Public Board of Directors

Schedule	Thursday 7 November 2019, 9:00 — 12:00 GMT
Venue	Large Training Room, Learning Centre, Calderdale Royal Hospital
Organiser	Amber Fox

Agenda

9:00	1.	Welcome and introductions: Peter Wilkinson, Non-Executive Director Denise Sterling, Non-Executive Director John Richardson, Public Elected Governor Veronica Woollin, Public Elected Governor To Note - Presented by Philip Lewer	1
9:02	2.	Apologies for absence: Helen Barker, Mandy Griffin, Anna Basford, Gary Boothby To Note - Presented by Philip Lewer	2
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9:14	6.	Chair’s Report a. Council of Governors Nominations and Remuneration Committee – Non-Executive Director Appointments b. WYAAT 18/19 Annual Report Summary To Note - Presented by Philip Lewer	18
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11:19	19.	Update from sub-committees and receipt of minutes & papers • Finance and Performance Committee – minutes from meeting held 27.9.19 • Audit and Risk Committee – verbal update from meeting held 30.10.19 • Quality Committee – draft minutes from meeting 3.9.19 and verbal update from meeting held 30.9.19 and 5.11.19 • Workforce Committee - minutes from meeting held 7.10.19 • Council of Governors – draft minutes from meeting held 17.10.19 • Charitable Funds Committee – minutes from meeting held 23.8.19 To Note - Presented by Phil Oldfield, Richard Hopkin, Linda Patterson, Karen Heaton and Philip Lewer	195
11:29	20.	Governance Report a) Constitution Changes for approval b) Appointment of Deputy Chair / Senior Independent Non-Executive Director c) Board of Directors Workplan 2020/21 d) Use of Trust Seal To Approve - Presented by Andrea McCourt	230
11:39	21.	Month 6 Financial Summary To Note - Presented by Kirsty Archer	254
11:49	22.	Date and time of next meeting Thursday 9 January 2020, 9:00 am Venue: Boardroom, Huddersfield Royal Infirmary To Note - Presented by Philip Lewer	258
		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).	259

1. Welcome and introductions:

Peter Wilkinson, Non-Executive Director

Denise Sterling, Non-Executive Director

John Richardson, Public Elected Governor

Veronica Woollin, Public Elected Governor

To Note

Presented by Philip Lewer

2. Apologies for absence:

Helen Barker, Mandy Griffin, Anna Basford, Gary Boothby

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 5 September 2019

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 5 September 2019 at 9:00 am in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Alastair Graham (AG)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Phil Oldfield (PO)	Non-Executive Director
Linda Patterson (LP)	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development (OD)
Dr David Birkenhead	Executive Medical Director
Andy Nelson (AN)	Non-Executive Director
Helen Barker	Chief Operating Officer

IN ATTENDANCE

Amber Fox	Corporate Governance Manager (minutes)
Andrea McCourt	Company Secretary
Anna Basford	Director of Transformation and Partnerships
Kirsty Archer	Deputy Director of Finance

OBSERVERS

Lynn Moore	Public Elected Governor (Lead Governor Deputy)
John Gledhill	Public Elected Governor – Lindley and the Valleys
Crispin Pettiser	Hempsons Solicitors
Peter Wilkinson	Member of the Public
Justin Grundy	Head of Business Development, Greenstaff Medical
Christine Mills	Public Elected Governor
James McHale	Healthcare Partnership Manager, Advanced Wound Care, Molnlycke

88/19 Welcome and introductions:
The Chair welcomed everyone to the Public Board of Directors meeting.

89/19 Apologies for absence:
Apologies were received from Karen Heaton, Mandy Griffin and Gary Boothby.

90/19 Declaration of Interests
The Board were reminded to declare any interests at any point in the agenda.

91/19 Minutes of the previous meeting held on 4 July 2019 and minutes of the Annual General Meeting held on 17 July 2019
The minutes of the previous meeting held on 4 July 2019 and the Annual General Meeting held on 17 July 2019 were approved as a correct record subject to the following amendment to minutes of the meeting held 4 July 2019:

- To note Helen Barker was present at the Board meeting on 4 July 2019

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 4 July 2019 and the Annual General Meeting held on 17 July 2019.

92/19 Action log and matters arising
The action log was revised and updated accordingly.

RH asked for future CQC updates to include use of resources and well-led.

The Medical Director provided a verbal update on flu vaccine uptake from black, asian, minority, ethnic (BAME) groups. He explained there is little public health data on uptake from BAME groups. The analysis provided is on age, area and pregnancy. On reviewing academic work on ethnicity flu vaccine uptake, there are lower uptake rates in BAME children. The areas with the highest uptake are in the Muslim population. Overall, BAME groups have a lower vaccine uptake rate. The Medical Director also reported there is a lower uptake rate in lesbian, gay, bisexual, transgender, queer (LGBTQ) groups, and the Chief Executive has reviewed data from staff at CHFT which shows a lower uptake rate from LGBTQ colleagues.

OUTCOME: The Board **NOTED** the updates to the action log.

93/19 Chair's Report

a) Progress with Non-Executive Director Appointments

The Chair introduced Peter Wilkinson who was observing the Board, who has recently been appointed as a Non-Executive Director with a capital background and announced Denise Sterling has been appointed as the clinical Non-Executive Director. Both Non-Executive Director appointments will be ratified by the Council of Governors meeting in October 2019.

The Chair informed the Board that Linda Patterson and Phil Oldfield's tenure has been extended to the end of December 2019. The review of Non-Executive Director time commitments and sub-committee allocations has commenced.

b) Climate Change Report

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

The next piece of work is focused on staff engagement working with new Managing Director for Calderdale and Huddersfield Solutions and reviewing how to reduce our contribution to climate change. The additional car parking spaces required will need to be balanced against the local authorities view on climate change which will affect decision making at planning committees.

The Chief Executive referenced the role that digital might play, including care closer to home and explained 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.

OUTCOME: The Board **NOTED** the progress with Non-Executive Director appointments and **NOTED** the climate change report and that a more thorough report will be shared at the Board meeting in January 2020.

94/19 Chief Executive's Report

1) Calderdale Health and Wellbeing Strategy

The Chief Executive reported that a Health and Wellbeing Strategy is now in place in most Trusts, though these do not often link to the local authority wellbeing strategy.

The supporting paper described the strategic aspiration for Calderdale from a health and wellbeing perspective.

