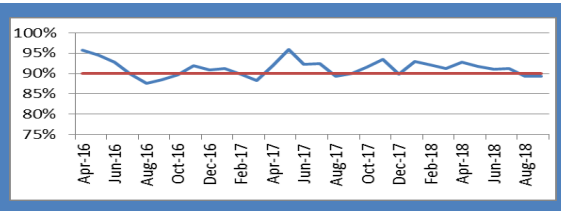
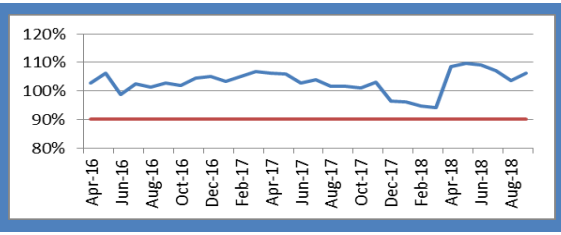
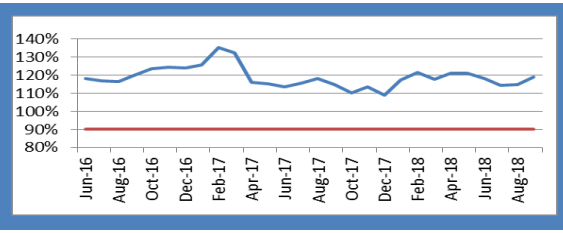
Some service disruption was seen during September following the failure of the Radiopharmacy isolator. This had some impact on those services relying on isotopes produced by the unit including Breast, Cardiology and Fluoroscopy. Plans are in place to repair the unit in early October ahead of a wider service change during 2019/20.

The Pathology team have been working with GPs to develop a scheme to support demand management - this involves highlighting tests which have been recently requested at the time of rerequest. This scheme is in place and having a positive impact on demand from GPs.

The Phlebotomy team presented some community model options to the Primary/Secondary care interface group. This went really well and plans are in place to develop something different from Q4 of 2018/19.

This month the Pharmacy team were finalising arrangements to commence an enhanced weekend service to wards during the winter months - this wil start from the beginning of October. The team were also winners at the Medipex Innovation Awards - the team won £2,000 in recognition of the work done in developing the AMoS software used in the Trust. The money will be used to further develop the software.

Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	85.67% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - ward 5 66.8% - 7a/d 73.7% - ward 8 74.7% - ward 12 74.7% - ward 17 68.8% - ward 21 66.3% - 8A 68.9% -ward 19 74%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy. This is managed on a daily basis against the acuity of the patients
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.24% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - Ward 10 66.9%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates on ward 10 are due to a level of vacancy. This is managed on a daily basis and CHPPD is maintained
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	107.18% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - 6c 69.8% - ICU 72.5 - NICU 68%	The low HCA fill rates in September are attributed to a level of HCA sickness within the FSS division and a reconfiguration of ward 6c. This is managed on a daily basis against the acuity of the work load. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; and support of reduced RN fill.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	114.53% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	There are no wards reporting fill rates for HCA's below 75%. Overfill can be attributed to maintianing CHPPD

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	DAY						NIGHT						Care Hours Per Patient Day						
	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies	Ward Assurance
	Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual										
CRH ACUTE FLOOR	3,029.07	2,728.07	1,839.83	1,958.92	90.1%	106.5%	2,628.00	2,328.00	1,649.50	1,813.00	88.6%	109.9%	30.5	29.4		1	15	12.89	1.13	48.9%
HRI MAU	1,876.88	1,703.75	1,879.83	1,873.83	90.8%	99.7%	1,650.00	1,532.33	1,320.00	1,387.50	92.9%	105.1%	10.4	10.1		4	15	4.4	0.95333	45.0%
WARD 5	1,614.00	1,077.67	1,112.67	1,457.08	66.8%	131.0%	969	913.00	990	1,082.50	94.2%	109.3%	5.9	5.7		1	12	4.75333	-3.02667	52.7%
WARD 15	1,769.17	1,505.17	1,481.17	1,936.83	85.1%	130.8%	1,309.00	1,264.00	1,309.00	1,562.50	96.6%	119.4%	9.1	9.7		2	6	3.93667	-0.32	75.3%
WARD 5BC	2,408.67	1942.4167	1583.3333	1,527.42	80.6%	96.5%	1980	1,536.00	660	1001.5	77.6%	151.7%	7.9	7.2			7	11.87	-7.18	57.8%
WARD 6	1,637.00	1,454.33	970	1,033.17	88.8%	106.5%	990	946	660	776.5	95.6%	117.7%	7.9	7.8		1	9	4.33	0.51	58.5%
WARD 6C	1,647.00	1,400.58	1,525.00	1,064.67	85.0%	69.8%	1,320.00	1,144.00	660	704	86.7%	106.7%	9.8	8.2			5	8.19	5.51	33.3%
WARD 6AB	1,059.83	847.83	780	720	80.0%	92.3%	715.00	671.50	715	704.5	93.9%	98.5%	4.5	4.1			5	2.04	-1.47	69.1%
WARD CCU	1,531.17	1302.3333	360	360	85.1%	100.0%	990	990.00	0	0.00	100.0%	-	10.6	9.7		1		3.01001	0.13	52.7%
WARD 7AD	1,688.00	1,244.33	1530	1980	73.7%	129.4%	990	959.8167	990	1199	97.0%	121.1%	7.0	7.3			4	3.58333	3.35	55.5%
WARD 7BC	2,469.43	1,919.75	1,592.67	2,059.68	77.7%	129.3%	1980	1579.5	660	1,432.00	79.8%	217.0%	11.6	12.1			2	1.03	-6.02	70.9%
WARD 8	1450.3333	1083	1145	1829.667	74.7%	159.8%	990.00	869.1667	990	1419.5	87.8%	143.4%	6.1	6.9		1	9	2.51	0.42667	65.5%
WARD 12	1621.5	1206	739.5	1069	74.4%	144.6%	814	660.00	506	660.00	81.1%	130.4%	6.2	6.0		1		1.81	2.16	56.7%
WARD 17	1983.8333	1365.5	1090.5	1094	68.8%	100.3%	990	946	660	748	95.6%	113.3%	6.0	5.3		1	3	5.13666	-1.01666	45.2%
WARD 5D	1038.8333	970.95	803.5	873.3333	93.5%	108.7%	671	638.00	330	440.00	95.1%	133.3%	5.1	5.2			2	-0.62667	-3.05666	67.3%
WARD 20	1756.0833	1444.75	1683	1816.083	82.3%	107.9%	1320	1,188.50	1309	1,446.00	90.0%	110.5%	6.6	6.4		2	2	10.13667	0.57666	69.6%
WARD 21	1550.4	1028.1667	1467.8333	1463.167	66.3%	99.7%	1,023.50	770.50	1,047.00	1,024.50	75.3%	97.9%	8.6	7.3			8	3.61401	-1.22999	46.0%
ICU	4152.5	3849.5	791.5	573.5	92.7%	72.5%	4,128.50	3500.5	0.00	0.00	84.8%	-	36.0	31.4		3	1	0.43	-0.22	71.3%
WARD 3	987.16667	866.5	718.16667	740	87.8%	103.0%	690.00	690.00	345	356.5	100.0%	103.3%	6.5	6.3			1	0.33667	0.37	44.0%
WARD 8A	966.5	665.66667	700.66667	686.8333	68.9%	98.0%	690	539.5	345	402.5	78.2%	116.7%	9.7	8.3			2	3.31667	-0.94667	63.1%
WARD 8D	920.81667	852	776.31667	691.5667	92.5%	89.1%	690	609.5	0	345	88.3%	-	7.6	7.9				2.24333	0.43	68.0%
WARD 10	1459.8333	1126.0833	796.5	990.5	77.1%	124.4%	1035	692.00	690	1035	66.9%	150.0%	7.1	6.9			1	4.07334	1.29667	60.7%
WARD 11	1690.1667	1448.3333	1093.1667	1092.967	85.7%	100.0%	1,035.00	963.42	690	931.50	93.1%	135.0%	6.1	6.0			3	3.07	0.29	61.4%
WARD 19	1662.1667	1229.3333	1136.5	1352.167	74.0%	119.0%	1,035.00	1,035.00	1035	1311	100.0%	126.7%	7.5	7.6		3	6	1.62333	-3.31666	73.0%
WARD 22	1192.1667	1127.3667	1092	1068.5	94.6%	97.8%	770.50	928.17	690.00	667.00	120.5%	96.7%	6.0	6.1		3		0.48667	-0.08	55.4%
SAU HRI	1903.3	1732.6667	930.33333	974.9667	91.0%	104.8%	1380	1,374.75	345	345	99.6%	100.0%	9.4	9.1			1	-2.61665	-1.19	49.0%
WARD LDRP	4317.8333	3645.8333	916	827.3333	84.4%	90.3%	4,099.67	3,486.47	685.16667	736.9167	85.0%	107.6%	21.0	18.2				0	-1.8	17.7%
WARD NICU	2234.5	1716.1667	750	510	76.8%	68.0%	2,070.00	1,602.25	690	564.5	77.4%	81.8%	13.8	10.6				0.26	1.92333	39.3%
WARD 1D	1244.5	1017.4167	348.5	337	81.8%	96.7%	690.00	692.00	345	333.5	100.3%	96.7%	4.7	4.2				1.60667	0.17334	9.6%
WARD 3ABCD	3694.25	3331.6667	1175	977	90.2%	83.1%	3077	2972.483	345	345	96.6%	100.0%	58.8	54.1				-2.26758	2.33333	19.9%
WARD 4C	1311	1164.6667	410.5	361	88.8%	87.9%	690.00	679.50	345	320	98.5%	92.8%	10.9	9.9		1	1	0.31668	0.52333	50.0%
WARD 9	840	820.25	345	341	97.6%	98.8%	690	681.5	345	345	98.8%	100.0%	4.7	4.6				0.57334	0.30668	9.9%
Trust	**58707.9**	**48818.05**	**33563.98**	**35641.2**	**83.15%**	**106.19%**	**44100.17**	**39383.4**	**21350.67**	**25439.4**	**89.30%**	**119.15%**	**9.04**	**8.56**						

Hard Truths: Safe Staffing Levels (3)

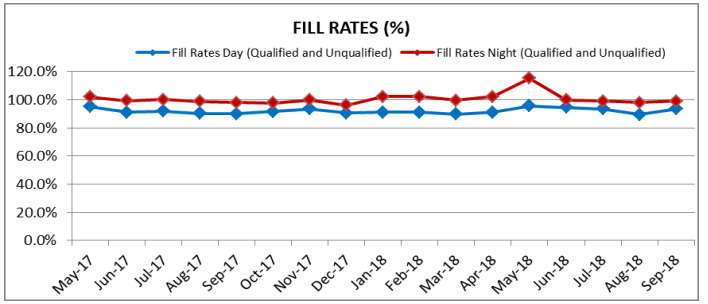
Care Hours per Patient Day

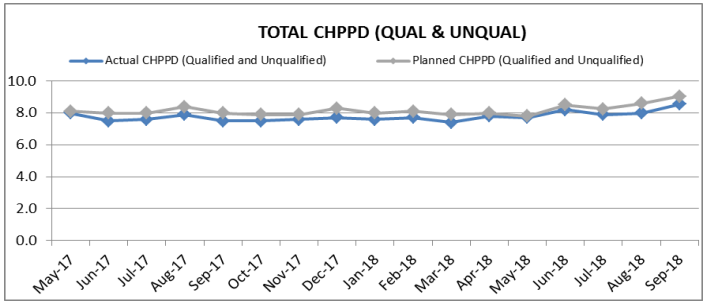
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Jul-18	Aug-18	Sep-18
Fill Rates Day (Qualified and Unqualified)	93.50%	89.40%	93.48%
Fill Rates Night (Qualified and Unqualified)	98.97%	97.90%	98.94%

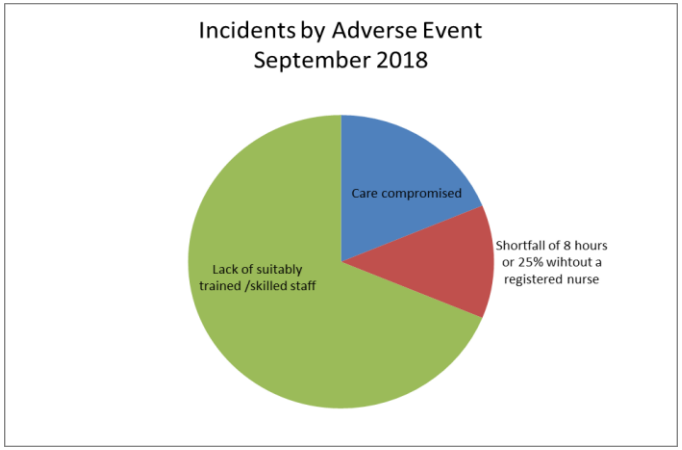
Planned CHPPD (Qualified and Unqualified)	8.2	8.6	9.0
Actual CHPPD (Qualified and Unqualified)	7.9	8	8.6

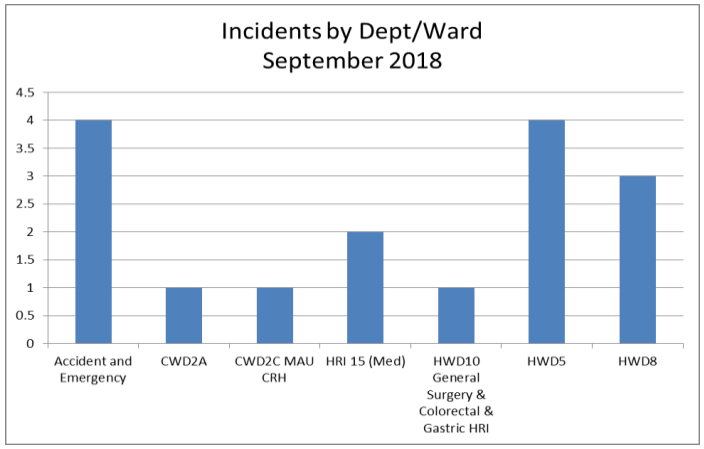
A review of September CHPPD data indicates that the combined (RN and carer staff) metric resulted in 24 clinical areas of the 32 reviewed having CHPPD less than planned. 8 areas reported CHPPD slightly in excess of those planned . Areas with CHPPD more than planned were due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and reviewed monthly through the Nursing workforce strategy group.
There were **16 Trust Wide Red shifts** declared in **September.**
As illustrated above the most frequently recorded red flagged incident is related to "lack of suitably trained staff"
No datix's reported in September have resulted in patient harm

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.
2. Further recruitment event planned for the 13th October.
3. Applications from international recruitment projects are progressing well and the first 15 nurses have arrived in Trust, with a further 6 planned for deployment in December 2018
4. A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. 57 candidates have now been transferred onto the OET programme.
5. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017. A proposal has being developed to up-scale the project in line with the national and regional workforce plans. A second cohort of 20 trainees commenced training on the 4th June. A further cohort are planned for training in December 2018
6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce
7. A new module of E roster called safe care has been introduced across the clinical divisions. Benefits will include, better reporting of red flag event and, real-time data of staffing position against acuity

17. Car Parking

To Approve

Presented by Lesley Hill

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday 1 November 2018	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Car Parking - -	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board – 10th May 2018, Governors Meeting – 4th July 2018, Staff Management Partnership Forum – 24th July 2018. WEB 18.10.18, Governors Meeting 18.10.18, SMPF 23.10.18.	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

Purpose - Propose a fair, open and transparent engagement plan relating to car-parking arrangements and increased charges to public and staff. The demand for car-parking far outweighs the availability of spaces at CRH in particular and whilst it is important to address the balance of parking for staff, patients and visitors it is important the Trust continues to deliver compassionate care to its patients courtesy of our dedicated colleagues. There is a common agreement that further improvements are required regarding the car parking situation and to do nothing is not an option.

CHFT colleagues recognise the need to review parking permits to provide a fair balance between supply and demand. In order to provide more spaces for patients and visitors we must look to providing alternative and greener travel arrangements for our staff where possible. Alternative travel arrangements have been suggested which include car share schemes, park and ride opportunities, and increase internal transport journeys between sites; in addition the Trust are working closely with West Yorkshire Combined Authority to ensure travel between hospital sites are incorporated into their future plans. Whilst these ideas are supported by staff each and every initiative requires funding to implement. It is recommended that introducing the following changes will provide funding to support such initiatives.

Main Body

Purpose:

-

Background/Overview:

Car-Parking increases were implemented in 2015/2016 for both public and staff. A number of improvements have since been introduced and further considerations have been made regarding further car-parking increases. Improvements include:-

- Removal of ANPR at Acre Mill resulting in a reduction of 80% of the Divisions complaints from initial installation up until removal. A barrier system is now in place which aligns with CRH and HRI.
- Created an additional 20 spaces at HRI and 15 spaces at CRH
- Installation of chip and pin payment machines across HRI, Acre Mill and CRH
- Introduction of specific parking permits for staff groups
- Travel and car-parking survey with over 1200 responses and suggestions
- Closer partnership working with Calderdale Council regarding the potential for off-site and subsidised parking for colleagues
- Quicker responses and fault finding regarding break-downs (barriers)
- Engagement with independent British Parking Association to help provide safe car-parking solutions

Significant engagement has taken place with colleagues who recognise the need for change. Colleague support has enabled the development of renewed online car-parking permit criteria for staff which will be available for launch in December 2018.

Consultation has taken place with Trust Governors and Staff Management Partnership Forum with expected opposition for increases.

There are occurrences when both public and staff are pressing the buzzers at exit barriers and, due to the back log of traffic, those remotely manning the barriers have no option but to lift the barriers letting drivers out without paying. This happens more frequently at CRH than HRI and the mix appears to be both public and staff. Concerted effort is being implemented to eradicate this practice and individuals will be challenged and expected to park up and pay. This should deliver an approximate £3.5k per month initially with a longer term expectation of £5k per month once the expected behaviour change becomes embedded. Support will be required from WOD and Managers to back up any challenges of non-compliant behaviours.

Impact on colleagues - It is felt that further engagement events with colleagues should be explored prior to the introduction of increased parking charges. However, early consideration should be given to changing the Learning and Development car-park at CRH to “public use only”. The car park is situated off Godfrey Road and nearby the Women and Children’s car-park providing 40 spaces for public use. Whilst this can be introduced quickly timing is essential as both HRI and CRH have lost *parking spaces on a temporary basis due to shipping containers being used to manage healthcare waste (CRH 17 spaces and HRI 19 spaces). Early indication from the Waste and Energy Manager is that shipping containers are a very short term measure. An additional 50 spaces could be released at Acre Mill tarmac area for CRH staff living in the Huddersfield area that would be willing to shuttle to CRH.

*Any lost car-parking income is being calculated along with other costs associated with the healthcare waste business continuity plans and will be submitted to NHS England

Whilst increased staff charges are likely consideration is being given to alternative ways of generating income from car-parking or other ideas. The proposal is that any increases will continue to be aligned to Agenda for Change pay bands with the majority of increases at £1 per month. It is expected that once all other options have been exhausted the increase would be introduced in the new financial year; this would deliver approximately £4k per month and £48k full year effect. We will also review permit allocation overall to improve the supply and demand ratio.

The proposal also recommends an increase in the number of spaces at Broad-Street to 50. Apcoa, the provider, is considering moving the current NHS spaces to a preferred floor level and improving signage to prevent public from using these spaces. Parking income generated equates to the cost of the additional spaces at an additional £10k p.a. This outcome will alleviate ongoing concerns for community colleagues alongside work around agile working thus negating the need to park on site.

Public –The Trust proposed increases of 20p (£2.80 to £3.00 for 2 hours) and increase of £1 (£7.00 to £8.00 for 24 hours) which are in line with other Trusts in the region. The introduction of this change on 2nd January would deliver approximately £7k per month and £84k full year effect. In response to requests from patients and their families the Trust also proposes to introduce a weekly charge of £35 for those visiting on a regular basis. These charges fall in the range of other Trusts as do concessions that remain in place along with free parking for those in receipt of certain benefits.

The Trust receives regular concerns from patients who attend for out-patient appointments and expect to park and pay for 2 hours. On occasions clinics run over resulting in patients paying a higher charge of up to 4 hours which is £5. An agreed solution is to ensure those patients whose appointments have overrun pay the standard 2 hour fee.

A phased engagement plan is recommended and colleague engagement is essential to ensure the successes are achieved.

Phase 1 (Oct – Dec 18)
- Begin engagement with colleagues
- Cease lifting barriers £3.5k/month income (£17.5k full year effect)
- Revisit Calderdale Council re parking in residential areas & reduced cost permits
- Allow use of priority car-park for colleagues (5:30pm to 7.30am)
- Implement BSP changes at £2.5k/quarter expenditure

Phase 2 (Jan - Mar 19)
- Introduce public parking increase - £7k/mth, £86k/year
- Change CRH L&D to public use only - £6k/mth, £72k/year (possibly sooner once shipping containers off sites)
- Release Acre Mill tarmac area for 50+ CRH users

Potential income of £52k based on above assumptions for 18/19

Phase 3 (April – June 19)
- Introduce staff parking increase - £4k/mth and £48k FYE (recognition that parking initiatives will require

funding)
- Introduce waiting list for permits
- Assuming parking initiatives deliver a positive outcome a complete review of parking permits must be undertaken to balance out supply & demand.
- Capital funding available to CHS to improve parking at Acre Mill hard-core area (improved parking arrangements will deliver more parking spaces)

Phase 4 (July – Dec 19)
- CHS discussions with West Yorkshire Combined Authority Vs Transport

The Issue:

-

Next Steps:

Support required from Executive Directors to recognise the challenge, opportunities and to provide support to implement a phased plan.

Paper to Council of Governors – 18th October 2018
Paper to Staff Side – 23rd October 2018
Paper to Board – 1st November 2018

Recommendations:

Approve actions in Phase 1 and 2. A further paper to be brought about Phases 3 and 4 to be brought in March 2019 following staff engagement.

Appendix 1 - Phased Communications Plan
Appendix 2 - Action plan V9

Appendix

Attachment:

There is no PDF document attached to the paper.

APPENDIX 1 – PHASED COMMUNICATIONS PLAN

A wider communications plan is essential to ensure CHFT colleagues see the full story taking into account the phased changes relating to car-parking.

PHASE 1 Oct18-Dec 18					
	What	**Who**	**When**	**Potential Income**	**Staff Outcome**
1	Gain approval of paper at WEB 18.10.18 – need staff engagement group (AW has names available of those interested)	LH / SD	18th Oct 18		
2	Staff - staff engagement event to understand:- • CIP ideas as opposed to staff parking increases up to value of £48k. • Inform staff re reduced spaces due to ISO waste storage units (duration TBC) • Planned challenge when exiting car-parks without swipe card. Support required from WOD if staff regularly fail to comply with rules. • Plans to open CRH L&D car-park to public only. Whilst this would generate approx. £5k/month this is currently used for staff (once shipping containers off site) • Share Calderdale council permit scheme. • Promote the use of shuttle bus • Open priority car-park to all staff at set times. • Advertise metro-card. • Explore park & ride / car share				
3	Staff & Public - Challenge barrier lifting at CRH & HRI for staff and public. This will attract charges from ISS to operate this initiative.	ISS /CHS	1st Nov 18	£3.5k/mth	
4	Staff - Open priority car-park barriers overnight for colleagues (set times to be agreed)	Engie CHS	1st Nov 18		
5	Staff - Go live with Broad-street Plaza proposals and inform BSP Staff Group.	Execs	18th Oct 18	£2.5k/mth	
6	Staff - Explore reciprocal agreement between Locala & Community Staff		18th Oct 18		
7	Public - Communicate consistent message to patients:- - Parking increases on 2nd Jan 2018 - Clear protocol for patient clinics over running resulting in extra car-parking costs. - Weekly parking permits for those visiting long term patients (1 per patient)	Execs / Public	Nov 18		
8	Trust - Gain clarity from PFI on regular guaranteed income / threshold figures.	GB	Oct 18		

PHASE 2 – Jan 19–March 19					
	What	Who	When	Potential Income	Staff Outcome
	Public Introduce parking changes for public (ensuring all signage / infrastructure in place to go live on 2nd Jan 2019. - All Increases - Reduced parking for weekly parking	CHS ISS Engie	2/1/19 2/1/19 2/1/19	£7k/mth £84k/pa	
	Staff Open tarmac acre mill (50 spaces) for CRH staff only living at Kirklees area (Ratio of 1.5 x 50 spaces = 75 permits)	CHS	2/1/19	TB Assessed	
	Staff Engagement Outcome dictates outcome of staff parking increases.	Trust / CHS / ISS	March 19 for April go live.		
	Staff Working party to explore:- - Car-share CRH & HRI (areas identified / free parking easy to administer) - Park & Ride – CRH priority - Park & Ride – HRI later				

PHASE 3 – April 19 – June 19					
	What	Who	When	Potential Income	Staff Outcome
	Staff - Increase staff parking charges	Trust	April 19	£4k/mth £48k/pa	
	Staff - Go live with Car-Share at CRH and HRI				
	Staff – Develop Park & Ride for CRH - Elland - Cedar Court (M62 Junction) - Halifax end				
	Capital funding to improve parking arrangements at Acre Mill hard-core ground	CHS	April 19		

PHASE 4 – July 19 – Dec 19					
	What	Who	When	Potential Income	Staff Outcome
	WYCA discussions regarding transport between Sites.	CHS/Trust			

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Car Parking Action Plan V9
Outstanding Actions

A total of 2500 parking spaces are available across HRI, Acre Mills and CRH Sites for use by colleagues, public, patients. Approximately 2400 permits are in use by staff and funded via salary sacrifice or monthly parking deductions. A proposal to review parking using an updated weighted decision matrix has been supported which will be automated (THIS). In order for this to work it is essential the Trust allocate specific "Trust colleagues" parking areas and "patient / public" parking areas which would result in a number of our colleagues being displaced. Whilst providing a positive patient experience is essential it is important to ensure displaced colleagues are supported where possible. It is important we consider "car-share" areas as indicated during a recent car-parking / travel survey.

The Tryst receives regular complaints / patient feedback regarding the cost of on-site parking as was echoed at June 2018 Governors meeting.

