Board of Directors

Schedule	Thursday 5 September 2019, 9:00 — 11:30 BST
Venue	HRI - Boardroom
Organiser	Amber Fox

Agenda

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11:23	20.	Date and time of next meeting Thursday 7 November 2019, 9:00 am Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital To Note - Presented by Philip Lewer	298
11:24		Resolution The Board resolves that representatives of the press and public be excluded from the meeting at this point on the grounds that the confidential nature of the business to be transacted means that publicity of the matters being reviewed would be prejudicial to public interest. (Section 1(2) Public Bodies (Admission to Meetings Act 1960).	299

1. Welcome and introductions:

To Note

Presented by Philip Lewer

2. Apologies for absence: Karen Heaton, Mandy Griffin, Gary Boothby

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 4 July 2019 and AGM on 17 July 2019

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 4 July 2019 at 9:00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Gary Boothby	Executive Director of Finance
Alastair Graham (AG)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Phil Oldfield (PO)	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development (OD)
Dr David Birkenhead	Executive Medical Director
Karen Heaton (KH)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director
Jackie Murphy	Chief Nurse
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Linda Patterson (LP)	Non-Executive Director

IN ATTENDANCE

Amber Fox	Corporate Governance Manager (minutes)
Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director – Digital Health
Nicki Hosty	Freedom to Speak Up Guardian/Equality Diversity Manager (for item 74/19)
Dr Anu Rajgopal	Guardian of Safe Working Hours (for item 77/19)

OBSERVERS

Helen Hunter	Stakeholder Governor, Healthwatch
Robert Hakin	Associate Director Corporate Planning and Business Development, Leeds Teaching Hospitals NHS Trust
Denise Sterling	Member of the Public
David Throssell	Member of the Public

64/19 Welcome and introductions:
The Chair welcomed everyone to the Public Board of Directors meeting, in particular Ellen Armistead, Deputy Director of Nursing/Deputy Chief Executive as of 1st July 2019.

65/19 Apologies for absence:
Apologies were received from Andrea McCourt, Company Secretary.

66/19 Declaration of Interests
The Chair reminded colleagues to declare their interest at any point on the agenda.

67/19 Minutes of the previous meeting held on 2 May 2019
The minutes of the previous meeting held on 2 May 2019 were approved as a correct record subject to the amendments outlined below.

Pg. 7 – re-opened complaints, change the wording to 'quality of responses to complaints'
Pg. 10 – change wording to 'qualified value for money audit'
Pg. 11 – change wording from 'provider sustainability funding to 'accepting £300k system control total'

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 2 May 2019, subject to the amendments highlighted above.

68/19 Action log and matters arising

The action log was revised and updated accordingly.

The Director of Workforce and Organisational Development confirmed Karen Heaton has been identified as the Non-Executive Director Champion for gender pay gap. This action is now closed.

69/19 Chair's Report

The Chair updated the Board on the activity he has been involved in since the last meeting on 2 May 2019. The key updates were:

- Attended the West Yorkshire and Harrogate Health and Care Partnership Board meeting in public held on 4 June 2019 where a paper was shared describing how to engage with the public
- Attended the Organ Donation Committee on 3 July 2019, he explained the second week of September 2019 is National Organ Donation week and the law will start to change over the next period whereby organ donation will be an 'opt out' process, rather than an 'opt in', there will be a challenge in how to engage with more ethnic groups and this will be managed through the Chaplaincy

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

70/19 Chief Executive's Report

1) Interim NHS Workforce Report

The Chief Executive reported back on the West Yorkshire and Harrogate ICS discussion regarding the interim People Strategy. There is an emphasis and commitment on cultural aspects and a push for BAME colleagues in the West Yorkshire and Harrogate region and how to promote this in the organisation. The Director of Workforce and OD added CHFT played an active part in the making of the interim People Strategy. There are two main themes which are one culture of care (The Cupboard) and digital working which are reflected in the strategy. The Director of Workforce and OD, SD described the key themes within the Strategy. SD advised she has completed an in-depth analysis of the interim People Strategy with The Cupboard. The interim strategy includes STP and ICS international recruitment plans and promotes flexible working based on the needs of the service.

AN recognised the nursing recruitment challenge and asked how the Trust can attract more. The Director of Workforce and OD responded with the international recruitment plans. The Trust are focusing on career ladders, nursing associate roles and apprenticeships. The Chief Nurse added the Trust are improving the placement offer and increasing this significantly in September 2019.

AG asked if there are any links to the local academic institutions in the West Yorkshire footprint and whether the Trust are looking at forming partnerships to tailor courses and provide placements. The Chief Executive supported this statement and added there is also a challenge in how the Universities work with regards to digital and the need to become more collaborative.

LP stated there needs to be a particular focus on Junior medical staff and quoted 40% of FY2's do not take up a definitive post. The Chief Executive explained there has recently been a star award celebration for foundation year which is the first time they have receive this recognition and this will be repeated.

2) Baby Friendly Initiative Report – Gold Award Status

The Chief Executive described the decade worth of work undertaken to achieve a Gold Award status. The Chief Operating Officer added only a handful nationally received the gold award status and it is a fantastic achievement. A key component to this status is no advertising that promotes formula feeding, sponsorship or association with companies that

make formula milk. A presentation on the Gold Award for Baby Friendly Initiative is taking place on 2 August 2019 with local councillors attending. There was a suggestion to schedule a joint Board of Director / Council of Governors workshop to discuss this piece of work.

The Chair offered to write to Locala on behalf of the Board to congratulate them on their achievement. The Chair asked the Chief Operating Officer to feedback to the team on behalf of the Board for their proud journey.

Action: Schedule BFI Gold Status Award at a joint Board / Governor workshop
Action: Chair to write to Locala to congratulate on the BFI Gold Award Status

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

71/19 1 Year Strategy on a Page Year Ending 2020

The Director of Transformation and Partnerships shared the key annual objectives to achieve the overall strategic plan have been identified for the year ending 2020. The Board are asked to approve these objectives and an update will be presented to the Board on a quarterly basis.

AN clarified the Trust is in the fourth year of the five-year strategy. The Director of Transformation and Partnerships explained there is reference to The Cupboard (the Trust Organisational Development Strategy) and the Trust's one culture of care. There was a suggestion to change the wording for digital strategy to 'design and continue implementation of the strategy'.

Action: Update digital strategy annual objective

The Chief Executive reported there is still an opportunity for the Trust to be a digital exemplar. The Managing Director of Digital Health suggested narrative within the digital strategy to describe the opportunity of funding and explained NHSX is being launched this week, a new joint organisation for digital, data and technology.

The Chief Executive suggested the strategy focuses on the next ten years rather than five years where the Trust will be further informed regarding the outline business case, digitally and the workforce.

OUTCOME: The Board **APPROVED** the 1 year strategy on a page year ending 2020.

72/19 Care Quality Commission (CQC) Update

The Chief Nurse explained following the CQC inspection in June 2018, the Trust received an overall rating of 'Good' with 'Requires improvement' in the safe domain and use of resources. The CQC inspection resulted in a 9 'must do' action plan and 54 'should do' action plan with the aim to fulfil this by 31 March 2019. Most actions are at a RAG rating of green and are moving towards an embedded RAG rating of blue.

Papers describing the two outstanding actions will be presented at the Executive Board to review the mitigations and ensure the Trust are delivering safe, effective care. The remaining seven actions are ongoing e.g. mental health strategy and cost improvement plan etc. and these will focus on moving to outstanding for the next inspection. A Quality Summit was held in April 2019 to review what good looks like and a summit is planned for October 2019 to share learning with key stakeholders.

The Chief Executive asked how the Trust will move to an embedded blue practice and the timeline to expect this achievement. The Chief Nurse described the amount of audit work undertaken that provides the Trust with assurance and quality Friday visits also seek assurance. Any support is welcome to ensure consistency across practices.

AG asked if the remaining two "must do" and nine "should do" actions are achievable before reconfiguration. He asked if it is possible for the Trust to move to outstanding when there are two actions the Trust are unable to meet. RH suggested the Trust look at how to evidence we are meeting the guidelines and recommendations.
Action: Update on use of resources and well led at the next meeting

The Director of Nursing reported CQC have moved towards a stronger focus on engagement which is a strength for this Trust. She advised that the Trust need to describe the mitigation or any link to safety and experience and particularly how staff feel. She described the three traits of outstanding performance and explained the well-led framework changed 18 months ago and there may be changes. She reported CQC are out to consultation this year around the future operating model.

AN asked if there is an opportunity to get external peer reviews from outstanding Trusts. The Chief Nurse explained the Trust look at all the reports and external reviews take place, e.g. colleagues from Mid-Yorkshire Hospitals undertook a ward-based pharmacy review. The Executive Director of Finance reported they have asked Leeds Teaching Hospitals to complete a review of use of resources. The Chair is also arranging to meet with the Chairs of Trusts that are outstanding.

OUTCOME: The Board **NOTED** the Care Quality Commission update.

73/19 Director of Infection, Prevention and Control Annual Report 2018/19

The Medical Director presented the Director of Infection, Prevention and Control annual report which has been a positive year. The key highlights were:

- MRSA has been consistent with previous years
- Single outbreak of c.difficile on one ward, there has been a high level of cleaning to stop the spread, remaining cases were sporadic
- The Trust are focusing on how to reduce e.coli cases in the organisation by reviewing how to control urinary tract infections and the use of catheters
- A review of e.coli cases from a variety of different sources is taking place and is an ongoing challenge
- Similar number of influenza cases to previous years, there may be an increase in the next flu season
- Hygiene compliance remains good in the organisation and policies continue to be reviewed
- There has been a reduction in the total number of antibiotics in the organisation

The Medical Director thanked Dr Gavin Boyd who has been the Infection Control Doctor for the past five years. The Medical Director explained Dr Anu Rajgopal will be the new Doctor as well as the Guardian of Safe Working Hours.

AN asked if CHFT benchmark against other Trusts. The Medical Director explained benchmarking reports are available and the data is included in the quarterly updates to Board. The Trust assess all infections to understand the avoidability factor. The Trust have made vast improvements, whereby ten years ago, up to 40-50 MRSA cases and over 100 c.difficile cases were reported.

The Chief Executive highlighted page 14 which describes the flu vaccine uptake and would like to see the uptake for pregnant women increasing in next year's report. The Chief Executive asked about the flu vaccine data for BAME groups.
Action: Medical Director to report back on public health data

AG reported there is a Decontamination Committee which is chaired by the Managing Director for Calderdale and Huddersfield Solutions Ltd.

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

74/19 Freedom to Speak Up Annual Report 2018/19

Nicki Hosty, the new Freedom to Speak Up Guardian and Equality Diversity Manager attended the Board to present the annual report. The key points to note were:

- The number of instances reported has improved
- 2018 – received nine reports
- 2019 – Q1 received nine reports and Q2 received 18 reports
- Number of concerns raised anonymously is reducing with the help of ambassadors and resources
- Introduced a mechanism where colleagues can raise concerns through a portal on the intranet and a follow up approach is implemented
- Adopted a 4-pillar approach with 'Go See' visits being arranged at other Trusts
- On average two concerns are being raised per week, increase in visibility
- Leaflets and posters are available across the Trust

The Chair thanked Nicki Hosty for all her efforts and hard work developing this role.

AG said that the increase in reporting may be a positive thing and recognised that no single theme is emerging which is positive. Nicki Hosty explained what staff are speaking up about and what the Trust are doing is included in the next 12-month plan. She confirmed there is no vexatious use of the system.

KH asked if the increase in numbers has been influenced by any specific staffing groups promoting this as an avenue. Nicki Hosty confirmed she also attends the BAME network which includes 100 colleagues.

OUTCOME: The Board **NOTED** the Freedom to Speak Up Annual Report.

75/19 High Level Risk Register

The Chief Nurse presented the High-Level Risk Register as at 23 April 2019. Five new risks have been added to the risk register which are:

- 7454 – Radiology staffing risk
- 7062 – Capital Programme
- 6493 – Complaints management
- 7474 – Equipment failure from medical devices
- 7251 – Optovue OCT (Ocular Coherence Tomography) machines risk

PO reported risk 7454 has been discussed at Finance and Performance Committee and the Chief Operating Officer is reviewing this at Performance Review meetings. The meeting took place yesterday where the Chief Operating Officer was not assured and a paper to the Finance and Performance Committee will be written by the Families and Specialist Services Division for the end of the month to describe the risk mitigation.

The Executive Director of Finance reported the capital programme risk was discussed at Finance and Performance Committee and a letter has been received from the national finance lead. There is a requirement for ICS to reduce the capital requirement by 20%. The Trust is assessing the impact and the deadline for submission is next week.

RH highlighted an inconsistency between high level risk register and heat map for risks 7315 and 7062.

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

76/19 Care of the Acutely Ill Patient Programme – Closing Report

The Medical Director explained the care of the acutely ill patient programme is planning to close after five to six years as it has reached a conclusion and a Clinical Improvement Group will be implemented. The Medical Director explained mortality figures, SHMI and HSMI were outliers at the time and this programme was put together to reduce these. The key updates from the closing report were:

- Focused on six key themes
- HSMR is in a better than expected position which is stably maintained
- Focus has been on quality improvement and recognising deteriorating patients
- Work has taken place on care bundles

LP confirmed she supports this piece of work and recognised the improvements made to HSMR. The new Clinical Improvement Group will report to the Quality Committee.

The Chief Executive highlighted the year ending March 2019 had the lowest number of deaths on the mortality data where the figures are available on the knowledge portal.

AG asked what the focus will be of the Clinical Improvement Group. The Medical Director confirmed this group will focus on areas of concern e.g. management of urinary catheters to reduce e.coli sepsis.

OUTCOME: The Board **NOTED** the Care of the Acutely Ill Patient Programme closing report.

77/19 Guardian of Safe Working Hours Annual Report 2018/19

Dr Anu Rajgopal presented the annual report. The key updates were:

- Exception reporting – slight increase in trainees compared to last year (14%)
- 187 exception reports – 1/3 of workforce
- Exception reports show a split amount between Medicine and Surgery
- Junior Doctor Awards took place in May 2019 and was successful and supported by the Executive team across 5 categories, this event will take place again

AG asked if there are financial consequences of the registrar rota gaps and if an equality impact assessment is undertaken to understand the split by different ethnic backgrounds. Dr Anu Rajgopal will feed this into her next report. She explained the rota gaps in Medicine have been recruited to, Obstetrics has been a challenge. The minimal staffing in A&E has always been maintained on a three-tier rota, opposed to two tier.

The Chief Executive thanked Dr Anu Rajgopal for her understanding and response. It is evident there has been a positive level of engagement and narrative. The Freedom to Speak Up Guardian and Director of Workforce and Organisational Development will work with Dr Rajgopal to look at the broader equality and diversity groups.

Action: Review the exception reporting from equality and diversity groups

KH asked for the time scale for moving onto e-rostering. The Medical Director confirmed e-rostering is rolling out this calendar year to medical colleagues.

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours annual report.

78/19 Integrated Performance Report

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

- No red domains, four green domains and two amber domains
- Areas of concern are:
    - Diagnostics – all radiology modalities and endoscopy are in a good position and echocardiogram are on trajectory to recover
    - Staffing in neurophysiology – no clear recovery plan to achieve 99% towards the end of the calendar year, unable to purchase additional capacity
- Challenging in June 2019 with performance slightly under 90%

- Activity challenge in months 1 and 2 – Deep Dives are taking place in Divisions with detailed reports to Finance and Performance Committee
- RTT achieved 92% in May 2019 and a small team has been identified to scope 3 months of work and 'Go See' to other Cerner sites
- Longer length of stay in stroke
- Positive performance in cancer – the radiologists were commended for their hard work as there are only 12 radiologists when there should be in excess of 20
- Some of CHFT's referral to report timescales are the best in the region
- Length of stay hit a 35% reduction (target of 25%) and now needs to achieve 40% reduction, the senior operational team review all patients with a 20-day length of stay and external testing suggests it is 60% internally driven
- New elective access target for field testing (RTT) – continue to report 92% position and reporting the new access standard

LP explained patients with a length of stay of over 21 days can be more complex and suggested there is more mileage reviewing patients with a length of stay between 7-21 days. The Chief Operating Officer confirmed there is an internal trajectory for this.

OUTCOME: The Board **APPROVED** the Integrated Performance Report for May 2019.

79/19 Transformation Programme Board Terms of Reference

AG declared his interest as Chair of Calderdale and Huddersfield Solutions Ltd.

The Director of Transformation and Partnerships presented the Transformation Programme Board terms of reference which will oversee the development and delivery of a complex programme of transformation. The first meeting of the Programme Board will take place in September 2019.

PO highlighted Finance and Performance in the governance structure suggests it meets bi-monthly and needs to be corrected to monthly.

AN asked if the responsibility of a budget should be added under section 3.2. The Director of Transformation and Partnerships confirmed the key suppliers/stakeholder groups on this Committee and budget responsibility will be added. The decision within delegated limits and standing orders will be the responsibility of this Board to which the Committee will be accountable.

The suggested wording for the equality impact assessment was 'to set and ensure accountability', rather than 'monitor'.

Dialogue has taken place with partners, commissioners and regulators regarding the proposed way forward. The already established Partnership Transformation Board with Calderdale and Kirklees Clinical Commissioning Group has an oversight of reconfiguration and progress will be reported through on a monthly basis.

The Trust have proposed round table meetings to take place between the Trust, NHS Improvement, NHS England and the Clinical Commissioning Groups.

AN suggested digital as a workstream. The Director of Transformation confirmed the workstreams are focused on pathways of care.

OUTCOME: The Board **APPROVED** the Transformation Programme Board terms of reference subject to the amendments above.

80/19 Update from sub-committees and receipt of minutes

The following minutes were received:

Finance and Performance Committee – 31 May 2019

PO reported the minutes attached have been covered. A revised benefits realisation paper went to the Finance and Performance Committee on EPR which enables change. The Committee focused on digital ways of working and how to embed. The common theme is around the GIRFT Programme, the engagement is strong.

Quality Committee – 1 April, 29 April 2019 and 3 June 2019
LP reported the Committee are focused on safeguarding, medication safety and compliance with input from the Chief Pharmacist. The Committee received a good news story regarding a frailty pathway and have looked in detail at complaints.

Workforce Committee – 17 May 2019
KP reported the Committee met twice in May and June. A hot house regarding staff benefits took place in June 2019 which was well attended. The staff survey results were reviewed during two meetings. The Committee has discussed recruitment and concern in areas and reviewed turnover and interventions. It was noted that sickness absence is reducing.

Charitable Funds Committee – 22 May 2019
The Chair reported a Fundraising Manager has been appointed and she has lots of energy and enthusiasm. The Committee meets quarterly and the next meeting is in September 2019. RH declared an interest as he is a member of Community Foundation of Calderdale.

81/19 Governance Report

The Corporate Governance Manager highlighted several governance items for review and approval by the Board.

a) Update to the Scheme of Delegation
Following the scheme of delegation review at the Board meeting on 2 May 2019, it is confirmed that within the detailed scheme of delegation, authority for the review of fire precautions is delegated to the Chief Operating Officer.

b) Board Workplan 2019/20
The Board work plan for 2019/20 has been updated with minor amendments and is presented to the Board for review. The Transformation Committee will be added to the workplan.

c) Board meeting dates 2020/21
The attached is a proposal of the future Board of Directors meetings from April 2020 up to March 2021.

d) Use of Trust Seal
There have been two documents sealed since the last report to the Board in March 2019, which were shared for information.

e) Governor Elections
Elections for two staff governors and five public governors are being held and the outcome of these, together with the announcement of a new partnership governor for Calderdale and Huddersfield Solutions Ltd., will be announced at the Annual General Meeting on 17 July 2019.

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

- Update to the Scheme of Delegation
- Board Workplan 2019/20
- Use of Trust Seal
- Process underway for the Governor elections

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

- Revised Board meeting date for January 2020

- Proposal of future Board meeting dates 2020/2021

82/19 6 Facet Survey Report

The Executive Director of Finance presented the 6 facet survey report which has been discussed at the Estates Sustainability Committee.

The total of £84m does not cover decant costs or asbestos issues.

OUTCOME: The Board **NOTED** the 6 facet survey report.

83/19 Month 2 Financial Summary

The Executive Director of Finance presented the month 2 financial summary year ending 31 March 2019, the key updates were:

- On plan to achieve £4.58m deficit
- The Cost Improvement Plan (CIP) is on track, underspend on agency trajectory and pay is underspent
- Non-pay challenges e.g. medical devices

OUTCOME: The Board **NOTED** the Month 2 Financial Summary.

84/19 Calderdale and Huddersfield Solutions (CHS) Update

AG declared his interest as Chair of Calderdale and Huddersfield Solutions Ltd.

The Executive Director of Finance reported the quarterly Joint Liaison Committee is meeting and a risk register for CHS is being considered. A health and safety consultant observed the last meeting.

OUTCOME: The Board **NOTED** the CHS update.

85/19 General Data Protection Regulation Assurance Compliance Report

The Chief Executive presented the General Data Protection Regulation assurance compliance report which shows compliance is positive in several areas and there are no concerns. The Data Protection Officer has undertaken a lot of work.

OUTCOME: The Board **NOTED** the GDPR assurance compliance report.

86/19 Any Other Business

The Chief Operating Officer explained a photo for the unsung hero awards for non-clinical NHS staff will be taking place at the Board of Directors workshop on Thursday 1 August 2019 and asked colleagues to wear pink for the theme.

The Chief Nurses reported CHFT are the first Trust to be provided clinical placement expansion funding which was released by HSJ this morning.

The Chair explained it was Jackie Murphy's last Board of Directors meeting and thanked her for all her hard work and making him feel so welcome in his first year as Chair.

The Chair reported it was also Lesley Hill's last Board of Directors meeting on her retirement at the end of July 2019. The Chair thanked Lesley for all her hard work and dedication on behalf of the Board.

87/19 Date and time of next meeting

Date: Thursday 5 September 2019
Time: 9:00 am
Venue: Boardroom, Huddersfield Royal Infirmary

Minutes of the Calderdale & Huddersfield NHS Trust
Board of Directors and Council of Governors Annual General Meeting held
Wednesday 17 July 2019 at 6:00 pm
Rooms 3 & 4, 3rd floor, Acre Mills Outpatients

PRESENT

Speakers
Philip Lewer, Chair
Owen Williams, Chief Executive
Gary Boothby, Executive Director of Finance
Alison Schofield, Lead Governor, Publicly Elected
Rashpal Khangura, KPMG, External Auditors

Board of Directors
David Birkenhead, Executive Medical Director
Helen Barker, Chief Operating Officer
Anna Basford, Director of Transformation & Partnerships
Andy Nelson, Non-Executive Director
Richard Hopkin, Non-Executive Director
Linda Patterson, Non-Executive Director
Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Jackie Murphy, Chief Nurse
Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive from 1.7.19
Mandy Griffin, Managing Director, Digital Health

In attendance
Mark Adderley, Non-Executive Director, Calderdale and Huddersfield Solutions Ltd.
Amber Fox, Corporate Governance Manager (minutes)

Public Elected Governors
Annette Bell, Public Elected Governor, East Halifax and Bradford
Brian Richardson, Public Elected Governor, Skircoat and Lower Calder Valley
Chris Owen, Public Elected Governor, South Kirklees
Christine Mills, Public Elected Governor, Huddersfield Central
Dianne Hughes, Public Elected Governor, South Kirklees
John Gledhill, Public Elected Governor, Lindley and the Valleys
Jude Goddard, Public Elected Governor, Calder and Ryburn Valleys
Lynn Moore, Public Elected Governor, North and Central Halifax
Nasim Banu Esmail, Public Elected Governor, North Kirklees
Paul Butterworth, Public Elected Governor, East Halifax and Bradford
Rosemary Hedges, Public Elected Governor, Lindley and the Valleys (Reserve)
Sheila Taylor, Public Elected Governor, Huddersfield Central
Veronica Woollin, Public Elected Governor, North Kirklees

Staff Elected Governors
Rosemary Hoggart, Staff Elected Governor, Nurses/Midwives
Sally Robertshaw, Staff Elected Governor, Allied Healthcare Professionals

Linzi Smith, Staff Elected Governor, Admin/Clerical
Sian Grbin, Staff Elected Governor, Nurses/Midwives

Stakeholder Governors
Emma Dickens, Locala
Prof Felicity Astin, University of Huddersfield
Salma Yasmeen, South West Yorkshire Partnership Foundation Trust
Jayne Taylor, Calderdale and Huddersfield Solutions Ltd.

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chair opened the meeting by welcoming everyone to Huddersfield Royal Infirmary. This meeting is an opportunity to reflect on the last 12 months within the Trust and share the Trust's plans and challenges for the coming year.

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

The Chair explained several Council of Governors will have completed their tenures, including Dianne Hughes, Nasim Banu Esmail and Rosemary Hedges and he thanked them for their valuable contribution to the Council of Governors.

The Chair noted special thanks to the Chief Executive, Executive Directors, Non-Executive Directors and Council of Governors for their active involvement. The Chair particularly noted the contribution of one of the Trust's Non-Executive Directors, David Anderson, who left in September 2018 when his tenure expired after 7 years with the Trust. He also noted the contribution of Professor Peter Roberts, an Independent Non-Executive Director who left at the end of June 2018 when his tenure expired after 8 years with the Trust.

The Chair noted special thanks on behalf of the Board of Directors and Council of Governors to Jackie Murphy, Chief Nurse, for her contribution in delivering exceptional services to our patients over her years at CHFT in her departure. The Trust wish her well in her new post.

The Chair welcomed Ellen Armistead, the new Executive Director of Nursing / Deputy Chief Executive from 1st July 2019.

2. APOLOGIES

Apologies were received from:

Board of Directors
Andrea McCourt, Company Secretary
Lesley Hill, Managing Director, Calderdale Huddersfield Solutions Ltd. (CHS)
Karen Heaton, Non-Executive Director
Alastair Graham, Non-Executive Director

Governors
Brian Moore, Public Elected Governor, Lindley and the Valleys
John Richardson, Public Elected Governor, South Kirklees

Stephen Baines, Public Elected Governor, Skircoat and Lower Calder Valley
Dr Peter Bamber, Staff Elected Governor, Doctors/Dentists
Chris Reeve, Locala
Helen Hunter, Healthwatch
Cllr Megan Swift, Calderdale Council
Cllr Lesley Warner, Kirklees Council

3. MEDICAL SERVICES SHOWCASE

Ashwin Verma, Divisional Director for the Medical Division presented an update on service improvements in Cardiology, Respiratory and Elderly Care.

The aim was to develop the cardiology, respiratory and elderly care services into single site models:

- Consultant presence 7 days a week
- Continuity of care
- Better access to speciality beds
- Enhanced care unit for respiratory patients
- Acute frailty service
- More daycase procedures
- Maximise benefits of EPR
- Better patient environment
- Acute Medical Floor
- Future Proof services and future opportunities

The Electronic Patient Record went live in May 2017 and the clinical services moved December 2017. A total of 8 months planning was involved which centred around patient, carer and staff engagement, working with other agencies such as the Yorkshire Ambulance Service (YAS) and approval was sought from the CCG, Health and Scrutiny Committee and Trust Board.

The benefits of the medical service improvements are:

- Less harm falls
- Less serious incidents
- Electronic Patient Record (EPR) ensures we are better at managing sepsis
- Less people die in hospital
- People with frailty have comprehensive assessment; more are managed at home
- Better access to procedures (e.g. PCI)
- More consultants and specialist staff want to work at CHFT
- Nurse retention and sickness is better

4. FINANCIAL REVIEW ANNUAL ACCOUNTS APRIL 2018 – MARCH 2019

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

EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS
Rash Khangura, External Auditor from KPMG gave a presentation outlining the work undertaken by the external auditors on the Annual Report and Accounts and the Quality Accounts.

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

The Chief Executive described the close working with different organisations and partners in the West Yorkshire and Harrogate Health Care Partnership. These changes and more collaborative working will continue to happen across these different partnerships. He discussed the services and how care is provided to make journeys as simple as stress-free as possible.

The Trust will continue to develop and become part of the local community, in terms of economic opportunities and employment. The biggest contributors to climate change and climate effect are the NHS. The Trust have an ambition to contribute to the local communities.

6. ELECTION RESULTS 2019 AND APPOINTMENTS
The Chair reported that the second half of the meeting would concentrate on the Council of Governors Annual General Meeting.

The Chair shared the results of the elections run by the Electoral Reform Services on behalf of the Trust over the period 17 April 2019 to 5 July 2019. This had resulted in 4 public seats being filled and 2 staff seats being filled.

The Chair extended a welcome to the newly elected and re-elected governors which is available in the Register of Governors in the packs.

Brian Moore was announced as the new Lead Governor effective from the 19th July 2019.

7. COUNCIL OF GOVERNOR UPDATE – OVERVIEW OF THE COUNCIL OF GOVERNORS CONTRIBUTION DURING 2018/19
A video of the lead governor, Alison Schofield was shared which outlined her contribution as lead governor during 2018/19, the support the Trust has provided the governors to support the role and a welcome to the new governors joining this year.

The Chair thanked Alison for her support and advice during her year as Lead Governor.

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

Q: Ed Greenwood – Calderdale Foundation Trust is a member of the GIRFT Process with NHS England, has the Trust measured themselves against model hospital and are there positive signs of improvement?
A: Ashwin Verma confirmed there have recently been 'Get it Right First Time' visits with external groups to review Cardiology services and Acute Medicine services. They were using the Acute Medical services to review how the GIRFT process would work. It was extremely positive, and they were impressed by the new services. An elderly medicine GIRFT hasn't taken place yet; however, benchmarking with all other Trusts took place last July – September 2018. It shows the Trust are ahead in terms of other Trusts e.g. education, staff retention, patient experience. The frailty team complete a comprehensive geriatric assessment and only 38% of Trusts in the country deliver this and CHFT are one of them.

Q: Two specialists helped with the medical service reconfiguration and I left as a governor two years ago. The Divisional Reference Group were well ahead of plans, how much help did you need?
A: Ashwin Verma responded that the help was needed, two visits from the Royal College took place which confirmed the areas needing improvement and the direction of travel. This gave the Trust outside credibility of what was being planned. Locating the elderly care on one site is better for patients. All the wards are doing quality improvement to enhance patient care and ensuring patients receive the right care in the right place. Nursing retention has improved, and sickness is lower. Compared to nationally the Trust are in a very good place.

Q: Pauline Nugent who is passionate about the NHS stated the community are frightened about there being no Accident and Emergency Department. Who can the community talk to, to work together? Will the Trust become involved in planning a people's commission, to bottom this out once and for all?
A: The Chief Executive explained the Trust has given evidence to the People's Commission when Calderdale Council asked. The Trust will contribute, if asked, to a People's Commission.

Q: Portia Roberts-Pophay – I am interested in sickle cell carcinoma and there is a particular focus on sickle cell in parliamentary group and it has been raised in parliament. What assurances can the Trust provide to confirm there have been improvements in sickle cell carcinoma? I am particularly interested in the electronic patient record and the lack of availability of this record in Leeds etc. I would like to see the Trust actively reach out to communities and see the benefits in doing this. There should be a more pro-active approach and the community are willing to work with the Trust on this journey.
A: The Chief Executive responded with the approach to diversity and how the Trust recognise the difference in people. Renee Comerford has been undertaking work around frailty and the BAME network. However, there is still a gap in knowledge and the Trust are not yet able to provide assurance. The Trust are undertaking a piece of work to understand the gap, for example, in mental health and there is still work to do regarding sickle cell carcinoma. The aspirations of the Trust are to ensure care is consistent so that patients don't have to describe their care needs to different providers.

Q: What is the child assessment for autism in this Trust?
A1: The Executive Medical Director explained that there are no specific targets and offered to look into this further if additional information could be provided.

Q: How come this hospital Trust is in continuity of deficit, is it PFI continuity?
A: The deficit is a fact and conversations are required to understand what is important right now.

Q: Paul Butterworth – The financial figures and staff totalling 4,800 in the annual report works out that on average staff are paid £46k per year. If you look at Executives (not Non-Executives), you are looking at over £1m in pay for 9 staff members. Should you be looking at reducing that top-level costs to look after patients? How does this help the Trust meet the equality process?
A: The Chair responded that compared nationally, the Executives at the Trust don't get paid as much as other Trusts. The Chair is proud of this Trust and the hard work of the Executives at CHFT and confirmed that the Trust does meet the equality process.

9. DATE AND TIME OF NEXT MEETING

Members were invited to attend next year's Annual General Meeting to be held at Calderdale Royal Hospital, date to be confirmed.

The Chair thanked everyone for attending and the questions asked and closed the formal meeting at approximately **19:30 pm**.

5. Action log and matters arising

To Note

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 4 July 2019 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
4.7.19 77/19	**Guardian of Safe Working Hours Annual Report 2018/19** Review the exception reporting from equality and diversity groups, working with Suzanne Dunkley and Nicki Hosty	Dr Rajgopal / SD / Nicky Hosty		November 2019		
4.7.19 73/19	**Director of Infection, Prevention and Control Annual Report** Medical Director to report back on flu vaccine uptake from BAME groups from public health data	DB		September 2019		
4.7.19 71/19	**1 Year Strategy on a Page Year Ending 2020** Update the wording of the digital strategy annual objective to 'design and continue implementation of the strategy'.	AB		September 2019		
4.7.19 72/19	**Care Quality Commission (CQC) Update** Update on use of resources and well led at the next meeting	EA		September 2019		
4.7.19 70/19	**Baby Friendly Initiative Report – Gold Award Status** Schedule Baby Friendly Initiative Gold Status Award session at a joint Board/Council of Governors workshop Chair to write to Locala to congratulate them on the BFI Gold Award Status	AM PL	 Complete	September 2019		
2.5.19 62/19	**Gender Pay Gap** Non-Executive and Executive champion to be identified for gender pay gap	SD	SD confirmed Karen Heaton has been identified as the Non-Executive Director champion for gender pay gap.	July 2019		4.7.19
7.3.19 33/19	**Learning from Deaths** Board Workshop on Learning from Deaths to be scheduled	AM	The options for an upcoming Board workshop are 5 December 2019 or 6 February 2020.	May 2019		4.7.19

6. Chair’s Report

a) Progress with Non-Executive Director Appointments

b) Climate Change Report

To Note

Presented by Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Chair's Report – Climate Change
Author:	Andrea McCourt, Company Secretary
Previous Forums:	None

Actions Requested:

- To note

Purpose of the Report

This report confirms the action taken by our local authorities in declaring a climate emergency, confirms Trust representation on the climate change forum for Calderdale Council and notes that further information on the Trust's response to climate change will be presented to the Board in January 2020.

Climate Change - national response by public organisations

Climate change is the greatest threat to health of the 21st century and the UK was the first country in the world to commit to legally binding carbon emissions reductions. Our public services have a substantial impact on the environment and public organisations can address many of the causes and impacts of climate change. To date 85 councils, two universities and one NHS Trust, Newcastle Hospitals, have declared a climate emergency in response to climate change. As part of their leadership in this area such organisations have committed to fast track environment sustainability plans to reduce their carbon emissions to zero, i.e. be carbon neutral.

Following a warning from the United Nations Intergovernmental Panel on Climate Change at global climate talks in Poland in 2018, that we have 12 years to make the necessary changes to limit a rise in global temperatures to 1.5ºC and the consequences if we fail to act, the UK and 200 other nations agreed action on climate change, with a much greater role strongly implied for local and regional authorities in assisting Governments to achieve their carbon emission savings.

Declarations of Climate Emergency – response from our local authority partners

Following these global climate talks in 2018 in January 2019 both of our local authority partners, Calderdale Council and Kirklees Council discussed motions on climate emergency at their Council meetings and declared a climate emergency to raise awareness amongst their local populations and support the public to take effective action.

Both councils identified actions to be taken. Kirklees Council requested a full environmental audit of the Council and set up a working party to oversee this, with an action plan to address the emergency to be brought back to a future meeting. Calderdale Council noted that the Council are on course to meet their 2020 CO2 reduction target of 40% but that their current targets were inadequate to respond to the challenge of keeping global temperature rises below 1.5ºC. In response Calderdale Council has set up a Calderdale Climate Change Committee and through this aims to set up a new target and action plan for Calderdale to be carbon neutral by 2030 as well as work with other local authorities and West Yorkshire Combined Authority on carbon reduction projects to ensure the UK is able to deliver on its climate commitments. The Trust has been invited to participate on this Committee.

The Trust
As a Trust we recognise the threat that climate change poses to both the health of individuals and public health, with opportunities to improve health by tackling climate change. As an organisation we aim to embed sustainability into our healthcare services and have a sustainable development plan in place, which has most recently focussed on travel and energy usage. As we progress the reconfiguration of services factors relating to futureproofing the hospital environment for climate change, such as energy efficiency and the resilience of buildings to climate change, sustainability and carbon reduction will be taken into account in the development of the Outline Business Case. There is further work to do on our environmental sustainability plans and achieving carbon neutrality and it is proposed that the Trust's plan to respond to climate change is presented to the Trust Board in January 2020.

To demonstrate the Trust's commitment to taking action on climate change and work with our partners to address the impact of climate change, as Trust Chair, I will represent the Trust on the Calderdale climate change forum which will meet in public with wide representation.

The Trust will undertake further work preparing its response to climate change and intends to bring a plan on climate change to the Trust Board on 9 January 2020.

Key Points to Note

- Trust Chair to represent the Trust on Calderdale Council climate change forum
- Intention to provide further information on the Trust's response to climate change at the 9 January 2020 Board meeting
- The following is enclosed confirming local authority climate change emergency declarations:
  - Minutes from Calderdale Council meeting of 30 January 2019 (see Appendix 1)
  - Minutes from Kirklees Council meeting of 16 January 2019 – see minute 120 (see Appendix 2)

EQIA – Equality Impact Assessment

Climate change exacerbates health risks and inequalities and leads to poorer health outcomes for people.

High risk groups include the elderly, particularly those living on their own, vulnerable people, individuals with pre-existing illnesses and those who are socio-economically deprived.

Examples include:

- weather patterns (flooding, drought, heat waves) leading to poorer health outcomes, with the elderly at most at risk from both heat and cold, links between weather / climate and disease (e.g. gastro intestinal disease)

- as a result of air pollution people with respiratory symptoms are affected due to earlier appearance of their symptoms and longer duration of these,

- Direct and indirect health implications from flooding due to climate change such as:

  - direct effects of the immediate effects of flood water, e.g. physical trauma, impact on vulnerable groups such as people with sensory, cognitive or physical impairments / mobility issues, children, with the elderly most at risk of flood mortality in the UK

  - indirect effects such as impact on mental health, impact on critical infrastructure

- Public health risks such as food and water-borne diseases, e.g. salmonella, legionella)

Recommendation

The Board is asked to **NOTE**:

i. the Chair will be the Trust representative on the Calderdale Council climate change forum.
ii. the Chief Executive and Managing Director of Calderdale Huddersfield Solutions are requested to present the Trust's action plan to address climate change to the Trust Board on 9 January 2020

Appendix 1

Extract from Calderdale Council Meeting minutes 30 January 2019
82 (B) CLIMATE EMERGENCY

It was moved by Councillor Sutherland,
Seconded by Councillor Patient,

The United Nations Intergovernmental Panel on Climate Change have warned that we have 12 years to make the necessary changes to limit a rise in global temperatures to 1.5c. Failure to act will see a marked increase in sea levels and flooding, extreme and abrupt changes to weather patterns, crop failures, extinctions of plant, insect and animal species and global economic disruption and crisis. The increased frequency and intensity of extreme weather events that we have experienced locally highlight why this is such an important issue for Calderdale Council to respond to.

At the Global Climate Talks in Poland last December the UK along with over 200 nations agreed action on climate change with a much greater role strongly implied for Local and Regional Authorities like Calderdale Council in assisting Governments to achieve their carbon emission savings.

This Council therefore:

- Declares a Climate Emergency;
- Notes that the Council and Borough are on course to meet their 2020 CO2 reduction target of 40%;
- Notes that our current targets are inadequate to respond to the challenge of keeping global temperature rises below 1.5c.

This Council Requests that:

(a) the Cabinet set up a Calderdale Climate Change Committee to respond to this challenge, that meets in public with wide representation including from all party groups;

(b) the Cabinet through this Committee sets a new target and action plan for Calderdale to be carbon neutral;

(c) resolves to work with other local authorities and West Yorkshire Combined Authority on carbon reduction projects to ensure the UK is able to deliver on its climate commitments; and

(d) Council calls on the Government to provide the resources and powers so that Calderdale can make its contribution to the Uk's Carbon Reduction targets.

It was moved as an **AMENDMENT** by Councillor Baker,
Seconded by Councillor Evans,

that the motion be amended by deletion of all the wording after the second paragraph and replacing with:

This Council therefore:

- Notes that the Council and Borough are on course to meet their 2020 CO_2 reduction target of 40%;
- Notes that our current targets are inadequate to respond to the challenge of keeping global temperature rises below 1.5^{o}C;
- Declares a Climate Emergency to raise awareness of this issue among the people of Calderdale.

This Council Requests that:

(a) the Cabinet set up a Calderdale Climate Change Working Group to respond to this challenge, that meets in public with wide representation including from all party groups;

(b) this Working Group advises Cabinet on the setting of a new target and provides a costed action plan for Calderdale to be carbon neutral by 2030, in line the Oslo Precautionary Principle and other councils across England. Such an action plan shall also set out how advice, encouragement and support can be provided to the people and businesses of Calderdale to take additional action in support of this aim.

Additionally,

(a) Council resolves to work with other local authorities and West Yorkshire Combined Authority on carbon reduction projects to ensure the UK is able to deliver on its climate commitments; and

(b) Council calls on the Government to stress the urgency of the climate emergency and provide the resources and powers to further enable Calderdale to make its contribution to the UK's Carbon Reduction targets.

The **AMENDMENT** with the replacement wording on being put to the vote was <u>not carried</u>.

Councillors Sutherland, Fenton-Glynn, Taylor, Scullion, Raistrick, Payne, Lynn, Dickenson and Hutchinson commented on the Amended Motion.

RESOLVED that:

The United Nations Intergovernmental Panel on Climate Change have

warned that we have 12 years to make the necessary changes to limit a rise in global temperatures to 1.5c. Failure to act will see a marked increase in sea levels and flooding, extreme and abrupt changes to weather patterns, crop failures, extinctions of plant, insect and animal species and global economic disruption and crisis. The increased frequency and intensity of extreme weather events that we have experienced locally highlight why this is such an important issue for Calderdale Council to respond to.

At the Global Climate Talks in Poland last December the UK along with over 200 nations agreed action on climate change with a much greater role strongly implied for Local and Regional Authorities like Calderdale Council in assisting Governments to achieve their carbon emission savings.

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This Council Requests that:

(a) the Cabinet sets up a Calderdale Climate Change Committee to respond to this challenge, that meets in public with wide representation including from all party groups;

(b) the Cabinet through this Committee sets a new target and action plan for Calderdale to be carbon neutral;

(c) resolves to work with other local authorities and West Yorkshire Combined Authority on carbon reduction projects to ensure the UK is able to deliver on its climate commitments; and

(d) Council calls on the Government to provide the resources and powers so that Calderdale can make its contribution to the Uk’s Carbon Reduction targets.

Contact Officer: Andrea Woodside

COUNCIL

KIRKLEES COUNCIL

At the Meeting of the Council of the Borough of Kirklees held at Council Chamber - Town Hall, Huddersfield on Wednesday 16 January 2019

PRESENT

The Mayor (Councillor Gwen Lowe) in the Chair

COUNCILLORS

Councillor Masood Ahmed
Councillor Bill Armer
Councillor Donna Bellamy
Councillor Cahal Burke
Councillor Nosheen Dad
Councillor Eric Firth
Councillor Michelle Grainger-Mead
Councillor David Hall
Councillor Lisa Holmes
Councillor Edgar Holroyd-Doveton
Councillor Judith Hughes
Councillor Christine Iredale
Councillor Viv Kendrick
Councillor John Lawson
Councillor Fazila Loonat
Councillor Naheed Mather
Councillor Bernard McGuin
Councillor Marielle O'Neill
Councillor Nigel Patrick
Councillor Mussarat Pervaiz
Councillor Andrew Pinnock
Councillor Hilary Richards
Councillor Cathy Scott
Councillor Will Simpson
Councillor Richard Smith
Councillor John Taylor
Councillor Graham Turner
Councillor Rob Walker
Councillor Habiban Zaman
Councillor Alison Munro
Councillor Mark Thompson

Councillor Mahmood Akhtar
Councillor Gulfam Asif
Councillor Martyn Bolt
Councillor Andrew Cooper
Councillor Richard Eastwood
Councillor Donald Firth
Councillor Charles Greaves
Councillor Steve Hall
Councillor Erin Hill
Councillor James Homewood
Councillor Mumtaz Hussain
Councillor Manisha Roma Kaushik
Councillor Musarrat Khan
Councillor Vivien Lees-Hamilton
Councillor Terry Lyons
Councillor Peter McBride
Councillor Darren O'Donovan
Councillor Shabir Pandor
Councillor Carole Pattison
Councillor Amanda Pinnock
Councillor Kath Pinnock
Councillor Mohammad Sarwar
Councillor David Sheard
Councillor Ken Sims
Councillor Mohan Sokhal
Councillor Kath Taylor
Councillor Sheikh Ullah
Councillor Michael Watson
Councillor Nell Griffiths
Councillor Richard Murgatroyd
Councillor Harpreet Uppal

112 Announcements by the Mayor and Chief Executive

The Mayor conveyed the congratulations of Council to both Judith Robinson and Saleem Tariq who had been recognised in the 2019 New Year's Honours List. Judith, who is a development librarian, had been awarded a British Empire Medal for services to public libraries. Saleem Tariq, former Kirklees Deputy Director of Children's Services, had been awarded an OBE for services to Children's Services.

The Mayor advised that she would be sending a letter of condolence to the family of Nigel Gawthrope, Mayor of Cambridge City Council, who passed away suddenly last week whilst on holiday in South Africa.

The Mayor also advised Council of the death of former Councillor Adrian Beldon, who had represented Birkby Ward. A tribute was paid by Councillor McBride.

The Monitoring Officer reminded Council of the restrictions applying to voting under Section 106 of the Local Government Act 1992, in respect of Agenda Item 11. (Minute No.123 refers)

(At this stage of the meeting it was moved by Councillor Pandor, and seconded by Councillor Sheard, that under the provision of Council Procedure Rule 15(3), Agenda Item 20 be considered after Agenda Item 8. It was moved by Councillor Lawson, and seconded by Councillor Cooper, that Agenda Item 17 be brought forward. Upon being put to the vote, both proposals were carried).

113 Apologies for absence

Apologies for absence were received on behalf of Councillors Allison, Kane, Smaje and Stewart-Turner.

114 Minutes of Previous Meeting

RESOLVED – That the Minutes of Council held on 12 December 2018 be approved as a correct record.

115 Declaration of Interests

Councillor Bolt declared an 'other' interest in Agenda Item 10 on the grounds that he has responsibility for an empty property. Councillors Smith and Watson declared Disclosable Pecuniary Interests on the grounds that they have interests in properties which are currently vacant.

116 Petitions (From Members of the Council)

Councillor McGuin submitted a petition which opposed the relocation of Almondbury Library at Stocks Walk to the site of the former Sure Start Centre.

117 Public Question Time

Council received a question from Aleks Lukic, arising from his deputation at the meeting of Council on 12 December 2018.

A response was provided by the Leader of the Council.

118 Deputations & Petitions (From Members of the Public)

(a) Council received a deputation from Ali Stopher, Kiran Bali, Joseph Byrne and Hugh Goulbourne in support of the Motion at Agenda Item 20 – Climate Emergency.
(b) Council received a deputation on behalf of Almondbury Library Friends Association, delivered by Dr Mike Mitchell and Rob Greenwood, which opposed the relocation of the library from Stocks Walk to the site of the former Sure Start Centre. A petition was also submitted.
(c) Council received a deputation from Hasan Badat in regards to the Council's Inclusion and Diversity Strategy.
(d) Council received a deputation from Hanifa Darwan and Yunus Lunat which requested that the Council continue to offer a choice of halal meals within its schools. A petition was also submitted.

The Cabinet Member for Communities and Environment (Councillor Mather) responded to (a). The Cabinet Member for Resources (Councillor Turner) to (b). The Leader of the Council responded to (c). The Cabinet Member for Learning and Aspiration responded to (d).

119 Council Petition Debate

Council debated the content of the following petitions which had previously been submitted and exceeded the 3,000 signatures petition threshold (i) the serving of non-stunned halal meat in Kirklees Schools and (ii) the impact of introducing car parking charges in Cleckheaton Town Centre.

The contents of the debate were received and noted.

120 Motion Submitted in Accordance with Council Procedure Role 14 as to A Climate Emergency in Kirklees

It was moved by Councillor Murgatroyd, and seconded by Councillor Cooper that;

"This Council notes;

The United Nations Intergovernmental Panel on Climate Change's warning that we have 12 years to make the necessary changes to limit a rise in global temperatures to 1.5c. Failure to act will see a marked increase in sea levels and flooding, extreme and abrupt changes to weather patterns, crop failures, extinctions of plant, insect and animal species and global economic disruption and crisis. This will detrimentally impact on the well-being of the people of Kirklees and billions of people around the world.

At the Global Climate Talks in Poland last December the UK along with over 200 nations agreed action on Climate Change with a much greater role strongly implied for Local and Regional Authorities like Kirklees in assisting Governments achieve their carbon emission savings.

In the words of Sir David Attenborough:

"Right now, we are facing a man-made disaster of global scale. Our greatest threat in thousands of years. Climate change. If we don't take action, the collapse of our

civilisations and the extinction of much of the natural world is on the horizon. The world's people have spoken. Their message is clear. Time is running out.'

We therefore resolve to:

(i) Declare a Climate Emergency and publicise this to the people of Kirklees to raise awareness, and support the public to take effective action.

(ii) Request Cabinet initiate a full Environmental Audit of Kirklees Council to measure its carbon footprint, identify hotspots and work toward being carbon neutral in line with the latest targets set and agreed by the United Nations Intergovernmental Panel on Climate Change; with Cabinet to report to the first meeting of the working party, referred to at (iv) below on the scope of the environmental audit

(iii) Significantly improve our recycling rate to reach the target of 55% by 2025, and ask that the Cabinet implement a range of short term measures to improve recycling rates, in advance of a full review of the waste collection and disposal service.

(iv) To set up a Councillor Working Party including the appropriate Cabinet Lead with a remit to:

a) Commission and oversee the Environmental Audit

b) Consult expert opinion in the field, as appropriate

c) Identify practical measures to reduce emissions and the Council's carbon footprint

d) encourage action in the wider community, businesses and other key organisations e.g. NHS and Educational Institutions

e) Report to Full Council within six months with an action plan to address the Emergency and incorporating proposals on the investment implications of this proposed activity

(v) The Council to consider Environmental Impact as part of any new policy

(vi) The Council to seek to collaborate with other Local and Regional Authorities on emission reduction projects as appropriate. The Leader of the Council to write to the Minister of State for Climate Change and Industry requesting that national policy is urgently developed to reflect the seriousness of the current emergency and to release funds to local authorities that would allow them to take the necessary measures at local level."

Upon being out to the Vote, the Motion was CARRIED, and it was therefore

RESOLVED – "That this Council notes;

The United Nations Intergovernmental Panel on Climate Change's warning that we have 12 years to make the necessary changes to limit a rise in global temperatures to 1.5c. Failure to act will see a marked increase in sea levels and flooding, extreme and abrupt changes to weather patterns, crop failures, extinctions of plant, insect and animal species and global economic disruption and crisis. This will detrimentally impact on the well-being of the people of Kirklees and billions of people around the world.

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(iv) To set up a Councillor Working Party including the appropriate Cabinet Lead with a remit to:

a) Commission and oversee the Environmental Audit

b) Consult expert opinion in the field, as appropriate

c) Identify practical measures to reduce emissions and the Council's carbon footprint

d) encourage action in the wider community, businesses and other key organisations e.g. NHS and Educational Institutions

e) Report to Full Council within six months with an action plan to address the Emergency and incorporating proposals on the investment implications of this proposed activity

(v) The Council to consider Environmental Impact as part of any new policy

(vi) The Council to seek to collaborate with other Local and Regional Authorities on emission reduction projects as appropriate. The Leader of the Council to write to the Minister of State for Climate Change and Industry requesting that national policy is urgently developed to reflect the seriousness of the current emergency and to release funds to local authorities that would allow them to take the necessary measures at local level."

121 West Yorkshire Combined Authority - Minutes

Item not considered (due to time constraints)

122 Council Tax - Empty Property Premium (Reference from Cabinet)

It was moved by Councillor Turner, seconded by Councillor Pandor, and

RESOLVED -

1) That it be agreed that, in accordance with Section 11B of the Local Government Finance Act 1992, a premium be set which applies with the maximum afforded by the Act under Sections 11B (1A) (1B) and (1C), with effect from the dates set out in those sections:

(1A) For the financial year beginning on 1 April 2019 the "relevant maximum" is 100.

(1B) For the financial year beginning on 1 April 2020 the "relevant maximum" is—

a) in respect of any dwelling where the period mentioned in subsection (8) ending on the relevant day is less than 5 years, 100;
b))in respect of any dwelling where the period mentioned in subsection (8) ending on the relevant day is at least 5 years, 200.

(1C) For financial years beginning on or after 1 April 2021 the "relevant maximum" is—

a) in respect of any dwelling where the period mentioned in subsection (8) ending on the relevant day is less than 5 years, 100;
b) in respect of any dwelling where the period mentioned in subsection (8) ending on the relevant day is at least 5 years but less than 10 years, 200;
c) in respect of any dwelling where the period mentioned in subsection (8) ending on the relevant day is at least 10 years, 300. "

2) That, pursuant to (1) above, this be integrated into the incentivising of bringing empty properties back into use to increase the Housing Supply.

123 Calculation of Council Taxbase 2019/2020 (Reference from Cabinet)

It was moved by Councillor Turner, seconded by Councillor Pandor, and

RESOLVED -

1) That the Council Taxbase 2019/2020 for Kirklees, and the five Parish and Town Council areas, be approved as follows;

- Whole of Kirklees £118,708.56
- Denby Dale £5,771.84
- Holme Valley £9,998.83
- Kirkburton £8,910.47
- Meltham £2,820.42
- Mirfield £6,617.91

2) That authority be delegated to the Service Director (Finance) to adjust the taxbase to reflect any changes that may be agreed by Members, and to recalculate the taxbase pursuant to Section 3 1B(1) and S67(1) and (2A) of the Local Government Finance Act 1992.

124 Healthy Weight Declaration (Reference from Cabinet)

Item not considered (due to time constraints)

125 Scrutiny Update

Item deferred.

126 Written Questions to the Leader, Cabinet Members, Chairs of Committees and Nominated Spokespersons

Item not considered (due to time constraints)

127 Key Discussion - Council Waste Strategy

Council held a key discussion debate on Council Waste Strategy. Prior to the debate commencing, a presentation was delivered by the Director of Economy and Infrastructure.

RESOLVED - Council received a presentation from the Director of Economy and Infrastructure prior to undertaking the key discussion debate.

128 Motion submitted in accordance with Council Procedure Rule 14 as to Universal Credit

Item not considered (due to time constraints)

129 Motion submitted in accordance with Council Procedure Rule 14 as to Giving People a say on the Final Brexit Deal

It was moved by Councillor Lawson, and seconded by Councillor Cooper that;

"This Council notes:

- The growing concern at the prospect of the UK leaving the European Union (EU) with either a bad deal or no deal at all.