It was noted the health and wellbeing strategy aligns with the Trust's four pillars of care. The Calderdale Wellbeing Strategy sits within the context of their 2024 vision.

RH asked if there are any timescale for a Kirklees strategy. The Chief Executive responded Kirklees works on seven shared outcomes and the Kirklees Strategy will be received after it has been through their decision-making process, which is expected to be between November 2019 and January 2020.

LP welcomed this item on the Board agenda and recognised the work that it involves. She added that the Trust does not use public health data enough. This data would influence the way the Trust deliver services in partnership.

AN asked how the Trust contribute to preventative measures and asked what the next step is in terms of engagement. The Chief Executive responded that public health information is a contributor to developing preventative strategies. The Chief Executive, Medical Director and Director of Transformation and Partnerships are part of the Health and Wellbeing Board and there are forums in both Calderdale and Kirklees to discuss the local strategic partnerships.

The Chief Executive explained there are four criteria of the wellbeing strategy and five criteria of vision with an expectation to review this and collaborate.

AG suggested the Trust inform the local authorities where greater emphasis is needed on preventative measures. He added that it is important to understand how the Trust can influence social care resources in the future. AG asked if the Trust are going to take the five Calderdale Cares localities into account regarding care closer to home. The Chief Executive confirmed the Trust are already a part of these five areas and are a regular attendee at these forums.

The Medical Director confirmed the strategy will be monitored at the Health and Wellbeing Board where public health and Clinical Commissioning Group (CCG) colleagues are present. The Director of Transformation and Partnerships and the Project Director, Capital and Estates Programme attend the Kirklees Health and Wellbeing Board. The Chief Executive attends the Kirklees Integrated Provider Board and he acknowledged more engagement is needed with Kirklees.

OUTCOME: The Board **NOTED** the Chief Executive's update on the Health and Wellbeing Strategy.

95/19 Patient Story – Positive Changes to Upper GI

Wendy Markey, Lead Upper Gastro Intestinal (GI) Clinical Nurse Specialist attended the Board to share the positive pathway changes made in Upper GI. Wendy is a core member of the Cancer Board.

The key changes to the service were:

- Development of a post multi-disciplinary team (MDT) clinic, pilot started 14th February 2019, to ensure the patient is seen by the right person at the right time
- New development of a cancer care co-ordinator
- Aligning patient care with MDT clinic and outcomes – patients are seen as quickly as possible after the MDT clinic by clinical nurse specialists who were previously finding it difficult to attend all appointments
- Patients are placed on the right pathway as soon as possible with referrals to tertiary care
- Currently in the process of a patient experience survey and the results will be reviewed
- Changes have prompted further decision-making taking place outside of the MDT process
- Set up of the MDT clinic has developed other services in line with this work

LP asked if there are still patients that are not going through the MDT clinic or if all patients are captured. Wendy confirmed they capture all patients and a provisional list for MDT is set up at the start of the week. The MDT clinic meet on Wednesday or Thursday and the patients are invited to come back in the afternoon for the results.

The Director of Nursing was interested in seeing the patient experience feedback which will go to the patient experience group. She recognised the strong nurse leadership and multi-disciplinary working which was evident to make these changes happen.

The Chief Operating Officer added the presentation was shared at the Cancer Board and there is effort to try replicate this work across other cancer pathways.

The Chair thanked Wendy Markey for attending the Board and asked her to formally thank the rest of the team for their dedication and hard work on behalf of the Board.

OUTCOME: The Board **NOTED** the patient story / service changes to upper GI.

96/19 Q1 Quality Report – 2019/20

The Director of Nursing presented the Q1 Quality report, recognising that a number of quality key performance indicators (KPIs) sit alongside the integrated performance report.

The key updates were:

- Section 3.1 includes an overview of external agency visits, inspections and accreditations and the oversight of this goes to Quality Committee
- Serious incidents report monthly into the Quality Committee and the risk management team is undertaking a deep dive into the outstanding actions, there will be an oversight of lessons learnt and service changes
- Schwartz rounds process has started and has been positive; this is a multi-disciplinary meeting where patient quality of care can be discussed in a safe place
- Patient experience and caring group – the report includes examples of reports received into this group
- Quality Committee received reports from Divisional Patient Safety and Quality Boards, work to strengthen these links is ongoing
- Quality Account priorities update included in report

AG highlighted the two ‘must dos’ and seven ‘should do’ CQC actions and explained the difficulty to address the two must dos before reconfiguration, referencing table 8 of the report which highlights the Emergency Department (ED) waiting times were worse in Q1 2019/20. The Chief Operating Officer explained attendances were high and this was seen nationally in Q1. Winter plan innovations are being implemented recurrently all year and policies and procedures are available to escalate when under pressure, and this escalation needs to take place each time the pathway is not followed. Senior clinical triage is being implemented 24/7 in ED. CHFT had the highest number of patient attendances with a mental health problem in West Yorkshire which is a significant contribution to the 4-hour breaches. There is recognition by CQC that there aren’t enough ED consultants. The Trust is comfortable with the position if patient safety outcomes are monitored closely.

The Chief Operating Officer provided an update on the must do action regarding ICU consultant cover. She explained a plan was agreed four weeks ago to implement a model as a mitigation which was offered to CQC. This was the safest option ahead of the reconfiguration and will be kept under close review.

OUTCOME: The Board **NOTED** the Q1 quality report and the quality review is planned to take place in Q2.

97/19 Safeguarding – Adults and Children Annual Report

The Director of Nursing presented the key points of the safeguarding annual report for adults and children in a presentation.

AG thanked the Director of Nursing for condensing the key updates down into a presentation which was easier to understand. He highlighted there are no findings of learning disability in the annual report and the Trust need to implement these findings to keep up the good work. He explained the conclusion in the annual report refers to 2018/19 and this should be 2019/20. The Director of Nursing confirmed the learning disability workstream will be made clearer in the workplan.

LP highlighted the good relationships with external partners and explained the legislation is changing again and new training will be rolled out.

OUTCOME: The Board **APPROVED** the Safeguarding Adults and Children Annual Report.

98/19 Care Quality Commission (CQC) Update

The Director of Nursing provided a verbal update on care quality commission (CQC) and confirmed a written report will be provided for future meetings.

The Director of Nursing explained a CQC response group has been in place for some time, to review all the findings from the CQC reports and provide oversight of where the Trust is achieving actions to become compliant. This group has a significant impact and reports directly into Quality Committee.