	Current Situation	Updates	Who	When
1)	**CRH** 926 Spaces available (app 1). This includes 23 spaces at Dry Clough Close (Trust accommodation which is unfit for purpose) **Issues:-** - Staff parking significantly over-subscribed - Complaints from on-site staff - Complaints from public / patients - Complaints from Community / Cross Site working staff - Paper to Board regarding the demolition of Dry-Clough Close to replace with additional 53 parking spaces. Cost far outweighs benefits.	**<u>Recommendation 1 – Review Public / Staff Spaces</u>** Identify specific spaces for staff / public. **<u>Recommendation 2 - Council / CRH Meetings</u>** Total of 60 council permits can be made available to CHFT colleagues @ £295 (less 5% discount) however, spaces not guaranteed. Areas within 5 mins walking distance of site. General view from Council that spaces are always available early mornings. Revisit to ensure permits remain available. Revisit opportunity for staff parking in residential areas. Indication there is potential for this in some areas near CRH.	Trust / CHS / PFI Trust / Council Trust / Council	April 19 Oct 18 April 19

CONFIDENTIAL

		<u>Star Chamber - Recommendation 3</u> Change L&D car park to public use only from Jan 19. 43 spaces @ £8.40 per day (turnover of 3 times /day) = £361.20/day; £1.8k/week; £7.2k/mth less 15% free parking = £6.1k/mth. Q4 - £18.25, FYE = £73k	Trust (CHS/PFI)	Q4
		<u>Star Chamber - Recommendation 4</u> Allow staff to use priority parking area after 5:30pm and 7am	CHS/PFI	Q3
		<u>Star Chamber - Recommendation 5</u> Challenge barrier lifting at CRH & HRI (Staff/Public).	CHS /PFI	Q3
2)	**BROAD STREET PLAZA, HALIFAX** 25 spaces available at £16.5k p.a. 83 + permits allocated. **Issues:-** - Insufficient parking bays for no. of colleagues' - Reclamation of expenses caused concerns - *Princess Royal Parking 20 spaces Concerns from colleagues there aren't sufficient permits and they are not always available to use when required.*	**<u>OW/BSP Engagement Event – Recommendation 6</u>** OW / AW met with BSP colleagues 10/9/18. Increase spaces to 50 with APCOA (Mon-Fri), move location and improve signage	Trust / Apcoa	Q3
		<u>OW/BSP Engagement Event – Recommendation 7</u> Explore generic parking passes at North Bridge (council). Safe Parking Status etc.	AW/Calderdale Council	Oct 18
		<u>OW/BSP Engagement Event – Recommendation 8</u> Clarity provided on Community travel expenses. Decision required from Community SMT in Oct 18.	Community Division SMT	Oct 18
		<u>Recommendation 9</u> Clarity on No. of permits issued to Locala & vice-versa at Princess Royal Hospital. Consider reciprocal agreement.	Trust / CHS / Locala	Q4
3)	**HRI** Total of 867 spaces available (App 2)	**<u>Recommendation 10 – Review Public / Staff Spaces</u>** Identify specific spaces for staff / public.	AW/CHS	April 19

4)	**ACRE MILLS** Total of 710 spaces available (App 2) 210 spaces in tarmac area (patients/public) *500 spaces in overflow area	Additional 50 spaces can be released adjacent to PMU building (top of Acre Mills area) to any displaced staff **<u>Recommendation 11</u>** Release of 50 spaces to displaced staff living in Kirklees area and working at CRH.	Exec Board / CHS	Jan 19
	Issues:- • Complaints from Eye Clinic patients regarding clinics running late. • Complaints from colleagues regarding over-flow area in terms of the pot-holes / damage to vehicles and health & safety risks. **Planning permission would be required for significant improvements (white lining / lighting etc) to Acre Mill overflow carpark. Therefore, risks mitigated by regular inspection of area / backfilling with hardcore and some capital funding allocated to this area for 2018/19 (improvements to improve parking behaviours).*	**<u>Recommendation 12</u>** Ticket validation of £2.80 for any patient clinics which run over (due to no fault of the public). Already in practice at some clinics; needs formalizing.	Exec Board	Nov 18
		<u>Recommendation 13</u> Improved parking in overflow area would provide additional spaces. FM Coordinators often patrol the area to encourage improved parking. Clarity required from CHS on capital spend / improvements / timescale.	Exec Board / CHS	April 19

<table>
<tr>
<td>5)</td>
<td colspan="2">COST INCREASE PROPOSALS
Paper to Governors and Staff Side regarding proposed increase:-

5a) PUBLIC

➢ Up to 2 hrs £2.80 increased to £3.00
➢ Up to 4 hours No Change
➢ Up to 6 hours No Change
➢ Up to 24 hrs £7 Increased to £8.00
➢ Weekly charge £35.00</td>
<td><u>Recommendation 14</u>
Introduce increase parking arrangements for public:-
a) All increase = £86k p.a.
b) 2 hour charge only = £60k p.a.

Go live 2nd Jan 19

Part year effect:- £21,500

Full year effect:- £86,000</td>
<td>Exec Board / WOD / Finance</td>
<td>Jan 19</td>
</tr>
<tr>
<td></td>
<td colspan="2">5b) STAFF (App 3)
WTE
As Is Prop
Band 1&2 £20 £10
Band 3 £22 £11
Band 4&5 £24 £12
Band 6&7 £26 £13
Band 8 & abv £28 £14
Priority £32

Staff Parking Permits

2147 WTE Permit Holders
175 Part Time P’Holders
2322 Total</td>
<td>=< 19 Hours
Part Time
As is Prop
£21 £11
£23 £12
£25 £13
£27 £14
£30 £15
£40</td>
<td>Current Annual Returns:
£56k / month
£672k / annum

Proposed Increases Resulting in following Returns:-
£60k / month
£722k / annum
Delivering £4k / mth & £48k / annum (FYE)

<u>Recommendation 12</u>
Carry out proactive colleague engagement events prior to increase to
• highlight financial challenges
• Share likely increase in parking charges
• Explore potential opportunities to travel differently
• Explain requirement to review staff parking permits to align demand to availability
• Agree patient / staff parking areas</td>
<td>Exec Board / Finance / WOS</td>
<td>Oct 18</td>
</tr>
</table>

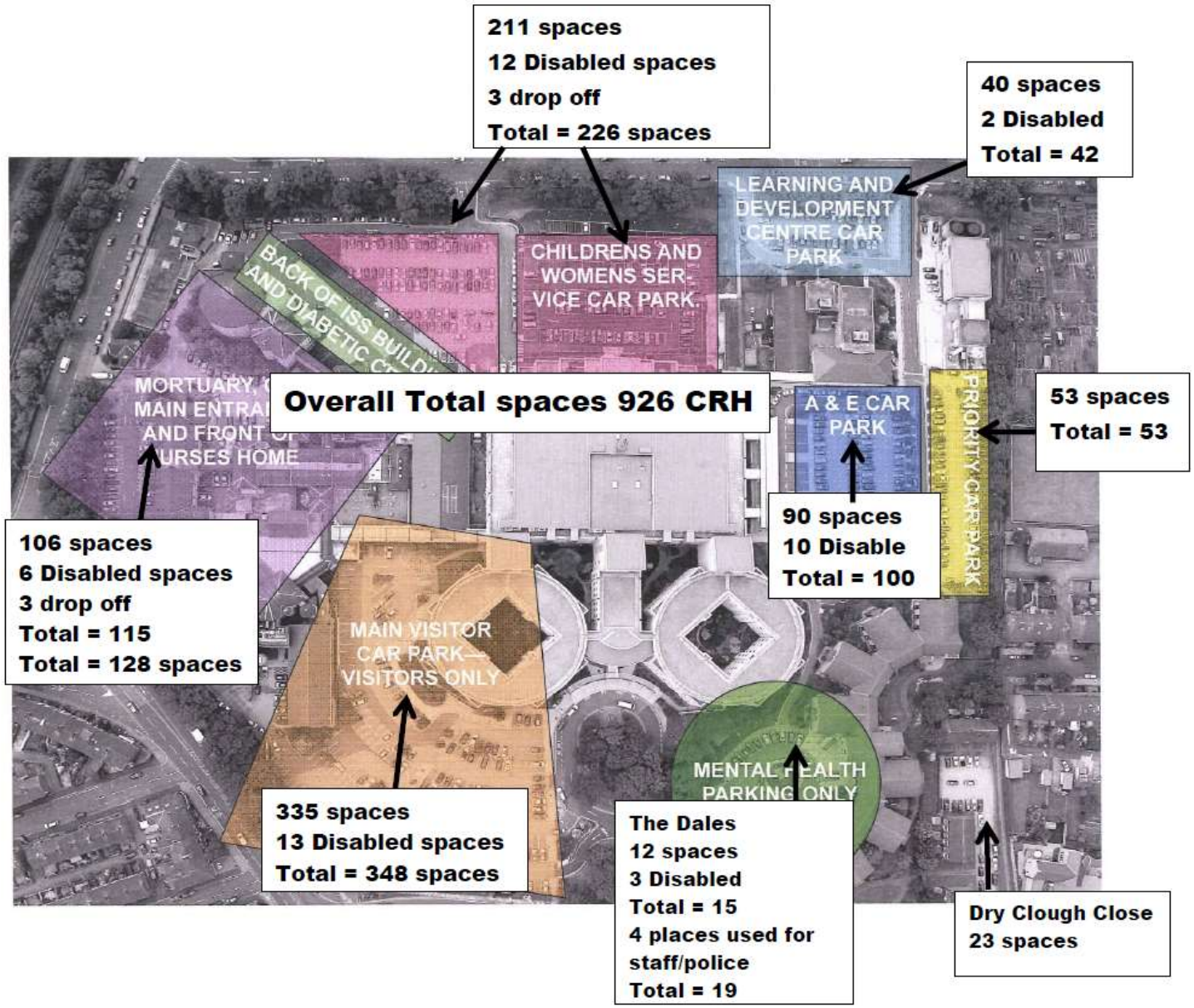
			• Enable colleagues to relinquish permits Careful and considerate engagement essential to its success. **<u>Recommendation 13</u>** Go live with increased parking charges (if no alternatives found)	Exec Board / Finance / WOS	April 19
6)	**SAVILLE ROAD; HRI** Saville road is an un-adopted road running adjacent to HRI South Drive. The road is owned by Thornhill Estates and managed by Savills. Conversation with Savills (in May 18) indicated Thornhill Estates were planned to make improvements to the road and passing the ownership to Kirklees Council. However, the costs for improvement works would be borne by the residents who appear to be unaware of this proposal. As at 30/9/18 no indication from Thornhill Estates of any change. Issues:- Public and colleagues park outside a number of residential areas which causes concerns for a number of the neighbours who are blue badge users and require 24/7 access to their premises.		AW met with residents on a number of occasions to support them with their ongoing challenges. Whilst there is little the Trust can do legally to prevent colleagues from parking on the un-adopted road we have appealed to their better nature and issued letters on vehicles explaining the situation and requesting their courtesy. As at June 2018 this approach has had the desired impact but may not be sustainable. CHS FM Coordinators continue to patrol the area in a proactive and supportive manner. **<u>Recommendation 14</u>** Continue with CHS FM Coordinators continuing in a support manner regarding parking.	Exec Board / CHS	Oct 1**8**

7)	**TRAVEL / CARPARKING SURVEY** Feb 2018 – 1273 responses to above survey providing much needed feedback. (App 4) Issues:- Completion was March 18 and essential to issue findings along with some clear next steps. Parking increase paper has prevented the Team from pushing forward on the survey findings.	**<u>Recommendation 15</u>** Use feedback on travel/car-parking survey outcome along with engagement events taking into account:- - Survey results - Options for displaced staff - Promotion of car-share - Promotion of Metro Offers - Consider park & ride offer - Introduction of waiting list for permits Use this feedback to initiate engagement process.	Exec Board / WOD	Nov 18
8)	**TRANSPORT** Shuttle services provided between HRI and CRH Site however, lack of spaces on shuttle at peak times.	Transport have added an additional driver at peak times to run the passenger transport bus which will provide an additional 7 spaces. If additional staff spaces are allocated at Acre Mill tarmac area there will be a requirement for a review of travel between hospitals. **<u>Recommendation 15</u>** Consider transport / WYCA as part of staff engagement event therefore essential to include CHS in discussions / next steps.	Trust / CHS / WYCA	July 19
9)	**PERMITS / DATABASE / EQUIPMENT** Staff Parking database no longer supported. THIS developed an online permit application with support / sign up from Focus Group; database provides:-	Database 90% complete. **<u>Recommendation 16</u>** Go live with database on completion of staff engagement event.	Exec Board / WOD/THIS/CHS	April 19

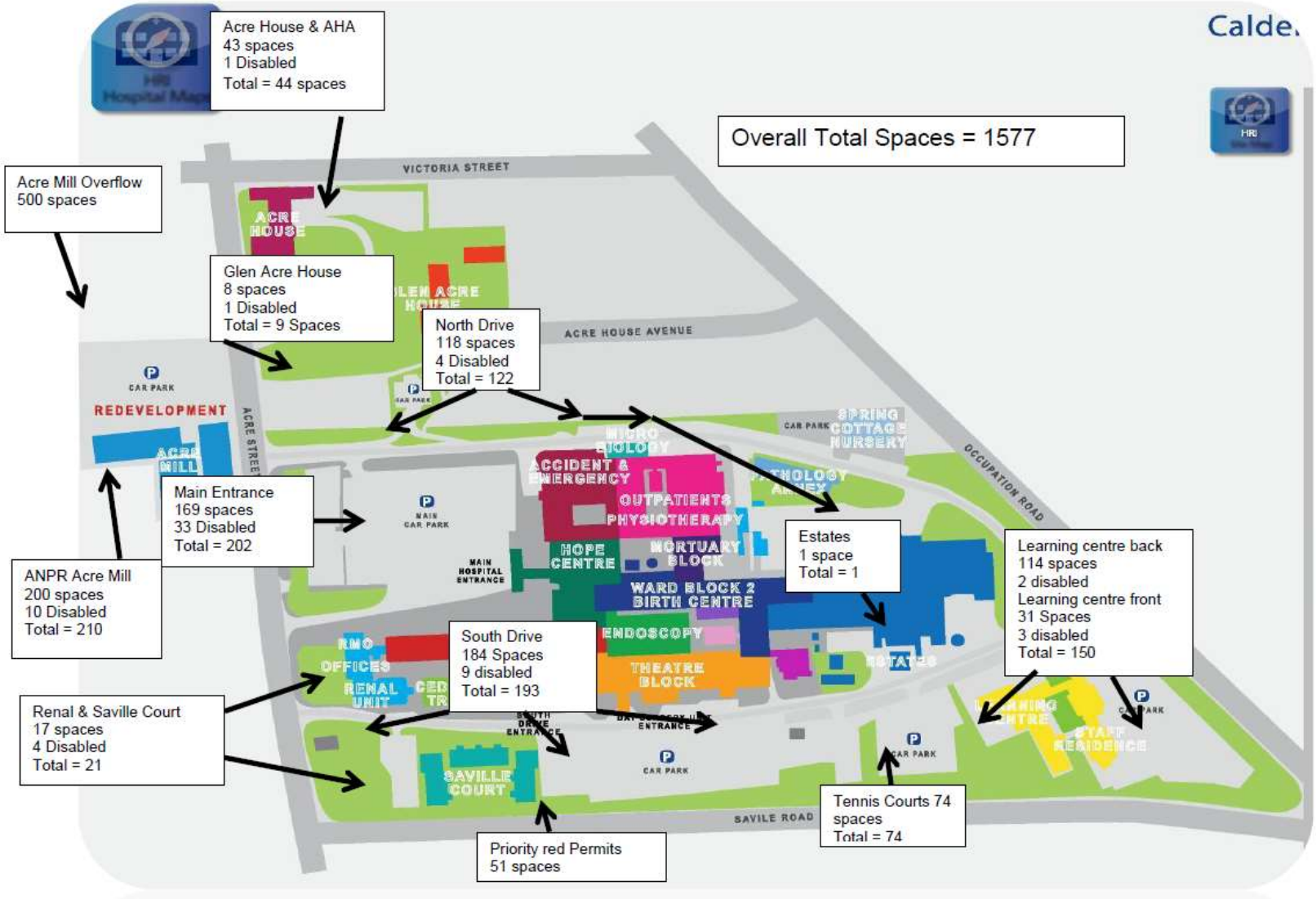
	- Live list of staff permits - Location of all permit holders - Live waiting list - Live list of leavers Administration of database managed by CHS Ltd, General Offices.			

AW
10th Oct 2018
V9.1

Appendix 1 - CRH



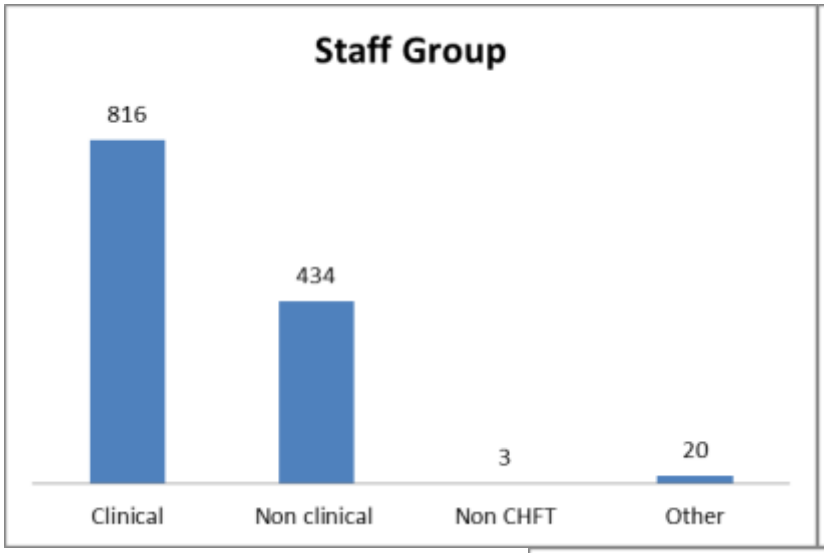
Appendix 2 - HRI

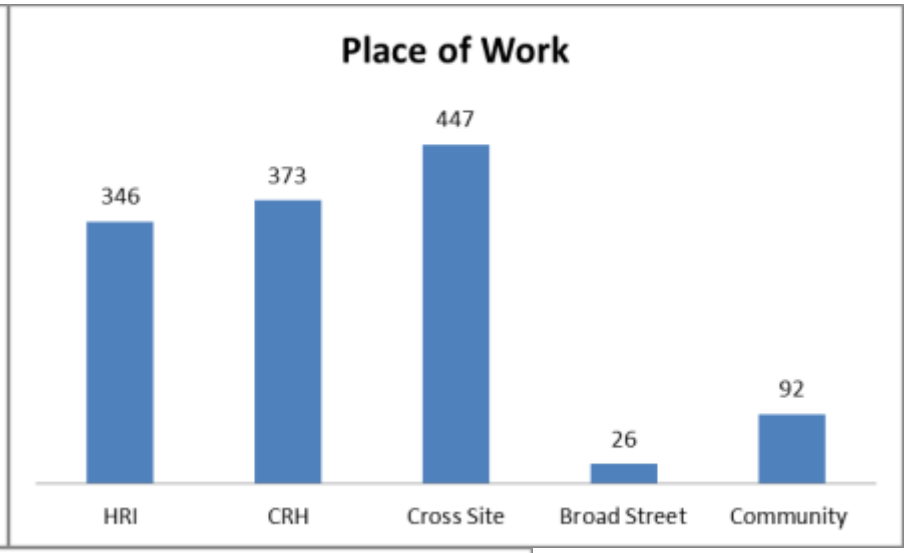


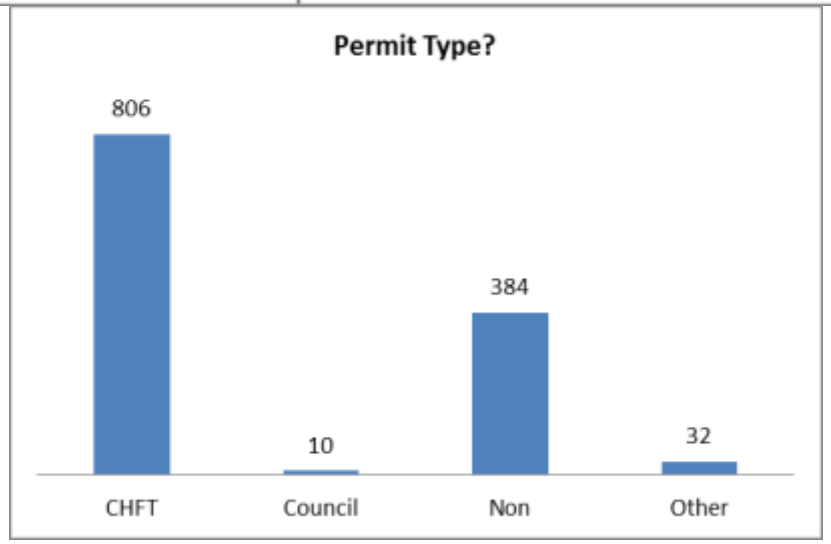
APPENDIX 3

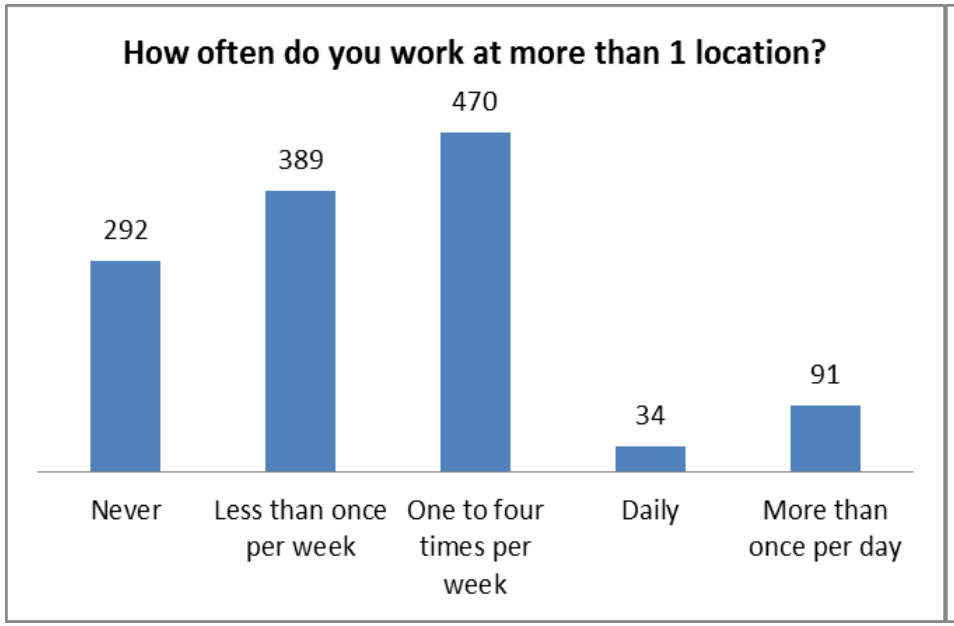
How many Staff		payment deducted	Proposed payments	F/T or P/T	At Oct 18	Following Increase	Outcome
286	Band 1 & 2	£20.00	£21.00	F/T	£5,720.00	£ 6,006.00	£ 286.00
49		£10.00	£11.00	P/T	£490.00	£ 539.00	£ 49.00
102	Band 3	£22.00	£23.00	F/T	£2,244.00	£ 2,346.00	£ 102.00
10		£11.00	£12.00	P/T	£110.00	£ 120.00	£ 10.00
684	Band 4 & 5	£24.00	£25.00	F/T	£16,416.00	£ 17,100.00	£ 684.00
49		£12.00	£13.00	P/T	£588.00	£ 637.00	£ 49.00
637	Band 6 & 7	£26.00	£27.00	F/T	£16,562.00	£ 17,199.00	£ 637.00
60		£13.00	£14.00	P/T	£780.00	£ 840.00	£ 60.00
227	Band 8 & abve	£28.00	£30.00	F/T	£6,356.00	£ 6,810.00	£ 454.00
7		£14.00	£15.00	P/T	£98.00	£ 105.00	£ 7.00
211	Priority	£32.00	£40.00	F/T	£6,752.00	£ 8,440.00	£ 1,688.00
2322				**Monthly**	£56,116.00	£ 60,142.00	£ 4,026.00
P/T is 19 hrs or under				**Annually**	£673,392.00	£ 721,704.00	£ 48,312.00

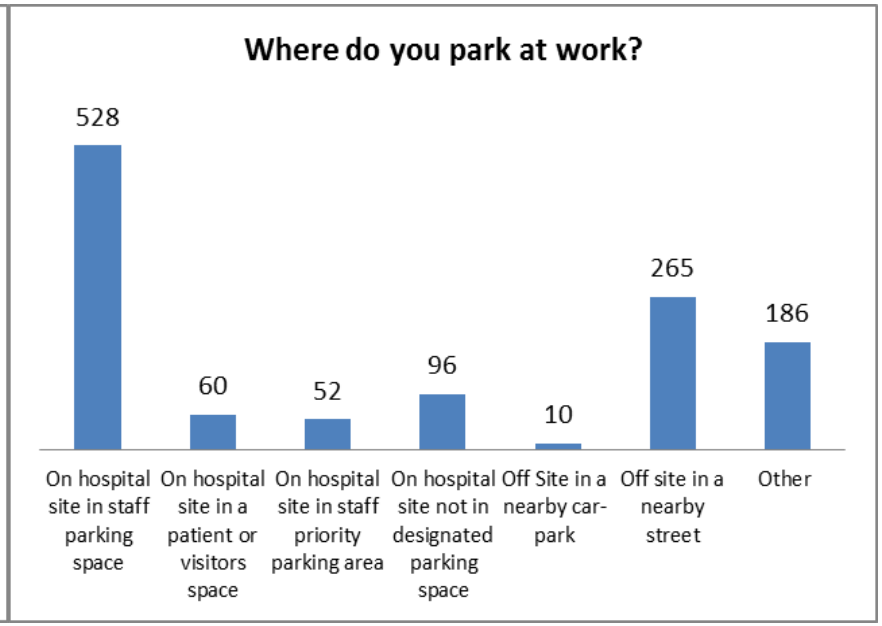
Appendix 4

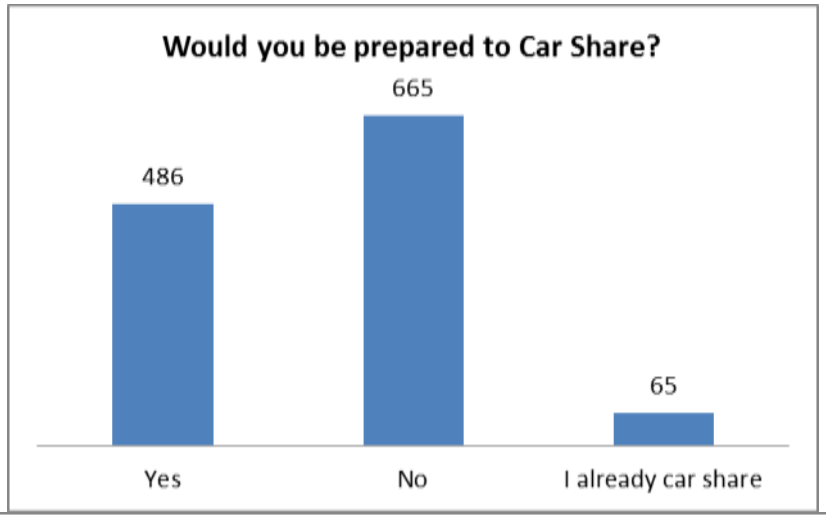

Staff Group
816
434
3
20
Clinical
Non clinical
Non CHFT
Other

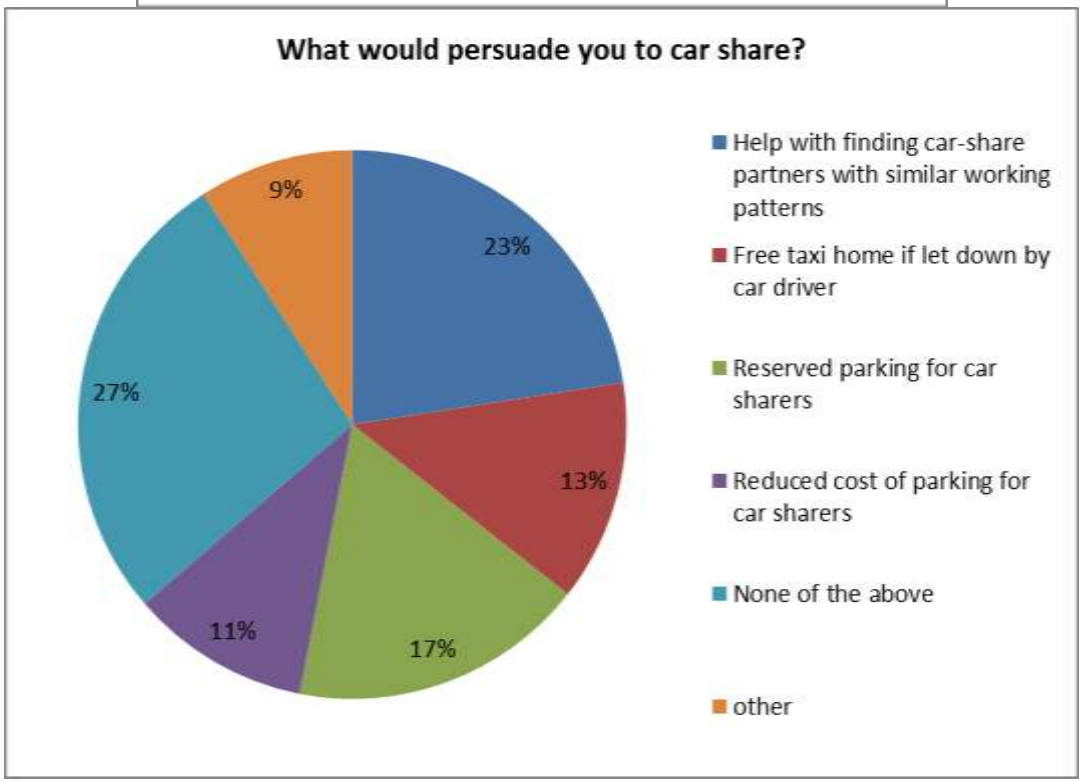

Place of Work
346
373
447
26
92
HRI
CRH
Cross Site
Broad Street
Community

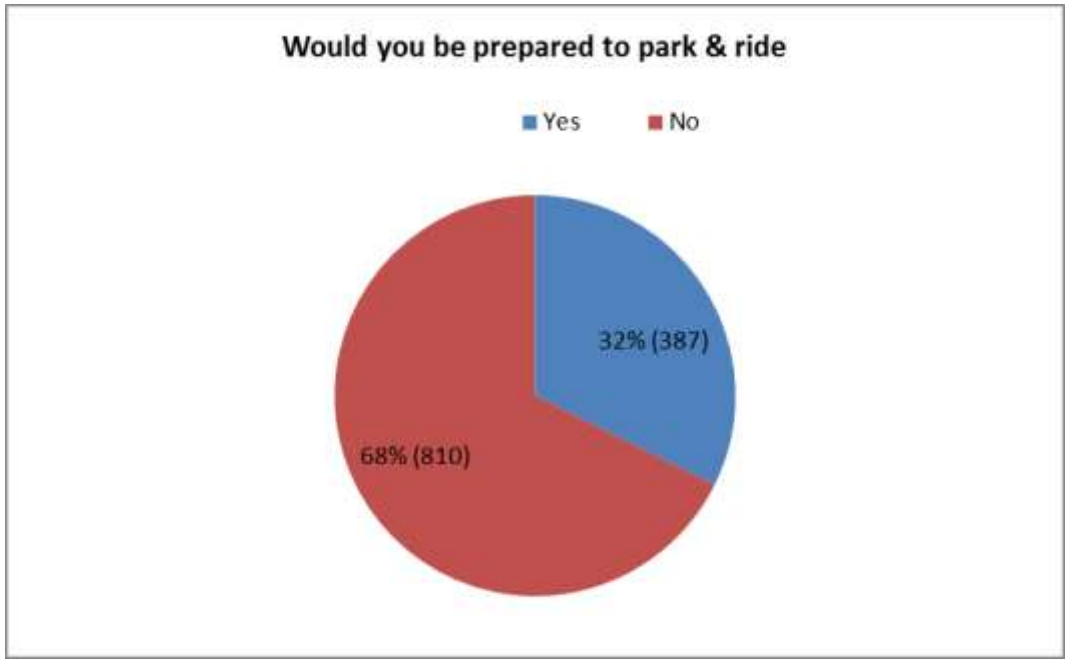

Permit Type?
806
10
384
32
CHFT
Council
Non
Other


How often do you work at more than 1 location?
292
389
470
34
91
Never
Less than once per week
One to four times per week
Daily
More than once per day