- The growing support for people to have a say on the final Brexit deal, including support from organisations such as the British Medical Association, the Royal

College of Nursing, GMB, Prospect, TSSA, business leaders and student unions representing over 980,000 students at 60 universities and colleges.

This Council believes that:

- By voting to leave the EU in June 2016, the UK voted for departure but not the destination. There has never been a consensus about how to leave and about our future relationship with the EU post-Brexit, but the years since the referendum on the UK's membership of the EU has shown the complexity of the task and how challenging Brexit is to deliver.

- Since the referendum, there has been meaningful debate about our EU membership; there is now greater public awareness about the nature and impact of Brexit on the UK and there is ongoing movement in public opinion.

- The future direction of the country post-Brexit should not be decided by a small number of parliamentarians in Westminster. This is too big an issue and will affect all of us for generations to come; sovereignty rests with the people.

- The decision to leave the EU and subsequent negotiations has created political, social and economic uncertainty in the UK. Brexit is likely to have a major impact on local authorities, including Kirklees Council, potentially reducing funding for local and regional investment and development projects, affecting governance and legal frameworks and impacting on the progress of devolution deals.

- There are implications for Kirklees as a result of Brexit and there is consternation from some of our residents, including non-UK EU nationals, about what Brexit may mean for them. For instance, leaving may have an impact on our local health services, with recent NHS data revealing that 31 nurses and health visitors from EU member states left Calderdale and Huddersfield NHS Foundation Trust between March 2017 and March 2018. Brexit is already having an impact on our local manufacturing industry, while some businesses in our region are reconsidering investment plans in new production and new jobs while they await the Brexit deal. Furthermore, Brexit may limit the educational opportunities for our young people. It may cause damage to our local economy and public services and result in a squeeze in living standards.

- As a country, we are not close to resolving the big issues about which people care about; parliament is deadlocked and the impasse will cause insurmountable damage to the UK. A public vote is the only way to move forward.

- The British people deserve the right to have a final say on what direction the country should take on Brexit and must have a vote on the UK's final deal with the European Union.

This Council, therefore, resolves to:

- Request that Cabinet updates and maintains the Council's Risk Register, ensuring that the Register includes an up-to-date and robust account of the risks associated with Brexit;

- Be proactive in planning, outlining the issues and risks associated with different Brexit scenarios, assessing the possible impact on the Council and local area and implementing recommend measures as soon as possible;

- Support people to have a say on any final Brexit deal through a vote;

- Ask the Leader of the Council to write to the Prime Minister expressing the Council's support for people to have a final say on the Brexit deal."

The Motion, upon being put to the Vote was not carried and it was therefore

RESOLVED – That the Motion not be approved.

130 Motion submitted in accordance with Council Procedure Rule 14 as to Period Dignity

It was moved by Councillor Zaman, and seconded by Councillor Richards that

"This Council:

Notes that women and girls find themselves in a position where they either can't access sanitary products or can't afford sanitary products.

Notes that, low wages and zero-hour contracts are just some of the reasons that women are forced to make difficult decisions about whether to purchase sanitary products.

Is concerned that women and girls are resorting to using items such as socks and tissues in place of sanitary products, putting their health at significant risk and more than one in ten girls have had to improvise sanitary wear due to affordability issues.

Is further concerned that women and girls are missing work or school each month because they can't afford sanitary products.

Believes that women and girls should be able to experience their periods with dignity.

The District of Kirklees is no exception to this national issue and its effects on women's health, who are more likely to suffer from anxiety, depression or in school bullying; the consequence of which can have a negative impact on the local economy and educational attainment.

This Council resolves:

To call on the Government to carry out research into the impact that inadequate sanitary protection can have on women and girls so that it has a better understanding of the true impact of period poverty.

To call on the Government and CBI to carry out research into the impact that inadequate sanitary protection has on the economy including factors such as lost

working days compared to the cost of business providing sanitary products at no charge to employees.

To further call on the Government to make sanitary products available for women and girls from low income households who are struggling to afford these essential items, including making sanitary products available in schools and colleges at no charge.

To ask Cabinet to work with schools and colleges to seek to provide sanitary products at no charge in toilet facilities until a time when the Government changes policy.

To ask Cabinet to conduct a feasibility study to assess the financial impact on the Council should it resolve in the future to provide sanitary products in its toilet facilities."

The Motion, upon being put to the Vote was CARRIED, and it was therefore

RESOLVED - "That this Council notes that women and girls find themselves in a position where they either can't access sanitary products or can't afford sanitary products.

Notes that, low wages and zero-hour contracts are just some of the reasons that women are forced to make difficult decisions about whether to purchase sanitary products.

Is concerned that women and girls are resorting to using items such as socks and tissues in place of sanitary products, putting their health at significant risk and more than one in ten girls have had to improvise sanitary wear due to affordability issues.

Is further concerned that women and girls are missing work or school each month because they can't afford sanitary products.

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working days compared to the cost of business providing sanitary products at no charge to employees.

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To ask Cabinet to work with schools and colleges to seek to provide sanitary products at no charge in toilet facilities until a time when the Government changes policy.

To ask Cabinet to conduct a feasibility study to assess the financial impact on the Council should it resolve in the future to provide sanitary products in its toilet facilities."

131 **Motion submitted in accordance with Council Procedure Rule 14 as to Adopt Parental Leave Policy for Elected Members**

It was moved by Councillor Mather, and seconded by Councillor O'Donovan that;

"This Council notes:

- That analysis of the 2018 Local Election results by the Fawcett Society found that only 34% of Councillors in England are women, up 1% since 2017. Of the seats that were up for election in 2018, 38% went to women, up just 3 percentage points on 2014 when these seats were last contested;

- As of summer 2017, only 4% of Councils in England and Wales have parental leave policies, according to research by the Fawcett Society;

- That the role of a Councillor should be open to all, regardless of their background, and that introducing a parental leave policy is a step towards encouraging a wider range of people to become Councillors, and is also a step to encourage existing Councillors who may want to start a family to remain as Councillors;

- That parental leave must apply to parents regardless of their gender, and that it should also cover adoption leave to support those parents who choose to adopt.

This Council agrees:

- to the principle of adopting a suitable parental leave policy to give all Councillors an entitlement to parental leave after giving birth or adopting, based on the policy attached to this Motion, to ensure that Councillors with children and other caring commitments are supported as appropriate;

and therefore RESOLVES to;

- refer this to the Council's Members Allowances Panel and Corporate Governance and Audit Committee to consider further"

Upon being out to the Vote, the Motion was CARRIED and it was therefore

RESOLVED – "That this Council notes:

- That analysis of the 2018 Local Election results by the Fawcett Society found that only 34% of Councillors in England are women, up 1% since 2017. Of the seats that were up for election in 2018, 38% went to women, up just 3 percentage points on 2014 when these seats were last contested;

- As of summer 2017, only 4% of Councils in England and Wales have parental leave policies, according to research by the Fawcett Society;

- That the role of a Councillor should be open to all, regardless of their background, and that introducing a parental leave policy is a step towards encouraging a wider range of people to become Councillors, and is also a step to encourage existing Councillors who may want to start a family to remain as Councillors;

- That parental leave must apply to parents regardless of their gender, and that it should also cover adoption leave to support those parents who choose to adopt.

This Council agrees:

- to the principle of adopting a suitable parental leave policy to give all Councillors an entitlement to parental leave after giving birth or adopting, based on the policy attached to this Motion, to ensure that Councillors with children and other caring commitments are supported as appropriate;

and therefore RESOLVES to;

- refer this to the Council's Members Allowances Panel and Corporate Governance and Audit Committee to consider further"

132 Responses to Motions - Child Sexual Exploitation/Modern Slavery

Council received and noted (i) the response of the Home Office to the Motion approved by Council as to the Child Sexual Exploitation on 7 November 2018 and (ii) the response of the Home Office to the Motion approved by Council as to Modern Slavery on 7 November 2018.

7. Chief Executive’s Report

a) Health and Wellbeing Strategy

To Note

Presented by Owen Williams

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Chief Executive's Update: Health and Wellbeing Strategy
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Calderdale Health and Wellbeing Board 8 August 2019

Actions Requested:
To note

Purpose of the Report

The purpose of this paper is to share the refreshed Health and Wellbeing Strategy approved by Calderdale Council on 8 August 2019, following work by a number of partners, voluntary organisations and commissioners within the Health and Wellbeing partnership.

The strategy, which is shared for information, is set within the context of Calderdale's vision for 2024 which is detailed in the strategy. There will be a formal launch of the strategy during September 2019. Progress against the strategy will be reported to the Health and Wellbeing Board.

Key Points to Note

The Health and Wellbeing Strategy is one of two key strategic pillars for Calderdale Council, the second pillar being the Inclusive Economy Strategy.

The strategy is high level and has a commitment to developing annual improvement plans. It is structured around four stages of life from birth, starting well, to ageing well. The strategy describes the emerging primary care networks as a key delivery vehicle for the strategy.

EQIA – Equality Impact Assessment

The Health and Wellbeing Strategy aims to improve the gap in life and healthy life expectancy and reduce gaps between different communities, focussing on the wider determinants of health such as environment, education and employment to improve health inequalities in Calderdale. Outcome measures of the effectiveness of the strategy in making change used will be life expectancy and healthy life expectancy.

Recommendation

The Board is asked to note the Calderdale Health and Wellbeing Strategy.

WELLBEING STRATEGY

Living a Larger Life - Calderdale 2018 - 2024

#VISIONCDALE2024

CALDERDALE CARES

VISION 2024

OUR VISION FOR CALDERDALE

The Wellbeing Strategy is set within the context of Vision 2024. Our vision for Calderdale in 2024 is for a place where you can realise your potential whoever you are, whether your voice has been heard or unheard in the past.

- We aspire to be a place where talent and enterprise can thrive.
- A place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope.
- Calderdale will stand out, be known, and be distinctive. A great place to visit, but most importantly, a place to live a larger life.

The Wellbeing Strategy and the Inclusive Economy Strategy describe a clear and challenging strategic aspiration for Calderdale.

Our ambition is to ensure that people of Calderdale enjoy more years of healthy life; that the gaps in healthy life expectancy between different communities are reduced; and that everyone whatever their health or disability is supported and enabled to lead the fullest life possible.

Good physical and mental health has a significant influence on overall wellbeing. It allows people to participate in family life, the community and the workplace. It has value in its own right and it also creates value. Put simply, health should be viewed as an asset that is worth investing in for our society to prosper. Indeed people generally place more value on being healthy than on factors like income, careers or education.

The ways to improve health are well known: investment in early years development; lifelong learning; provision of good-quality, affordable housing; availability of high-quality jobs; public transport systems; and a food system that supports healthy options.

Calderdale is a great place to live. Most of us are fit and healthy, and generally the quality of life here is good. However, like everywhere, the picture in Calderdale is not perfect. The health and wellbeing of people in some of our communities is not improving at the same rate as others. Every year, far too many people suffer avoidable ill health or die earlier than they should – this is known as health inequality. These inequalities need to be tackled to make life better for everyone living in Calderdale.

We also have a growing number of people living into old age. Whilst it is good news that people are living longer, it is important that the quality of our life remains high too.

The things that affect our health and wellbeing vary over the course of our lifetime. Therefore, the strategy has been developed using four significant stages of the life course.

- **Starting well (0-5)**
- **Developing Well (6-25)**
- **Living & working well**
- **Ageing well**

This strategy sets our high level priorities, based on these four life stages,with an overall priority of impacting on the wider determinants of health.

The success of the strategy will be measured against the outcomes we have included, which

Tim Swift
Leader of the Council

will also be used to shape commissioning across the health and care system and to develop more detailed action plans to improve the health and wellbeing of people who live and work in Calderdale. Average is not good enough for Calderdale people. We will aim to be in the top 25% nationally for all of the measures we have identified in this strategy. A small number of measures will be common to both the Wellbeing and Inclusive Economy Strategies and align with the outcomes set out in Vision 2024. These outcome measures and action plans will be developed with Calderdale citizens and stakeholders and will be reviewed regularly by the Health and Wellbeing Board.

This strategy does not list everything that all organisations will be undertaking to improve health and wellbeing; instead it focuses on setting out our vision and priorities for integrated working over the next five years to 2024. The strategy will further evolve. For example Calderdale has recently declared a climate emergency, the actions needed to support our environment will very clearly link to protecting and promoting our health.

A wide range of partners, including those from health, local government, voluntary and community sectors will contribute towards the delivery of this overarching strategy through their own strategic aims.

This strategy is fundamentally concerned with people being all they can be. people should be able to “lead a larger life”. This includes being creative, being able to express ourselves fully and engage in quality relationships.

Doing things differently - Our principles

We have identified four key principles that will inform the way we all work together, what we do and how we report our progress on improving health and wellbeing:

A new relationship with communities

We believe the relationship between organisations and communities needs to change. We will listen so people feel heard and we will demonstrate - with evidence - that people have been heard. We will involve our communities in the work we do, and co-design our plans for change with them. People are empowered to take greater control over their lives and outcomes - with improved health, so they are happier and better connected. As organisations we need to focus our limited staff time and money on the things that only we can offer, and support communities to use their valuable skills and time to do more for themselves and each other. We need to work together to create stronger communities that can cope with and recover from problems well. We need to develop 'kindness by design' to ensure our offers best meet the needs of our diverse populations. We will establish methods to ensure a transfer of resources to support community action.

A shift to prevention and health outcomes

Our systems need to shift towards prevention, which will require us to change the ways our organisations and our staff work. As organisations we need to make sure it is easier for people to have healthier options and we need to have a relentless focus on health outcomes and not just on service delivery. These outcomes will be agreed with the people we serve. Our focus will be on reducing the unjust health inequalities that prevail in Calderdale and we will seek to ensure our resources are used in the most effective and efficient way to reduce inequality. We will change the nature of the relationship between people and services, and the relationship between people and their own health, changing the way our staff see their roles, their day job and constant improvement in the work they do.

Support integrated care services

A stronger focus on joining up health and care services - moving more services from hospitals to community settings, only having to tell your story once, and making it easy to find out what support is there to help you and how to access it. Calderdale Cares articulates a vision of integrated commissioning and integrated delivery with organisations coalescing around a single set of outcomes.

Health in all policies

A commitment to ensure that all policies consider and promote the health and wellbeing of citizens, and address the climate change emergency. Resources and assets will be used to address the wider determinants of health and support wellbeing.

Improving health and wellbeing throughout people's lives

Our goal is to optimise the health and wellbeing of people in Calderdale throughout the course of their lives. For this reason, our strategy is divided into four sections, each relating to one of the major life stages:

Starting Well

The first section focuses on babies and very young children, and covers ages 0-5 years (including pregnancy).

Developing Well

Childhood and young adulthood (6-25)

Living & Working Well

Working age adults.

Ageing Well

With a focus on older people, covering people 65 and older.

Being Well

A healthy person is someone with; meaningful work or purpose in life, secure housing, stable relationships, high self-esteem, and healthy behaviours.

Health is not just in the gift of our health and social care services. A healthy society, in turn, is not one that waits for people to become ill, but one that sees how health is shaped by social, cultural, political, economic, commercial and environmental factors, and takes action on these for current and future generations.

The Strategy will monitor and accelerate actions to improve the conditions and environments in which people in Calderdale live.

Some key social determinants of health are: our education and employment opportunities; our housing; our income; our social networks; and where we live and the extent it facilitates physical activity, good food and social connection. These factors shape the conditions in which people are born, grow, live, work and age (our key life courses)

Addressing these determinants is crucial in reducing health inequality and improving health.

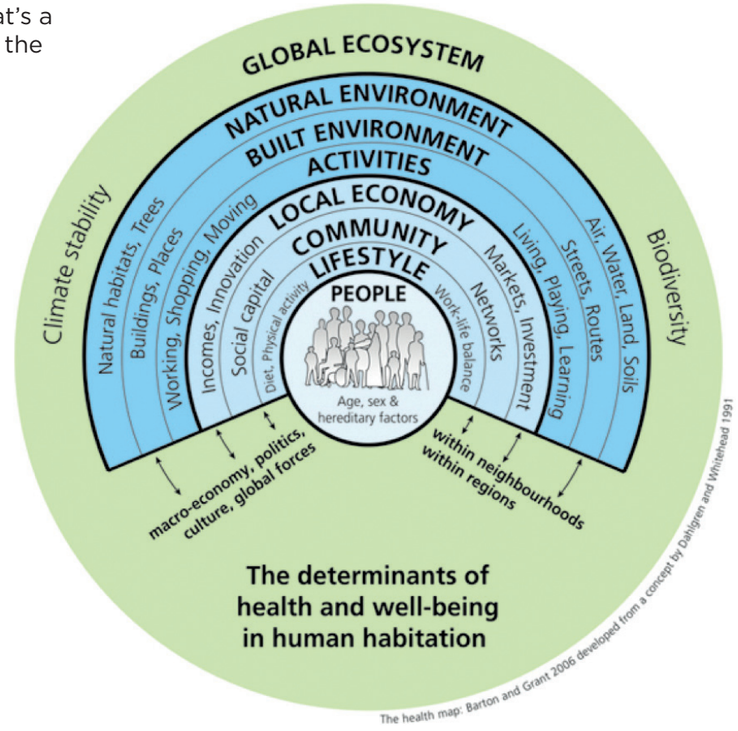
Calderdale has declared a climate emergency. The dramatic consequences of climate change are already being seen in our borough, with presumed once in a life time floods occurring at much more regular intervals. Our climate and environment have clear impacts on our health, whether it is the mental health impact of flooding or the impact on future generations

People's health is affected by where they live, how well-off they are, their gender, and whether they have a disability. A girl born in the least deprived 10% of local areas can expect to live 70.4 years in good health, but she would live only 52.0 years in good health if born in the most deprived 10% of local areas – an 18.4-year gap. That's a difference of almost two-decades in the years of life spent in good health.

Underpinning the work across the life stages will be our commitment to ensure that the wider determinants of health are considered and addressed. Some of these determinants are addressed in other strategies e.g. employment and income measures are monitored through the inclusive Economy Strategy. The Wellbeing Strategy will focus on improving air quality, access to green space, poverty and housing.

There are two key outcomes that will describe the effectiveness of the strategy in making change:

- Life expectancy
- Healthy life expectancy



	Year	Calderdale	England
Life expectancy at birth - males	2015-17	78.6	79.76
Life expectancy at birth - females	2015-17	81.6	83.1
Healthy life expectancy at birth - males	2015-17	61.6	63.4
Healthy life expectancy at birth - females	2015-17	64.4	63.8

There are significant inequalities in life expectancy in Calderdale, with the least deprived men expected to live seven and a half years longer than the most deprived For women, the gap is even wider: the least deprived are expected to live just over 9 years longer than the most deprived.

Starting Well

What happens in pregnancy and early childhood impacts on physical and emotional health all the way throughout our lives.

Supporting good maternal health is important for safe delivery and good birth weight to give babies the best start. The prevention of adverse health factors in pregnancy is vital. Premature and small babies are more likely to have poorer outcomes.

The earliest experiences, starting in the womb, shape a baby's brain development. During the first 2 years of life the brain displays a remarkable capacity to absorb information and adapt to its surroundings. Positive early experience is therefore vital to ensure children are ready to learn, ready for school and have good life chances.

It is shaped by a number of factors such as:

- Sensitive attuned parenting.
- Effects of socio-economic status.
- The impact of high-quality early education and care.

Healthy mothers and healthy babies.

Support parents to take care of their own health and the health of their babies.

- More support to help women look after their mental health in the period immediately before and after the birth of their child.
- Improve outcomes for mothers and babies by reducing domestic abuse.
- Reduce the proportion of women who smoke during pregnancy.

Parenting for a bright future: All young children given a strong foundation.

- Work with parents of young children to help them develop well and give them a healthy start in life.
- Reduce the variation across Calderdale in young children's school readiness.
- Reduce the proportion of 4-5 year old children who are overweight or obese.

	PHOF / fingertips indicator	Year	Rate	Calderdale	England
Infant Mortality	4.01 Infant Mortality	2015-17	Rate per 1000	5.1	3.9
Expected development aged 2-2 ½	Percentage of children at or above expected level of development in all five areas of development at 2-2½ years	2017-18	%	Not available	83.3
Children achieving a good level of development at the end of reception	1.02i – School Readiness: the percentage of children achieving a good level of development at the end of reception	2017 -18	%	70.0	71.5
Healthy weight reception	Reception: Prevalence of healthy weight	2015-17	%	73.8	76.6

Developing Well

The well-being of our children and young people is vital if they are to become active participants in society, their communities and their families.

Evidence shows that well-being in children and young people has a wide range of social and personal benefits. These include; positive mental health, social connection, and a reduction in the likelihood of victimisation and involvement in risky behaviours. Increasing the level of well-being will ensure that young people growing up in Calderdale have a good childhood, and positive life chances.

Good mental health and wellbeing for children and young people.

We will:

- Address the wider causes of poor mental health in children and young people, including domestic abuse, and support those who are experiencing mental health problems.
- Address commonly experienced issues, such as bullying, which have a negative impact on children and young people's mental wellbeing.

Parenting for a bright future: Children and young people equipped to become healthy and successful adults.

We will:

- Support parents to help children and young people develop well and give them a healthy start in life.
- Improve life chances for our most disadvantaged children and young people, especially those looked after by the Council.

  Help children and young people to adopt healthy lifestyles (including developing an understanding of healthy and safe relationships, and improving levels of physical activity), which will reduce their risks of experiencing health problems in later life.
- Reduce the proportion of 10-11 year olds who are overweight or obese.

	PHOF / fingertips indicator	Year	% or Rate	Calderdale	England
Healthy weight year 6	Year 6: Prevalence of healthy weight	2017-18	%	63.1	64.3
Emotional wellbeing	eHNA % year 7 and 10 pupils with high life satisfaction (assessed as "thriving" on Cantril's ladder of life scale)	2018	%	65	N/A
	eHNA % year 7 and 10 pupils with low self esteem	2018	%	19	N/A

Living and Working Well

Good health and well-being for people of working age, and enabling people to work longer in good health are important.

Exercise and an active and healthy lifestyle can work wonders for both physical and emotional wellbeing, whatever your age, health status, ability or gender. An individual's health is shaped by their workplace cultures and values, and the increase in mental health conditions is taking place in the context of increasing stress within the workplace and life in general. The negative effects of unemployment on health and mortality are well documented. The effects of a positive working-life, and supporting people to return to work are important, and link closely to the aspiration in our Inclusive Economy Strategy.

Good mental health and wellbeing for working age adults.

We will:

- Address the wider causes of poor mental health and support people who are experiencing mental health problems to recover or manage their condition.
- Tackle homelessness and housing issues and their underlying causes.

Healthy lifestyles for working age adults.

We will:

- Reduce avoidable disability and premature deaths by designing our environment to help people adopt more healthy lifestyles.
- Increase the proportion of working age adults who achieve recommended levels of physical activity and reduce levels of overweight and obesity.
- Reduce the harm caused to health by smoking, alcohol and drug use among working age adults.
- Assist people with learning disabilities to live a fulfilling life as citizens in their own local community.

	PHOF / fingertips indicator	Year	% or Rate	Calderdale	England
Healthy life expectancy at birth	2.13i - Percentage of physically active adults	2017-18	%	68.4	66.3
Levels of physical activity	2.13i – Percentage of physically active adults	2017-18	%	68.4	66.3
Smoking prevalence	Smoking prevalence in adults (18+) – current smokers (APS)	2018	%	15.5	14.4
Alcohol-specific mortality	Alcohol-specific mortality (persons)	2015-17	Rate per 100,000	13.8	10.6
Wellbeing	Overall, how satisfied are you with your life nowadays? (APS survey ONS wellbeing index)	2017-18	Mean score on a scale of 1 to 10 with 10 being "completely satisfied"	7.59	7.69

Ageing Well

Health as we age is fundamental to our quality of life, allowing us to remain independent, to work or be involved in our local community and maintain social connections.

While people are living longer, the number of years lived in poor health and with disability are increasing. Aging does not necessarily decrease a person's ability to contribute to society: older people can and do make valuable and important contributions to society, and enjoy a high quality of life. Retirement is an increasingly active phase of life where people have opportunities to continue contributing to society by working longer or volunteering in their communities, enabling them to take personal responsibility for their own wellbeing by working, and looking after their health.

Older people remaining physically active and independent

We will:

- Enable people over 65 to remain physically active and we will reduce levels of frailty.
- Reduce hip fractures and injuries due to falls by people over 65.
- Support older people to regain their independence following a stay in hospital.

Good support in older age and end of life

We will:

- Enable people to live in their own homes for as long as possible and reduce social isolation in people aged over 65, ensuring good support and access to services for the rest of their lives.
- Work together to develop different kinds of accommodation for older people who need support to be as independent as possible.
- Improve the quality of our care homes and ensure people who live in care homes can access all the health services they need.
- Reduce preventable winter deaths of older people.
- Improve the support, care and quality of life of people with dementia and their family carers.
- Increase the number of people who die in their preferred place of death.

	PHOF / fingertips indicator	Year	% or Rate	Calderdale	England
Life expectancy at 65	Male	2015-17	Years	17.8	18.8
	Female	2015-17	Years	20.6	21.1
Social isolation indicator	1.18i – Social Isolation: percentage of adult social care users who have as much social contact as they would like	2017-18	%	53.7	46.0
Hip fractures	Hip fractures in people aged 65 and over	2017-18	Per 100,000	535	578
Excess winter mortality	4.15iv – Excess winter mortality deaths index (3 years, aged 85+)	Aug 2014 – July 17	%	29.3	29.3

Our distinctive Communities

Calderdale is made up of distinctive and different towns and communities. We will work with the people of our distinctive communities to keep them well and to develop and improve services with them in five localities through the Calderdale Cares programme.

We will take an asset-based approach, starting from people's strengths, not their deficits. And we will develop the assets in communities, rather than assuming formal health and care services as the first option.

Our distinctive localities are where we will plan the services for people when they need support. Council staff, NHS staff and third sector organisations will work together with local people to design services that will mean:

- Easier and faster access to a wider range of joined-up care options where people only have to tell their story once.
- Better outcomes based on what is important to people.
- Fewer trips to hospital as more services will be available in the community.
- More advice and guidance to help people make the right choices and manage their own health.
- Better access to local voluntary, cultural and community groups.
- More involvement in the design of care services.

We will identify the resources our organisations use in each locality, so that those resources can be moved around to get the best outcomes. And we will tackle health inequalities by moving resources to those areas that need them most.

A Kinder Service

All of the Wellbeing Strategy applies to all Calderdale people and seeks to maintain and improve their wellbeing. But, too often, addressing people's physical wellbeing has taken precedence over their mental wellbeing. We will seek to put that right by giving mental wellbeing parity with physical wellbeing. This will mean moving some resources to help prevent mental ill health and to provide more and different services for people with mental ill health.

Our Enterprising and Talented Staff

The Calderdale health and care system has fantastic staff who provide efficient and effective services to many people, whether they work in the NHS, for the Council or for third sector organisations.

We will continue to support our staff deliver efficient and effective services. Sometimes this will mean integrating services across different sectors and staff doing their jobs in different ways. We will develop an organisational development programme and training schemes that will support staff to do this and help ensure a supply of professional staff in areas where there are sometimes national shortages.

A resilient health and care system

The foundations of this Wellbeing Strategy are addressing the wider determinants of health and helping people make good choices. But services to help people when they are less well are also very important. The resources available to us as a system have reduced over the last ten years, meaning that we have to operate as efficiently as possible.

We will:

- Arrange Care Closer to Home services through an Alliance approach ensuring that the system works together towards achieving shared agreed outcomes.
- Develop digital solutions that allow the efficient sharing of information across organisations, but, just as importantly, allow service users and patients easy access to their own information, advice, support and to services.
- Some direct service provision will be delivered digitally.
- Develop an estates strategy that will allow the most efficient use of our land and buildings, including co-locating services wherever it is of benefit to patients and is more efficient.
- A Population Health approach will make sure that our system reduces health inequalities and make the most impact.
- It is our ambition through the Wellbeing Strategy to reduce the number of people who need care in hospital. When people do need care in hospital we will improve the quality of those services, including urgent care, through our Right Care, Right Time, Right Place programme.
- Details of the full range of activities being undertaken to deliver our Calderdale Cares Programme can be found on the CCG and Calderdale MBC websites. This includes a set of key enabling activities including; digitisation and workforce.

Who will do all this?

Services will be planned and delivered through Calderdale's five localities wherever possible. Only if that is not possible will they be arranged Calderdale wide or, exceptionally, at a sub-regional level, working on the principle of 'do it once' where possible.

- Our five Calderdale Cares localities will be the place where the needs of the local population and local services are planned and delivered.
- The Integrated Commissioning Executive, informed by the individual needs of our five localities, will produce and implement a strategic commissioning strategy, focussing on delivering better outcomes for Calderdale people.
- The Health and Wellbeing Board will be the place where this strategy is overseen in public and partner organisations are held to collective account for its delivery.
- The West Yorkshire and Harrogate Health and Care Partnership will maximise opportunities for services are planned when a sub-regional approach is better for Calderdale people than more local arrangements.

Role of Primary Care Networks

Primary Care Networks (PCNs) have a critical role in delivering the Wellbeing Strategy - building on the early successes of Calderdale Cares and the evolution of the five Calderdale localities.

The Health & Well-being Board believe that the following principles will support the continued strengthening of the work we do in our localities:

- Recognising the Well-being Strategy and Inclusive Economy Strategies as the health and wellbeing system's strategic vision.
- Fostering system support for the new PCNs, building on the approach set out in Calderdale Cares, and ensuring their success as a key part of our system architecture.
- Recognising the mutual dependency between PCNs and the broadest range of local partners and communities in improving the lives of local people.
- Ensuring we build on the specific expertise and skills which already exist within the broad range of organisations and communities across the health and wellbeing system.

CALDERDALE CARES

VISION 2024

#VISIONCDALE2024

8. Patient Story - Wendy Markey, Lead Upper GI Clinical Nurse Specialist – Member of the Cancer Board

To Note

9. Q1 Quality Report

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Quality Report Quarter 1 2019-2020
Author:	Anne-Marie Henshaw, Assistant Director of Quality and Safety
Sponsoring Director:	Ellen Armistead, Deputy Chief Executive and Director of Nursing
Previous Forums:	Quality Committee 2 September 2019

Actions Requested:
To note the content of the report.

Purpose of the Report

The purpose of the report is to provide an overview of assurances on quality for quarter 1.

The report is in addition to the monthly Integrated Performance Report which provides details of progress with CQUIN and quality indicators over time.

Key Points to Note

The report provides an overview of assurance mechanisms, a summary of progress to date and highlights areas where ongoing improvement work is taking place.

During quarter 1:

- The fist bi-annual report on external agency visits, inspections and accreditations was received by Quality Committee.
- 9 serious incidents were reported to the commissioners. 5 serious incident investigation reports were submitted to commissioners. This is in line with previous quarters.
- Progress has been made across all three Quality Account priorities.
- The assurance framework for managing and monitoring Central Alerting System Patient Safety Alerts has been strengthened.
- 2 'must do' and 7 'should' actions from the 2018 CQC action plan are not yet embedded, these are areas of specific focus for the CQC Response Group. Progress is monitored on a monthly basis via the 2019 - 2020 Exceptions CQC Action Plan and the CQC Response Group.
- A new Trust CQC intranet resource centre has 'gone live'.
- A Quality Governance Review is planned to take place in Quarter 2 to inform further development and continuous improvement of trust quality governance arrangements.
- Further work will be done to refine quality and safety priorities, and the quality of reporting, going forwards.

EQIA – Equality Impact Assessment
Whilst the document does not have an adverse impact on equality, a gap has been identified in reporting how inclusive services are and further work has been identified to capture the views of people with protected characteristics about quality.
Recommendation
Board of Directors are asked to: − Note the content of the report and quality improvement actions being taken. − Note that a Quality Governance Review is planned to take place in Quarter 2 to inform further development and continuous improvement of trust quality governance arrangements.

1. Introduction

This report provides an overview of assurances on quality for quarter 1 for the Trust Board covering each of the following areas:

- Summary of assurances on quality presented to the Board of Directors.
- Summary of assurances on quality presented to Quality Committee.
- Update on Care Quality Commission Inspection Response and Preparation.
- Update on quality account priorities.
- Summary of NHS Quest Experience Day.

The report is in addition the Integrated Performance Report which is published monthly and provides an overview of all Trust quality, safety and performance indicators over the year including CQUINs and workforce information.

2. Summary of assurances on quality presented to Board of Directors

During quarter 1 three quality assurance reports were received by Board of Directors (Table 1).

Table 1: Summary of assurances on quality presented to Board of Directors 2019-2020 Quarter 1.

Assurance Type	Title	Summary
Patient Story	Living with decompensated liver disease – patient story.	A patient story was presented by a patient with decompensated liver disease. Patients with decompensated cirrhosis develop many serious and life-threatening symptoms and complications. The patient shared his experience of the pathway and the positive impact this was having on his life and wellbeing.
Audit	Thematic analysis of learning from structured judgement reviews (SJR).	The report provided learning from the thematic review of SJRs completed between August 2017 and July 2018. Areas of good practice and priorities for improvement were identified. Board of Directors were advised that learning would be shared with Clinical Divisions through Patient Safety & Quality Boards, and that quality improvement would be monitored through the Clinical Improvement Group during 2019-2020.
Progress report	Quarterly Report from the Director of Infection Prevention and Control (IPC) 2018-2019 Quarter 4	The report provided an update on key IPC performance and quality indicators during Q4. To note: − C.difficile objectives met. − 2 MRSA bacteraemia during 2018/19 − Flu CQUIN achieved.

3. Summary of assurances on quality presented to Quality Committee

Quality Committee provides assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care. The Committee meets monthly and is responsible for ensuring that the risks associated with the quality of the delivery of patient care are managed appropriately.

During quarter 1 the following assurances on quality were received by the Quality Committee:

3.1 External Agency Visits, Inspections and Accreditations

Quality Committee received the first bi-annual report on external agency visits, inspections and accreditations. The report outlines the outcome of quality assurance visits that took place during 2018-2019 Quarter 3 and 4 and provides a summary of forthcoming quality assurance visits. Work continues to promote the trust External Agency Visits, Inspections and Accreditations Policy to ensure colleagues are fully supported to prepare for and manage visits, and that governance processes to provide assurance about progress against any actions or gaps identified are robust.

Table 2: External agency visits, inspections and accreditations 2018-2019 Quarter 3 and 4.

Assurance Type	External agency visits, inspections and accreditations	Position Statement (Aug 2019) and Governance Arrangements
Accreditation	Imaging Services Accreditation Scheme	Accreditation awarded. No outstanding actions.
Accreditation	United Kingdom Accreditation Service (UKAS) ISO 15189 Cellular Pathology	Action plan completed. Evidence cleared by UKAS. Accreditation awarded.
Accreditation	UNICEF UK Baby Friendly Initiative (BFI) Accreditation	Awarded.
Accreditation	UNICEF UK Baby Friendly Initiative (BFI) Accreditation GOLD Award	Awarded with commendation.
Regulatory	Audit of Aseptic Services	Complete and action plan in place DATS PSQB
Accreditation	Microbiology UKAS ISO 15189	Action plan in place and progress. Pathology Governance Board and DATS PSQB
Regulatory	Trust Human Tissue Act (HTA) Inspection	Action plan in place and progressing Pathology Governance Board and DATS PSQB
Advisory	Getting It Right First Time (GIRFT) – Radiology Deep Dive and department tour	Awaiting Report. DATS PSQB
Accreditation	Blood Sciences UKAS 15189	Accredited All actions cleared
Regulatory Inspection	CQC & OFSTED special education needs & disability (SEND) inspection	Report received and now action planning FSS PSQB CQC Group
Invited Service Review	Respiratory Services – Invited Service Review	Final report received August Factual accuracy checking in progress. Medicine PSQB

Table 3: External agency visits, inspections and accreditations 2019-2020 Quarter 1.

Assurance Type	External agency visits, inspections and accreditations	Position Statement (Aug 2019) and Governance Arrangements
Accreditation	National accreditation process for Occupational Health Services in public and private sectors	Awaiting update
Peer Review	Diabetes Peer Review Royal College of Paediatrics and Child Health (RCPCH)	Letter received by Trust Action plan in progress FSS PSQB
Quality Assurance Visit	Quality Assurance visit from LTHT Fertility Service to Yorkshire Fertility.	Awaiting letter Action plan in progress FSS PSQB
Accreditation	CHKS Children's Services 1st surveillance visit	Accreditation maintained

3.2 Serious Incidents

Quality Committee receives a monthly serious incident report from the Risk Team which summarises new serious incidents reported to commissioners, learning from serious incident investigations and risk assessment of any outstanding serious incident actions.

During quarter 1 the Risk Team has undertaken a deep dive to evaluate the level of risk presented by the outstanding actions. This evaluation is based on available evidence, knowledge of the case and on historical knowledge of similar incidents and their impacts. The risk profile of outstanding actions is being assessed and agreed in consultation with Divisions allowing for prioritisation and specific focus on delivery of actions to mitigate high risk.

Sharing learning from serious incidents is a key focus of the Serious Incident Review Group (SIRG) which meets once a quarter. Following discussion at quarter 1 SIRG, the risk management team have worked with divisional colleagues to refine the serious amend the learning summary template to provide more prompts to support discussion around cases and learning.

During quarter 1:

- 9 serious incidents were reported to the commissioners.
- 5 serious incident investigation reports were submitted to commissioners.

Table 4: Serious incidents reported to commissioner Quarter 1.

Serious Incident Type	Number
Slips/trips/falls meeting SI criteria	1
Treatment delay meeting SI criteria	5
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2
Sub-optimal care of the deteriorating patient meeting SI criteria	1

Table 5: Examples of learning from serious incident investigations during Quarter 1.

Description of incident	Learning
Category 4 pressure ulcer - The patient developed an unstageable pressure damage to the heel as a result of a long leg back slab cast that was in situ for 17 days and subsequent category 4 damage to the Achilles area contributed to by equipment (a splint) and likely insufficient assessment of the area.	The investigation found a lack of multidisciplinary working which led to a failure to put in place a comprehensive and clear plan of care. A red band system for patients with POP (plaster of Paris) and at high risk of pressure damage is being introduced. Care plans for external devices and POP are being updated. Care of Casts leaflets are to be standardised, and a policy for pressure ulcer management under casts/external device guideline/policy is to be developed.
Suboptimal care of the deteriorating patient - identification and management of sepsis	Ensure staff are aware of sepsis policy and the triggers for sepsis and importance of early intervention. Ensure staff escalate when unable to obtain IV access and consider alternate routes of accessing blood such as femoral stab. Recognise the importance of communication including handovers, referring to other teams and recording in EPR and the use of the SBAR tool.

3.3. Safeguarding Committee Annual Report 2018-2019

The 2018- 2019 Safeguarding Committee Annual report is the 6th Annual report and provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust. The report demonstrates that safeguarding children, young people, families and vulnerable adults remains a Trust key priority. It demonstrates that CHFT is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework. Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2019-20. These may change in line with other Trust priorities and the wider partnership priorities.

3.4 Schwartz Rounds

The Quality Committee received an update on progress with Schwartz Rounds. Two Schwartz Rounds have been held to date. The first was held at Huddersfield Royal Infirmary with the topic 'A patient I will never forget', the second at Calderdale Royal Hospital with the theme 'The day I made a difference'.

In total 37 colleagues attended the two sessions across a variety of staffing groups ranging from Doctors, Nurses, Healthcare Assistants, Chaplains, Psychologists, Administration and Clerical, Managers and Board members. Both Rounds were extremely well received with attendees identifying the following:

- 83% felt the stories presented by the panel were relevant to their daily work
- 94% identified they have a better understanding of how their colleagues feel about their work
- 94% intend to attend a future Schwartz Round
- 100% would recommend Schwartz Rounds to colleagues.

The next Schwartz Round will be held on Monday 30 September, 12.00hrs to 13.30hrs in the

Learning and Development Centre, CRH. The theme is ‘In at the deep end’.

3.5 Medication Safety and Compliance Group

The Medication Safety and Compliance Group ensure that medicines are managed in a safe manner throughout the Trust and that risks in relation to medicines are controlled. The group reviews current medication issues and concerns, and implements actions to be taken to reduce risk and maximise patient safety. The Medication Safety and Compliance Group meets monthly, reporting to Quality Committee on a quarterly basis.

During quarter 1, the Medication Safety and Compliance Group escalated to the Quality Committee:

- Some progress with improving standards of medication safe storage and administration across all clinical areas (including controlled drugs) – action plan in place, managed by the CD Sub Group reporting to the Medication Safety and Compliance Group.
- An update on safe prescribing and use of Gentamicin. A change in the antibiotic prescribing policy as part of the national drive to reduce the use of broad spectrum antibiotics/ incidence of C Diff, has increased the prescribing of gentamicin. There has subsequently been an increase in Datix incidents due to incorrect prescribing and monitoring of gentamicin. The Antimicrobial stewardship team have reviewed these incidents and developed an action plan to support prescribers with the safe use of this drug.
- Review of previous medication National Patient Safety Alerts. Work has been done in pharmacy and the Trust risk team to prioritise medications audits in order to assess embeddedness and ongoing compliance with these alerts.

3.6 Patient Experience and Caring Group

The Patient Experience and Caring Group (PEG) oversees and monitors the implementation of Patient Experience initiatives within the Trust. PEG meets on a monthly basis and reports to Quality Committee quarterly.

During quarter 1, PEG updated Quality Committee on the following quality initiatives:

Table 6: PEG Patient Experience Initiatives update to Quality Committee Quarter 1.

Title	Summary
Mencap - Treat Me Well Campaign	CHFT are in the first phase of this campaign which aims to transform how the NHS treats patients with a learning disability in hospital. A co-designed survey has captured feedback form 85 people with a learning disability locally. Things to improve include better communication – raising awareness of VIP passports and the matron role, and clearer information, particularly in appointment letters.
Learning disability care NHSI improvement standards	In October 2018 CHFT was the first Trust to pilot the NHSI improvement took kit. This allowed the Trust to benchmark itself against the standards and action plan from this. Performance against the standards was: Respecting and protecting Rights (70%), inclusion and engagement (90%), workforce (58%). Five main areas have been identified for improvement - checks and support for patients on waiting lists; responding to mortality reviews; improving staff knowledge and skills, making reasonable adjustments, supporting the national LD mortality review
Learning from complaints	Top subjects of complaints remain clinical treatment, communications, appointments, patient care, staff behaviour / values. A recent positive change in practice is being shared to demonstrate the importance of putting the patient first when considering the issues raised in a complaint: a baby had a tendon release procedure without anaesthetic. Although, there is no best practice established or NICE guidance, it was recognised that a SOP was needed to avoid the distress occurring again. This showed that the impact was recognised, and a service improvement has been made
Dementia café (Butterfly lounge)	The café opens each Wednesday, supported by Age UK and run by the Prevention of Delirium team. This is part of the Trust's *Dementia strategy* to develop a dementia friendly environment, which has some common priorities with the *Elderly care strategy* such as communal dining, relatives bringing in personal possessions / familiar items, wearing clothes rather than nightwear during the day.
Local patient surveys	PRASE survey (Patient Reporting and Action for a Safe Environment)remains the main survey used in addition to the national surveys and FFT. A sub-group will review if this is the most effective means of capturing structured feedback.
Risk regarding suitable facility for changing places and safe space (learning disability patients)	Unable to find a suitable area for changing facilities on either site - remains on the risk register and Matron for Estates aware, to be considered in line with any new builds or reconfiguration of services; No safe space/quiet area identified (proposed for Acre Mill site), due to capacity.

3.3 Divisional Patient Safety and Quality Board (PSQB) escalation to Quality Committee

Divisional Patient Safety and Quality Boards provide assurance to the Divisional Board and the Quality Committee that there is continuous and measurable improvement in the quality of the services provided and that the risks associated with its activities are managed appropriately. The PSQB is responsible for monitoring the implementation of the Trust's quality improvement priorities, in addition to the ongoing monitoring of compliance with national standards and local requirements applicable to the Division. PSQBs meet monthly and report to Quality Committee on a quarterly basis.

During quarter 1, Divisional PSQBs made the following escalations about quality of care to the Quality Committee:

Table 6: Divisional PSQB escalations to Quality Committee quarter 1.

Division	Escalation to Quality Committee
Community Healthcare	Central Operations has been incorporated into the Community Division forming a new Division, the Community Healthcare Division. This is a welcomed development which will enable further streamlining of patient pathways whilst maximising and strengthening the out of hospital offer. It also represents the beginning of a significant journey with service integration at the heart of the agenda.
Families and Specialist Services	5 maternity cases have been referred to the Healthcare Service Investigation Branch (HSIB) during Q3 and Q4 (none in Q1). Investigations are ongoing, no final reports have been received. HSIB investigate: Eligible babies include all term babies (at least 37+0 completed weeks of gestation) born following labour, who have one of the below outcomes: − Intrapartum stillbirth − Early neonatal death − Severe brain injury Maternal deaths of women while pregnant or within 42 days of the end of pregnancy.
Medicine	The Acute Floor at Calderdale has been shortlisted in 2 categories of the HSJ Patient Safety awards. Integrated Medical Specialities Directorate have embedded 2 hour turns on the stroke wards following 2 recent hospital acquired category 3 pressure ulcers. No further category 3 pressure ulcers reported following implementation.
Surgery and Anaesthetics	Critical Care has continued to work through the Must and Should Do actions following the CQC (Care Quality Commission) visit. Good progress has been made against most elements. The outstanding action regarding medical staffing has now been completed. Orthopaedics - Spinal surgery continues to be delivered on the CRH site. The team are measuring the patient experience and their outcomes; feedback remains positive. General & Specialist Surgery - Surgery School started for colorectal patients, which is an enhanced recovery programme for patients.

3.4 Patient Safety Group

The purpose of the Patient Safety Group (PSG) is to champion and embed a patient safety culture and demonstrate continuous improvement in patient safety within CHFT. It is responsible for providing the Quality Committee and ultimately the Board with assurance concerning all aspects of the delivery of safe, reliable, high quality and compassionate care for patients. PSG meets monthly and reports to Quality Committee on a quarterly basis.

During quarter 1, PSG made the following escalations to Quality Committee.

Table 7: PSG escalations to Quality Committee during quarter 1.

Title	Escalation to Quality Committee
Compliance with Central Alerting System Alerts	The Patient Safety Group is responsible for ensuring compliance with NHS England Patient Safety Alerts. PSG has reviewed trust process from receipt to closure of patient safety alerts and implemented more robust monitoring of actions and action plans. A retrospective review of all Central Alerting System Patient Safety Alerts has been undertaken to ensure that any outstanding actions have been completed. The Central Alerting System alert actions have been included in the 2019/2020 Trust audit programme to test ongoing compliance with alert actions.
Improved Governance Arrangements for Outstanding Serious Incident Actions	A review of outstanding serious incidents (SI) and Orange action plans has been undertaken by the Risk Team to identify commonality between actions across investigations and across divisions. This will allow for a collective response to management of multiple actions and positively impact closure of incidents and risk mitigation. As part of this review, the categorisation of type of action has been assessed, with those actions recorded as 'other' being re-categorised into the appropriate type; this category will be monitored over the next 6 months to ensure it is used by exception. Robust data quality will allow for better analysis and risk profiling of actions and ensure collective analysis captures all relevant entries.
Update from Pressure Ulcer Collaborative	The Pressure Ulcer Collaborative continues to work across all Divisions to reduce the incidence of pressure ulcers, improving data quality and attribution decisions, education and practice. During Quarter 1 the collaborative has implemented a new decision support tool to justify and evidence rationale to refer to gateway to care, and the PUSH (pressure ulcer safety huddle tool) for rapid review within 48 hours.

4. Update on Care Quality Commission Inspection Response and Preparation

In July 2019 Board of Directors received the quarter 1 update on delivery of the Trust's response to the 2018 CQC report, future improvement work, preparation for our next CQC inspection and CQC engagement activities from the CQC Response Group. The CQC Response Group meets monthly and is responsible for ensuring there is a timely and effective response to the issues raised as part of the CQC inspection process, and that preparation for our next CQC inspection is robust.

By 31 March 2019, evidence received by the CQC Response Group confirmed that 49 actions (4/9 'must do' and 45/54 'should do') had been completed and embedded in the relevant core service areas. This recommendation was supported by the April 2019 Quality Committee. At the end of quarter 1, a further 3 'must do' and 2 'should do' had been completed and embedded in relevant core service areas. 2 'must do' and 7 'should' are not yet embedded, these are areas of specific focus for the CQC Response Group. Progress is monitored on a monthly basis via the 2019 - 2020 Exceptions CQC Action Plan and the CQC Response Group. Board of Directors were briefed that 2 'must do' actions remained incomplete pending further consideration of the quality and financial impact of the CQC actions. Both actions are on the Trust risk register and the CQC relationship team are kept fully briefed on progress and trust quality and safety monitoring across these areas:

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

During quarter 1 CQC colleagues attended the following as part of their engagement programme of activities:

- Visit to Critical Care (CRH and HRI).
- Quality Committee June 2019.
- Patient Safety Group May 2019.

Our programme of internal and external peer reviews has commenced. The purpose of the peer reviews is to revisit CQC actions and test out whether actions are embedded and consistently showing evidence of sustained improvement, as well as assessing services against the CQC 5 domains and relevant regulatory requirements and standards. Where possible, reviewers from 'outstanding' organisations have been invited to collaborate with trust colleagues to share learning and improve standards.

A Quality Summit facilitated by Creative Connections was held on 18 April 2019. Colleagues from commissioning, partner organisations, the CQC and the trust joined together in a series of metavisioning exercises which took a creative approach to how we can work together to achieve our ambition of providing outstanding, compassionate care to the communities we serve and our colleagues. Colleagues from a range of core service areas presented posters celebrating and sharing achievements; excellent feedback was received from all attendees about the opportunity the event created to think differently about the potential our individual and collective contributions would make to bring about a change in culture to embed outstanding, compassionate care.

Figure 1: Output of April 2019 Quality Summit

A new CQC intranet resource centre has 'gone live'. This can be accessed at https://intranet.cht.nhs.uk/non-clinical-information/chft-cqc-homepage/

5. Update on quality account priorities

Each year the Trust works on a number of quality priorities. Last year the Trust identified three projects to be highlighted as key priorities for 2019-2020:

- Priority One: Clinical outcomes linked to waiting times in the Emergency Department (SAFE).
- Priority Two: Deteriorating Patients - ensuring that the new national guidance around observations for deteriorating patients (NEWS2), National Early Warning Scores, is implemented and understood by frontline staff to ensure effective and reliable care is given at all times.
- Priority Three: Mental Health in the Emergency Department - Improving psychological and social support for mental health patients in the Emergency Department.

An BRAG[1] rated update on progress with each quality priority at the end of quarter 1 is provided below:

Table 8: Priority One: Clinical outcomes linked to waiting times in the Emergency Department (SAFE).

Action	Quarter 1 Update- BRAG Rated
To reduce the number of patients waiting over 8 and 10 hours we will review all the clinical rotas to ensure we have the right number of appropriately trained staff to meet the demand.	All clinical rotas and workforce models have been reviewed. All nursing vacancies have been recruited to with staff coming into post during Quarter 2. 2 new Consultants have been appointed which means that from October 2019 the enhanced Consultant rota will 'go live' providing additional senior decision making and clinical supervision in the evening. Housekeeper vacancies have been filled, and colleagues are in the process of completing their induction programme.
As part of this we will have clear escalation protocols for the teams, explaining how to request support when patients are experiencing delays in their pathways.	Escalation protocols have been reviewed and strengthened.
We will work to embed the Trust action cards, which are Trust agreed rules to ensure patients receive timely specialty reviews, transfer to the ward and are treated in the most appropriate environment for their care, to ensure patients are transferred to the next location in their journey (e.g. the ward) as soon as possible.	There is some variability between speciality to speciality about how the action cards are used and so the Emergency Department General Manager is leading work to ensure consistent application across all areas.

Summary of progress:
Waiting times for patients in Quarter 1 are worse than those experienced in 2018-2019; improvement actions have been implemented.

[1] BRAG Rating explained:
Blue – action complete and evidence action./ improvement embedded
Green – action complete, embeddedness to be tested
Orange – work ongoing, in line with timescales
Red – work failing or faltered// not within timescales

A and E 4 hour target - No patients waiting over 6 hours	National Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	QTR 1
2018/19		562.00	408.00	302.00	534.00	469.00	629.00	632.00	602.00	733.00	792.00	574.00	335.00	6572.00	1272.00
2019/20		638.00	395.00	529.00										1562.00	1562.00
A and E 4 hour target - No patients waiting over 8 hours		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**	**QTR 1**
2018/19		238.00	159.00	82.00	224.00	173.00	230.00	215.00	212.00	273.00	314.00	226.00	127.00	2473.00	479.00
2019/20		249.00	129.00	229.00										607.00	607.00
A and E 4 hour target - No patients waiting over 10 hours		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**	**QTR 1**
2018/19		103.00	61.00	26.00	104.00	61.00	79.00	59.00	62.00	109.00	127.00	59.00	48.00	898.00	190.00
2019/20		125.00	53.00	94.00										272.00	272.00

Table 9: Priority Two: Deteriorating Patients

Action	Quarter 1 Update – BRAG Rated
Embed the changes needed within Nervecentre and the electronic record, EPR, to allow the NEWS2 score to be recorded.	Action complete, changes needed within Nervecentre and EPR have been made and NEWS 2 is embedded
Support all clinical colleagues to access the online e-learning training for NEWS2	Action complete and ongoing with new members of staff.
Revise the escalation policy with respect to raised NEWS	Action complete
Facilitate additional training of nursing staff to ensure that physiological observations are timely and of high quality	Action complete.
Review and evaluate the use of the Confusion score and support any training required.	Action continues.
Analyse outcome data from patients with raised NEWS	Action continues.

Summary of progress:
All areas that record patient physiological observations through Nervecentre continue to do so with all NEWS2 results visible within the EPR. Implementation was without any particular difficulties once the technologies were realigned. All adult physiological observations now include a Confusion score as part of their routine set of observations. In line with this the escalation policy has been revised, agreed and published on the intranet. There will need to be further evaluation of NEWS2 and outcome data from patients with raised NEWS (including the Confusion score) in 2019/20.

Table 10: Priority Three: Mental Health in the Emergency Department - Improving psychological and social support for mental health patients in the Emergency Department.