The next step for the Trust is to move from 'Good' to 'Outstanding' and all Divisions have been asked to undertake a gap analysis by calendar year end. Peer reviews have started, inviting neighbouring Trusts who are outstanding to undertake a deep dive for the Trust and the assurance visits are piloting a change to directly map across to CQC domains and 'must do' compliance.

The Director of Nursing explained the development of a CQC portal on the intranet which includes all accreditations and outstanding reports from other organisations.

The Trust is waiting for confirmation from CQC on any updates to the well-led framework and the use of resources. The Director of Nursing confirmed the shift is moving towards the culture of the organisation with a focus on 'Freedom to Speak Up'. The Trust will undertake a table top review of the well-led framework and an external well-led developmental review will then take place. This review will be scheduled at a Board workshop.

AN asked if it is possible to understand what outstanding looks like and if there is a tangible measurement. The Director of Nursing confirmed all the CQC frameworks and guidelines are readily available with key characteristics of what outstanding looks like. Very few organisations were rated outstanding for safe and she explained it is difficult to become outstanding in the safe domain being a large organisation. CHFT are very close to becoming outstanding in the caring domain.

Lynn Moore asked if there is an area on the portal for staff to comment. The Director of Nursing explained there are a range of forums for staff to raise their comments / concerns. The portal will include key themes. The Director of Workforce and OD confirmed that use of the Freedom to Speak Up guardian portal has improved and there have been over 60 concerns raised. CHFT has the highest number of freedom to speak up ambassadors compared to other Trusts and an 'Ask Owen' is also in place for staff to raise questions.

RH asked if the Trust will be asking for an external peer review regarding use of resources. The Chief Executive confirmed Leeds Teaching Hospitals who were assessed as outstanding may undertake a peer review. The Director of Finance and Director of Nursing will discuss these arrangements. The Director of Nursing added the Trust are also involved in 'Go Sees' to other Trusts that are outstanding, which is one of the Trust's four pillars.

OUTCOME: The Board **NOTED** the update on Care Quality Commission (CQC).

99/19 High Level Risk Register

The Director of Nursing presented the high-level risk register which has been to the Quality Committee. The key points to note were:

- 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)

The Medical Director explained there is limited resource of consultant radiologists and four staff are moving to other organisations which presents significant challenges in interventional radiology. The mitigations are outsourcing and use of agency staff. The next West Yorkshire Association of Acute Trusts (WYAAT) meeting is focused on reviewing the radiology resources across the region and Working Together to Get Results (WTGR) sessions with radiologists have been scheduled to address this. PO added that the wider WYAAT group is key to this. It was noted that performance is still good in radiology; however, it is not clear how long this will continue to mitigate this transitional risk. The Medical Director anticipates this situation will decline towards the end of the year and there is a need for trainees.

The Chief Operating Officer highlighted the named lead of the radiology risk, (7454) needs to be reviewed and changed.

AN pointed out the high-level risk register cross references to the Board Assurance Framework need updating.

Action: Company Secretary to review lead for radiology risk and update cross references to the Board Assurance Framework

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

100/19 Board Assurance Framework (BAF)

The Company Secretary presented the latest Board Assurance Framework (BAF). The key points noted were:

- Detailed updates following individual meetings with all lead risk owners
- Movement on the Board Assurance Framework is less than on the Risk Register
- 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, this will appear on Divisional risk registers
- Risk 10/19 relating to staffing has been separated into risk 10a, relating to medical staffing and risk 10b relating to nursing staffing to allow for clarity of controls, assurance and actions for each aspect of the 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 new risk is being developed around health and safety, currently awaiting a review of the externally commissioned report on health and safety and a meeting has been scheduled in October 2019

AN pointed out the lower risk score of 12 for the capital planning risk, ref 14/19 and PO confirmed this followed a challenge at the Finance and Performance Committee that this risk was too high at a 16 and is currently a 12 on the BAF.

AG highlighted that risk 14/19 referred to the emergency capital approval being imminent the end of August 2019. The Deputy Director of Finance confirmed the emergency capital bids have been approved which helps to reduce this risk.

RH highlighted the risk appetite statement is still dated October 2016 and needs to be updated and that the summary risk 01/19 had a target score of 15 which should be 10.
Action: Company Secretary to update

RH asked if the workshop to be held in December 2019 can pick up the benchmarking that has taken place on the BAF and high-level risk register. The Company Secretary confirmed this will be developed as part of this review and will include the risk appetite statement.

AG highlighted the risk of a no-deal Brexit increasing. He suggested that this is on the high-level risk register. The Chief Operating responded there is a weekly group meeting taking place which considers risks and a verbal update will be provided in private.

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

101/19 Safer Staffing Hard Truths Report

The Director of Nursing presented the interim progress report on safer staffing hard truths prior to the annual report, the key updates were:

- Well-embedded robust annual strategic staffing review in place across all clinical areas
- Level of detail at operational level to ensure 'right staff at the right time in the right numbers' – clear escalation and communication across the organisation
- Fill rates have been maintained over the last year
- Care hours per patient day – maintained performance between 7.5 and 8.6 on average and reviewed the split between qualified and unqualified, this is monitored on an ongoing basis
- Sickness and turnover rates are in line with national best practice – unqualified higher than registered nursing workforce
- Right skills – developing a comprehensive learning need analysis at the Workforce Delivery Board
- Skill mix – number of trainee nurse associates and six qualified nurse associates, enhanced care providers and co-ordinators to support the registered nurses
- Concern regarding vacancies – recently welcomed 30 nurses from the Philippines
- Bi-annual staffing review – concerns on ward 10 and Emergency Department, ensuring that these areas are supported and issue around maternity staffing levels
- Fill-rate and patient care hours per day are as expected
- Continue to work with staff to speak out safely if there are any concerns

RH referred to a review presented at Finance and Performance Committee last year and asked if the Trust is overstaffing to achieve a higher staffing fill rate than necessary. The Director of Nursing responded that benchmarking is difficult regarding fill-rates and staffing levels are set against best practice guidance. The Trust is performing well across West Yorkshire in the percentage of registered nurses. Future reports will map across fill rates to nursing quality indicators.

AN asked if there is good succession planning in place. The Director of Workforce and OD explained this is work in progress and a retention planning toolkit is being introduced.

The Chief Operating Officer described a piece of work to look at how many external appointments have been made into these roles compared to internal colleagues being promoted (leadership). There is a need to ensure the leadership element is there for early promotion into senior roles.