Where do you park at work?
528
60
52
96
10
265
186
On hospital site in staff parking space
On hospital site in a patient or visitors space
On hospital site in staff priority parking area
On hospital site not in designated parking space
Off Site in a nearby car-park
Off site in a nearby street
Other


Would you be prepared to Car Share?
486
665
65
Yes
No
I already car share


What would persuade you to car share?
23%
13%
17%
11%
27%
9%
Help with finding car-share partners with similar working patterns
Free taxi home if let down by car driver
Reserved parking for car sharers
Reduced cost of parking for car sharers
None of the above
other



Options for Consideration-

- Acre Mills – 50 spaces
- Saville Park (Shuttle)
- Eureka
- Low-fields (Elland)

Closed Actions

	What	Updates	Who	When
1.	Paper to WEB for discussion.	Completed on 16/2/17. Completed on 13/7/17 Completed on 9/11/17 Completed Dec 2017 Completed June 2018 (Price increase proposal)	AW/LH	
a)	Meeting Council re parking around CRH	Meeting with Calderdale Council, Mark Thompson; Director, Economy & Env; Alan Lee – Lead for Corporate Asset & Fac's Robert Summerfield - Lead for Corporate Projects	AW/OW/LH	Complete
		Mary Farrah (Calderdale Council) supported with developed of CHFT Travel / Car-Parking Survey.	AW/Calderdale Council	Complete
		Meeting organised with Robert Summerville regarding corporate programme / traffic planning.		Complete
b)	WEB Actions – Revisit Latter Day Saints Option	No way forward.	LH / OW	Complete
c)	WEB Actions - Ensure priority car-park for red permit holders only - Review priority parking list Vs reality - Ensure Designa software allows only priority into both HRI & CRH Areas WEB Actions – Proposed Parking Criteria - Request to discuss wider throughout organisation	Carried out manually & via software.	GD	Complete

	Staff Engagement Events	Theatres Staff (CRH), Consultants, Community, Ops Directors, Staff Side Meetings, colleagues. 20+ events held along with feedback via travel / car-parking survey. Focus Groups at CRH, HRI, BSP & Beechwood Suggestions made & concerns raised Car-Parking inbox utilized with many suggestions	AW / FB / GD / Staff / THIS	Complete
		All focus groups complete; to request approval from WEB for new car-parking criteria. Approved 9th November 2017	AW / FB / GD / Staff	Complete
d)	WEB Actions – Revisit meccano idea. Costings for approx. 100 additional spaces. http://www.anotherlevelcarparks.co.uk/ http://www.anotherlevelcarparks.co.uk/view-assembly-video.html	HIRE COSTS – 1 YEAR 1 year min hire @ £4780 per week X 52 = £248,560 Delivery & Assembly Cost = £68,200 Dismantle & collection cost = £68,200 Initial Inspection & PI Cover @ £1,500 Monthly compulsory Inspection Fee @ £500 x 12 = £6,000 1 year total hire costs = £392,460 HIRE COSTS – 5 YEAR 5 year min hire @ £4124 per week X 5 year = £1,072,240 Delivery & Assembly Cost = £68,200 Dismantle & collection cost = £68,200 Initial Inspection & PI Cover @ £1,500	AW	Complete

		Monthly compulsory Inspection Fee @ £500 x 60 = £30,000 5 year total hire costs = £1,240,140 OUTRIGHT PURCHASE - £816,000 Buyback at 10% up to 10 years.		
e)	WEB Action – Staff travel arrangements - Understand colleague travel arrangements	Consider Trust wide survey monkey regarding travel arrangements. Travel survey completed early 2017 (via SDMP Group). Poor response with limited knowledge of the survey (163 responses).	DMcK	Complete
2.	CRH Priority Parking – meeting with Consultants	Suggestions put forward to make good. To include suggestions in prioritisation exercise discussion. • Double parking permitted for those who are happy to do so (however, this is not all consultants) • Parking elsewhere in hospital (Visitors car-park) and reclaim parking • Meet & greet service • Remove green permit holders from this area • Remove Junior Doctors from this area • Payback parking subscriptions to those who cannot park. Once review of parking completed this should be resolved (i.e. only priority cross site parkers allowed)	AW	Complete
3.	Visit BRI to share experiences	Met ADD's Facilities (A Dalton & K Snape) agreed to share documentation. Advised BRI approach where car-parking completely overhauled taking into account sustainability, green travel etc. Estates ADD (Annette Binns) led the project with McDonald car-parking Consultants.	AW/FB/GD	Complete

		AW to obtain paper from Annette Binns. Conversation held with Mott MacDonalds (Transport Planners). Costs @ £10k for BTHT work. Outcome from meeting; CHFT have progressed majority of ideas that MM recommended to BRI.	AW – requested 12/3/17 29.3.17	Complete
4.	Visit Leeds to share experiences.	Leeds parking policy and Board paper shared with CHFT. Meeting required re Leeds parking criteria and prioritisation exercise.	AW – requested 12/3/17 (via Pete Aldridge)	Complete
	ANPR – Acre Mill	Complete; barriers in. Complaints reduced to zero following changes.	AW / DMcG	Complete.

18. Month 6 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday 1 November 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Finance Headline Message - Month 6 - A summary of the financial position as reported to NHS Improvement for Month 6	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Weekly Executive Board	
Governance Requirements: Financial sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

See attached

Main Body

Purpose:

See attached

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

Trust Board Financial summary Month 6.pdf

FINANCE HEADLINE MESSAGE – MONTH 6
BOARD OF DIRECTORS
1 NOVEMBER 2018

Year to Date Summary

- The year to date deficit is £24.31m, a £0.25m favourable variance from plan.
- The variance reflects the Department of Health pay announcement on Medical Staff pay which confirmed that pay awards would be implemented in October and not backdated as assumed in the plan. This is a timing difference and is not expected to impact on the forecast. Aside from this the position is in line with plan.
- Clinical income performance is below plan by £1.88m. The Aligned Incentive Contract (AIC) protects the income position by £1.65m in the year to date (see Appendix 1) leaving a residual pressure of £0.23m. However, a proportion of this income protection (£0.82m) is as a result of CIP plans and management decisions where there is a corresponding reduction in cost. When these elements are adjusted for, the impact on Divisional variances is reduced to £0.83m as shown below.
- CIP achieved in the year to date is £6.05m against a plan of £6.51m, a £0.46m pressure.
- All operational budgets (excluding Calderdale & Huddersfield Solutions and technical adjustments) are now overspent by £1.00m year to date, a slight improvement compared to month 5. This pressure has been mitigated by the release of all of the Trust's contingency reserves in the year to date a total of £1.00m. In addition the winter element of the reserve has been released in the short term to offset the shortfall on CIP and will need to be reinstated as CIP is achieved per the re-profiled forecast.
- Agency expenditure is £0.03m below the agency trajectory set by NHSI, despite last month's prior period adjustment.
- The working capital position at the end of Month 6 remains stable, supported by borrowing.
- The underlying year to date pressure is £1m

Key Variances

The table below outlines the Month 6 financial position adjusted to show underlying operational variance from plan by Division.

Month 6 Finance Position adjusted to show underlying operational variance from plan by Division

	Reported Position YTD (M6)			Adjustments	Underlying Variance from Plan (YTD)	
	Plan	Actual	Variance	Remove Impact of AIC[4]		
	£'000	£'000	£'000	£'000	£'000	
Corporate Services	(21,438)	(21,483)	(44)	(0)	(44)	
Families & Specialist Services	(2,210)	(2,686)	(475)	(192)	(668)	
Estates & Facilities	(7,049)	(7,465)	(415)	(0)	(415)	
Health Informatics	3	(5)	(8)	0	(8)	
Medical Division	12,625	13,304	679	(619)	61	
Surgery & Anaesthetics	5,568	4,780	(788)	(165)	(953)	
Community Division	1,467	1,439	(28)	146	118	
Pmu	1,379	1,460	81	0	81	
Divisional Operating Position	**(9,656)**	**(10,655)**	**(999)**	**(830)**	**(1,829)**	
CHS[1]	654	697	43	0	43	
Technical Accounting & Reserves[1 2]	(15,551)	(14,594)	957	0	957	
Total Trust Surplus / (Deficit)	**(24,553)**	**(24,553)**	**0**	**(830)**	**(829)**	
Medical staff pay award		246	246			
Reportable Surplus / (Deficit)[3]	(24,553)	(24,307)	246			

Notes:

1 Plan includes actual M6 inter-company transfers.

2 Includes Contingency Reserves released of £1,000k.

3 Favourable variance includes £246k Medical Staffing pay award that had been budgeted at 1% from April, but will now be 2% from Oct (timing difference).

4 The £830k adjustment for Aligned Incentive Contract reflects the net impact of protection provided by the contract where activity is lower than plan. Net impact is the full protection less any benefit from savings made.

- It should be noted that the monthly profile of CIP delivery differs from the fixed original plan. This drives a pressure in the year to date and whilst this is a timing difference, it places greater risk into the latter part of the year.
- The AIC protection primarily impacts Medical Division's position which includes £0.62m net benefit from the AIC. This is £1.15m protection less costs saved of £0.53m
- Medical staffing expenditure continues above plan in both Surgery and FSS with a year to date adverse variance to plan at Trust level of £1.60m. However, against the agency trajectory there was a significant improvement in month, with Medical Agency dropping below the planned level in month for the first time this year.
- There are also significant pressures on non pay expenditure particularly in FSS and Estates. A proportion of the Estates costs incurred in Month 6 should rightly be charged across to CHS. These costs are being reviewed and will be corrected prior to Month 7 reporting where appropriate.
- Nursing pay expenditure reduced in month, with a reduction in both agency and bank expenditure compared to month 5. Year to date the adverse expenditure variance has reduced to £0.21m (excluding the impact of pay awards which is funded as income).
- In overall terms the Month 6 position was a slight improvement from the position projected in the Month 5 forecast refresh exercise.

Forecast

- Achieving the planned £43.1m deficit for this financial year is now reliant on both the delivery of the full £18m of CIP and an additional recovery requirement with a total value of £1.66m. Divisions are forecasting to achieve a level of recovery totalling £0.68m. This relates to actions that have been agreed or are already delivering results. A further £0.96m of recovery plans are being scoped against a recovery requirement of £0.98m and this will need to be delivered in full in order to achieve the financial plan.
- This recovery requirement has reduced slightly from last month due to the improved Month 6 position but all recovery opportunities must be maximised to cover any risk as no contingency reserves remain.
- The CIP forecast is currently indicating a £0.15m shortfall in portfolio schemes which must also be recovered.
- Reinstatement of the full winter reserve also relies upon full achievement of the £18m CIP.
- Agency expenditure is forecast below the planned trajectory.
- The forecast will also require an improvement in the underlying run rate (£1m) to contain expenditure within budgeted levels

Action Required

- **Full delivery of £18m CIP**
- **Finalisation and delivery of recovery plans of c. £1.5m**

CLINICAL CONTRACT UPDATE – MONTH 6

Summary

The in-month and year-to-date clinical contract position across all Commissioners is shown below:

Point of Delivery	In-month						Year-to-Date					
	Activity			Income			Activity			Income		
	Plan	Actual	Variance	Plan (£'m)	Actual (£'m)	Variance (£'m)	Plan	Actual	Variance	Plan (£'m)	Actual (£'m)	Variance (£'m)
Daycase	2,932	2,941	9	2.12	2.08	-0.04	18,242	18,160	-82	13.14	13.09	-0.05
Elective	522	465	-57	1.64	1.32	-0.31	3,177	2,883	-294	10.01	8.92	-1.09
Non-Elective	4,652	4,918	266	8.35	8.13	-0.21	27,980	28,831	851	50.36	50.18	-0.18
A&E	12,850	12,369	-481	1.56	1.57	0.01	77,528	76,337	-1,191	9.39	9.62	0.23
Outpatient	29,350	29,970	619	3.48	3.46	-0.02	182,487	185,194	2,707	21.65	21.56	-0.10
Other NHS Tariff	10,418	9,807	-611	1.67	1.55	-0.12	63,784	63,808	24	10.23	10.12	-0.11
Other NHS Non-Tariff	148,859	133,140	-15,719	6.06	5.64	-0.42	860,237	852,648	-7,588	36.05	35.51	-0.53
CQUIN	0	0	0	0.56	0.54	-0.02	0	0	0	3.42	3.39	-0.04
Sub-total - pre AIC adjustment	**209,582**	**193,609**	**-15,973**	**25.44**	**24.29**	**-1.15**	**1,233,434**	**1,227,860**	**-5,573**	**154.27**	**152.40**	**-1.87**
AIC Adjustment	-	-	-	-	1.04	1.04	-	-	-	-	1.65	1.65
Net Reported Position	**209,582**	**193,609**	**-15,973**	**25.44**	**25.33**	**-0.10**	**1,233,434**	**1,227,860**	**-5,573**	**154.27**	**154.04**	**-0.23**

- The overall clinical contract position pre-AIC adjustment is £1.15m below plan in-month and £1.87m below plan year-to-date.
- The AIC contract positions for GHCCG and CCCG are £1.04m below plan in-month and £1.65m below plan year-to-date. Income is therefore protected by the AIC adjustment to this level. This represents reduced activity performance in-month which has materially moved the AIC further away from contract value. This in-month reduction is driven by elective, non-elective long stay, diagnostics, critical care, maternity pathway and high cost drug spend.
- The net reported income position, relating to all other CCGs and NHS England, is £0.01m below plan in-month and £0.23m below plan year-to-date.
- Within the above position, high cost drug income is £0.18m below plan in-month and £0.35m year-to-date which will therefore be off-set by a non-pay underspend.

Greater Huddersfield CCG and Calderdale CCG AIC Positions

- The year-to-date variance against the AIC of £1.65m can be summarised by CCG as:

Point of Delivery	GHCCG		CCCG		TOTAL	
	Activity Variance	Income Variance (£'m)	Activity Variance	Income Variance (£'m)	Activity Variance	Income Variance (£'m)
Daycase	231	0.08	-88	-0.07	143	0.01
Elective	-118	-0.47	-127	-0.43	-245	-0.91
Non-Elective	46	-0.36	572	-0.19	617	-0.56
A&E	-1,012	0.00	-597	0.13	-1,609	0.14
Outpatient	1,410	-0.02	2,999	0.20	4,410	0.17
Other NHS Tariff	778	0.00	473	-0.13	1,251	-0.13
Other NHS Non-Tariff	2,999	-0.20	-11,138	-0.14	-8,139	-0.33
CQUIN	0	-0.02	0	-0.02	0	-0.04
Total	**4,333**	**-1.01**	**-7,905**	**-0.64**	**-3,572**	**-1.65**
AIC	0	1.01	0	0.64	0	1.65
Net Reported Position	**4,333**	**0.00**	**-7,905**	**0.00**	**-3,572**	**0.00**

- The main areas of year-to-date variance below AIC are elective inpatients, non-elective long stay admissions, rehabilitation, critical care and maternity pathway. These are partially off-set by over-performances within A&E and outpatient attendance activity.
- Greater Huddersfield CCG has continued to see lower performance against the AIC in-month compared to Calderdale CCG although to a lesser degree than seen in previous months. The main areas driving this difference in Greater Huddersfield continue to be are lower levels of non-elective admissions, A&E attendances and outpatient attendances. These are partially offset by higher levels of maternity pathway and rehabilitation bed days than seen in Calderdale.

19. Calderdale and Huddersfield Solutions Update

a.Novation Report

To Note

Presented by Gary Boothby

Integrated Facilities Management

25 October 2018

Board Update – Calderdale and Huddersfield Solution Ltd: Novation Agreements

Background

As part of the set-up of the wholly owned subsidiary; Calderdale and Huddersfield Solutions Ltd, the Procurement and Supplies team were responsible for the novation of major contracts from the Trust to CH Solutions Ltd. In addition, we wrote to all companies with whom the Trust had transacted with over previous 12 months to inform them of the changes and to ask that invoices for transactions post go-live were sent to the new company.

Action

For information

Update

The Procurement Team wrote to circa 1200 suppliers notifying them of the organisational change in June and has received in the region of 50 Credit Account Forms prior to company go-live. Whilst this may not seem a high number, it is worth noting that the majority of those we communicated with will have had few and extremely low value transactions in the previous 12 months and we are now receiving new credit applications for new company set up as and when we transact with organisations. As mentioned in previous updates, feedback from other Wholly Owned Subsidiaries suggests his is not uncommon.

Further to the initial communication, we identified 124 contracts that were to be novated to the new company from the Trust. Of those we have to date received 31 signed novations back. We are aiming to follow up with those who have not replied, but key ones not received as yet are Berensdens, Compass (although we have been informed that they are both currently considering the agreement), BBraun, and Siemens.

We have received notification that due to the relationship between Leeds, Bradford and Calderdale and Huddersfield, BBraun did not feel it was appropriate to novate the current Decontamination Contract as they believed we are only one party to a joint Trust contract. Further investigation shows that each Trust has an individual

contract and as such the Trust view is that our agreement can be novated. We will continue to engage and discuss with BBraun.

Of those contacted, a number initially raised concerns about the ability of the new company to service debt and where appropriate, we have provided a parent company guarantee. To date we have provided seven Parent Company Guarantees to the following companies: Siemens and Compass (both of which we are yet to receive the novation back); Interserve; Hartmann; AGFA; Olympus and FPHCare.

It is important to note, that whilst we await signed novations we have not seen any significant delays as a result of unsigned novations. Suppliers continue to send new company account forms to be completed and where there may be a threat to supply; priority is given to the completion of the documentation.

Matthew Barker
Head of Procurement

20. Medical Services Reconfiguration Update

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday 1 November 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Medical Services Reconfiguration - 10 month review - The purpose of this paper is to provide an update on the clinical services in the Medical Division reconfiguration project.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors: Thursday 5th July 2018	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this paper is to provide an update on the clinical services in the Medical Division reconfiguration project. A review of the services to establish if the assumed benefits have been realised was scheduled for 6/10 months post implementation. The timeframe was chosen to enable a fair analysis using a data set that minimises bias through seasonal activity and allows settling down of clinical teams. The paper provides an overview of methodology used to complete the review, a summary of the impact on the clinical services including feedback from staff and patients, and a review of the KPI's

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note the contents of this paper and support the transition to business as usual as part of core divisional performance monitoring arrangements

Appendix

Attachment:

Medical Services Reconfiguration - a 10 month review.pdf

Medical Services Reconfiguration: A 10 Months review

1. Purpose of the Paper

The purpose of this paper is to provide an update on the clinical services in the Medical Division reconfiguration project. A review of the services to establish if the assumed benefits have been realised was scheduled for 6/10 months post implementation. The timeframe was chosen to enable a fair analysis using a data set that minimises bias through seasonal activity and allows settling down of clinical teams. The paper provides an overview of methodology used to complete the review, a summary of the impact on the clinical services including feedback from staff and patients, and a review of the KPI's.

2. Background

The reconfiguration of Cardiology, Elderly Care and Respiratory in-patients services was completed 12th December 2017. The time around the move held many challenges for staff, primarily as it took place in the winter months which presented usual seasonal issues around staffing additional capacity. The three months following the move also had unprecedented activity which had a particular impact on the clinical services central to the changes.

The early days of the move was identified as a stressful time for many staff, particularly the nursing staff on the elderly care wards at HRI. This was, in part, due to smaller ward teams coming together into single large ward and in part due to the high number of vacancies compounded by an increased bed base. Staff during this time also identified problems with IT connectivity, access to PC's and delays in repairs and small works being completed. Our staff during this period worked extremely hard to ensure patients safety and experience whilst in our care was not compromised. The lessons learnt from this period are captured in the project closure document which is being circulated for future reference.

Following the settling down period all three clinical services were engaged in a variety of ways to get an understanding of the impact of the change and the future plans.

3. Methodology

A range of qualitative and quantitative methods were used in the review. This included feedback from matrons and ward managers with particular reference to the views of staff, patients and families/carers, a Divisional workshop, engagement with wider affected services in the Trust and external partners (YAS). Although continued to be reviewed, the data collection for the KPI's is a routine 'business as usual' for the Division. The findings from the three reconfigured services and supporting services affected by the change are summarised below

4. Cardiology

The cardiology inpatients services are established at CRH. The consolidation of the clinical teams allowed the Consultant of the Week (COW) model to start 1st April '18. The model allows continuity of care by having the same Consultant review ward patients each day. This ensures quicker decision making and supports earlier discharge from Cardiology beds. The COW model also supports phone advice to other areas to support admission avoidance. The service has also implemented a full 7 day working for cardiology clinical teams

The service is now meeting the 60% target for the NSTEMI patients having Angio +/- PCI within 72 hours of admission (based on MINAP patient list). This is primarily due all in-patients being at CRH with a reduction of approximately 220 inter-hospital transfers from HRI (per year). The team have now also implemented service improvements in the catheter lab pathways resulting in a shift from in-patient to day case from 60%-90%. The pathway has improved the experience of patients with less waiting time on the day for procedures and less service initiated cancellations.

The review identified only a very few patients require clinical transfer from HRI to CRH for specialist cardiology services. This is less than anticipated and therefore the daily on-site presence for cardiology nurses at HRI was found not to be required. The nurses now travel across site as required throughout the day. This capacity has allowed development of the nurse led One Stop Arrhythmia Clinics and Virtual MDT for post pacemaker patients which started in April 2018. The clinic reduces unnecessary appointments for patients, has audited well and is looking to expand.

What our patients say: For Cardiology services, patients fed back they "like knowing who their consultant of the week is", specifically, they get to know them and get a better understanding of their own condition and the management plan.

What our staff say: There were some experienced staff that transferred from HRI to CRH with the service then subsequently left to work back at HRI; however the recruitment position has improved as the single site service is more attractive. Staff describe the COW model as positive with consistency of medical review making patient management easier. The junior doctor's spoke of feeling "far more supported now" and spoke of how the "training has improved". Previously the Trust had quite poor feedback from the deanery and it is anticipated this will improve in the next report

The service has benefited from the consolidation of staff and facilities and is working on several service improvement initiatives, including improving the pathway for a nurse led follow up MI clinic to reduce waits and improve triage, implement Heart Failure clinics & repatriation of primary PCI & ablation.

Due to consultant led care and improved flow, it has allowed us to close 8 Cardiology beds and look at delivery of care via a day case model.

5. Respiratory services

Due to the consolidation of clinical teams and successful recruitment, on the 21st May the respiratory team have been able to implement the Consultant of the week model to provide continuity of care and improves discharge rates. This minimises the reliance on agency staff. The COW model also allows phone advice to other areas to support admission avoidance.

All patients presenting to hospital now have access to the respiratory 'hot clinic', this was previously only available to Calderdale patients. The clinic offers rapid access to Consultants that reduces admissions and allows patients to be managed at home where appropriate.

As in cardiology, daily in-reach for Respiratory clinical staff at HRI has been reduced as the numbers of patients requiring the service were found to be low. A daily review is always available and nurse's travel across site when required. The COW is also available on the phone for advice

Subject to recruitment, the clinical team now has the opportunity for a Respiratory model moving to 7 days working, which will allow a set-up of a full acute Respiratory unit. The number of specialist beds in respiratory services will further increase at this point.

What our patients say: Having the same doctor every day is a real positive as patients get to know them.

What our staff say: Post the move, 9 staff left the ward to relocate back to HRI. All these moves were for travelling time reasons only and staff were sad to leave. Recruitment is easier as the service is expanding and there are more development opportunities. The teams have settled down and are working well together.

Nursing team's spoke of feeling they are working towards a single patient's plan, which doesn't constantly change based on different consultants doing the daily ward round. This means nurses can discharge plan better and get the patients home sooner.