Action	Quarter 1 Update – BRAG Rated
Improve the environment for high risk patients in the Emergency Department, requiring a ligature free environment, by now having a ligature free room on both sites.	A ligature free room has been created in both Emergency Departments. SWYFT have assisted the Trust to review environmental risks and all straightforward changes recommended have been made. A further review has been completed by SWYFT and the report is awaited.
We will ensure staff have access to the best guidance on how to appropriately support and manage the patients requiring access to these rooms by using a clear standard operating procedure to guide staff on using these rooms with patients.	Staff training and education programme being developed. New SOP available on intranet to support care assessment and decision making.
Funding support received from commissioners to have a mental health nurse on site 24/7 to provide 1:1 support to mental health patients in the emergency department.	Funding has not continued as the scheme had limited success; cover was ad hoc as in reality it was not possible to fill the post or vacant shifts via Bank so shift fill was low and there

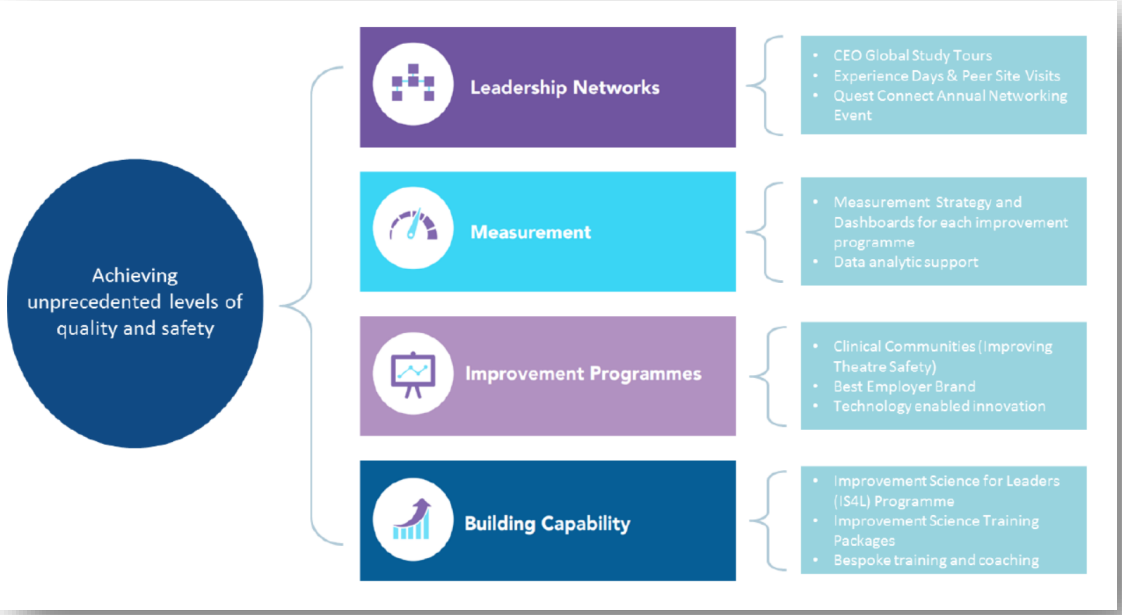
	was minimal impact on patient experience.
Continue to work with the mental health liaison team to ensure timely review and care planning for mental health patients.	Work continues; the mental health liaison team are core members of the trust Mental Health Strategy and Operations group.

Summary of progress:
Progress is being made across all four actions, led by the Emergency Department Quality Improvement Group.

7. NHS Quest Experience Day

In April the trust hosted an NHS Quest Experience Day. NHS Quest is a member-convened network for NHS Trusts, who focus relentlessly on improving quality and safety. The aim is to develop an optimistic and compassionate culture for our workforce, in order to reliably deliver the best possible care.

Figure 3: NHS Quest Mission



Colleagues from NHS Quest trusts around the country joined together in Acre Mill to network and consider 'Leading as peers – humility to lead and courage to follow'. The event provided opportunity to:

- Highlight and learn from innovations, stand out improvements and new ways of working within member organisations.
- Bring together peers face to face to share learning, exchange ideas, debate different approaches and observe results on the ground.
- Get 'beneath the surface' of improvements to understand what works and why.
- Bring collective know-how to bear on common problems and thorny issues.
- Inspire new ways of thinking and doing within member organisations.

8. Next Steps and Recommendations

- Board of Directors are asked to note that a Quality Governance Review is planned to take place in Quarter 2 to inform further development and continuous improvement of trust quality governance arrangements.
- Board of Directors are asked to note the content of the report and quality improvement actions being taken.

10. Safeguarding – Adults and Children Annual Report

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	SAFEGUARDING ANNUAL REPORT 2018 - 2019
Author:	Lindsay Rudge, Deputy Chief Nurse Vicky Thersby, Head of Safeguarding
Sponsoring Director:	Ellen Armistead, Director of Nursing
Previous Forums:	Safeguarding Committee Meeting 9th April 2019 Quality Committee Meeting 29th April 2019

Actions Requested:
To approve

Purpose of the Report

This report is the 6th Annual Report and provides overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated.

The Safeguarding strategy as part of this report will describe priorities for 2019-20.

Key Points to Note

- All statutory posts for Safeguarding Adults and Children are in place and have been throughout the year. The Designated Nurse for Children Looked After (Calderdale) retired in June 2018 and as part of new arrangements supported by Public Health and the CCG the functioning and arrangements of the Children Looked After Team in Calderdale was reviewed. The previously commissioned Designated role is now absorbed into the Designated role for Safeguarding Children of which is part of the CCG Governance arrangements.

- Adult safeguarding has noted an increased awareness of safeguarding adults and how to report into the procedures; and a reduction of safeguarding referrals and concerns made against CHFT. The largest category of abuse identified under the 'neglect' heading related to discharge from hospital; we are continuing to be involved in discharge improvement work.

    - The Adult Intercollegiate Document has been published which puts adult safeguarding training on a statutory footing. This will be reviewed and implemented this year.

    - Significantly improved the quality of DoLS submitted; only 33% of referrals required some minor amendments; wards are now completing their own authorisations.

- The Mental Capacity (Amendment) Bill was introduced to the House of Lords on 3rd July 2018 for its first reading, following a law Commission consultation in 2017. The Amendment Bill received Royal Assent and became law on the 17th May 2019. No start date for the Liberty Protection Safeguards (LPS) has been announced and this will be decided by the Secretary of State for Health and Social Care at some point in the future. There will be key changes to note:

    - that Hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager.
    - Referral pathways and authorisation process will need to be considered.
    - Staff will need to be trained and aware of what the new Liberty Protection Safeguards constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP).
    - CHFT will need to await the agreement to the Bill and Royal Ascent. The MCA and DoLS Codes of Practice will be revised and remain as separate documents.
    - A more detailed report to Board of Directors as the Bill and Codes of Practice develop will be produced. Consideration of the impact of changes and introduction of training, processes and authorisations with the planned new system, and CHFT as a responsible body who will authorise applications will need to review its resources to implement the new scheme.

- The Partnership arrangements between SWYPFT and CHFT for Mental Health has been reviewed; including the Service Level Agreement, the scheme of delegation and the joint clinical working protocol.
    - Processes for use of the MHA sections has been agreed and in place. We have noted a small increase in the number of section 5(2) this year.

- Level 3 Children training has been updated in line with 'Working Together 2018'. Level 1 and Level 2 are outstanding ESR packages that require completion in line with this document. This is statutory guidance for multi-agency working.

- The Intercollegiate Document published in 2019 required the Trust to ensure its staff have the competencies to recognise child maltreatment, opportunities to improve well-being and take effective action as appropriate to their role. This document provides a clear framework that identifies the competencies required for all health-care staff. This requires reviewing this year.

- The FGM Information Sharing System (FGM-IS) has been successfully embedded in Maternity since 30.11.18 with a new process of adding a flag to the record of the female child born to a survivor of FGM. This has also been backdated to 2015 when the data collection commented. This system will generate a flag onto the record if a child or young person attends who is at risk of FGM.

- CHFT has been awarded the West Yorkshire Domestic Abuse Quality Mark; awarded when there is consistent and high-quality service provision to women, children and men affected by DA. CHFT have now been awarded this at Level 2 (Safety, Good Practice, Routine and Triggered Enquiry and Policies) for three years.

- The Domestic Abuse (DA) Health Service which is in Calderdale Domestic Abuse Hub in the Police station. This service has now been awarded recurrent funding and a permanent contract is now on place for the Specialist Advisor for DA.

- There has been a reduction in the number of referrals by Maternity Services to MARAC in Kirklees and DA Hub in Calderdale along with a significant increase by ED; the reduction in the number of incidents of DA incidents has decreased significantly. A deep dive into this data is currently been commissioned along with an audit.

- Calderdale has secured funds to provide a domestic abuse support worker role to work into Calderdale ED. This is in the very early stages of development, but it is hoped that the role will mirror the IDVA service CHFT has at HRI.

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

- The team ensured sufficient level 3 training places provided and additional sessions facilitated by the team for non-compliant staff and those likely to come out of compliance in 2018-19; but despite non- attenders at training sessions; the predicted target of 95% compliance of all levels has not been met by March 2019. The Overall safeguarding compliance has increased from 91.2% to 93.63%

- There has been a total of 19 requests this year for information relating to children and adults from the safeguarding Boards and Domestic Abuse Partnerships; this is an increase of 6 from last year's 13 requests.

- There are outstanding actions that relate to Kirklees Children's and Children Looked After CQC Inspection (January 2018).

- Ofsted Inspected Calderdale Metropolitan Borough Council last November – there overall effectiveness was rated as Good.

- Ofsted SEND Inspection in March 2019 – Report due to be published in May 19.

- Ofsted have continued to monitor progress since the Kirklees Ofsted Inspection in 2016 and a re-inspection is likely shortly in Kirklees.

- Changes noted in 'Working Together 2018' has led to the CSCB becoming the Calderdale Safeguarding Children Partnership. This change follows the Department for Education's Working Together to Safeguard Children report from July 2018 which introduced Safeguarding Children Partnerships to replace local Safeguarding Children Boards across the country. Calderdale area was one of 17 in the country to become an 'early adopter'.

FUTURE IMPROVEMENT WORK: (Next steps)

Our safeguarding Strategy and Plans for 2019-2010 is identified at the end of the report.

EQIA – Equality Impact Assessment

This safeguarding report does not impact on any of the different protected groups, as defined in the Equality Act 2010. All safeguarding policies and procedures are reviewed in line with EQUIP guidance and refer to national, regional and local safeguarding guidance and legislation.

Recommendation

The Board is asked to approve the annual report and the Trusts Safeguarding Strategy for 2019/20 contained within the report.

Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding Annual Report

2018-2019

Foreword

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is committed to ensuring that safeguarding its patients, staff and the wider community is given the highest priority in all that the Trust does. Safeguarding work across the Trust is underpinned by CHFTs values by demonstrating our behaviours, known as our four pillars

- putting patient's first,
- we go see,
- we do the must-do's
- we work together to get results.

CHFT is committed to ensuring that safeguarding is part of its core business and recognises that safeguarding children, young people and adults is a shared responsibility and is seen as everyone's business. Effective multiagency partnership working across the Districts of Kirklees and Calderdale ensures that we work together to protect the most vulnerable in our society from harm. We work together to protect individual human rights, treat individuals with dignity and respect and safeguard from all forms of abuse and neglect.

During this challenging time we have used our existing resources to safeguard those most vulnerable, creating a culture of safeguarding as part of our core business and we continue to develop our digital systems to support and transform care.

Contents

INTRODUCTION

Safeguarding is a statutory responsibility of all NHS organisations as detailed under the Care Act (2014), and the Children Act (1989/2004). Legislation and guidance is built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children, families and adults at risk.

This is a combined Children and Adults Safeguarding Report that describes all areas of safeguarding activity. The report describes how the Children and Adults Team work together across the Trust and demonstrates to the Trust Board and external agencies how Calderdale and Huddersfield NHS Foundation Trust discharges its statutory duties in relation to:

- The Mental Health Act (1983)
- The Children Act (1989)
- The Sexual Offences Act (2003)
- Female Genital Mutilation Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11
- Domestic Violence and Victims Act (2004)
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- Registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety
- Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework (2013)
- Care Act (2014)
- Counter- Terrorism and Security Act (2015)
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (First Edition: August 2018)
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Fourth edition: January 2019)

The 2018-2019 Annual report is the 6th Annual report and provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated. The Safeguarding strategy as part of this report will describe priorities for 2019-20.

GOVERNANCE ARRANGEMENTS

The Executive Lead for Safeguarding Children and Adults is the Chief Nurse. The Chief Nurse is responsible for ensuring that there are robust and effective arrangements for safeguarding adults and children within CHFT. This responsibility is delegated to the Deputy Chief Nurse.

The Head of Safeguarding provides strategic support and direction to the governance and safeguarding arrangements within CHFT, and for ensuring systems and processes are robust and effective. The Head of Safeguarding is responsible for key safeguarding staff and reports directly to the Deputy Chief Nurse. CHFT is represented at the Local Safeguarding Adults and Children's Boards for both Calderdale and Kirklees. CHFT has active Local Safeguarding Board membership and attendance at the Domestic Abuse Boards for both Calderdale and Kirklees Local Authorities.

Designated Doctors employed by CHFT attend the Local Safeguarding Children Boards as part of their Designated role. The Trust attends the Local Child Death overview panel meetings with representation from the SUDIC Paediatrician and midwifery service.

The Named Nurses, Named Midwife and the Matron for Learning Disability attend the sub-groups of the local Safeguarding Boards and contribute to multi-agency collaboration and partnership working.

The key functions of the Local Safeguarding Boards are to develop and publish a strategic plan about how members and partners contribute, publish an annual report of the effectiveness of the Board, and commission Serious Practice Reviews and Serious Adult Reviews for any cases that meet the criteria.

The Safeguarding Team links closely with other key departments such as Risk and Governance, Human Resources, and also Patient Safety and Quality Boards within the Divisions.

The Safeguarding Committee reports directly to the Quality Committee and provides twice yearly updates. This has raised the profile and accountability of the Safeguarding agenda within the Trust and ensures lines of accountability are aligned within the Trusts governance structure and directly with the Trust Board.

Operationally the Safeguarding Committee has in place 3 sub-groups, Learning and Audit, Training and Policy, and Incident and Review Subgroup. Safeguarding Subgroups provided a forum to bring together key senior professional and operational managers. Within the subgroups the terms of reference describe accountability for reporting, escalating and assurance. Each subgroup communicated with the other where there were shared agendas. The individual Groups reported directly to the Safeguarding Committee and supported the Chief Nurse in discharging their responsibilities in relation to safeguarding and strengthening accountability. Attendance at the sub groups has been revised to promote attendance from across the organisation and a decision has been made at the safeguarding Committee to merge the work streams from the individual sub groups to form a safeguarding operational sub group.

All statutory posts for Safeguarding Adults and Children are in place and have been throughout the year; these comprise of the

- Named Nurses for Safeguarding Children
- Named Nurse for Looked After Children,
- Named Professional and Specialist Advisor for Adults,
- Named Midwife and the Named Doctor.

- The Designated Nurse for Children Looked After (Calderdale) retired in June 2018 and as part of new arrangements supported by Public Health and the CCG the functioning and arrangements of the Children Looked After Team in Calderdale was reviewed. The previously commissioned Designated role is now absorbed into the Designated role for Safeguarding Children of which is part of the CCG Governance arrangements.
- CHFT hosts two Designated Doctors for Safeguarding Children, and two Designated Doctors for Looked After Children.

The Safeguarding Team play a pivotal role in supporting colleagues within CHFT and the wider multidisciplinary arena in carrying out their safeguarding responsibilities. Work has continued with other partner agencies across Kirklees and Calderdale to ensure CHFT is discharging its statutory responsibilities.

PREVENT

The Counter-Terrorism and Security Act (2015) places a duty on CHFT to have; 'due regard to the need to prevent people from being drawn into terrorism.'

CONTEST is the UK national counter-terrorism strategy, and one of the elements of it is Prevent, which aims to stop people becoming terrorists or supporting terrorism. The NHS is a key strategic partner in the PREVENT work stream, as it is recognised that healthcare professionals may meet and treat people who are vulnerable to radicalisation.

The Act with relevance to PREVENT includes a duty on specified bodies, including the police, prisons, local authorities, schools, universities and health, to have due regard to preventing people being drawn into terrorism. It also makes Channel (the voluntary programme for people at risk of radicalisation) a legal requirement for public bodies so that it is delivered consistently across the country.

The Statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015 became statute on 1 July 2015. The Counter-terrorism strategy has several strands:

- Pursue - to disrupt terrorist activity and stop attacks;
- Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities;
- Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack;
- Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence. The overall principle of agencies including health providers is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation.

PREVENT has 3 national objectives:

- Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it.

- Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
- Objective 3: work with sectors and institutions where there are risks of radicalisation which we need to address.

This duty is incorporated into the NHS Standard Contract 2017-19, and the National Variation Agreement.

Current position of CHFT

- CHFT's Prevent Policy describes how the Prevent Strategy is implemented in CHFT and has been reviewed this year.

- CHFT Prevent Lead is the Named Professional for Safeguarding Adults, who is supported by the Head of Safeguarding. Both act as points of contact for Regional Prevent Coordinators. These two roles work in partnership to comply with the reporting requirements to NHSE. On a quarterly basis, data is requested and submitted to the Regional Prevent Coordinator (NHS England) of Prevent activities undertaken by the Trust which includes training figures.

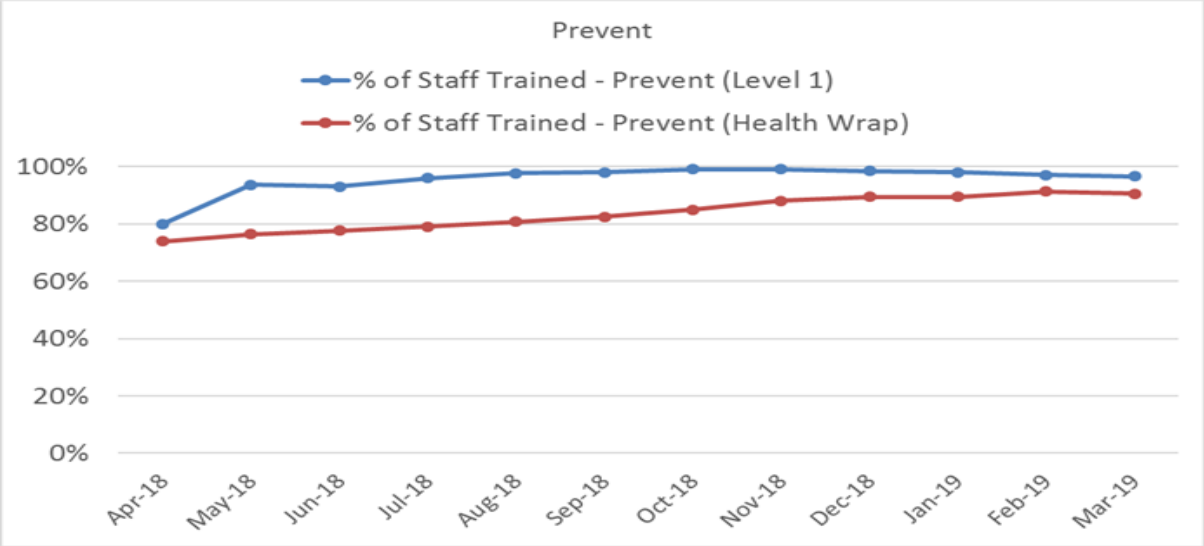
- The Trust Safeguarding Committee receives a quarterly update regarding Prevent.

- CHFT Safeguarding Team provides representation at Channel panels within the local Districts.

- PREVENT training compliance is monitored monthly at the safeguarding committee meeting and quarterly updates are submitted to the Regional Prevent Coordinator for Health (NHS England).

- Promotion of the eLearning training package on ESR with Divisional support to meet the Trust target of 95% and NHSE target of 85%. We have promoted this widely and used intranet screensavers to raise awareness.

- In line with the Prevent Training Competencies Framework 2017 developed in order to meet the Prevent Duty and ensure a consistent approach to training Prevent training is delivered at level 1 and Level 3.
    - CHFT delivers Level 1 Prevent training as part of adult safeguarding level 1 mandatory eLearning training and is repeated every 3 years.
    - The Home Office Workshop to raise awareness about Prevent (WRAP) training (level 3) has been delivered as a classroom session with WRAP facilitators registered with NHSE and the Home Office, and via the new Home Office eLearning package accessible via ESR during 2018-19.
    - The Trust has seen an increase of 5% since last April 18 to 93%; just 2% away from the overall Trust target of 95%. CHFT met the NHSE target of 85% by the end of March 2018. Level 1 Prevent is 97% with a combined compliance of approximately 95%.
    - CHFT is considered an exemplar site in relation to the number of staff trained. This has been confirmed by the NHS Regional Prevent Coordinator.



**Graph show increase over past year of both Levels of Prevent training*

Further work in 2019-20

- To achieve the Trust target of 95% and maintain this compliance.
- To continue to attend and be a part of the Channel Panel group in Calderdale and link into Kirklees PREVENT work as/when required.
- Update the PREVENT Policy to outline changes in delivery of NHSE training strategy.

Calderdale Safeguarding Adults Board

Kirklees Safeguarding Adults Board — Partners in preventing abuse and neglect

ADULT SAFEGUARDING

Following the introduction of the Care Act (2014) implemented in April 2015; adult safeguarding has been on a statutory footing. To meet our statutory, regulatory, contractual and Safeguarding Board requirements and obligations, there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

The Safeguarding Team is the single point of contact for advice and support for all adult safeguarding concerns. A Named Professional and Specialist Advisor are in post, and the safeguarding adults' staff continue to provide advice and practical support for a wide range of safeguarding issues relating to adults who are or may be at risk of abuse or neglect.

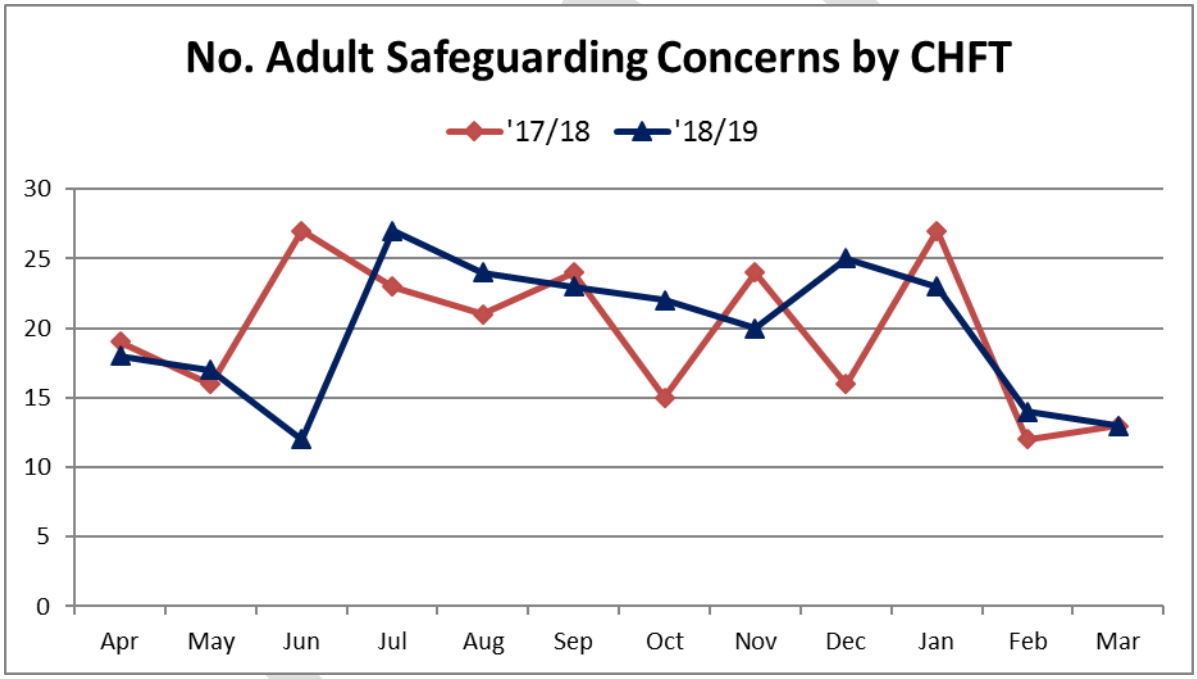
All Trust incidents are reviewed from a safeguarding perspective when initial reporting occurs to confirm or adjust the category of safeguarding concern: either quality of care issue, or safeguarding referral where harm or the risk of harm has occurred and reporting into the multi-agency safeguarding procedures is indicated. The Safeguarding committee has an overview of all allegations of abuse or neglect through reporting onto the safeguarding

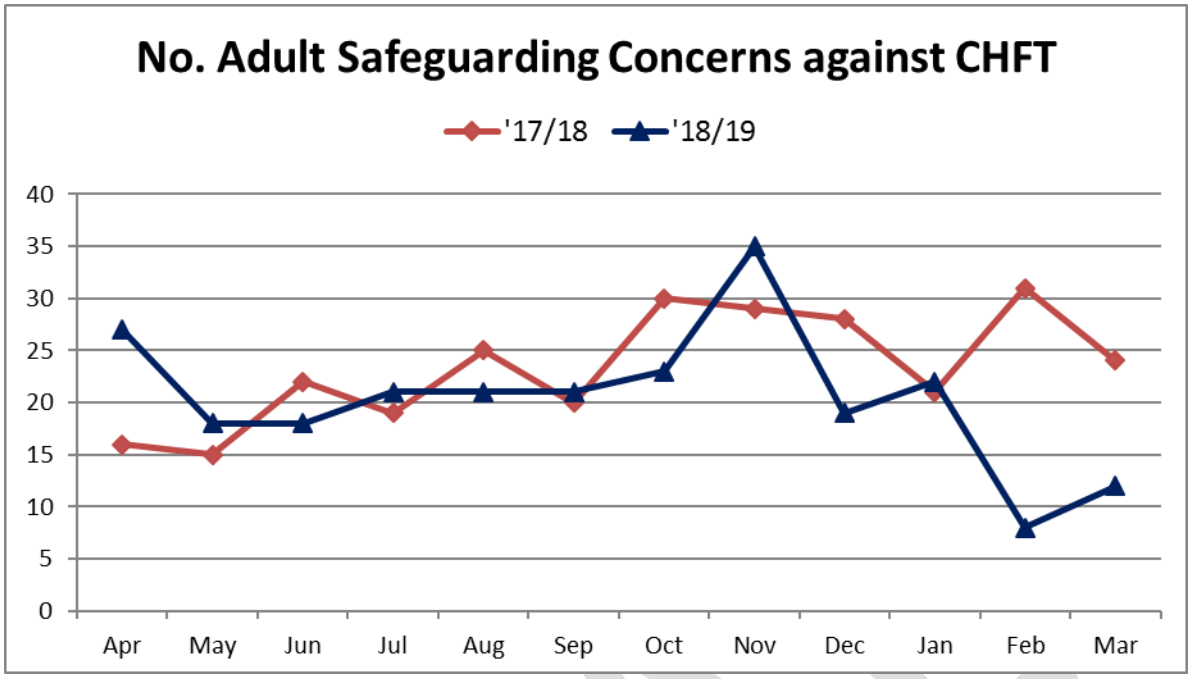
dashboard, and a deep dive analysis monthly for the Integrated Board Report and sharing of key messages at Divisional PSQB meetings.

The data does not include advice calls and support to wards and individual members of staff. All incident activity is recorded on Datix.

- There has been a **total of 884 incidents** recorded for 2018-19, compared to 2017-18 activity where there was a total of 882 reported incidents. This activity includes referrals made by CHFT and allegations against CHFT. There is an increase in activity of 2 incidents this year.

- Of these incidents **482 relate to quality of care** issues. These are concerns that do not meet the threshold for referral and are reviewed by the safeguarding team and are thematically analysed. These incidents are reviewed and investigated by the departments and divisions and learning is at department level. There is a reduction of 35 incidents overall of quality of care issues.

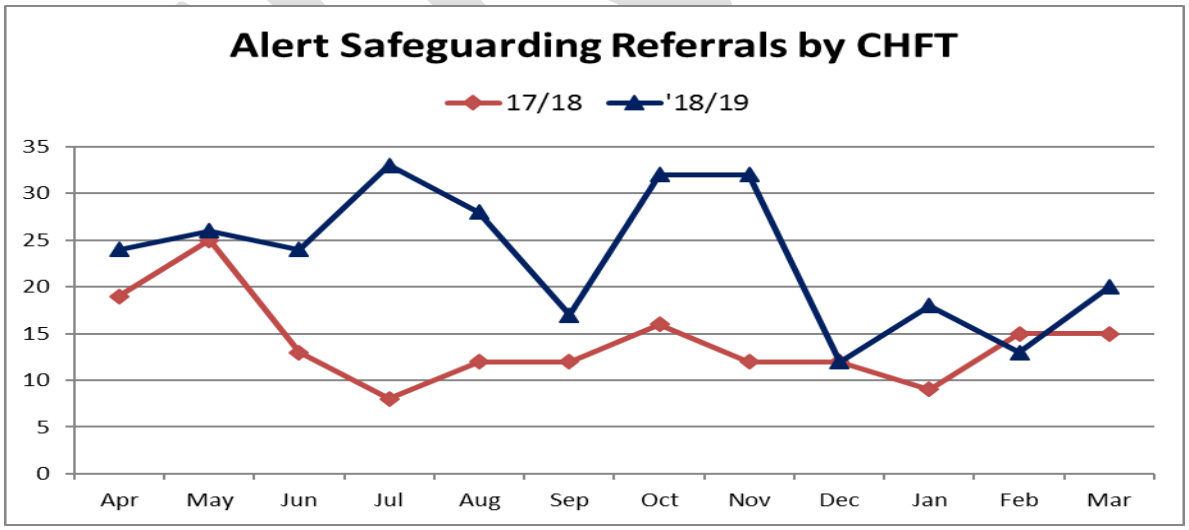




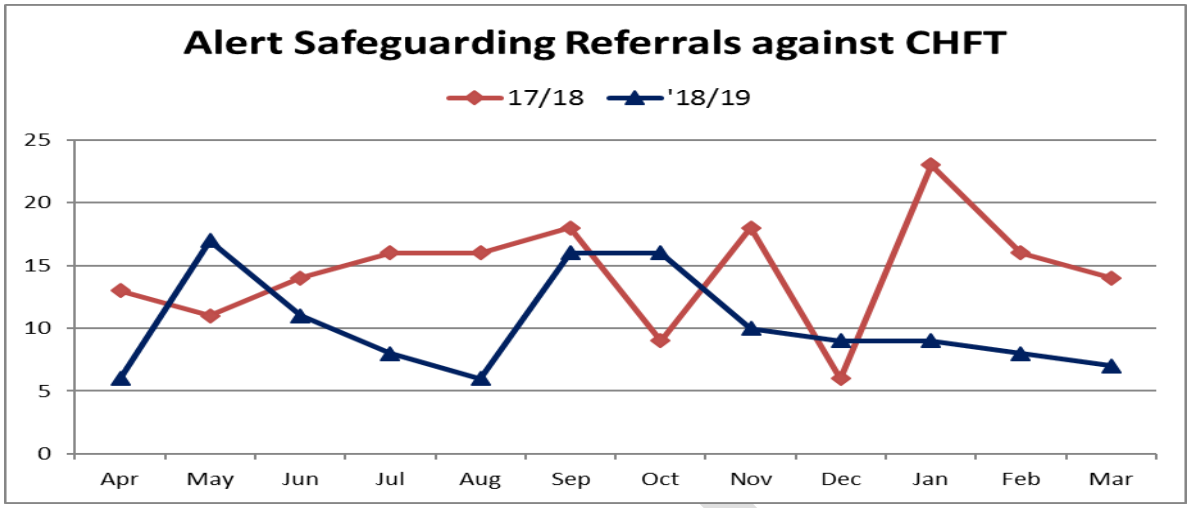
**The above data shows the reduction in the numbers of concerns by 35 from the previous year.*

There was a total of 402 safeguarding referrals made. This includes referrals by CHFT and against CHFT.

- There were 279 safeguarding referrals made by CHFT compared to 168 made in 2017-18 which is an increase of 66%. This shows an increased awareness of safeguarding adults and how to report into the procedures.



There has been a reduction of safeguarding referrals made against CHFT from 197 to 123 this year equates to a 37% reduction in referrals.



- Overall there has been a reduction of safeguarding referrals and concerns made against CHFT.
- The continued high numbers of all concerns and referrals provide assurance that there are robust reporting arrangements in place, and staff are aware of safeguarding procedures.
- The largest category of abuse identified is recorded under the 'neglect' heading; further analysis of this category identified that discharge from hospital was involved.

Current Position

- The Safeguarding Adults Policy was updated in line with the New West, North Yorkshire and York Multi- Agency Safeguarding Adults Policy in September 2018.
- Continuing to develop a network of Safeguarding Champions in wards and departments.
- Continued attendance to Safeguarding Adult Board and Subgroup meetings and working with other multi-agency partners collaboratively on safeguarding matters.
- Further work with incident department to review and analyse the reporting of Datix as category of abuse.
- Updated the Safeguarding Intranet Pages.
- Developed flow charts for ward and departments to follow when safeguarding concerns are identified.

Further work 2019-20

- To contribute to the update of the Allegations Policy to include new PIPOT (Persons in a Position of Trust) Guidance issued by the Safeguarding Adults Board. The revised Care Act (2014) in 2016, removed the Designated Adult Safeguarding Manager role (DASM) and was replaces with a new section on allegations management.
- To continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we do by embedding this culture, and to work with adult social care and gain assurance that referrers are given feedback from concerns raised and that a more consistent approach to referral thresholds is achieved.

- Continue to develop systems that are lean and accessible for staff at times of high demand and impact.
- To review the Missing Person Policy in response to the West Yorkshire Police demand Reduction Project and deliver further training for staff.
- We anticipate that referrals relating to pressure ulcers may increase over the next 12 months with more consistent reporting due to the new guidance.
- Further work is required to ensure all staff are aware of the circumstances when a fall should be reported through the safeguarding procedures.
- Further analysis and reporting will be developed over the next 12 months to aim to report on outcomes more consistently as indicated in the Making Safeguarding Personal Agenda.
- To review safeguarding adult training in line with the new Adult Intercollegiate Document, feedback form staff and benchmarking with other Trusts. The aim is to provide an array of different training resources to allow more flexibility in attending sessions and content will be more practical based. It is anticipated that organisations reach the required levels of workforce training over time by the next iteration in 2021.
- Continue being involved in Discharge Improvement work

SAFEGUARDING WEEK (CHILDREN AND ADULTS) AND OTHER PROMINENT DAYS

Safeguarding Week was held between the 25th June and 1st July 2018 emphasising one of the key themes of the week, 'Safeguarding is everyone's business.' Events were based around this and encouraging people to 'speak out about the unspeakable', with sessions being held throughout the week at venues across Calderdale. The week culminated with an information event at Brighouse Gala on Saturday 30 June.

Events held in Calderdale and Kirklees were widely advertised on the Trust intranet

Local Police in Calderdale and CHFT staff promoted widely the Herbert Protocol. This protocol is a shared protocol that helps to keep people with Dementia safe. We had a stand in the main entrance and visited ED Department which was well attended by both staff and members of the public

West Yorkshire police led a multi-agency awareness raising week of action for modern day slavery w/c 18th February which CHFT have promoted, and National CSE Awareness day on the 18th March 2019.

Further Work 2019-20

- Safeguarding team will continue to be involved in Safeguarding week this year 24th - 29th June, the theme is 'Listen to me & help keep me safe.'

LEARNING DISABILITY

The Matron lead for learning disabilities continues to lead the strategic agenda for CHFT to ensure new guidance; policy and procedures are in place for people with a learning disability accessing acute services.

In June 2018 NHSI published the first ever new standards for NHS Trusts. They have been developed to help NHS Trusts measure the quality of care they provide for people with learning disabilities. There are four standards with three applicable to acute providers with a total of 14 improvement measures.

Data collection for the standards took place from late September - November and although raw data has been sent to the Trust, we are awaiting the National report due in May. CHFT has an action plan in place and is already working towards achieving the standards.

CHFT took part in the pilot of the improvement toolkit with NHSI one of only four acute providers within England. Plans are in place to implement this toolkit and undertake improvement work across the acute floor on both sites with support from the acute medical directorate.

CHFT is also in the first phase of Royal Mencap's Treat Me Well campaign with an active campaign group from Kirklees and Calderdale with members from local day centres, care providers and local self-advocacy groups. The campaign is "simple adjustments make a big difference". The local group designed and undertook a patient survey of over 80 people with a learning disability, with some positive feedback and areas for the group to campaign for locally. The group is going to raise awareness of hospital passports and reasonable adjustments during learning disability week in 2019 with walk the wards and have stalls in main entrance.

CHFT is fully compliant with the National Mortality Review Programme (LeDeR), reporting all deaths on line, ensuring structured reviews take place, the matron is the Trust LeDeR reviewer and attends the local steering group. Reporting takes place every 6 months with an annual report which goes to the Mortality Surveillance group chaired by the medical director. During 18/19 reporting period CHFT had 11 deaths for people with a learning disability in an inpatient bed.

The matron reports to the safeguarding committee a number of data collections including total number of patients subject to Deprivation of Liberty (DoLS) and when we have instructed an IMCA for serious medical treatment, as well as safeguarding referrals made by the Trust to Gateway to care, including any investigations taking place with themes and trends.

This year was the first year we have undertaken our Mental Capacity Act/consent form 4 audit ensuring we reviewed the care of people with learning disabilities and we also undertook the first reasonable adjustment audit, both due to be reported in April/May to the relevant Trust committees with action plans in place.

The transition leads for CHFT this year have produced the first ever policy for the transition of young people transitioning to adult services in a secondary care setting. To aid this policy to be taken forward and embed in practice CHFT has been successful in been selected to take part in the NHSI improving Health Care Transition Collaborative. This collaborative work will enable CHFT not only to embed the policy into practice but drive the change within the organisational culture to embrace and embed developmentally appropriate care, understanding the unique needs of young people. This will have a huge impact on young people with learning disabilities and their families.

The matron continues to provide clinical support as required to patients whether inpatient or outpatient, and last year we had over 500 admissions alone. We continue to work with Bradford to ensure the development of EPR meets the needs of people with learning disabilities and the ability to record and share reasonable adjustments

PRESSURE ULCERS

During 2018-19 the Tissue Viability team have continued to work closely with the Safeguarding Team (adults) to ensure that all category 3 / 4 and unstageable pressure ulcers are reviewed from a safeguarding perspective. The incident reporting system (Datix) is screened by the Tissue Viability team to ensure the severity grading of the incident is correct. All "orange" incidents then go to divisional panel for further investigation. The

Safeguarding Team attend Divisional Orange Panel meetings to discuss safeguarding concerns.

Guidance published in January 2018 from the Department of Health and Social Care "Pressure Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern (DH 2018), provides a framework to, identify if a pressure ulcer is primarily an issue for orange clinical investigation rather than a safeguarding enquiry led by the local authority. This requires completing a decision tool and based on the score determines if a safeguarding enquiry is raised with Gateway to Care. This has been approved by the Safeguarding Committee and is being shared with external organisations including Calderdale CCG and Calderdale Safeguarding Adults Board.

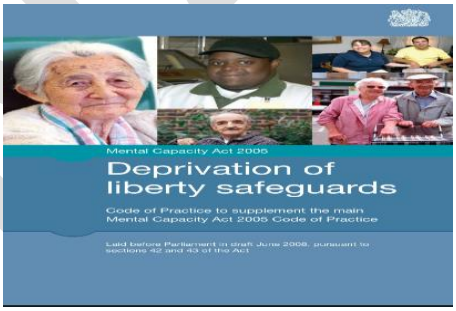
Current Position

- Implementation of Decision support tool to justify and evidence rationale to refer to Gateway to Care.
- Implementation of PUSH (pressure ulcer safety huddle tool) for rapid review within 48 hours.

Further work 2019-2020

- To continue to embed the above areas of progress and evaluate its effectiveness through the safeguarding committee meeting.

Mental Capacity Act 2005



MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009). The Mental Capacity and Deprivation of Liberty Policy is currently in date and MCA DoLS training is delivered as part of the essential skills framework approved by WEB. The current arrangements in place support staff and vulnerable patients to ensure that their Liberty under Article 5 of the Human Rights Act is protected whilst in hospital, and that staff are aware of their responsibilities in relation to the Mental Capacity Act 2005.

The Safeguarding Team are the point of contact for advice and support in relation to MCA and advice calls.

The Local Authority DoLs teams both in Calderdale and Kirklees are continuing to receive large numbers applications from both Care Homes and Hospitals resulting in a significant backlog to review; this is not just an issue locally but nationally. The Safeguarding team continues to work closely with DoLS managers for Calderdale and Kirklees to support consistency of applications across the CHFT footprint.

Reasons that contribute to this decrease include:

- Prioritisation of reviewing these is on a case by case basis and this priority has changed favouring patients in longer term placement in care homes rather than those with a shorter hospital stay.
- Safeguarding team are monitoring patients longer who lack capacity whether or not to remain in hospital before applying the DoL safeguard. These situations are usually acute presentations of delirium and alcohol withdrawal that resolve quickly and therefore would invalidate the DoLS. During this time the principles of the MCA are followed and at approximately 48 this is reviewed; this shows a greater understanding of the MCA.
- the change in approach due to the Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWCA Civ 31.

Current and Historical Data

Year	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2014	**11**	**5**	**0**	**0.9**
2015	**194**	**33**	**11**	**16**
2016 – 2017	**369**	**50**	**212**	**31**
2017-2018	**324**	**42**	**242**	**27**
2018-2019	**219**	**27**	**192**	**18**

**These figures suggest that despite a decrease in applications overall there is a positive level of awareness and recognition of patients who may fall within the ACID test for DoLS. There has been a decrease in the number of authorisations applied for 2018-19 however comparably from 2017-18 to 2018-19 1:7 and 1:8 DoLS are approved which is very little difference; and less than 1% authorisation rate.*

Current Position CHFT

- Data around DoLS is captured monthly and reports are shared at the Safeguarding Committee meeting. The CQC are notified of all DoLS authorisations and outcomes. This is in line with the requirements of the current legislation. All patients who are subject to an urgent or standard authorisation are monitored by the Safeguarding Team.
- MCA and DoLS training continue as part of the essential skill framework for staff.
- Progress is being made with more teams completing applications, although it is noted that not all areas are completing these, and further work continues to encourage and support areas and give them the confidence with making their own applications
- Continued work embedding knowledge and skills in all areas regarding MCA DoLS
- A significant key achievement was that the team delivered 14 face to face sessions this year.
- Significantly improved the quality of DoLS submitted; only 33% of referrals required some minor amendments; wards are now completing their own authorisations.

Further work 2018-19

- To continue to support wards in completing their own DoLS applications
- Adding the MCA template into Cerner and Athena electronic Systems
- Deliver bespoke training regarding MCA/DoLS and Mental Health to maternity services
- To continue to aid staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding
- Work with legal services department to ensure plans for new systems are embedded

MENTAL CAPACITY (AMMENDMENT) BILL

Background

The Mental Capacity (Amendment) Bill was introduced to the House of Lords on 3rd July 2018 for its first reading, following a law Commission consultation in 2017. The Amendment Bill received Royal Assent and became law on the 17th May 2019. No start date for the Liberty Protection Safeguards (LPS) has been announced and this will be decided by the Secretary of State for Health and Social Care at some point in the future.

Implications for CHFT

- Hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager.
- Referral pathways and authorisation process will need to be considered.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
    - The person lacks capacity to consent to the care arrangements
    - The person is of unsound mind
    - The arrangements are necessary and proportionate

  All 3 of the above criteria must be met

- The deprivation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre.
- Staff will need to be trained and aware of what the new Liberty Protection Safeguards constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) – acting as a form of mediation prior to a Court of Protection Appeal.

Next Steps

- We await agreement to the Bill and Royal Ascent.
- The MCA and DoLS Codes of Practice will be revised and remain as separate documents.
- Provide more in-depth report to Board of Directors as the Bill and Codes of Practice develop.
- Consider the impact of changes and introduction of training, processes and authorisations with the planned new system.
- CHFT as a responsible body who will authorise applications will need to review its resources to implement the new scheme.

The purpose of the Bill is to provide a simplified legal framework and authorisation process which is accessible, clear, deliver improved outcomes for people deprived of their liberty and place the person at the heart of decision making.

MENTAL HEALTH ACT

CHFT have continued to work in partnership with SWYPFT over the last 12 months formally with the review of the service level agreement, the scheme of delegation and the joint clinical working protocol. This service level agreement formalises partnership arrangements between both Trusts and ensures that CHFT are compliant in fulfilling their statutory duties.

Current Position

- As part of this partnership working the Safeguarding Lead (CHFT) attends SWYPFT MHA Committee Meeting and the Lead for Mental health Act (SWYPFT) attends the Safeguarding Committee Meeting. Copies of all MHA Committee papers are made available to the CHFT Safeguarding Lead and the Safeguarding Committee. CHFT and SWYPFT Partners meet regularly at the mental health operation group.
- CHFT Trust Board were notified of an error in the processing and completion of a detention under section 5(2) of the Mental Health Act (MHA) 1983. The paperwork was not completed correctly by two junior medical colleagues and it was not possible to rectify the error, therefore this was an unsafe section. Subsequent actions were taken to ensure compliance, and this was supported by the Mental Health legislation team.
    - Three actions arose from this incident:
    1. Facilitating receipt and scrutiny training for senior nurses,
    2. Ensuring that medical colleagues are aware of how to complete section 5(2) paperwork and
    3. Informing the Trust Board of this incident.

    All actions have been carried out.

- The Mental Health Liaison Team (MHLT) support and work with CHFT Trust staff to ensure that all patients who are referred are reviewed and supported in a timely way. The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.
- There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.
- The “Hospital Managers” for the purpose of MHA reviews all had personal annual reviews as required by MHA code of practice. These were undertaken by a Non-Executive within SWYPFT. All were re approved for a further 12 months.
- A MHA tribunal was held in June 2018 after an appeal of a Section 2 – the section was upheld.
- The implementation of the MHA is fully supported within CHFT by the Mental Health Liaison team and supported by the MHA Office where statistical information regarding the use of the MHA in CHFT has been provided to Safeguarding Lead on a monthly basis and shared with the Safeguarding Committee meeting.

- Further collaborative working with CHFT and SWYPFT Child and Adolescent Mental Health service have reviewed the out of hours on call arrangements for the service.
- The MHA 1983 has been reviewed during 2018. The Government appointed Sir Simon Wessley as the chair for the review with the Final report published in December 2018. The report is being monitored and reported via the SWYPFT MHA committee. SWYPFT Mental Health Act Committee are awaiting further action and the formal government response to the Independent Review.

	2017 -18	2018-19
Section 5(2)	6	10
Section 2	25	21
Section 3	6	3

** Statistical information regarding the use of the MHA within CHFT is made available to the Safeguarding committee meeting every month. There is an increase in section 5(2) recording from previous year.*

Current Position

- The process for the use of Sections within CHFT has been reviewed and agreed with SWYPFT Mental Health Liaison Team and MHA Office to ensure robust oversight of all Section 5(2), Section 2 and Section 3 detentions at CHFT.
- Training sessions have been arranged with SWYPFT to facilitate receipt and scrutiny training

Further work 2019-2020

- Update the Joint Protocol in line with the CAMHS Out of Hours Working Arrangements
- Continue to promote 'Receipt and scrutiny' training for members of staff who will accept Section papers on behalf of CHFT.

SAFEGUARDING MENTAL HEALTH AND MIDWIFERY

CHFT continue to work in partnership with SWYPFT and Locala, to provide care for pregnant women who have mental health concerns. The Clinical Lead for Perinatal Mental Health (PNMH-Midwifery Services) , supports women and families with mental health difficulties in the antenatal and post-natal period. The PNMH Clinical Lead provides case supervision, consultation and advice to midwives and Obstetric colleagues within the acute Trust and community setting in regard to PNMH issues.

High risk women with a diagnosed mental illness, such as bi polar, schizophrenia, previous puerperal psychosis and/ or severe depression are referred to the Specialist PNMH Team (SWYPFT) for close partnership working. Collaborative working safeguards the woman and her unborn /baby – promoting optimum physical and mental health in the ante natal and post natal period. Mental ill health, both in the ante natal or post natal period can have a negative impact upon the attachment between the mother, baby and family unit, which may result in safeguarding issues.

The Clinical lead for Perinatal Mental Health (PNMH) works closely with the Named Midwife (Safeguarding), and also the Substance Misuse Specialist Midwife. There is a link between mental ill health, substance misuse and safeguarding. A joint ante natal clinic involving the

Perinatal Clinical Lead, Lead Obstetrician for Perinatal mental health and the PNMH Team Psychiatrist has recently been developed. This promotes greater multi - agency working and enhances the care provided for women with severe mental health difficulties. PNMH care plans are developed for high risk women (between 28-32 week gestation), in collaboration with SWYPFT, Midwifery and Health Visiting services, and in partnership with the woman and her family. PNMH care plans further safeguard the woman and baby. CHFT Midwifery services have a close partnership working with SWYPFT Mental Health Liaison Team (MHLT), whom frequently review and assess women's mental health following birth and prior to discharge home from CHFT.

The PNMH Clinical Lead and Named Midwife attend the CHFT/SWYPFT Liaison meetings.

The PNMH Clinical Lead co facilitates Multi Agency PNMH Awareness Training with co facilitators from the PNMH Team and Locala Health Visiting services. Training is delivered across Kirklees and Calderdale on a monthly basis. This training is available for midwives, health visitors, mental health staff, children's centre staff, social care and voluntary sector staff.

Further work 2019-20

- to continue to work in collaboration with partner agencies and develop appropriate care pathways in relation to PNMH and safeguarding.
- To identify SMART outcome measures for this cohort of women

SAFEGUARDING CHILDREN AND YOUNG PEOPLE

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2018,' The Children Act 1989/2004 and to joint working with both the Calderdale and Kirklees Safeguarding Children Boards. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of children within Calderdale and Kirklees, and its relevant polices are aligned and refer to these documents.

There are no current vacant posts within the children's safeguarding service.

Named nurses for Safeguarding Children ensure that CHFTs' safeguarding responsibilities are effectively discharged by the provision of day to day advice, supervision & support, promoting good professional practice, including identifying the training needs on child protection issues & delivering key safeguarding messages from research & lessons learned from serious case reviews. They support the work around supervision, bespoke training for staff in the Emergency Department, and the successful implementation and ongoing development of safeguarding champions to facilitate safeguarding supervision and the introduction of a new safeguarding strategy.

Current Position 2018-19

- A significant piece of work has been completed by reviewing the Safeguarding Supervision Policy and the implementation of a supervision strategy developing new ways of working to ensure that all staff who require mandatory safeguarding children's supervision have been allocated this on their ESR. The team have utilised existing resources and structures to introduce this new way of working.
- CHFT Safeguarding Team work closely with the Safeguarding Children's Boards for Kirklees and Calderdale, Children's Services and the Clinical Commissioning Groups Designated Professionals for Safeguarding Children. They achieve this by delivering multi-agency training, by attending multi-agency meetings partaking in multiagency audits, Safeguarding Board subgroup meetings and undertaking pro-active multi-agency work to support the safeguarding Boards in devolving statutory Trust responsibilities to ensure children and young people are kept safe.
- The Team represent the Trust at internal and external meetings, training events and case reviews/lessons learned reviews.
- The continued distribution of the Safeguarding Team Virtual Notice Board to all CHFT staff which delivers key safeguarding messages monthly Trust wide.
- New intranet pages have been updated and developed as a resource for staff with current safeguarding practice
- Alerts/ Flags are added to all patient records that relate to high risk Domestic Abuse (MARAC), CSE, Child protection plans, Looked After Children and FGM. The Children Safeguarding Policy was reviewed and updated, and amendments made to reflect the updated 'Working Together to Safeguard Children 2018.'
- Arrangements are in place for both Kirklees and Calderdale's 'front door' to contact the safeguarding team if any poor-quality referrals are made.
- Attendance & contribution at Multi-Agency 'Care and Education Treatment Review' (CETR), meetings for children/ young people who either have been or about to be admitted to a specialist mental health/ learning disability hospital in the NHS or Independent Sector.
- Continue meetings with SAU and MAU to discuss safeguarding flags for 16-17.
- Work with the Datix team to breakdown incidents regarding the category of abuse, collating themes & trends incorporating the learning from these into training & supervision.
- Level 3 children's training has been updated in line with Working Together 2018.

Further work 2019-20

- Continue to embed and provide safeguarding supervision in line with CHFT supervision strategy.
- To work closely with the Risk Department regarding requests for Court statements
- To work with Maternity Services in relation to implementing a Safeguarding Supervision Strategy and delivery model.
- Raising awareness of child abuse with a religious implication.
- Continue to develop the Safeguarding Champions membership and look at different ways of engagement.

- Further work on the EPR regarding enhancing the Paediatric Liaison referral process and implementation of mandatory safeguarding questions for children & young people attending ED.
- To introduce the updated Under 18 proforma to SAU and MAU, ED and Paediatrics.
- To update the training strategy in line with the Intercollegiate Document (2019).
- Developing a standard operating procedure for Under 18 attending for TOP following a suspected sexual assault.
- Level 1 and Level 2 training packages require updating to reflect 'Working Together 2018' statutory guidance, and the Intercollegiate Document 2019.
- Level 3 training requires updating in line with the Intercollegiate Document 2019.

Performance Data Children

Children's data is recorded in a number of different formats and shared with the Safeguarding Children Boards; The Safeguarding Team identify themes and trends in relation to incident reporting. Where safeguarding procedures have not been followed, these are recorded on the Datix reporting system. When the Safeguarding Team are notified of referrals made to children's social care by CHFT, these are collated on the Safeguarding Team dashboard. Within maternity services, reports can be generated from Athena to confirm the number of referrals made from CHFT to children's social care. There is ongoing work with Kirklees children's social care to establish whether this information can be provided directly from the local authority.

Further information is collected at the request of the Safeguarding Children Boards and shared on a quarterly basis. This information provided by CHFT informs the Safeguarding Children Boards and their subgroups of activity relating to attendances of children and young people in the Emergency Department; particularly in relation to self-harm and alcohol and substance misuse. This data supports and informs partners and contributes to multi-agency working and safeguarding of vulnerable children and young people.

The team also support staff to provide legal and police statements and any subsequent court attendances.

This data shows a slight increase in the number of incidents. Further analysis regarding themes, patterns and trends will be reported on a quarterly basis to the Safeguarding Committee Meeting.

Incidents Reported on Datix	2016 - 2017	2017-2018	2018-2019
Child Safeguarding Concerns	56	52	76
Child Safeguarding Referrals	22	17	25
TOTAL	78	69	101

Referrals made to Children's Social Care by CHFT	2017-2018	2018-2019
Kirklees	29	39
Calderdale	29	39
TOTAL	58	78

- *This data does not inlcude maternity referrals.*

Further work 2019-20

- The team continue to raise awareness of ensuring that the Safeguarding Children team have overview of all referrals made to children's social care by departments and ward areas though training, supervision and awareness raising.
- To work with Calderdale and Kirklees Social Care to validate and compare numbers of referrals made.

CONTEXTUAL SAFEGUARDING

Is an approach to understanding young people's experiences of significant harm beyond their families and recognises the impact of the public and social context on young people's lives, and consequentially their safety. Contextual safeguarding seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or young people. This can include CSE, peer or peer violence, abuse, modern day slavery, harmful sexual behaviour, abuse in gangs and groups, criminal exploitation and going missing from home or care; should not be seen in isolation as they often overlap, creating a harmful set of circumstances and experiences for children, young people, families and communities.

Working Together (2018) states that Local authorities with their partners should develop and publish local protocols for assessment setting out its clear arrangments for how cases will be managed once a child is referred into the local authorities childres's social care and be consistent with the requirements of Working Together statutory guidance (2018).

Current Position

- Safeguarding team are involved with the Kirklees Strategic and Operational Contextual Safeguarding Group

CHILD SEXUAL EXPLOITATION

'CSE is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual.

Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'

Current Position 2018-19

- We have an identified CSE Lead.
- Young people at risk of CSE are flagged on the electronic patient record system.
- Training for staff in relation to CSE is included in detail in level 3 safeguarding children training & specific safeguarding training for ED staff. Learning disseminated from case reviews relating to CSE via CHFT learning and audit sub group and virtual noticeboard and safeguarding supervision.
- CHFT contribute to the multiagency CSE Hub meetings in both Kirklees and Calderdale by providing written reports containing relevant health information to share with partners.
- CHFT contributes to KSCB and CSCB Operational CSE meetings and action plans.
- CHFT have developed use of an under 18 safeguarding risk assessment proforma; which includes CSE, this is used in the Integrated Sexual health Service (ISHS), Maternity and Gynaecology services. We continue to review and promote this document.
- Any pregnant young people identified as risk of CSE are referred to multiagency Supporting Women in Antenatal Services (SWANS) Kirklees. Where there are significant concerns from Children's Social Care or at Specialist Midwifery Panel meeting; these cases can be escalated and heard at the MAPLAG meeting in Calderdale.
- We have promoted the National CSE Awareness day on the 18th March within the Trust
- We have been involved in the trafficking and modern slavery call to action March 2018.
- Attended focus groups as requested by the KSCB as part of the National Working Group independent review into CSE within Kirklees

Further work 2019-20

- For further promotion and use of the Under 18 proforma in SAU; MAU; ED and Paediatrics

FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) encompasses "All procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons." FGM can have far reaching consequences for the physical, psychological and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK. With increasing international migration, the UK has become host to many women affected by FGM. Research suggest

279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure.

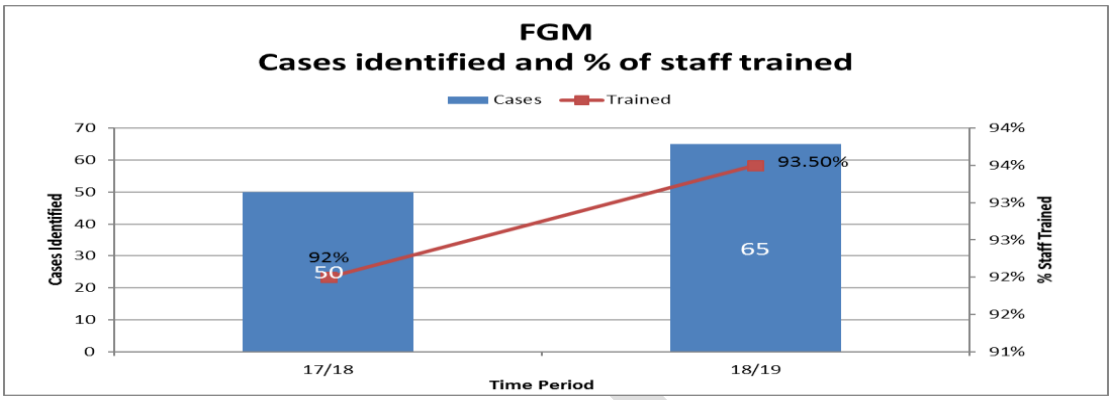
Since the introduction of the Female Genital Mutilation Act 2003 (replacing the Prohibition of Female Circumcision Act (1985), FGM has been a criminal offence. The first successful prosecution took place in February 2019.

It is estimated that there are 137,000 women and girls with FGM born in countries where FGM is practiced that are permanently resident in the UK. Since 2008 women with FGM have made up about 1.5% of all women delivering in England and Wales.

Current Position 2018-2019

- We have an identified FGM Lead.
- CHFT has an FGM Policy which includes a flow chart to support staff with enquiring and assessing the levels of risk in relation to FGM. Statutory FGM reporting is carried out and the numbers of cases are also reported internally through the Safeguarding Committee Meeting.
- FGM is routinely asked within maternity services.
- Staff working in FSS, the Emergency Department, the Safeguarding Team, Health Visitors and the Integrated Sexual health Service receive additional training to what is already delivered in the levels of Safeguarding training for Children and Adults. Our training compliance has increased from 92 to 94%.
- The Named Midwife attends FGM task and finish groups for both Calderdale and Kirklees.
- Mandatory reporting of all cases of FGM is embedded within CHFT; reported quarterly to NHSE and monthly at the safeguarding committee meeting.
- As well as a separate eLearning package for certain staff groups for FGM we have included FGM training in safeguarding training also.
- The safeguarding team have developed an under 18 safeguarding risk assessment proforma that was initially developed and used in Integrated Sexual Health Service (ISHS) which includes FGM. This has now been adapted for use in the Gynaecology assessment unit and is to be embedded into practice throughout maternity services. This was seen as good practice when CQC visited in January 2018.
- This is to assess the risk of any females under 18 that may present as a survivor or at risk of FGM. If a woman is identified as a survivor of FGM during pregnancy, the women are reviewed by the obstetric team and a data collection form is completed. Leaflets and information are provided to identify families of FGM cases. This is given to survivors of FGM and staff to raise awareness.
- We have successfully implemented the FGM Information Sharing System (FGM-IS) by working closely with NHS Digital. This is now embedded in maternity. From the 30.11.18 any female child born to a survivor of FGM has their electronic record flagged. We have backdated this to 2015 from when the data collection commenced. The system will generate a flag into the record if a child or young person attends who is at risk of FGM. This flag will automatically be removed at age 18.
- Routine flagging of records if a mother identified as being a survivor of FGM and any female new born and female siblings (the flag is placed directly onto the NHS Spine).

All Trust who have this information sharing system will benefit from this information should they attend.



**this data shows a consistently high compliance which has resulted in increased reporting of adult cases of FGM this year of 30%.*

Further work 2019-2020

- To develop and embed the FGM Risk assessment tool into the Athena electronic System in Maternity.

DOMESTIC ABUSE

Any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'- based violence and forced marriage.

Current Position

- The Named Professional for Safeguarding Adults remit has been expanded and is the Named Lead for DA. The role also supports Occupational Health and managers of staff who are victims/perpetrators of DA e.g. safety management plans. The role leads on policy and procedures and represents the Trust at strategic and operational multi-agency meetings specific to DA.
- A new campaign to promote Clare's Law which is also known as the Domestic Abuse Disclosure Scheme was launched on the 24th January 2019. The campaign encouraged the public to use their 'right to ask' if they are worried that a partner or

ex-partner may have a history of domestic abuse. CHFT supported in promoting this campaign.

- CHFT has been awarded the West Yorkshire Domestic Abuse Quality Mark; awarded when there is consistent and high-quality service provision to women, children and men affected by DA. CHFT have now been awarded this at Level 2 (Safety, Good Practice, Routine and Triggered Enquiry and Policies) for three years.

**award being presented by Jackie Murphy Chief Nurse*

- CHFT hosts the Calderdale Commissioned Domestic Abuse (DA) Health Service which is in Calderdale Domestic Abuse Hub in the Police station. This service has now been awarded recurrent funding and a permanent contract is now on place for the Specialist Advisor for DA. Being a part of this service enables us to lead in our development and support of staff. The Specialist Advisor for DA supports the DA Hub operationally on behalf of health services.
- Maternity Services have a full time Specialist Midwife for DA. The role includes case-loading highest risk pregnant women, clinical supervision with generic community midwives who have women on their caseload subject to DA, facilitation of training, awareness raising, maternity Guideline/pathway/policy development.
- HRI has benefitted from a hospital based Independent Domestic Violence Advocate (IDVA) working alongside the Named Professional for Safeguarding Adults in facilitating training and embedding the IDVA role in ED and maternity services. The IDVA now provides drop in sessions for staff three times a week at ED to collect referrals, support staff and raise the awareness of CHFT DA pathway and referral system.
- Reviewed the DA referral pathway.

Number of CHFT Referrals	2015 -2016	2016 - 2017	2017-18	2018-19
To MARAC	27	37 (Kirklees) 60 (Calderdale)	61 (Kirklees) 59 (Calderdale)	64 (Kirklees) 81(Calderdale)
TOTAL	27	97	120	145

**There has been an increase of 25 referrals this year across both Local areas. The largest increase is for Calderdale. Kirklees has seen a steady increase in referrals from ED which is believed to be due to the promotion of the Domestic Abuse Pathways by the Hospital IDVA who is based at HRI whilst on short term secondment to CRH ED.*

By Department	2015 -2016	2016 - 2017	2017-18	2018-19
Emergency Department	19	48	85	122
Maternity	8	9	25	9
Community		3	10	15

**there has been a reduction in the number of referrals by Maternity services and a significant increase by ED.*

This data is for CHFT referrals only and does not include referrals made by GP's, SWYFT or LOCALA. This data evidences that there is continued acknowledgement of DA across the Trust due to establishment of the DA Hub and Kirklees Hospital IDVA service and continued promotion of services across the Trust.

It is anticipated these figures will continue to increase as awareness improves across all health providers.

Number of Datix Alerts	2014-2015	2015-2016	2016-2017	2017-2018	2018-19
Domestic Abuse/violence	4	6	22	28	11

**there has been a significant reduction in the numbers of DA incidents reported this year.*

Ongoing risks/challenges

The Domestic Abuse Bill new legislation identifies that DA costs the country £66 billion and the cost implication of DA for health alone is £2.3 billion.

Whilst this is not yet in force, the legislation has identified some anticipated changes:

- the definition of DA to include economic abuse and controlling and manipulative non-physical abuse. It will identify a domestic abuse commissioner to drive the domestic abuse agenda forward. The other benefits of the legislation are prohibition of cross examination of victims by their abusers at family court and other protection orders that are currently being used now (DVPO/N's). The government is making 120 commitments which are non-legislative measures which includes:
- £8 million of Home Office funding to support children affected by domestic abuse · a new crisis support system for those with no recourse to public funds.
- additional funding and capacity building for services for disabled, elderly and LGTB victims · updated support, training and guidance on economic abuse.
- new and additional training for job centre work coaches, police, social workers and probation staff to help them recognise and effectively tackle abuse
- improved support for victims in the family court
- additional £500,000 funding for provisions for male victims

Further work 2019-20

- Calderdale has secured funds to provide a domestic abuse support worker role to work into Calderdale ED. This is in the very early stages of development, but it is hoped that the role will mirror the IDVA service CHFT has at HRI.
- Review the recommendations arising from the Domestic Abuse Bill and implement once this is in effect. This will include training and updates for staff, reviewing policies

and procedures that may impact on practice and any funding opportunities for hospital IDVA services that can support frontline staff.

CHILDREN LOOKED AFTER TEAM CALDERDALE

Our Children Looked After Health Team are based at Brighouse Health Centre and are the CHFT commissioned service who work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of looked after children (CLA) and young people in Calderdale are met. The health team provides advice and support to health and social care practitioners in order to improve health outcomes for looked after children and young people. The Designated Doctor for Children Looked After is part of this team and completes all the initial health assessments for all Calderdale CLA placed in Calderdale. A Looked after Child is subject to a care order (placed into care of local authorities by order of a court) and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

A Care Leaver is a young person who has been looked after for at least 13 weeks since the age of 14, and who was in care on their 16th birthday. This definition has been extended following the introduction of The Children and Social Work Act which received Royal Assent on 27th April 2017.The Act includes provision about: Extension of local authority support to Care Leavers to age 25, including provision of Personal Advisers, assessment of the needs of former relevant children and preparation of a Pathway Plan.

Current Position 2018-19

This year the CLA Health Service Specification was re-designed with an agreed configuration of the service. This has allowed a more co-ordinated and joined up service for CLA and young people with the expansion of the team which is led by the Named Nurse for Children Looked After. We are currently awaiting the final signed off version of this specification.

- The Designated Nurse CLA role is now located in the CCG with existing funding remaining as part of the commissioned service resulting in a remodelled workforce to meet the revised specification.
- An additional two seconded posts from Locala have been successfully inducted into the existing team into the remodelled service to support in delivery of the new specification which now covers are CLA and Young People.
- The new service now carries out Review Health Assessments up to a 50-mile radius and beyond in consultation with the relevant service in the placement area.
- The team successfully completed a backlog of Health Passports for Care Leavers and modelled into service delivery the offer of providing these passports to care leavers.
- The Named Nurse and Designated Nurse work closely together to ensure that performance monitoring and service development is enhanced.

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

Future Plans 2019-20

- Procurement of additional Health passports
- Consolidate the caseload where all CLA specialist nurses are experts at Review health assessments for all children /young people age 0-18.

- Identify the post 18-25 caseload and build a pathway of how we can support this vulnerable group.
- Build a corporate leaflet/information sheets for both professionals/children/young people on differing aspects of what we deliver.
- Continue to build the expertise of the staff with training/1-1 supervision/case management/safeguarding supervision.
- Improve the clinic rooms used for IHA/RHA clinics with regular health promotion notice boards/child/family friendly messages which are updated regularly.
- Attend the weekly CSE operational meeting sharing information and being part of the multi-agency discussion.

To note a separate Children Looked After report will be presented in more detail to the Board.

CHILDREN LOOKED AFTER TEAM KIRKLEES

The Looked After Children's Health Team covers the whole of Kirklees not just the Huddersfield area. The Designated Doctor and Medical Advisers are based at Huddersfield Royal Infirmary and the Designated Nurse and Specialist LAC nurses are employed by Locala but based within Children's Social Care at Civic Centre 1 with access to Social Care's IT system.

Looked After Children Health services in Kirklees perform well in meeting the required timescales set out in statutory guidance.

Kirklees Childrens Social Care have recently had a mock Ofsted inspection. The Inspectors were very impressed by our very high rates of Initial Health assessments within 20 days and challenged the Designated Nurse for LAC strongly. Our good figures are achieved by all the team seeing this as a priority sand working closely with Children's Social Care. The last few months have been challenging however due to the introduction of Liquid Logic, a new computer system in social care.

The Kirklees LAC Health Team had their Children Looked After and Safeguarding CQC Inspection in January 2018. All actions have been completed.

Priorities for 2019-20

- A separate Looked After Children Report for Kirklees will be presented to the Board with information about progress against priorities and new priorities for 2019-20.

TRAINING

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

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

Historically only children's safeguarding training was mandatory, however since the introduction of the Adult Intercollegiate Document; adult safeguarding is now on a statutory footing. The CQC report for CHFT published this year noted that not all areas had met 95%

training compliance set for that year. Training compliance is sent monthly to Divisional leads and discussed quarterly at PSQB meetings.

The team ensured sufficient level 3 training places provided and additional sessions facilitated by the team for non-compliant staff and those likely to come out of compliance in 2018-19; but despite non- attenders at training sessions; the predicted target of 95% compliance of all levels has not been met by March 2019. The training compliance has now been reviewed and re-evaluated for 2019-20.

	31.03.18					31.03.19					2018-2019
Competence Name	Assignment Cou	Required	Achieved	Outstanding	Compliance %	Assignment C	Required	Achieved	Outstanding	Compliance %	% deviation
Level 1 Mental Capacity Act/ DoLS - 3 Years|	465	465	327	138	70.32%	390	390	385	5	98.72%	28.40%
Level 2 Mental Capacity Act / DoLS - 3 Years|	3140	3140	2955	185	94.11%	3067	3067	2659	408	86.70%	-7.41%
Level 3 Mental Capacity Act / DoLS - 3 Years|	705	705	540	165	76.60%	720	720	640	80	88.89%	12.29%
Level 1 Safeguarding Adults - 3 Years|	1653	1653	1623	30	98.19%	1587	1587	1536	51	96.79%	-1.40%
Level 2 Safeguarding Adults - 3 Years|	3498	3498	3306	192	94.51%	3447	3447	3329	118	96.58%	2.07%
Level 3 Safeguarding Adults - 3 Years|	583	583	444	139	76.16%	604	604	548	56	90.73%	14.57%
Level 4 Safeguarding Adults - 3 Years|	2	2	2	0	100.00%	2	2	2	0	100.00%	0.00%
Level 1 Safeguarding Children - 3 Years|	1653	1653	1621	32	98.06%	1587	1587	1543	44	97.23%	-0.84%
Level 2 Safeguarding Children - 3 Years|	3615	3615	3431	184	94.91%	3593	3593	3442	151	95.80%	0.89%
Level 3 Safeguarding Children - 3 Years|	543	543	491	52	90.42%	545	545	502	43	92.11%	1.69%
Level 4 Safeguarding Children - 3 Years|	6	6	6	0	100.00%	5	5	5	0	100.00%	0.00%
Prevent WRAP - No Renewal|	4636	4636	3943	693	85.05%	4520	4520	4201	319	92.94%	7.89%
Female Genital Mutilation|	494	494	457	37	92.51%	482	482	449	33	93.15%	0.64%
Totals	**20993**	**20993**	**19146**	**1847**	**91.20%**	**20549**	**20549**	**19241**	**1308**	**93.63%**	**2.43%**

Mental Health Act Receipt and Scrutiny Training|						60	60	19	41	31.67%	

Key
Aspirational Target > 95%
On Target 90 %- 94.9%
Near Target 85% - 89.9%
Below Target < 85%

Aspirational Targets have been met for

- Level 1 MCA DoLS
- Level 1 Safeguarding Adults
- Level 2 Safeguarding Adults
- Level 4 Safeguarding Adults
- Level 1 Safeguarding Children
- Level 2 Safeguarding Children
- Level 4 Safeguarding Children

Training is on target for

- Level 3 Safeguarding Adults
- Level 3 Safeguarding Children
- Prevent WRAP (NHSE Target of 85% is met)
- FGM

Near Target training:

- Level 2 MCA DoLS

- Level 3 MCA DoLS
- Mental Health Act Receipt and Scrutiny Training

The Trust overall safeguarding compliance has **increased from 91.2% to 93.63%**

SAFEGUARDING SUPERVISION

Further work 2019-20

- To deliver enough face to face training sessions for staff becoming out of compliance in 2019-20 and meet an aspirational 95% compliance.
- To continue to encourage Divisions to complete training and consistently raise the profile of safeguarding training and delivery of 95% training compliance.
- Review the Adult and Children's Intercollegiate document's and work with Workforce Dept. to identify any changes these documents will result in and changes in targeted levels for staff.

SERIOUS CASE REVIEWS, SERIOUS ADULT REVIEWS and DOMESTIC HOMICIDE REVIEWS

Under Regulation 5 of The Children Act (2004), The Care Act (2014), and under Section 9 of the Domestic Violence and Victims Act (2004), statutory duties apply in cases of Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews.

The purposes of reviews enable Local Safeguarding Boards and Community Partnerships to fulfil their obligations under each of these Acts and for us as a partner agency to contribute to the carrying out of a review, identify any lessons to be learned and apply these lessons to future practice.

Each Act defines a slightly different obligation and review of a case in relation to adults, children and domestic homicides.

Key themes in each review enable services to look at establishing what lessons to be learned about how professionals/ agencies (individually and together), work to safeguard children and/or adults at risk; review the effectiveness of local safeguarding procedures (multi-agency and single agency) and inform and improve local inter-agency practice.

The Safeguarding Team have fulfilled partnership requests for information and contributed to several reviews that have been published and are ongoing.

Current Position

- The Trust participates fully in both the Serious Case Review process for children and the Serious Adult Review process. The Trust also works in partnership with Community Safety Partnerships in relation to the Domestic Homicide review process, which may include representation and participation by the Trust. We receive requests from both local authority areas and local authorities out of this area.
- The Trust is fully committed to identifying the learning with regards to safeguarding and review processes thus promoting the welfare of those who are vulnerable and to make changes that will improve practice, multi-agency working and outcomes.
- Any finalised overview reports and individual management reports are presented through the Trust and partner agency governance structure. The actions for the Trust

are monitored through the Review and Incident Subgroup of the Safeguarding Committee meeting. Minutes of the group go to the Safeguarding committee meeting.

- The recent updated Working Together to Safeguard Children (2018) sets out a new approach, criteria and timescale for conducting reviews into deaths or serious injuries. The review must be completed quickly and efficiently; recommendations and actions must be SMART. The duty to notify the National Childrens safeguarding Panel rests with the Local Authority through Childrens Social Care (Children Act 2004). Requests must be returned to the Safeguarding Board Panel meeting within 5 days. As a partner agency we should regard any guidance which the panel publishes which includes timescales for undertaking a rapid review. As a partner we are involved in the new process.

- There has been a total of 19 requests this year for information an increase of 6 from last year's 13 requests.

Cases for 2019/20

- **Serious Case Reviews (now Child Serious Practice Reviews)**
    - There has been 2 new Serious Case Review's commissioned by the Local Safeguarding Children Board in Calderdale and Kirklees and one from out of our area.
    - The Trust has been involved in 2 cases from previous years at varying stages of progress.
    - There have been 2 SCR completed.

- **Serious Adult Reviews**
    - There has been 2 new Serious Adult Review commissioned by the Local Safeguarding Adult Board in Calderdale.
    - The Trust has been involved in 1 case from previous years where action plans have been re-visited by the Safeguarding Board.
    - There have been 2 SAR completed.

- **Domestic Homicide Reviews**
    - There have been no new DHR's commissioned locally.
    - The Trust is currently involved in 2 DHRs from previous years

AUDIT

Section 11

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

1. Kirklees Safeguarding Children Board requested CHFT complete an online self-assessment which was submitted in February 2018. This online assessment was against 10 standards with a further 61 questions to complete.

2. Calderdale Safeguarding Childrens Board and Adults Board requested completion of a joint adult and children self-assessment.

Internal Audits

- Several internal safeguarding audits have taken place this last year. These are presented to the Safeguarding Committee for discussion and action.
- All audits are now on the Trust Audit Programme for 2019-20.

Further Work 2019-20

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

COMPLAINTS AND LEGAL SERVICES

All complaints are triaged and any complaints with a safeguarding aspect have this identified on the triage form and safeguarding staff are notified of these. Learning this year has been the need to train the patient advice team further on recognising safeguarding issues raised through phone calls they receive and escalating immediately to a senior level. This has now been completed.

A monthly meeting takes place with the Governance and Risk team and Head of Safeguarding. At this meeting active safeguarding cases / incidents / complaints / claims / inquests with safeguarding aspects are discussed in terms of next steps and ensuring we all have an awareness of ongoing cases. There is discussion on individual cases with members of the team as needed through the year and the Legal Services team has helped in supporting obtaining statements for court proceedings when needed.

This year the safeguarding team has worked closely with the Legal Service Team in relation to a possible Court of Protection application for one of our patients. Through joint working with the Legal Services Team, the Safeguarding Team have been able to support Trust staff in reaching a best interest decision for the patient. Learning from this case has identified the lack of formal process within the Trust for these types of cases and Safeguarding and Legal Services were informed of the situation late.

SERIOUS INCIDENTS

For serious incidents with a safeguarding aspect it is usual to seek a safeguarding expert view at draft report stage or as an assigned expert investigator working with the lead investigator.

The Senior Risk Manager has reported to the Safeguarding Committee on serious incidents during the year. A Serious Incident sub group was established to allow for more in-depth review of cases. Going forwards the Senior Risk Manager will share serious Incident reports and provide assurances on delivery of actions. Key highlights will continue to be notified to the safeguarding committee which the Senior Risk manager is also a member of.

Further Work 2019-20

- We will continue to build on these links during 2019-20.
- Work with the Legal Services Team to formalise process for Court of Protection cases.
- Work with Legal Services for oversight of the process for Court Statement requests.

GENERAL DATA PROTECTION REGULATION (GDPR)

GDPR came into force on 25 May 2018 and was designed to modernise laws that protect

the personal information of individuals. Working together to Safeguard Children (July 2018), states that practitioners must have due regards to relevant data protection principles which allow them to share personal information as provided for the Data Protection Act 2018 and the General Data Protection Regulation. All practitioners should be confident of the processing, storage and sharing of information for safeguarding purposes, including 'special category personal data.' Practitioners sharing this special category data should be aware that this Act contains safeguarding children and individuals at risk as a processing condition that allows practitioners to share this information.

Current Position

This is delivered in Level 3 safeguarding children training

Further work

- To continue to support staff in their Safeguarding responsibilities and deliver in training

EXTERNAL REVIEW AND CHALLENGE EVENTS

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

Both these reviews were conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
Individual action plans, progress and assurance are monitored by the CCG through the Safeguarding Committee meeting attended by the CCG Designated Nurse for Safeguarding Children.

For Calderdale 2016 Inspection

- All actions completed.

For Kirklees 2018 Inspection

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

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

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

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

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

Ofsted Inspection Calderdale Metropolitan Borough Council

Ofsted Inspected children's social care services between the 12th November to the 23rd November 2018. In their summary of the inspection:

- The experiences and progress of children who need help and protection – requires improvement
- the impact of leaders of social work practice with children and families – Good
- The experiences and progress of children in care and care leavers – outstanding

Overall effectiveness – Good

The inspection noted 'that the culture in Calderdale is one of reflection, learning and appropriate action; strong collaborative working with partners is reflected through shared priorities which improve children's lives.' They gave the example of the DA Hub in Calderdale.

Ofsted SEND (Special Educational Needs and Disability) Inspection March 2019

This was a multi-agency inspection and Ofsted/CQC inspectors visited a range of providers and services between the 11th – 15th March 2019 and spoke with children and young people and their parents and carers about their experiences. The report will be published in May 2019.

Ofsted Inspection Kirklees

Ofsted inspected Kirklees Children's Social Care in September and October 2016, focusing on local services for children in need of help and protection, looked after children and care leavers. The Independent Safeguarding Children Board was also inspected and an overall assessment of inadequate was made. Adoption performance and the experience and progress of care leavers were assessed as requiring improvement. Ofsted have continued to monitor progress since 2016 and a re-inspection is likely shortly in Kirklees.

CHFT continues to support and attend the Safeguarding Children's Board and provide representation and membership to all its subgroups to support in delivering the Safeguarding Children's Boards action plan.

SAFEGUARDING BOARDS AND CHANGES

The Safeguarding team support the multi-agency partnership working with the Safeguarding Children and Adults Boards for Kirklees and Calderdale. This involves true partnership and shared goals and development.

Current Position

- On Monday 1 April 2019, the Calderdale Safeguarding Children Board (CSCB) became the Calderdale Safeguarding Children Partnership (CSCP). This change follows the Department for Education's Working Together to Safeguard Children report from July 2018 which introduced Safeguarding Children Partnerships to replace local Safeguarding Children Boards across the country. These new legal requirements make local police, councils and health services jointly responsible for keeping children safe, and accountable for how well agencies work together. It will also increase opportunities to work more closely with the other Safeguarding Partnerships across West Yorkshire in order to improve learning, share resources, increase understanding of the effectiveness of safeguarding activity and ultimately to improve services for children and families. Progress towards these changes has been taking place since 2018 in Calderdale, as the area was one of 17 in the country to become an 'early adopter'. This means that the Council and partners have been working with the National Children's Bureau to launch the new safeguarding arrangements before being adopted across the rest of the UK.

- The death of any child is reviewed by the Child Death Overview Panel (which reports to the Safeguarding Childrens Board in the area). Currently Calderdale and Kirklees are a shared Panel. Plans are in place for Wakefield to join this panel.

OUR SAFEGUARDING STRATEGY 2019-2020

In line with the Trust 5-year strategy to deliver outstanding compassionate care to the communities we serve, as a safeguarding team we put the patient first, we go see, we do the must dos and we work together to get results.
We will continue to implement and organisational approach to safeguarding and promoting the welfare of children, young people and adults ensuring that this is embedded across all divisions and services provided by the Trust and in every aspect of the Trust's work.

There will be robust governance arrangements around the safeguarding agenda and staff working within CHFT will be able to discharge their statutory responsibilities within their professional boundaries supported by the Integrated Safeguarding team.

This will work towards the Trusts overall goals of: Transforming and Improving Patient Care, Keeping the Base Safe, A workforce for the Future and Financial Sustainability.

Our key Priorities for this year are:

1. **PREVENT**

- To achieve the Trust target of 95% and maintain this compliance.
- To continue to attend and be a part of the Channel Panel group in Calderdale and link into Kirklees PREVENT work as/when required.
- Update the PREVENT Policy to outline changes in delivery of NHSE training strategy.

2. **Adult Safeguarding**

- To contribute to the update of the Allegations Policy
- To continue to embed 'Making Safeguarding Personal'
- Continue to develop systems that are lean and accessible for staff at times of high demand and impact.
- To review the Missing Person Policy.

- Monitor and review pressure ulcer prevalence.
- Improve analysis and reporting on outcomes as indicated in the Making Safeguarding Personal Agenda.
- To review safeguarding adult training in line with the new Adult Intercollegiate Document.
- Continue being involved in Discharge Improvement work.
- Ensure all staff are aware of the circumstances when a fall should be reported through the safeguarding procedures

3. Safeguarding Week

- To be involved and contribute to Safeguarding week.

4. Pressure Ulcers

- Implementation of Decision support tool to justify and evidence rationale to refer to Gateway to Care.
- Implementation of PUSH (pressure ulcer safety huddle tool) for rapid review within 48 hours.

5. MCA and DOLS

- To continue to support wards in completing their own DoLS applications
- Adding the MCA template into Cerner and Athena electronic Systems
- Deliver bespoke training regarding MCA/DoLS and Mental Health to maternity services
- To continue to aid staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding.
- Provide more in-depth report to Board of Directors as the Bill and Codes of Practice develop.
- Consider the impact of changes and introduction of training, processes and authorisations with the planned new system.
- Work with legal services department to ensure plans for new systems are embedded

6. Mental Health

- Update the Joint Protocol in line with the CAMHS Out of Hours Working Arrangements
- Continue to promote 'Receipt and scrutiny' training for members of staff who will accept Section papers on behalf of CHFT.

7. Children and Young People

- Continue to embed and provide safeguarding supervision in line with CHFT supervision strategy
- To work closely with the Risk Department regarding requests for Court statements
- To work with Maternity Services in relation to implementing a Safeguarding Supervision Strategy and delivery model.
- Raising awareness of child abuse with a religious implication.
- Continue to develop the Safeguarding Champions membership and look at different ways of engagement

- Development of Midwifery Supervision Strategy and implementation plan in response to supervision figures
- Further work on the EPR regarding enhancing the Paediatric Liaison referral process
- To introduce the Under 18 proforma to SAU and MAU, ED and Paediatrics
- To update the training strategy in line with the Intercollegiate Document (2018).
- Developing a standard operating procedure for Under 18 attending for TOP following a suspected sexual assault.
- The team continue to raise awareness of ensuring that the Safeguarding Children team have overview of all referrals made to children's social care by departments and ward areas though training, supervision and awareness raising.
- To work with Calderdale and Kirklees Social Care to validate and compare numbers of referrals made.
- Level 1 and Level 2 training packages require updating to reflect 'Working Together 2018' statutory guidance, and the Intercollegiate Document 2019.
- Level 3 training requires updating in line with the Intercollegiate Document 2019.
- To work with Calderdale and Kirklees Social Care to validate and compare numbers of referrals made.

8. CSE

- For further promotion and use of the Under 18 proforma in SAU and MAU

9. FGM

- To develop and embed the FGM Risk assessment tool into the Athena electronic System in Maternity

10. Domestic Abuse

- Support the domestic abuse support worker role to work into Calderdale ED.
- Review the recommendations arising from the Domestic Abuse Bill and implement once this is in effect.

11. Children Looked After Calderdale

- Procurement of additional Health passports
- Consolidate the caseload where all CLA specialist nurses are experts at Review health assessments for all children /young people age 0-18.
- Identify the post 18-25 caseload and build a pathway of how we can support this vulnerable group.
- Build a corporate leaflet/information sheets for both professionals/children/young people on differing aspects of what we deliver.
- Continue to build the expertise of the staff with training/1-1 supervision/case management/safeguarding supervision.
- Improve the clinic rooms used for IHA/RHA clinics with regular health promotion notice boards/child/family friendly messages which are updated regularly.
- Attend the weekly CSE operational meeting sharing information and being part of the multi-agency discussion.

12. Training

- To deliver enough face to face training sessions for staff becoming out of compliance in 2019-20 and aspirationally meet 95% compliance.
- To continue to encourage Divisions to complete training and consistently raise the profile of safeguarding training and delivery of 95% training compliance.
- Review the Adult and Children's Intercollegiate document's and work with Workforce Dept. to identify any changes these documents will result in and changes in targeted levels for staff.

13. Audits

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

14. Serious Incidents, Complaints and Legal

- Work with the Legal Services Team to formalise process for Court of Protection cases.
- Work with Legal Services for oversight of the process for Court Statement requests.
- We will continue to build on these links during 2019-20.

CONCLUSION

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

The Trust has responded to these changes and to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

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

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

11. Care Quality Commission (CQC) Verbal Update

To Note

Presented by Ellen Armistead

12. High Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing and Deputy Chief Executive
Previous Forums:	Risk and Compliance Group 5 August 2019

Actions Requested:
To approve

Purpose of the Report

To assure the Board of Directors that all risks are accurately identified and mitigated adequate ly through reviewing the risks identified on the high level risk register as at 19 August 2019.

Key Points to Note

Movement on the high level risk register since the last report to the Board on 4 July 2019 is summarised in the attached paper. In brief there is:

- One new risk added to the risk register which is risk 7477 at a risk score of 15, a
- corporate risk regarding Tissue Viability capacity

- One risk with an increased score, risk 7454 regarding Radiology Consultant staffing, increased to a risk score of 20 (from 15)

- Two risk with a decreased score:

  - risk 7338 regarding saving entries on the electronic patient record which has been reduced from a risk score of 15 to 10. This risk will be removed from the high level risk register and will now be managed within the Corporate division risk register

  - risk 7253 regarding paediatric staffing has been reduced from a risk score of 15 to 12. This risk will be removed from the high level risk register and will now be managed within the Family and Specialist Service's division's risk register

  Further detail on these risks is given in the attached paper.

Equipment failure from Medical Devices
At the Risk and Compliance Group on 5 August 2019 a review took place of risk 7474 regarding out of service medical devices and following discussion about increasing this risk score from 15 to 20, it was agreed that the risk should remain at a risk score of 15.
EQIA – Equality Impact Assessment
No significant risk
Recommendation
The Board is asked to: • consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed • approve the current risks on the risk register • advise on any further risk treatment required

High Level Risk Register Board Summary – August 2019
Risks at 19th August 2019

TOP RISKS

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

7278 (25) Longer term financial sustainability risk
7454 (20): Radiology Staffing Risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
5806 (20): Urgent estates schemes not undertaken

The Trust risk appetite is included below.

NEW RISKS

7477 (Score 15) Corporate Nursing
Tissue Viability Risk

There is a risk of reduced capacity in the Tissue Viability Team due to vacancy resulting in potential delay in expert appraisal, supervision and education, care planning and review of patient at risk of pressure damage or who have sustained pressure damage.

INCREASED RISKS

7454 ↑20 (Score 15) FSS
Radiology Staffing Risk

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

RISKS WITH DECREASED SCORE

7338 EPR Risk ↓10 (15) Corporate

The Risk of an incomplete Electronic Patient Record due to the ability to save an entry on the EPR system which is not submitted to the patient record until signed option is selected

October 2018 there were 65,000 entries on the system that had not been signed poteintilaly since the start of EPR – 0.5% of the records

Rationale for Reduction

The risk has been reduced as
1. Computer tags now viewable on all hardware in clinical areas.
2. Figures remain around the 40,000 figure.
3. There is a request to the data team to produce a link on the Knowledge Portal for divisions to have sight of unsaved entries in their areas and which clinicians are responsible.
4. A further meeting has been arranged with the Infrastructure team to provide a date when historical entries can be committed to the system.

7253 Paediatric Staffing Risk ↓12 (15) FSS

This is a Paediatric and Neonatal medical staffing rotas risk due to the gap if 5 WTE staff in the 11 person Tier 2 medical staffing rota resulting in inadequate service provision for local children, young people and their families.

Rationale for Reduction

The risk has been reduced as there in an improved Tier 2 allocation from the Deanary which will improve staffing.

August 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 19/8/2019

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Mar 19	April 19	May 19	June 19	July 19	Aug 19
Quality and Safety Risks										
10/19	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
09/19	5806	Keeping the base safe	Urgent estate work not completed	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
05/19	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (EA)	=15	=15	=15	=15	=15	=15
10/19	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
08/19	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)	=16	=16	=16	=16	=16	=16
11/19	7248	Keeping the base safe	Mandatory Training	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
06/19	7315	Keeping the base safe	Out patient appointments capacity risk	Director of Operations, FSS (CG)	=15	=15	=15	=15	=15	=15
06/19	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
06/19	3793	Keeping the base safe	Opthalmology follow up appointment capacity risk	Divisional Director of SAS (WA)	=16	=16	=16	=16	=16	=16
05/19	7345	Keeping the base safe	Referral to the District Nursing Service	Director of Nursing (EA)		!16	=16	=16	=16	=16
09/19	7414	Keeping the base safe	Buidling safety risk	Director of Finance (GB)		!15	=15	=15	=15	=15
10/19	7413	Keeping the base safe	Fire compartmentation at HRI	Director of Finance (GB)		!15	=15	=15	=15	=15
08/19	6493	Keeping the base safe	Complaints Quality and performance Risk	Director of Nursing (EA)			!15	=15	=15	=15
10/19	7454	Keeping the base safe	Radiology staffing risk	Director of Operations, FSS (GH)			!15	↑20	=20	=20
06/19	7474	Keeping the base safe	Medical Devices Risk	Director of Finance (GB)				!15	=15	=15
06/19	7251	Keeping the base safe	Optovue OCT (Ocular Coherence Tomography) machines risk	Divisional Director of SAS (WA)				!15	=15	=15
10/19	7477	Keeping the base safe	Tissue Viability Risk	Deputy Director of Nursing (LR)						**!15**

FINANCE RISKS										
10/19	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
10/19	7062	Financial sustainability	Funding of capital programme	Director of Finance (GB)					**!16**	=16

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

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

Board Assurance Framework risks referenced above.

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

TRUST RISK PROFILE AS AT 19/8/2019

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation = 6493 Complaint management = 7251 Optovue OCT Risk !7477 Tissue Viability Risk =7315 Appointment Risk	= 6345 Nurse Staffing = 7078 Medical Staffing =7454 Radiology staffing	=7278 Financial sustainability
Likely (4)				=7223 Digital IT systems risk =7248 Mandatory training =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity =7345 District Nurse Referral Risk =7062 Capital programme	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed
Possible (3)					= 5747 Vascular /interventional radiology service =7413 Fire compartmentation HRI =7414 Building safety risk =7474 Medical Devices Risk
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

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

	We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.		
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**

High Level Risk Register

AUGUST 2019

The Health Informatics Service
Informing Healthcare

Risk No	Div	Dir	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
7278	Corporate	Finance and Procurement	Trustwide Finance	Jun-2018	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £37.99m (as per the NHS Improvement 19/20 control total). Acceptance of this control total gives the Trust access to £6.15m MRET funding, £7.33m Provider Sustainability Funding (PSF) and £14.81m Financial Recovery Funding (FRF), reducing the planned deficit to £9.71m. The receipt of PSF and FRF are dependant on achievement of the control total. The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2018/19 external audit opinion raised concerns regarding going concern and value for money. Whilst the Trust is developing a business case that will bring it back to balance within the next 8 years, this plan is subject to approval and the release of capital funds. =	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 Development of 5 year LTFP in conjunction with ICS 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 ICS priorities for resources Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors The Trust does not currently have an agreed plan to return to in year balance or surplus. No additional revenue costs have been included for the development of the Reconfiguration Business Case.	25 5 x 5	25 5 x 5	20 5 x 4	Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case submitted in April. Capital forecast for 19/20 includes £2.5m relating to reconfiguration and the development of the Business Case: £1.5m for HRI and £1m for Fees. 19/20 Forecast now incorporates £0.4m of Revenue costs for 19/20 Stretching CIP target of £11m (3%) for 19/20 reflects the fact that the Trust needs to find greater efficiencies than the baseline incorporated within Tariff as part of its journey towards financial sustainability. The target is in excess of the minimum expected of 1.6% (1.1% national efficiency factor plus 0.5% additional requirement for Trust's in deficit).	Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case submitted in April and currently being reviewed by NHSI, NHSE and DH. Current plan indicates that the Trust would return to balance in year 7. 19/20 Financial plan has been submitted to NHS Improvement and the Trust has submitted a plan that accepted the Trust's allocated control total of £37.99m. This will allow the organisation to access non-recurrent MRET funding of £6.13m, Provider Sustainability Funding (PSF) of £7.33m and Financial Recovery Funding (FRF) of £14.81m reducing the overall planned deficit to £9.71m. A five year long term plan for the Integrated Care System is due to be submitted in November 19 and preparation for this submission will provide a further opportunity to test planning assumptions.	Sep-2019	Mar-2020		FPC	Gary Boothby	Philippa Russell

7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in consultant capacity resulting in gaps in some specialist areas, a reduction in overall general capacity and the potential for breaching national targets.	- Agency locum cover. - NHS Locum cover. - Additional support from external providers. - Head and neck: Additional support from external providers and short term support was provided up until end June 2019 from adjacent Trust. - Lung and chest: Additional support from external providers and temporary change to job plans. - IR: Agency locum cover. - Neuro: Additional support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in: - Head and neck: No vetting of requests . No on-site cover. - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap during annual leave/other leave of one remaining Consultant. - Breast: Reduced capacity and no capacity during annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave. Impact on the general on-call rota.	15 3 x 5	20 4 x 5	0 0 x 0	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all areas. - Actively seeking two radiology overseas fellows. - Successfully recruited one head and neck Radiologist (due to start July 2019). - Successfully recruited one IR Radiologist (due to start June 2019). - NHS locum position offered to one breast Radiologist.	June: IR radiologist commenced 10th June 2019 (as NHS locum, fixed term) but existing substantive leaves the organisation on the 28th June. Breast radiologist accepted NHS locum fixed term contract (12 months) and is due to start on the 19th August 2019. July 2019 - Agreed increased score from 15 to 20 for the HLRR July 2019 Update: We no longer have any head and neck cover. **August 2019**: New Consultant Radiologist commenced end July 2019.	Sep-2019	Dec-2019		PSQB	Caroline Gizzi	Sarah Clenton
6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - 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	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - staff redeployment where possible - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - Active recruitment activity, including international recruitment - Introduction of new roles eg Nurse associate	Low numbers of applications to nursing posts across grades and specialities	16 4 x 4	20 4 x 5	9 3 x 3	• Recruitment including international recruitment of Nurses • Nursing associate role development • Developing nursing retention strategy • Use of flexible workforce	**August 2019 Update** Currently recruiting next cohort of Return to Practice nurses which will start in September 5 offers to be made. Planning has started for the next Trainee Nurse Associate programme in December 2019 for a further 20 trainees. Currently 60 TNA in post. Head Nurse is working with procurement to review the overseas tender. 30 nurses have now been recruited from the Philippines trip with a further 5 due to start over the next couple of months.	Sep-2019	Dec-2019		WF	Ellen Armistead, Suzanne Dunkley	Rachael Pierce

2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	Apr-2011	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	20 5 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	July 2019 Anticipated a few gaps at HST level from October as 1 allocated trainees has reached CCT and leaving the scheme. Another 2 on Maternity leave. School of EM has been challenged to no avail. New rotas will be in place for August. While the gaps will increase the utilisation of locum doctors, the new rotas will mitigate the times when locums are the sole senior decision maker. **August 2019** New rotas in operation.	Sep-2019	Aug-2020		WEB	David Birkenhead	Dr Mark Davies
7078	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Oct-2017	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) 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, Gastroenterology, Radiology, Care of the Elderly, Opthalmology, Urology and dual site working which impacts 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	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties 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 Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	July 2019 Consultant recruitment remains a priority within Medical HR. The second AAC for an Emergency Medicine Consultant has been arranged for Thursday 18 July, and the candidate has confirmed attendance. An AAC has been confirmed for August for the following Consultant posts, Paediatrics, Obstetrics and Gynaecology and Care of the Elderly which all have active applicants in the process. Almost half of the doctors in training due to join the Trust in August have already been cleared in this first week in July which is a reflection of the hard work and organised approach that the Medical HR team have applied. There are a number of late notifications of gaps from Health Education England due to people failing exams or not progressing satisfactorily within their training programme and having to stay with their current employer. These are more difficult to manage and often lead to fixed term trust appointments, with a time delay before the gap is filled. There are also gaps in service due to an increasing number of less than full time trainees (LTFT). In previous years 2 slot share trainees may have been available to provide full time cover. However, it is now common for a full time slot to be filled by a trainee who is undertaking 60% WTE working. The gaps created	Sept-2019	Mar-2020		WF	David Birkenhead	Pauline North

						key strategic objectives							are particularly notable in Paediatrics on the higher grade rota. Personalised rotas are created for all LTFT trainees. **August 2019** All the new Doctors in Training that were allocated to CHFT (169) were fully cleared to commence in post without any delays. This included 46 FY1 doctors who had a 4 day induction period commencing Thursday 1 August. In addition to the 169 new starters, there were also 87 trainees moving from one department to another that required work schedules and new contracts and pay arrangements putting in place. During the month of August there are a number of new trust doctors commencing in post, including 5 for the new shared General Surgery and Trauma and Orthopaedics rota, which should significantly reduce agency expenditure. At Consultant level, there is a new starter that has commenced in Emergency Medicine and a second candidate has been given an unconditional offer to commence once they have served their notice in their current employment. There are Advisory Appointment Committees scheduled for a number of consultant posts in August including; Obstetrics and Gynaecology, Paediatric (neonates), and Medical Oncology. Care of the Elderly and General Surgery candidates will be interviewed during early September. Two of the recently appointed Consultant Radiologists and a Consultant Anaesthetist will also be commencing in post in August.						
5806	Calderdale and Huddersfield Solutions	Estates	Estates Department	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural	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.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. Each of the risks above has an entry on the risk register and details actions for managing the risk.Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	12 3 x 4	• Monitoring of the estate structural and infrastructure through annual report • Ongoing programme of works	June 19 Update - Work has now commenced on developing the Estates Strategy for Huddersfield Royal Infirmary. This work stream will use the 6 facet survey and external consultancy to develop the strategy. Capital work continues to progresses with live schemes on fire safety, pipework and critical infrastructure. **July/August 19 Update** - Work continuing to develop the Estates Strategy for Huddersfield Royal Infirmary. This work stream will use the 6 facet survey and external consultancy to develop the strategy. Capital work continues to progresses with live schemes on fire safety, pipework and	Sep-2019	Mar-2020		RC	Stuart Baron	Paul Gilling / Chris Davies

						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 industrial disease to staff, patients and general public • 6771 Emergency Lighting: Statutory compliance in order to provide adequate emergency lighting	When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.				critical infrastructure.						

						• 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												
7223	Corporate	THIS	THIS -Operational	Mar-2018	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 4 x 4	16 4 x 4	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).	June 19 - TTE Carried out around EPR on the 11th of June. This raised some further concerns around how perpared clinical areas are for any downtime. There is an planned downtime in early July (10th) where these plans will be tested again and this risk can be reassessed - No change in the current score. **July/August 19 Update:** A planned downtime of EPR took place on the 24th of July, this brought divisional BCPs into play in a real scenario with positive results, the lessons learned are being collated and will feed a review of this risk in August. The patching process has been tightened along with starting to identify maintenance windows to reboot hardware for the patches to take effect. These actions address some of the gaps in controls outlined in the action plan. The score will be re-assess following the downtime feedback.	Sep-2019	Oct-2019		RC	Mandy Griffin	Rob Birkett

							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											
7248	Corporate	Workforce & Organisational Development	Workforce Development	Apr-2018	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated essential safety training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts. The proposal has been agreed for 2019/2020. Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our essential safety training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 essential safety training subjects alongside the 29 role specific essential skills training. This approach strengthens the importance of completing the essential skills designated to specific roles and by combining the two areas into one enhances the Trust's requirement to reach 95% across all the competency offerings. Risk:- There have been issues with ESR and the consequences of not being	All electronic e-learning training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16 4 x 4	16 4 x 4	4 4 x 1	January 2019 Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support. Additional training dates have been added for safeguarding and MCA/DoLS level 3.There are sufficient places to train ALL staff who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.	June 2019 - The work identified above is continuing but the completion date has been put back to the end of July 2019. This is due to some technical issues identified in the process - the Workforce BI Team have raised these with the ESR Functional Advisor and IBM. Additional DSA classroom sessions have been attended to raise compliance in this subject. **August 2019** - The 9 core subjects of EST have been 're-set' in the system and this has enabled colleagues to play the learning without difficulty. A 'deep-dive' into Infection Control Level 2 and all Resuscitation subjects has taken place to identify capacity.	Sep-2019	Mar-2020		WF	Suzanne Dunkley	Claire Wilson

						able to undertake e-learning. ESR was down for 15 days from 31 December 2018 - 14 January 2019. Impact:- Employees have been unable to access ESR to undertake e-learning and in turn affects our ability to reach and maintain 95% compliance.											
7345	Community Healthcare	Community Nursing	District Nursing / Matrons	Oct-2018	Transforming and improving patient	Patient Safety Risk - There is a risk of patients with a nursing need not being referred on discharge to the District Nursing service. Due to lack of referral facility on EPR and the discontinuation of the PASWEB referral pathway prior to the implementation of EPR. Resulting in patients not receiving district nursing care deteriorating at home and being re admitted to hospital.	Wards have been advised to contact the DN teams via telephone to make referrals on discharge. Community Division to work with the other division to test out if this process is being followed and understood. Community Division are reporting incidents of non referral on to Datix to enable monitoring	System has not yet been tested	16 x 4	16 x 4	2 x 2	Directory of Community services circulated to wards and departments Ward staff encouraged to refer to District nurse via telephone E referral option being scoped Wards and discharge coordinators encouraged to invite District nurse to MDT	April 2019 - Update from Digital Board. E Referral is now with the IT build team. Proposed go live date is end of June/July 2019 June 2019 Final demonstration of e referral form taking place on 21 June and testing implementation of e referral form with wards 12,17 and frailty service on 1 July 2019 (update from Helen Webster-Mair) **August 2019** EPR referral now active. Wards slow to roll out but reinforcing with all refers to use EPR. Communication circulated	Sept-2019	Sept-2019		PSC	Liz Morley	Caroline Lane
3793	Surgery & Anaesthetics	Head and Neck	Ophthalmology	May-2017	Keeping the base safe	Risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 x 2	16 x 4	3 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) Appointment made, anticipated start date July 2019 - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	**July/August update** New locum Consultant commenced in post 22/7/19 - undertaking new and follow-up General Ophthalmology capacity. Appointed specialty Dr - due to commence in post approx. Dec 19 (awaiting VISA), bank Consultant providing Vitreo-retinal, general, macular capacity (2 days a week for approx. 3-6 month) commenced in post 2/8/19, full-time substantive cornea Consultant to commence in post 9/9/19 and re-advertised for substantive Glaucoma Consultant (closing date 6/9/19). Holding list reduced over last 9 months from approx. 2400-1300.	Sept-2019	Dec-2019		DB	Will Ainslie	Pnt Laloe

6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 and January 19 EL (97) 52 external audit which reported 3 major deficiencies limiting its capacity to make parenteral products, resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be implemented before October 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition, update the product catalogue, and from May 2020 -outsource radiopharmacy (buy in MDVs of radioisotopes)	Until the strategies outlined above to improve capacity have been implemented we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm	15 3 x 5	16 4 x 4	3 3 x 1	Agreed Action Plan October 18 to reduce capacity at HRI ADU i - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit. Delays in project have delayed the temporary closing of the CRH unit to October 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in . Target 100% by Aug 19. Phasing in of ready to use chemo batches also underway.	June 19 update. Aseptics progress reported at June Divisional PRM. Aseptic Staffing in new model reviewed to ensure meet the required QA standards. Financial costs have increased from original feasibility study. Project has been delayed due to procurement process issues initially and more recently due to extra estates works (air extractors/ planning permission). New target date for opening June 2020. Aseptics managers continue to work on EL audit action plan to ensure necessary quality standards are reached. **August 19 update** Units had an EL Audit on 30th July and are awaiting report from that. Use of bought-in bags of PN is at over 60% when stock is available -- there have been delays from the supplier on occasion which have necessitated in-house production. No firm timescale available for the start of the build at CRH	Sep-2019	Jun-2020		DB	Ellen Armistead	Elisabeth Street

7062	Corporate	Finance and Procurement	Corporate Finance	Sep-2017	Financial sustainability	Risk that the Trust will have insufficient funding available to complete its planned capital programme	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.	Limited Contingency available. Uncertainty regarding long term capital planning while FBC is awaiting approval. The Trust has planned capital expenditure for 19/20 of 20.2m, £12m more than available internally generated capital funds of £9.33m. Only a very small contingency of £0.3m is included. Some elements of the Capital plan are reliant on securing external funding through a combination of Public Dividend Capital and capital loans. A further £5.2m of externally funded capital expenditure has been stripped out of the 19/20 forecast due to lack of national funding, with emergency capital bids for MRI, Cladding and Reconfiguration costs partially slipped into 20/21.	20 5 x 4	16 4 x 4	6 3 x 2	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances. ICS has requested confirmation that Emergency capital funding for 19/20 has been approved.	**August 2019** Capital Forecast has been reduced to £15.01m, but this is still £6.80m more than internally generated: • £3m agreed PDC funding for National Pathology Exchange (confirmed as approved) and Energy Efficiency scheme (awaiting final confirmation) • £1.3m emergency capital bid to fund MRI £0.8m and Cladding £0.8m, subject to confirmation of funding, (assumed as Loan funding) • £1.5m of the £197m SOC case – provisional split of £1.5m for HRI and £1m for fees (assumed as Loan funding) • Internally generated relies on sale proceeds from Acre House and Glen Acre House at £1.7m (net) Since the initial plan submission the internally generated capital funding has been reassessed based on asset revaluation and has had to be constrained by £1.4m, including a reduction in the contingency down to £0.3m. A further £5.2m of externally funded capital expenditure has been stripped out of the 19/20 forecast due to lack of national funding, with emergency capital bids for MRI, Cladding and Reconfiguration costs partially slipped into 20/21. The external elements of capital funding have not been confirmed at this stage, although it was indicated that if the ICS successfully reduced its capital plan (which it has) remaining emergency funding bids would be made available. The risk was increased to 16 (Likelihood 4 x Impact 4). Confirmed by Finance & Performance Committee on 31.05.19.	Sep-2019	Mar-2020		FPC	Gary Boothby	Philippa Russell
7315	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2018	Keeping the base safe	Risk of delay to patient care, diagnosis and treatment caused insufficient outpatient appointment capacity to meet current demands resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and possible claims. Currently there are in excess of 11,000 patients awaiting appointments. circa 3500 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 8,000 follow up patients that have all exceeded the appointment due date.	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	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	Monitoring of appointment backlog at Performance Meetings Validation of Holding List and Appointment Slot Issues List SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level	Update 11/06/19 New patient ASI's remain high. All specialities instructed to clear long waiters over six months by the beginning of July. Will look at managing ASI's on ERS to ensure we are working from an up to date position. SOP being developed between appointments and divisions. ASI presentation given at WEB. F/up patients exceeding there to be seen by date continues to reduce now at 5014. Continue to discuss with divisions and ensure all capacity is used to best effect. **August 2019** Capacity and demand tool on knowledge portal has been developed. Being shown to all ops managers during	Oct-2019	Nov-2019		PSQB	Caroline Gizzi	Kimberley Scholes