AG asked if the Trust is recruiting locally through colleges and universities and if there is a trajectory. The Director of Nursing explained the overseas recruitment will continue as part of the recruitment strategy. Appointing nursing associates provides a longer retention period and the aim is to ensure the standards of the working environment is maintained. She explained nursing retention is related to how staff feel at work and if you can demonstrate patient outcomes, retention rates rise. There will be no single strategy for nursing and "The Cupboard" includes developing our own talent and career paths.

AG asked if there will continue to be 150 vacancies in March next year or if there is a target. The Director of Workforce and OD confirmed the vacancies are in the plan to be filled; therefore, the target is 0 vacancies. The national vacancy rate is at 11% and the Trust is at around 9%, this is a national issue.

Lynn Moore asked if the vacancy rate has always been at this level at this time of the year due to student placements. The Chief Operating Officer explained the vacancy rate is static throughout the year and the Trust overrecruit in some areas to even this out.

PO asked for an update on WTE vacancies. The Director of Nursing confirmed work on bank has taken place to fill in rotas which provides continuity. Part of the strategy was to turn this around from agency. The Director of Nursing confirmed the use of bank will be included in the report going forward.

OUTCOME: The Board **APPROVED** the Safe Staffing Hard Truths Report.

102/19 Winter Plan 2019/20

The Chief Operating Officer presented the winter plan which has been built on from 2018/19. The key points to highlight were:

- Winter Plan describes the roles and responsibilities
- Ownership is needed from partners to trigger escalation
- Funding has been used from the aligned incentive contract from CCGs to fund the work around frailty
- Internal winter money is being used to fund what worked last winter
- The bulk of schemes are implemented recurrently, some schemes are non-recurrent i.e. norovirus
- Work has taken place to ensure there are effective key performance indicators (KPIs) – impact on patient experience and safety
- Senior decision makers are included in the pathway
- Page 7 of the winter plan describes different innovation schemes
- Deep clean programme to ensure all prioritised inpatient wards are fully deep cleaned
- Senior decision makers in triage in ED have been recruited recurrently, this is non-recurrent funding from a winter funding perspective and will need to be worked through at the next budget setting meeting
- Training of triage nurses to stream services by asking the right questions for care
- To note the external emergency care transformation funding has an emergency care hub which is being worked through to have direct access from triage to community pharmacy
- Command and control arrangements will be in place through to end of April 2020
- Reduced outpatient capacity and re-directed clinical staffing for emergency care
- Winter plan of partners has been requested

- Showcase is taking place on Thursday 3 October during the Board workshop where there will be stalls on both main sites and in the community, partners have been invited to share their plans at the stalls

AN asked if the budget is available for the recurrent schemes. The Chief Operating Officer confirmed there has been a further increase in frailty as the budget wasn't available recurrently, the Trust are still on a journey.

AN asked if there have been many changes to last year's plan. The Chief Operating Officer clarified the Trust have reviewed what worked well last year and has included a further development around frailty with a dedicated frailty assessment area.

The Chief Operating Officer explained the support with community clinics who have rapid access into the frailty assessment clinic, there has been a trial in primary care networks. There is also funding for high risk patients who are in their last year of life to receive an advanced care plan. The current default is for these patients to be admitted through the Emergency Department.

AG asked how operational pressures escalation level (OPEL) alerts are managed and if this is a decision made by the Trust as there has been previous disagreement with local authorities not sharing our view. The Chief Operating Officer confirmed there is clarity for every partner on the triggers and responses for OPEL. This will be discussed at the A&E Delivery Board.

OUTCOME: The Board **APPROVED** the Winter Plan 2019/20.

103/19 Integrated Performance Report – July 2019

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

- Emergency care standard – improved position last month above 91%
- Referral to treatment, RTT delivered in July 2019 against 92%, this is the last report for RTT incompletes and an RTT field testing update will be provided in future months
- Specialty by specialty RTT – issue with choose and book appointments being cancelled and not re-scheduled, these are now back on the appointment slot issue, ASI list, the RTT clock was inaccurate for this cohort of patients and a piece of work has taken place for all specialties, as a result two patients passed the 52 weeks wait, NHS Improvement, NHSI were alerted to this issue
- Achieved all cancer standards – on the back of the radiology pressures
- Complaints performance has deteriorated in July following improvement in June
- Fractured neck of femur – Trauma and Orthopaedic surgery (TNO) team attended the performance review this week and presented a compelling presentation which highlighted the Trusts delivering the best within 36 hours are not delivering the best outcomes, the outcomes at CHFT have improved and a more detailed evidence base has been requested on CHFT's patient outcomes
- Concerns in stroke - early intervention has taken place and the stroke team are attending the next performance review meeting

PO asked for an update on length of stay. The Chief Operating Officer reported on the 21 day length of stay review which has moved away from national targets and partners are included in these reviews. This is seeing a step change improvement with weekly patient reviews. There has been an agreement with NHSI to review 7 day and 21 day stays which are of different volumes.

AG acknowledged the Trust have no domains in the red and passed on his congratulations to the staff who are consistently delivering performance. The Chief Operating Officer agreed to pass on a formal thank you to the team.

OUTCOME: The Board **APPROVED** the Integrated Performance Report – July 2019.

104/19 Update from sub-committees and receipt of minutes & papers

Finance and Performance Committee – minutes from the meeting 28.6.19 & 26.7.19

PO, Chair of the Finance and Performance Committee explained the key points from the previous Finance and Performance Committee have already been discussed.

Audit & Risk Committee – minutes from meeting 17.7.19

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

- KPMG qualified indicator on A&E 4 hour waiting times – further exercise carried out on 350 patients and there is now assurance that the indicator is being correctly reported
- Reviewed the clinical audit procedures and benchmarking which provides a cross reference between committees
- The revised Audit and Risk Committee terms of reference were approved with a change of membership to include the Managing Director for Digital Health
- Deep dives will take place at future meetings to focus on topics such as data quality and cyber risks

Quality Committee – minutes from the meeting held 1.7.19

LP, Chair of the Quality Committee provided an update from the last meeting. The key points to note were:

- Lots of work on medication safety and compliance undertaken by Lis Street, Clinical Director in Pharmacy
- Work around fractured neck of femur has been discussed

Workforce Committee – minutes from the meetings held 7.6.19 & 6.8.19

The Director of Workforce and Organisational Development provided a verbal update from the last meetings, the key points to note were:

- Two positive meetings in terms of performance
- Concerted effort on leadership development
- Agreed hot house topics – leadership, quality of appraisals, inclusion, freedom to speak up, how to escalate items from Performance Review Meetings

Council of Governors meeting – minutes from the meeting held 18.7.19

The Chair provided a verbal update from the last meeting, the key points to note were:

- Hand over from Alison Schofield to Brian Moore as new Lead Governor
- Governors have been contacted to review the constitution and have been provided with details of the West Yorkshire vascular consultation

Charitable Funds Committee – minutes from the meeting held 22.5.19

The minutes of the previous meeting were received.