Due to the consolidation of the service, the Respiratory team has been able to develop a further range of service improvement initiatives which they are now working up:

- There is a proposal for the Huddersfield commissioners to match the Calderdale model – with more early supportive discharge, increased in-reach into A&E and hot clinic access (access to a consultant clinic for urgent appointments) from community to avoid A&E and potential admission
- Virtual MDT for Nodule Clinic patients
- Telephone consultations for Respiratory patients
- The triaging of ERS referrals with a potential to reduce unnecessary out-patients appointments
- As part of the growth we have been able to take on an extra ward and cover as part of the Respiratory team – 5BCD.

5. Elderly Care services

The consolidation of the elderly care team has allowed the development of a Specialist geriatrician rota that supports 7 day working. The rota is expected to be live in the autumn. The benefits of a 7 day geriatrician review for patients will be to support consistency of discharge and avoid admissions. There will be more support for YAS 'silver phone' to provide advice and guidance to avoid unnecessary hospital attendances. The Consultant teams have expressed views the co-location of wards at HRI improves ability for consultants to provide cross cover ensuring more consistent patient reviews.

The frailty team at HRI was expanded above substantive funding over winter to support the reconfiguration and seasonal activity. The aim was to improve the care of frail older patients and provide an enhanced response early in the patient's journey.

Whilst there is no dedicated frailty service from the Acute frailty team at CRH, there are service provisions made for this group of patients who will benefit from clinical services from clinicians working in close collaboration with the frailty team:

- That once a frail patient has been reviewed for their presenting respiratory/cardiac condition, for example, at CRH, colleagues in community teams have provided pathways and protocols to refer patients onwards into appropriate community based services.
- There is front end therapy that still work in the same process of admission avoidance for discharge of frail patients at CRH.
- There is a daily geriatrician in-reach at the CRH site.
- The acute frailty team continue to provide advice over the phone and then liaise with community staff and social services through MDT.

Going forwards the team are going to review the frailty pathway at CRH on an ongoing basis to ensure frail patients receive the appropriate input to facilitate earlier discharge and care planning.

The benefits of the Frailty service so far are:

- Patients identified as frail (as defined by Rockwood score) in the front end care are referred into the frailty team and commence a Complex Geriatric Assessment which is either partially or fully completed. The number of patients being seen in this service has increased from average 175 per month (Apr-Nov'17) to an average of 320 per month (Jan-April '18)
- All assessed patients are reviewed and discussed at the MDT twice daily expediting discharge and avoiding re-admissions
- 31% of referred patients now have an admission avoided. The length of stay for these patients has also fallen from an average of 1.4 days to 1.1 days. This demonstrates how the frailty service is improving the experience of our elderly patients by facilitating timely discharge back home or to a community setting.
- The number of re-referrals back to the frailty team (through re-admission) has also increased from an average of 16 to 44 per month. This is above what would be expected and is being further investigated.

- Post reconfiguration, the frailty team support the 'Silver phone' which is an advice and guidance line for YAS and GP's to support decision regarding acute admissions. This has proved very popular.
- The clinical teams are starting to care for frail older patients differently as they are becoming expert in this field due to the increased number of frail patients they are looking after.
- A better patient experience for all frail patients and eliminating variations across the localities for frail patients. Pathways are written jointly with both localities.
- A comprehensive geriatric assessment is carried out on every patient that is brought to the hospital.
- The reconfiguration has given us the opportunity to grow relationships with the community and voluntary services. We have developed trusted assessments for patients creating better efficiency and stopping delays of patients being discharged.

The consultants are providing in-reach to CRH by phone or site presence however there was a concern raised that a number of patients who have recovered from a different primary condition and are frail, may not be getting sufficient review. The level of in-reach is currently being reviewed including expansion of the frailty team.

We have now expanded the team to increase capacity and working hours allowing the team to manage more patients at the front door and extend their skill into assessing and supporting frail patients within surgery. We have introduced non-traditional roles such as physician associates into the team. The uplift in the team had short term funding and we seek the support of the organisation to fund this substantively - we are confident we can demonstrate the benefits. Reconfiguration has allowed us to develop a 7 day consultant geriatrician service to support the frailty working.

The ward areas/ estates at HRI have benefits and challenges for managing frail elderly patients. Although an improved number of side rooms from CRH there are less on-suite facilities. Some ward areas have reduced visibility which was addressed through workforce models. Benefits from the estates have included more space for patient therapy areas and for socialisation particularly at mealtimes.

The wards at HRI have worked hard to come together as teams and have implemented improvements post-reconfiguration for all patients. These include:

- All ward areas now having engagement workers to provide support and socialisation for patients
- All patients, clinically fit enough, are dressed and have meals together (PJ paralysis initiative). At CRH there was limited room for communal eating.
- Nutritional assistants are on every ward

A high level of vacancies of ward nursing staff remains; however this is inconsistent across the wards (between 15% and 50%). The overall vacancy rate is in line with pre-reconfiguration figures. The 4 elderly care wards flex the substantive staff between themselves ensuring all wards have nursing staff experienced in elderly care patients.

Four of the Elderly Care wards are each taking a lead on an initiative to improve patient's safety and experience, including nutrition, tissue viability (pressure sores) & falls. Each ward

will become the champion for the improvement and will provide support, training and guidance for the other wards.

Each ward has started to focus on areas of Quality Improvement and once refined and embedded, will share across all of the elderly care wards. The go live date for this piece of work commenced on 1st October 2018. We are already seeing a vast reduction in the number of pressure ulcers.

What our patients say: The impact of the frailty team at HRI is viewed as having a positive benefit by patients. The family from a patient from Todmorden who was brought by YAS to HRI spoke of being "overwhelmed at the lengths [the staff] went to ensuring [the patient] was cared for in the right place" (App1). The patient was a frequent attender who quickly became delirious post admission. This always protracted a hospital stay. The frailty team made sure the family had the support required to return the patient home from ED. There was no previous frailty provision at CRH to enable this

What our staff say: "The wards are now working more as a team, supporting each other". "After a difficult start, trying to manage the winter capacity, the staff are getting on well and working as a team". "The elderly care services have benefited from improved therapists presence on the wards. This is for response times and continuity of therapist. This has not been without challenge for staff changing working patterns and some have increased weekend commitments" "The therapy staff have adapted well and just got on with it"

A workshop in February with the Elderly Care team identified 5 areas for service improvement, building on the opportunities from centralising the wards. These are:

- Expansion of the frailty support: The main aims are to scope and find a solution to supporting a frailty service at CRH, to increase the hours of the current service, to expand into acute wards and provide a direct referral route from primary care.
- To pilot and recommend a model for 'Home First' in Calderdale: This is a CCG supported initiative to support admissions avoidance and better care for patients at home
- Improvements in dementia care; The aims are to upskill staff using innovation and technology to develop training packages and to improve nutrition and hydration for patients
- Improved flow through better MDT: To be achieved by having consistency of MDT, standardising handover for nursing staff and embedding Board rounds.
- Maximising the benefits of EPR: Particularly around MDT and assessment information capture.

All Workstreams have a clinical and operational lead and a developed implementation plan.

6. ED/ AMU

ED and AMU teams were a key part of the project team and the impact of the changes was modelled and risks assessed. The review looked at the impact and if the planned mitigation was effective.

HRI: The dependency of patients in ED/AMU at HRI has increased with 81% frailty and both nursing and medical staff reported significant changes in the type of care they are providing. Following feedback, the Divison are working with the deanery to ensure junior medical staff get the breadth of experience required. The frailty team is seen as a key presence in ED and AMU and feedback indicates this is a key support for ward staff.

Early review of modelling also suggests there continues to be a pressure on both ED and capacity at HRI. Further investigations has identified an increased demand as a result of a neighbouring Trust's reconfiguration both on ambulance attendances and admissions attributable to out of area postcodes which is currently being discussed between local trusts, YAs and the local CCG.

The impact on the delivery of the 95% 4 hour target remains unclear and further work is ongoing. There is an increase in the number of ED breaches due to waits for medical beds; however this fluctuates with a peak in March '18 and may be due to seasonal pressures.

CRH: The increased acuity of patients at CRH is as predicted with critical care reporting no adverse incidents and the contingency for additional ICU capacity working as planned.

The ED/ AMU teams are reviewing rotas and rotation for Middle Grades, junior doctors and nurses to address the needs for different workforce models cross sites.

7. General Rota Timeline

Reconfiguration has allowed the division to move towards 7 day services for all our specialities and to see patients as early as possible following admission by these specialities.

Phase 1 Commencing - Gastro and Elderly – 1/10/2018

Phase 2 Commencing - Respiratory – 1/09/2019

HRI site

1. The Care of the Elderly Consultant:
    a. Will see 12 new appropriate elderly patients on AMU
    b. Will cover the elderly care wards
    c. Will cover ward 17 with support from the Long Day and Twilight Registrar (when no gastroenterologist on call)

2. The Acute on call Consultant:
    a. The rest of the patients on AMU
    b. Post take patients who have been outlined
    c. Will cover ward 6

3. Ward 17:
    a. The Long Day/Twilight Registrars will start the shift by reviewing appropriate patients who need to be seen on ward 17. Patients needing Consultant

review will still be seen by the Care of the elderly Consultant on the weekends when there is no gastroenterologist on call
   b. The gastroenterologist will see the patients on the weekends they are present

4. Gastroenterology on call:
   a. Currently 2 in 8 weekends. This will increase as we increase the gastroenterology consultant numbers
   b. Will review all the patients needed on ward 17
   c. Will in reach post taked patients on AMU
   d. Will be on call for GI bleeds for the whole weekend (including overnight)
   e. Available for telephone discussion of patients at CRH

CRH site

1. The Acute and Support Consultant will see all the patients on the Acute floor
2. The Support Consultant and Acute Consultant will see the ward patients needing a Consultant review
3. The Long Day/Twilight Registrars will start the shift by reviewing appropriate patients who need to be seen on the wards

8. Triage of patients by YAS

The triage of patients by YAS is perceived to be working well by ED staff. YAS operational teams have indicated good relationships with ED staff and a process of continual learning with no issues for escalation.

The average daily patient transfers required from HRI to CRH and from CRH to HRI was estimated to be 1.7 and 1.4 respectively. The actual numbers of transfers are <1 per day each way indicating YAS triage is working well and patients are self-presenting to the specialist sites.

9. Patients Flow

Patients flow was improved by the service change. There was an unprecedented rise in normal seasonal activity that pushed the opening of extra capacity across the Trust. Respiratory, which saw a larger increase in number and acuity of patients were able to flex to cover 5D. Cardiology had reduced length of stay that improved flow through the beds.

“Having frail elderly patients at HRI supported by the frailty team and Patients Flow supporting infrastructure [LA, Locala] avoided the need for opening further unplanned capacity” (Patients Flow team).

10. Critical Care

CRH ICU staff describe the service as 'feeling' busier, however has only reached the planned escalation capacity a few times. HRIs issues have been minimal, other than flexing to ensure more optimal nursing cover at CRH,

The critical care team describe how "the Outreach workload at CRH has increased since the reconfiguration, but with no significant issues and Patient safety has not been compromised"

NIV use at HRI has been dealt with appropriately, and patient safety maintained. From the NIV audit at HRI since the reconfiguration there have been 4 patients requiring NIV out of the designated areas. These took place between December 2017 – January 2018 with no cases since.

11. Impact on Patient Numbers

The number of patients who would be impacted by the service change was estimated in the case for change. The review assessed if these estimates were found to be correct. All information was triangulated and agreed with YAS.

Huddersfield postcode patients: It was estimated between 2180-2840 patients a year who previously attended HRI by ambulance would be taken to CRH. The data extrapolated from January-May 2018 actuals indicates 2640 patients per annum. This is in line with estimates.

Calderdale postcode patients: It was estimated 1880-3022 patients who attended CRH by ambulance would go to HRI. The variance in the estimates was due to the level of potential ambiguity in identifying 'frailty'. The higher value represents all patients 75 and over. The data extrapolated from January-May 2018 actuals indicates 1968 patients per annum. The triage YAS is using is working well and in line with the co-developed clinical model. Patients 75 and over, who do not have frailty as the primary clinical condition, remain treated on the closest site or the site with the appropriate clinical service.

The findings indicated estimates to be correct and benefited from close working and prospective audit with YAS during the planning phase.

12. Impact on Staff

6 months on, informal staff feedback is, in the main is positive, however travel remains the key issue for a few staff. Following the initial move several staff found roles back on the original hospital sites due to difficulties travelling. These were found to be staff with childcare or other dependents as well as staff who found it difficult to access transport. No staff left the Trust citing the reconfiguration as the primary reason.

For the services affected, an analysis of turnover for April17'-May '18 demonstrated only normal monthly variation for staff turnover, with overall, 69.67 WTE staff leaving and 62.32 WTE commencing employment with the Trust.

13. Complaints and Incidents

There were no incidents or complaints from families during the ward moves. There have subsequently been no formal complaints about the location of the services following reconfiguration; however a Ward Manager from Elderly Care spoke of occasional comments from families who would prefer the service at CRH.

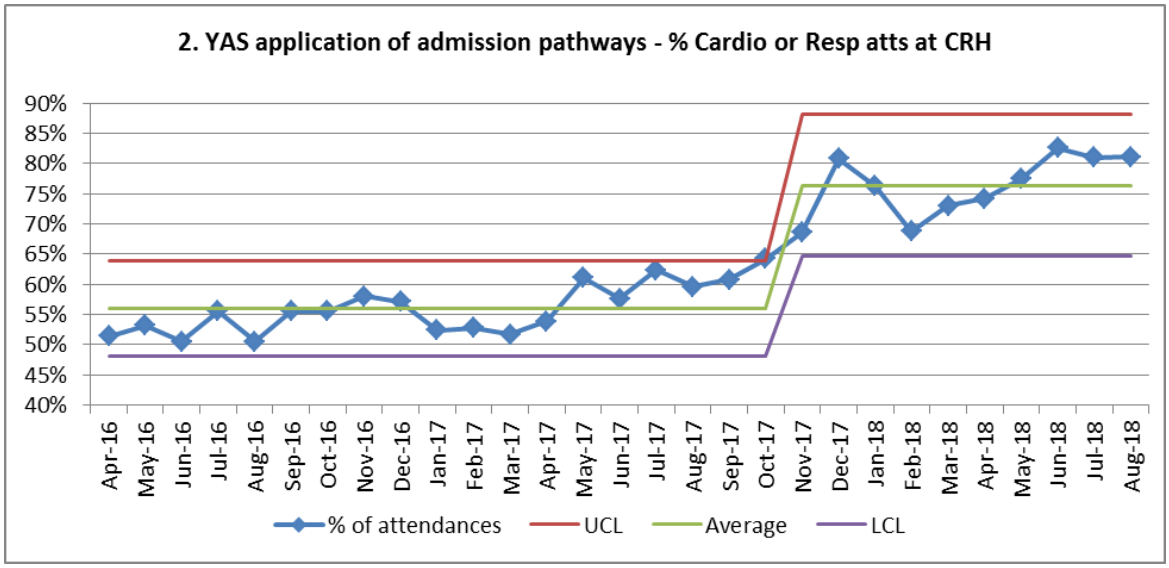
There have been no further DATIX incidents or complaints attributed to the reconfiguration.

14. KPI's

Key performance indicators were developed during the planning phase to monitor both risks and benefits of the change. None of the KPI's have shown significant deterioration in performance compared to last year (Appendix 2) and indications show that for the majority performance has improved. SPC charts and run rate graphs have been developed as appropriate as part of a dashboard to monitor performance. The dashboard is a live document which is being worked through a PDSA cycle and is used as a tool to constantly review the quality and impact of reconfiguration. Some of the SPC charts are included below. For reference, the green line shows an average level of performance with the red and purple lines indicating where there has been a significant improvement or deterioration in performance. We would expect performance to lie between the upper and lower levels with anything outside of these flagging the need for investigation.

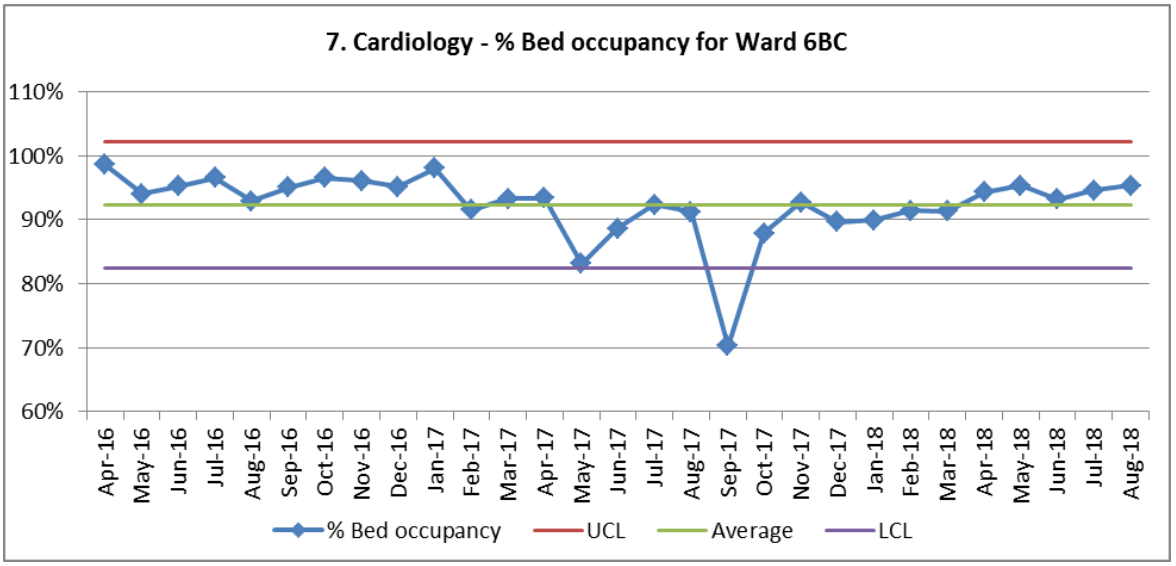
We set out to improve the following;

<u>YAS application of admissions pathways for cardio and respiratory patients:</u>



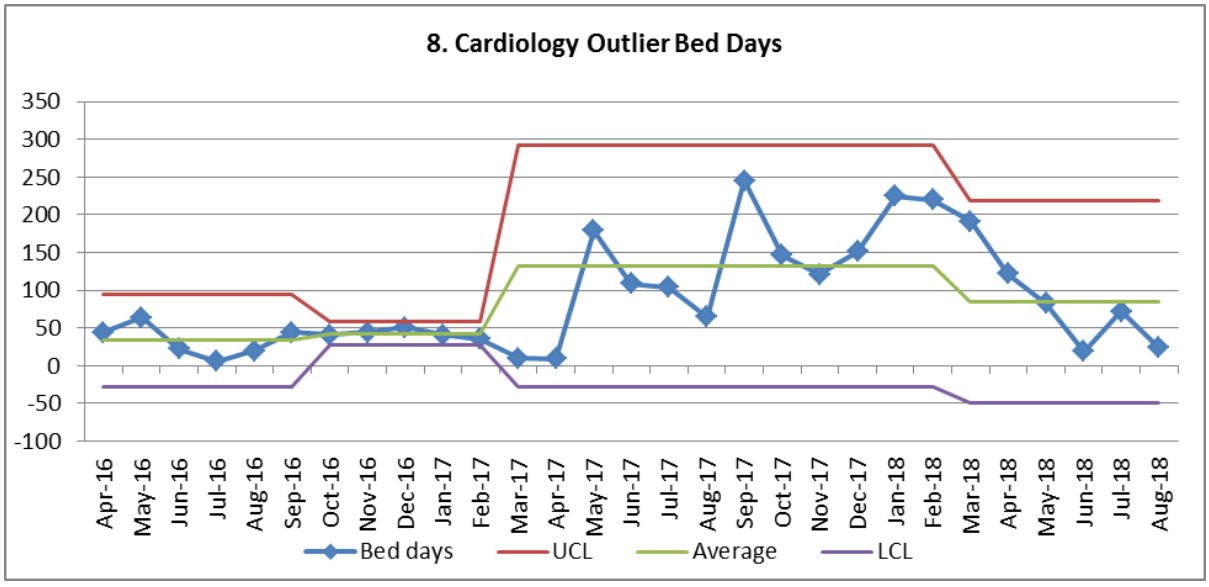
There is an upwards trend demonstrating YAS is improving in its application of the admissions pathway.

% Bed Occupancy for Cardiology and Respiratory



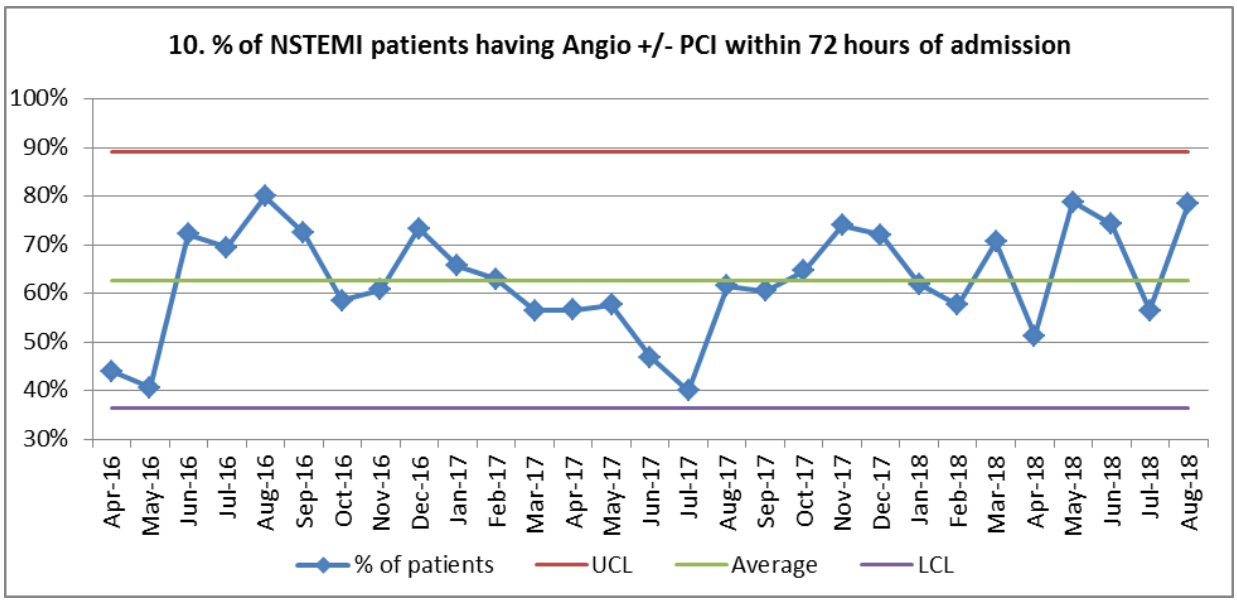
Performance since reconfiguration is demonstrating activity within normal variation with an upwards trend.

Cardiology Outlier Bed Days



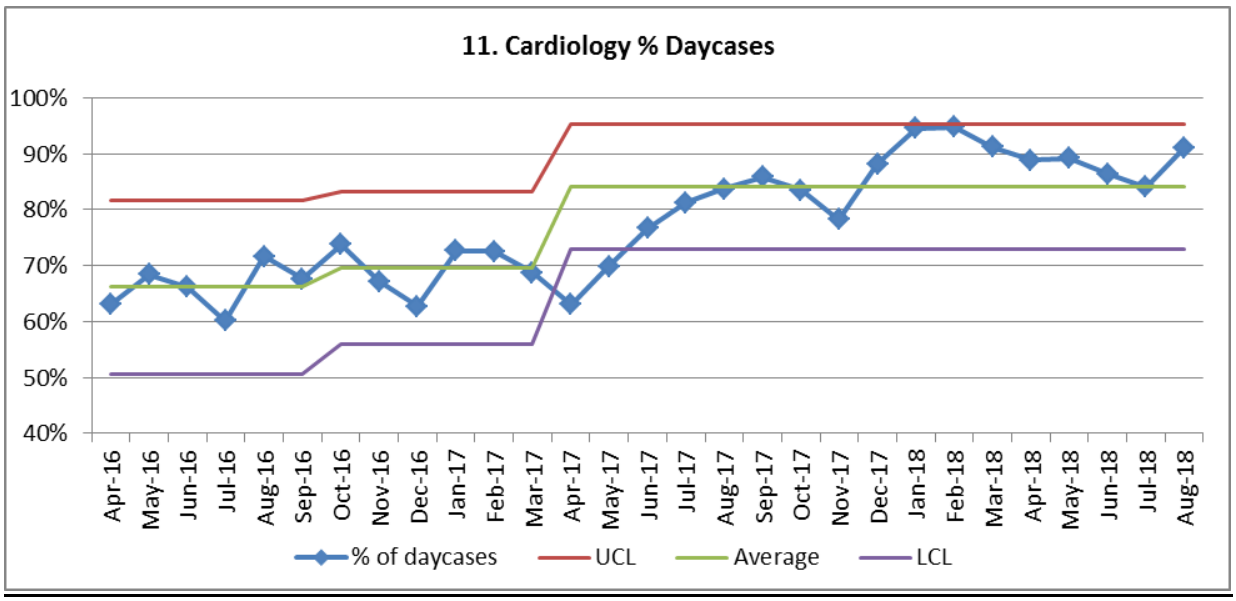
The graph indicates a downwards trend and therefore shows an improvement pre to post reconfiguration.

% of NSTEMI patients having Angio +/- PCI within 72 hours of admission



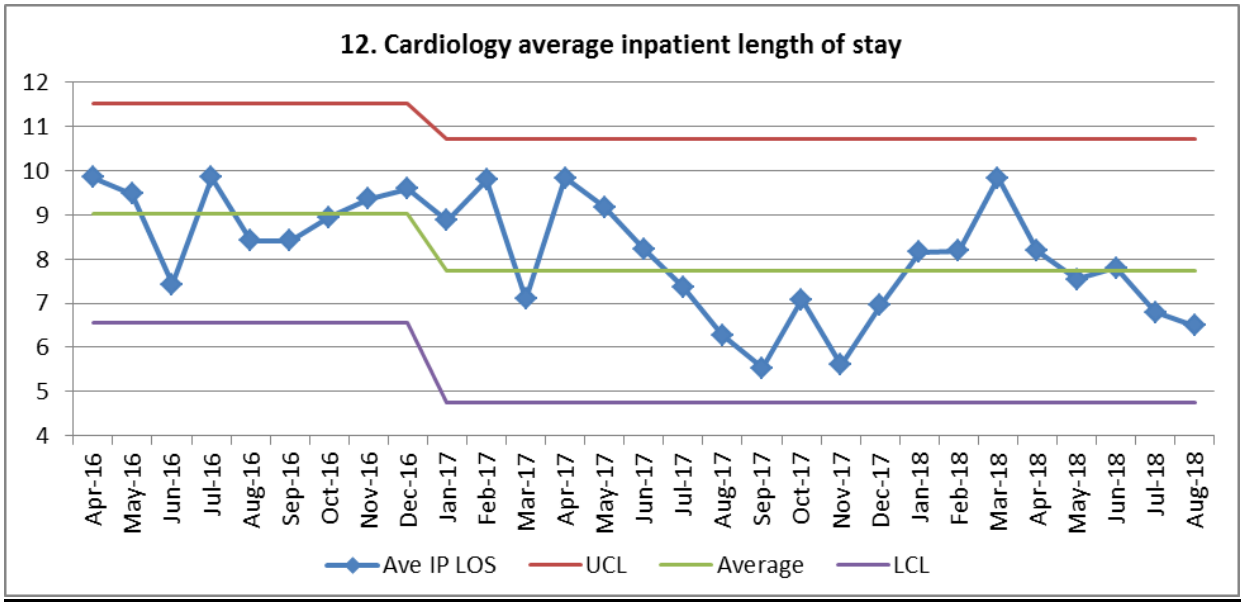
Performance since reconfiguration is demonstrating activity within normal variation with a slight trend of improvement overtime.