						Please refer to following individual risks: 4050 6078 6079 7199 7202	Delivery of 18 weeks RTT..						customer contact session. Clearly shows the demand and what capacity is available which will help planning. WTGR sessions booked to include wider organisation to pull plans together to ensure patients receive their appointment in a timely manner. Smaller sub group formed to look at detail and root cause analysis.						
7474	Trustwide	All Divisions	All Departments/Wards	May-2019	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and use across CHFT due to the lack of assurance of the Trust Asset Register being up to date including equipment which has been gifted or bought without CHS involvement resulting in potential patient harm. CHS Risk 7438 –(Rating 20) - There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, resulting in potential patient harm CHS Risk 7438 –(Rating 20) CHFT Risk 7474 (Rating 15)	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.	Failure to manage, maintain and service medical devices.	5 5 x 1	15 5 x 3	1 1 x 1	2019/05/17-Update-High Risk numbers continue to fall High risk (643 to 592), Medium risk fell (2635 to 2612), Low risk rising (1956 to 1987), a total of (5234 to 5195) 2019/05/21-Update Contract meeting held with SLA provider Mid York's now in agreement with them to complete outstanding work, problem identified individuals within CHFT retaining un-serviceable medical devices within community(this will be stopping have instructed Mid York's to remove devices), a forecast of dates for servicing will be pushed out to community. Feedback on good progress has reduced the likelihood from 4 to 3. (28th May 2019) As agreed by DoN and DoF.	20190707-Update-High Risk numbers continue to fall High risk (574 to 561), Medium risk rose (2488 to 2505), Low risk rose (1824 to 1893), a total of (4886 to 4959). Another anesthetic machine has been removed from service for disposal, two more will not be supportable beyond the end of the month and will require replacement. Medical devices have been found that have had unauthorised repairs made by unqualified personnel, which have compromised the devices, their results, patient safety and IPC. Also a previously decommissioned device that had not been seen for 9 years has been found, returned and withdrawn from service. 30th July 2019 Update - numbers of hi, med, low devices maintained - Increase in staffing levels (to be confirmed) - Positive Awareness raising exercise (via screen savers etc) - visits planned to matrons / sisters meetings **August 2019** -High Risk numbers continue to fall High risk (561 to 490), Medium fell greatly (2505 to 2244), Low fell (1893 to 1775), a total of (4959 to 4509). Both Draeger Fabius anesthetic machine have been removed from service for disposal, they have also been identified for replacement. Medical devices training team produced a poster and screen saver, which has been published this has increased the identification of devices that are out of date, therefore enabling the reduction of the number of devices at risk. We are finding more devices that are End of Life or end of support these are being added to CHS risk 7478.	Sep-2019	Oct-2019		RC	Ellen Armistead	Robert Ross

7477	Corporate	Corporate Nursing	Tissue Viability	Jun-2019	Keeping the base safe	There is a risk of reduced capacity in the Tissue Viability Team due to vacancy resulting in potential delay in expert appraisal, supervision and education, care planning and review of patient at risk of pressure damage or who have sustained pressure damage.	1) Recruitment on a fixed term basis has been completed providing a full time bank TVN and Band 6 TVN. 2) Community are using the resource of a D/N who has recently had a 6 month secondment into the team. 3) Matrons have been up skilled to become second validator of PU within their areas to ensure only appropriate referrals are made to the TV service 4) Robust management of inappropriate referrals by Ward Managers and Matrons overseen by Lead Nurse - Corporate. 5) All TVN training suspended for the moment (with the exception of ESR training).	1) Validity and understanding of available data to plan service and manage demand for care homes.	15 3 x 5	15 3 x 5	1 1 x 1	Oversight of remedial action plan by Deputy Chief Nurse and Assistant Director of Quality and Safety. Action plan led by Senior Lead Nurse - Corporate. Increase specialist TVN team on a fixed term basis using bank contracts and refocusing work of community nurse with subject matter expertise. ADQS to provide supervision and oversight to Pressure Ulcer Collaborative until new Lead Nurse in post Senior Lead Nurse - Corporateto continue to support Matrons to validate pressure ulcers in clinical areas and to support clinical and ward managers with local improvement work.	July 2019 Update A new Tissue Viability Lead Nurse has been appointed and comes into post in October 2019. successful appointment to the Band 7 post which commenced 1st July 2019. The Band 6 post has been recruited to and is progressing through the recruitment process. July 2019 - Agreed for inclusion on the HLRR **August 2019 Update**. Band 7 now in post 1 month band 6 commenced 5th August. However, due to A/L risk remains high. Mitigation is in place for A/L with the use of bank nurse fulltime for W/C 12th August very reduced service W/C 19th.	Sep-2019	Dec-2019		NA	Lindsay Rudge	Catherine Briggs
5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1wte substantive consultant in post - Ad-hoc locums supporting the service - Continue to try to recruit to vacant posts	- Failure to secure long term locum support. - Lack of clarity on regional commissioning arrangements relating to vascular services	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response	June 2019 - Regional reconfiguration project will establish longer term solution - expected to take 12-18 months to complete June 2019 Update - NHS locum in post for 12 months commenced June, undertaking a period of orientation into the UK. Substantive consultant left 21 June 2019, Working to secure a second agency locum for 2/3 months. Ongoing discussions with agency re:locum on-call, Leeds and Bradford regarding on-call cover. **August 2019** Position remains as per update above.	Sep-2019	Oct-2019		DB	Caroline Gizzi	Sarah Clenton
6493	Corporate	Corporate Quality	Governance and Risk Quality	Nov-2015	Keeping the base safe	Complaints Management - quality and performance risk Risk that the Trust does not respond in a timely way to complaints and breaches NHS Complaints Regulations 2009 due to complaints responses not being investigated and drafted within agreed timescales, staff not recording all complaints investigations on Datix and not updating complainants in a timely way, resulting in dissatisfaction for complainants due to poor	Agreed response timescales for all complaints and confirmation of these for each complaint. lead complaints investigator role to keep complainant informed of expected response date. All stages of complaints now managed and recorded via Datix complaints module. Weekly tracker identifying complaints due and days remaining. Weekly complaints panel in	Medical division complaints position continues to be challenging - to be addressed through performance route also following lack of assurance to Quality Committee on 30 July 2018 re: sustained improvements. Quarterly meetings with senior complaints team and Assistant Directors of Nursing to be introduced.	12 3 x 4	15 3 x 5	4 2 x 2	Continue to monitor overdue complaints via weekly tracker and revise risk score and actions required if improved position is not sustained. Position escalated to Chief Nurse and Chief Operating Officer and discussed with divisional teams through PRM route. External review of complaints being planned by Chief Executive.	June 2019 - Chief Executive presenting findings of deep dive into compliant handling at CHFT across all Divisions and Corporate meetings. Chief Executive is reinforcing to all colleagues his accountability and responsibility for improvement. Improvement to be assessed through 1/4rly Serious Incident Review Group. New improvement 'dashboard' developed which focuses on patient and staff experience as well as timeliness, upgrading from concern to complaint and proportion of complaints reopened. Complaint Policy being revised in line	Sept-2019	Oct-2019		QC	Ellen Armistead	Anne-Marie Henshaw

						communication, delays in responses, poor performance on complaints responsiveness identified within the integrated performance report, reputational damage, increasing number of complaints referred to the Ombudsman	surgical division to manage timeliness and quality of responses with senior managers. Escalation of performance issues via PRMS. Weekly review of 5 day KPI turnaround in complaints team and escalation process if nearing a breach. Complaints response letter and report template introduced in line with PHSO clinical standard. Divisional Directors or Assistant Director of Nursing reviewing complaints in before sending to complaints team for review. . Complaints Policy details process for managing all complaints including cross divisional complaints. Quality assurance process in division and central team to ensure complaint is responded to appropriately. Escalation process of 10% complaints by division overdue highlighted to Director of Nursing. Complaints Investigation training reiterates key timescales and investigator responsibilities. complaints improvements within Governance and Risk action plan.	Investigators not routinely contacting complainants within 7 days. Quality of responses received variable Further WEB report on complaints and tracking of individual cases for September 2018					with patient and colleague feedback and national standards. Learning Lessons from Complaints work extended to include learning around process as well as care and care outcomes. July 2019 - Action plan based on Chief Executive findings developed with progress reported into Patient Experience Group. Actions include new approach to training for complaint handlers and a new buddy scheme. **August 2019** Action plan in progress, no barriers to implementing actions at this time. Additional actions include bringing medicine division complaint administrator into CHFT Complaints Team to offer direction and supervision from 19.08.19. Daily huddle established to prioritise work.						
6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2	Establish clinical documentation group	June 2019 - Further work required around Digital Champions requested by the Board - liaising with Leeds as they do use Digital Champions - arranging a go see. Through the Clinical Records Group and audit tool is being produced to look at the Clinical Record for data that cannot be extracted from the system to further reassure regarding the clinical record. July 2019 - Conference call with Leeds who are happy to facilitate a go see. Audit Tool being trialled in 2 ward areas as to usability and data extracted. Engaged with Acute Floor at CRH to look at record keeping in particular care plans and universal use. Sought assistance of training team in the first instance. Almost a trial of a Digital Champion Role as Ward Manager keen	Sep-2019	Nov-2019		WEB	Ellen Armistead	Carol Gregson/Graham Walsh

													to support and train. **August 2019** To arrange a go see with Leeds in connection with Digital Champions. Do not have sign off from the Board as to whether this can be progressed. Met with Ellen Armistead to discuss Digital Champions - under review. Progressing with the engagement with the acute floor. Looking at reviewing care plans, encounters, saved not signed. All high risk items relating to record keeping within the Trust are being cascaded with greater emphasis as part of the induction of new staff.						
7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Keeping the base safe	HRI There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of Areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 x 3	15 x 3	1 x 1	Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard. Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. May 2019: Delivery of fire training June 2019: Fire risk assessments, installation of sockets July 2019: NHSI capital bid for 19/20	June 2019 1) A number of fire risk assessment have been carried out at CRH on Wards 1, 2, 3 and 4. 2) 90% Sockets completed at HRI & message to be communicated Trust wide relating to the reason for the additional sockets (LOWs) 3) Toaster replacement at HRI complete 4) Fire Risk Assessment programme being explored with CHS and Fire Safety AE 5) WOD providing support to identify those who have received fire warden training across CHFT to cross reference with Departments Sockets installed at HRI:a total of 33 twin or 66 extra sockets. CRH have had 36 sockets fitted in total - (all double): **July/August 2019** Chief Operating Officer appointed as Exec Lead for Trust Fire Safety. CHS briefing COO with an update on fire safety. Independent Fire Engineer to provide fire risk assessments for CHS (Trust) CHS Fire Safety SLA to be reviewed to ensure suitable & sufficient for Trust purposes.	Sept-2019	Dec-2019		FC	Helen Barker	C Davies / A Wilson
7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors and staff. CHS RISK = 7318	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 x 3	15 x 3	1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at	**July/August 2019** Report provided from engineer regarding cladding and option appraisal to be presented to Capital Management Group. CHS confirmed high-risk areas need to be addressed in 2019. The cost to do this is either £7.5m or £15m. CHS recommended the £15m option as this would resolved the problematic windows in the same area.	Sept-2019	Dec-2019		FC	Gary Boothby	Alison Wilson

							carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.					monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan						
7251	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2018	Keeping the base safe	There is a risk to patients receiving a poor experience and delays in out patient clinics due to the Optovue OCT (Ocular Coherence Tomography) machines at both Acre Mills and CRH Eye Clinics not functioning to expected levels. The machine can "crash" leading to inability to perform scans and access historical results for progression of eye conditions to determine diagnosis, treatment and management plans. This is resulting in a slower patient flow through clinics (increase complaints due to waiting times) due to the increase time taken per scan and reduction in clinic capacity available. The OCT machines 16TB storage limit has been reached - a temporary solution has been found to build an additional storage and backup system alongside current storage. Recent risk presented and reported on DATIX - the OCT's computer has registered somebody's else left eye OCT scan as another patients right eye OCT (this is now the 4th patient incident). There has been 4 other patients with incorrect information linked to their OCT scan including the wrong pathology for the wrong patient.	- Increase use of the Heidelberg OCT machine on Floor 2 to spread demand for scans during clinics - Encourage ophthalmologists to rationalise the use of OCT to pathologies for which it is mandatory - Ophthalmology IT system admin role approved Sep 2018 (funded 80% S&A, 20% THIS) - commenced in post 13/5/19 - patients who have had their apt cancelled due to slow running of the machines have been re-booked within a week following validation from Macular Consultant Lead - should additional capacity be required to ensure patient safety this will be provided.	- Use of second floor OCT requires patients to travel between 2 floors during their visit - Patient's pathology still require OCT in many instances	9 3 x 3	15 3 x 5	1 1 x 1	- Explore technical options (Nov 2018) - Take Sys Admin role job description to job matching panel (due 1/11/18) - Advertise for SysAdmin (Dec 2018) - Haag-Streit are already investigating the recent risk, and there is nothing we can do to speed this process up except keep reporting these issues as they are seen and reporting them on Datix.	**August 2019**: new OCT scanners now in department. IT links for software in progress. Staff training currently underway cross-site. Risk discussed at July 2019 DMT and only to be downgraded once machines are running. In July 2019 and August 2019 macular, glaucoma and retinal clinics continue to run with reduced patient numbers because of slowness of the current OCT scanners. Expected resolution: 31 August 2019.	Sept-2019	Sept-2019		PSQB	Will Ainslie	Louise Corp

13. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Board Assurance Framework
Author:	Andrea McCourt, Company Secretary
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report

The Board Assurance Framework (BAF) provides Board members with an understanding of the principal risks to the achievement of the Trust's strategic objectives.

Meeting have been held with all risk owners to update and review the content of the Board Assurance Framework during August 2019. Each Director has reviewed the full risk, including the risk description, made it clearer how the stated controls help manage the risk and ensured that actions are aligned to address gaps in control. The BAF is presented to the Board for approval.

Key Points to Note

The Trust has 15 risks on the BAF and has the following risk profile for the risks on the Board Assurance Framework using the 5x5 risk matrix to assess risk likelihood and impact:

- 7 risks rated red with a risk score between 15 and 25
- 7 risks rated amber with a risk score between 8 and 12
- 1 risk rated green with a risk score between 1 and 6

There has been the following movement on the BAF:

- Removal of risk 2/19 relating to non delivery of the West Yorkshire Association of Acute Trust programme, which had a risk score of 10. Any risks aligned with specific programmes of delivery, for example relating to pharmacy, pathology or vascular services will be added to the risk register and any of these risks that are scored above 15 will be reported to Board members through the high level risk register report

- Risk 10/19 relating to staffing has been separated into risk 10a, relating to medical staffing and risk 10b relating to nursing staffing. This is to ensure greater clarity on the specific controls and assurances for each aspect of this risk

- The risk score for risk 04/19 relating to patient and public involvement has increased from a score of 6 to a score of 9

A strategic risk relating to health and safety will be developed following review of the external health and safety report by the Board and be presented on the BAF at the next iteration of this report. Also to note that the planned workshop on risk and the Board Assurance Framework will now take place at the Board workshop on 5 December 2019.
EQIA – Equality Impact Assessment
No impact identified.
Recommendation
The Board is asked to approve the Board Assurance Framework as at August 2019.

Calderdale and Huddersfield
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2019/20

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

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Appetite
Transforming and improving patient care							
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	15 =	**15**	AB	2827, 5806,7413,7414	Seek / Significant
03/19	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.	15	**6 =**	**4**	DB	None	Cautious / Moderate
04/19	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	12	**9 Î**	**4**	EA	None	Cautious / Moderate
05/19	Risk that the resource, capacity and capability of full optimisation of the EPR system does not continue to further enhance quality and safety.	15	**15 =**	**10 =**	MG	6715	Seek / Significant
Keeping the base safe							
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**12 =**	**10**	EA	6345,7078, 5747 7345, 6715, 7396	Minimal / Low
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement resulting in enforcement action	25	**15 =**	**10**	OW	None	Cautious / Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**12 =**	**10**	HB	See sheet	Cautious / Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**20 =**	**8**	GB	5806	Minimal / Low
A workforce fit for the future							
10a /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	**9**	DB	2827,7078, 5747	Minimal / Low
10b /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	**9**	EA	6345	
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues	16	**12 =**	**9**	SD	7248	Seek / Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms	**12 =**	**9 =**	**4**	SD	None	Seek / Significant
Financial sustainability							
13/19	Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention	16	**25 =**	12	GB	7278	Open / High
14/19	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	12 =	12	GB	7062	Open / High
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution.	**9 =**	9 =	**6**	GB	None	Open / High

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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)			14. Capital =		10a Medical Staffing levels = 10b Nursing staffing levels= 9 Estate
Possible (3)		3. Seven day services =	4. Public involvement Î 12. Staff engagement = 15. Commercial growth =	6. Compliance with Quality and safety standards = 8. National and local targets = 7. Compliance with NHS E/I = 11. Compassionate care and leadership = 13 Financial plan =	5. EPR optimisation = 1. Approval of hospital reconfiguration strategic outline case 7. Compliance with NHS Improvement =
Unlikely (2)					
Rare (1)					

Assessment is Likelihood x Consequence

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019 UPDATE

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 August 2019**		
1.19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC), and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	• Formal governance structure established within the Trust via Transformation prorgamme Board to overseee hospital reconfiguration. The Trust has regular review meetings with NHSE/NHSI, and DH colleagues to advise on content and assumptions used in business cases to ensure compliance with HM Treasury and DH requirements and facilitate future approval. • The Trust is procuring the necessary external professional and technical skills and advice required to complete the business cases • Engagment - The Trust is working closely with the Joint Health Scrutiny Committee and wider stakeholders to ensure full involvement in the development of the business cases • The Trust continues to work closely with the West Yorkshire and Harrogate Health and Care Partnership and commissioners to ensure support of the business cases for reconfiguration • Partnerhsip Transformation Board with membership of CCGs, ICS, YAS, and the Trust meets monthly to ensure alignment and support for business case assumptions and deveolopment.	First line Transformation Programme Board review of business cases and response to queries that may be raised by NHSI, NHSE, DHSC Second line Trust Board approval of SOC, March 2019. Trust Board review of business cases. Third line NHS E/I have been provided with all supplementatry information and are finalising their recomnedation report for the SOC to be approved by DH.	• Mechanism to involve stakeholders and colleagues in design o • Insufficient internal capacity to support development of the business case • Unable to procure the necesary expertise and techincial skills to develop the business case	The Trust is working with regulators to secure agreement that the early call down of capital to fund necessary professional and technical fees to produdce the OBC will be agreed.	**Initial** 5x5 = 25	**Current** 3x5 = 15	**Target** 2x5 = 10
Action					**Timescale**			**Lead**		
Involvement plan developed and implemented Identified internal resource and are appointing additional capacity, Q4 Using national call off contracts wehre approiate to specify the work that will need to be market tested					Q3 2019/20 Q4 2019/20 December 2020.			AB for all actions		

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in A&E - workforce standards, A&E and critical care
5806 - urgent estate work not completed
7413 - fire compartmentation risk HRI
7414 - building safety risk, HRI

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019 UPDATE

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 August 2019**		
								Initial	**Current**	**Target**
3.19	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	• Governance systems and performance indicators in place • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) • Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology and gastro with discussions progressing in palliative care • Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR and SHMI within expected range Second line Integrated Board report Benchmarked against four priority seven day standards - full compliance at most recent audit in May 2018. Bi-annual submission for compliance against the seven day standards to NHS England / Improvement approved at WEB 20/06/19, confirmed compliance against all four standards. Single Oversight Framework. Quality Accounts 2019/20 confirmed compliance against standards 2018/19. Third line Positive feedback from NHS I/E, NHSE-led, WYAAT-wide implementation scheme	Radiology staffing pressures present risk of continued delivery of standards 5 and 6 - access to diagnostic tests and access to consultant - directed interventions	• Scope for futher implementation limited without service reconfiguration or additional investment	5x3 = 15	3x2= 6	2x2 = 4

Action	**Timescales**	**Lead**
National survey completed twice a year	October 2019	DB/CP

Links to risk register:
No high level risks with score >15

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019 UPDATE

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 August 2019**		
								Initial	**Current**	**Target**
4.19	Quality Committee	Executive Director of Nursing / Deput	**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 not designing services using patient recommendations **Impact** - Non delivery of improvements in services - Risk of legal challenge - Reputational impact	•Working with HealthWatch on key areas of interest / concern • Patient Experience Group in place • Patient engagement in Out patient transformation programme, including online survey of patients about future O/P service model and work with Healthwatch on protected groups on barriers to communication • Pilots of changes to service models being tested with patients • Engagement champions in place across the Trust • Engagement toolkit being developed • Engagement events re: Strategic Outline Case	First line Public involvement and engagement included in Patient Experience Group Areas of good practice identified within the Trust Second line Governor attends Patient Experience Group Patient Experience Group reporting to Quality Committee Project Management information on service change and engagement (PMO workbooks) Third line Annual reporting to CCGs CQC rating of Good - report referenced positive examples of patient engagement Healthwatch reports (Out patients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and invovlement data Co-ordination role for egnagement to be agreed. Lack of consistent approach when seeking patient input to re-designing services Lack of resource to support effective and meaningful engagement Action: Staffing structure review by Director of Nursing by December 2019 Patient and service User Engagement Strategy being reviewed, Director of Nursing December 20 19.		**3x4 = 12**	**3x3= 9**	**1x4 = 4**
										Lead
Quality directorate staffing structure review Patient and Service User Engagement Strategy					31/12/19 31/12/19					EA
Links to risk register: No risks on the risk register >15										

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019 UPDATE

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 August 2019**		
5.19	Finance and Performance Committee	Managing Director of Digital Health	**Risk** Risk that the resource, capacity anfd capability of full optimisation of the EPR system does not continue to further enhance quality and safety. **Impact** - limited opportunity to deliver improvements in clinical outcomes	• Digital Health Forum meets monthly with Executive Directors where any escalations and updates are presented Managing Director attends Audit and Risk Committee to provide udpate on digital issues Non executive sponsor for digital including EPR. • Operational Delivery Board in place with cross divisional representation Digital Boards in place at divisional level which discuss the current digital agenda and operational impact and business continuity requirements of any digital change. • Business as Usual structure to be aligend with demand and capacity • Transformation Board reporting • Programme Board in place with cross trust representation Change prioritisation meetings in place which should complement the needs of this Trust and EPR partner Bradford Teaching Hospitals Trust	First line Digital Health Forum Operational Board reporting Digital open days held Second line Audit and Risk Committee focus on digital agenda including EPR (July 2019 meeting) Report to Finance and Performance Committee Financial benefts report to Board confirmed EPR system return on investment was realised June F&P reported to Board in July Third line Digital maturity assessment 2017 Trust 13th in country. Clinical digital maturity index - Trust number 1. nationally (NHS England) Reference site for Cerner for EPR	• 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 Agree optimise resource to realise the benefits Business as usual structure not aligned to demand and capacity Action: Full review of digital health support infrastructure and identify the gap to inform the investment required Lead: Managing Director, Digital Health Timescale: Plan agreed by end of November 2019. New Director of Transfomration for the HIS being recruited, by December 2020, MD lead	• Lack of capital funding for developments. •. Work is ongoing to document all quality and safety benfits. Awaiting results of digital maturity asssessment submitted to NHS England / Improvement July 2019	**Initial** 3x5 = 15	**Current** 3x4 = 12	**Target** 2x5 = 10

Action	**Timescales**	**Lead**
Work on quality and safety benefts realisation continues within annual planning arrangements	Mar-20	GB / MG

Links to risk register:
EPR related risks 6715 documentation
There are no high level risks realtintg to benefits realisation.

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 AUGUST 2019**		
								Initial	**Current**	**Target**
6.19	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	• Partial review of quality governance arrangements • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements at divisional level, including compliance registers • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures via ward assurance tool. H&S review (Draft) • Programme of quality visits in place (Quality Fridays) • Process in place for policy review and approval • Safety "must do's" embedded on wards • Consistent mandatory and essential training compliance • Process in place for reviewing quality metrics at ward and department level	First line Assessment of compliance with NICE guidance Ward accreditation - Performance against saferty must dos reviewed at ward / matron level Improvement in HSMR & SHMI Mandatory training compliance at August 2019 94.04% Second line Clinical audit plan reviewed Quarterly Quality Report to Quality Committee and Board KPIs in Integrated Perforamnce Report. PSQB reports to Quality Committee Infection Prevention and Control report to Board Serious incident report to Quality Committee Third line CQC rating of Good Quality Account reviewed by External Auditors and stakeholder bodies Independent assurance on clinical audit strategy Feedback through ongoing relationship with arms length regulatory bodies Independent Service Reviews (ISR) and accreditations. ISR March 2019 assurance on process for responding to NPSA alerts Health Services Investigation Branch reports	• Standard of serious incident investigations needs further improvement • Estate issues identified - Development of HRI estates strategy • Completion of 2 actions from CQC action plan from 2018 well-led inspection relating to: - medical staff in the Emergency Department - critical care staffing Actions: Critical care and ED workforce plans in place to mitigate risk Quality Governance - quality governance arrangements and structures to be reviewed Lead: Director of Nursing / Medical Director timescale Dec 19 Well Led Governance review to be commissioned - Lead Owen Williams Timescale: Autumn/ winter 2019/20	• CQC assessed the Trust as requires improvement for safe domain • Staff FFT and staff survey (2018) responses show marginal improvement • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements (Allocate)	3x5 = 15	3x4= 12	2x5 = 10

Action	**Timescales**	**Lead**
Roll out of Allocate for Medical and Therapy staff	Ongoing 2019	CP
Incomplete CQC actions for critical care and ED to be delivered	December 2019	EA

Links to risk register:
Risk 6345 - nurse staffing risk, risk 7078 - Medical staffing risk , risk 7345 - Referrals to district nursing service, risk 5747 interventional radiology staffing, 6715 clinical documentation, risk 7396 inadvertent connection to air flow instead of oxygen.

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 AUGUST 2019**		
								Initial	**Current**	**Target**
7.19	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement (NHS E/I) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Quarterly review meeting with NHS E/I • Control total for 2019/20 accepted • Standing Financial Instructions and budget managent • Corporate compliance register in place • Review of monthly NHS E/I bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Well Led CQC review 2018, rating of "good" • Use of Resources inspection completed and action plan being implemented • Board approved 5 Year Strategic Plan	First line Clear PMO and PRM reporting from Divisions provides assurance performance is on track with close monitoring of emergency care standard Second line Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee which shows cip delivery on track at month 4, 2019/20, Review by Quality Committee and Board of progress with CQC action plan and use of resources action plan. July 2019 Board report on CQC shows 49 actions completed and embedded. Third line Further autnomy granted from NHS E/I as result of performance and acceptance of the 2019/20control total from NHSE/I. Quarterly PRM with NHS E/I 8 July 2019 Round table meetings being held with CCGs, NHS England / Improvement	• Challenging financial position - refer to risk 7278 on risk register. Action: Progression of reconfiguration of hospital services to move to a more sustainable financial position in the future, with close management of in-year financial plan and delivery.	• Performance against key targets • Use of Resources rating of requires improvement Governance well-led review to be undertaken (Q3 2019/20) Trust eligibility for Provider Sustainability Fund and Financial Recovery Fund is contingent on delivery of 2019/20 control total on a quarterly basis. Q1 acheived and monitoring of delivery for Q2,3 and 4 by Finance and Performance Committee.	5x5 = 25	3x5 = 15	2x5 = 10

Action	**Timescales**	**Lead**
Use of resources and CQC action plan (2 actions) being implemented	Ongoing - reported to Quality Committee and Finance and Performance Committee	EA / GB

Links to risk register:
Risk 7278 - Financial sustainability

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 AUGUST 2019**		
								Initial	**Current**	**Target**
8.19	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	• General performance controls include weekly performance monitoring and management arrangements, CQUINs, leadership masterclasses held weekly, monthly Quality & Performance Executive Board meeting, IPR presented to relevant Board Committees- eg F&P Performance Review Meetin(PRM), bronze, silver and gold command arrangements and escalation process **Specific** performance controls established for key metrics: •A& E delivery board with partners which oversees overall emerency care performance • System wide urgent and emergency care programme established focused on transforming urgent care • Dedicated lead rols in planned care, urgent care, cancer and performance • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Urgent Care Board, cancer Board and Diagnostics Board estabished with Clinical Director attendance to ensure robust medical leadership	First line Weekly performance review with divisions. Divisional board and PRM reviews of performance with executive attendance Regular clincial director (CD) attendance at specialty boards and CD sign off of urgent care innovation plans. Weekly escalation at WEB Intergrated Performance 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 Imprvoing IPR score as at June 2019 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 Quarterly review meeting with NHS E/I on performance	• System responsiveness depdndent on formal escalation by CHFT when agreed tiggers reached. Action: single system dashboard to be agreed with clear resposibilities for action. Lead: Director of Urgent Care Timescale: December 2019 • Achievement of 4 hour emergency care standard requires micro-management. Action: Establishment of system wide urgent and emergency care programme. • Continued incorrect use of RTT codes increasing validation dependancy Action - established RTT diagnostic programme Lead: Head of Planned Care Timescale: November 2019	Lack of assurance on the quality of dafa used for performance reporting and shared understanding of what constitutes good data quality Action: Commissioning independent audit of data quality, re-established data quality board, facilitated Board session on data quality (October 2019)	**4x4 = 16**	**3x4 = 12**	**4 x 2 = 8**

Action	**Timescales**	**Lead**
Dashboard to be developed to support system escalation RTT Diagnostic Programme	December 2019 November2019	Bev Walker Katherine Fletcher

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 August 2019**		
								Initial	**Current**	**Target**
9.19	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	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Contract performance framework with CRH PFI estates and facilitites providers • Systematic review of Divisional and Corporate compliance, • Medical device and maintenance policies and procedures and Planned Preventive Maintenance (PPM) Programme • Estates in 5 Year Strategic plan • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Audit of medical devices by independent assessor • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRh and HRI Estates against statutory guidance. • Authorising engineer for fire • Concordat in place with West Yorkshire fire authority	First line • Close management of service contracts to ensure planned maintenance activity has been performed Risk register reports Audits of routine checks, estates Second line Health and Safety Committee monitors medical devices training Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via service performance reports Assurance provided by Authroised Engineerss following audits against Estates statutory requirements WEB reports on medical devices July 2019 H&S Training 95% target achieved, report to WEB 22.8.19. 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line PLACE assessments CQC Compliance report 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 Familiarisation visits by local operational Fire and Rescue teams External assurance from authorising engineers for high voltage/ low voltage systems, reviewed at CHS Contracts and Performance Committee 21.8.19.	• Investment strategy in response to 6 Facet Survey for HRI to be agreed by Board - November 2019, lead Anna Basford • Capital funding awarded, confirmation of capital funding from NHS Improvement - expected imminently. Awaiting external review of estates to priorities expenditure in financial plan 2019/20 • Ongoing issues around Medical Devices PPM and end of life service contracts to be addressed • Meeting to be arranged with Chief Operating Officer to review authorising engineer reports and how they impact on ICU & Resus at HRI. Also to review Fire Safety to ensure gaps identified and clear actions for improvement September 2019, lead Alison WIlson • H&S Review to be finalised and report to Board November 2019	• Issues identified with estate requiring urgent work	4x4 = 16	5x4= 20	2x4 = 8

Action	**Timescales**	**Lead**
Meeting re; auhtorised engineers reports and fire safety	30/09/2019	HB / AWilson
Estates investment strategy to be agreed by Board	07/11/2019	AB
Health and Safety report to Board	07/11/2019	SD

Links to risk register:
Risk 5806 - Urgent estate schemes not undertaken
Risk 7414 - Building safety risk, HRI
Risk 7413 - Fire compartmentation risk, HRI
Risk 7474 - Medical Devices

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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*	**RATING Auguat 2019**		
								Initial	**Current**	**Target**
10a /19	Workforce Committee and Quality Committee	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 on** - 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 - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	Medical Staff • Guardian of Safe Working in place which ensures safe working hours for junior doctors. • Job planning ensures visibility of Consultant activity • Use of CESR programme to increase Consultant workforce in appropriate specialties supports recruitment and retention • Agency and bank use of medical staff • Service improvement in cardiology, respiratory and frailty, with developmnent of acute floor and frailty service at HRI to aid recruitment • Medical workforce steering group meets bi-monthly, focus on using current staff effectvely, retention and recuitment. Workforce Committee • WYAAT networking approach to pressured specialties, eg Vascular Surgery, Interventional Radiology and programme of work • ED business continuity plan in place; • Ongoing recruitment programme in place, including international recruitment; • Medical Workforce Programme Steering Group meets bimonthly Segmentation approach and vacancy tracker in place to focus medical recruitment resource on clinically high risk and likelihood of appointment. Vacancy tracker maps medical workforce to medical establishment, tracks vacancies, pipeline and retention Electronic job planning in place for all consultants Junior doctor awards Adopted SAS doctor charter	First line Staffing levels, training & education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IPR shows slight decrease in sickness levels, and reduction in agency spend Weekly meeting on agency spend and report to Turnaround Executive 6 additional PA posts recruited to Improvements in mortality (HSMR / SHMI). Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend - medical agency spend halved in 2018/19. Vacancy tracker broadly shows improvement in some medical specialties. Second line Monthly performance meetings (PRM) review workforce reports Workforce Committtee - eg report on retention Medical Appraisal and revalidation report to Board, demonstrates high quality workforce. Guardian of Safe Working Board report (4.7.19.) on working hours KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Report on Junior Doctor Experience	Recruitment and retention strategy for medical and therapy staffing required Medical E-rostering only partially implemented for doctors - to roll out from May 2019 for sub-consultant doctors and from October 2019 for consultants - dependent in part on support from Allocate Pensions rules reduce willingness of medical staff to deliver additional work (national issue).	• Need to embed workforce plan	4x4 = 16	4x5 = 20	3x3 = 9

Action	**Timescales**	**Lead**
E-rostering being rolled out to medics	Sep-20	SU

Links to risk register:
Risk 6345 - nurse staffing risk
Risk 2827 - Over reliance on middle grade doctors in A&E
Risk 7078 - medical staffing risk
Risk 5747 - Vascular / interventional radiology staffing

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 Auguat 2019**		
								Initial	**Current**	**Target**
10b.19	Workforce Committee and Quality Committee	Executive Director of Nursing	**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 on** - 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 - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	Daily and weekly nurse staffing escalation reports • Ongoing recruitment programme in place, including international recruitment; • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • 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 and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance	First line Staffing levels, training & education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IPR shows slight decrease in sickness levels, and reduction in agency spend Bi-annual review of ward nursing levels Weekly meeting on agency spend 6 additional nursing associate posts recruited to Medical : Improvements in mortality (HSMR / SHMI).Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend Agency spend reported weekly to Turnaround Executive Medical agency spend halved in 2018/19. Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues., Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board September 2019 KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Nursing Despite controls in place there will still be occasions where nurse staffing rosters do not fully meet patient need.	• Need to embed workforce plan	4x4 = 16	4x5 = 20	3x3 = 9
Action					**Timescales**			**Lead**		
Ongoing monitoring of staffing situation								EA		
Links to risk register: Risk 6345 - nurse staffing risk										

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 August 2019		
								Initial	Current	Target
11.19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able 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	• Organisational Development Strategy, The Cupboard recipe cards for Working Together to Improve (leadership and engagement), equality, diversity and inclusion and talent management recipe cards which set out key actions in these areas and measures for monitoring success. • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Performance appraisal based around behaviours with temperature check guide introduced to help colleagues to think about the four pillars and their contribution to one culture of care • Development of new roles across professional groups, eg physicians associates., development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Development of Managers Essentials programme and compassionate leadership orgramme, CLIP, being designed collaboratively with colleagues New Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. Development of specific behavipours to support 4 pillars by BAME network	First line Clinicians leading of transformation programmes e.g. cardio /respiratory Recruitment to key Consultant roles across the Trust, Second line Integrated Perfformance Report and Workforce Committee reports show a rolling absence rate of 3.41% (lowest) and rolling turnover scor of 8.8% (lowest recvorded) as at July 2019 Revalidation report to board Board approval of OD strategy - March 2019 Third line Investors in People (IIP)Silver Accreditation to 2021 based on assessment of the IIP principles of leading, improving and supporting. Feedback from Royal Colleges Junior doctor GMC questionnaire feedback Positive feedback from Junior doctors on medical training - Health Education England survey, July 2019, showed improved scores in Anaethesia, Paediatrics, Urology, Obstetrics and Gynaecology, Trust moved from 8th in region to 5th, with 100% response rate OFSTED Interim report has given reasonable progress on all actions relating to the clinical assessment team for Apprentices (August 2019)	Approval and launch for Management Essentials and CLIP development programmes which includes the need to cost and identify funding Action - see below	Annual IIP review October 2019	4x4 = 16	3x4 =12	3x3 = 9

Gaps in Controls	Action, Timescales	Lead
Approval and launch for Management Essentials and CLIP development programmes which includes the need to cost and identify funding	Approval needed in December 2019 to launch in April 2020, lead: Assistatnt Director Organisational Development	Ruth Mason

Links to risk register:
Risk 7248 - mandatory training

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*	RATING August 2019 Initial	Current	Target
12.19	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 behaviours of the organisation due to 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	• Colleague engagment is a key recipe card in The Cupboard which set out key actions in these areas and measures for moniroing success. Hot house events to ensure all strategic colleague policies and practices are developed collaboratively across the Trust Leadership visibility increasing through tea trolley rounds and a series of events in the engegament calendar Quality Friday visits ensure senior clinical and non clinical visibility and engagement based on themes • Quarterly staff FFT in place provides interim feedback on whether colleagues would like to receive treatment by the Trust • 'Ask Owen' being responded to and a similar mehcanism to allow colleagues to say thank you to each other is being developed • Celebrating success year long programme of events • Staff survey action plan implemented to improve take up of staff survey • Health and wellbeing strategy refreshed and includes modules for both mental and physical good health • Ways of engaging colleagues include CDAG, Colleague Disability Action Group , LGBTQ network, BAME network in place and well attended	First line CQC preparation for self assessment shows some areas reporting GOOD in well led domain Improving absence position (see 11/19) Freedom to Speak Up concerns increased from 2 in September 2018 to over 50 in July 2019, reflecting better communication and engagement with the process Second line Integrated Board report shows sickness absence improved, July 2019 Freedom to Speak Up annual report to Board July 2019 Third line Staff FFT / staff survey provides some positive feedback, 2018 survey had highest respose rate of 51% Investors in People accrediation - Silver award to 2021, which shows a more qualitiative review of Trust culture than the annual NHS staff survey CQC rating of Good	Plans to coordinate all celebrating succcess activities across the Trust, including the annual awards ceremony, celebrating the positives and other events will ensure improved engagement in colleague and Trust wide improvement and success. Action to address gap in control: see below	None	3x4 = 12	3x3 = 9	1x4 = 4

Action to address gap in control	Action and timescale	Lead
Plans to coordinate all celebrating succcess activities across the Trust, including the annual awards ceremony, celebrating the positives and other events will ensure improved engagement in colleague and Trust wide improvement and success	To launch CHuFT - the rolling programme of events to celebrate success across the Trust including an annual event to take place in summer 2020, lead AD OD	Ruth Mason

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 August 2019**		
13.19	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 PSF (Provider Sustainiability Funding and FRF Financial Recovery Fund - increased regulatory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Finance and Perofrmance Committee meets monthly and considers overall expenditure, income , cotnract performance, cip delivery Cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process Weekly agency report to Turanround Executive • 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 • Vacancy control panel process, controls around additional hours. • Clear communications plan around financial pressures	<u>First line</u> Divisional Board performance reports Achieving agency target Aligned incentive contract in place supporting guarnateed in year income Agreed levels of income with CCG for next 5 years within SOC 2019/20 control total accepted and curently being delivered. <u>Second line</u> Turnaround Executive Reports NHS I reporting Reporting at Finance and Performance Committee Board Integrated Performance Board report including CQUIN delivery reporting Report on use of resource action plan to Finance and Performance Committee, regular report on metrics and CQC action plan <u>Third line</u> Monthly return to NHS I QRM meeting with NHS I NHS I review of CIP arrangements NHS I review of agency usage ICS control total to be accepted	• Deficit plan in place for 19/20 after receipt of PSF and FRF • Not all CIP identified recurrently Turnaround Executive monitoring action plans to fully identify a recurrent cip programme. Lack of ownership of budgets: Action: Working Together to Get Results sessions with budget holders , action plan in place - lead Director of Finance and Chief Operating Officer Use of resources (UoR) action plan re financial balance - all actions implemented but not in balance therefore UOR score remains at 3.	• Residual deficit after receipt of PSF and FRF • 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 7278 financial sustainability - long term risk remains high. Returning to balance reliant on support for SOC and OBC

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 August 2019**		
								Initial	**Current**	**Target**
14.19	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 2018/19 Capital Plan delivered Second line Turnaround Executive Reports Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Third line Monthly return to NHS I Quarfterly meeting with NHS I	The long term capital spend required for HRI is in excess of internally generated capital funds. The 19/20 Capital plan is reliant on land sales (Acre House and Glenacre House) plus a combination of both emergency capital bids and business case drawdown to fund a repllcement MRI and meet essential health and safety requirments at HRI in relation to both fire safety and cladding.	Land sales of Glen Acre / Acre House not yet agreed - progressing as per plan Emergency capital approval from NHS Improvement imminent (end of August 2019) Backlog maintenance costs will remain in excess of planned capital spend.	4x5 = 20	4x3 = 12	3x4=12

Action	**Timescales**	**Lead**
Capital Development Executive group to be established to have oversight of significant strategic investment. Ongoing monitoring of financial position through F&P and Board	30 October 2019 Ongoing	OW GB

Links to risk register:
Risk 7062 re: capital programme is scored at 16 .

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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 August 2019**		
								Initial	**Current**	**Target**
15.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Pharmacy Manufacturing Service, Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place New Managing Director for Calderdale Health Solutions Limited inplace (September 2019) Health Informatics Service (THIS) contract income for all customers for 2019/.20 approved and monitotred via quarterly contract review meetings THIS ad hoc income target 2019/20 identified THIS Executive Board meeting with Non-Executive attendance Escalation process if THIS targets not met via Turnaround Executive and Finance and Performance Committee	**First line** Individual boards and feeding into Finance and performance committee HIS Executive board meets monthly and reports on performance against targets	PMU requires further capital investment to continue to grow. Exploring future commercial options - lead: Director of Finance THIS continue to bid for aditional external work but at present this is not fully identified to meet the income plan for 2019/20 THIS continue to maximise commercial opportunities for 2019/20. Contract with Bradford and Craven district due to commence 1.4.21. CHS commercial strategy still being developed	PMU requires capital investment to meet its ambitious growth plan for 2020/21 Ad hoc THIS income for 2019/20 is £1.2m (40% target achieved at month 4)	**3x3 = 9**	**3x3 = 9**	**2x3= 6**

Action	**April 2019**	**Lead**
Ongoing monitoring of financial position through F&P and Board	Ongoing	GB
Exploring commercial options for PMU	March 2020	GB

Links to high level risk register:
None

BOARD ASSURANCE FRAMEWORK RISK REVIEW
AUGUST 2019

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
ICS	Integrated Care System
DH	Department of Health

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
HB	Helen Barker, Chief Operating Officer
AMH	Anne-Marie Hensahw, Assistant Director of Quality and Safety
MG	Mandy Griffin, Managing Director of Digital Health
RM	Ruth Mason, Associate Director of Engagement and Inclusion
AM	Andrea McCourt, Company Secretary
CP	Cornelle Parker, Deputy Medical Director
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
OW	Owen Williams, Chief Executive
EA	Ellen Armistead, Director of Nursing / Deputy Chief Executive
ALL	All board members

14. Safer Staffing Hard Truths Report

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	**Safer Staffing, Bi-Annual update to the Board of Directors**
Author:	Lindsay Rudge, Deputy Chief Nurse Michelle Bamforth, Head Nurse for Workforce and Professional Development
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Weekly Executive Board - 22 August 2019

Purpose of the Report

The purpose of the following report is to provide the Board of Directors assurance that mechanisms are in place to monitor nursing and midwifery staffing levels across the Trust and in doing so ensure that these support the delivery of safe and effective care.

The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England have continued to issue guidance to optimise nursing, midwifery and care staffing capacity and capability and the report provides an update against these recommendations.

The report provides a position against what was set in the Nursing and Midwifery staffing Annual Review and highlights any areas of concern.

Key Points to Note

Emergency Care Nursing workforce model is under further review using a valid acuity tool for Emergency Care Nursing.

Ward 10 General Surgical Ward acuity scores have increased, and the workforce model is under review in year.

Maternity staffing remains unchanged and work is being undertaken internally and supported by the Local Maternity System (LMS) to transform models of care.

District Nursing services remains under close monitoring to ensure the District Nurse pipeline is maintained at CHFT and is in line with national guidance specifically for community services.

EQIA – Equality Impact Assessment
An equality impact assessment has taken place in relation to staffing recruitment and development of new roles.
Recommendation
The Board is asked to approve the report and to note the 4 key points in relation to the bi annual review of establishments.

Calderdale and Huddersfield NHS Foundation Trust

Safer Staffing

Bi-Annual update to the Board of Directors

5 September 2019

CONTENTS	
1.0	Introduction
2.0	Right Staff
3.0	Right Skills
4.0	Right Place and Time
5.0	Quality impact on Nursing and Midwifery staffing levels
6.0	Bi-annual staffing review May 2019
7.0	Conclusion
8.0	References

1.0 INTRODUCTION

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's ten expectations) and the Care Quality Commission. The paper provides assurances that nursing and midwifery staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance.

1.1 Background

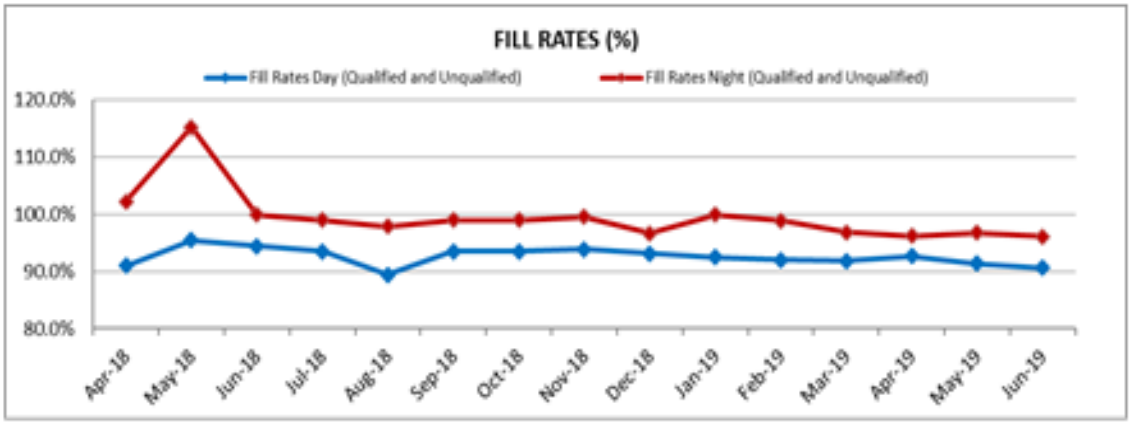
In July 2016, the National Quality Board updated its guidance for provider Trust, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery staffing levels. This guidance has been updated in 2018. The nursing workforce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

2.0 RIGHT STAFF

Calderdale & Huddersfield Foundation Trust ensure that there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients across its services. There is a robust annual strategic staffing establishment review across all inpatient clinical areas.
The workforce plans and resulting workforce models contain sufficient provision for planned and unplanned unavailability, e.g. sickness, parent leave, annual leave and training requirements. This is set at 22%.

2.1 Fill Rates

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



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

2.2 Care Hours per Patient Day (CHPPD)

In line with the updated NQB guidance, CHFT report monthly on CHPPD data.

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

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

2.3: Sickness and Turnover Rates:

Table 3 indicates that the organisational sickness % for qualified registered nurses has fallen to less than 4% through quarter 1 of this year, for unqualified colleagues the % rate has remained above 4%. The Trust maintains a continued focus on absence management and support to reduce the % of sickness and absence.

Table 3: Organisational nursing sickness %

Qualified Nursing & Midwifery

	Total Absence %											
Division	2018/08	2018/09	2018/10	2018/11	2018/12	2019/01	2019/02	2019/03	2019/04	2019/05	2019/06	2019/07
372 Community L3	3.31%	4.74%	6.45%	6.09%	7.35%	5.99%	5.33%	4.06%	3.08%	2.91%	2.59%	2.27%
372 Corporate L3	2.66%	3.87%	4.56%	3.42%	1.34%	1.13%	2.09%	3.23%	2.46%	1.41%	1.39%	1.32%
372 Families & Specialist Services L3	5.09%	5.13%	5.17%	5.58%	5.25%	4.11%	3.46%	2.50%	4.02%	5.26%	4.20%	3.83%
372 Health Informatics L3												
372 Medical L3	3.39%	3.67%	3.56%	3.40%	3.93%	3.97%	3.89%	2.45%	2.26%	2.61%	3.17%	3.14%
372 Surgery & Anaesthetics L3	2.57%	3.49%	4.40%	4.94%	4.59%	5.07%	5.27%	5.23%	4.87%	4.38%	2.81%	3.94%
Grand Total	**3.53%**	**4.10%**	**4.54%**	**4.62%**	**4.66%**	**4.36%**	**4.21%**	**3.39%**	**3.46%**	**3.69%**	**3.18%**	**3.33%**

Unqualified Nursing

	Total Absence %											
Division	2018/08	2018/09	2018/10	2018/11	2018/12	2019/01	2019/02	2019/03	2019/04	2019/05	2019/06	2019/07
372 Community L3	5.10%	6.20%	5.41%	4.00%	5.08%	0.98%	1.05%	0.28%	1.84%	1.26%	7.15%	5.21%
372 Corporate L3	0.83%	4.55%	5.38%	8.91%	7.72%	7.05%	10.89%	11.40%	9.43%	2.60%	5.31%	5.60%
372 Families & Specialist Services L3	3.01%	3.46%	5.09%	5.20%	5.75%	5.78%	5.65%	5.32%	5.16%	5.41%	6.15%	5.00%
372 Medical L3	4.74%	6.09%	5.21%	4.66%	4.83%	5.71%	6.58%	5.07%	4.34%	3.97%	5.81%	5.45%
372 Surgery & Anaesthetics L3	5.87%	5.47%	5.71%	7.17%	5.41%	6.47%	7.62%	5.39%	4.89%	6.59%	5.71%	4.54%
Grand Total	**4.54%**	**5.35%**	**5.34%**	**5.63%**	**5.30%**	**5.84%**	**6.72%**	**5.34%**	**4.75%**	**4.84%**	**5.87%**	**5.09%**

3.0 RIGHT SKILLS

In line with NQB guidance CHFT are progressing work to develop a comprehensive “Learning Needs Analysis”. The Trust is represented on the West Yorkshire and Harrogate Local Workforce Action Board (LWAB) and also the Delivery Group (WY&H).

The main purpose of the delivery group is to focus on the collective delivery of non-medical education, learning, development and the operational aspect of workforce development informed by the LWAB and Health Education England (North).

The resulting analysis will result in a clear position on training requirements and enable the nursing workforce to prioritise needs to support service delivery, staffing retention and quality of care.

3.1 Training and Education

Staffing establishments take into account of the need to allow clinical staff the time to undertake Essential Safety training and continuous professional development (CPD) to meet the Nursing and Midwifery Council (NMC) revalidation requirements, and fulfil teaching, mentorship and supervision roles to support the provision of learning environments required by the NHS

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

Table 5:

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
Dementia Awareness	1679	1679	1672	7	99.58%
Health, Safety and Welfare	1679	1679	1618	61	96.37%
Fire Safety	1679	1679	1604	75	95.53%
Equality & Diversity	1679	1679	1585	94	94.40%
Conflict Resolution	1679	1679	1551	128	92.38%
Manual Handling	1679	1679	1530	149	91.13%
Safeguarding Adults	1668	1669	1511	158	90.53%
Safeguarding Children	1668	1669	1507	162	90.29%
Data Security Awareness (IG)	1679	1679	1481	198	88.21%
Infection Control	1679	1679	1455	224	86.66%
Grand Total	**1679**	**16770**	**15514**	**1256**	**92.51%**

3.2 Development and Modernisation of the Nursing Workforce:

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

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

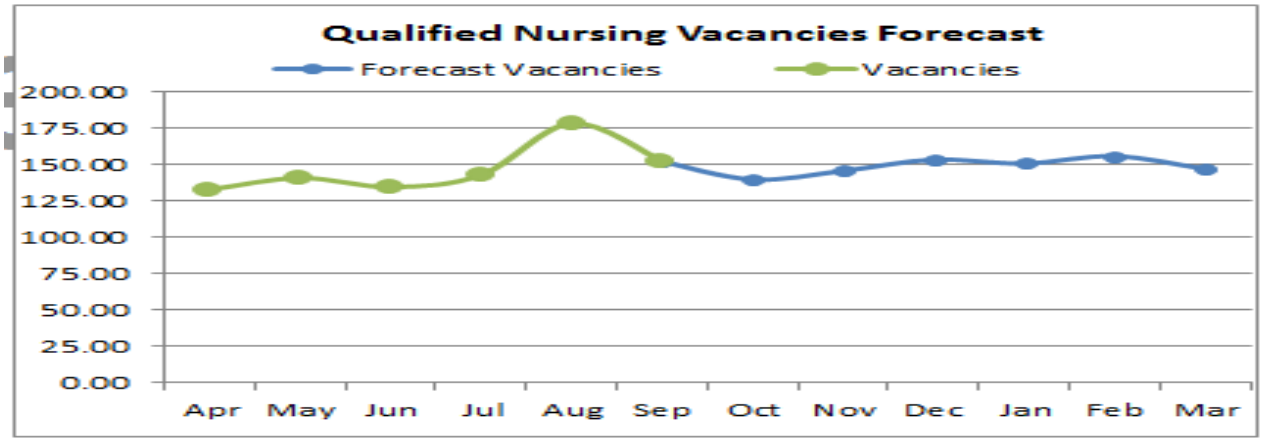
Development of these roles provides assurance that the nursing workforce embraces the growth of future care models by creating an adaptable and flexible workforce, which will be responsive to changing demand and able to work across the care setting, care teams and within the integrated care systems.

CHFT currently have 6 qualified Nursing Associates across the clinical divisions, and a further 60 in training. Funding is being identified to support the recruitment of a further 20 to begin training in December 2019. The result will be a cohort of 86 registered Nursing Associates by 2021 – giving the organisation the opportunity to develop nursing establishment levels in line with national guidance and quality assurance metrics.

3.3 Recruitment and Retention

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

Table 7 Band 5 nursing trajectory.



3.3.1 Oversees Recruitment

The Trust has welcomed 30 nurses from the Philippines into the organisation who have all successful passed the OSCE exam and are now contributing to shift fill within the nursing workforce. The Trusts approach to supporting colleagues to progress through the OSCE exams has been nationally recognised for its high pass rate.

3.3.2 Domestic Recruitment

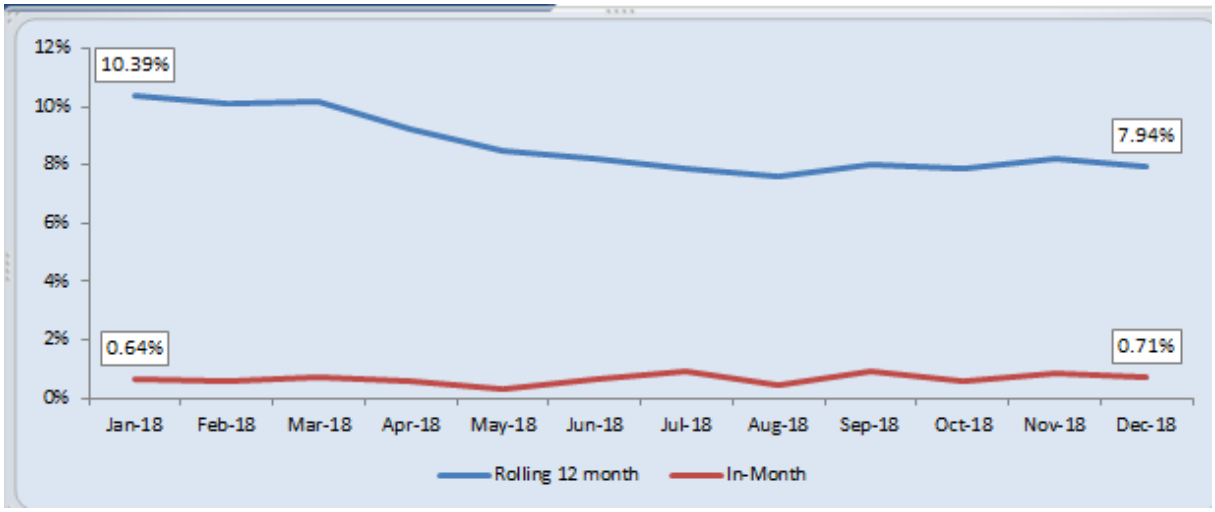
The Trust continues to recruit expected number of new graduates from local Universities. This has been attributed to increasing the placement capacity for undergraduate nurses and thus giving exposure to the trust for new employees. CHFT secured 48 new graduates who joined the Trust between September and November 2018. To date the Trust has 50 graduate nurses/ODP under offer that will qualify and join the Trust in September –November 2019.