A&E Delivery Board – minutes from the meeting held 12.3.19

The Chief Operating Officer confirmed the minutes reflect an accurate record.

OUTCOME: The Board **NOTED** the minutes of the various sub-committees.

105/19 Governance Report

The Company Secretary highlighted 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.

OUTCOME: The Board **APPROVED** the revised Audit and Risk Committee terms of reference.

106/19 Month 4 Financial Summary

The Executive Director of Finance presented the month 4 financial summary, the key updates were:

- Year to date on track against the financial plan and forecast delivery of plan
- Cost Improvement plans (CIP) are slightly ahead of plan year to date
- Clinical contract income is £0.01m 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
- Budget holder accountability and engagement work is ongoing with Divisions
- There remains a balance of risks and opportunities at a Trust level and the forecast assumes full delivery of the planned overall £11m cost improvement programme (CIP)

PO added the activity is down on the aligned incentive contract and there is a piece of work to understand what is driving the change in activity e.g. change of pathway. The year-end performance is dependent on Integrated Care Systems (ICS) funding, year to date £3m ahead of plan.

OUTCOME: The Board **NOTED** the Month 4 Financial Summary.

107/19 Any Other Business

The Chair explained it is Organ Donation week and an update will be provided at the next Non-Executive Director and Governors informal workshop on Thursday 26 September 2019.

Date and time of next meeting

Date: Thursday 7 November 2019
Time: 9:00 – 12:30 pm
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital.

5. Action log and matters arising

To Note

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 30 Oct 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
5.9.19 100/19	**Board Assurance Framework (BAF)** Company Secretary to update the Risk Appetite Statement in the Board Assurance Framework	AM	This is planned for a Board workshop on the 5 December 2019	November 2019		Oct 19
5.9.19 99/19	**High Level Risk Register** Company Secretary to review leads for radiology risk and update cross references to the Board Assurance Framework	AM	Completed September 2019	November 2019		Sep 19
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	This is complete and included in the GOSWH report for November 2019.	November 2019		Nov 19
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	Verbal update reported under matters arising. Action closed.	September 2019		5.9.19
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	Completed and a further update will be provided in November 2019.	September 2019		5.9.19
4.7.19 72/19	**Care Quality Commission (CQC) Update** Update on use of resources and well led at the next meeting	EA	Verbal update provided and a written report will be provided in future meetings.	September 2019		5.9.19
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	AM	This is being scheduled at the joint Board / Council of Governors workshop on 22 November 2019.	September 2019		5.9.19

6. Chair’s Report

a. Council of Governors Nominations and Remuneration Committee – Non-Executive Director Appointments

b. WYAAT 18/19 Annual Report Summary

To Note

Presented by Philip Lewer

West Yorkshire Association of Acute Trusts

Our progress and achievements during 2018/2019

West Yorkshire Association of Acute Trusts

West Yorkshire and Harrogate Health and Care Partnership

What is the West Yorkshire Association of Acute Trusts (WYAAT)?

WYAAT is a collaboration of six NHS trusts who deliver acute hospital services to 2.6 million people across West Yorkshire and Harrogate.

We're part of the wider **West Yorkshire and Harrogate Health and Care Partnership**. WYAAT gives us a strong and consistent voice within the Partnership.

Our vision is to provide a region-wide, efficient and sustainable healthcare system that uses innovation and best practice for the benefit of patients.

We're working together because we believe we are stronger together.

We are all hugely committed to WYAAT, demonstrated by the £2m budget we provide to support collaboration through WYAAT and the extensive time invested by our staff, including clinicians, on the work we do together.

The time we spend working across our trusts has grown substantially to the extent that we all now view it as part of our everyday business. WYAAT does not deliver programmes for the trusts - we deliver them together, supported by the WYAAT programme management office.

We are very proud of the work we are doing through WYAAT. The decisions we have been able to take together, the progress our various projects are making, and the strength of the WYAAT voice nationally shows that an association of trusts is an effective way of working to bring about better services for our patients.

It also helps us deliver the best possible experience and outcomes for our patients and populations, one of the main reasons we exist.

The following pages give you an overview of our work during 2018/19.