Cardiology % day cases



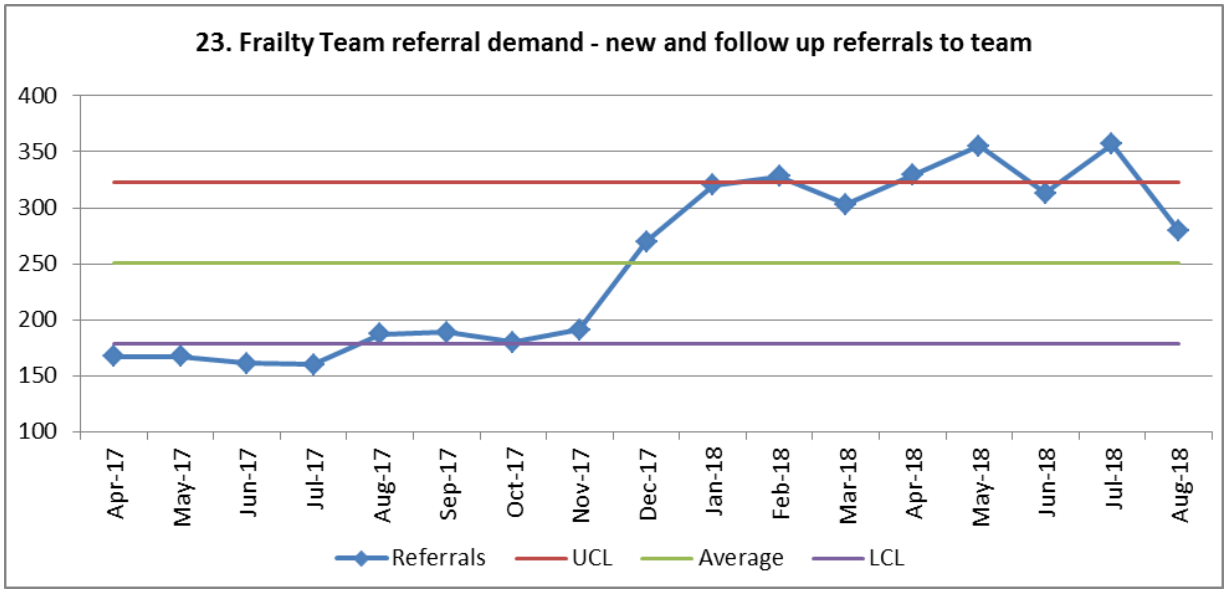
The graph indicates an upwards trend and therefore shows an improvement pre to post reconfiguration.

LOS for Cardiology



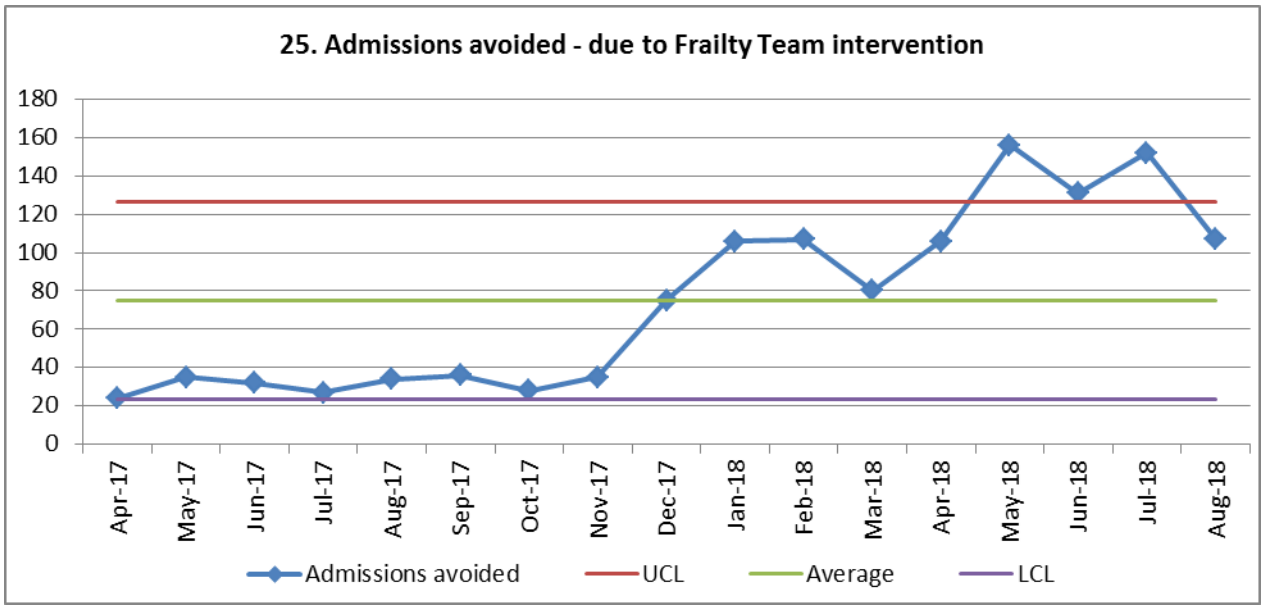
There is an improving trend from March 2018 demonstrating a reduction in Cardiology LOS.

Frailty Team Referral Demand



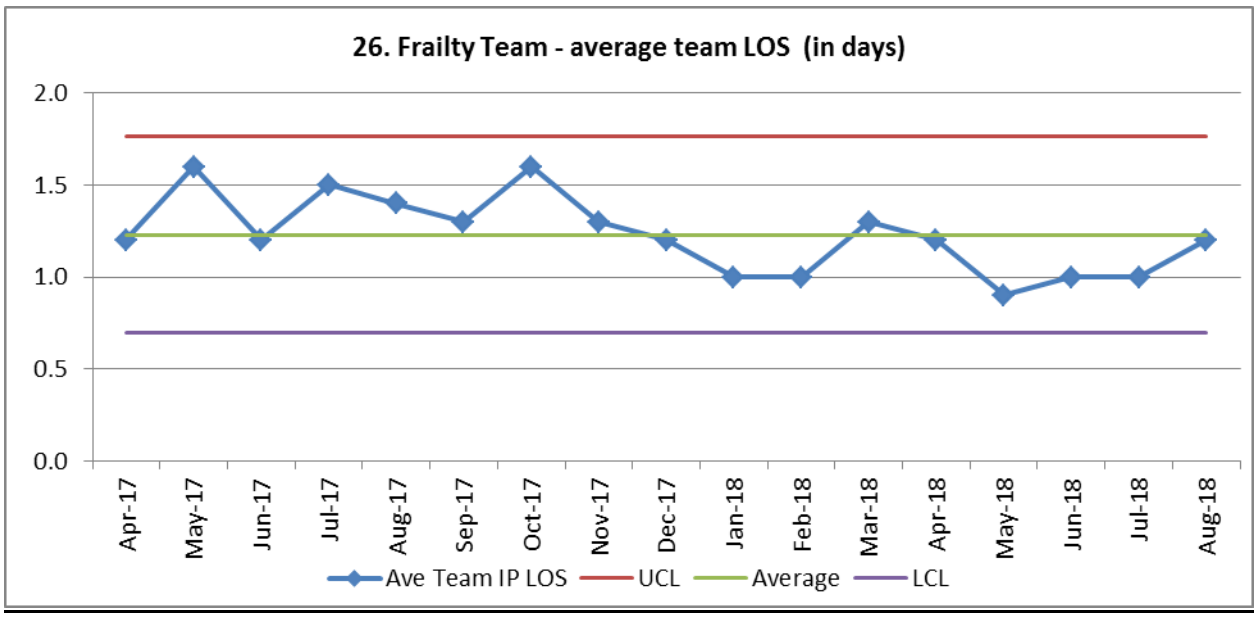
As expected the number of referrals increased in line with the increased number of patients through ED.

Frailty – Admissions Avoided



The chart indicates improvement pre to post reconfiguration regarding the number of avoided admissions by the frailty team.

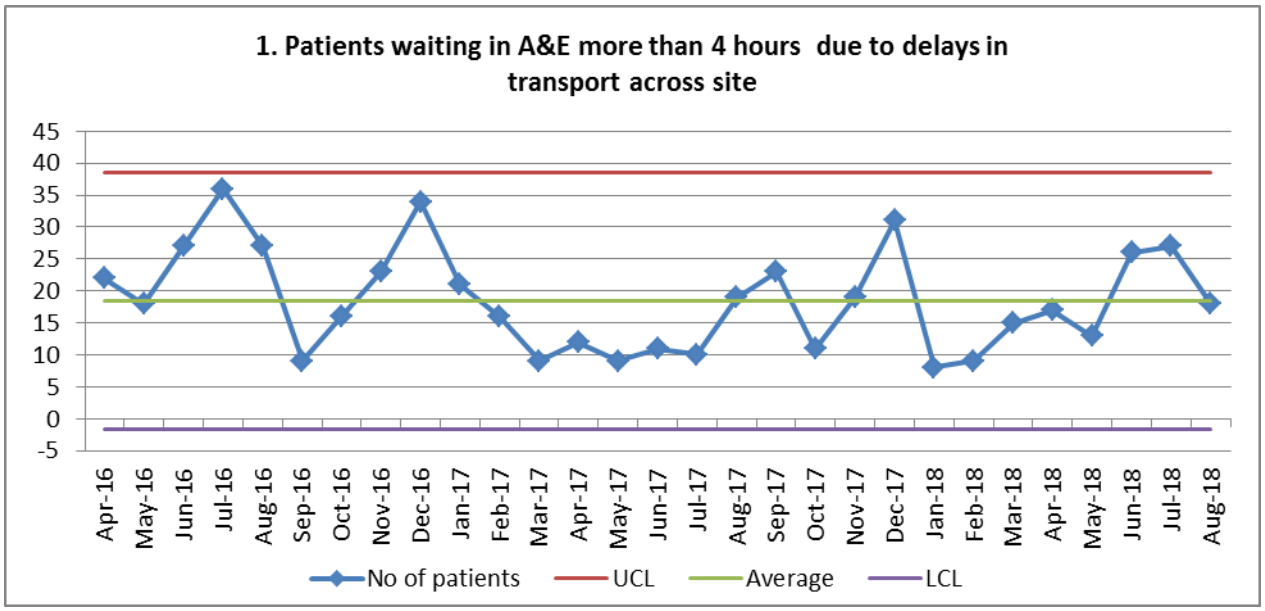
Frailty – Average LOS



The chart indicates a decrease in the average frailty LOS pre to post reconfiguration/

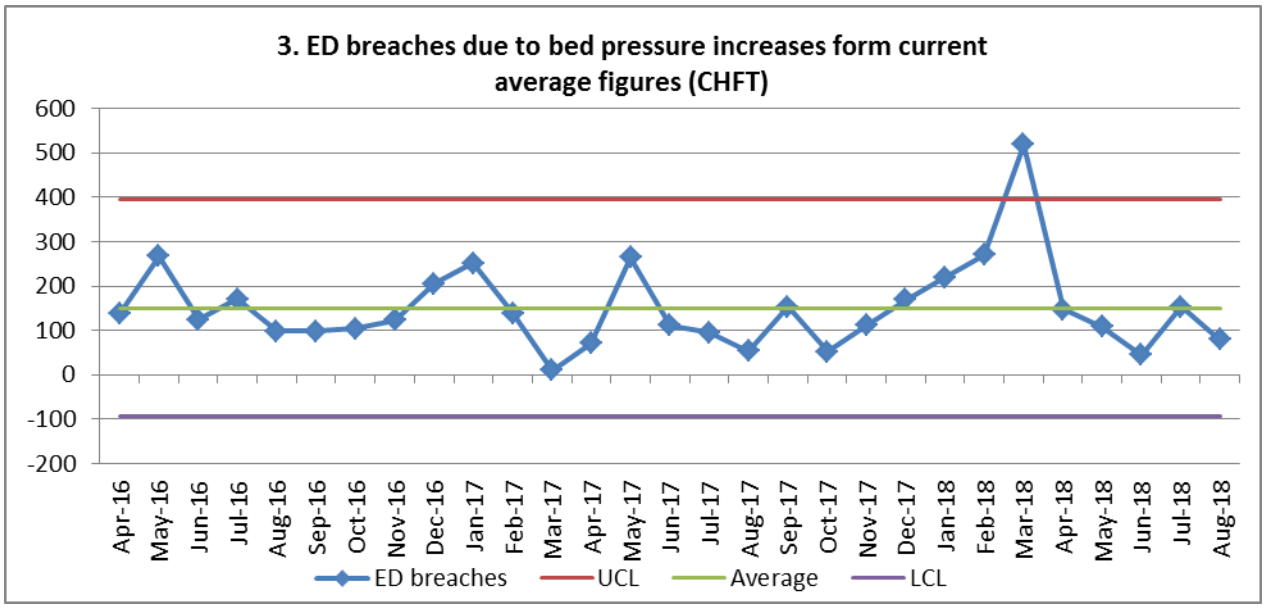
We set out to monitor the following to ensure there was no deterioration in performance;

Patients waiting in A&E more than 4 hours due to delays in transport:



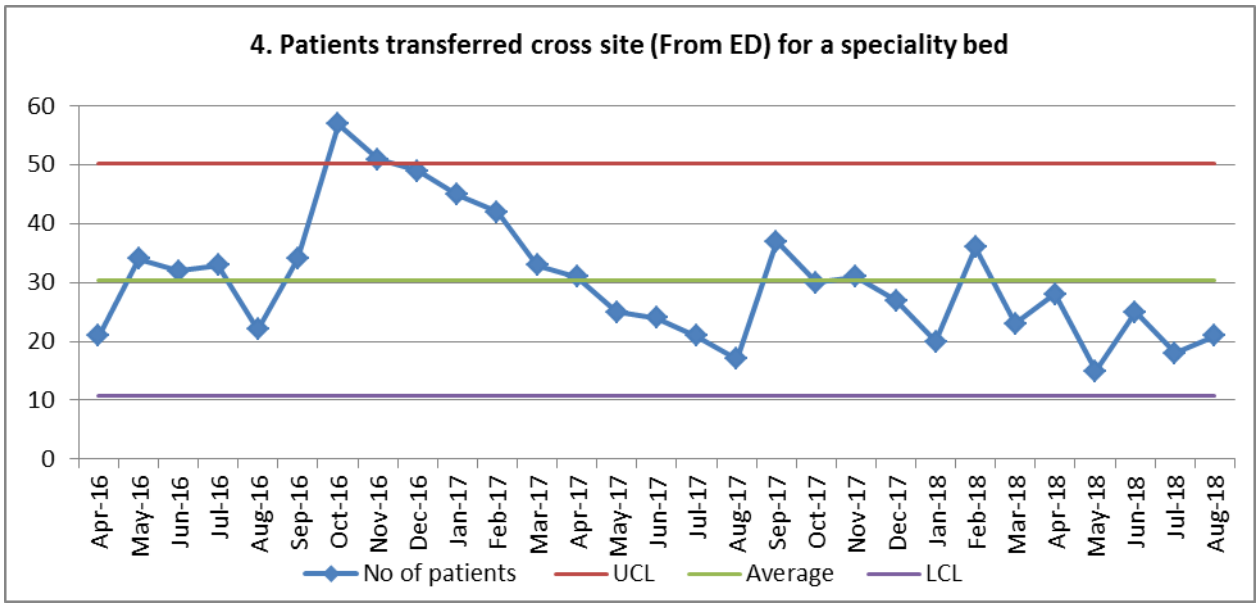
There was no increase in delays due to transfer of patients across site.

ED breaches due to bed pressures (blip in March 2018)



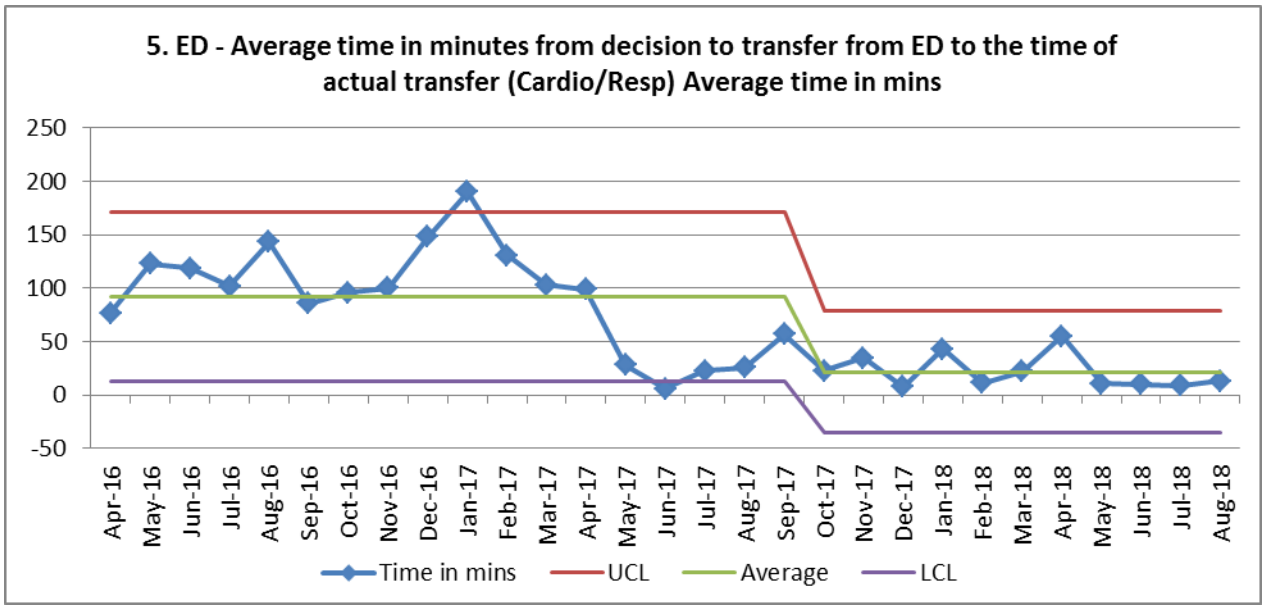
Performance is within normal variation with the exception of March ’18 which was due to unprecedented levels of activity.

Patients transferred cross site from ED for a specialty bed



Pre-reconfiguration the number of patients being transferred across site showed a trend of reduction and was predictable. The current numbers are more variable however remain with planned activity with YAS.

Time from decision to transfer from ED to the time of actual transfer to Cardio/Resp



The improvements in transfer wait times have been maintained post reconfiguration.

All the above show either improvements or no deterioration however there are a number of actions in place which will further improve performance across a number of the above indicators;

- Embedding the consultant of the week model in Cardiology and Respiratory. The expected outcome of this is that length of stay will reduce across both specialties. As a result of this it is likely that harm free care will also improve.

- Development of the Frailty team through the winter planning and UCB. The proposal sets out to increase and develop the Frailty team so that more patients can be seen in the front end and comprehensive geriatric assessments completed for all patients. This will in turn reduce admissions, length of stay and readmissions.

KPI's continue to be monitored through the Directorate and Divisional processes.

15. Update on Aims and Objectives:

The project aims and objectives were agreed following engagement with patients, staff and external partners. The following table outlines if the changes made have met these expectations.

	Aims	**Was this achieved?**
1	Make sure we can offer the same high standard of care to every patient, where ever they live.	Yes, consistent service provision
2	Get better at assessing and supporting patients to avoid admitting and keeping them in hospital unnecessarily	Yes, frailty service at HRI increases home first
3	Give the best care for patients by making sure they are admitted into the most appropriate specialty bed or day case	Yes,

	area	
4	Ensure patients receive same care and input wherever they enter the service, whatever day of the week'.	Partially: Pending consultant recruitment
	Objective	**Was this achieved?**
1	To develop new and sustainable models of care, using capacity differently, reducing variation and making best use of facilities, staffing, technology and equipment	Yes
2	For patients and staff to support development of the best service model	Yes
3	To Optimise community services to provide care closer to or at home	Partially: further work to do
4	To respond to the Invited Service Reviews by implementation of recommendations including providing single site service provision for acute Respiratory and Elderly Medicine services	Yes
5	To create the foundations to support the delivery of 7 day specialist consultant cover on Cardiology, Respiratory and Elderly Medical	Yes
6	Innovate and create wider system solutions with other health providers and the third sector	Partially: Foundations set for further service improvement work
7	Improve efficiencies in the end to end services to support the Health Economy cost reduction and bed reduction strategy	Yes; Reduced Cardiology beds, improved flow

16. Summary

The aims and objectives for this complex project have either been met of have a platform now set for delivering the improvements. The KPI's re-enforce this position by either demonstrating improvements or no deterioration to patients services. Our patients welcomed the changes and described how improved communications with their Consultants helped with the understanding of their treatment plans; however travel, for some family and friends

of Elderly patients in particular, has remained an issue, preferring the service more local. Whilst a few staff found travelling difficult, this has been mainly been resolved through reallocation of jobs on the site of choice. Many staff articulated improvements in training and supervision and improved continuity of clinical care supporting earlier discharge.

There have been challenges to the front end services which are being worked through; however there have been good working relationships with YAS and evidence that the modelling and data predictions were accurate which kept the services safe during transition. Patients flow has improved and the three reconfigured services have articulated positive clinical benefits. Importantly, the project has allowed further service improvement initiatives as described above to both expand and mature as the teams grow in confidence to enact more transformational changes in the future.

17. Recommendation

The Board are asked to:

1. Note the contents of this paper and to support the transition to business as usual as part of core divisional performance monitoring arrangements.

Appendix A
Patient's story:

This is a patient from Todmorden who had previously being getting admitted with UTI, falls etc. It became clear when looking back through the notes and speaking to family that he suffers with delirium each time he is admitted and this is what is increasing his length of stay. We spoke to family and to him who was just starting to become very confused and agreed home today was the best place for him to be. We spoke to CRISIS who had no capacity to do a discharge to assess and then spoke to Virtual ward that could not visit today but asked them to prioritise a call tomorrow which they agreed to do. We then spoke to his family and private care providers and agreed that we would take him home with our therapy staff and do his assessments at home today as he also had a stair lift and given his delirium it would be good to do this in his own environment where he would feel better orientated. It went well and we have left him at home to be cared for with a plan in place RC 31st May 2018. The family said they were overwhelmed at the lengths we went to ensuring he was cared for in the right place. The repercussions would have been worse for him and us if we hadn't got him home on the day.

The patient would not have been seen at all by frailty pre reconfiguration.

Appendix B Current KPI dashboard

				Comparing Pre to Post Reconfiguration			
				Whats happening to KPI ?			
Ind	Area	KPI	Rationale	Improving	No Change	Worsening	SCP charts analysis
1	Emergency Department	Patients (Aged 18+) waiting in A&E more than 4 hours in ED due to delays in transport across site - Trust	Low - good		YES		
2	Emergency Department	YAS application of admissions pathways - % Cardio or Resp atts at CRH Site (All patients)	Higher - good	YES			SCP charts shows improvement pre to post reconfiguration
3	Emergency Department	ED breaches due to bed pressures increases from current average figures (CHFT)	Low - good		YES		
4	Emergency Department	Patients transferred cross site (from ED) for a specialty bed (ie from HRI to CRH)	Low - good		YES		
5	Emergency Department - Cardiology/Respiratory	ED - Time from decision to transfer from ED to the time of the actual transfer Cardio/Resp - Average time in mins	Low - good		YES		
6	Emergency Department - Cardiology/Respiratory	ED - Time from decision to transfer from ED to the time of the actual transfer Cardio/Resp - Longest time in mins	Low - good		YES		
7	Cardiology Inpatients	Cardiology speciality - % bed occupancy for Ward 6BC	High - good		YES		
8	Cardiology Inpatients	Cardiology outlier bed days	Low - good	YES			SCP charts shows improvement pre to post reconfiguration
9	Cardiology Inpatients	CCU - Ward % bed occupancy	High - good		YES		
10	Cardiology Inpatients	% of NSTEMI patients having Angio +/- PCI within 72 hours of admission (based on MINAP patient list)	High - good		YES		
11	Cardiology Inpatients	Cardiology % day cases	High - good	YES			SCP charts shows improvement pre to post reconfiguration
12	Cardiology Inpatients	Cardiology - Avg IP LOS	Low - good	YES			SCP chart shows no real change over time but an improving trend since March 2018
13	Cardiology Inpatients	Cardiology - % harm free care	High - good		YES		
14	Respiratory Inpatients	Respiratory Specialty - % bed occupancy for Ward 5BC	High - good		YES		
16	Respiratory Inpatients	Respiratory outlier bed days - non respiratory wards	Low - good		YES		
17	Respiratory Inpatients	Respiratory - Avg IP LOS	Low - good		YES		
18	Respiratory Inpatients	Respiratory - % harm free care	High - good		YES		
19	Elderly Inpatients	Elderly Avg IP LOS	Low - good		YES		
20	Elderly Inpatients	Elderly - % harm free care	High - good		YES		
21	General Medicine LOS	General Medicine LOS	Low - good		YES		
22	Overall	patients transferred across site / to another facility due to capacity issues	Low - good		YES		
23	Frailty	Frailty Team Referral Demand - New & F/UP referrals to Team	High - good	YES			SCP charts shows improvement pre to post reconfiguration
24	Frailty	Time from referral to being seen < 2 Hours	High - good		YES		
25	Frailty	Admissions avoided - due to Frailty Team intervention	High - good	YES			SCP charts shows improvement pre to post reconfiguration
26	Frailty	Frailty Team - average team LOS (in days)	Low - good	YES			SCP charts shows improvement pre to post reconfiguration
27	Frailty	% of Readmissions back to Frailty Team	Low - good		YES		

21. Care of the Acutely Ill Patient

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday 1 November 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient Report - Care of the Acutely Ill Patient - The Board are asked to note the contents of the CAIP report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

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

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

The CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee. Performance is measured in the CAIP dashboard and a brief progress against themes is noted in the attached paper.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

CAIP BoD October 2018 SU.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors October 2018

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

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

The CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee. Performance is measured in the CAIP dashboard and a brief progress against themes noted below.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** Data released in September showed the SHMI for Apr 2017 to Mar 2018 = **98.89** (categorised as Band 2 – as expected. **HSMR** Data released in September 18 showed the HSMR for Aug 17 – July 18 is at 82 and is showing as a positive outlier (better expected range). **Alerting Conditions** No alerting conditions in the latest release of data **Learning from Death** The LfD policy has been revised and will focus on quality of care in line with RCP guidance. The online initial screening tool (ISR) has been revised to simplify the questions and to include additional speciality questions as	SHMI and HSMR performance continues to be monitored and reported monthly to the Mortality Surveillance Group (MSG), all within expected range. The 'mortality risk' will be reviewed in January 2019 and further reduced if this is maintained. Further work includes revision of the information provided to relatives following the death of their loved one to ensure they are aware of the process to review deaths and given the opportunity to be involved if they wish.

	requested by specific speciality teams. Engagement with the different speciality teams has taken place for these teams to perform ISR with their teams.	A random selection of deaths from each of the speciality teams will be selected monthly to have structured judgment reviews completed to provide assurance of learning.
2) Reliability in clinical care	AKI and Sepsis continue to be prioritised for evidence-based care bundle improvement work. The focus for Sepsis is now the antibiotics within an hour element, which is showing an improved position. A team from ED has been accepted onto an improvement collaborative run by Haelo to look at antibiotic delivery in ED The AKI group has core membership and is looking at how best to improve the management of AKI patients in the trust. Awareness of how to access the AKI bundle in EPR is being raised.	The Sepsis group will continue to manage the performance of sepsis. Improving compliance around sepsis 6 elements is the focus of the coming months. The ED team will be returning for session 2 in October. The AKI group are continuing to develop agreed guidance to promote better patient care when AKI is alerted on EPR.
3) Early recognition and treatment of deteriorating patients.	The Deteriorating Patient Group has had a refresh with a new set of TOR. Membership and attendance has improved as a result. The Trust performance of observations on time has improved and remains about 70%. Benchmarking is underway with other organisations to see if this is an acceptable level of obs on time. As a Trust we have agreed to pilot level 1 HDU competencies for certain cohorts of nurses. The NEWS2 T&F continue to report progress into this group. Capital funding has been approved	The newly appointed Associate Nursing Director of Quality has been tasked to co-design an improvement plan for high quality observations and barriers to escalation. NEWS2 comms and training through the e-learning package on ESR is being disseminated across the Trust. A pilot has been agreed to use an EPR ward view as a prompt to reviewing raised NEWS and

	to update Nervecentre. An e-learning package is also now available on ESR.	patients at risk of further deterioration within Safety Huddles. The pilot will run on both AMU's and ward 6 at HRI.
4) End of life care	Bereavement Survey Each year, CHFT currently takes part in an annual bereavement survey, whereby Next of Kin (NOK) for deaths occurring in the month of May are sent a survey to comment on their experiences. Of the 90 surveys sent, the trust has a 30% response rate. In order to gather more feedback to both highlight the areas of excellent care and areas that we can improve on, a 6 month pilot audit is being undertaken on our four stroke wards at CRH. Prior to sending the survey, a bereavement card was sent to offer support and also inform them of the upcoming survey. So far we have had a 51.5% response rate. Bereavement cards A bereavement card is being developed with input from our bereaved relatives. This card will be sent out 1-2 weeks after death to offer a phone number for relatives to ring if they have unanswered questions or need support. This is going to be trialled within the surgical division. Bereavement café The Chaplain department alongside the end of life care facilitator have developed - The marigold café which is a bereavement café started on the 7th September. It is to run the first Friday of every month on alternate sites. This is open to anyone who has suffered bereavement.	Work is continuing regarding how best to incorporate the ICODD (integrated Care of the Dying Document) into EPR Engagement with wards for those that are not documenting that the discussion took place correctly on the form. Review of the stroke pilot study.