3.3.3 Retention

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

Table 7 indicates that through the above strategies the Trust has reduced nursing Turnover by 2.24% through the early part of 2018/19.

Table 7: Retention data



4.0 RIGHT PLACE AND TIME

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

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

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

4.1 Efficient Deployment of Nursing Staff

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

4.2 Acuity and Dependency Studies

The Shelford Safer Care Nursing Tool (SCNT) was used in May 2019 to support the Nurse staffing reviews.

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

5.0 QUALITY IMPACT OF NURSING AND MIDWIFERY STAFFING LEVELS

Red flags are currently reported via the Trusts incident reporting system and are designed to support the nurse in charge of a shift to assess systematically that the available nursing staff for each shift, or at least each 24hour period, is adequate to meet the actual nursing needs of patients on that ward.

Additional categories for Ref Flags for the staffing position and outcomes will be built into the system to give additional focus on the outcomes for both staff and patents when staffing levels are low. This feature will be operational from the 1st of September 2019.

6.0 BI-ANNUAL STAFFING REVIEW – May 2019

In May 2019 all nursing workforce models (WFMs) were reviewed by the nursing workforce model review panel. This ensured a consistent approach was utilised across each division to complete the reviews using standardised templates and guidance. The resulting models and establishment levels are evidenced based, integrated with finance, activity and performance plans.
A comprehensive Quality Impact Assessment (QIA) has taken place where there is any workforce transformation or redesign including a change in skill mix and/or the introduction of new roles.
The process will be repeated through the 2019/20 workforce review process and is aligned to strategic workforce and business planning.

6.1 Surgery

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

Divisional colleague's highlighted ward 10 as an area for review due to an increased level of acuity and additional demand from ward attenders/medical outliers.

The high level proposal from the division was to increase the RN cover on the late shift to 4 registrants. Acuity data supports this recommendation.

Recommendation/actions:

- The division to ensure that staff are deployed and used flexibly to support the required workforce on ward 10
- To ensure this is factored into the business planning cycle
- Continue to monitor monthly both workforce and nurse indicators
- Deploy the current WFM in the interim to manage the pressure
- Review the data related to the ward attenders

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

Within A&E services no changes to the current establishment have been made. However, work using the "BEST" acuity studies indicates that enhanced staffing models are needed within the departments. In the interim this will be funded via innovation funds and will result in additional triage support from Q3. The recommendation from the panel was for the BEST studies to be repeated in Q4 to assess impact and support a case for longer term divisional investment

6.3 Families and Specialist Services
No investment proposed to the current Nursing/Midwifery establishments within the division of Families and Specialist services. The updated NHS Long Term Plan 2019 and Better Births 2016 are the main national drivers to transforming maternity care in relation to the way it will be delivered in the future.

Traditionally, maternity staffing models have staffed buildings rather than use a model that follows the women and provides greater continuity of carer. The NHS Long Term Plan and Better Births provide an evidence-based case for changes in the way care is provided to improve maternal and neonatal outcomes – the division continues to work towards delivery of this agenda.

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

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

7.0 CONCLUSION

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

8.0 REFERENCES

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

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

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

Safer Care Nursing Tool (2014), Shelford Group.

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

15. Winter Plan

To Approve

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Winter Plan 2019/20
Author:	Bev Walker, Deputy Chief Operating Officer
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Weekly Executive Board

Actions Requested:
To approve

Purpose of the Report

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

Key Points to Note

The Winter plan builds on learning from previous winters via the Urgent Care Board with membership of all Clinical Directors.

Schemes have been developed and implemented that improve the experience and safety of patients presenting with an urgent or emergency care need all year with a smaller cohort of schemes providing additionality for specific winter pressures. These will rem ain in place until 30th April 2020.

There is an EU Exit plan in development and monitoring post 31st October may require adjust ments to the winter plan.

There is an expected surge of patients with 'flu' in 2019/20. Guidance through public health an d CHFT internal IPC team including the lead clinician will be managed through the Pan Flu Pla nning Group with all key partners within CHFT. A table top exercise will take place prior to winter to ensure the Pan Flu Plan is robust and any learning shared and acted upon prior to winter, all divisions will be represented. This will be above and beyond normal surge and escalation and the plan for this will be confirmed in due c ourse

A market staff approach on both main hospital sites and in the community is scheduled for 3rd October to provide for wider staff and public understanding of the plan. Key stakeholders have been invited to join.

EQIA – Equality Impact Assessment
The plan provides for individual assessment and management of patients presenting for urgent and emergency care. Staff working in all areas pertaining to the plan have access through Trust HR policies to request specific arrangements and support as required. There is a Matron on duty 24/7 for escalation.
Recommendation
The Board is asked to approve the winter plan but note this may be subject to change, any changes will be notified to Board members electronically to ensure in real time and submitted to note on future agendas.

Review Date: June 2019
Review Lead: Deputy Chief Operating Officer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Winter Plan 2019/20

Document Summary Table	
Status	Final
Version	2
Implementation Date	October 2019
Current/Last Review Dates	October 2020
Next Formal Review	June 2020
Author	Deputy Chief Operating Officer
Where available	Emergency Preparedness, Resilience and Response Section of the Trust Intranet
Target audience	Executive Directors, On-call General Managers, Directors, General Managers, Senior Nursing Colleagues, Matrons, Senior Ward & Department staff, on call teams and CHS.

Ratifying Committee	
Board of Directors	

Consultation Committees		
Committee Name	**Committee Chair**	**Date**
A&E Delivery Board	Chief Officer, Calderdale CCG	September 2019

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

Document Version Control	
V1	Updated for Winter 2019/20
V2	Updated
V3	

Contents

1. 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. This has been a focus in CHFT where seasonal variation is less defined and the improvements implemented benefit patients therefore should be in place at all times, winter only additionality is focussed on management capacity to support patients and staff, testing of ideas and those interventions that are specifically prevalent in winter for example Flu. For winter only schemes these will remain in place until the end of April 2020 reflecting learning from the last 2 years.

A separate plan is being developed to manage the potential exit from the EU on 31st October; this will be closely monitored and changes to the winter plan may be required as a consequence.

2. 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

3. 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 Trust's capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November 2019 until the end of March 2020.

THIS will support the reporting of the Sitrep on a daily basis and the Deputy Chief Operating Officer or deputy will complete the sign off, a rota has been created.

4. Duties (roles and responsibilities)

Chief Operating Officer

- Reportable officer at Executive level for Winter Planning
- Will represent Trust on the A&E Delivery Board
- Chair of Urgent Care Board

Deputy Chief Operating Officer

- 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

Divisional Director of Operations

- 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 and in community buildings where CHFT staff and patients are working/attending
- 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.

5. 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 2018/19 is incorporated into 2019/20 Winter Plan.

6. Winter planning arrangements

The Trust Operational Lead for winter planning is the Deputy Chief Operating Officer in collaboration with the Divisional Senior Management Teams.

The local 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's internal Urgent Care Board with membership of all Clinical Director's, has contributed to planning by developing new innovative schemes providing increased resilience and clinical effectiveness for urgent and emergency care with the majority of developments commencing prior to the winter period but will be recurrent. All innovations are being monitored against clear aims and KPIs specific to the scheme. There is an overall aim of improving patient safety through early assessment, diagnosis and treatment as well as an improved patient and staff experience.

Recurrent Innovation Schemes			
Work Stream	Project Number	Description	KPIs
Enhanced Frailty Service To introduce a frailty on stop community clinic	1	The project is to open an ambulatory/admission area for Frailty patients To provide an environment/clinic that has an MDT approach for patients who are deemed frail in community to ensure they can be maintained in their own home.	• Reduction in admissions • Reduction in readmissions • Reduce LOS • Reduced occupancy levels • Increased discharge to usual place of residence
Enhanced Paediatric Admission Avoidance	2	To increase paediatric consultant cover in ED at CRH over 5/7 To provide a GP rapid access assessment/ambulatory clinic	• Reduce admissions • Reduce ED attendance for paediatrics • Improved patient experience
Stroke - Early Supported Discharge (ESD)	3	To increase capacity within the stroke ESD to enable an enhanced rehabilitation offer on discharge to patients who have had a stroke and to enable more patients on the ESD case load	• Reduce LOS for stroke patients • Improved patient outcomes
Expansion of Surgical Ambulatory Care	4	To provide dedicated nurse coordination on SAU	• To improve the patient experience • To prevent delays in the ambulatory pathway
Proactive Care for	5	To provide a dedicated elderly care senior medic to	• Reduced LLOS for

Older People (Surgical)		enable assessments for frail/elderly patients within surgery, to prevent complications and improve discharge	elderly/frail patients in surgical division • Reduce readmissions for this cohort of patients
Advance Care Planning	6	To improve the number of patients who have an advanced care plan at the end of life	• Increased number of patients with an advanced care plan • Increased number of patients who die in their preferred location • Improved completion of DNACPR forms
Acute Kidney Injury Nurse	7	To recruit a dedicated nurse to support patients with an AKI	• Reduction of LOS for patients with an AKI • Reduce readmissions
Acute Physician in ED	8	To provide an acute physician dedicated into ED to prevent avoidable admissions	• Reduce admissions • Improve patients experience
Pharmacy Prescribers- enhanced service	9	To provide pharmacy prescribers to prevent delayed discharge and risks associated with medications errors on discharge.	• Reduce delays due to TTOs not being prescribed timely. • Reduction in medication incidents/errors on discharge
Radiology Coordinators	10	To improve links with radiology, attend patient flow meetings, visit key areas e.g. ambulatory, ED, MAU, SAU as needed to help manage demand and improve flow and prevent delays for diagnostics. To pick up clinical calls/ queries and direct to the most appropriate person e.g. ensuring requesting clinicians (e.g. ED) access a radiologist quickly. They will also prevent unnecessary interruptions to radiologists during reporting sessions	• Improved access to diagnostics • Improved staff experience
DeepClean/HPV programme	11	To ensure all prioritised inpatients wards are fully deep cleaned and have HPV applied	• Reduce incidents of C Difficile • Reduction in closed wards due to IPC issues

Non-Recurrent Innovation Schemes			
Work Stream	Project Number	Description	KPIs
Home First Team	11	Develop senior nurse team to focus on patients with a LOS of 7 days and support ward staff to improve the discharge planning.	• Reduce the number of patients with a LOS over 7 days. • Reduce the number of incidents due to poor discharge planning
Point of care testing for Flu	12	Facilitate early diagnosis of patients presenting with flu like symptoms and ensure appropriate isolation	• Decreased number of patients with flu in open wards. Datix reduction • Available side room capacity
Point of care testing for Norovirus	13	Facilitate early diagnosis of patients and ensure appropriate isolation	• Decrease number of IPC related ward closures • Availability of side rooms

Pilot Innovation Schemes			
Work Stream	Project Number	Description	KPIs
Emergency Department Senior Nurse Triage & Steaming	12	To recruit senior nursing staff and develop an enhanced senior triage and streaming services. This scheme links to the Integrated Care System transformation scheme as agreed through the AEDB that will test the benefit of an Urgent Care Hub at both HRI & CRH working with Community Pharmacy, social care, the voluntary sector, GPs and Mental Health to refer patients from triage to other services more appropriate to their needs	• To reduce ED attendances • Reduces time to first assessment for patients presenting to Majors area • To prevent unnecessary delays for patients to be seen by the most appropriate service. • Reduce admissions • Improve patients experience

7. Command, control and co-ordination

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 Deputy Chief Operating Officer/Director of Operations/Deputy Chief Nurse after high level validation with fully validated data submitted daily. Arrangements have been 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 Deputy Chief Operating Officer, 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.

8. 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 have aligned 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 are 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 Deputy Chief Operating Officer will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

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

9. 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 2nd 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 and incentive schemes have been agreed. District nursing services in Calderdale provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine. The Flu vaccine performance will be monitored weekly via Executive Board.

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.

10. 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 Operations as point of escalation and will chair of the critical 12pm Patient Flow Meeting if OPEL 3 is triggered. From the beginning of January 2020 until the end of April 2020 there will be a twice 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 and learning is quickly acted upon.

From New Year to the end of April the on call manager will remain on site until 10pm each evening and there will be an additional support (buddy 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.

Urgent Care Action Cards and a revised surge and escalation plan will be relaunched in October to prevent exit block within ED, improve daily operational management in a more consistent way and prevent and any patient waiting on hospital corridors.

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, are action focused and ensure 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

Hold a register of registered 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 (buddy) 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 Discharges

SAFER Patient Flow Transformational Programme is supporting initiatives throughout 2019/20 to improve flow, prevent avoidable admissions, reduce LOS and improve timely discharges.

The weekly Long Length of Stay (LLOS) meetings will continue on both sites and feed into the winter room to determine delays and facilitate discharge. The LLOS team will continue to consist of senior members of CHFT. Liaising with partner's organisations as required. 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. They will also look at reducing diagnostic and pathway delays for in patients by supporting teams with appropriate challenges to medical teams

Pharmacy

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 November-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.

11. 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 completed the new medical staffing rotas for consultants in 2018 but these will be further enhanced with the introduction of a respiratory consultant rota 7/7. These rotas provide more specialist weekend reviews. All wards will have a daily ward round. The Medical Division has developed specific plans to provide flexible escalation capacity to meet the expected increased demand on inpatient capacity however further innovation schemes are being developed to mitigate the risk of fluctuations and risks associated with escalation 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.

The division will stand down several meetings within the month of January 2020, to support operational resilience and response. Annual leave has been monitored and planned through an annual leave planning meeting to ensure that cover is appropriate throughout the winter months.

Many of the innovation schemes that have been planned support the division to be able to deliver good quality safe care throughout the winter months.

The division will hold an 11.30am huddle every day 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 1-5pm. GP referrals will continue in the usual way.

An acute medical floor is now in place on 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 work on a speciality rota covering the service 7 days a week.

There will be a significant expansion of frailty services across the Huddersfield Royal Infirmary site as part of the innovation schemes with in-reach to CRH and links to community. GP referrals for frailty will commence in December 2019, these patients will be referred via telephone with advice or asked to come to ambulatory for assessment.

Escalation Capacity - HRI

A dedicated winter escalation ward on the HRI will be open from January until the end of April 2020 with a workforce in place and a robust MDT approach including community colleagues.

Flexible Escalation Capacity
This will be based at CRH allowing the effective management of surges in demand and avoiding the use of ambulatory capacity which historically has impacted on the effectiveness of same day emergency care.

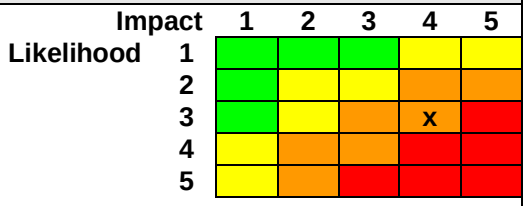
Division	Escalation Capacity	Trigger & Action	Lead
Medicine	8 escalation beds are planned flexibly, using additional beds on 6B	Triggered through the Winter Room Meetings using demand management data/daily predicted discharges after all other admission avoidance has been exhausted. **Risk assessments 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 Associate Director for Nursing for medicine. Plan to flex these beds as required (overnight).	Winter Room -Divisional Manager/Matron/Clinical Site Commander. Director of Operations Associate Directors of Nursing

Emergency Department

The Emergency Department (ED) will have:

- Surge triggers developed for ED Consultants have been implemented to extend the working hours of the consultant until midnight
- Additional assessment capacity was created, adjacent to the ED to ensure **all** ambulance and ambulatory majors' patients even at times of surge are seen within 15 minutes.
- Front end senior nurse triage to sign post and stream to alternate appropriate services will commence in October 2019.
- 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
- Daily huddle held with coordinators from ED. MAU/AMU, SAU and the clinical commanders to discuss 'what went well' the day before, with the ethos of 'working together to get results', this is a more coordinated, collective, supportive approach.
- 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 is being developed.
- The Senior Lead Nurse B7 for each department is supernumerary
- The Frailty Team works closely with the ED team to ensure all opportunities to support avoidable admissions are taken.

Surge in Non-Elective Demand

Overview		
Impact		
• Unpredicted increase activity in EDs, 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 Matron/Discharge Team.	• Liaise with YAS to agree priority order for patient movement. • Initiate spot purchasing agreements via LAs • Start discharges with medicines to follow. (Use of taxis of transportation of medicines post discharge.) • Use of day rooms and discharge lounges to facilitate expedite discharge. • Discharge thresholds to be challenged.

Surgical Divisional Plans

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

- 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, 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. The innovation scheme for SAU will provide dedicated nurse coordination, both of these additions will improve timely pathway management and an improved patients experience,
- Improved 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 with the innovation of a POP service and extended hours to provide support on the SAU to support/expedite discharge and reduce unnecessary complications for complex elderly patients.

Elective Orthopaedic activity

The Surgical Division will continue to deliver elective inpatient orthopaedic surgery as planned through the winter period reflecting the ring fenced bed capacity to manage infection risks.

From January 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 continued to progressively moved more work to day-case this year, thereby further reducing the risk of elective cancellations.

The General Surgery rota ensures 24hr Consultant led emergency care and with investment into the surgical assessment unit will improve flow and Same Day Emergency Care.

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 ANNPs 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. An innovation scheme supporting a new way of daily coordination is being introduced through winter to prevent delayed and improve clinician access to radiologists.

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 (November to March); 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

Central Operations (COT)

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

Discharge Team

- 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
- Case reviews of all patients daily with a manager of the discharge team

Home First Team

- Daily review of where the pressure points are each site and by ward area
- Stringent review and follow up of outliers to ensure plans in place and are followed
- Identification of where clinical pathways are unclear or delayed for some reason or where there is no clear discharge plan.
- To suggest where possible, Criteria Led Discharge and follow through these plans to support ward areas.

Discharge Planning

- Implement the 8 High Impact Changes to improving Patient flow and discharge
- Twice weekly MADE Room triggering into daily if required with Director level attendance from partner organisations at this point
- Senior review team led by an Associate Director or above, to carry out the long stay reviews on the wards and enable decision making and support planning discharges. Focus will be patients with a LOS of 7 days

- To escalate where needed any gaps in community or social support eg Packages of care or reablement

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 Deputy Chief Operating Officer/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
- An additional transport service will continue to be available managed through the Clinical Site Commanders to support discharge and inter-hospital transfers
- Increased task management will be in place 'in hours' through quarter 4.

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

Priority 1 Clinical Services

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

- District Nursing priority one patients (complex wound care, blocked catheters, administration of medications, OPAT and palliative care)
- Administration of medications including IV therapy and syringe drivers
- Support for discharge out of hospital
- Palliative Care
- Crisis Response 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
- Home Enternal Feeding
- Community Matrons
- Community Rehabilitation Team

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 Response 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) 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	Donna Wood
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	Karen Willows	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 Response Team

Crisis Response 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 has 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	Caroline Lane

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	Jenny Dyson	07795 825139
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
Bladder and Bowel	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 Clair Jones	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 two 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 835195

Cardiac Rehabilitation Services

There will be increased capacity which will support extended working hours Monday – Thursday supporting the Cath Lab. 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. An enhanced service will be in place from November as part of the innovation scheme plans.

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

Therapy Services

Therapy services provide interventions across in-patient, intermediate care and Community Services and will work flexibly across all areas to provide support where pressures manifest during the winter period.

Lead Manager	Debbie Wolfe 07825902363

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 Healthcare Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

Senior manager contact details are as follows:

Name	Role	Work mobile
Bev Walker	Director of Operations	07766905553
Andrea Dauris	Associate Director of Nursing	07920251715
Michael Folan	Head of Therapy Professions	
Nicola Ventress	Assistant Director of Finance/ Deputy Director of Operations	07765 306617
Liz Morley	Head Nurse	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
Caroline Smith	General Manager- Therapies	07741004547

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 Manager's 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

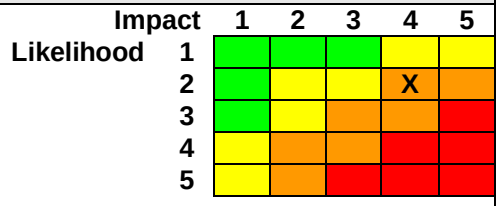
The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout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

12. 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's Adverse 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 staff 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

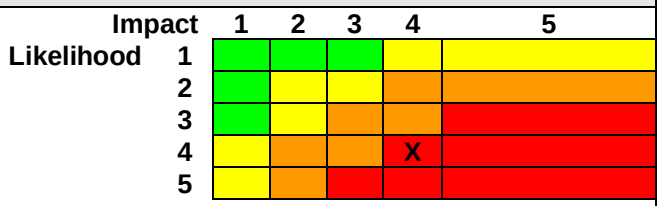
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council Highways		01484 414818
St John's Ambulance	24hr pager	Via switchboard

13. Seasonal influenza

Overview

Business Impact

- Absence of staff due to influenza illness
- 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



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 is an expected surge of patients with 'flu' in 2019/20. Guidance through public health and CHFT internal IPC team including the lead clinician will be managed through the Pan Flu Planning Group with all key partners within CHFT. A table top exercise will take place prior to winter to ensure the Pan Flu Plan is robust and any learning shared and acted upon prior to winter, all divisions will be represented. This will be above and beyond normal surge and escalation and the plan for this will be confirmed in due course.

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, thumb in loop gowns and eye protection is established on each site. The stockpile is managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks or the positive pressure hood are required for specific infectious diseases (MERS and by staff performing cough inducing procedures for patients with suspected or confirmed infectious condition spread via respiratory secretions. FFP3 masks must be worn when performing the following procedures:

- Intubation, exubation and related procedures (e.g. manual ventilation and open suctioning)
- CPR
- Bronchoscopy
- Surgery and post-mortem procedures involving high speed devices;
- Some dental procedures (e.g. drilling);
- Non-invasive ventilation (e.g. bi-level positive airway pressure and continuous positive airway pressure ventilation)
- High-frequency oscillating ventilation; Induction of sputum.

Staff performing these types of procedures will include staff in ED, theatre, respiratory ward, ICU, and the acute floors in addition to staff groups such as Anaesthetists, Intensivists, endocopists and physiotherapists (chest). Many wards and departments stock these masks and the following wards are 'top up' areas:

HRI = SAU, acute floor, 18, ICU, Emergency Department

CRH = acute floor, 3, 5, ICU and Emergency Department

Fit Testing For FFP3 Masks

Prior to using an FFP3 mask the make/model and size of mask MUST be fit tested to the user to ensure a seal can be attained and the member of staff will be safe. Face masks come in various shape sizes so users can determine the most effective.

There are competent 'fit testers' in most clinical areas within the Trust who can carry out the assessment (register held on the intranet). Fit test kits are available from the IPC team for competent fit testers to use. It is the responsibility of the fit testers in each area to fit test their staff and to record the make model and size of mask that they require. Staff who have been fit tested are adding onto the equipment training database by the fit tester or the staff members manager.

Where a member or staff does not successfully fit test with the FFP3 mask used by the Trust, each management team must put in place appropriate risk mitigation measures to protect the member of staff from being exposed to a respiratory infection at work. This may involve:

- Training to use the positive pressure hood
- Reassigning to an alternative task

Positive pressure hood systems have been purchased for use in the emergency departments on both sites. Training is required prior to use by a competent user.

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.

14. 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 call pack 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 Divisional Directors of Operations and identified leads for winter planning have 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
- 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 2019

- 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

Winter Market Place

On October 3rd there will be a Winter Market Place where key teams and services including all innovation scheme leads will have a stall in the main hospital entrance at both acute sites. With further smaller market place staff being hosted in community health centres. This is a new approach to sharing the Trusts Winter Plan with not only staff but patients, carers, relatives and visitors.
Key health messages via the IPC Team and communication department will be available and gives an opportunity for wider dissemination.

Trust Equalities 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 Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period and learning shared and acted upon. The Urgent Care Board membership will also play a key role in the review process.

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:
All can be found on the intranet- link
https://intranet.cht.nhs.uk/non-clinical-information/emergency-preparedness-resilience-response-local-secuirty-management-specialist/

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

This plan has been shared with external stakeholders for comments and identification of any areas of concern. Stakeholders have been invited to host stalls of their own plans at the Winter market Place. The AEDB will undertake a system review of all plans and a Joint Surge and Escalation & Winter Plan will be agreed.

APPENDIX 1

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

16. Integrated Performance Report – July 2019

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Weekly Executive Board

Actions Requested:

- To note

Purpose of the Report

To provide the Board of Directors with the performance position for the month of July 2019.

Key Points to Note

July's Performance Score is 74% with 3 green domains. The **SAFE** domain continues to be green. The **CARING** domain remains amber however further focus on both of the FFT A&E metrics could see this improve. The **EFFECTIVE** domain remains green, he #NoF has yet to improve. The **RESPONSIVE** domain is amber and has improved with Cancer 38 day target hit for the first time. Unfortunately, 2 of the 4 stroke indicators have worsened in month and the 6 weeks Diagnostics target remains a challenge. The RTT diagnostic work continues. **WORKFORCE** remains green with sickness levels continuing their strong performance. All 9 EST areas are now green. **EFFICIENCY & FINANCE** is amber with a small deterioration in Efficiency metrics in month.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

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

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

July 2019

Report Produced by : The Health Informatics Service

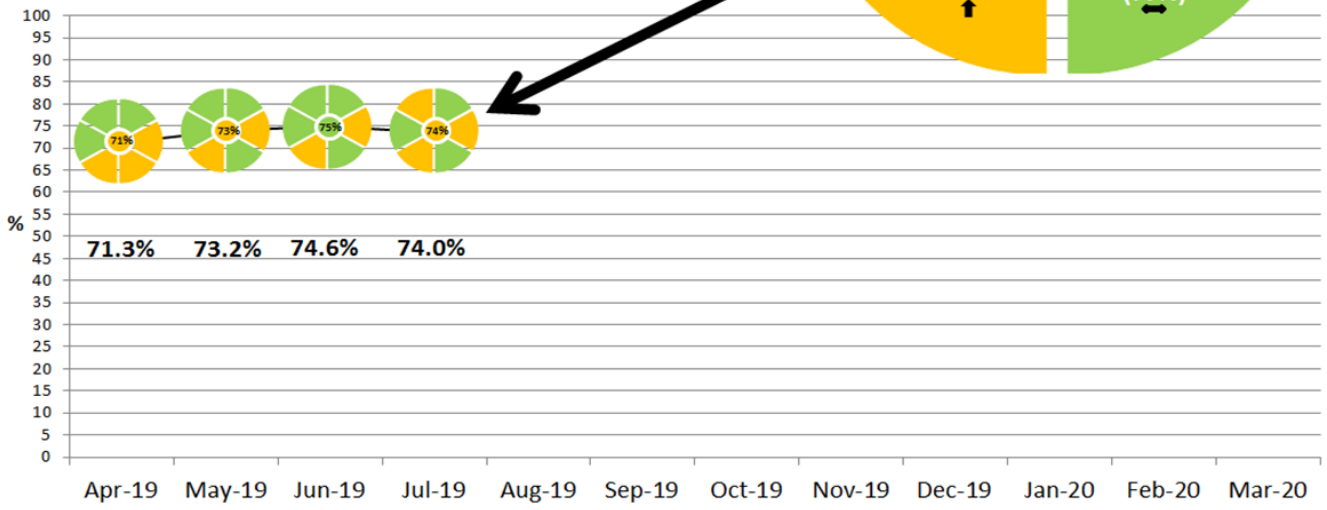
Data Source : various data sources syndication by VISTA

Performance Summary

July

RAG Movement

July's Performance Score is 74% with 3 greens domains. The SAFE domain continues to be green. The CARING domain remains amber however further focus on both of the FFT A&E metrics could see this improve. The EFFECTIVE domain remains green, the #NOF has yet to improve. This RESPONSIVE domain is amber and has improved with Cancer 38 day target hit for the first time. Unfortunately 2 of the 4 stroke indicators have worsened in month and the 6 weeks Diagnostics target remains a challenge. The RTT diagnostic work continues. WORKFORCE remains green with sickness levels continuing their strong performance. All 9 EST areas are now green. EFFICIENCY & FINANCE is amber with a small deterioration in Efficiency metrics in month.



SINGLE OVERSIGHT FRAMEWORK

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

Key Indicators

	18/19	Apr-19	May-19	Jun-19	Jul-19	YTD	Annual Target
SAFE							
Never Events	4	0	0	0	0	**0**	0
CARING							
% Complaints closed within target timeframe	42.00%	29.0%	38.0%	58.0%	**37.0%**	**40.0%**	100%
Friends & Family Test (IP Survey) - Response Rate	36.39%	34.35%	36.50%	32.61%	**33.58%**	**34.27%**	>=24.5
Friends & Family Test (IP Survey) - % would recommend the Service	97.46%	97.29%	97.56%	96.91%	**97.40%**	**97.30%**	>=96.7
Friends and Family Test Outpatient - Response Rate	10.75%	7.93%	9.25%	9.93%	**10.11%**	**9.32%**	>= 4.7
Friends and Family Test Outpatients Survey - % would recommend the Service	90.92%	91.13%	90.36%	91.81%	**92.11%**	**91.39%**	>= 96.2
Friends and Family Test A & E Survey - Response Rate	13.03%	11.56%	11.48%	14.46%	**11.37%**	**12.09%**	>= 11.7
Friends and Family Test A & E Survey - % would recommend the Service	83.80%	83.88%	84.79%	85.60%	**82.29%**	**84.12%**	>=87.2
Friends & Family Test (Maternity Survey) - Response Rate	36.51%	30.84%	41.78%	52.54%	**38.29%**	**30.68%**	>=20.8
Friends & Family Test (Maternity) - % would recommend the Service	98.64%	100.00%	99.19%	99.43%	**99.53%**	**99.50%**	>=97.3
Friends and Family Test Community - Response Rate	4.91%	3.38%	5.74%	2.15%	**2.48%**	**3.46%**	>=3.2
Friends and Family Test Community Survey - % would recommend the Service	94.64%	96.69%	95.48%	97.96%	**98.15%**	**96.28%**	>=96.7
EFFECTIVE							
Number of MRSA Bacteraemias – Trust assigned	2	1	0	0	**0**	**1**	0
Preventable number of Clostridium Difficile Cases	5	0	0	0	**1**	**1**	40
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.25					**100.25**	<=100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	84.51					**85.82**	<=100
RESPONSIVE							
Emergency Care Standard 4 hours	91.29%	90.19%	92.30%	89.32%	**91.44%**	**90.83%**	>=95%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	64.00%	46.55%	50.88%	63.41%	**55.36%**	**53.27%**	>=90%
% Incomplete Pathways <18 Weeks	92.05%	**91.79%**	**92.15%**	**92.27%**	**92.05%**	**92.05%**	>=92%
Two Week Wait From Referral to Date First Seen	98.46%	96.56%	96.84%	97.92%	**98.82%**	**97.59%**	>=93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.56%	98.34%	94.05%	93.56%	**97.87%**	**95.94%**	>=93%
31 Days From Diagnosis to First Treatment	99.63%	100.00%	99.40%	100.00%	**99.34%**	**99.68%**	>=96%
31 Day Subsequent Surgery Treatment	99.04%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%
38 Day Referral to Tertiary	52.42%	31.58%	27.78%	57.69%	**87.50%**	**50.63%**	>=85%
62 Day GP Referral to Treatment	88.37%	88.51%	91.76%	89.16%	**89.78%**	**89.80%**	>=85%
62 Day Referral From Screening to Treatment	94.42%	91.30%	96.15%	100.00%	**100.00%**	**96.47%**	>=90%
WORKFORCE							
Sickness Absence rate (%) - Rolling 12m	3.69%	3.67%	3.64%	3.64%	*	-	4%
Long Term Sickness Absence rate (%) -Rolling 12m	2.39%	2.37%	2.36%	2.36%	*	-	2.5%
Short Term Sickness Absence rate (%) -Rolling 12m	1.30%	1.29%	1.28%	1.28%	*	-	1.5%
Overall Essential Safety Compliance	94.45%	93.18%	93.40%	93.36%	93.36%	-	90%
Appraisal (1 Year Refresher) - Non-Medical Staff		16.52%	50.88%	96.43%	96.43%	-	95%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	92.85%	87.23%	86.89%	85.28%	85.28%	-	95%
FINANCE							
I&E: Surplus / (Deficit) Var £m YTD	0.01	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Cancer 38 Day Referral to Tertiary - achieved for the first time. This is in addition to the 2 week wait, 31 day and 62 day targets which have all achieved for the 9th month running.	% Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - performance not yet fully recovered	The Division are undertaking a review of their total trauma management including daily trauma waiting list management and theatre list allocation.There is a deep dive on T&O at the Surgery PRM scheduled for 2nd September with this KPI a key focus incudng both delivery of standard and a review of patient outcomes
Overall Sickness absence - Sickness rolling 12 month total (3.67%) is at its best position since September 2018.	Complaints deteriorated in July following improvement in June	CEO briefings continue. Additional capacity in place within central team. Further actions required to move performacne to an acceptable position and ensure this is sustained. Actions not yet identified
	6 week Diagnostics - Echocardiography has moved away from trajectory due to some capacity constraints in the outsourced provider	Working with provider to recalculate trajectory with an expected slippage of 4 - 6weeks from plan

Executive Summary

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

Domain	Area
Safe (77%)	• **Maternal smoking at delivery -** at 14.2% highest rate since December. Work ongoing with NHSI to raise the profile of the issue within maternity services. Full action plan with multiple workstreams monitored through CPAIG and Stillbirth reduction group. • **Health & Safety Incidents (RIDDOR) - there was one incident in July within FSS.**
Caring (59%)	• **Complaints closed within timeframe** - Complaints performance has dropped in July with only 37% responded to within time. The Complaints Department has been providing additional support to the ED in relation to their complaints to ensure that these are being worked on during the current ED pressures. Divisional Senior Management Teams and Corporate Complaints Team colleagues continue to work together to improve the quality and timeliness of complaint responses, and training and supervision of colleagues responding to complaints. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 92% against the 96.2% target. Orthopaedics are trailing manual data collection of FFT rather then using the automated text messages. The pilot started in June and response rates have improved significantly. Staff feel that patients are providing richer more positive feedback. At the end of the trial will analyse the impact and if positive will look to roll out to other areas within the directorate, starting with ENT then Medicine and Surgery. Improvement plans are also on the agenda for July PRMs. • **Friends and Family Test A & E Survey - Response Rate. At 11.37% lowest rate in over 12 months. Work is being carried out alongside the Information team to ensure all responses are captured as some cards are not being processed due to no encounter number.** • **Friends and Family Test A & E Survey - % would recommend the service**. Performance is at 82% lowest since February. A new poster has been displayed in both ED's encouraging patients and relatives to alert the nurse in charge if there is an issue in real time. This also makes patients aware they can contact the Matron or Clinical Director after their visit to discuss any issues. Each Staff Member in the ED has written a pledge on their 'Pledge Tree' which is displayed in the waiting areas and has comments which demonstrate their commitment to patients. • **Friends and Family Test Community Survey - Response Rate**. Performance is still low at 2.48%. A volunteer has been identified to make follow-up FFT telephone calls for the district nursing service. • **% Dementia patients screened following emergency admission aged 75 and over** - performance has fallen to 48.45% lowest since January and is a long way from the 90% target. Multi-disciplinary dementia screening quality improvement programme continues to work across all clinical areas to improve the proportion of screens fully completed and recorded. A benchmarking exercise will be undertaken to assess how the Trust compares to other Cerner Trusts and this will contribute to a deep-dive report scheduled with WEB in Q2.
Effective (77%)	• **Preventable number of Clostridium Difficile Cases** - there was one preventable case within Medicine, first in over 12 months. The investigation is currently ongoing and learning will be shared once this is complete. • **% Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - performance has improved to 69% although still some distance from the 85% target. RCA undertaken for all organisational breaches with patient outcomes monitored. Joint working with Theatres to consider alternative options for planned trauma. Planned discussions with Executive team at next PRM.

Background Context

The field testing of the new Elective Care Standard using the ***average wait for all patients on incomplete pathways and the headline measure of elective RTT performance*** began at the start of August. The Trust has managed to maintain its achievement of the 92% incomplete pathways target at the end of July.

In FSS a review of divisional governance architecture is in progress to reduce duplication of information, realign information flow through and beyond the division and redefine divisional accountabilities, in partnership with the divisional team and corporate governance.

Senior nursing leaders in AED have been released to provide more direct coaching to colleagues within the department and identify areas for futher patient expereince improvements. There have been staffing gaps on both sites for nursing and medical rotas with bank and agency unable to cover all shifts. the team have responded well to this position ensuring focus on patient safety and experience

Following the deep-dive into unplanned attendances in the ED a benchmarking exercise has shown that we are currently performing 26/128 trusts nationally with an average of 6.72% against the national average of 8.32%.

Ward 14 was opened in July to create decant capacity to support the continuation of the HPV programme and has enabled the testing out of a enhanced model for Frailty. The ward will be kept open until the end of the HPV schedule with learning used to refine this.

The Respiratory Floor continues to actively recruit into nurse vacancies. Training for new staff into this area is being developed with a bespoke package in conjunction with Critical Outreach and the Clinical Educators.

Maternity has had periods of escalation where there have been surges in demand particularly around induction and Neonatal demand has seen a slight increase

Executive Summary

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

Domain	Area
Responsive (72%)	• **Emergency Care Standard 4 hours** - improved to 91.44% in July, (92.44% all types) - We have developed a 3 month recovery plan to ensure performance improves in quarter 2, this includes support from corporate teams to release the lead nurses and matron to be supernumerary for a larger proportion of their time. Short term we are putting a rota for senior cover in for the next 3 months. Long term we are looking how we could maintain this with Lead nurses, Matron and central ops nurses. • **Stroke targets** - % Stroke patients spending 90% of their stay on a stroke unit has fallen to 77% against the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival has also fallen to 55% against the 90% target. MADE events are being held to review the length of stay and provide challenge to the teams to ensure discharge planning is starting as soon as possible. This is to reduce the number of delayed discharges and thus improve the flow across the unit. • **RTT Waits over 52 weeks** - • **% Diagnostic Waiting List Within 6 Weeks** - now at 90.45%. ECHO - Backlog currently at 660 patients in Echo with ongoing capacity issues within the department. ECHO - ICS outsourcing company are providing scanning capacity but not the numbers they originally predicted due to staff leaving their service. CHFT teams currently exploring additional weekend lists with ICS to increase their capacity with CHFT staff also performing extra weekend lists through July/August to maximise the number of scans available. A revised trajectory has been proposed which clears ECHO backlogs by the end of August. For sustainability, posts have been advertised again and interviews scheduled. In July two new bank members of staff have started providing one day scanning each per week. Neurophysiology - Staff in post are running additional sessions, vacant posts are out to advert and a new rota has been implemented to better match capacity and demand. Internal training opportunities are being explored to maximise capacity and a WTGR session is scheduled. Outsourcing is being explored and a recovery trajectory is in development. • **Appointment Slot Issues on Choose & Book** - performance has fallen to 36% against the 20% target. Action plans in place including Specialty Level Plans, Advice & Guidance, Reviewing of Referrals, Development of Straight to Test Services and DNA management. CAS has had a significant impact in the specialties where it has been implemented. Plans to introduce to a wider number of specialties.
Workforce (88%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total (3.61%) is at its lowest position since September 2018. RTWI performance has improved to 77% and remains below the 90% target. • **Essential Safety Training -** overall at 94.7% with all 9 EST focus areas now achieving.
Finance (78%)	• **Finance**: **Year to Date Summary** The year to date deficit is £6.69m, a £0.01m favourable variance from plan. • There is some pressure year to date due to lower than planned clinical income and higher than planned non-pay expenditure including outsourced services, utilities, printing and maintenance contracts. • These pressures have been offset in the reported position by lower than planned pay expenditure. • Clinical contract income performance is below plan by £1.77m. The Aligned Incentive Contract (AIC) protects the income position by £1.66m in the year to date leaving a residual pressure of £0.11m, an improvement compared to the position in Month 3. • CIP achieved year to date is £2.82m, £0.16m more than planned. • Agency expenditure year to date is £2.94m, £1.13m below the planned level. **Key Variances** • Clinical contract income is below plan overall despite £1.66m protection offered by the Aligned Incentive Contract and indicating lower than planned activity levels across all points of delivery with the exception of A&E. • With the exception of Medical Division, clinical divisions continue to show favourable variances to plan, reflective of lower expenditure linked to lower activity levels across Divisions; and vacancy levels in Community. • Some non-clinical areas are experiencing pressure with higher than planned costs for the Health Informatics Service and higher than planned cross charge for services from CHS due to pressure on maintenance contracts and utilities. • There is a favourable variance on Medical staffing expenditure of £0.30m, with lower than planned activity in some specialties resulting in a reduction in the requirement for agency / bank premium. • Nursing pay expenditure is also lower than planned by £0.19m year to date, although agency costs continued to increase in month. **Forecast** • At this early stage of the year the Trust is forecasting to achieve the planned £9.7m deficit with the assistance of the full allocation of conditional funding available as a result of accepting the 2019/20 Control Total, (a £37.99m deficit). • Conditional funding consists of three separate funds: Marginal Rate Emergency Tariff (MRET) funding (conditional on acceptance of Control Total but not on achievement of plan), Provider Sustainability Funding (PSF) and the Financial Recovery Fund (FRF), both of which are conditional on the achievement of the quarterly plan. 15% of the PSF funding is reliant on the ICS as a whole achieving its Control Total. • A number of unplanned, unavoidable cost pressures have been identified which are likely to swallow up the bulk of the Trust's £1m general contingency reserve, including charges from the NHS Pensions Authority for final pay controls and costs incurred due to changes in HMRC rules relating to the Brookson contract.

Background Context

The Community Healthcare division has concluded a review of its data and validation process to ensure accurate, validated data is included in the IPR.

Some significant improvements continue in delivering high quality care within community evidenced through no category 3 and 4 pressure sores and all leg ulcers healed within 12 weeks, demonstrating excellent patient care.

Key challenges continue to be around workforce - with vacancies and sickness in a number of areas. Strategies both short term and long term have been developed to improve the position. The impact is being seen specifically across therapy services and the OoHs team and whilst this is causing pressures on staffing , mitigation is in place.

Within FSS Consulatnt Radiologist vacancies continue to provide challenges with deamd continuing to increase. Despite the pressures the whole department remains very patient focussed delivering excellent care and a responsive service. In August there were a further 2 consultant resignations . Outputs from the WTGR session continue to be taken forward. A bespoke sustainable workforce solution is in development within the directorate. Discussions continue across WYAAT to develop short and long term options for future workforce. A new CD has been appointed.

NICU - Cot modelling concluded and associated workforce reductions considered to align with annual reduction in birth rate and 80% occupancy. Network visit re: neonatal transformation pending in October.

In Surgery the Theatre Matron has been appointed and will be in post in August.

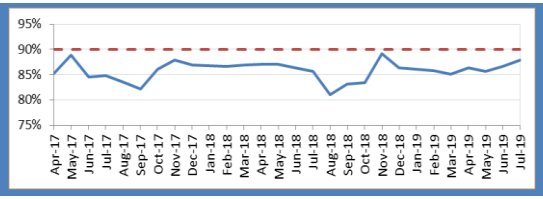
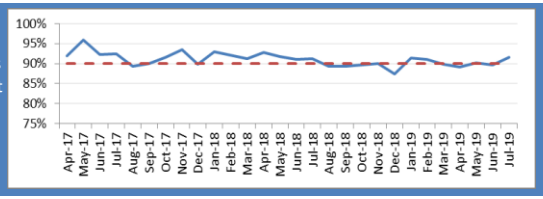
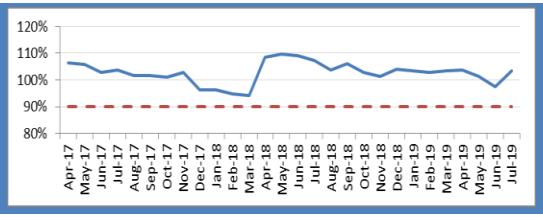
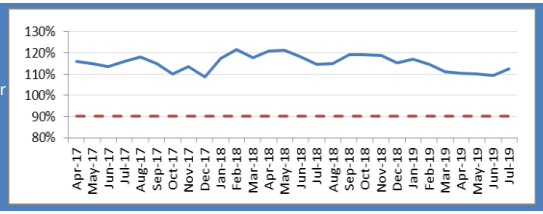
In Surgery the Matron for Operating services is now in post. Once established the role will start to work with Scheduler and Theatre Project manager to improve KPIs for Theatre Utilisation

Activity has improved across most PoDs for most specialties however long term sickness is having an additional impact upon the already challenged Ophthalmology capacity. Deep Dives on activity are being undertaken and each specialty will confirm plans to rectify where applicable

Out patient Transformation work continues in Ophthalmology and interviews for Failsafe co-ordinators due to take place in August.

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

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.	87.95% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 15 72.4%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy . CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.60% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - 7a/d 72%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to a level of vacancy . CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	103.31% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - LDRP 63.5% - NICU 58.6%	The low HCA fill rates in July 2019 are attributed to a level of HCA sickness and vacancy within the FSS division This is managed on a daily basis against the acuity of the work load. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; and support of reduced RN fill.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	112.51% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - NICU 69.5%	the low fill rate of unqualified staff on night shift on NICU is due to some current vacancy however this has not impacted on care as these staff provide care for lower intensity babies alongside a registered B5 workforce. Intensive and High dependency care is provided specifically by qualified in neonatal speciality registered nurses

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT						Care Hours Per Patient Day							
		Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	% Bed Occ	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual											
CRH ACUTE FLOOR	GENERAL MEDICINE	2,927.33	2,797.55	2,296.75	2,189.75	95.6%	95.3%	2,523.00	2,419.50	2,046.00	2,090.50	95.9%	102.2%	8.4	8.1				2	14		
HRI ACUTE FLOOR	GENERAL MEDICINE	3,157.83	2,903.25	2,703.83	2,638.97	91.9%	97.6%	2,728.00	2,521.83	2,046.00	2,084.75	92.4%	101.9%	8.9	8.5				4	13	11.84	
WARD 5	GERIATRIC MEDICINE	1,654.50	1,251.67	1,153.33	1,541.60	75.7%	133.7%	1,023.00	1,012.00	1,023.00	1,133.00	98.9%	110.8%	7.5	7.7				2	6	2.15	-1.08
WARD 15	GENERAL SURGERY	1,896.00	1,372.50	1,541.50	2,311.50	72.4%	150.0%	1,353.00	1,195.50	1,364.00	1,771.00	88.4%	129.8%	7.4	8.0				1	9	3.79	-0.01
RESPIRATORY FLOOR	GENERAL MEDICINE	3,550.93	2,985.67	2,385.50	2,466.83	84.1%	103.4%	2,727.75	2,325.25	1,023.00	1,307.00	85.2%	127.8%	6.9	6.5				1	4		
WARD 6	GENERAL MEDICINE	835.25	822.50	1,198.50	1,163.67	98.5%	97.1%	682.00	682.00	682.00	693.50	100.0%	101.7%	5.6	5.5						3.73	-0.80
WARD 6C	GENERAL MEDICINE	1,057.00	796.50	768.50	697.83	75.4%	90.8%	682.00	671.00	341.00	341.00	98.4%	100.0%	6.0	5.3				1	4	1.88	
WARD 6AB	GENERAL MEDICINE	1,406.17	1,234.50	1,131.63	1,232.75	87.8%	108.9%	1,012.00	1,078.00	1,023.00	1,233.50	106.5%	120.6%	5.8	6.1				1	6	-0.10	
WARD CCU	GENERAL MEDICINE	1,413.50	1,317.67	372.00	360.00	93.2%	96.8%	1,023.00	1,011.00	0.00	0.00	98.8%	-	9.3	8.9					2	2.99	0.00
WARD 7AD	STROKE MEDICINE	1,415.32	1,339.92	1,283.47	1,091.97	94.7%	85.1%	1,023.00	737.00	759.00	847.00	72.0%	111.6%	8.0	7.2					3	-2.37	0.00
WARD 7BC	STROKE MEDICINE	2,516.83	2,034.18	1,688.50	1,689.00	80.8%	100.0%	2,046.00	1,826.00	682.00	814.00	89.2%	119.4%	9.0	8.3				1	1	4.88	
WARD 12	MEDICAL ONCOLOGY	1,594.50	1,291.75	772.50	1,133.50	81.0%	146.7%	1,023.00	990.00	341.00	546.00	96.8%	160.1%	6.4	6.8				1	2	1.62	
WARD 17	GASTROENTEROLOGY	2,045.33	1,601.83	1,156.67	1,241.83	78.3%	107.4%	1,364.00	1,023.00	682.00	957.00	75.0%	140.3%	11.0	10.1					4	6.80	
WARD 20	GERIATRIC MEDICINE	1,733.67	1,478.75	1,524.33	1,748.83	85.3%	114.7%	1,364.00	1,284.50	1,364.00	1,532.50	94.2%	112.4%	7.2	7.2				1	4	3.02	-0.93
WARD 21	TRAUMA & ORTHOPAEDICS	1,574.08	1,258.08	1,461.33	1,354.25	79.9%	92.7%	1,058.00	966.00	1,106.50	987.50	91.3%	89.2%	8.6	7.5				1	4		
ICU	CRITICAL CARE MEDICINE	4,002.00	3,756.25	822.00	643.25	93.9%	78.3%	4,277.50	3,786.00	0.00	0.00	88.5%	-	31.5	28.3				2		2.51	
WARD 3	GENERAL SURGERY	1,012.42	955.17	589.00	594.17	94.3%	100.9%	701.50	713.00	526.50	507.50	101.6%	96.4%	5.8	5.7					4	0.80	-2.00
WARD 8A	TRAUMA & ORTHOPAEDICS	955.28	759.78	724.50	648.50	79.5%	89.5%	713.00	552.00	356.50	313.00	77.4%	87.8%	10.5	8.6					1		
WARD 8D	ENT	911.83	802.33	578.73	571.23	88.0%	98.7%	712.50	689.50	172.50	169.00	96.8%	98.0%	8.3	7.8					1	2.34	
WARD 10	GENERAL SURGERY	1,465.42	1,284.92	828.50	873.00	87.7%	105.4%	1,069.50	1,047.50	713.00	805.00	97.9%	112.9%	7.0	6.9					4	6.82	-0.93
WARD 11	CARDIOLOGY	1,769.92	1,542.20	1,140.92	1,063.58	87.1%	93.2%	1,242.00	1,090.00	713.00	736.50	87.8%	103.3%	6.2	5.7					2	5.10	-6.52
WARD 19	TRAUMA & ORTHOPAEDICS	1,707.17	1,497.00	1,178.00	1,399.83	87.7%	118.8%	1,069.50	1,046.50	1,069.50	1,334.00	97.8%	124.7%	7.5	7.9				2	5		
WARD 22	UROLOGY	1,225.50	1,187.75	1,126.50	1,088.50	96.9%	96.6%	713.00	713.00	713.00	690.00	100.0%	96.8%	7.7	7.5					2	1.58	-0.24
SAU HRI	GENERAL SURGERY	1,389.00	1,227.00	713.00	728.50	88.3%	102.2%	1,651.50	1,574.50	356.50	406.00	95.3%	113.9%	13.1	12.6				1	3	1.66	
WARD LDRP	OBSTETRICS	4,103.75	3,711.75	944.50	599.67	90.4%	63.5%	3,911.00	3,447.58	690.00	605.00	88.2%	87.7%	26.0	22.5							
WARD NICU	PAEDIATRICS	2,347.15	2,034.83	808.00	473.48	86.7%	58.6%	2,139.00	2,029.50	713.00	495.50	94.9%	69.5%	10.7	9.0						1.75	
WARD 3ABCD	PAEDIATRICS	3,472.83	3,209.75	755.50	1,248.83	92.4%	165.3%	3,636.50	3,177.50	345.00	1,230.50	87.4%	356.7%	12.4	13.4						0.47	
WARD 4ABD	OBSTETRICS	2,414.00	2,317.50	713.00	690.00	96.0%	96.8%	1,778.25	1,772.75	713.00	701.50	99.7%	98.4%	4.5	4.4						0.97	
WARD 4C	GYNAECOLOGY	887.00	866.50	381.00	339.83	97.7%	89.2%	713.00	715.00	345.50	318.00	100.3%	92.0%	7.0	6.7					1	1.02	-1.08
TRUST		########	**49639.05**	**32741.5**	**33824.7**	**87.95%**	**103.31%**	**45959.5**	**42096.9**	**21909.5**	**24649.8**	**91.60%**	**112.51%**	**8.5**	**8.1**							

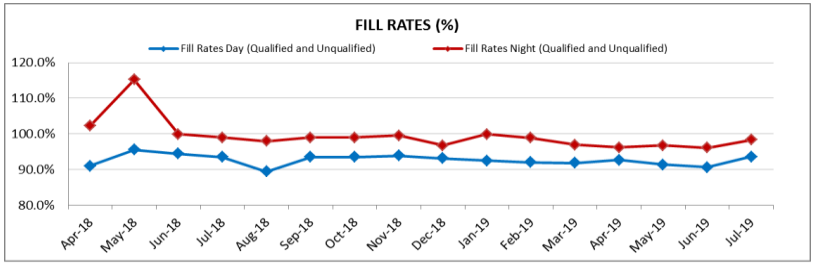
Hard Truths: Safe Staffing Levels (3)

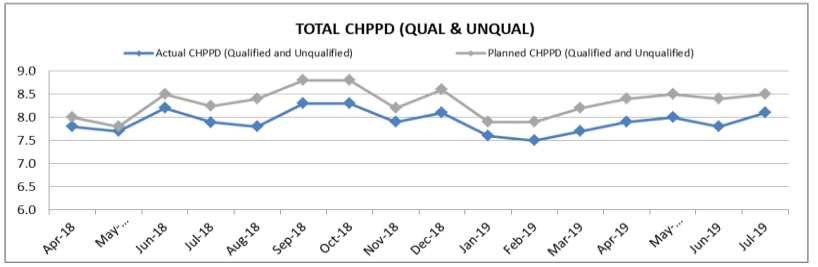
Care Hours per Patient Day

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

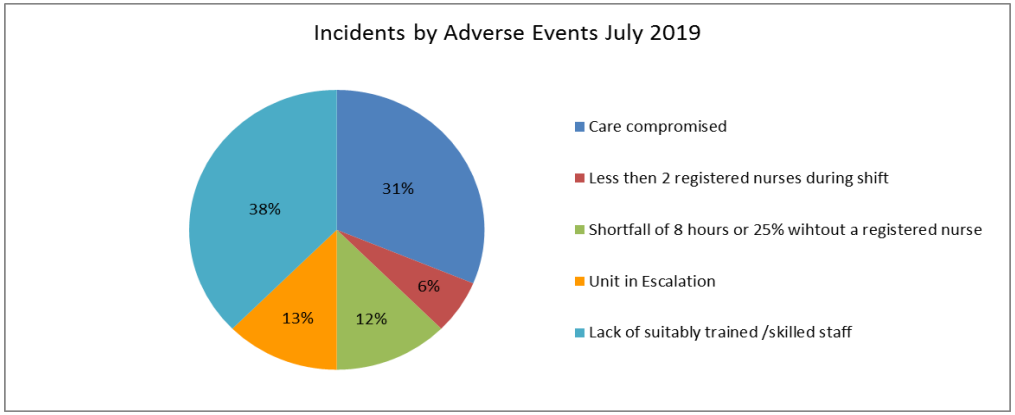
	May-19	Jun-19	Jul-19
Fill Rates Day (Qualified and Unqualified)	91.3%	90.6%	93.6%
Fill Rates Night (Qualified and Unqualified)	96.7%	96.1%	98.3%
Planned CHPPD (Qualified and Unqualified)	8.5	8.4	8.5
Actual CHPPD (Qualified and Unqualified)	8.0	7.8	8.1

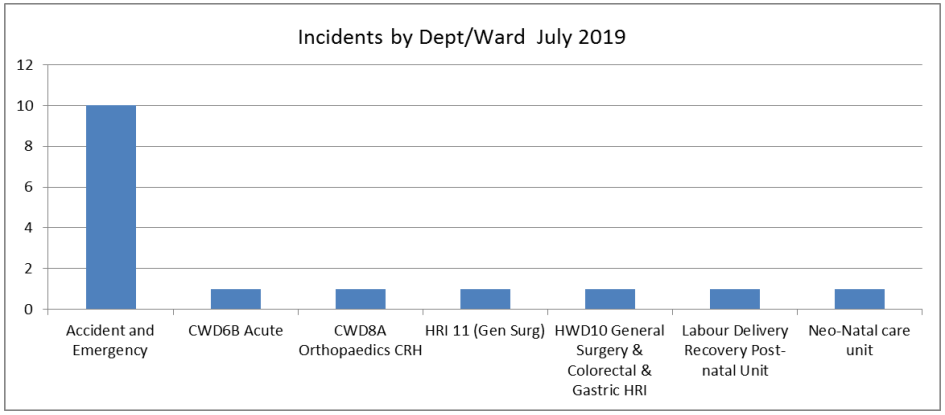
A review of July 2019 data indicates that the combined (RN and care staff metrics) resulted in 21 clinical areas or the 28 reviewed having CHPPD less than planned. Six departments reported CHPPD slightly in excess of those planned and two have CHPPD at planned levels. Areas with CHPPD greater than planned is attributed to 1-1 enhanced care requirements.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correc t but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There were **16 Trust Wide Red shifts** declared in July **2019**
No datix's reported in July 2019 have resulted in patient harm

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.
2. Monthly recruitment initiatives continue
3. Applications from international recruitment projects are progressing well and the first 30 nurses have arrived in Trust, with a further 4 planned for deployment in late September 2019
4. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 6 NA who started in post in April 2017. A further 60 trainees are on programme and will graduate in 2020. The programme will next run in December 2019 with 20 recruits
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

CQUINS - Key messages

Area	Reality	Response	Result
CCG1: Antimicrobial Resistance	Lower UTI - Overall this cquin indicator is performing at 8% against the 90% target, this is being driven by low compliance with the dip stick test used to diagnose the lower UTI. Other elements of the bundle perform better at around 60%. Colorectal Surgery - Overall this cquin indicator is performing at 85% against the 90% target so will receive partial payment.	Lower UTI - Identified consultant and matron to work with AMT. UTI guidelines to mirror PHE for diagnosis and treatment Poster, screensaver, teaching to raise awareness of not using dipstick in > 65 years. Exploring options to use dipsticks which exclude markers of infection Colorectal Surgery - Continue to audit and on-going discussions with surgery to make improvements and agree consistent recording	Lower UTI - Improvement expected by Q2 but not expected to reach 90% target. Colorectal Surgery - 90% to be achieved by Q2. Accountable: Clinical Director for Pharmacy
CCG3: Alcohol and Tobacco	Screening: Overall this cquin indicator is performing at 57.8%, the acute trust is performing better at 64.5%, however the community area need improvement at 25.3%. Tobacco Brief Advice: Overall this CQUIN indicator is performing at 25.1%, with community service achieving 92%. Alcohol Brief Advice: Overall this CQUIN indicator is performing at 28.7%	The screening figures are being negatively impacted upon by the low levels of tobacco screening. The templates within community have been reviewed and changes requested. A request has also been made to add the smoking and alcohol brief intervention e-learning training to ESR for those staff involved in this CQUIN.	An overall improvement is expected in Q2. Accountable: Associate Director of Nursing - Community
CCG7: Three high impact actions to prevent Hospital Falls	Overall this cquin indicator is performing at 12% against the 80% target, this is being driven by low compliance with the lying and standing BP being recorded. Other elements of the bundle perform better at around 70% for mobility assessment and 90% for hypnotics rationale documented.	Following the results of the Q1 audit, Matrons have been focusing on improving measurement and recording of lying and standing blood presure. The Falls collaborative will monitor improvements and implement an action plan going forward.	Continous improvement expected by the end of Q2. Accountable: Consulant lead for Falls.