Airedale NHS Foundation Trust

Andrew Gold
Chair

Brendan Brown
Chief Executive

Bradford Teaching Hospitals NHS Foundation Trust

Maxwell Mclean
Chair

John Holden
Acting
Chief Executive

Calderdale & Huddersfield NHS Foundation Trust

Philip Lewer
Chair

Owen Williams
Chief Executive

Harrogate & District NHS Foundation Trust

Angela Schofield
Chair

Steve Russell
Chief Executive

Leeds Teaching Hospitals NHS Trust

Linda Pollard
Chair

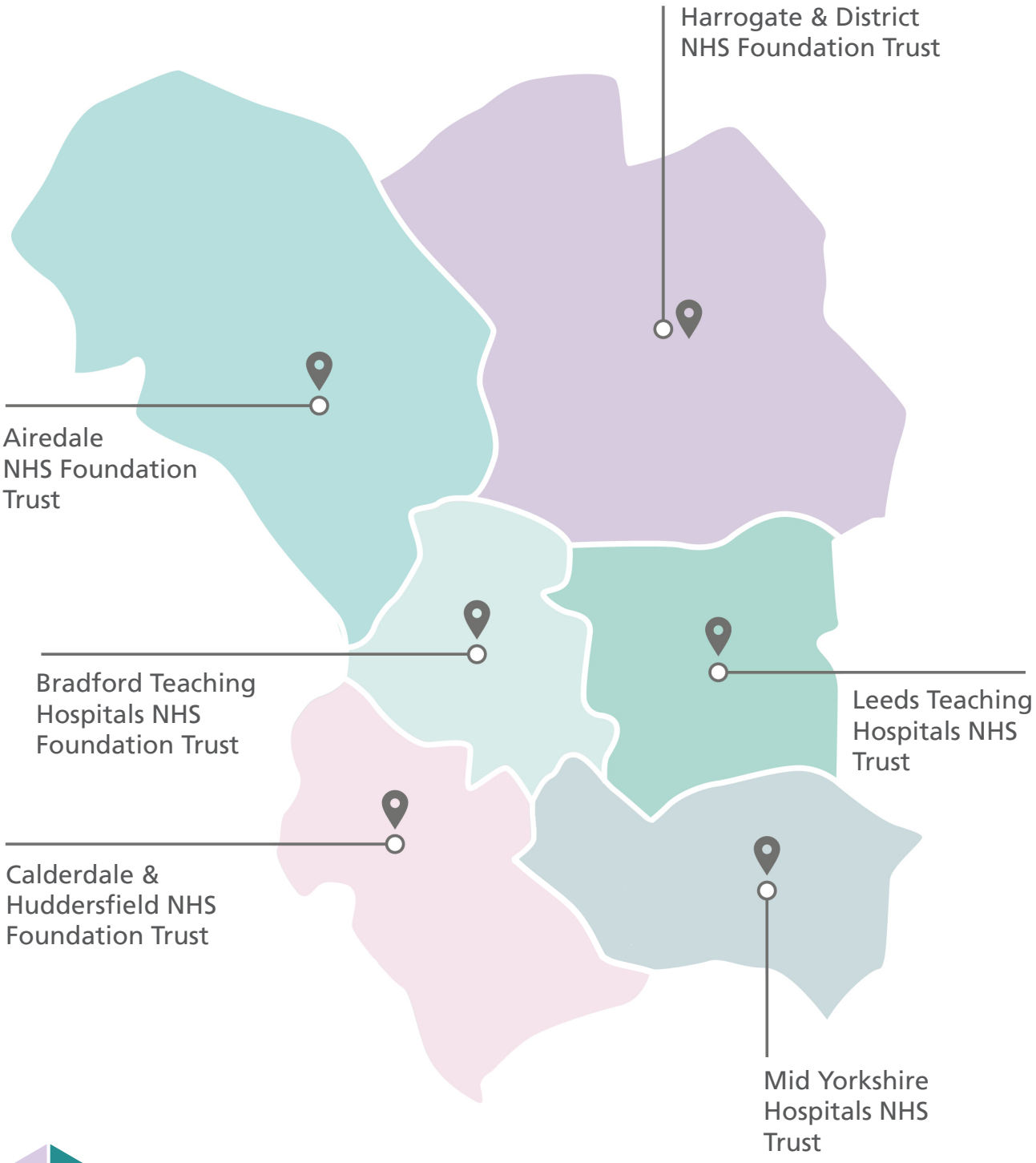
Julian Hartley
Chief Executive

Mid Yorkshire Hospitals NHS Trust

Keith Ramsay
Chair

Martin Barkley
Chief Executive

September 2019



The West Yorkshire Association of Acute Trusts
is made up of six trusts working closely together
to deliver health and care services across the area.

Procurement

Benefits for patients

This programme brings together procurement specialists from the WYAAT hospitals to identify areas where our combined strength in the region can be used to save money by standardising products.

Achievements in 2018-19

The programme saved over £1m by having consistent products across all WYAAT trusts and using the increased volume to obtain better prices from suppliers.

We have standardised a variety of products across our trusts, including surgeons' gloves which has ensured clinical staff can use the same gloves in any hospital in the region and saved over £200,000

We appointed a procurement lead to help increase capacity and reduce costs.

Plans for 2019-20

- Further focus on reviewing services to bring about greater regional collaboration, avoid duplication and improve service quality.
- Deliver further savings by continuing to standardise more products and services.
- Complete the development of a regional procurement model.

Information Management and Technology

Benefits for patients

This programme is about using information technology to improve and transform our services, patient facing and support services, to enable better care for our patients.

Achievements in 2018-19

We started work on migrating all WYAAT trusts to a common e-mail system which will help collaboration between trusts and ensure they are GDPR compliant, more efficient and resilient.

We began looking into a common e-rostering solution for the workforce in all WYAAT trusts.

We started designing technology so that health and social care data can be shared across all organisations.

Plans for 2019-20

- Complete the migration to the common e-mail system.
- Support trusts to progress the sharing of health and social care data.
- Support the purchase of a common Laboratory Information Management System for pathology services across WYAAT.

Programmes

Scan4Safety

Benefits for patients

Scan4Safety uses barcodes and scanning technology to track patients and products across the trusts - improving patient safety whilst reducing the cost of care. It also improves data quality in patient records and administrative systems.

Achievements in 2018-19

The programme was allocated £15m capital funding to bring in Scan4Safety across WYAAT trusts.

Leeds Teaching Hospitals Trust hosted a live demonstration of the system and its benefits.

Work began across all WYAAT trusts to start preparing to introduce Scan4Safety.

Plans for 2019-20

- Build teams in each trust to deliver and run Scan4Safety.
- Establish the physical and IT infrastructure to support Scan4Safety.
- Work with each trust to build in scanning at point-of-care.

"Scan4Safety allows us 24/7 tracking of our patients enabling our endoscopy, radiology and theatre teams to be as efficient as possible. It allows our clinicians to manage their patients more closely and safely".

David Berridge,
Leeds Teaching Hospitals Trust
Deputy Chief Medical Officer.

Workforce

Benefits for patients

The workforce programme aims to help the trusts implement common, consistent, top quality employment practices to deliver sufficient staff in the right roles to provide care to our patients.

Achievements in 2018-19

The WYAAT trusts have reached agreement to make it easier for staff to work across all six organisations to provide the best possible services for patients and to help their own personal development.

The trusts have agreed that those who are competent to carry out roles and are already cleared to work in one organisation, can work in another WYAAT trust without the need for an honorary contract and all the associated checks.

Plans for 2019-20

- Having a cohesive voice on behalf of the WYAAT trusts feeding into the National People Plan and working together to make it happen.
- Field testing a workforce development tool, via the West Yorkshire and Harrogate Health and Care Partnership, which will support and enable transformation of the workforce.
- All trusts signed up to the national core skills mandatory training framework.
- Alignment of the clinical support worker role profile.
- Developing a collaborative medical bank to offer more opportunities for additional work, particularly to our junior medical staff, and reduce the use of agency doctors.
- Signing all trusts up to a standard apprenticeship pay framework.