	End of life care companions The companions are here to sit alongside patients at the end of life, either if they have no family or their families need a break. 20 companions have been trained to support our dying patients, their families and the ward teams. Horizon group This is a collaborative group which includes CHFT, Calderdale Council, the Council of Mosques and Overgate Hospice. DNACPR Compliance around DNCAPR review dates and discussion date as now being reported directly from EPR, compliance has dropped slightly in relation to this while sample approach. Noted that discussions are documented in the notes but the corresponding box not ticked on the form.	
5) Caring for frail patients	The Acute frailty Service continues at the HRI site only as all frail patients are brought the HRI site. Helpline still available for CRH site but rarely contacted as very few frail patients are taken to CRH The Acute frailty Service has seen a growth in referrals, admission avoidance and follow up visits. Following a successful business case for an investment into the frailty service they have recruited more nurses, therapy, a pharmacist (new into frailty), Advance Clinical Practioner ACP (New into frailty).	The Acute frailty service will expand its service to cover all front end services incorporating the Surgical Assessment Unit. The frailty team will start on the 3rd December. The frailty unit and ambulatory area is in the process of being described with a view to the frailty unit being open on 15th December. The frailty ambulatory area will be early next year once we have recruited into all ACP posts and a geriatrician Going forward once all staff in post the Acute frailty Service will deliver

	These are not all substantive posts and will be for review in March.	a frailty unit and ambulatory service. The frailty service is expanding into surgery in December
6) Clinical coding	The audit work continues within specialties and specific cohorts. Percentage of sign and symptoms remains high. Average diagnosis and average Charlson scores both deteriorated in September with average diagnosis dropping below local target. Work is progressing to understand reasons for the deterioration. There is variation at Division and specialty level across each of the coding targets. Coding KPI performance aims to be in line with the top 25% in the country.	The 3 new trainee coders are due to complete their foundation training at the end of Oct. The Clinical Coding Action plan for the next 2 years during Sept it aims to address some of the key issues affecting the quality of the coding, including EPR documentation, data quality and education and engagement. Progress will be monitored via the Clinical Coding Improvement Steering Group.

22. Guardian of Safe Working Hours Report

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Amber Fox, Corporate Governance Manager
Date: Thursday 1 November 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Guardian of Safe Working Hours Q3 Report - Quarter 3 Report 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

See report attached.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to approve the Guardians of Safe Working Hours report for Quarter 3.

Appendix

Attachment:

Q3 GOSWH report.pdf

Guardian of safe working hours (GOSWH); CHFT

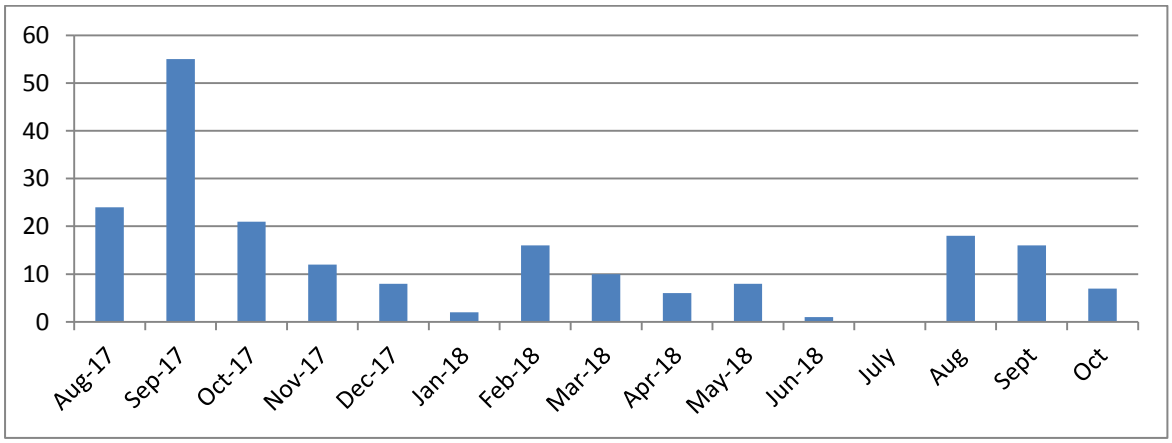
Quarter 3 report 2018

All our doctors in training, including the GPSTs are on the 2016 Contract. Since August 2018 the Trust had been the lead employer for all GPSTs in GP practices who have access to me as their GOSWH.

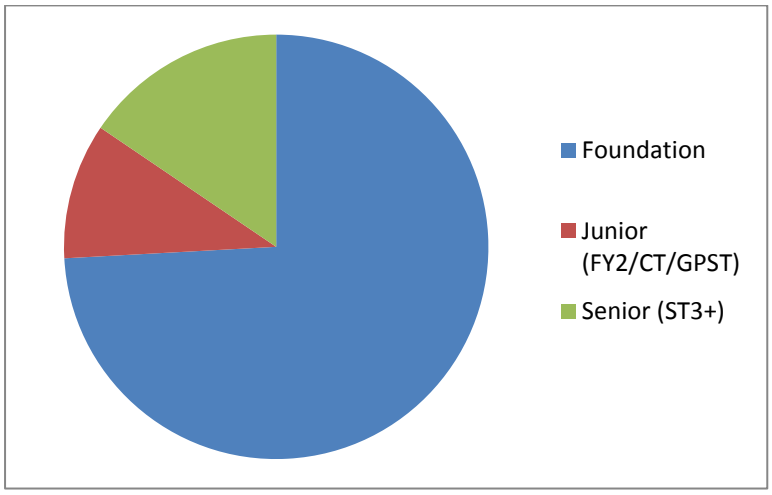
a) Exception reports (1st July 2018-15th October 2018)

There have been a total of 41 exception reports this quarter which represent 58 episodes. Approximately 80% of these have been completed. This is an improvement over Q1 and Q2 data and is likely due to a clearer process for following up exception reports and the provision of administrative support for the GOSWH.

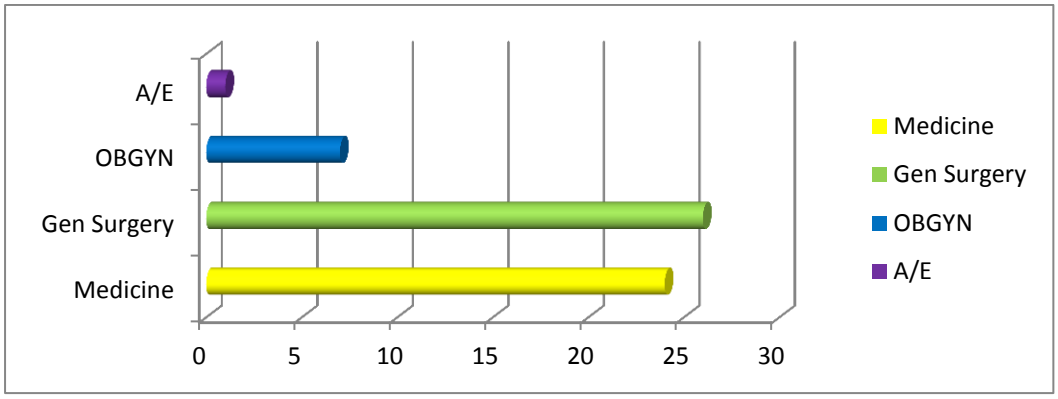
Monthly Exception reports



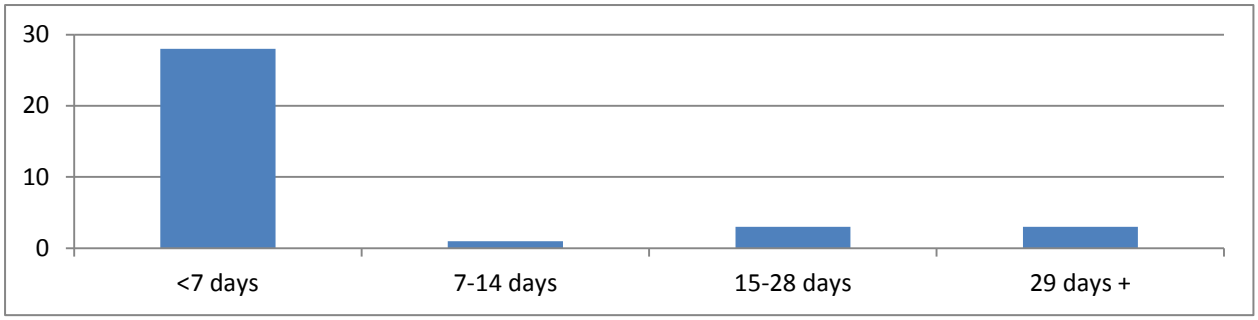
Exception reports by grade



Exception report by Rota (no. of episodes)



Time to resolution of ER episodes



b) Work schedule reviews

A review has been requested by a senior trainee in Trauma and orthopaedics. This is now been discussed within the division and Medical HR and is awaiting a final agreement. It may result in a group work schedule review.

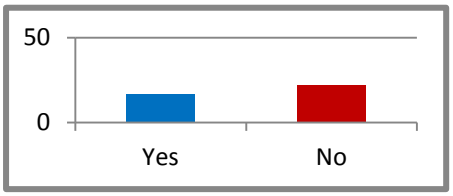
c) Main issues arising and steps taken to resolve them

1. Feedback from the CHFT Junior doctor survey (July 2018)

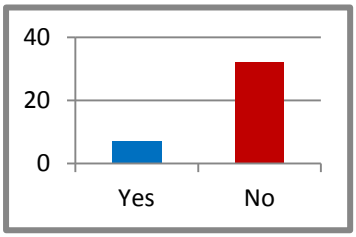
One of the FY2 doctors in Anaesthetics designed a survey with input from the BMA, GOSWH and CHFT Human Resources to try and improve Junior Doctors' working lives. The survey was based on the recently published BMA charter on junior doctor fatigue and facilities. The survey was sent out to all junior doctors (FY1-ST8) in July 2018 and responses from the 39 doctors around exception reporting are detailed below.

Doctor Grade	
FY1	7
FY2+	9
CT1+	13
ST3+	10

a) Do you know how to use the system (i.e. Allocate)?



b) Have you exception reported?



c) **Reasons for not exception reporting**

Lack of time	7
Lack of knoweldge	17
Peer pressure	4
Nothing will change	2
Feel responsible	2
Not applicable	7

In response to the above, I have sent out guidance on using the Allocate system to all junior doctors and their supervisors. I am in the process of creating a 'GOSWH' webpage on the Trust intranet and will populate it with relevant information on exception reporting. I also plan to introduce myself at the FY1/FY2 teaching and do a monthly GOSWH walk around or drop-in sessions.

2. Cancelled locums in paediatrics

In October, the department was understaffed (the planned locums to fill the gaps for the month of October were all cancelled by the department at short notice) leaving the registrars on shift covering multiple roles on a very busy evening. They were unable to take breaks and unable to train the junior trainees. It was escalated at the time to the consultant on call who stayed on the unit to help. This issue was raised by the division as a concern and the locums have now been reinstated. An exception report will be filled in retrospectively.

3. Urology training issues

There were trainee concerns reported to the TPD which were forwarded to the Head of School and the Deputy Postgraduate Dean. The concerns were mainly around lack of protected training time arising from the on-call rota and missed learning opportunities due to service provision.
An extraordinary Monitoring the Learning Environment Meeting took place in May 2018. Adjustments had been made to the rotas to include more Paediatric Urology and the effects were currently being monitored. The ES and Head of School agreed to meet with trainees to discuss ongoing concerns relating to the timetable. This quarter, there has been only one exception submitted by a urology FY1 relating to the workload and extra hours worked.

d) Rota Gaps

Rota	Speciality	Number of gaps	Reason for Gap	Cover arrangements	Vacancy period
1st on call CRH	Anaesth 1-7 rota	1	MTI doctor left the trust	Speciality or MTI for extra payment	
1ST on call HRI	Anaesth 1-7 rota	2	1 x trainee off on long term sick Novice anaesthetists in their training period	Trainee, Speciality or MTI for extra payment	
CT1	Urology	1	Deanery post	Ward-cover Bank. On-call bank & Agency	Aug 18 – Feb 19
CT1	Gen Surgery	2	Trust posts	1) Full bank cover 2) On-call bank cover	Ongoing Ongoing
ST3+ SAS CT1 ST3+	Urology Urology A&E ENT	1 1 3 2	Deanery post Trust post GPST Gaps Trust posts	On-Call bank & Agency On-Call bank & Agency On-Call bank & Agency On-Call bank & Agency	Oct 18 – April 19 Ongoing Aug 18 – Feb 19 Ongoing
FY1-CT	Acute medicine	2	Doctor resigned from programme. Deanery vacancy	On-calls covered by new trust appointee none (unbanded post)	Aug 18-Dec 18
FY1-CT	Cardio	1	Deanery vacancy	On-calls covered by new trust appointee	Aug 18 - Feb 19
FY1-CT	Stroke	1	trust post	No on-calls to cover.	Ongoing
ST3+	elderly	1	Trust doctor moved to respiratory as per CESR programme	Locum cover for on-call duties	Ongoing
ST3+	Gastro	1	trust vacancy	Locum cover for on-call duties	Ongoing
ST3+	Acute Medicine	2	Deanery vacancy	Locum cover for on-call duties	Until aug 2019
ST3+	Diabetes	3	1 trust doctor on maternity leave, 2 deanery gaps	Locum cover for on-call duties	Until aug 2019
ST3+	Resp	1	trust gap	Locum cover for on-call duties	Ongoing
ST3+	Cardio	1	trust gap	Locum cover for on-call duties	Ongoing
ST3+	OBGYN	2.5	1 gap due to mat leave 1 deanery gap 0.5 gap due to LTFT trainee	2 MTIs started-plan to put on ST3+ rota	Until Aug 2019
FY-ST1-2	OBGYN	0.5	Due to a LTFT trainee	Covering on calls with MTI/locums	Until Feb 2019
ST4+	Paeds	2 (3 from Nov)	Deanery gaps 3rd gap from November due to mat leave	Covering on calls with locums Looking into other options within division	Until Feb 2019
FY-ST1-3	Paeds	2	Deanery gaps (1 GPST, 1 FY2)	Locums for on-call FY2 gap filled Dec'18 2018	Until Feb 2019
ST	Ophthal	1	Deanery gap	Covering on calls with trust doctor	Until Feb 2019

e) Locum bookings

GRADE	**AGENCY**		**BANK**		**UNFILLED**
	Shifts filled	Cost	Shifts filled	Cost	
CT1-2			128	£ 79,276.24	16
FY1			13	£ 7,131.66	1
FY2			100	£ 57,386.08	16
Speciality Reg	12	£ 8,772.36	204	£ 137,182.79	69
ST1-2	283	£ 175,585.13	549	£ 300,389.05	159
ST3+			37	£ 33,508.28	14

The total cost of locums (Agency and Bank) from August-October was £ 653,276.44 of which >70% was filled by Bank staff. The average cost of a bank locum shift was £578 versus £620 of an agency shift.

f) Fines

No fines had been levied in this quarter. The total amount raised from previous fines is approximately £1,200.
JDF representatives will speak to their colleagues and identify what the funding could be used for to enhance junior doctor experience at CHFT. There was some discussion regarding mess facilities.

g) Junior doctors Forum (JDF)

Attendance at this remains poor however those in attendance were well engaged. TheFY2 representative suggested that it would be beneficial for his grade to be able to meet as a group. At present there was no facility for this since there is no FY2 specific teaching. Medical education would take this forward with the Foundation Training Programme Director to arrange an FY2 session. The GP trainee representative reported that Practice Managers had really taken on board the requirements of the new contract and where they felt hours or training opportunities would be compromised; changes had been made to the work pattern. She also added that due to the close working relationship of GP trainees and their supervisors (based in the same practice) issues arising were likely to be resolved informally as opposed to submitting exception reports.

Any GOSWH messages around exception reporting will be disseminated by the trainee representatives via individual Whatsapp groups in addition to emails.

Anu Rajgopal

Guardian of safe working hours

October 2018

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

•Audit & Risk Terms of Reference – To approve

•Audit & Risk Committee – minutes from meeting 17.10.18

•Quality Committee – minutes from meeting 1.10.18

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

•Council of Governors – minutes from meeting 18.10.18

•Workforce Committee - minutes from meeting 8.10.18

To Approve

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

Calderdale and Huddersfield
NHS Foundation Trust

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Version:	2
Approved by:	Board of Directors
Date approved:	Audit and Risk Committee – 11 July 2018 Board of Directors –
Date issued:	
Review date:	July 2019

AUDIT and RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing sub-committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit and Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit and Risk Committee is authorised by the Board of Directors 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 Audit and Risk Committee.

1.3 The Audit and Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls corporate governance and assurance frameworks of the Trust and its subsidiary(ies).

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks and clinical audit.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the Foundation Trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition the Audit and Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit and Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit and Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Company Secretary, Head of Governance and Risk and Head of Internal Audit of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit and Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit and Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit and Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit and Risk Committee.

4.6 The Chair of the Board of Directors will appoint a Governor to attend the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Corporate Governance Manager as soon as possible in advance of the meeting except in extenuating circumstances.

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

5. Administration

5.1 The Corporate Governance Manager shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice. Their duties include but are not limited to:

- Agreement of the agenda with the chair of the Audit and Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;

- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

6. Frequency of meetings

6.1 Meetings shall be held at least three times per year, with additional meetings where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance of the Trust and its subsidiary(ies).

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing;
- Its co-ordination with External Audit;

Complying with the public sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

7.2.4 To consider the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.2.5 To conduct an annual review of the Internal Audit function.

7.3 External audit

7.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Membership Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the foundation trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Membership Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Annual accounts review

7.4.1 To review the annual statutory accounts, before they are presented to the

Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 To seek assurance from the Quality Committee that the Trust's Quality Account and opinions of External Audit have been scrutinised in detail.

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit and Risk Committee.

7.6.2 To examine any other matter referred to the Audit and Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit and Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit and Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as

reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7.6.6 To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive the minutes of the Risk and Compliance Group, Information Governance and Risk Strategy Committee and Data Quality Board.

7.6.7 The Audit and Risk Committee will receive a self-assessment and annual report from each of the committees for approval.

8. Reporting

8.1 The minutes of all meetings of the Audit and Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit & Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes.

8.2 The Audit and Risk Committee will report annually to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the foundation trust; the integration of and adherence to governance arrangements; its view as to whether the self-assessment against standards for better health is appropriate; and any pertinent matters in respect of which the Audit and Risk Committee has been engaged.

8.3 The Foundation Trust's Annual Report shall include a section describing the work of the Audit and Risk Committee in discharging its responsibilities.

9. Review

9.1 The Terms of Reference of the Audit and Risk Committee shall be reviewed by the Board of Directors at least annually.

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 17 October 2018 in the Large Training Room, Calderdale Royal Hospital commencing at 10:30 am

PRESENT

Richard Hopkin	Chair, Non-Executive Director
Andy Nelson	Non-Executive Director

IN ATTENDANCE

Gary Boothby	Executive Director of Finance
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Mobeen Kauser	External Auditor, KPMG
Victoria Pickles	Company Secretary
Adele Jowett	Local Counter Fraud Specialist
Andrea McCourt	Head of Governance and Risk
Amber Fox	Corporate Governance Manager (minutes)

OBSERVERS

Philip Lewer	Chair

52/18 APOLOGIES FOR ABSENCE

Apologies were received from Jackie Murphy and Linda Patterson.

53/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

54/18 MINUTES OF THE MEETING HELD ON 11 JULY 2018

The minutes of the meeting held on 11 July 2018 were approved as a correct record subject to an amendment under matters arising with the revised wording:

- 19/18 - the Company Secretary is looking at good practice elsewhere on the Board Assurance Framework (BAF) with Internal Audit; Internal Audit is currently undertaking a benchmarking exercise to review a sample of BAFs and the resulting report will be shared with the Trust to feed into the Trust's review of their BAF.

55/18 ACTION LOG AND MATTERS ARISING

The actions arising from the meeting in July were discussed and the action log was updated.

56/18 COMPANY SECRETARY'S BUSINESS

1. Board Assurance Framework

The Company Secretary presented the updated Board Assurance Framework (BAF) following a review of good practice elsewhere. Following feedback from Non-Executives, some initial work by Internal Audit and advice from the governance consultant working in the trust, there has also been some work on the board assurance process.

Comments from the Audit and Risk Committee have been taken into consideration and the report from Internal Audit will be received next week.

Work has taken place on the Risk Appetite following the Board workshop in the summer, led by Andrea McCourt. The Risk Appetite Statement will be presented to Board on 1 November 2018.

The Trust's Governance arrangements are being reviewed to understand the reporting arrangements as there is duplication and too much reporting under the Quality Committee. The Corporate Governance Manager has been collating terms of reference and a report on the previous 12 months of work the sub-groups. These will be collated into a report and recommendation to the Audit and Risk Committee in January 2019.

Andy Nelson commented on page 22, section 8.10, the Director of Nursing role and asked if there is a role for the Medical Director. Andrea McCourt explained the risk management strategy describes the roles and that the main responsibility is of the Director of Nursing. Andrea recommended signposting the reader to the Risk Management Strategy in section 1.1.

All risks on the Board Assurance Framework are reviewed by a Sub-Committee with the exception of two risks which will report to Board. The Executive Director of Finance asked if these risks should go to the Estates and Sustainability Committee. As these risks are so vast, it was agreed they would go to the Board.

Andy Nelson suggested referencing the Board of Directors in the 'Sources of assurance' on page 12.

Andy Nelson suggested the questions in Appendix 3 are shared with the Board to prepare for the Risk Workshop to understand where the Trust can improve and the Head of Internal Audit agreed this can help identify any development/training needs. It was agreed to create a sub-section of these questions as a handy guide.

Andrea McCourt asked if question 13 which refers to the Intelligent monitor report could be changed to the Insight report.

Richard Hopkin drew attention to section 8.3 detailing the responsibility of the Audit and Risk Committee and section 9.1 the role of the Committee in assessing the BAF and framework process. Richard suggested section 10.1 is amended to confirm the BAF will be presented to each Committee meeting.

The Committee noted the work being done to revise the structure of the BAF and approved the current BAF to be presented to the Board in November.

2. Review Declarations of Interest Policy and progress on new system (MESDeclare)

The Company Secretary explained the two upcoming tasks to get the new declarations of interest system up and running and the engagement piece with the organisation.

The plan is for the new system to be implemented by December with engagement taking place early in the new year to link it with the appraisal season 1st April – 31st March.

A visit has taken place to Leeds Teaching Hospitals where the system is working well. The Company Secretary highlighted that nationally Trusts have struggled with declarations of interest and although the Trust's system is delayed, it is not behind compared to other Trusts.

The declarations of interest policy has been adapted using the national template. Declarations will be mandatory for decision making staff from band 7+. This recognises the decision making responsibilities of budget holders and is aligned to the scheme of delegation. It was agreed that a link to appraisals would be useful alongside completing mandatory training..

The Audit and Risk Committee will be kept up to date on progress.
Action: Update January 2019

The Company Secretary referenced the publication section 9 and explained the system will publish relationships but not who or the details, as only only certain fields are published.

Section 9.3 Wider Transparency Initiatives - Andy Nelson asked if there are clear rules around what can be accepted and what can't particularly in relation to speaking roles. The Company Secretary agreed to contact Company Secretaries across other Trusts to see if anything has been developed.
Action: Company Secretary

Andy Nelson suggested it would be simpler to align under Hospitality the Trust's travel and accommodation policy. There was agreement that this would limit what the Trust could accept.

It was suggested senior approval is changed to your immediate line manager.

The new system will be rolled out with attendance at Divisional meetings, training will be offered to administration support and a communications plan will follow.

OUTCOME: The Committee **SUPPORTED** the policy to go through Weekly Executive Board for approval

3. **Self-Assessment Feedback**
Progress against the action plan will need to be updated for the next meeting and an update will be provided in January with the next assessment.
Action: Updated Self-Assessment to be provided in January 2019 – Company Secretary

57/18 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. **Review Waiving of Standing Orders**
The Executive Director of Finance provided details regarding the Trust's waiving of standing orders to enable volume and value to be monitored during the second financial quarter of 2018/2019.

During this quarter, 11 contracts were placed as a result of standing orders being waived, at a total cost of £334,909.00.

Andy Nelson asked if the challenge regarding maintenance costs is taking place with the supplier. The Executive Director of Finance confirmed challenge is taking place, for example with Huddersfield Pharmacy Specials (HPS).

The Executive Director of Finance provided re-assurance that staff are being advised to work with procurement for a better price.

There was no tenders completed over the second quarter. The total value of spend that was transacted through the Procurement department was £9,806,337.41.There were very few orders placed in September (there were no waivers of standing orders) as orders were deferred during the Calderdale and Huddersfield Solutions (CHS) go live.

2. **Review of Losses and Special Payments**
The Deputy Director of Finance presented the report for the quarter. The total is just short of £60k in the last quarter. The Standing Financial Instructions are issued in accordance with the Code of Accountability for NHS Boards and have prior Board approval.