CQUIN - Key Measures

	Services in Scope	Indicator Name		Target	Apr-19	May-19	Jun-19	Q1	Jul-19	Aug-19	Sep-19	Q2	Oct-19	Nov-19	Dec-19	Q3	Jan-20	Feb-20	Mar-20	Q4
Prevention of Ill Health	Acute	CCG1: Antimicrobial Resistance	CCG1a: Antimicrobial resitance - Lower urinary tract infections in older people	90%	Data available at quarter end			8%												
			CCG1b: Antimicrobial resistance - Antibiotic prophylaxis in colorectal surgery	90%	Data available at quarter end			85.40%												
	Acute & Community	CCG2: Staff Flu Vaccinations	CCG2: Staff Flu Vaccinations	80%	Data collection starts 1st September 2019				Data collection starts 1st September 2019											
	Acute & Community	CCG3: Alcohol and Tobacco	CCG3a: Alcohol and Tobacco - Screening ACUTE	80%	Data available at quarter end			64.5%												
			CCG3a: Alcohol and Tobacco - Screening COMMUNITY		Data available at quarter end			25.3%												
			CCG3a: Alcohol and Tobacco - Screening TRUST (combined)		Data available at quarter end			57.8%												
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice ACUTE	90%	Data available at quarter end			13.8%												
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice COMMUNITY		Data available at quarter end			92.0%												
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice TRUST (combined)		Data available at quarter end			25.1%												
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice ACUTE	90%	Data available at quarter end			29.0%												
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice COMMUNITY		Data available at quarter end			22.2%												
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice TRUST (Combined)		Data available at quarter end			28.7%												
Patient Safety	Acute & Community	CCG7: Three high impact actions to prevent Hospital Falls	CCG7: Three high impact actions to prevent Hospital Falls	80%	Data available at quarter end			12%												
Best Practice Pathways	Acute with type 1 emergency department	CCG11: Same Day Emergency Care	CCG11a: SDEC - Pulmonary Embolus	75%	100.0%	100.0%	100.0%	100.0%												
			CCG11b: SDEC - Tachycardia with Atrial Fibrillation	75%	100.0%	70.0%	100.0%	91.4%												
			CCG11c: SDEC - Community Acquired Pneumonia	75%	100.0%	97.1%	96.2%	97.7%												

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

• Finance and Performance Committee – minutes from meeting held 28 June 2019 & 26 July 2019

• Audit and Risk Committee – minutes from meeting held 17 July 2019

• Quality Committee – minutes from meeting held 1 July 2019

• Workforce Committee - minutes from meeting held 7 June 2019 & 6 August 2019

• Council of Governors – minutes from meeting held 18 July 2019

• A&E Board – minutes from meeting held 9 July 2019

To Note

Presented by Phil Oldfield, Richard Hopkin, Linda Patterson and Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 28 June 2019, 9.30am – 12.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

Asifa Ali	Research & Development Lead – for Item 107/19 only
Kirsty Archer	Deputy Director of Finance
Nicola Bailey	Transformation Programme Manager, PMO Team – for Item 107/19 only
Neeraj Bashin	Consultant – Vascular Surgery – for Item 107/19 only
Sian Grbin	Governor
Betty Sewell	PA (Minutes)

ITEM

101/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

102/19 APOLOGIES FOR ABSENCE

Apologies from Mandy Griffin and Stuart Baron were noted.

103/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

104/19 MINUTES OF THE MEETING HELD 31 MAY 2019

The Draft Minutes of the meeting held 31 May 2019 were approved subject to minor amendments on Page 2, 3 and 7.

105/19 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as follows: -

Matters Arising

009/19: Use of Resources – GB confirmed that conversations have taken place with NHSI/E with regard to them reviewing our action plans, however, this has not progressed. The Committee suggested that GB should approach Simon Worthington, Director of Finance, LGI to carry out a peer review – **GB, 26 July 2019**

056/19: Marvellous March – HB presented a paper which provided the Committee with an overview of the event and how we will take the learning forward. Communications was an area which was highlighted as being particularly poor, the fact that we did not communicate early enough and personally enough which resulted initially in push back.

The nature of the event was not to introduce anything new but to have a particular focus on performance. As the month progressed there was significant improvement, albeit with the help of two managers who were dedicated to the process.

It highlighted capacity in ED and SAU which has been helpful for the urgent care programme for this year, it also highlighted areas where we need investment. The key benefit was the focus around frailty, it allowed us to test different models within frailty which has led to one of our biggest investments. Overnight frailty was also tested which made a huge difference, however, it is the one thing we have not implemented as it requires further investment.

The Chair suggested that there could be learnings from the GIRFT work in terms of engagement which could be applied to the next event. The Chief Executive noted that the (Equality Impact Assessment) EQIA section of the report was blank and that this should have been key to this piece of work and questioned if it had been understood what the impact may or may not have been.

In terms of summary, the Chief Operating Officer was pleased that the event had taken place and was taking negatives and positives out of this exercise. The next steps would be to have conversations with the GIRFT team and to take one of the specialties who have been through the GIRFT process to look with a performance lens to help construct a process. In addition, the Director of Transformation and Partnerships suggested that we could link with HealthWatch who are carrying out a specific piece of work in relation to EQIAs for the Outpatient Transformation work.

ACTION: To provide an update re next steps at a future F&P Committee – **HB, 27 September 2019**

096/19: Finance & Performance Self-Assessment Update – following the outcomes from the Self-Assessment questionnaire, the Chair explained that discussions had taken place at a meeting of Committee Chairs and it had been confirmed that the Board are happy with the feedback received from the F&P Committee. In addition, conversations have taken place regarding the balance between Finance and Performance on the agenda. It has been agreed that the agenda will have an equal split of time for Finance and Performance which will include feedback from PRMs.

Richard Hopkin agreed that there should be some flexibility with the agenda to focus on the items which need in-depth discussion.

It was agreed that the agenda would be reviewed over the next couple of months.

106/19 EPR – ENABLING BENEFITS

The Committee agreed that Mandy Griffin could be stood down for this item, the Committee acknowledged the benefits realised against the scale of investment.

As a point of clarity, the Director of Finance clarified that within the section which talks about financial implications of a contract extension, this is an estimated view.

The Chief Executive also commented that we are very much focussed that we make sure that we get value for money from Cerner.

The Committee **NOTED** the paper.

107/19 GET IT RIGHT FIRST TIME (GIRFT)

Neeraj Bhasin, Vascular Surgeon and Associate Medical Director gave a presentation on the GIRFT programme which is a Department of Health initiative with the aims of reducing clinical variations, improving the quality of care and patient outcomes and bringing efficiencies. It was noted that it is a clinically led peer review and MDT focus which the Trust has found very positive and helpful. The CHFT approach has been to develop Terms of Reference and to establish a central function to support and co-ordinate the programme. One of the reasons for the success of the GIRFT programme is down to a non-clinical and clinical joint Trust-level working team who have an excellent relationship. The national clinical visiting teams have universally complimented the Trust on the attendance to the events and are sharing CHFT as an exemplar site.

Neeraj stressed to the Committee that the involvement from the Chief Executive down demonstrates the investment of the Trust in the process. The benefits to the organisation were described as follows: -

- Clinical specialty development
- Learning from recurrent themes
- Excellent collaborative working
- Challenge to teams/ownership of service
- Clinical MDT as one – highlighting the Specialist Nurses and Therapy teams
- External view to drive and monitor improvement and standardisation

In terms of Finance it brings opportunities with efficiencies not only for the Trust but across WYAAT for such as Vascular and Orthopaedic joint replacements. A clinical focus is maintained at the events as this helps with attendance and engagement, however, it is recognised that there are CIP opportunities.

The Chief Executive thanked the team who have brought to life and got behind this initiative which is worthy of a 'Celebrating Success' nomination. It has highlighted the benefits of the multi-disciplinary piece allowing all professions to come together as equal partners. In addition, it has not just been an opportunity to discuss the re-configuration, but it has also given us an opportunity to describe the Trusts' Clinical Strategy and what we could offer the region in the future.

Richard Hopkin commented that it had been very helpful to understand the process and get real examples of where the benefits lie. However, he questioned if GIRFT cross-references into model hospital and where this is picked up. The Director of Finance confirmed that there is a piece of work taking place to link the GIRFT themes with efficiency workstreams. Nicola Bailey also confirmed that model hospital is starting to use a lot of the GIRFT matrix which will make it easier.

Richard Hopkin asked how GIRFT is filtering down to nursing staff and how is this built into the process. Neeraj explained that a pack is received about 3 weeks before the deep-dive, at that time a prep meeting is organised with the team which includes the Clinical Director, Service Lead, General Manager and a nursing lead. Neeraj, once

again, highlighted the Specialist Nurses who have been the most motivated and have provided a huge clinical contribution to the process.

On behalf of the Committee the Chair thanked the team for their very positive and interesting presentation and agreed that it was a good example of multi-disciplinary working.

The Committee **NOTED** the presentation.

FINANCE & PERFORMANCE

108/19 INTEGRATED PERFORMANCE REPORT

Items raised from the April IPR

Radiology – The action was to understand the risk for the Risk Register, HB confirmed that conversations have taken place with the FSS team at their Performance Review Meeting (PRM). It was noted that Radiology have 6 risks relating to Radiology staffing with scores between 6 and 15. They have been asked to review a cumulative risk and the outcome will be discussed at their next PRM next week. It was also noted that WTGR work has been carried out with Radiology and there are several workstreams which were described to the Committee. HB also confirmed that a Diagnostic Imaging Board had been established to help with decision making and planning.

ACTION: To provide a further update after the next PRM and WTGR sessions – **HB, 30 August 2019.**

RTT Pathways – The Chief Operating Officer reported that the Trust secured 92% in May, however, it continues to be based on a lot of validation. It was noted that a senior Informatics Manager has been released for 3 months to complete a dedicated piece of work around RTT along with the Head of Planned Access. It was noted that we need to ensure the scope is correct to ensure a long-term fix and conversations will also take place with other Cerner users/sites to find out if they do things differently.

ACTION: To provide assurance with a more defined scope on RTT next month – **HB, 26 July 2019**

OW confirmed that conversations have taken place with Philip Lewer to dedicate a Board Workshop to Data Quality.

Complaints – The Chief Executive gave a presentation which has already been presented to several forums within the Trust. The presentation was a summary of a two-month review by the Chief Executive of our care and practice with regards to complaints and was based on the 3 R's – Reality, Result and Response.

The Committee recognised the issues raised within the presentation and the cultural change which needs to be enacted.

Discussions took place with regard to the necessary skills, competencies and training required to help colleagues with conversations which may be challenging when dealing with complainants. It was agreed that it is important that we look after all colleagues involved in the process as well as our patients to help us provide 'Compassionate Care'.

The key elements from the presentation were noted as engagement, support and making it a priority in putting the patient first. Action plans will be co-developed and will be monitored through the Quality Committee.

The Director of Operations reported the May headlines as follows:-

- May position slightly improved from April.
- Responsive is one of the four domains which is improving.
- Cancer remains strong – work still to do with Day 38 and the Radiology risks link into the diagnostics element.
- Sickness continues to be positive.

In terms of the RED areas:

- Continue to report a failed position on Diagnostics and actions are in place as per the report, the main impact is on Neurology in terms of RTT.
- Stroke – working well but our performance is based on when the patient has been discharged and this may impact on May and June.
- Emergency Care – June has been very challenging with a high number of breeches – we are holding daily sessions at 8am which includes senior clinical colleagues across the Divisions to try to get a view. This will be kept in place until we have a level of resilience.
- ASIs – position improving, the focus is on patients who were ASI and are still awaiting appointments.
- Referrals – issue with patients being discharged from the ward and then need an appointment particularly in Cardiology. Need to implement a 'fix' and we will need to work with Bradford.

The Director of Operations reminded the Committee that we are taking part in the Length of Stay Improvement Programme which means we have to report on a 30-set data on a weekly basis for patients who have occupied a bed for over 20 days. Those patients require a review on a weekly basis by an Associate Director or above. This information is then transferred onto a Patient Tracking List (PTL).

It was also noted that we have been 'invited' to be one of the field sites to test the targets for RTT.

ACTION: To provide the Committee with an update with regard to the Length of Stay Improvement Programme and how this is progressing – **HB, 26 July 2019**

The Committee **NOTED** the report for May and the overall steady performance.

109/19 MONTH 02 FINANCE REPORT

The Director of Finance reported that we are on plan and highlighted the following:-

- Pay underspent by £900k.
- CIP on track
- Activity is low but we are protected by the AIC by £900k after two months.
- Aged Debt has increased
- Capital – emergency capital bids have been submitted but there is a further challenge from the Centre for an additional 25% reduction from capital programmes. Discussions to take place regarding the emergency capital which equates to £5m to get assurance and to ensure that this money will be received in the future.

Discussions took place with regard to how we would manage our current capital programme, it was confirmed that MRI, Aseptic spend and anything we are doing on the Calderdale site will be a challenge. The Chief Executive recognised the Calderdale issue but raised his concerns regarding the delay to the MRI and Aseptic schemes as these are schemes which we have needed for some time but the Business Cases are still not where they need to be and we require the right level of oversight. The Director of Finance commented that in light of this weekly meetings are taking place with regard to the large capital schemes.

The Chair raised a question with regard to the Overspend, it was confirmed that this is being explored and recovery plans are being developed.

ACTION: To provide an update of the Overspend recovery plans at the meeting next month – **GB, 26 July 2019**.

Richard Hopkin mentioned conversations which had taken place at TE regarding Agency breeches and whether it was a continuing trend. The Chief Operating Officer explained that costs in Radiology are being re-profiled and with the start of the ward deep-clean programme nursing staff had not been transferred to CRH but this is now being picked up. The Director of Transformation & Partnerships commented that it is still too early to tell if this will continue.

Richard Hopkin also asked if we are still looking at cost reduction opportunities as we are £1m down on income and activity assuming this continues. The Director of Finance referred to previous discussions with regard to ensuring quality and performance is not compromised, discussions took place at TE this week and it was agreed that it was too early and surges are still expected.

Discussions took place with regard to activity and RTT, the Chief Operating Officer confirmed that we are carrying out deep-dives with each of the specialties to try to triangulate with finance and performance.

The Committee **RECEIVED** and **NOTED** the report.

110/19 FISCALLY UNIQUE – SUPPLEMENTARY INFORMATION

The Director of Finance presented a paper which addressed a question raised by the Committee as to whether the drift of elective activity to other providers, particularly private sector providers, was another contributory factor in the Trust's deficit position.

As per the paper, it was noted that the approach taken to consider this questions was to analyse the Trust's share of the local market, the conclusion was that if our market share was the same it would equate to an additional £3.5m of income and, therefore, against our £43m challenge last year it would not have made a material contribution.

The Chair challenged how much cost is still addressable within the organisation. The Director of Finance noted the challenge and admitted that there are a lot of subjectives which have been applied. Discussions took place with regard to whether the gap was an income, cost out or funding issue and that we need to defend our Use of Resources and to understand the narrative.

The Committee agreed that a large element of the gap was due to external funding but accepted that there are still cost-out improvements which could be made but this must be without the comprise of quality.

The Committee **NOTED** the paper and thanked The Deputy Director of Finance for her hard work pulling this together.

STRATEGIC ITEMS

111/19 CIP UPDATE

The Committee noted the CIP position as stated within the Finance Report.

112/19 FINANCE & PROCUREMENT SYSTEM UPDATE

The Deputy Director of Finance confirmed that the Trust has a more stable operational risk position following the upgrade of our key finance ledger system and procurement ordering system. However, frustrations remain within the Financial department.

The Committee **NOTED** the paper.

GOVERNANCE

113/19 DRAFT MINUTES FROM SUB-COMMITTEES

- Draft Commercial Investment & Strategy Committee held 16 May 2019
- Draft HPS Board Meeting held 20 May 2019
- Draft Capital Management Group held 12 June 2019.

The Minutes were **RECEIVED** and **NOTED** by the Committee.

114/19 WORK PLAN

The Work Plan will be reviewed to try to get a balance going forward.

The Committee **NOTED** the Work Plan.

115/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following points for cascading to the Board:

- Radiology Risk – ongoing work continues to get to an aggregate risk.
- RTT Pathways – issues re validation noted, a further scope of the project to come back to the Committee

- GIRFT presentation – was well received, the Trust has been recognised by national/regional teams as an exemplar site.
- UoR Update – GB to pick up with Simon Worthington from LTH NHS Trust regarding a peer review.
- Marvellous March – discussions took place regarding how this could be improved in the future, especially regarding communication and how we could embed GIRFT principles.
- EPR Business Case was noted.
- F&P Committee Self- Assessment – PO stated that we trying to get the balance between Finance and Performance and the way forward.
- Complaints presentation – OW to present to the Quality Committee and then feedback to the Board. An action plan will be co-developed to take back to the Quality Committee.
- IPR – the following points were noted: Emergency Care Standards, Diagnostics, issues regarding underlying quality. A Length of Stay Patient Improvement programme was described, and updates were requested. The 'invitation' to take part in the access standard target site-testing was noted.
- Finance – on plan at Month 2. The Capital challenge which will mean the capital programme may need to be reviewed again was noted. Internal processes relating to the MRI scanner and major capital works were discussed.
- Fiscally Unique – the Committee accepts that there are improvements which can be made but not anything which majorly stands out at this point in time.
- Systems Update – the NEP system is operationally stable but is still a frustration within the Finance department.

116/19 REVIEW OF MEETING

Due to time constraints, the Committee did not review the meeting.

117/19 ANY OTHER BUSINESS

There were no additional items raised.

DATE AND TIME OF NEXT MEETING:
FRIDAY 26 July 2019, 9.30am – 12.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Advance apologies were received from: Owen Williams and Richard Hopkin

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 26 July 2019, 9.30am – 12.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnership
Phil Oldfield	Non-Executive Director (Chair)

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Philip Lewer	Trust Chair
Andrea McCourt	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

118/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

119/19 APOLOGIES FOR ABSENCE

Apologies from Gary Boothby, Owen Williams, Richard Hopkin and Sian Grbin were noted.

120/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

121/19 MINUTES OF THE MEETING HELD 28 June 2019

The Draft Minutes of the meeting held 28 June 2019 were approved.

122/19 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as follows: -

Matters Arising

009/19: Use of Resources – It was confirmed that Simon Worthington, Director of Finance, LGI has agreed to carry out a peer review but no timescales have been agreed - **action closed**.

108/19: Length of Stay (LOS) Improvement Programme – HB provided a verbal update explaining the process relating to the data collection which is taking the core team between 6-8 hours per week. We are using the same team for 4 weeks for continuity purposes but we haven't managed to secure medical input due to capacity, this is being reviewed. It is believed the biggest impact will be to take a cohort of patients between day 1 and 7 but the volume to do this is greater, therefore, it has been decided that we will monitor 1 patient from each ward and cover their whole pathway. A formal update will be available from the end of August.

ACTION: To provide a written report back to this Committee at the September meeting – **HB/Bev Walker, 27/9/19**

088/19: RTT Update – HB provided the following updates in relation to RTT:-
Pre- Board Update – following the invitation to be one of the field test sites for RTT we are required to sign a Memorandum of Understanding (MoU) which has still to be received, there is time on the next Board Agenda for this to be covered. HB explained the Trust's proposal and advised the Committee that we are required to stop monitoring performance against the 92% RTT target in our monthly IPR. We will continue to report the number of patients on the incomplete waiting list and we will continue to report 52 Weeks. Testing will be for 4 months, the results will then be collated for public consultation in April 2020.

Deep-Dive - a small dedicated team is in place and a scope has been drafted, this has been sent to NHSI for an external lens. There are several components which includes 'go-sees' to other Cerner Trusts. The deep-dive will include several key specialties. An example went to Executive Board yesterday for Dermatology and HB agreed to bring the presentation along with the final scope to the next meeting.

ACTIONS:
To present the slides from Executive Board regarding Dermatology and the final scope of the deep-dive at the next meeting – **HB, 30/8/19**

To update with regard to the field testing – **HB, 29/11/19**

123/19 CQC RECOMMENDATIONS – The CHFT Clinical Care Model

The Chief Operating Officer explained that this is only one element of the CQC Recommendations, the ED Workforce Staffing requires further work before being presented to the Committee.

It was noted that the Critical Care paper had been presented and discussed at WEB. It was also noted that the paper was well received and lengthy and appropriate discussion followed, the outcome was unanimous support for Model 4 and the headlines were highlighted:-

- It was agreed that we would look at the wider support infrastructure.
- Medical HR in Critical Care recognised that we need to have a robust nurse staffing model.
- Requirement to socialise Model 4 with colleagues to ensure full support for the proposal.
- A request to review the governance to ensure we are reporting all incidents and near misses and to provide training.
- Develop a consistent narrative regarding the interim model with the long-term reconfiguration plan which is included in the FBC.
- Revamp the advert and change the narrative.

The challenge will be to financially support this model.

The Committee appreciated the well written and well-structured paper and **SUPPORTED** the decision made at WEB.

124/19 REVIEW OF PROCUREMENT – PROCESS & OPPORTUNITIES

The presentation developed by Kate Roberts, Head of Procurement was made by the Associate Director of Finance in her absence.

The presentation gave an overview of the current team structure which includes Materials Management and R&D and the positive position regarding appraisals and mandatory training. It was also noted that Procurement are currently on track with their CIP realisation, however, it was confirmed that Kate is in the process of reviewing governance to introduce greater scrutiny at project level.

It was also noted that initially the Model Hospital/Procurement League Table looks like we have deteriorated from 51 to 85 out of 133 Trusts, however, data quality seems to be driving this suggestion and every metric is being reviewed week by week. In addition it does not reflect our different operating model, and this is being worked on.

With regard to the national initiatives, the lack of engagement from 'Category Towers' was described and WYAAT are formulating a response to the centre regarding local concerns. Also, the current steer regarding the procurement target operating model is that it will not be mandated but expectation that best practice is adopted. The spend comparison tool is being replaced, however, there has been no visibility of this to date with webinars due to take place late July.

It was noted that the following two key projects are being undertaken by Procurement working with Category Tower 7, free of charge:-

1. Radiology Capital Replacement vs Managed Services
2. Equipment Maintenance Review

The presentation raised the following questions/comments:-

- In terms of the procurement baseline, as we go through the validation would we see an improvement?
- What opportunities regarding Model Hospital do we have?
- The clinical variation within the organisation is unclear and the attendees to the clinical forum looking at the outcomes of clinical trials may need to be reviewed.
- There may also be an opportunity in connecting with local private providers.
- The review of key projects may not be cost savings but could be cost drivers.
- How much do we connect to the Orthopaedic collaborative procurement work across WYAAT?
- In terms of the Scan4Safety work across West Yorkshire which we are part of, it is understood that it should allow us better control, is there any connectivity into this area?

It was noted that the Procurement team has had as much of a challenge with the change in the NEP system as the Finance team,

Stuart Baron agreed to take away all the questions and comments and will feedback to this Committee later in the year.

ACTION: To review the points raised within the discussion and to provide a further update to the Committee at the December meeting – **SB/KR, 06/01/20**

The Committee **NOTED** the presentation.

FINANCE & PERFORMANCE

125/19 INTEGRATED PERFORMANCE REPORT - JUNE

The Chief Operating Officer reported the June headlines as follows:-

- Overall GREEN position at 74.8%, 3 domains are improving, 1 is static and 2 have a slight deterioration.
- The following key areas of deterioration were highlighted:-
  - #NoF is not stable and will be an agenda for the S&A PRM.
  - Deep dive of Orthopaedics will also take place at the PRM next month.
  - Diagnostics issues have been discussed previously – the ECHO recovery has had slippage due to staffing levels with the external provider, revised trajectory proposes the ECHO backlogs are clear by end of August. Recent staffing constraints in Neurophysiology have further impacted on performance, a WTGR session is scheduled and a recovery plan will be presented at July's PRM.
  - Emergency Care Standard remains a challenge with regard to medical staffing overnight.
  - There has also been a discrepancy regarding the trajectory we have been working to and the one being submitted, which means we are further away from trajectory. Conversations have taken place with NHSI and it was agreed that we should acknowledge that we have missed plan with no financial implications.
- Hot weather forecast - plans are in place for the weekend specifically around frailty.

- The positive headlines are:-
- Stroke continues to deliver its recovery plan.
- Cancer performed GREEN across the board.
- ASIs are improving particularly in Gastro and Cardio following implementation of new pathways around clinical assessments.
- Endoscopy data received but needs clarity, HB not confident with the information.
- Complaints is an improving picture, but sustainability is key.

It was noted that the pension issues are impacting on loss of capacity, but that this needs correlation. Pensions will be an item on the Agenda for the Weekly Directors Meeting. Discussions took place with regard to Activity, it was noted that deep-dives are taking place regarding Qtr. 1 Activity, however, Month 3 is closer to plan than Month 2.

ACTION: To collate the output of the deep-dives at PRMs this month for the next Finance & Performance meeting – **HB, 27/8/19**

The Committee **NOTED** the general good performance reported for June.

126/19 MONTH 03 FINANCE REPORT

The Deputy Director of Finance reported that we are on plan and highlighted the following:-

- YTD Deficit slightly better than plan at £6.68m
- Over achieved CIP YTD
- Agency Expenditure is below the planned level by £1.0m
- Pay Expenditure is down vs. plan but this includes £0.54m relating to the profiling of planned Pay Reserves. It was noted that there was a one-off element this month which relates to the pension rule around the final salary pay controls. This unplanned cost has been highlighted to regulators.
- Non-pay pressure relating to maintenance and utilities contracts, the maintenance contract is undergoing a detailed analysis within Divisions to confirm that the budget moved over to CHS correctly and that the expenditure being incurred is correct.
- Capital is below the original plan YTD.

The Committee **RECEIVED** and **NOTED** the report.

127/19 2019/20 CAPITAL PLAN RE-PRIORITISATION

The Deputy Director of Finance presented a paper which explained that the original capital plans submitted in April substantially exceeded the overall limit set by Parliament for the DH&SC. As such there was a national call to Trusts to reduce their capital commitments. The first round of this review in May saw an average reduction of 3% which was insufficient, as such a letter was received from NHSI in July requiring a reduction of 20% and for this to be managed at a collective level through the Integrated Care System (ICS). Capital control totals were set at ICS level with the assurance that commitment to the overall control total by the partners would enable the release of emergency capital funding without further delay. The collective re-submission of plans by the ICS has met the control total set and as such it is assumed that the emergency capital projects, namely the MRI Scanner and HRI Cladding, can now be progressed.

The Committee **NOTED** the revised Capital Plan for 2019/20.

128/19 BUDGET HOLDER TIME OUT

The Chief Operating Officer gave a verbal update, confirming that the event received good engagement, had been well attended with a good mix of colleagues. The event had four themes/outcomes:-

1. Incentives – for over-delivery, autonomy
2. Escalation – to be support not sanctions
3. Training – to become mandatory for the primary budget holders
4. Exemplar Wards – should have a balance of good finances and quality

It was noted that the action plans are being populated with another session scheduled for September. It was also noted that there is more to do regarding budget holder responsibility especially involving colleagues from the bottom up. Opportunities were suggested regarding team budget setting which will also help with capacity within the Finance department. The outcome of the time-out was encouraging, it also gives budget setting a higher profile and engagement within the organisation.

STRATEGIC ITEMS

129/19 CIP UPDATE

The Director of Transformation & Partnership reported that Month 3 had delivered £2.03m against a plan of £1.93m and the forecast remains at £11m. It was noted that within the plan there is £500k not at the expected level of planning and will be subject to deep-dive reviews on the 5 August at Turnaround Executive (TE). It was also noted that to allow headroom to the plan a further £500k of schemes have been identified and are in the pipeline, these will also come back to TE to firm up. In terms of the risk profile, 27% are categorised as high risk schemes and in terms of recurrent savings this is significantly below the ambition of 100%.

It was noted that there are strengths and positive within our current position, however, there is still significant work to do.

The Committee **NOTED** the CIP position.

GOVERNANCE

130/19 DRAFT MINUTES FROM SUB-COMMITTEES

- Draft CHFT/CHS Joint Liaison Committee held 2 July 2019
- Draft HPS Board Meeting held 15 July 2019
- HPS Annual Report 2018/19
- Draft Capital Management Group held 17 July 2019.
- Draft Cash Committee held 11 July 2019

In Gary Boothby's absence Helen Barker highlighted to the Committee concerns raised relating to the absence of the results of their Staff Survey within the HPS Annual Report. It was agreed that the Director of Finance would be asked to feedback to this Committee to receive assurance regarding the response from HPS and their action plan to address those concerns.

ACTIONS:

- To receive an updated HPS Annual Report 2018/19 to include Staff Survey results – **GB, 30/8/19**
- To report back to the Committee regarding the concerns and the HPS action plan – **GB, 30/8/19**

The Minutes were **RECEIVED** and **NOTED** by the Committee.

131/19 WORK PLAN

The Committee **NOTED** the Work Plan which will be updated to reflect the actions from this meeting.

132/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following points for cascading to the Board:

- RTT discussions took place regarding the MoU and the deep-dives.
- CQC Critical Care – looking at the mitigations from a financial perspective. Option 4 had been discussed at WEB and was supported by this Committee.
- Procurement Update – Metrics used suggests a deteriorated position, however, this is being validated. A further update was requested for the December meeting (6/1/2020)
- IPR – good solid performance
    - Discussions took place regarding the Activity and Pensions.
    - Complaints – improvement
- Finances - on plan
    - Pay underspend
    - One-off pension issue was noted
    - Maintenance overspend – further work ongoing
- Capital Plan – revised plan noted which provides challenges
- Budget Holder Time Out was well received – looking at training and support
- HPS Annual Report – to be re-submitted to include the results from the Staff Survey, update required next month regarding staff engagement

133/19 REVIEW OF MEETING

The Committee agreed that there had been good discussions.

134/19 ANY OTHER BUSINESS

The Deputy Director of Finance highlighted a paper which related to a property concerning the Pennine Property Partnership which would be covered at the Board Workshop. Following in depth discussions several questions were raised which would try to be addressed prior to that meeting.

DATE AND TIME OF NEXT MEETING:
FRIDAY 30 AUGUST 2019, 9.30am – 12.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 17 July 2019 in Room 4, Acre Mills Outpatients commencing at 10:00 am

PRESENT

Richard Hopkin (RH)	Chair, Non-Executive Director
Andy Nelson (AN)	Non-Executive Director
Linda Patterson (LP)	Non-Executive Director

IN ATTENDANCE

Gary Boothby	Executive Director of Finance
Kirsty Archer	Deputy Finance Director
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Amber Fox	Corporate Governance Manager
Mandy Griffin	Managing Director, Digital Health

OBSERVERS

Philip Lewer	Chair

36/19 APOLOGIES FOR ABSENCE

Apologies were received from Andrea McCourt, Adele Jowett, Clare Partridge and Brian Moore.

37/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

38/19 MINUTES OF THE MEETING HELD ON 21 MAY 2019

The minutes of the meeting held on 21 May 2019 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the meeting held 21 May 2019.

39/19 ACTION LOG AND MATTERS ARISING

(i) Update on Accident and Emergency 4 hour waiting times

A paper has been circulated from internal audit regarding A&E 4 hour waiting times target. The review of 350 patients confirmed the reported departure times matched the Patient Summary Report for all examined A&E visits. However, it has been observed that the departure time for patients who are subsequently admitted to a ward is replaced by the discharge time from that ward in the patients' records (the departure time from A&E is still recorded in the Patient Summary Report) and as a consequence, a clear audit trail was not being maintained in the patient records section of EPR. The reason why patients did not breach the target when they were back-timed was recorded in 29% of examined cases; a recommendation has been made to address this issue.

The Executive Director of Finance confirmed that a weekly review is taking place with the General Manager and the Clinical Director for ED. LP asked if waiting times are now recorded correctly and are showing within the 4 hours. The Executive Director of Finance confirmed the waiting times are being recorded correctly as a process is now in place for an adjustment as they can't always be entered in real time in ED. Reporting to regulators is correct and this is common practice as all ED departments have the same issue which is discussed with regulators.

The Managing Director for Digital Health explained most electronic systems won't allow entering retrospectively; therefore, there is a need to amend this time somehow by an adjustment. The Internal Audit Manager confirmed the breach form is now mandatory. The

Executive Director of Finance explained that KPMG haven't commented since their findings which were correct at the time. The Chief Operating Officer will be sharing a briefing paper with the Executive Director of Finance.

(ii) Clinical Audit Programme and related benchmarking
LP described the Clinical Audit Department and Programme which has four major categories. LP declared an interest as a member of Healthcare Quality Improvement Partnership (HQIP), which is a national body that NHS England give the money to in order to carry out the national audits.

The clinical audit team follow NICE guidelines and the audit tool and a local audit is carried out by the department to measure against the standard. Jr Drs are required to complete audits as part of their training. LP explained the challenge is repeating the audits in order to follow through with quality improvements. There is now national benchmarking of the national audits through HQIP and the results are available on the website, which shows a comparison to other Trusts.

LP explained the stroke audit is meeting the standards which is positive improvement and the results are fed back to Divisions and repeated every 2-3 years. LP added that EPR should start to assist with audits to look at forward data. AN has reviewed this with the Managing Director for Digital Health and explained that some audits are now easier to undertake. The Managing Director for Digital Health added audits are more transparent electronically, compared to paper. The Executive Director of Finance stated some audits are very time consuming. The future will look at an RPA solution, "robotic process automation" to speed up the ability to comply.

LP challenged the location of the clinical audit team as she feels they have an isolated profile. The Internal Audit Manager explained the clinical audit department were down for a review on the audit plan for this year; however, feedback from the Company Secretary was the team are currently undergoing a service review and suggested next year.

The Managing Director for Digital Health explained the clinical safety officer is currently part time and they are looking at appointing the chief nurse information officer (CNIO) as the clinical safety officer full time to support audits and clinical interventions. She is currently in discussions with the Executive Medical Director.

RH confirmed the Risk Management Strategy is still outstanding and will be carried forward to October 2019.

The Executive Director of Finance confirmed an update on the Finance and Procurement system was discussed at the Finance and Performance Committee. The Trust are not where they were prior to moving over to the new system and there are ongoing challenges. The Executive Director of Finance confirmed requirements of external audit have now changed and the Committee agreed to close this action.

40/19 COMPANY SECRETARY'S BUSINESS

1. Review of the Board Assurance Framework

The Board Assurance Framework is currently under review and will be discussed at the Board meeting on Thursday 5 September 2019. A Board workshop has been arranged to review the Board Assurance Framework and high-level risk register on Thursday 3 October 2019. A further update will be presented to the Committee in January 2020.

OUTCOME: The Committee **NOTED** the update on the review of the Board Assurance Framework.

2. Audit and Risk Committee Workplan

The annual workplan for the Audit and Risk Committee was circulated for consideration whether there are any other items they would like to add for the forthcoming year.

AN suggested a deep dive is scheduled on the agenda for each meeting. This was agreed and will be added to the workplan. The deep dive for the meeting in October 2019 will focus on data quality.

LP asked for feedback on whether Committee papers are public or private. PL has reviewed other Trust websites and papers are confidential and the minutes are public. There needs to be clarity on the position with the governors and whether the deputy governor for the Committee regularly receives the papers in confidence in case they need to attend. PL highlighted the papers can be requested under the FOI Act unless they are commercially sensitive. Once the arrangements have been agreed, they will be written into the constitution. The Head of Internal Audit confirmed Audit and Risk Committee minutes are not always public as there is sensitivity regarding inspections and regulations discussed at this Committee. RH will discuss this outside the meeting to clarify.

Action: RH to have discussions with the Company Secretary regarding confidentiality of the Audit and Risk Committee minutes

OUTCOME: The Committee **NOTED** the workplan for next year.

3. Proposal of future Audit and Risk Committee meeting dates

A proposal of the future Audit and Risk Committee meetings for 2020 were circulated for approval. RH explained he will review the dates with the Corporate Governance Manager and revised dates will be re-circulated. RH confirmed deputies can attend the meeting on behalf of the members.

OUTCOME: The Committee **NOTED** the proposal for future dates and revised dates will be circulated.

4. Review ARC Terms of Reference

The Audit and Risk Committee terms of reference were circulated for review during July 2019.

The Executive Director of Finance asked if cyber security should be referenced in the terms of reference. AN suggested this would not be necessary.

The terms of reference will be updated to reflect that the meetings are held quarterly and the Managing Director for Digital Health is an invited member.

OUTCOME: The Committee **APPROVED** the terms of reference subject to the amendments above.

41/19 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review Waiving of Standing Orders

The Deputy Finance Director confirmed there have been no items out of the ordinary. The waiving of standing orders totals over £400k which includes maintenance or support contracts. The Deputy Finance Director highlighted the maintenance contracts for HPS have been agreed for a 3-month period and these are of higher value. The Executive Director of Finance explained discussions have taken place at HPS Board regarding maintenance and they are starting an exercise to review suppliers. The Managing Director for Digital Health confirmed this exercise is also taking place in THIS.

PL asked if there is a trigger after a certain number of waivers. The Deputy Finance Director confirmed there is challenge after the 10th waiver. She suggested a 3 year contract with a negotiation for a longer term would be preferable and this needs to be worked through by procurement from the start. The Executive Director of Finance added maintenance is considered as part of the tender.

The Executive Director of Finance highlighted THIS Caché Enterprise where the company owns the rights of the software. The Managing Director for Digital Health confirmed this is attached to the data warehouse and work would be required to move this elsewhere which would cause additional costs and an assessment would be needed.

The Managing Director for Digital Health asked if the report demonstrates the initial lock in and the negotiated reduced price for continuing. The Deputy Finance Director confirmed this is filled in on the form and can be captured. The Executive Director of Finance agreed to include the discounted price to demonstrate value for money.

OUTCOME: The Committee **APPROVED** the waiving of standing orders report.

2. Review of Losses and Special Payments

The Deputy Finance Director stated there has been a slight increase in quarter. The increase has been around Pharmacy aseptic medicines write offs (expirations). There are processes focused on stock management and there is a plan to invest in an aseptic unit upgrade on one site which will be a change in provision.

OUTCOME: The Committee **APPROVED** the review of losses and special payments.

42/19 INTERNAL AUDIT

1. Review Internal Audit Follow-up Report

The Internal Audit Manager confirmed that during May 2019, a number of recommendations were implemented. Last year, a total of 89 were implemented between Q1 – Q4 and 6 were closed. This year, 19/20 Q1-Q5, there were a total of 123, with 117 being implemented. There are 16 recommendations across both years that are still outstanding and a breakdown of management responses are included in the report.

The Internal Audit Manager confirmed a Fundraising Manager has been in post since May 2019 to implement the charitable funds recommendations and 4 were completed by Q2 out of a total of 8. The Executive Director of Finance explained the Fundraising Manager has shared the draft strategy and has arranged several meetings. This strategy will address most of the areas.

The Executive Director of Finance explained there have been initial delays to go out for tender for patient appliances for orthotics staff due to new category towers in procurement. This was a national tender which did not take place. The latest proposal is for a managed service contract with a potential to save £250k. The Division will write the specification which will take up to 6 months.

AN raised his concern with the major overdue recommendations that are older than 2 years. The Executive Director of Finance stated improvement with visibility is evident and he will share the report with the Executives and report back on progress.

Action: The Executive Director of Finance to report on progress on the 8 major overdue recommendations at the next meeting

LP stated the audits with a limited opinion have been escalated at Quality Committee and there are several quality improvements taking place.

AN highlighted page 13 which describes 3 overdue recommendations regarding the Gosport reviews. LP felt this had been resolved. The controlled drugs are an ongoing issue and the Director of Pharmacy is running a Programme with the Director of Nursing and Medical Director. The Internal Audit Manager confirmed controlled drugs is on the follow up and an audit is being planned. A report will be provided to the next Committee. The Managing Director for Digital Health suggested checking whether the digital intervention is available as the drugs catalogue is being updated next week. She explained a meeting took place last week to integrate the pharmacy EMIS stock system with the pharmacy system. This should also tie into the medicines optimisation appraisal that was reported to the Executive Board.

Action: Internal Audit Manager to check the Gosport review recommendation and feedback to LP on status

OUTCOME: The Committee **APPROVED** the internal audit follow up report.

2. Review Internal Audit Progress Report

The Internal Audit Manager confirmed there are 11 finalised reports and 1 in draft.

There is 1 limited report regarding study leave of consultants which was highlighted in the annual report. She confirmed that consultant study leave will be picked up next year for a detailed follow up to track recommendations. All remaining audits were of significant assurance.

A review of audiology and procurement were on last year's plan and was deferred. Last year's plan is now complete.

The remaining report is around governance in the Medical Division and the draft report will be completed this week.

A cyber security report will go out in draft this week. The Managing Director for Digital Health confirmed there is a lot of work taking place on cyber security and there has been an offer from NHS Digital to provide training for the Board which is a must-do training for this Trust. This is currently being reviewed and will be scheduled at a workshop or Board meeting.

LP asked what happens to those reports with limited assurance. The Internal Audit Manager confirmed those with limited assurance are in a follow up process by internal audit. A staff member will be assigned to have oversight of each area. The Internal Audit Manager confirmed Sal Uka is taking over the workforce senior management role from Cornelle Parker.

The Internal Audit Manager confirmed since benchmarking took place on mandatory training there have been some changes on national modules being mandated.

RH raised concern around payroll overpayment benchmarking. The Executive Director of Finance confirmed there have been a number of challenges in relation to change forms. There are KPIs in place which are monitored by Leeds Teaching Hospitals. Any change in hours are being reviewed weekly by the Executive team and a form goes to payroll. The Managing Director for Digital Health highlighted leavers being overpaid is another issue. The Deputy Finance Manager confirmed a meeting with Finance and workforce is taking place to understand the end to end process and where the delays are. The outcome of this meeting will be followed up with Payroll.

Action: Executive Director of Finance/Deputy Finance Manager to feedback on the steps to address this issue around payroll overpayments

AN highlighted it is important that Board sub-committees have visibility of risks and a review of the performance report was debated at the Chairs meeting and the Board.

OUTCOME: The Committee **APROVED** the internal audit progress report.

43/19 EXTERNAL AUDIT

1. Sector Update

There was no representation from External Audit at the meeting.

There were no concerns in the sector update. The Deputy Finance Manager explained the Department of Health confirmed it will be a quiet year for accounting changes.

RH highlighted e-rostering on page 9 which states NHS Improvement found 43% of Trusts are at level 0 for e-rostering. The Executive Director of Finance confirmed CHFT are ahead of 0 for nursing and are currently working on medical e-rostering. He has agreed an action plan to review new areas moving onto e-rostering which includes demand from therapists and community teams. The contract with Allocate runs out 1st October 2019 and will likely be a waiver as it needs to be the same provider. The Trust are currently scoping what is being included in the next contract which is being led by the Deputy Director of Nursing.

OUTCOME: The Committee **APPROVED** the sector update.

44/19 ITEMS TO RECEIVE

1. Risk and Compliance Group Terms of Reference

The revised terms of reference for the risk and compliance group were shared for approval. There has been a slight change in membership.

The Executive Director of Finance suggested the terms of reference may need changing after the report from the health and safety advisors is received, who have been asked to review our risk processes and reporting.

Action: Review Risk and Compliance terms of reference once the report from the health of safety advisors has been received

2. Risk & Compliance Group Minutes – 7.5.19 & 10.6.19

The minutes of the previous meetings were received.

3. Information Governance & Records Strategy Committee Minutes – 28.3.19

The minutes of the previous meeting was received.

4. Health & Safety Committee – 23.4.19

RH raised concern that there is no attendee from the Health and Safety Committee at the Audit and Risk Committee. This Committee is chaired by the Director of Workforce and Organisational Development and previously sat with CHS. Health and Safety needs to be reported annually at the Board.

Action: Review representation of the Audit and Risk Committee

The Health and Safety annual report will be added onto the ARC workplan.

RH suggested HPS are invited to the Health and Safety Committee as THIS and CHS are already members of this meeting.

Action: Executive Director of Finance to ensure HPS are invited to the Health and Safety Committee

OUTCOME: The Committee **APPROVED** the Risk and Compliance terms of reference and **NOTED** the minutes of the various meetings.

45/19 ANY OTHER BUSINESS

LP asked if the Committee will review the annual self-effectiveness action plan. RH met with the Company Secretary to review and this will be on the agenda for the next meeting in October 2019.

Action: Self-effectiveness action plan – October 2019

The Corporate Governance Manager informed the Committee that the new declarations of interest system went live on 1st June 2019 and so far, a total of 250 declarations have been made. An annual report will be added onto the workplace and the timings of this report will be confirmed. There are 1,010 decision makers that are required to declare to comply with the pay progression requirements and this requirement is included in appraisal paperwork for non-medical staff. There is ongoing work to incorporate this requirement in the medical appraisal.

RH highlighted an action from the meeting in May 2019 regarding the theatre stock takes concern. An update will be provided to the next meeting in October 2019 following discussion at the Cash Committee.

46/19 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Indicator recording of 4 hour wait time in ED – a review of 350 patients has taken place and this matter is now being recorded correctly in the system
- Review of clinical audit processes and national benchmarking appear to rate good in most areas – concern was raised regarding the profile of the clinical audit department
- Approved the Audit and Risk Committee terms of reference subject to a few minor tweaks
- Workplan will be amended to include deep dives which will focus on Data Quality at the next meeting
- Internal audit has seen significant progress on outstanding recommendations, there are concerns regarding old major recommendations that need to be addressed – a follow up will take place in October 2019
- Health and Safety – need to be clear on responsibility and how this feeds into the Audit and Risk Committee

47/19 DATE AND TIME OF THE NEXT MEETING

The next meeting is scheduled on Wednesday 16th October 2019, 10:00 – 12:00 pm in the Medium Training Room, Learning Centre, Calderdale Royal Hospital.

REVIEW OF MEETING

Feedback was the meeting was useful; however, there will be broader attendance at the next Committee. There is more comprehensive assurance with attendance from Chair of the Quality Committee.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 1 July 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

115/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Chief Nurse
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce and Development
Karen Heaton **(KH)**	Non-Executive Director
Dr Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Christine Mills **(CM)**	Public Governor
Lindsay Rudge **(LR)**	Deputy Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Maxine Travis **(MT)**	Senior Risk Manager
Owen Williams **(OW)**	Chief Executive **(item 120/19 only)**

116/19 APOLOGIES

Andrea McCourt **(AMcC)**	Company Secretary

117/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

118/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 29 April 2019 were approved as a correct record.

119/19 ACTION LOG AND MATTERS ARISING

The action log can be found at appendix B at the end of the minutes.

120/19 DEEP DIVE – COMPLAINTS OR GIFTS

Owen Williams (Chief Executive) was in attendance to present a comprehensive an detailed presentation on a two month review of our care and practice with regard to complaints.

During the month of March, the Chief Executive met with investigators who had been unable to complete their investigations within the Trust timeframes to understand the reason for the delays. Following those meetings, the Chief Executive undertook a piece of work to look at the complaints process. It was discovered that investigators were asked to undertake a detailed, thesis-like investigation report, where the quality is only judged at the end of the process, however, senior management teams should be involved from the beginning. Good documentation is crucial to complaints, as it saves time and money. The response from the Chief Executive was to present the findings of the review to every divisional, clinical and nursing meeting and to be made personally accountable for delivering the desired results of:

- Treating complaints or gifts as an opportunity to immediately share learning
- Being thanked and receiving feedback on the outcome of a review once a complaint is recorded

- Halving the need for complaints by using systems to advise patients where they are on their care pathway
- Having a consistent quality of care approach regardless of whether a patient is known to be dying or dies unplanned
- Being told that the CHFT is constantly living up to the mantra of providing compassionate care

The Chief Executive will also hold the Medical Director, deputy Chief Executive and Chief Nurse, Chief Operating Officer and divisional directors personally accountable for developing and enacting an approach to delivery and improvement, and will also use the Serious Incident Review Group for regular assessment of improvement and the Assistant Director of Quality and Safety will support with fulfilling this requirement.

Discussions took place and the Committee welcomed the findings from the review and agreed that accountability should be shared. It was stated that this would underpin and enable a process to support colleagues by providing a framework and guidance on how to carry out good investigations. It was also stated that this is a huge cultural issue as complaints are not seen as part of the same episode of care and behavioural changes are required. It was suggested that death and the experience of death should be used as an opportunity to review legacy complaints, which will also link into the Serious Incident Review Group.

The Chief Executive requested returning to this meeting in the near future to provide an update on the development of the next steps in the complaints process.

The Committee thanked the Chief Executive for the in-depth and informative presentation.

Action: OW to be invited to a future meeting to present next steps.

121/19 ANNUAL COMPLAINTS REPORT 2018/2019

Dr Anne-Marie Henshaw (Assistant Director of Quality and Safety) presented the annual complaints and concerns report for 2018-2019 (appendix C).

The report provides detailed information on the concerns and complaints received by the Trust between 1 April 2018 and 31 March 2019; the main issues raised; trends identified; key learning; performance against agreed response targets and the number of complaints re-opened by complainants following receipt of their final response. The following items were highlighted from the report:

- Between 1 April 2018 and 31 March 2019 the Trust received 565 complaints, an 8% decrease from the same period in 2017 – 2018 when 615 complaints were received. The average number of complaints received per month was 47.
- There has been an increase each quarter in the percentage of complaints re-opened following final response.
- The total number of overdue complaints at the end of 2018/2019 was 21. Significant work has taken place within divisions to improve the timeliness of responses to complainants.
- The Trust closed a total of 614 complaints in 2018/2019; an increase of 19% from 2017/2018.
- The Trust re-opened a total of 86 complaints in 2018/2019, a 30% increase from 2017/2018 (66). The Trust will re-open a complaint for one of the following three reasons; Response failed to address all issues and concerns; a new issue and concern; or a Parliamentary and Health Service Ombudsman (PHSO) Investigation
- The trust had 13 cases referred to the PHSO during 2018/2019
- The top three subjects of complaints for the Trust were communications, clinical treatment and patient care.
- A concern is an issue raised by patients, their families and their carers to our Patient Advice and Liaison Service Team (PALS) which can be resolved within 72 hours of

receipt. The Trust received a total number of 2049 concerns in 2018/2019, a 3% increase from 2017/2018.