"I think we're incredibly fortunate to operate in the environment that is created and fostered by the Partnership and by WYAAT. It feels like an environment in which collaboration, respect, support and peer challenge are promoted and I think that's an incredibly important enabler for us to do our work in our places".

Steve Russell,
Chief Executive for Harrogate and District NHS Foundation Trust

Programmes

Pharmacy

Benefits for patients

Patients will benefit from the improvement of the medicines supply chain serving the six WYAAT hospital trusts and three partner hospital trusts. This includes reducing operational costs, driving forward innovation, managing risks in the supply chain and making sure the service can meet future challenges and demands.

Achievements in 2018-19

We concluded work to investigate the potential for a partnership with a commercial supply chain organisation. We decided that the benefits were not sufficient to outweigh the risks. The work has demonstrated the benefits of a shared approach to pharmacy services and we will now focus on collaborative opportunities between our pharmacy services.

Plans for 2019-20

- Further opportunities for working together within pharmacy services and developing them into a new pharmacy programme to benefit patients.

Pathology

Benefits for patients

This programme plans to develop a network for pathology services in West Yorkshire and Harrogate. It will address challenges around staffing and increasing demand, investment in new technology and ways of working so that patients get the highest quality service.

Achievements in 2018-19

Pathology clinical and scientific leads worked together to develop the case for a pathology network in West Yorkshire and Harrogate. The case was formally agreed by the trusts in January 2019.

We also obtained permission to build a new pathology laboratory at St James's University Hospital and were allocated funding to bring in new technology to store, share, report and analyse microscope slides digitally.

Plans for 2019-20

- Develop and assess the options for the best approach to deliver the new pathology network, with increased staff involvement and engagement.
- Start the procurement of a common Laboratory Information Management System to allow trusts to work together and ensure they all have access to the latest technology.
- Start the process to build a new pathology laboratory at St. James's University Hosital in Leeds.

Radiology - Yorkshire Imaging Collaborative

Benefits for patients

The Yorkshire Imaging Collaborative works across the six WYAAT trusts and three regional partner trusts to provide an integrated radiology service that is responsive to the needs of patients across all our hospitals. Using common approaches and technology we will be able to deliver patient images and reports wherever patients receive their care within the network.

Achievements in 2018-19

We held workshops on common practices, processes, workforce and shared core services with clinicians and managers which generated a wide range of ideas for improved ways of working.

We started to establish 13 regional expert groups to improve radiological practice around clinically important and difficult subjects, and statutory targets such as cancer and stroke.

Gained agreement to release the £6.1m of capital funding allocated to West Yorkshire and Harrogate to develop a shared radiology reporting system to help with management and image reporting across WYAAT trusts.

Successfully deployed the Agfa Enterprise Imaging system for viewing radiology images in Harrogate and District NHS Foundation Trust and North Lincolnshire and Goole NHS Foundation Trust.

Plans for 2019-20

- Appointment of a clinical fellow to the programme team.
- Fully establish and maintain the 13 regional expert groups to create common imaging protocols, patient advice, post procedural and safety documents, imaging pathways and reporting standards so that new technology can be shared.
- Complete the procurement of a common reporting system across WYAAT trusts for sharing radiology images and reports.
- Deploy Agfa Enterprise Imaging into Airedale NHS Foundation Trust, Calderdale & Huddersfield NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust. Complete the planning for deployments at Leeds Teaching Hospitals NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust.

Key Achievements in 2018-19

Vascular

Agreeing to create a single integrated vascular service for the region to provide consistent and expert treatment for patients

Procurement

Saving £1m by using standard medical products across all WYAAT trusts and leveraging cheaper prices from suppliers

Radiology

Releasing £6m capital funding for a shared radiology reporting system with the aim of improving care for patients

Since the end of 2016 WYAAT has created a series of programmes covering corporate and clinical support and clinical services, each with its own management team.

Service Sustainability

Securing funds from NHS England to allow WYAAT clinicians and managers to work together to improve services for patients

Pharmacy

Concluding our work to investigate a shared regional supply chain for medicines

West Yorkshire
Association of Acute Trusts

Elective Surgery

Making pre-surgery arrangements standard for hip and knee replacement patients to provide a more consistent service

Scan4Safety

Releasing £15m funding to use barcode technology to safely track patients and products across all WYAAT trusts

Patients are at the centre of everything we do. By sharing resources, expertise and innovation we can collectively provide a better service for all our patients throughout West Yorkshire and Harrogate.

Workforce

Transferring workforce skills by making it easier for staff to work in any of our hospitals and services

Pathology

Agreeing to establish a single West Yorkshire and Harrogate pathology network enabling us to improve quality and productivity

Information Management & Technology

Working together to enable health and social care data to be shared across all trusts

Programmes

Service Sustainability

Benefits for patients

Identifying the services that are most at risk of being unsustainable and finding the best way to address those risks.

Achievements in 2018-19

Identified three services that were at risk of being unsustainable – ophthalmology, dermatology and gastroenterology – and developed programmes to address this.

Successfully bid for funding from NHS England to create networks to allow WYAAT clinicians and managers to work together to improve services.

Plans for 2019-20

- Begin developing a new service model for ophthalmology across all care settings with staff and patients.
- Create clinical service networks in cardiology, maxillo-facial surgery and urology.
- Carry out diagnostic reviews in paediatric surgery and oncology following concerns about sustainability.

Elective Surgery

Benefits for patients

This clinically-led programme aims to deliver clinical excellence while providing a consistent best value-for-money service for orthopaedic patients across the region.

Achievements in 2018-19

A standard West Yorkshire and Harrogate commissioning policy has been developed and agreed with our clinicians for hip, knee and shoulder surgery.

Theatre teams in all six trusts shared best practice and innovation across their orthopaedic theatre teams to develop a model to increase productivity and capacity to enable us to do more orthopaedic operations.

We have standardised pre-surgery patient education information and are investigating making it available through an “app”.

Plans for 2019-20

- Complete the introduction of standard patient educational materials across all trusts.
- Embed and expand the plan for making more efficient use of theatre lists.

West Yorkshire Vascular Service

This programme aims to create a single West Yorkshire Vascular Service for Airedale, Bradford, Calderdale and Huddersfield, Leeds and Mid Yorkshire NHS Trusts, with two arterial centres in line with the recommendations of the Yorkshire and Humber Clinical Senate.

Achievements in 2018-19

To provide consistent and expert treatment for patients, WYAAT unanimously recommended to NHS England that the preferred option for the second arterial centre in West Yorkshire (alongside Leeds General Infirmary) should be Bradford Royal Infirmary*.