OUTCOME: The Audit and Risk Committee **NOTED** the contents of the report

58/18 Risk Management

1. Review of risk management arrangements

Andrea McCourt presented the annual report, highlighting the key points:

- EPR risks were reviewed last year which was a large piece of work incorporating these into the business as usual process
- Internal Audit have been asked to identify good practice on the use of Board Assurance Frameworks
- Analysis of movement on the risk register showed that risks were being regularly reviewed and managed with 15 new risks and 20 closed over the period
- The revised Risk Appetite Statement will be presented to Board for approval on 1 November
- THIS, HPS and CHS risks are being worked through to confirm where they sit
- CQC Well-Led Inspection Report provided positive feedback in relation to the systems for risk management and in particular highlighted that there is a maternity risk management strategy in place.

Positive feedback was provided from Andy Nelson that the challenge at Board is much sharper.

OUTCOME: The Audit and Risk Committee **APPROVED** the risk management arrangements report

59/18 Internal Audit

1. Review Internal Audit Follow-up Report

The Internal Audit Manager explained there will be a new format of the follow-up report from the next meeting in January 2019.

The launch of the new electronic system for reporting will email officers as a reminder, and will include old recommendations. The Committee requested that recommendations for 2016/17 should be addressed and closed as a priority.

There has been an increase in the number of recommendations not yet due, this is due to the timing of the meeting. These recommendations are due on 31 October.

The Internal Audit Manager shared positive news in that overdue recommendations have decreased to 4%. New dates have been agreed for all four overdue recommendations.

Andy Nelson highlighted the numbers in the table are incorrect as they don't add up. The Head of Internal Audit confirmed the overall totals are correct.
Action: Re-issue the table

It was noted that the forward plan would be discussed at Weekly Executive Board on 18 October.

2. Review Internal Audit Progress Report

The Internal Audit Manager confirmed there were six finalised reports with significant Assurance and 3 draft reports with limited assurance.

Andy Nelson asked for more information on the Gosport review. The Internal Audit Manager explained the enquiry which is in relation to controlled drugs and how they were administered which has been a focus in the last quarter. The detailed Gosport report has been to Quality Committee and will be presented to the Board on 1 November 2018.

Benchmarking of the risks will be reviewed at the Risk and Compliance Group.

DRAFT

Andy Nelson enquired about Medical Devices which will be discussed in the next few months in terms of issues around training and inventory.

Internal Audit have completed a piece of work on backlog maintenance which will be reviewed by the Executive Director of Finance and External Audit.

Andy Nelson highlighted HPS should be included in the plan in terms of their key risks.
Action: Internal Audit Manager to include HPS key risks in the 19/20 plan

The Internal Audit Manager confirmed GDPR and cyber security is included in the plan; however, business continuity as a whole is not included in the plan for 18/19.

OUTCOME: The Committee **APPROVED** the 2018 / 2019 Internal Audit Annual Operational Plan

60/18 Local Counter Fraud

1. **LCFS Progress report**
   The Local Counter Fraud Specialist provided an update on current investigations including an issue in relation to overtime requests.

OUTCOME: The Committee **RECEIVED** the progress report.

61/18 External Audit

1. **Technical Update**
   The technical update was received.

The Executive Director of Finance explained the first month of accounting with Calderdale and Huddersfield Solutions has been very time consuming for the Trust, and highlighted that other Trusts employed additional finance staff to undertake this work.

The External Audit report will be circulated to the Board.

OUTCOME: The Board **NOTED** the technical update for information.

62/18 ITEMS TO RECEIVE AND NOTE:

- Information Governance & Records Strategy Committee minutes – 20.08.18
- Risk & Compliance Group Minutes – 16.7.18 & 21.8.18
- Data Quality Board – 20.09.18

OUTCOME: The Committee **RECEIVED** the minutes from the relevant groups.

63/18 ANY OTHER BUSINESS
No other business to note.

64/18 MATTERS TO CASCADE TO BOARD

- BAF procedure has been drafted and the BAF itself is under review
- New declarations of interest system and updated policy
- Risk Management Arrangements annual report
- Internal Audit review – overdue recommendations have reduced to 4%
- Limited assurance reports
- Benchmarking of the risk register
- Overtime controls

DRAFT

DATE AND TIME OF NEXT MEETING
The next meeting is scheduled to take place on Wednesday 23 January 2019 at 10:00 am in Meeting Room 4, Acre Mills Outpatients.

REVIEW OF MEETING
Feedback from Philip Lewer was that the challenges at the Committee are re-assuring and there is helpful, constructive dialogue.

Internal Audit thanked the Executive Director of Finance for his assistance in engaging with colleagues.

The Chair formally closed the meeting at 12:30 pm.

DRAFT

QUALITY COMMITTEE

Monday, 1 October 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

167/18 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Helen Barker **(HB)**	Chief Operating Officer
Dr David Birkenhead **(DB)**	Medical Director
Paul Butterworth **(PB)**	Public Elected Governor **(reserve)**
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Jackie Murphy **(JMy)**	Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Natalie Lofthouse **(NL)**	Student Nurse – Observer **(Shadowing Andrea McCourt)**
Jo Middleton **(JMidd)**	Associate Director of Nursing – Surgical **(for item 173/18)**
Dr Sal Uka **(SU)**	Associate Medical Director **(for item 174/18)**

168/18 APOLOGIES

Alistair Graham	Non-Executive Director
Anne-Marie Henshaw	Assistant Director of Quality and Safety
Lynn Moore	Public Elected Governor
Lindsay Rudge	Deputy Director of Nursing

169/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

170/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 3 September 2018 were approved as a correct record.

171/18 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

At the last meeting (3 September 2018), discussion took place on progress following the medical division's management of complaints. Further review work has taken place and an improvement plan is due to be presented to the division.

172/18 CARE QUALITY COMMISSION (CQC) UPDATE

Jackie Murphy (Chief Nurse) presented appendix C, which provides an update on the delivery of the Trust's response to the CQC report.

The current position with the action plan is that there are nine must-do (MD) actions and 54 should-do actions. The monitoring of the should-do actions is being delivered through a schedule of core service updates, which is detailed in the report. The must-do actions are being reviewed based on their dates for expected completion.

Two actions are complete, four actions are on track to be delivered and three actions have not progressed to plan. These are MD 6 – ligature room, MD 7 – ligature risks and MD 8 – medical staffing (CRH).

Discussion followed on the challenge posed with implementing MDs 6 and 7, and the urgency for them to be completed within the next two weeks.
Action: JMy to follow-up

The CQC Response Group continues to oversee the delivery and sign-off of the action plan and submits continual progress updates to the Quality Committee, who in turn provides assurance to the Board that the action plan is achieving the expected impact and gives final sign-off for sustained actions.

Discussion also took place on what would be required for the Trust to achieve an 'outstanding' rating, and JMy stated that a presentation is due to be given at the Weekly Executive Board this week with Sarah Dronsfield (CQC Head of Hospital Inspections for Yorkshire and Humber). Following the progress against approaches to achieve 'outstanding', a quality summit is planned, which will review the CQC report with key stakeholders. The Quality Committee requested a copy of the report from the Quality Summit once the even has been held.

OUTCOME: The Quality Committee received and noted the content of the report.

173/18 NASOGASTRIC TUBE TRAINING UPDATE

Jo Middleton (Associate Director of Nursing – Surgical) gave a verbal update on nasogastric (Ng) tube insertion training. Compliance, monitored at the artificial nutrition group, is 74% as of today, against a target of 95%.

Discussion ensued as to whether there are any colleagues on high risk areas inserting Ng tubes that are not trained, and whether there is enough resource for a colleague on another ward to be used to insert a tube if needed. It was reiterated that if a colleague is not signed-off as competent to place a tube that they should not be carrying out the procedure. Dr David Birkenhead (Medical Director) and Jackie Murphy (Chief Nurse) were happy to forward a message to both nursing and medical colleagues reminding them of this.

Training for new doctors generally feels better, however it was stated there is no core training for foundation or trainee doctors that stipulates Ng tube insertion skills are required, although some specialties may require this.

It was asked whether Ng tube insertion compliance data is included in the quality and performance report. JMidd reported that there is debate as to whether this should be kept on the medical devices database, however, it was stated that assurance of compliance needs to be visible and to feed into a governance group. It was suggested that each division reports Ng tube insertion compliance as part of their quarterly PSQB reporting.
Action: Divisions to include Ng tube insertion compliance within their Q2 PSQB report in December

JMidd was thanked for the update and a further report was requested for February 2019.
Action: Further update required for the February 2019 meeting.

174/18 LEARNING FROM DEATH

Dr Sal Uka (Associate Medical Director) was in attendance to provide an update on the learning from death (LfD) mortality review process.

The mortality review process is one that includes a revised screening process with structured judgement reviews (SJR) keeping in with the requirements of the National Quality Board.

The LfD policy has been revised to stipulate the need to learn from deaths, the addition of the role and responsibility of the LfD panel, revised escalation process for mortality reviews,

a process for stillbirths and neonatal deaths, and an updated process of how families are involved.

Structured judgement reviews (standardised case notes reviews) are completed by nine trained consultants, with a bi-monthly LfD report to the Mortality Surveillance Group and a quarterly report to the Board of Directors. A LfD summit took place on 12 July 2018 with 70+ people in attendance. The summit generated good discussion and thought and the output from the summit will be shared.

CHFT ambition was to perform initial screening reviews on all deaths, with training and face-to-face engagement provided, however, year to date; only approximately 30% of all deaths have been reviewed. Better uptake has been noted for specialty-specific screening reviews on deaths relevant to practice. These reviews have been agreed with general surgery, urology, orthopaedics, critical care, gastroenterology, stroke and the emergency department. Further reviews with other specialties are proposed from quarter 3, and if agreed, this will provide screening with approximately 50% of all deaths.

Discussion followed on the difference between an expected and a general death and whether a review is needed. It was stated that a review is not anticipated on an expected death; however, there may be some lessons to be learned. It was also asked whether reviews should be carried out on patients with a positive experience, as there may be some learning to gain from the care given to patients.

The Committee agreed to support specialty-specific screening, for specialties to report progress and learning to the Mortality Surveillance Group and for guidance with bereaved families and carers to be included in the End of Life Care group agenda this month. It was also stated that some background work needs to be done on understanding and recognising impending death as well as learning from good care given to patients. A lot of work has taken place in the last three years resulting in the decreasing Hospital Standardised Mortality Ratio due to multifactorial efforts made - this now needs to be maintained. SU stated that these processes may take some time to implement; however, quarterly LfD reports will be submitted providing any progress.
Action: An update on LfD to be provided at the end of April 2019

175/18 PATIENT SAFETY GROUP REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix E highlighting key points from the last two Patient Safety Group meetings held on Thursday, 16 August and Thursday, 20 September 2018, which included updates on coding, incident reporting, duty of candour, pressure ulcers and falls.

Discussion followed on incident reporting and whether this was part of mandatory training. It was stated that this is not mandatory, as anyone can report an incident. In general, junior doctors are not good at reporting incidents, and focus work has taken place with them including the creation of the trigger list, which is a guide to the types of incidents that should be reported. It is anticipated that this can assist in changing a reporting culture, which is not unique to CHFT.

The report further details updates received from the Venous Thromboembolism (VTE) Committee, the Pressure Ulcer Collaborative, Falls Collaborative and the Medical Devices and Procurement Group.

OUTCOME: The Quality Committee received and noted the content of the report.

176/18 SERIOUS INCIDENT REPORT

Andrea McCourt (Head of Governance and Risk) presented appendix F highlighting the four new serious incidents reported to commissioners in July and August 2018, and learning summaries from nine incidents.

The breakdown of the four new incidents comprised of three incidents in July 2018 (one relating to blood sugar monitoring, one relating to a lack of medical review and one relating to delays in identifying cancer) and one incident in August 2018 relating to a fall. There were no theme to the incidents declared in July and August due to the low numbers.

Nine incidents were submitted to commissioners in July and August 2018 and one of these was subsequently delogged as a serious incident, but has been included in the figures. Full details of the lessons and learning from the nine incident investigations are included in the report.

Discussion followed on the learning summaries and it was stated that if an incident is reported by another Trust, that this should be stated on the learning summary.

OUTCOME: The Quality Committee received and noted the content of the report.

177/18 HIGH LEVEL RISK REGISTER

Andrea McCourt (Head of Governance and Risk) presented appendix G highlighting risks as at 24 September 2018:

- Seven top risks scoring 20 or 25:
  - 7278 (25) *Longer term financial sustainability risk*
  - 6903 (20) *Estates / Resuscitation risk, HRI*
  - 7271 (20) *HRI ICU collective infrastructure risk*
  - 2827 (20) *Over-reliance on locum middle grade doctors in the Emergency department*
  - 5806 (20) *Urgent estates schemes not undertaken*
  - 6345 (20) *Nurse staffing risk*
  - 7078 (20) *Medical staffing risk*
- Three new risks:
  - 6299 (16) *Risk of failure of high risk medical devices due to lack of routine maintenance resulting in potential patient harm and inability to meet CQC requirements for medical devices*
  - 7318 (16) *Risk of falling stone debris from stone cladding on Ward block 1 west elevation resulting in potential harm to patients, staff and visitors and to the hospital building.*
  - 7273 (16) *Risk of 20 Optiflow medical devices not working due to exceeding their life expectancy – 9 years against an expectancy of 5 years resulting in potential patient harm*
- One risk with a reduced score:
  - 7134 (12 from 16) - *Sepsis CQUIN risk*

    The risk was of the Commissioning for Quality and Innovation (CQUIN) target not being met for 2018/19 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non-compliance with NICE guidelines for sepsis. The CQUIN data demonstrates that the Trust is consistently achieving 100% of all patients being screened as well as 100% of patients in the emergency department receiving antibiotics within 60 minutes.

    Following work in this area, the risk no longer adequately described the existing risk, and has been amended to a score of 12 and reworded to:
    'CQUIN target 18/19 for inpatients with sepsis receiving antibiotics within 60 minutes at risk of not being met'

    The risk is now a partial loss of CQUIN payment, rather than the whole sum.

Discussion followed on the medical devices risks and whether there is an annual budgeting system for equipment. It was stated that there is an annual budget, but there is a limited amount of capital which is dependent on financial position.

A copy of the complete high level risk register was also available in the report.

OUTCOME: The Quality Committee received and noted the content of the report.

178/18 CLINICAL OUTCOMES GROUP REPORT (including update from Mortality Surveillance Group)

Dr David Birkenhead (Medical Director) presented appendix H summarising key points raised at the Clinical Outcomes Group meetings held in July and August 2018.

An area of concern is infection control. There has been one Meticillin-resistant staphylococcus aureus (MRSA) bacteraemia against a target of zero, and 13 Clostridium difficile (C.diff) infections (seven non-preventable, five preventable and one pending), against a limit of 20 for the full year. MRSA screening has improved and meeting the 95% target. A big concern is carbapenemase producing enterobacteriaceae (CPE) – a very resistant bacterium emerging in the UK. Eight or nine cases are usually seen in a year and tend to be from abroad. It has been found that there was cross-transmission of CPE between two patients on Ward 20 and advice is being taken from national experts.

Clinical coding is working well with average diagnoses above target. A celebratory workshop was held at the end of July to share the reality of the first year following implementation of the Electronic Patient Record.

There was a noted improvement in the timeliness of observations, with approximately 70% of observations done on time, which is the highest since the Electronic Patient Record was implemented.

The referral rates for organ donation are also improving on a year on year basis.

The report also included key points discussed at the Mortality Surveillance Group in July and August 2018, including the Summary Hospital-level Mortality Indicator (SHMI) now at 98.98%, the first time being below 99%. The Hospital Standardised Mortality Ratio (HSMR) is also being closely monitored. National recommendations with learning from death are also being met.

Discussion ensued on the significant positive shift with the SHMI and it was stated that there have not been any alerts or flags in conditions since May 2017. It was asked whether the Learning from Death summit will be repeated, and it is hoped that the summit could take place on an annual basis. A query was raised as to whether the report should be linked to the work done with the end of life care group on learning from death, however, it was indicated that this is reported through the end of life report.

OUTCOME: The Quality Committee received and noted the content of the report

179/18 QUALITY AND PERFORMANCE REPORT

Helen Barker (Chief Operating Officer) presented appendix I which highlighted August's performance score which has fallen to 65%. The safe domain has improved to green with no category 4 pressure ulcers in month, although the percentage of electronic discharges is now below target. The caring domain's performance has fallen as community's Friends and Family Test 'would recommend' has missed target in-month. Effective is just below green with Fractured Neck of Femur, Methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia coli (E.coli) missing targets, although Summary Hospital-level Mortality Indicator has achieved target for the first time. The responsive domain remains amber but has deteriorated as cancer 62 days missed target alongside all four stroke targets. In

workforce, all nine essential safety training areas have deteriorated in-month. Within efficiency and finance, agency usage has deteriorated further in-month.

Most improved indicator was Summary Hospital-level Mortality Indicator, which is under 100 for the first time. Most deteriorated indicator this month is stroke. Focussed actions have been put in place with the aim of achieving an 'A' for SSNAP that is sustainable across all areas. Currently achieving a 'C' in both patients scanned within an hour of arrival and admitted to the stroke unit within 4 hours of arrival, and achieving a 'B' with patients thrombolysed within 1 hour. The one hour scanning will link in with the new assessment beds which opened on Friday at CRH, where patients will be seen within 10 minutes after admission to order a scan and therefore will be seen within an hour.

Emergency Care Standard 4 hours - all directors now meeting with leadership teams. Last week's meeting had contribution from all clinical directors regarding the winter plan.

Discussion ensued on the decreased essential safety training compliance, which is being escalated to the Workforce Committee on Monday; and the caring domain which is very weighted with friends and family tests. It was stated that work currently being done with families could be an alternative measure.

With regard to the performance summary slide, HB stated that the RAG rating under the responsive domain for cancer 62 day screening to treatment and cancer 62 day referral to treatment have been transposed, and an updated report will be issued.

OUTCOME: The Quality Committee received and noted the content of the report.

180/18 ANY OTHER BUSINESS

Non-Executive Director

Alastair Graham, who will be stepping down from his role as Non-Executive director representative on the Committee, was thanked for his contribution. Karen Heaton will be taking over the role from 1 November 2018.

181/18 MATTERS FOR BOARD

- Detailed report received on learning from death and structured judgement reviews
- CQC report received, which will also be submitted to the Weekly Executive Board

182/18 EVALUATION OF MEETING

- The meeting was less about the volume of papers and more about the quality
- Meeting would have been better if started on time (previous meeting in room over-ran)
- Meeting would be better if members considered language and jargon used in reports especially if guests / governors are in attendance. It was suggested that an appendix could be provided in reports if abbreviations are used.
- A comment from the observer was that this was a very eye-opening experience

183/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix J) was accepted.

NEXT MEETING

Monday, 29 October 2018
3:00 – 5:30 pm
Acre Mill 3, HRI

DRAFT

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 28 September 2018, 11.20am – 1.00pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Andy Nelson	Non-Executive Director
Gary Boothby	Director of Finance
Helen Barker	Chief Operating Officer
Owen Williams	Chief Executive
Phil Oldfield	Non-Executive Director (Chair)
Richard Hopkin	Non-Executive Director

IN ATTENDANCE

Betty Sewell	PA (Minutes)
Kirsty Archer	Deputy Director of Finance
Philip Lewer	Chair of the Trust
Rob Aitchison	Director of Operations – FSS (for Item 179/18)
Stuart Baron	Associate Director of Finance

ITEM

172/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

173/18 APOLOGIES FOR ABSENCE

Apologies noted for: Anna Basford, Brian Moore

174/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

175/18 MINUTES OF THE MEETING HELD 31 AUGUST 2018

The Committee approved the minutes of the meeting held 31 August as an accurate record subject to an amend on Page 2 which should read "that 62 day Cancer standards for August will not be met" and an amend on Page 5 relating to "the FYE of £17.5m CIP of which 91% is recurrent".

176/18 ACTION LOG AND MATTERS ARISING

There was a request to add an action for GB and RH to pick up with regard to how business cases approved at CMG are reviewed and scrutinised.

The agenda was re-prioritised due to the remaining time.

180/18 MONTH 05 FINANCE REPORT

The Director of Finance reported that the year to date deficit is £20.29m, in line with plan. The Aligned Incentive Contract (AIC) is protecting the year to date income position by £0.85m. However, this position has relied on the release of reserves in addition the winter element of the reserve which has been released in the short term to offset the shortfall of CIP. It was noted that the required £18m CIP for the full year

has now been identified in full. It was also noted that there is an underlying position of just over £1m deficit as at Month 5.

The Director of Finance highlighted that this report goes to NHS I and is the report against the original plan also the Cash position has improved significantly in month allowing payment to suppliers of outstanding approved invoices to be paid. In addition, our debtors' position has improved with our payments.

The Committee **RECEIVED** and **NOTED** the report.

181/18 UNDERLYING FINANCIAL POSITION AND YEAR END FORECAST

The Deputy Director of Finance took the Committee through a presentation which tried to answer questions raised from previous meetings.

It was noted that whilst the Trust has been able to report a year to date financial position that is in line with the planned deficit, the underlying operation position is a £1.01m adverse variance from plan. One of the questions raised is what risks are there for the remainder of the year and what are we doing to mitigate those risks. The latest forecast position was described and before recovery actions are taken there is a risk of a £2m adverse variance from plan.

An in depth deep dive was presented to the Committee which described all the factors which are skewing the income and expenditure position. A list of recovery actions has been identified and this continues to be reviewed with considerable management focus on scheme generation.

Discussion took place with regard to budget holders and whether they have the skills and competencies to control spending and it was noted that this will be addressed, it has been decided that Executive colleagues will spend time with them to ensure the right communication is taking place.

Concerns were expressed with regard to the recovery actions and are we pushing hard enough the fact that they do not describe cash coming out and any reduction in headcount. It was noted that a more granular level of expenditure is required to be clear about what this means from a clinical point of view and to be clear of the consequences this may have for patients.

The Chair summarised discussions as follows:-

- The underlying deficit is larger than £1m and it would be useful to understand the assumptions and to quantify those assumptions
- The spending of the contingency 'pot' was challenged
- SLR variations – are we sending the right messages
- Budget Holders – to ensure they have the right skills and competencies
- Parameters around clinical risk – this has not been tested

The following actions were agreed:

ACTION: To help understand the true position it was requested that Project Echo costs and WOS costs are extracted.

ACTION: To update progress with regard to the Executives meeting with Budget Holders for the next meeting.

ACTION: It was agreed that timely conversations should take place within this forum in preparation for the Budget Plan for 2020.

The Committee **RECOMMENDED** that the risk rating of not achieving the 2018/19 Financial Plan should be increased from 12 to 15 subject to the caveat that this is reviewed at the next meeting.

177/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the following points relating to performance:-

- Slight dip in performance within August.
- Stroke performance was the material issue which dipped across several of the matrix
- The Safe domain is Green with all remaining domains in Amber.
- There has been challenge around the Emergency Care standard with an escalation meeting taking place last week.
- Cancer failed in August – some issues with the pathway into Bradford
- SHMI achieved target for the first time.
- Overall, in summary, expecting an improvement in September.

178/18 ACTIVITY UNDERPERFORMANCE – AUGUST 2018

This paper was not covered due to lack of time.

179/18 OUTPATIENT SERVICES

The Director of Operations, FSS, Rob Aitchison presented a paper which focussed on three key areas:-

1. Access to services
2. Utilisation of resources
3. Clinic efficiency

The following headlines were shared with the Committee in relation to income:-

- 2017/18 Plan was to deliver £48m, however, the actual income delivered was £41m, £7m below plan.
- 2018/19 Plan is to deliver £44m of activity, the revised planning assumption is based upon availability of core capacity only and some agreed pathway changes.
- After Month 4 the Trust is on track to achieve the 2018/19 plan by year end.

Access to services

Appointment slot issues (ASI) – CHFT is above national average for ASI% and slightly above average regionally

Access to E-Referral services (E-RS) – CHFT is a leader in this area and has been recognised at a national level for the innovative work done. We have also recently moved to offering fast-track appointments which is working well with GPs. It was noted that in future only activity referred via E-RS is likely to be paid, CHFT's progress in this area will protect from any financial risk in the future.

Average wait time to access first outpatient services – It was acknowledged that this information is a crude average. Our market share is currently 77%, with 6% going to

Leeds due to the specialist nature of those pathways and the private provider share is 7%.
Call waiting times and abandoned calls – The average queue time has reduced and the percentage of abandoned calls is back within pre EPR range levels, however, this is being maintained with the capacity of additional unplanned investment post-EPR.

Utilisation of resources
Did not attend (DNA) rates – This has been positively recognised by CQC when undertaking the Use of Resources ratings. Follow up rates are comfortably below the Trust's target of 8%, however, a better understanding of this performance is required. Our mobile capture rate is currently 86% one of the highest nationally.
Cancellation rates – This is an area of real significant focus in light of patient experience and work is needed to gain better understanding.
Clinic slot utilisation – This indicator is a key measure of clinic efficiency driven by the appointments booking team ensuring all available capacity is utilised. Our current performance shows 93%-94% of all clinic slots are full prior to clinics starting, however, the data also includes on the day cancellations from patients. Our position has deteriorated post-EPR and the aim is to get back to pre-EPR go-live levels.

Clinic efficiency
Clinic start/finish times – The data relates to 2016/17 and the functionality to obtain this data is not currently available. It was noted that there is a piece of work to do around whether we re-profile the allocation of clinic admin within job plans to be done outside of clinic. It was also noted that start/finish times is a key indicator of OPD efficiency and patient experience and should be an area of focus.
Patient satisfaction – We are a significant outlier when compared to national and regional Trusts.
Clinic templates configuration at specialty level – The data demonstrates the average number of new and follow up slots seen by each speciality. However, the data is not routinely available from the system but there is an opportunity to develop the Knowledge Portal model to allow this. It was acknowledged that there is work to do to improve the templates.
Discharge rates at first outpatient appointment – Currently 3 out of every 10 patients who attend a new appointment at the Trust are discharged without the need for further appointments. Of those patients who DNA their first appointment the discharge rate is 55% - this should be much higher in line with the Trust's access policy.

The contents of the presentation along with the summary and next steps were **NOTED** by the Committee.

ACTION: The Committee agreed to receive a further update in the new year. It was requested that this should include an Opportunity Portfolio following annual planning – **HB/RA, January 2019**

182/18 USE OF RESOURCES UPDATES
It was requested that a simplified report should be worked up to include a view of direction of travel.

ACTION: Gary Boothby agreed to follow up with Anna Basford.

183/18 CIP UPDATE

Following the Turnaround Executive Andy Nelson commented that he felt encouraged in terms of ratios and risk to hit the £18m, however, it is getting harder in identifying additional projects to bolster CIP. Richard Hopkin asked if progress had been made in relation to the system recovery programme, Gary confirmed that £1.1m had been identified as contributing to our schemes. Conversations have taken place with Commissioners with regard to helping contribute to our challenge.

184/18 WORK PLAN

The Work Plan was **NOTED** by the Committee.

185/18 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following areas of discussion for cascading to the Board:

- Underlying deficit of £1m, however, closer to £2 to £3m looking at the re-forecast, the debate continues.
- Some recovery plans, however, concern as to the right budgetary controls which needs be tested. There is still a feeling of assurance that we will be close to budget.
- Risk Score increase from 12 to 15/16 moving forward.
- Performance – Stroke performance deteriorated in month / SHMI better performance, overall looking for a better performance in September.
- In depth discussion following the Outpatients Productivity presentation.
- Clinic utilisation - further work to be done with regard to the outpatient transformation work and the development of an opportunity portfolio.
- Use of Resources noted, a simplified summary was requested.

186/18 REVIEW OF MEETING

This item was not covered due to lack of time.