- Recommendations from the report include:
  - To achieve 95% of complaints being closed in time by the end of Quarter 1.
  - To reduce the number of complaints re-opened due to response failing to address all issues and concerns.
  - To make changes to the DATIX system to enable reporting on re-opened complaints for analysis and to support improvement work.
  - Strengthen our volunteer workforce so that the PALS service can be more visible across the Trust.
  - Scope opportunities to develop an '*Everybody can be a PAL*' programme to help colleagues deal with patients concerns at the time the concerns are raised rather than referring all contacts to PALS. This programme will be primarily aimed at medical secretaries, appointment centre staff, receptionists and ward clerks.

OUTCOME: The Quality Committee received and noted the content of the report.

122/19 ED QUALITY ACCOUNTS

Action: To be deferred.

123/19 MENTAL HEALTH STRATEGY

Lindsay Rudge (Deputy Chief Nurse) provided a verbal update on the mental health strategy and tabled the three year strategy and the objectives for the year ending 2022.

Colleagues were asked to review and send any feedback to Lindsay, who will submit the final document next month.

Action: Mental Health Strategy to be forwarded to Committee for comments to Lindsay by 15 July 2019

124/19 SERIOUS INCIDENT REPORT

Maxine Travis (Senior Risk Manager) presented the serious incident report (appendix F) which summarises the new serious incidents reported to commissioners in May 2019 and a summary and learning of the serious incident reports submitted to Commissioners in April and May 2019.

No new serious incidents (SIs) were reported in April 2019, however six were reported in May 2019:

- 1 slip/trip/fall
- 3 treatment delays
- 1 diagnostic incident including delay
- 1 sub-optimal care of the deteriorating patient

Two completed serious incident investigation reports were submitted to commissioners in April and May 2019, and the key actions and learning to improve care were also detailed:

- One report into two never events of unintentional connection of a patient requiring oxygen to an airflow meter (one combined report into both incidents)
- Category 4 pressure ulcer

The Quality Committee is requested to:

- note the six newly reported serious incidents in May 2019
- note the learning from two serious incident reports submitted to commissioners in April

and May
- be assured that robust serious incident investigations are being delivered in line with regulatory timescales of 60 days and that actions to mitigate risk and provide learning for sharing within the Trust and where appropriate with partners or regional networks are identified

OUTCOME: The Quality Committee received and noted the content of the report.

125/19 HIGH LEVEL RISK REGISTER

Maxine Travis (Senior Risk Manager) presented the high level risk register (appendix G) highlighting risks as at 21 June 2019, which included:

- Six top risks:
  - 7278: longer-term financial sustainability risk
  - 2827: over-reliance on locum middle-grade doctors in the emergency department
  - 5806: urgent estates schemes not undertaken
  - 6345: nurse staffing risk
  - 7078: medical staffing risk
  - 7454: radiology staffing risk

- Five new risks:
  - 7454: radiology staffing risk
  - 7062: capital programme
  - 6493: complaints management
  - 7474: equipment failure from medical devices
  - 7251: Optovue OCT (Ocular Coherence Tomography) machines risk

- Two closed risks:
  - **7396**: *risk of inadvertent connection to air*
    This can now be closed as the risk has assurance that all air flowmeter have been completely removed from clinical areas and all areas are permanently capped (other than Paediatrics) or fitted with semi-permanent caps. The Trust had purchased electric nebulisers. New risks will be added to the risk register for the Paediatric caps and the Air/Oxygen training

  - **7132**: *Emergency Department NEWS score risk*
    Since NEWS2 (National Early Warning Score) has been implemented, there have been no incidents. The NEWS score is now calculated on the Electronic Patient Record.

This report will also be submitted to the Board of Directors on Thursday, 4 July 2019.

OUTCOME: The Quality Committee received and noted the content of the report.

126/19 CANCER BOARD REPORT

Action: Report to be deferred to the next meeting

127/19 QUALITY AND PERFORMANCE REPORT

The key points from the May 2019 Quality and Performance Report (appendix I) were summarised:

The safe domain has remained green and it was noted that three of the four maternity targets were missed. The caring domain remains amber with a continued and slight decrease in the Emergency Department's Friends and Family Test response rate. The effective domain is green although the Fractured Neck of Femur target was missed again.

The responsive domain has improved to 67% although stroke indicators are underperforming and the six-week diagnostics target was missed again. Workforce is still green with sickness levels at their lowest position.

Concern remains on the dementia standard, and it was stated that the task and finish group meet on a fortnightly basis to review dementia screening, and have a stronger sense of assurance that clinicians understand the importance of screening. Weekly performance reports on some wards shows improvement. Discussion ensued on whether there were any falls or pressure ulcers where dementia screening did not take place. It was stated that from an initial review, none were found; however, a review will be carried out for the next quarter.

It was identified that this is the first time that workforce is reporting as green, and are looking to drive improvement on sickness and staff turnover.

Stroke achieved a SSNAP (Sentinel Stroke National Audit Programme) grade A, and the SHMI (Summary Hospital-level Mortality Indicator) has now stabilised. Clostridium difficile rates are within limits, with one MRSA (Meticillin-resistant Staphylococcus Aureus) bacteraemia case. It was also stated that the emergency care standard was just missed, however, due to significant pressure at the moment; this position may change next month.

OUTCOME: The Quality Committee received and noted the content of the report

128/19 ANNUAL REPORT 2018/2019

Dr Anne-Marie Henshaw (Assistant Director of Quality and Safety) presented the 2018/2019 annual report (appendix J) which describes how the Quality Committee met the duties within the terms of reference; the overview of the role of the Quality Committee; details of membership and attendance during 2018/2019; information of the work of the Committee in areas of quality improvement, governance and risk / patient safety, audit and assurance and quality and safety reporting. Details of the effectiveness of the Committee are also included in the report, which summarises the response of the self–assessment undertaken by members in March 2019.

OUTCOME: The Quality Committee received and noted the content of the report and recommended submission to the Audit and Risk Committee for review.

129/19 ANY OTHER BUSINESS

There was no other business.

130/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- Complaints were reviewed in detail this month
- The Quality Committee work plan was approved in line with annual report.

131/19 EVALUATION OF MEETING

What went well……

- Meeting ran very smoothly
- Good discussion on complaints with Chief Executive

Even better if……

The Committee would consider discussing one safety item per meeting, for example deteriorating patient, discharge planning, end of life care, etc., and to take some time to work on key items from complaints and incidents.

132/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix K) was accepted.

NEXT MEETING

Monday, 29 July 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Friday 7 June, 2.00pm – 4.30pm, Board Room, CRH/Discussion Room 2, Learning & Development Centre, HRI

PRESENT:

Will Ainslie	(WA)	Divisional Director, S&A
Alexis Brown	(AB)	Human Resources Business Partner
Suzanne Dunkley	(SD)	Executive Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(KH)	Non-Executive Director (Chair)
Azizen Khan	(AK)	Assistant Director of Human Resources
Diane Marshall	(DM)	Human Resources Business Partner
Ruth Mason	(RM)	Associate Director of Organisational Development
Adam Matthews	(AM)	Workforce BI Manager – Analytical Lead
Alison Schofield	(AS)	Lead Governor
Sharon Senior	(SS)	Staff Side Representative
Claire Wilson	(CW)	Assistant Director of Human Resources

IN ATTENDANCE:

Anne-Marie Henshaw	(AMH)	Assistant Director of Quality and Safety

36/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

37/19 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
David Birkenhead, Medical Director
Gary Boothby, Director of Finance
Jackie Murphy, Chief Nurse
Andy Nelson, Non-Executive Director
Charlotte North, Assistant Director of Human Resources
Julie O'Riordan Divisional Director, FSS
Jackie Robinson, Human Resources Business Partner
Ashwin Verma, Divisional Director, Medical
Deb Wolfe, Head of Therapies

The Committee noted Caroline Smith, General Manager, Medical and Bev Walker, Director of Operations, Community intended to VC to the meeting but were unable to connect.

38/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

39/19 **MINUTES OF MEETING HELD ON 7 JUNE 2019:**

The minutes of the Workforce Committee (Deep Dive) meeting held on 7 June 2019 were approved as a correct record.

40/19 **MATTERS ARISING**

(i) Unplanned Turnover Position (destination on leaving)

CW presented a leavers analysis for the period June 2018 to May 2019. The report

highlighted that worklife balance was the highest reason for collegues voluntarily resigning from the Trust. It was noted a significant number of these colleagues had taken employment in other NHS organisations.

(ii) Benchmarking data for Turnover

CW confirmed to the Committee the NHSI iView system had been de-commissioned in May 2019 and therefore there is no other tool available to benchmark turnover data.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

(iii) Fire Safety Training

CW advised that a draft training needs analysis had been presented to Keith Rawnsley for both him and Lesley Hill to review in order for the training programme to be agreed prior to Lesley leaving the Trust at the end of July.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

(iv) Infection Control Training

CW advised that Level one compliance has increased. The demand capacity for the role specific Level two face to face training had been shared with the Executive Board and provision of extra sessions at CRH is being explored with the Infection Control team. Additionally there is focussed activity across the HR BP team. SD advised that training videos are to be considered across EST and produced wherever appropriate.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

(v) CQC Post Inspection Action Plan

The 2018-2019 CQC action plan was formally closed on 31 March 2019. CW advised the two incomplete workforce actions had been transferred to the 2019-2020 Exception report. Revised action dates were agreed through the CQC Response Group. Both actions are on the Trust risk register and a report is to be presented at Executive Board in July 2019 for further consideration of the quality and financial impact of these actions.

A 2019-2020 Quality Improvement action plan has been developed to provide ongoing assurance that completed actions continue to remain embedded in the organisation and there are plans in place to test this via a QCQ peer review programme.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

(vi) Analysis of WYAAT Trusts Contractual Notice Periods

JE advised that the WYAAT chief nurse group had agreed to co-ordinate a piece of work to resolve the inconsistencies of notice periods within the nursing workforce. Work will commence to align policies to gain consistency. The proposal being to agree to the shorter notice periods. The outcome would be shared with the Committee once available.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

41/19 **ACTION LOG (items due this month)**

The action log was reviewed and updated accordingly.

41/19 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – APRIL 2019**

The report had been circulated with papers to the Committee meeting.

AM provided an overview of the workforce metrics.

The Workforce domain improved from 67.2% in March 2019 to 82.7% in April 2019. AM reported this is the first time that the Workforce Domain has been 'Green'.

The Staff in Post decreased, for the 2nd consecutive month, by 19.69 FTE, which, despite a reduction of 9.12 FTE Establishment, led to an increase in vacancies (10.58 FTE).

Turnover position has improved (by 1.98%) from the same point in March 2018. SD suggested we need to know why people are choosing to stay at the Trust – what are we doing different?

The in-month sickness absence improved to 3.47% in March 2019 (3.2% as at the date of the meeting). The rolling 12 month position improved again to 3.69% from 3.74% in February 2019. This is the lowest rolling sickness absence rate recorded on ESR. JE reported that staff side representatives at the May 2019 Staff Side Partnership Forum staff side enquired if changes could be made to the trigger points in the attendance management policy. A response was given that the existing policy supports the 'one culture of care' approach in supporting colleagues when in a process. The Committee supported this response.

RTW completion rate decreased to 74.1% in March 2019 from 76.15% in February 2019.

Performance has deteriorated in 7 of the 9 core suite of essential safety training with improvements made in Health, Safety and Wellbeing and Dementia Awareness. Overall compliance dropped to 93.18%.

Appraisal completion as at the date of the meeting was c60% - a slightly worse position when compared to last year. The position is being closely monitored. KH reported that medical appraisal compliance rates had been noted at a different meeting and assurance was given the rates would get back on track.

Substantive spend increased by £1.80M in April 2019, this is due to the Agenda for Change uplifts on 1 April 2019.

There were 23 open disciplinary, grievance or harassment cases at the end of April 2019.

2 of the 5 recruitment metrics reported improved in March 2019. It currently takes 15 weeks to get from final authorisation to a colleague starting in post. AM advised work around change forms is currently being undertaken. JE reported a benchmarking exercise is being undertaken to assess that our targets are reasonable.

The Committee recognised the good progress made in the workforce metrics and KH thanked everyone for their contribution.

ACTION: Undertake a deep dive into reasons for improved retention levels **(CW/AM).**

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

42/19 **ANY OTHER BUSINESS**

AS reminded the Committee the first meeting of the Inclusive Advisory Group is scheduled to take place on 13 June 2019. Nikki Hosty, ED&I Manager has been attending various

forums across the Trust to introduce herself and talk about plans to improve colleague engagement and inclusion.

43/19 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

There were no matters for escalation.

44/19 **EVALUATION OF MEETING**

What went well: Committee remained focussed on agenda items.

Even better if: Improved attendance by Directors and Divisions.

45/19 **DATE AND TIME OF NEXT MEETING:**

6 August 2019, Workforce Committee Deep Dive, 10am–12 noon, Room 3, AM Outpatients, HRI + Board Room, CRH
12 August 2019, Hot House, 2pm–4pm, Large Training Room, Learning Centre, CRH

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Tuesday 6 August 2019, 10am – 12 noon, Room 3, 3rd Floor, Acre Mill

PRESENT:

Ellen Armistead	(EA)	Chief Nurse
Helen Barker	(HB)	Chief Operating Officer
David Birkenhead	(DB)	Medical Director
Suzanne Dunkley	(SD)	Executive Director of Workforce and Organisational Development
Karen Heaton	(KH)	Non-Executive Director (Chair)
Andrea McCourt	(AMC)	Board Secretary
Cornelle Parker	(CP)	Deputy Medical Director
Alison Schofield	(AS)	Lead Governor

IN ATTENDANCE:

Alexis Brown	(AB)	Human Resources Business Partner
Nikki Hosty	(NH)	FTSU/ED&I Manager
Azizen Khan	(AK)	Assistant Director of Human Resources
Ruth Mason	(RM)	Associate Director of Organisational Development
Adam Matthews	(AM)	Workforce BI Manager – Analytical Lead
Keith Rawnsley	(KR)	Fire Safety Officer
Lindsay Rudge	(LR)	Deputy Chief Nurse
Pam Wood	(PW)	Head of Apprenticeships & Vocational Learning

46/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

47/19 **APOLOGIES FOR ABSENCE:**

Gary Boothby, Director of Finance
Jason Eddleston, Deputy Director of Workforce and Organisational Development
Andy Nelson, Non-Executive Director
Sharon Senior, Staff Side Representative

48/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

49/19 **MINUTES OF MEETING HELD ON 7 JUNE 2019:**

The minutes of the Workforce Committee meeting held on 7 June 2019 were approved as a correct record.

50/19 **ACTION LOG (items due this month)**

The action log was reviewed and updated accordingly.

51/19 **WORKFORCE DATA DEEP DIVE: REASONS FOR IMPROVED RETENTION LEVELS**

AM presented a comprehensive review of the Trust's retention and turnover position since July 2015 to June 2019.

The review showed that turnover was as high as 14.42% in July 2015. This had reduced to 8.37% in June 2019 – the lowest on record.

FSS Division had shown the greatest improvement, on average a colleague stays 10 years in the FSS Division. It was noted that FSS have less ward based staff. Healthcare science showed the highest turnover.

Investment in recruitment and retention specific initiatives have produced positive results with other activity plans being designed to deliver further improvement.

HB asked if CHS data had any effect on the figures. AM confirmed this was not the case as there had been a steady decline in the figures. The CHS position would be made clear in future reports.

Discussion on the link between retaining colleagues and strength of leadership took place. The next Hot House events are 'Leadership Management' and 'Learning and Development'. It was noted the CLIP (Compassionate Leaders in Practice) programme is being refreshed. SD also advised she is attending a nursing huddle in September and that she and RM are undertaking a piece of work to take this forward. HB suggested a 3RS approach for medical, nursing and corporate.

KH requested that there is a presentation and discussion on the Learning and Development offering at a Committee meeting in autumn.

ACTION: Present Learning and Development proposals to November Committee meeting (SD/RM)

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

52/19 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JUNE 2019**

AM reported that the whole workforce domain remains green in June 2019 for the third month although dropped slightly from 84.6% in May to 82.8% in June. This is due to Data Security Awareness and Safeguarding EST compliance dropping below the 90% target.

Turnover improved to 8.37% for the rolling 12 month period July 2018 to June 2019. This is the lowest turnover on record. Last month's reported figure of 8.25% has been updated to 8.69% following some terminations added to ESR after the report was compiled. The highest turnover remains within the Healthcare Scientists staff group at 9.87%. This is an improvement from 11.30% reported in May 2019.

The in-month sickness absence improved to 3.20% in May 2019. The rolling 12 month position improved again to 3.64% from 3.67% in April 2019. This equates to an average of 13.32 FTE days lost per FTE. This is the lowest rolling sickness absence rate recorded on ESR and equates to an additional 1.4 FTE days worked per employee since June 2018. Work is ongoing to maintain attendance this August.

The RTW completion rate deteriorated to 68.69% in May 2019 from 75.63% in April 2019. The drop in completion rate is being investigated.

Overall Essential Safety Training has dropped to 93.36% but remains above the 90% target.

Appraisal compliance at the end of July was 97.63%, this is the final figure at the end of the appraisal season.

There were 16 open disciplinary, grievance or harassment cases at the end of June 2019. HB asked if the grievance cases were across all divisions and staff grades. AK confirmed this was the case and that there were no hot spot areas. It was noted that bullying and harassment was the highest incidence. There was discussion about expected behaviours linking in to the 4 pillars. SD stated there had been over 50 reported FTSU concerns. Nikki Hosty is talking with concerned colleagues so that issues can be triaged appropriately and addressed before they may become a grievance or disciplinary case.

Bank and agency spend is showing a positive picture as under trajectory.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

53/19 **FIRE SAFETY TRAINING**

KR attended the meeting to provide an update on the current position and proposals for future fire safety training. Discussion took place on the Trust's obligations and the challenge in capacity to attain satisfactory fire safety training. HB advised that KR should make contact with Bev Walker, Associate Director for Urgent Care. HB also advised she is now the Executive Director for fire safety and will invite Keith to the meetings, the matter will then progress to the Health and Safety Committee.

Further work will be undertaken on defining the action plan (and associated resource) as KH expressed conceren that as currently presented, the plan was too challenging. This will be picked up by the Executive.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

54/19 **EQUALITY, DIVERSITY & INCLUSION STRATEGY – UPDATE**

NH presented a summary of the initiatives and engagement activities ongoing to support the development of the strategy; FTSU listening channels going well, popular use of social media, LGBTQ publicity material, visit from the Mayor, 100 attendees at the BAME Network meeting. 360 colleagues have signed up to the LGBTQ pledge and are wearing the NHS rainbow lanyard. It was noted work is ongoing to develop an inclusive 360 approach to recruitment and retention together with leadership development. The Strategy will also factor in governance aspects such as Gender Pay, WRES and WDES.

EA asked about commitment to unconscious bias training for all colleagues and the need to create capacity for service users. Discussion followed and it was noted that a proposal paper is being written, consideration will need to be given as to how NH can take this forward.

The Strategy is planned to be finalised in the autumn and will be brought to the Committee for comment.

ACTION: Present the draft strategy to the Workforce Committee (NH)

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

55/19 **RISK REGISTER WORKFORCE RISKS**

MEDICAL STAFFING RISK
DB advised this risk remains. Dermatology and radiology are substantial risks, patients have been transferred to other areas. Conversations are taking place with partner

organisations to look at resolutions. Consultant electronic job plans and progress with e-roster are further interventions.

NURSING STAFFING RISK

LR advised this risk remains and will be reviewed at the end of October when new graduates are in post. The register is in need of update to reflect more staff are joining than leaving, a cohort of 50+ nurses start in September. Demographics, skill mix, programmes of place of work all being reviewed. EA stated the Nursing Strategy is being refreshed.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

56/19 **CQC ACTION PLAN**

The Committee noted that 2 actions (MD8 and SD9) remain incomplete. At its meeting on 25 July 2019, the Executive Board supported a proposed enhancement of the existing Critical Care Model of Care which would mitigate some of the risks attached to SD9.

Workforce and OD have undertaken a comprehensive self-assessment using the CHFT Health Check tool. An 'Outstanding' Trust will be invited to CHFT to undertake a peer/mock CQC visit to identify areas for improvement. The resulting report will be shared with the Workforce Committee in January 2020.

ACTION: CQC peer inspection report to be shared at the January Committee Meeting (CW).

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

57/19 **OD STRATEGY (THE CUPBOARD) UPDATE**

The Cupboard launched on 17 April 2019. RM reported that 2472 people have accessed The Cupboard with main areas visited being the Home Page, Health and Wellbeing and Work Together to Improve (WT2i). Since April, new stock to The Cupboard has included the CHS People Strategy, Succession Planning Tool, Pay progression Guide, Colleague Engagement Calendar new buttons and lives links to the Kirklees Strategy and Calderdale Vision.

WT2i, Apprentice Strategy and Investors in People Roadmap will be part of the next re-stock on 6 September. An ongoing comms campaign is in place designed to increase awareness of The Cupboard.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

58/19 **2018 STAFF SURVEY RESPONSE**

RM presented an update of the activities taking place both Trust wide and more locally within Divisions, these included listening events for HCAs, establishment of Equality Forum and Colleague Disability Action Group, Divisional focussed listening events and a 'you said, we did' video in production.

AB talked about specific Divisional activities and events. There is a real focus on engagement, communication and 'know your team'. Attention is being given to standardisation of information. It was noted that integration work is needed as some areas don't feel like one trust.

The 2019 Staff Survey is due to be launched in October.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

59/19 **2020 HOT HOUSE TOPICS**

SD referenced the previous Hot House topics which were all now included in The Cupboard.

The Committee agreed the next round of Hot House topics:-

- Leadership development
- FTSU/ED&I
- Quality of appraisals
- Skill mixes and hybrid roles – create a couple in the room – career ladders

OUTCOME: The Committee **RECEIVED** and **AGREED** the topics.

60/19 **QUARTERLY ESCALATION FROM PRMS**

HB provided key points to note:-

Nursing and medical staffing in ED problematic due to leave, sickness and vacancies. Plans from September - good preceptor/induction package. New rota from August in terms of middle grade. Medical staffing challenging – looking at 10 man rotas. Emergency nurse practitioner vacancies, CHFT paying lower banding – looking at job description consistency/re-banding and going to advert.

Radiology – should have 25+ WTE. Reality have 11 + 2 locum (2 consultants applied elsewhere). Working with colleagues (WTGR), colleagues positive. Advert refreshed. Regional forum planned – possible WYAAT solution, needs to be the right thing for CHFT. Looking at agency to maintain safety. CHFT deliver best cancer performance in region.

Junior medical staff – agreed with rota co-ordinators for first 8 weeks new medics will have rostered half day built into their job plan for EST.

HB 'go see' junior doctors undergoing EPR training.

National recruitment problem in Physiology specialties. Looking at training our own, long term plan but a good recruitment strategy.

Urgent Care - piece of work being carried out.

Head of therapies new post recruited to, September start date.

Staffing pressures in Maternity. Looking at this as inconsistent with activity/income and doesn't triangulate.

Neo natal intensive care – more capacity than demand. Looking at recommendations to this.

Q1 activity down: looking at leave management, pensions, waiting list initiative, hotspots on sickness.

Community Division been given autonomy to manage their own vacancies.

OUTCOME: The Committee **RECEIVED** and **NOTED** the key points.

61/19 **APPRENTICESHIP**

- **2019/2020 STRATEGY**
- **OFSTED INSPECTION**

PW provided an overview of the Apprenticeship Strategy. The Strategy was framed from a collaboration of ideas and input at the June 2018 Apprenticeship Hot House.

The Committee noted the Trust had a high retention rate for apprentices and a 100% success rate for finding roles on completion of apprenticeships. Apprenticeships are increasing and currently make up 3% of our workforce (target was 2.3%). 40% of the levy credits were spent in 2018/2019 (compared to 10% in 2017/2018). The proposed target for 2019/2020 is to utilise 60% of the credits. There are currently 5 career ladders in place with a plan to develop 5 more in 2019/2020.

As the Trust holds Employer Provider status it is subject to Ofsted regulations and monitoring. An unannounced Ofsted inspection took place in June. A very positive outcome has been received with the report due to be published soon.

The Committee commended the excellent progress and looked forward to receiving regular updates.

ACTION: Include in future reports E&D breakdown of apprentices (PW).

OUTCOME: The Committee **RECEIVED** and **NOTED** the report

62/19 **ANY OTHER BUSINESS**

AS advised that she is no longer the Lead Governor but continues in the Trust as Governor.

63/19 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will take the following to Board:-

- Sign up to pledge for LGBTQ
- Progress update on ED&I Strategy
- Refresh of Risk Register
- Mock assessment for CQC
- Apprenticeship Targets

64/19 **EVALUATION OF MEETING**

What went well: Agenda covered large spread of workforce topics.

65/19 **DATE AND TIME OF NEXT MEETING:**

7 October 2019, Review Quality & Performance Report – Workforce, 1.15pm–1.45pm, MR3, Learning Centre, HRI
7 October 2019, Hot House, 2.00pm–4.00pm, Discussion Rooms 1 & 3, Learning Centre, HRI

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 3:30 PM ON THURSDAY 18 JULY 2019 IN THE BOARDROOM, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Philip Lewer	Chair

Publicly Elected Governors

Alison Schofield	Public Elected - North and Central Halifax / Lead Governor
Brian Moore	Public Elected - Lindley and the Valleys
Dianne Hughes	Public Elected - South Kirklees
Rosemary Hedges	Public Elected - Lindley and the Valleys (Reserve Register)
Stephen Baines	Public Elected - Skircoat and Lower Calder Valley
Lynn Moore	Public Elected - North and Central Halifax
Annette Bell	Public Elected – East Halifax and Bradford
John Richardson	Public Elected - South Kirklees
Paul Butterworth	Public Elected - East Halifax and Bradford
Nasim Banu Esmail	Public Elected – North Kirklees
Sheila Taylor	Public Elected - Huddersfield Central
Christine Mills	Public Elected - Huddersfield Central

Staff Governors

Linzi Smith	Staff Elected – Management / Admin / Clerical
Dr Peter Bamber	Staff Elected – Drs / Dentists
Sian Grbin	Staff Elected – Nurses/ Midwives

Stakeholder Governors

Felicity Astin	University of Huddersfield

IN ATTENDANCE:

Karen Heaton (KH)	Non-Executive Director
Linda Patterson (LP)	Non-Executive Director
Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance
Suzanne Dunkley	Executive Director of Workforce and OD
Amber Fox	Corporate Governance Manager (minutes)
Ellen Armistead	Director of Nursing / Deputy Chief Executive

29/19 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Owen Williams	Chief Executive
Andrea McCourt	Company Secretary
Brian Richardson	Public Elected - Skircoat and Lower Calder Valley
Chris Reeve	Locala
Salma Yasmeen	South West Yorkshire Partnership NHS FT

David Birkenhead	Medical Director
Jude Goddard	Public Elected - Calder and Ryburn Valleys
Veronica Woollin	Public Elected - North Kirklees
Anna Basford	Director of Partnerships and Transformation
Helen Hunter	Healthwatch Kirklees and Calderdale
Mandy Griffin	Managing Director – Digital Health
Cllr Megan Swift	Calderdale Council

30/19 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors and staff colleagues to the meeting. Introductions were made around the table.

The Chair introduced Ellen Armistead, the new Director of Nursing / Deputy Chief Executive from 1st July 2019 and welcomed her to the meeting.

31/19 DECLARATIONS OF INTEREST

The Chair reminded the Council of Governors and staff colleagues to declare their interest at any point in the agenda.

32/19 MINUTES OF THE LAST MEETINGS HELD 11 APRIL 2019

The minutes of the previous minutes held 11 April 2019 were approved as a correct record.

OUTCOME: The minutes of the previous meeting held 11 April 2019 were **APPROVED** as a correct record.

33/19 MATTERS ARISING / ACTION LOG

The action log was reviewed and updated accordingly.

Rosemary Hedges asked for feedback on ward 11, as it was reported at the last meeting there was a high level of falls. A written response from the Chief Nurse was provided after the last meeting for the minutes and this has been forwarded onto Rosemary Hedges. It was confirmed Ward 11 is a General Surgery ward.

Paul Butterworth re-iterated his concern that the complaints procedure doesn't match the policy. An update will be reported back at the next meeting.
Action: Update on complaints procedure and policy – Company Secretary

34/19 INTERACTIVE SESSION WITH NON-EXECUTIVE DIRECTORS

The Chair confirmed that two Non-Executive Directors are allocated to each of the Council of Governors meetings on a rotation going forward. An interactive session took place with the governors and Non-Executive Directors in attendance, Karen Heaton and Linda Patterson. This provided an opportunity for the governors to ask the Non-Executives questions and hold them to account.

35/19 UPDATE ON STAFF CONSULTATION (CAR PARKING)

The Executive Director of Finance provided an update following the engagement piece of work which has taken place with staff and visitors. The results of this engagement have been collated and common themes have been reviewed. A common theme is the number of car parking spaces available.

The purpose of the engagement piece was to review car parking charges and the Executive Director of Finance confirmed there are no proposals to increase staff car parking charges until the findings have been worked through. Once this process has concluded, a further update will be provided within a timeline of 2-3 months.

Paul Butterworth asked what income the Trust generate from staff parking. Alison Schofield asked if the Trust have consulted with Nikki Hosty, Freedom to Speak Up Guardian/Equality Diversity Manager regarding disability car parking.

Action: Executive Director of Finance to provide feedback once the consultation has ended and a way forward established

OUTCOME: The Council of Governors **RECEIVED** the update on staff consultation.

36/19 UPDATE FROM LEAD GOVERNOR

A video by the lead governor was shared which was presented at the Annual General Meeting on Wednesday 17 July 2019.

The Chair thanked Alison Schofield for all of her support in her last day as lead governor and welcomed Brian Moore as the new lead governor from the 19th July 2019.

OUTCOME: The Council of Governors **NOTED** the lead governor update and new lead governor appointment.

37/19 CHAIR'S APRAISAL OUTCOME

The Chair, Executives and Non-Executive Directors, apart from Karen Heaton left the room for this discussion. Karen Heaton provided the governors with the outcome of the Chair's appraisal.

OUTCOME: The Council of Governors **NOTED** the outcome of the Chair's appraisal.

38/19 CHAIR'S REPORT

The Chair reported that a stakeholder governor from Kirklees Council joined the Council of Governors, Cllr Lesley Warner.

<u>Nominations and Remuneration</u>

The Chair provided an update on the recruitment for the two upcoming Non-Executive Director vacancies.

Capital Non-Executive Director - An appointment was not made following interviews for the capital Non-Executive Director post and this post has been re-advertised. This was a unanimous decision by all governors on the panel.

Clinical Non-Executive Director - A shortlisting panel took place for the Clinical Non-Executive Director post where a selection of 4 applicants were made. The interviews for this post are taking place on Thursday 15 August 2019. The Non-Executive Directors have been invited to be involved in the interview panel.

The Chair announced that an appointment was made to the post of Managing Director of Calderdale and Huddersfield Solutions, Stuart Sugarman.

OUTCOME: The Council of Governors **NOTED** the Chair's report.

39/19 PERFORMANCE AND STRATEGY

a) Performance Report

The Chief Operating Officer reported a positive position for May 2019, the main highlights from the report were:

- Good solid month across all domains with general improvement
- May's performance score is 73.3%
- Challenges in diagnostic performance
- Workforce issues in echocardiogram and neurophysiology, Cardiology will be recovered this quarter; however, there needs to be a plan for neurophysiology
- Emergency care standard for May 2019 is good, there was a struggle in June where the Trust should've hit 90% and were just over 89%. This is currently at 92% in July 2019.
- Cancelled as many meetings as possible for clinical and operational managers to focus on back to the floor
- Good performance in cancer, CHFT are one of the best performing organisations across the cancer standards
- Radiology capacity – there should be over 20 radiologists in post and the Trust are currently sat with 11 in post, although the Trust have lower staffing levels, they are delivering the best cancer performance
- A focused piece of work is taking place to reduce length of stay of over 21 days, the senior clinical and operational team are reviewing each patient, this is time consuming but valuable - the feedback so far is the majority are internally generated delays

Alison Schofield asked if there are less people in for 21 days in the frailty service. The Chief Operating Officer confirmed there are less in the frailty service who are delivering an excellent service. The Chief Operating Officer suggested the frailty team are invited in for a joint Board and Council of Governors workshop.

Action: Frailty Team invited to a Joint BOD/CoG Workshop – Company Secretary

Sian Grbin asked how Paediatrics and A&E are performing together. The Chief Operating Officer explained the teams are working on how to separate the two and this will be invested in as part of urgent care funding. The Trust will facilitate more rapid access clinics. There is a high volume of children attending ED at Calderdale that do not get admitted, this is being reviewed as a piece of work.

Peter Bamber asked for an update on stroke. The Chief Operating Officer reported stroke is being recovered in terms of length of stay and now records when a patient is discharged.

Paul Butterworth highlighted that alcohol and tobacco misuse is reported on and asked about substance misuse. The Chief Operating Officer explained the CQUIN element is focused on alcohol and tobacco.

Rosemary Hedges asked about the emergency care standard (ECS) target which is at 95%. The Chief Operating Officer explained the Trust submitted a plan for this year which was accepted by regulators to say that the Trust would not perform below 95%. CHFT are performing in the upper quartile nationally. This is currently being field tested in ED. The Chief Operating Officer added that the length of waiting hours for ED is reducing since the new standard has been brought in, following a consultation in April 2019.

The Chief Operating Officer reported that the Trust have been invited to field test the referral to treatment standard of 92% within 8 weeks. This starts on 1st August 2019.

Brian Moore asked if the ED standard is still four hours. The Chief Operating Officer confirmed the ED standard is still 95% within 4 hours. The Trust are currently sat at 92% this month. CHFT sit within the top 20 and 30 organisations and are one of the busiest Emergency Departments in the country.

b) Financial Position and Forecast – Month 2

The Executive Director of Finance summarised the key points from the Month 2 position;

- Capital estate has been revalued, the Executive Director of Finance confirmed this does not impact on reconfiguration as revalued assets include the CRH site and the land, the bulk of revaluation affected the HRI building
- Reduced value of assets generates less depreciation
- £69m deficit opposed to £43m deficit
- Revenue plan – planned to spend £3m on interest this year

RH asked for an update on the loans that are to be repaid in January. The Executive Director of Finance explained that a loan will be provided to the Trust and will need to be repaid. Part of the plan is to borrow additional cash. The Trust have a planned overspend of £10m this year and an

additional £10m which is being borrowed. The Trust have accepted the control total and borrowing will be at 1.5% rate interest. Other Trusts are paying a 2.2% or 2.4% interest rate.

The Director of Finance explained the advantage of borrowing as all organisations pay into public dividend capital, which is 3% of net assets and borrowings are worth more than assets.

OUTCOME: The Council of Governors **NOTED** the Performance and Finance report.

40/19 COMPANY SECRETARY'S REPORT

a. Review Council of Governors Workplan 2019

The annual Council of Governors workplan for 2019 was attached, for information. This workplan will be updated for 2020.

b. Proposal of future Council of Governors dates 2020

The proposal of future Council of Governors dates was attached for approval. There will be four Council of Governors meetings per year, two joint Board of Directors and Council of Governors workshops and three joint Non-Executive Directors and Council of Governors informal workshops.

In total there will be 9 meetings/workshops scheduled throughout the year.

OUTCOME: The Council of Governors **NOTED** the Workplan for 2019 and **APPROVED** the future Council of Governors dates for 2020.

41/19 UPDATES FROM SUB-COMMITTEES

Quality Committee

Christine Mills provided a verbal update following the last Quality Committee where she finds the staff compassionate and open. The key updates were:

- New stockings have reduced the number of falls taking place
- Health and Safety have corrected fridge temperatures
- Mental Health report is due at the next meeting
- Reviewed complaints and a big piece of work is taking place to reduce response times to complaints

Charitable Funds Committee

Sheila Taylor provided a verbal update from the last Charitable Funds Committee held 22 May 2019. The main item for discussion is the Todmorden Project and the need to engage with the community of Todmorden to find out why the Centre is not being utilised. A new fundraising manager has been appointed to improve the charity status, she is very passionate with lots of ideas. Sheila suggested the Board and Council of Governors receive the strategy presentation after it has been to the Charitable Funds Committee. LP added that a large piece of work is ongoing to transform Outpatient Services and Todmorden is being fed into this group.

Organ Donation Committee

The Chair reported on the Organ Donation Committee which meets twice a year. The government have altered the rules where you must opt out rather than opt in. This will become active next year. The Chair is assured by the consultant and nurse in charge on the Committee that the Trust score well in having these difficult conversations with families.

Stephen Baines asked if the family can overrule this. The Chair explained that the new legislation will clarify this.

Audit and Risk Committee

The Chair reported the Audit and Risk Committee meetings are attended by internal and external auditors and counter fraud. The Committee is chaired by Richard Hopkin. This is a very rigorous meeting. The Executive Director of Finance explained there was a conversation about the profile of clinical audit at the last meeting held 17 July 2019 and whether clinical audit should attend the Committee.

Finance and Performance Committee

Sian Grbin reported on the last Finance and Performance Committee held 28 June 2019. The winter plan will stretch into April next year and will have a flexible approach. The Chief Operating Officer added that the Trust have learned from the last few winters and there will be investment this year to make what happens in winter recurrent. A market stall will take place during October to make it more interactive.

Workforce Committee

Alison Schofield reported on the last Workforce Committee held 7 June 2019. The focus has been on testing of the cupboard and reviewing the staff survey results. They are recognizing the groups that were not feeling valued. The Committee are working with Nikki Hosty, Freedom to Speak Up Guardian and Equality Diversity Manager on the first Disability Action Group meeting and BAME group.

OUTCOME: The Council of Governors **RECEIVED** the updates from the Sub-Committees.

42/19 INFORMATION TO RECEIVE

a. Council of Governors Calendar 2019

The updated Council of Governors calendar for 2019 was circulated for information.

b. Governors – Who to Contact List

An information sheet on who the governors should contact if they have any queries was circulated, for information.

OUTCOME: The Council of Governors **RECEIVED** the Council of Governors Calendar for 2019 and contact list for any queries.

43/19 ANY OTHER BUSINESS

Paul Butterworth commented on the Chair induction as part of the Chair's appraisal. Brian Moore suggested this is reviewed as part of the constitution review to ensure there is a longer period of dual working.

Paul Butterworth asked if the annual report and accounts is proofread. He highlighted that the report quotes '7 complaints against the Trust, of these 11…'. The Executive Director of Finance responded that the timeframe to produce the annual report was shorter this year and the governors are welcome to proofread. The Audit and Risk Committee proofread the annual report and it is approved by the Board.

The Chair formally thanked Rosemary Hedges and Nasim Banu Esmail as this was their last Council of Governors meeting.

The Chair will be meeting with all new governors individually.

Brian Moore thanked Alison Schofield for her year as lead governor.

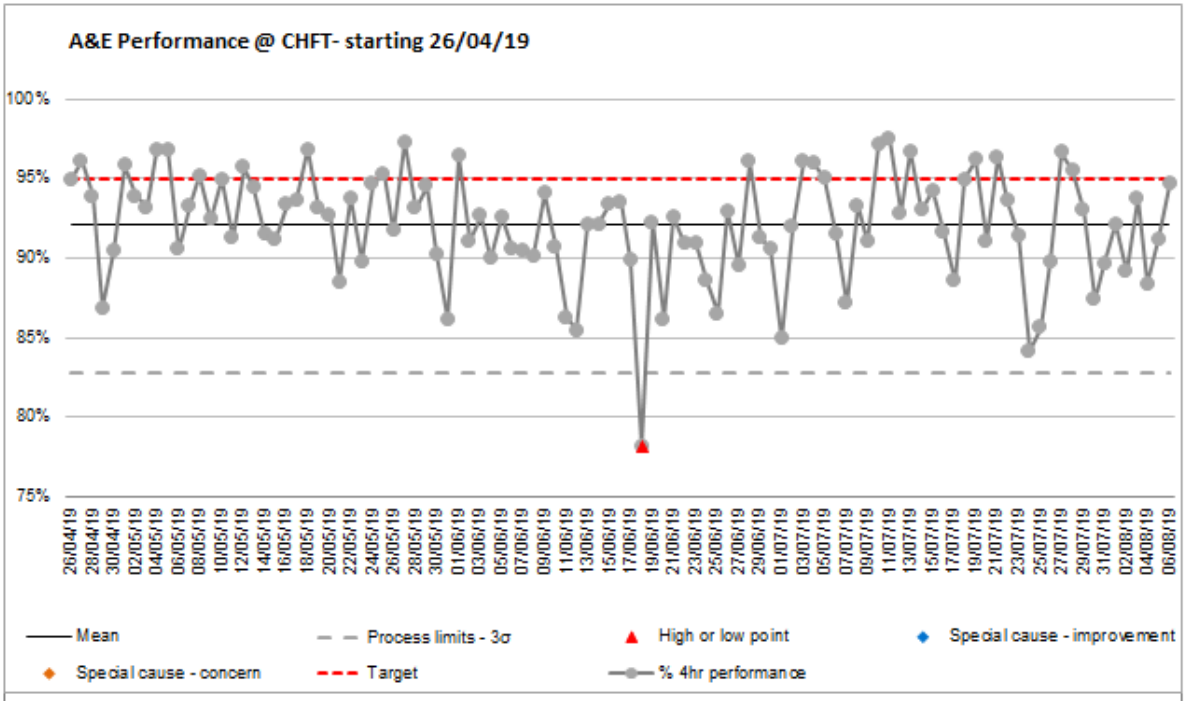
DATE AND TIME OF NEXT MEETING

The Chair thanked the Council of Governors, Non-Executive Directors and Executive Directors for attending the meeting. The Chair formally closed the meeting at 17:44 pm and invited members to the next meeting.

Council of Governors Meeting
Date: Thursday 17 October 2019
Time: 3:30 – 5:30 pm (private meeting 2:00 – 3:15 pm)
Venue: Large Training Room, Learning & Development Centre, Calderdale Royal Hospital

Calderdale and Greater Huddersfield A&E Delivery Board (A&EDB) Highlight Report		
9th July 2019	**12:30 – 14.00**	**Shibden Room Dean Clough**

Chair	Matt Walsh (MW) – Calderdale CCG
Attendees	Amanda Evans (AE) – KMBC Cath Bange (CB) – YAS Debbie Graham (DG) – CCCG Farrukh Javid (FJ) – CCCG Helen Barker (HB) – CHFT Iain Baines (IB) – CMBC Jane Close (JC) – Locala Jill Holbert (JH) – CMBC John Keaveny (JK) – SWYPFT Louise Metcalf (LM) – NHSE Matthew Bleach (MB) – CCCG Vicky Dutchburn (VD) – GHCCG
Note Taker	Emily Addison – Calderdale CCG
1. Welcome and Apologies	
Lead	**MW**
Apologies	Members were welcomed to the meeting and a round of introductions made. The following apologies were noted: Andrew Bottomley, Balrajjit Leighton, Helen Wraith, Carol McKenna, Bev Walker, Andrew Simpson, Mark Davies, Helen Carr
2. Sign off Highlight Report and Action log	
Lead	**MW & HW**
Matt Walsh **Helen Wraith**	The board reviewed the notes from 9th July 2019 and agreed they were an accurate record of the meeting. DG reviewed the action log with the board: Actions Closed: 247 (Bring back content of developing SRG UC programme to board- On agenda), 336 (Brexit risk and vulnerable patient definitions on agenda) , 343 (Further risks to be pick up by bored in relation to Brexit on agenda), 355 (to be picked up in the UC work streams in order to create a wider DOS across west Yorkshire including GPs, work to be brought together to avoid duplication), 357/8 (transformation funding on agenda) 359 (Extended Length of Stay now in SPC format, YAS to share some data also in SPC format) 360 (6% A&E rise on agenda), 362 (to be picked up by A&E Attendance task and finish group) 354 follow on to priorities presentation communications resource to link 361 September 2019 363 September 2019 365 October 2019

3. Performance Update	
Lead	**MB**
	Strong performance throughout May, June and July.  ACTION to look at data to see if penitents been sent home on a Saturday has had an effect on community services
4. Feedback from UEC Board	
Lead	**DG**
	The structure has been shared and is up and running, the A&E DB has not been included as the board made the decision to wait until these groups are firmed/running well Most work streams have leads except frail elderly, Calderdale Council and Kirklees Council are in conversation as to whether the local authorities could step up and provide a different dimension to this work. Helen Barker will send out email with lead names and groups to each organisation in order to get nominations for each group. Clarity of scope and KPIs to come back in November. A&E Delivery Board is to take responsibility for the oversight of performance and is a place of escalation for operational challenge, to work through unblocking any blockages; this is a space of transformation to allow us to improve our system. Headlines to come through to A&E DB for information
5. YAS Mental Health Programme	
Lead	**CB**
	Catherine Bange gave a presentation around the YAS Mental Health Programme Gap in Adult Crisis Care across West Yorkshire and Harrogate FJ point about generic hubs putting more resources into generic hubs in order to allow them access to mental health records.

	Kirklees and Calderdale – Mental Health Nurses in the police hub during hot periods Agreed care plans for high intensity users. Currently fits with Mental Health Scope in the SRG Work
6. Urgent Treatment Centre Development	
Lead	**DG**
	Debbie Graham presented The board was shown an email from Vicky McEvoy at WY for the board to send back a view of our plan for Urgent Treatment Centre development. UTC development will not be until 2023 but in the interim we are looking at what can be delivered for our population in the interim. Explicitly around the details that this is all subject to FBC approval and that building will begin in January 2023 but the UTC will not be fully functioning at this time. The board confirmed they were comfortable with this way of describing our strategic intention. **Action: Louise Metcalf to make changes and send back to Vicky McEvoy** The plan on a page was created to be one plan for the whole board area it identified priorities, identified host of funding (Matt Walsh A&E DB Chair), identified mitigations and mile stones, notional view around financial summary. Board supportive of plan and sees it as a robust piece of work fitting with the direction of travel. A new focus on A&E and then working outwards from there instead of starting in community and working up.
4. Transformation Funding	
Lead	**DG**
	Understanding totalities of winter monies presenting as to sight A&E Delivery Board on the plan. Assurance that the submission of the BCF template is the 22nd September Matt to write to Tim Swift for him to be sighted on the recommendation from the A&E DB – To present at the October Health and Well Being Bored Meeting
4. Brexit Assurances	
Lead	**DG**
	Medicine and Medical Device shortages stand out, flu vaccine supply chair mentioned and each provider has a full plan for EU exit. The government has sent out a plan to social care providers looking at potential impact on food supply chain (other things which may not be seen as medical) Warehouse capacity seen as a challenge. ACTION: Louise Metcalf to invite Screening team, NHS Commissioning team, Paul Butcher & Emily Parry-Harris invited into conversation around flu chain supply. ACTION: Matt to bring challenge to H&CP around the impact on health EU exit will have.

	Brexit to be a standing order on the agenda
5. WY&H UEC Programme	
Lead	**DG**
	The minutes were shown to the board for information. The narrative was shown in a very draft form, it has only just come out to the network and the board needs to think about the stories we would like to see within this document. Commentary will be given by both place and the board. Proposal of a large workshop style facilitated session in order to see where the UEC Programme is currently and how this can be improved.
6. AOB	
Lead	**DG**
	UCI Road World Championships – For information CHFT on with assurance checking ACTION – Send out to on call **CPWY – Contractual Framework and roll of pharmacy how they are involved in UC T&F Groups**
Next Meetings	10th September 2019, Shibden Room, Dean Clough, 12.30-14.00 8th October 2019, Shibden Room, Dean Clough, 12.30-14.00 12th November 2019, Shibden Room, Dean Clough, 12.30-14.00 10th December 2019, Shibden Room, Dean Clough, 12.30-14.00 14th January 2020, Shibden Room, Dean Clough, 12.30-14.00 11th February 2020, Shibden Room, Dean Clough, 12.30-14.00 11th March 2020, Shibden Room Dean Clough, 12.30-14.00

Calderdale & Greater Huddersfield Health Economy
A&E Delivery Board (A&EDB)
Action log

No	Minute Ref	Action	Who	Date	Update	Status
247	Planning	To bring the content of the developing SRG urgent care programme to the Board once it had been through its first gateway on 28 February 2019	HB/DG /VD	May 19	On schedule/on forward plan SAFER Ops meeting 8/7 and SRG UC Board 11/7	Open
336	System	Organisations agreed that they would work to identify vulnerable services users and a view on how key workers would be identified in the event of a fuel shortage – responding to both S&E plan and Brexit For the board to clearly define what the criteria for a high risk or vulnerable patient is. A conversation with both continuing health care teams in relation to them being able to identify high risk vulnerable patients.	All	March 2019	Work not yet concluded – update to be provided at August meeting. Agreed that a focused piece of work needed compiling on our response to a revised Brexit date.	Open
343	Brexit Readiness	May A&EDB to continue to pick up an further risks and mitigating actions related to Brexit	All	August 2019	To review again in August	Open
352	Performance	To bring an analysis of bed base in the last 5 years to look at where we have come from and show the direction of travel for the bed base.	MB	August 2019	In draft will be brought to the August meeting	Open
354	YAS 999	Urgent Care and Communications leads meeting to discuss joint response to members at scrutiny and H&WBB	CB	August 2019	Emailed to ask for update	Open
355	YAS 999	CHFT to provide YAS with a Directory of services to reduce hospital admittance and create links to the place based services	BW	August 2019	In progress; ensuring the DoS is useful to YAS will report back in August.	Open
356	Board Governance	Update on next steps from the May workshop and governance arrangements to the October A&EDB to review our position and decide future actions	DG	October 2019	After groups have a chance to embed this will be brought back for discussion	Open

Enclosure A

No	Minute Ref	Action	Who	Date	Update	Status
357	WY Transformation Funding	A&E DB to incorporate the task of signing off use of transformation funding.		August 2019		Open
358	WY Transformation Funding	To bring a clearer view of how the resources will come into the system.	MW/ CM	August 2019		Closed
359	Performance	Review the current performance charts and update those which would benefit from using an SPC format.	MB	August 2019		Closed
360	Performance	Present a plan of how the board will respond to the 6% rise in A&E Attendance.	HB/BW /DG	August 2019		Closed
361	Local Government Social Care Funding	To review how we use the vehicle of urgent and emergency care redesign to prepare for the 2020 challenge.	IB/DG/ /HB	September 2019		Open
362	Engagement Report	Feedback requested on how the findings would be used and incorporated in our transformation programmes.	HB/DG	August 2019		Closed
363	UEC	Workforce planning piece to come back to the September A&E DB	MD	September 2019		Open

Key
Closed Shaded Grey
Open Due at later date Shaded Green
Outstanding due at later date, Shaded Red

18. Governance Report

a) Audit and Risk Committee Terms of Reference

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee – 17 July 2019

Actions Requested:
To approve

Purpose of the Report

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

Key Points to Note

The Audit and Risk Committee terms of reference are attached following an annual review. The main changes relate to membership, to include the Managing Director for Digital Health and the frequency of the Audit and Risk Committee which is quarterly.

EQIA – Equality Impact Assessment

No impact identified.

Recommendation

The Board is asked to:

- approve the revised Audit and Risk Committee terms of reference

Calderdale and Huddersfield
NHS Foundation Trust

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Version:	3
Approved by:	Board of Directors
Date approved:	Audit and Risk Committee – 11 July 2018 Board of Directors – 1 November 2018 Audit and Risk Committee – 17 July 2019 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, Head of Internal Audit and the Managing Director for Digital Health 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 quarterly, 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 & 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 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.

19. Month 4 Financial Summary

To Note

Presented by Kirsty Archer

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Month 4 Financial Summary
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance
Previous Forums:	Turnaround Executive
Actions Requested: To note	
Purpose of the Report	
To outline the headline financial messages for Month 4.	
Key Points to Note	
The year to date deficit is £6.69m in line with the plan.	
EQIA – Equality Impact Assessment	
Attached paper is for information only.	
Recommendation	
The Board is asked to note the attached summary.	

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NHS
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NHS Foundation Trust

Month 4 Financial Summary – Board of Directors

Year to Date Summary

- The year to date deficit is £6.69m in line with the plan.
- The CIP delivered in the year to Month 4 is £2.82m slightly ahead of a planned £2.67m.
- There is an under spend of £1.15m against the budgeted agency trajectory. The overall operational pay position is underspent by £0.63m (excluding reserves).
- Clinical contract income is £0.1m below plan overall after £1.66m protection offered by the Aligned Incentive Contract (split Greater Huddersfield CCG £1.30m and Calderdale CCG £0.36m) reflecting lower than planned activity levels.
- Clinical Divisions continue to show favourable variances to plan, reflective of lower expenditure linked to lower activity levels across Divisions; and vacancy levels in Community. Surgery Division benefits from £0.92m protection from the AIC. Medicine division is the exception to this, with expenditure pressure particularly on staffing.
- Non clinical areas are experiencing pressure with the THIS position being driven by lower than planned income generation and higher spend. Work is ongoing to assess whether any opportunity exists within elements of the CHFT requested services to release costs.
- A higher than planned cross charge for services from CHS including utilities and maintenance is being held centrally by the Trust (Technical Accounting and Reserves) at present at £0.12m. Work has progressed with divisional involvement to understand these charges. This interrogation has reduced the overall pressure from the prior month and the basis for distribution to divisions is being finalised for sign off.
- Other costs being attributed to reserves include unplanned charges from the NHS Pensions Authority re: final pay controls and costs incurred due to changes in HMRC rules relating to the Brookson contract.

Division	Reported Position YTD - Month 4			
	Plan	Actual	Variance	
	£'000	£'000	£'000	
Corporate	(14,410)	(14,206)	204	🟢
FSS	(1,666)	(1,661)	5	🟢
THIS	843	536	(307)	🔴
Medicine	13,591	13,287	(305)	🔴
Surgery	4,653	5,236	583	🟢
Community	(941)	(651)	291	🟢
PMU	1,018	1,131	113	🟢
Divisional Operating Position	**3,088**	**3,671**	**584**	🟢
CHS Ltd	69	51	(18)	🟡
Technical Accounting & Reserves[1]	(9,856)	(10,412)	(556)	🔴
Total Trust Surplus / (Deficit)	**(6,700)**	**(6,691)**	**9**	🟢

Forecast

At the end of month 4, the year-end forecast is to achieve the planned £9.7m deficit, the position is differential across the divisions with the key areas of pressure reflecting the year to date positions. Additional forecast outsourcing and agency pressures are impacting the FSS forecast whilst the CHS forecast incorporates CIP pressure.

Division	Forecast Position - 19/20		
	Plan	Forecast	Variance
	£'000	£'000	£'000
Corporate	(42,976)	(42,827)	150
FSS	(4,534)	(4,697)	(163)
THIS	2,525	1,805	(720)
Medicine	41,111	40,834	(277)
Surgery	13,919	14,558	640
Community	(2,842)	(2,584)	258
PMU	2,994	3,134	140
Divisional Operating Position	**10,198**	**10,224**	**27**
CHS Ltd	525	318	(207)
Technical Accounting & Reserves	(20,430)	(20,250)	180
Total Trust Surplus / (Deficit)	**(9,708)**	**(9,708)**	**0**

There remains a balance of risks and opportunities at a Trust level and the forecast assumes full delivery of the planned overall £11m CIP.

20. Date and time of next meeting

Thursday 7 November 2019, 9:00 am

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

To Note

Presented by Philip Lewer

Resolution

The Board resolves that representatives of the press and public be excluded from the meeting at this point on the grounds that the confidential nature of the business to be transacted means that publicity of the matters being reviewed would be prejudicial to public interest. (Section 1(2) Public Bodies (Admission to Meetings Act 1960).