187/18 ANY OTHER BUSINESS

There were no items to note.

DATE AND TIME OF NEXT MEETING

30 October 2018, 9.00am – 12.00noon

Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

DRAFT

APPENDIX A

Calderdale and Huddersfield NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 4:30 PM ON THURSDAY 18 OCTOBER 2018 IN THE BOARDROOM, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Philip Lewer	Chair

Publicly Elected Governors

Alison Schofield	Public Elected - Constituency 7 / Lead Governor (+ carer)
Annette Bell	Public Elected - Constituency 6
Brian Moore	Public Elected - Constituency 8
Brian Richardson	Public Elected - Constituency 5
Christine Mills	Public Elected - Constituency 2
Dianne Hughes	Public Elected - Constituency 3
John Richardson	Public Elected - Constituency 3
Jude Goddard	Public Elected - Constituency 1
Paul Butterworth	Public Elected - Constituency 6
Rosemary Hedges	Public Elected - Constituency 8
Sheila Taylor	Public Elected - Constituency 2
Stephen Baines	Public Elected - Constituency 5

Staff Governors

Linzi Smith	Staff Elected - Constituency 11
Dr Peter Bamber	Staff Elected – Constituency 9
Sian Grbin	Staff Elected – Constituency 13

Stakeholder Governors

Felicity Astin	University of Huddersfield

IN ATTENDANCE:

Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance
Suzanne Dunkley	Executive Director of Workforce and OD
Amber Fox	Corporate Governance Manager (minutes)
Alastair Graham	Non-Executive Director
Lesley Hill	Managing Director, Calderdale & Huddersfield Solutions Ltd.
Richard Hopkin	Non-Executive Director
Jackie Murphy	Chief Nurse
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive

OBSERVERS:

Sal Uka	Consultant Paediatrician & Associate Medical Director

57/18 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Lynn Moore	Public Elected Governor
Chris Reeve	Stakeholder Governor – Locala
Helen Wright	Stakeholder Governor – Healthwatch
Veronica Maher	Public Elected – Constituency 4

58/18 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors, staff colleagues, and observers to the meeting.

59/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

60/18 MINUTES OF THE LAST MEETINGS HELD 4 JULY & 19 JULY 2018

The minutes of the previous minutes held 4 July and 19 July were approved for accuracy subject to the recommendation to include all governors names in the minutes moving forward, as the minutes sometimes reference ‘a governor’.

61/18 MATTERS ARISING / ACTION LOG

The action log was reviewed and updated accordingly.

Paul Butterworth raised an action from the previous minutes regarding governors comments on the car parking proposal to be collated for the Board of Directors on 1 November 2018. The Company Secretary will collate the responses and share with the governors the responses that will be going to the Board of Directors on 1 November 2018.

62/18 CHAIR’S REPORT

The Chair advised the recent changes to the Non-Executive Directors, confirming David Anderson has now left as a Non-Executive Director and will not be replaced. The Chair referenced the discussions that took place in the private meeting on clinical waste and the response to the Secretary of State. In relation to the clinical waste issue it was noted that the Trust waste was now being collected by the new provider. Paul Butterworth asked about the cost to the Trust of the new arrangements. The Company Secretary confirmed that additional costs had been incurred as a result of the need to implement contingency arrangements and that details of all additional costs were kept for discussion with NHS Improvement. With regards to reconfiguration it was noted that the next key milestone will be the decision by the Secretary of State whether or not to approve the bid for capital.

Paul Butterworth raised concern on the cost incurred of maintaining the buildings and asked how much capital will be spent. The Managing Director for CHS explained the buildings are due to have a six facet survey which is a detailed report on the condition of the buildings and utilisation. This will take around 4 months and will be shared with the governors and Board of Directors. This report will include a

value for backlog maintenance. Paul also stated staffing levels is a concern regarding the reconfiguration over the 2 sites.

The Chair provided verbal feedback from the Organ Donation Committee and Charitable Funds Committee and explained as Chair of the Organ Donation Committee he is required to attend a Chair Induction; however, the next available date is not until next March 2019.

The Chair is arranging to meet with all of the public governors at a convenient time and place. The governors were thanked for their valuable feedback at these meetings.

Council of Governors Register
The most recent register of Council of Governors was circulated for information.

63/18 PERFORMANCE AND STRATEGY

a. Performance Report

The Chief Operating Officer reported a slight deterioration overall in August 2018. The main highlights from the report were:

- The **SAFE** domain has improved to green
- The **CARING** domain's performance has fallen as Community Friends and Family Test has missed target in month
- The Trust has struggled to sustain a high level of performance against the Fractured Neck of Femur target – 5 consecutive patients requiring a Total Hip Replacement presented within 2 days; therefore, lots of operational work had to take place to enable this
- Stroke performance is disappointing and most deteriorated in month
- Cancer 62 days - Urology pathways into Bradford have been challenging due to capacity problems at Bradford, the Trust is working with Bradford and Leeds colleagues to improve on this
- Emergency care standard remains a challenge; however, the Trust still performs in the upper quartile and is in the top 25% at the moment.
- Referral to Treatment (RTT) remains positive, and the Trust is in discussion with Leeds to offer support to help them achieve their RTT
- The rate of sickness is positive and achieving target in month
- Transfer of care – 5% improvement in performance, length of stay 21 days, improved to about 12%
- Mortality indicator hit under 100% for the first time in August which is a fantastic achievement, Sal Uka explained there are 2 statistics of mortality;
    - Standard Hospital Mortality Index (SHMI) is one indicator released quarterly, 100 is the benchmark, if above 100, the mortality stats are higher than they should be; less than 100, better than they should be
    - Hospital Standardised Mortality Rate (HSMR) – co-morbidities where the indicators are released monthly i.e. stroke, cardio, there are 56 indicators

in a statistical model, for example, what the expected death rate is, e.g. 100 and there were a total of 120, our index would show 120 which enables a comparison.

The Chief Executive explained the Trust has Qlikview screens which show mortality updates, A&E live data and if any governors are interested in a demo on real data to contact Owen Williams, Victoria Pickles or Amber Fox

Paul Butterworth highlighted the complaints target is 95% whereby the Trust in August only achieved a YTD target of 33%, YTD the Trust have never been above 44%.

Rosemary Hedges highlighted that Ward 5B have a red score of 45% for average fill rate of registered nurses. The Chief Nurse explained Ward 5B is one of the wards that were moved when cardiology and respiratory services were reconfigured. There is a lower fill rate at the moment; however, skills are being reviewed to spread this out.

Dr Peter Bamber asked about the cause of the deterioration in stroke performance. The Chief Operating Officer explained the impact is as a result of sickness and a staff member leaving. Stroke will be closely monitored at a weekly performance meeting and an improvement it expected.

Brian Moore asked if the Trust are managing to suppress the use of high cost agency. The Executive Director of Finance confirmed the Trust is within the overall value for this year which is a target set by our regulators. There has been a positive uptake of posts being filled by the Trust's internal bank staff.

b. Financial Position and Forecast

The Executive Director of Finance presented the key highlighted from the report which were:

- The year to date deficit is £20.29m
- Total of £4.68m has been saved in the Cost Improvement Programme (CIP)
- The Trust is on target to save £18m CIP
- Overall risk to the financial position at month 6 of £1m, working with colleagues in divisions to identify solutions to recover the £1m
- Number of cash challenges in the year relating to payments from regulators, some suppliers have been waiting up to 80 days for payment
- Clinical contract income down by £1m
- The Trust has an aligned incentive contract with NHS Greater Huddersfield Clinical Commissioning Group (CCG) and NHS Calderdale CCG. The Trust also receives income from NHS England and other CCGs. The main reason income is down is due to 'other income' and less activity from external CCGs; however, month 6 has improved this position

Paul Butterworth asked if that the governors are kept up to date on the costs being incurred for waste disposal. The Executive Director of Finance is in discussion with the regulators to understand how the additional costs could be recovered. The cost to date on the forecast for this year is £180k.

Paul Butterworth asked for an update on the costs that weren't anticipated for the additional staffing and structure in place to support the Electronic Patient Record Programme. The Executive Director of Finance explained the trust planned for a £43k deficit position and support costs (additional staffing and licence) were built into this plan for EPR.

Action: Executive Director of Finance to feedback on the total costs for additional EPR staffing

Rosemary Hedges asked for an explanation on the aligned incentive contract which is a new way of payment. The Executive Director of Finance explained this is a new contract changing behaviors and cultures. The income amount from CCGs is a fixed amount this year with the same funding based on the previous contract (payment by results). This has allowed transformational approaches as to how care is provided. A Nursing Home scheme is being launched, with care being provided in a nursing home setting, which has allowed the Trust to save on costs.

Jude Goddard reminded colleagues the performance at the Trust is really good and the majority of other providers are in a deficit position. She added that it is recognised cancer is achieving 5% more than local trusts and the performance in other areas is higher than the average.

Rosemary Hedges asked if the Trust has agreed the control total. The Executive Director of Finance explained the Trust hasn't agreed the control total. If the Trust committed to the control total they were entitled to £14m provider sustainability funding by achieving a certain level of A&E performance and delivering £20m CIP. A total of 90-95% of Trusts have accepted the control total.

Dr Peter Bamber asked where the governors can see the quality impact assessments for the Cost Improvement Programme (CIP). The Chief Nurse explained that these are all signed off by the Chief Nurse and Medical Director.

c. Updating against the Quality Priorities

The Chief Nurse presented an update against the Quality Priorities. The key highlights were:

- CQC rating as good
- Three areas identified by the governors as key priorities were Care of the Acutely Ill Patient, Patient Flow and Experience on End of Life and Learning from Deaths
- Task and Finish Group has been established to respond to a new NEWS score (national early warning score) that has been recommended

- Lots of improvement has taken place in terms of escalating and responding to sepsis very quickly

Brian Moore asked about the relationship with Locala. The Chief Nurse explained having our own Community service allows for flexibility and response to patients, however the Trust works closely with Locala to ensure the patient pathway is smooth.

Sian Grbin asked if the Trust will look at bringing services back in house when the Locala contract is up. The Chief Executive responded that the Trust is ambitious; however, this hasn't been explored.

Rosemary Hedges referenced the data which shows delays in Huddersfield are worse than in Halifax. The Chief Operating Officer clarified that this is due to a range of issues.

Paul Butterworth referenced the concern regarding nasogastric tube training that was flagged up at Quality Committee on 1 October and the length of time this has been going on. The Chief Nurse confirmed that feedback will be presented to Quality Committee with a verbal update provided at the next Council of Governors meeting.

Action: Chief Nurse to provide an update to the Council of Governors in January 2019

64/18 CAR PARKING PROPOSAL

The Managing Director for CHS asked for comments on the car parking proposals.

The comments made were as follows:

- Alison Schofield – Accessing parking meters for wheelchair users is very difficult in certain places and asked if 'A Day in Your Shoes' could be arranged. The Managing Director for CHS agreed to support this.
- Brian Moore referenced an article published today which references 'car parking is a tax from the sick', his comments were a weekly charge for a very sick relative or a long term condition should not be charged and asked why parking costs are increasing every two years, this was seconded by Rosemary Hedges
- Paul Butterworth stated staff should receive free parking to stay loyal to the Trust and proposed staff charges are wiped out, this was seconded by Alison Schofield
- Brian Moore stated staff parking should be reduced as staff are not guaranteed a parking space at HRI or CRH.

Action: Managing Director for CHS to support 'A Day in Your Shoes'

Sian Grbin asked for clarity on what the Council of Governors are being asked to do. The Managing Director for CHS explained this is part of the engagement and

consultation process and the decision rests with the Board. The Board is to make an informed decision whereby the Chair will represent the governors views at the Board.

Annette Bell was informed by a community staff member there is a lot more car parking permits given than spaces available. The Managing Director for CHS confirmed this is correct; however, the Trust has a workforce that work shifts and therefore it would not need to work on a permit per space basis. She explained that one part of the work would be to review who gets a permit.

The Chief Executive referred to the sentiment of not charging staff for parking and highlighted how important it is that patients can get a space near the hospital. If staff parking is offered for free, most of the spaces would be occupied by staff which would result in less convenient parking for patients. He pointed out the importance of the digital agenda to maximize the opportunities for staff not having to travel to the building and that patients attending for regular blood tests will eventually take place at home. He added that Sal Uka has been piloting clinics with patients using Skype.

Alison Schofield asked for advice on where the disabled bays are for staff with parking permits.
Action: Managing Director for CHS to confirm

Dr Peter Bamber stated parking costs should not increase further and should only be in line with any increase in costs of maintenance, for example security and lighting. Peter stated staff should not be charged different amounts as it is incorrect to tax people.

Paul Butterworth proposed the governors vote on the car parking proposal. The Company Secretary advised that as the Council of Governors were not being asked to make a decision, a vote was not necessary. Their comments would be presented to the Board of Directors.

65/18 PROPOSED AMENDMENTS TO THE CONSTITUTION

The Company Secretary confirmed that any newly appointed staff to CHS are informed of their right to become a public member of the Trust.

The Board of Directors reviewed the amendments to the constitution in September where a further meeting between the Board and Council of Governors was required. This will be one of the items on the Board / Council of Governors workshop on Friday 16 November 2018.

66/18 CALDERDALE & HUDDERSFIELD SOLUTIONS LTD UPDATE

The Executive Director of Finance provided an update on CHS which went live on 1st September and has been through the first month end process.

There is a clear timeline for finalising the service level agreements and key performance indicators and ensuring governance arrangements are fully established.

Brian Moore referenced NHS Providers who state business cases for subsidiary companies are not just a vehicle to recover VAT. The Chief Executive responded that the Trust supports NHS Improvement's approach and that the CHS Business Case had clearly set out the organisational benefits, patient benefits and business benefits.

Sian Grbin asked if new staff have been recruited into CHS yet. The Managing Director for CHS confirmed CHS are out to advert for a number of vacancies and are getting lots of applicants. There have been no issues with the new pay scales.
Action: Managing Director for CHS to circulate the new terms and conditions

Sian Grbin asked if staff get paid on their 1st day of sickness. The Managing Director confirmed staff do not get paid on the first day of sickness.

Paul Butterworth highlighted CHS are a wholly owned subsidiary of the Trust and therefore is the Trust in breach of its equality policy by having different terms and conditions. The Executive Director for Workforce and OD explained CHS are a different entity; therefore, this would not apply.

The Chief Executive recently attended a BAME network staff had reflected positively the flexibility allowed by the new terms and conditions.

67/18 UPDATES FROM SUB-COMMITTEES

Quality Committee

A meeting will be arranged with the Chair, Chief Nurse, and Paul Butterworth to discuss the management of complaints and nasogastric tubes training.
Action: Corporate Governance Manager to arrange a meeting

Charitable Funds Committee

The Chair attends the Charitable Funds Committee and a meeting is due to take place with Todmorden Town Council regarding the funds from the Abraham Ormerod Centre. The Charitable Funds Committee matched £27.5k of funding for Todmorden flooding.

The Calderdale Community Foundation (CCF) had asked the Chair to spend a day looking at services they provide which is currently being arranged. Richard Hopkin declared an interest as treasurer of CCF and the Chief Executive declared an interest as a subscriber to the CCF.

The Chair reported meetings take place quarterly and provided assurance money is invested ethically and audited properly.

The Chair confirmed the League of Friends raise money for Charitable Funds and there is some fund raising that takes place; however, the Trust is not as active as could be.

Organ Donation Group
The Chair is attending an Organ Donation Chair Induction March 2019.

Audit and Risk Committee
Richard Hopkin highlighted the key points from the Audit & Risk Committee which were:

- Further work taking place on the Board Assurance Framework, the Board hasn't assessed it's appetite for risk, benchmarking will take place against other Trusts across the country
- The Trust is looking at new system and policy for declarations of interest as there is a requirement to improve the standard and rate of declarations, the new system will be aligned with the appraisal system for compliance
- Annual report on risk management was received at the last Audit and Risk Committee
- Internal audit are monitoring arrangements and are making good progress getting more prompt responses which has reduced to only 4% overdue
- Approval of overtime is an area of concern
- Payroll issues have been largely resolved with changes in arrangements

Jude Goddard asked how the Trust has benchmarked other Boards on appetite for risk. The Company Secretary explained appetite for risk has not been benchmarked yet, the Trust is comparing BAF's and risk registers. She added that not many Trusts have articulated their risk appetite as yet. The Chief Executive has shared work on the Trust's risk appetite with other Trust colleagues positively as they have do not have one.

Finance & Performance Committee
No further update.

68/18 INFORMATION TO RECEIVE

1. **Future Council of Governors meetings**
   A calendar of upcoming meetings for 2018 was circulated and a reminder of the new governor allocations.

2. **Review Sub-Committee Allocations**
   Brian Moore asked if governors can request changes to attendance at the Divisional Reference Groups. The Company Secretary confirmed governors can request a new DRG as there will be gaps created with governors leaving and new governors joining. Attendance at Committees will change every year.

69/18 ANY OTHER BUSINESS

Appraisals and Increments

The Executive Director of Workforce and OD confirmed that an error had ocured which resulted in all staff being awarded their increments. A more robust process will be in place going forward which will be applied for the next appraisal season.

Private meetings and Facebook Group

Brian Moore raised a concern about the creation of the Closed Facebook Group for governors. This was seconded by John Richardson and Christine Mills. Sian Grbin explained that the page should be private as it is by invitation only and a platform for governors to talk in private. Paul Butterworth reinforced that from 1st November the Trust will only be using NHS.Net email addresses for the public governors and anything shared via NHS.Net should not be shared publically.

The Company Secretary raised concern regarding equality for the whole of the Council of Governors in how we ensure governors who don't have easy access to IT also have a voice and are included in discussions.

Other business

The Chief Executive asked if any governors are interested in equality and diversity, our Trust have been identified as a role model with the LGBT community and gender equality and governors can be included in these forums.

The Company Secretary confirmed the photos of the governors will be available in the foyer shortly.

DATE AND TIME OF NEXT MEETING

BOD/CoG Workshop
Date: Friday 16th November 2018
Time: 9:00 – 12:30 pm
Venue: Boardroom, Sub Basement, HRI

CoG Development Session
Date: Tuesday 18 December 2018
Time: 12:30 – 4:30 pm
Venue: Boardroom, Sub Basement, HRI

The Chair formally closed the meeting at 18:38 pm and invited attendees to the next meeting.

Dr Peter Bamber thanked Philip for his great chairmanship.

Paul Butterworth thanked Amber for her excellent job with the minutes.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Monday 8 October 2018, 1.30pm – 3.30pm, Board Room, Huddersfield Royal Infirmary

PRESENT:

Will Ainslie	Director of Operations, Surgery & Anaesthetics Division
Rob Aitchison	Director of Operations, FSS
Asif Ameen	Director of Operations, Medical
David Birkenhead	Medical Director
Alexis Brown	Human Resources Business Partner
Suzanne Dunkley	Executive Director of Workforce and Organisational Development
Leigh-Anne Hardwick	Human Resources Business Partner
Karen Heaton	Non-Executive Director (Chair)
Diane Marshall	Human Resources Business Partner
Ruth Mason	Associate Director of Organisational Development
Jackie Murphy	Chief Nurse
Charlotte North	Assistant Director of Human Resources
Julie O'Riordan	Divisional Director, FSS
Jackie Robinson	Human Resources Business Partner
Vicky Pickles	Corporate Secretary
Linzi Smith	Council of Governors
Ashwin Verma	Divisional Director, Medical
Claire Wilson	Assistant Director of Human Resources

IN ATTENDANCE:

Janette Cockroft	Matron, Estates/Facilities (for Lindsay Rudge)
Helen Curtis	Librarian
Adam Matthews	Workforce Information Analyst
Jo Middleton	Associate Director of Nursing, Surgery and Anaesthetics

73/18 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

74/18 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
Jason Eddleston, Director of Workforce and Organisational Development
Azizen Khan, Assistant Director of HR
Lindsay Rudge, Deputy Director of Nursing
Debbie Wolfe, Head of Therapies

75/18 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

76/18 **MINUTES OF MEETING HELD ON 10 July 2018:**

The minutes of the meeting held on 10 July 2018 were approved as a correct record.

77/18 **ACTION LOG (items due this month)**

SAS Doctors Career Progression

VP confirmed media comms around SAS doctors and the wider medical workforce are being drawn up.

MAIN AGENDA ITEMS

FOR ASSURANCE

78/18 **LIBRARY AND KNOWLEDGE SERVICES STRATEGY**

The Strategy had been circulated with papers to the Committee meeting.

Helen Curtis attended the meeting to present the Strategy to the Committee and also to raise awareness of the expertise and resources available within the Library which contribute to:-

- Evidence Based Patient Care
- Staff Revalidation and Continuing Professional Development
- Digital Innovation
- Knowledge Management
- Research And Teaching
- Collaborative Working
- Staff Health And Wellbeing

The Strategy was positively received and approved by the Committee and requested it is added to the Committee Workplan for annual review.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Strategy.

79/18 **WORKFORCE PERFORMANCE REPORT**

The report had been circulated with papers to the Committee meeting.

AM provided an overview of the main highlights from the September 2018 report.

- Vacancies decreased – CW reported a discrepancy as July budget not updated in ESR
- Increase in Turnover – analysis taking place around career grade doctors movements significantly affecting data
- Decrease in Sickness absence – confirmed July 3.41%, August data being verified but showing 3.15%
- Employee relations – showing increase in number of cases, particularly bullying/harassment

CW confirmed from September 2018 data onwards would be exclusive of Calderdale and Huddersfield Solutions

ACTIONS:

1. CW to work with Finance/HR BPs to correct budget discrepancy and bring outcome/data back to future Committee meeting.
2. Deep Dive into Employee Relations Cases at the next Committee meeting

OUTCOME: The Committee **RECEIVED** and **NOTED** the report

DRAFT

80/18 **WORKFORCE DATA DEEP DIVE:**

The Committee had requested Divisions present to the Committee assurance on activity to reduce sickness absence and increase return to work (RTW) interviews.

Divisional representatives reported very similar activities and increased results across their patches.

S&A
Sickness Absence
Weekly data shared with managers
Focus on hot spots
Weekly meetings with specific areas
RTW
Weekly data shared with managers
RTW conversations increasing
Confirm and Challenge - Ensure RTW Conversations taking place are logged
Cross checking E-Roster absence data with ESR

FSS
Sickness Absence
Weekly data shared with managers
Sickness decreasing
Change to HR Adviser support for consistent approach
Monthly sickness summit in Childrens and Womens Directorates
RTW
RTW increasing (75% in July 2018 to 87% in September 2018)

Medical
Sickness Absence
Month on month reduction in reported sickness absence
RTW
Currently 77.5%
Weekly data shared with managers and at IPR meetings

Community
Sickness Absence
Long-term absence decreased from 2% to 1.3%
RTW
Increased from 60% to 88% (equates to 2 outstanding RTW)

Corporate Directorates/THIS
Diane Marshall reported similar activities within corporate functions to address these workforce issues.

Coughs/colds, gastro and stress were reported as the main reasons for short-term absence. RA advised that Divisions promote Trust services, working in conjunction with Occupational Health on the best way forward for colleagues.

The Committee noted that stress and anxiety was the main reason for long-term sickness and were advised that Assistant Directors in the S&A Division are attending the Stress Health Matters workshops with other Divisions to follow.

ACTION:
1. TR - Corporate and THIS Directorates to attend next Workforce Committee Deep Dive meeting to provide assurance on Sickness absence and return to work interviews.

DRAFT

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the Divisions' responses to the workforce issues.

81/18 **ESSENTIAL SAFETY TRAINING (EST)**

The Committee had requested Divisions present to the Committee its activity to address compliance issues. A position paper along with Divisional plans had been circulated with papers to the Committee meeting.

RM advised the approach to EST is being reviewed which included review of delivery of methods, cycle of refresher training, new roles to consider and the 95% target – is this realistic, for example Harrogate's target is 90% with an excellent line of 95%.

It was suggested evidence from ESR in terms of pay progression is articulated in plans. Include in manager performance meetings accountability for appraisal, EST and RTW.

RA expressed particular concern regarding doctors in training and the risk with regard to manual handling training. The Committee requested the preferred recommendation is set out in a plan on a page.

ACTIONS:

1. RM to produce an all-inclusive in year recovery plan on a page for next Committee meeting.
2. CW/BI Team to build into BI weekly EST expiration dates

Fire Safety Training - Keith Rawsnley, Fire Training Officer and Lesley Hill, Managing Director of Calderdale and Huddersfield solutions attended the meeting for this item.

Keith highlighted the need for quality fire safety training in order to satisfy fire safety regulations. Keith expressed concern regarding the number of DNA's at the sessions.

The Committee expressed concern that at the current rate of uptake compliance rate would be far from target. To support recovery a series of actions were agreed.

ACTIONS: KR:-

1. Send a list of no shows to training sessions since start of financial year to HRBPs so that they can chase their attendance at future sessions
2. Work with HRBPs to identify appropriate Managers to approach for bespoke training sessions
3. Work with HRBPs to identify any areas in each Division that may benefit from bespoke training
4. Identify locations where larger face to face sessions can be run
5. Develop a plan of action/calendar to show number of sessions and number of trainees per session required in order to deliver face to face training for staff matched against your annual leave / time required on other performance objectives or targets
6. Develop a five point plan to deliver fire safety training compliance, including support from colleagues in Division and WOD
7. Consider if varying levels of training need to be delivered to different staffing groups (clinical/non clinical, ward based/ office based etc taking feedback from colleagues who have attended training sessions
8. Oversubscribe to sessions to ensure at least 18 participants - and evaluate the possibility of increasing trainees per session

OUTCOME: The Committee **RECEIVED** and **NOTED** the report and actions.

82/18 **QUARTERLY ESCALATION FROM PRMS**

Good Roster Management

Jo Middleton presented to the Committee the approach to ensuring nursing rosters are maintained at appropriate levels. Key points were:-

Activity monitored at Nursing Workforce Steering Group
Confirm and challenge approach to sign off e-roster (clear on KPIs)
Adhere to workforce model
Fewer staff on annual leave when new starters on shift
Study time monitored
Only Matron can sign off additional shifts
Only use Trust bank for HCA cover
Supervisory time for senior staff support for band 7 admin role
Any pattern of over and above rosters are escalated to JM
Some colleagues opting out of EWTD

JOR queried the lead in time for outpatient department rosters. It was noted outpatients had been aligned to 6 weeks in line with other clinical services.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the approach.

83/18 **CQC POST INSPECTION ACTION PLAN**

JM advised actions are incumbent across the Trust with some actions only resolvable following reconfiguration of services. In addition there is a need for the Trust to demonstrate its OD and leadership strategy to the CQC.

ACTION:
1. Business Intelligence Team/JM to jointly update the action plan and build into the report alternatives in the delivery of leadership training.

ITEMS TO RECEIVE AND NOTE

84/18 **ANY OTHER BUSINESS:**

Schwartz Rounds Jo Middleton gave a brief update. All colleagues had now received training. The group will meet again in October when they will progress a comms message ahead of the January 2019 launch date.

Recruitment fair JM confirmed a CHFT nursing recruitment fair is taking place on Saturday 13 October 2018. 34 nurses had booked on the event.

ESR Manager Self Service CW advised the Project is to conclude at the end of November 2018. The BI team are pulling together a closure plan.

85/18 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

86/18 **DATE AND TIME OF NEXT MEETING:**

Recruitment & Retention Hot House: 7 December 2018, 9.30am – 11.30am, Learning & Development Centre, HRI.

DRAFT

24. Date and time of next meeting

Thursday 3 January 2018, 9:00 am

Venue: Large Training Room, Calderdale Royal Hospital

Presented by Philip Lewer