The appointment of a clinical director, general manager and head of nursing to oversee the development and running of the West Yorkshire Vascular Service.

Plans for 2019-20

- Clinical staff engagement over the recommendation to NHS England of Bradford Royal Infirmary as the preferred option for the second arterial centre in West Yorkshire.
- Continued work to design and deliver an integrated single vascular service.
- Increased and ongoing engagement with West Yorkshire Vascular Service staff.

* This recommendation is subject to public consultation by NHS England during 2019.

West Yorkshire & Harrogate Health & Care Partnership

Cancer Alliance

The WYAAT trusts are key partners in the West Yorkshire and Harrogate Cancer Alliance and a particular focus in 2018-19 was on improving the cross-trust performance of the 62-day target for the start of treatment.

Other key actions this year have included:

- Inter-hospital transfer policy to streamline referral pathways
- Developing pathways and clinical guidelines for the main tumour groups
- Detailed analysis and improvement of prostate, colorectal and lung pathways.

For 2019-20 the trusts have asked the Cancer Alliance to develop an Improvement Collaborative for the prostate and lung cancer pathways.

The Partnership

WYAAT's second role is to provide a strong and consistent acute trust voice into the West Yorkshire and Harrogate Health and Care Partnership. Over the last year this has been in two main areas: the development of West Yorkshire and Harrogate as an integrated care system; and the development of a clinical strategy for West Yorkshire and Harrogate.

West Yorkshire and Harrogate Integrated Care System

In May 2018 NHS England announced that West Yorkshire and Harrogate would be one of the second wave of shadow integrated care systems. Over the last year, the WYAAT trusts and senior leaders have played a significant part in the further development of our Health and Care Partnerships. WYAAT was also allocated significant funding, in particular £4m for a second "West Yorkshire Acceleration Zone" to sustain urgent and emergency care performance over winter 2018/19.

West Yorkshire and Harrogate Clinical Strategy

The aim of the West Yorkshire and Harrogate Clinical Strategy is to develop an outline description of the future West Yorkshire and Harrogate health and care system. Firstly it

connects our vision and ambition to the programmes of work and ensures the West Yorkshire and Harrogate local place plans are aligned.

Secondly it will help ensure that West Yorkshire and Harrogate plans and local plans (Leeds, Bradford and Airedale, Calderdale, Kirkees, Wakefiled and Harrogate) are aligned.

In 2019/20 we will be pulling together all the work we have done and reporting back on our findings and recommendations.

Governance

The WYAAT governance has been tested a couple of times during 2018-19, the most challenging being the work on the West Yorkshire Vascular Service.

The decision to end the pharmacy regional supply chain work because we noted that the risks far outweighed the benefits, showed how robust our programme management and governance is.

We believe our ability to take collective decisions, and the strength of WYAAT's voice regionally and nationally, shows that an association of trusts is a good alternative to mergers and other structural changes to deliver collaboration between organisations.

Financial Position 2018-19

Total spend in 2018/19: **£1.5m**

WYAAT Funding: **£1m**

Other funding (West Yorkshire and Harrogate, Health Education England and non-WYAAT trusts): **£0.5m**

In Conclusion

This year we have seen our programmes move forward, with a number gaining key approvals and securing capital funding.

Our portfolio of programmes has grown, particularly those in clinical services where the trusts have all recognised the great benefits of working together.

We've also cemented our position at the heart of the West Yorkshire and Harrogate Health and Care Partnership which in turn has attracted significant funding to help transform our work – and key leadership roles being taken by WYAAT chairs and chief executives.

We advance into 2019-20 with another year of collaborative working under our belts bringing with it further benefits for our patients and staff.

For more information about WYAAT please go to our website: **www.wyaat.wyhpartnership.co.uk**

wyaat.wyhpartnership.co.uk

@WYAAT_Hospitals

West Yorkshire
Association of Acute Trusts

A collaboration between:
Airedale NHS Foundation Trust,
Bradford Teaching Hospitals NHS Foundation Trust,
Calderdale and Huddersfield NHS Foundation Trust,
Harrogate and District NHS Foundation Trust,
Leeds Teaching Hospitals NHS Trust,
Mid Yorkshire Hospitals NHS Trust.

The West Yorkshire Association of Acute Trusts is part of
West Yorkshire and Harrogate Health and Care Partnership

7. Chief Executive’s Report

To Note

Presented by Owen Williams

8. Patient Story – Marilyn Rogers, Midwife – Success of CHFT in improving breast feeding over the years

To Note

9. Guardians of Safe Working Hours Quarterly Report

Presented by Dr Anu Rajgopal

To Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title:	Guardian of Safe Working Hours, Q2 report
Author:	Anu Rajgopal, Guardian of Safe Working Hours
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	None

Actions Requested:

- To note the key points and approve the report

Purpose of the Report

To provide a report from the Guardian of Safe Working to the Board on the safety of doctors' working hours and rota gaps as required under the terms and conditions of the 2016 Junior Doctor Contract.

Key Points to Note

All Doctor in Training rotas are complaint with the national contract.

Significant Registrar gaps exist within Paediatrics and A&E.

Exception reports are being managed within the required timescales. main concerns are lack of dedicated time in work schedules for mandatory training and staff shortages.

EQIA – Equality Impact Assessment

The medical workforce is ethnically diverse. Analysis has been included by ethnic group and gender to ensure that any differential impacts on trainee doctor working has been noted and understood. A similar analysis has been completed for disability. Due to the nature of this group the age range is limited to young adults, largely in their twenties.

Recommendation

The Board is asked to note the key points and approve the report.

Q2 report: (1st July-30th September 2019)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

There is an increase in exception reports (ERs) this quarter reflecting the start of new foundation trainees in August. The reports have been submitted from a wide range of specialities, suggesting that our juniors are engaging with the process and are being supported within their divisions. Majority of the ERs are being dealt within the required time frame and the escalation process is followed as required. The main theme flagged up in ERs is the lack of dedicated time in work schedules for mandatory training and staff shortages.

There are significant registrar-grade gaps in A/E and Paediatrics which are being managed with the help of a new rota system and advanced nurse practitioners respectively. The number of unfilled locum vacancies shows a significant decrease with a proportional increase in bank locums.

The recommendations from the 2018 review of the junior doctors' contract are being implemented as per the required schedule. All our current rotas at CHFT are compliant.

Essential data Q2:

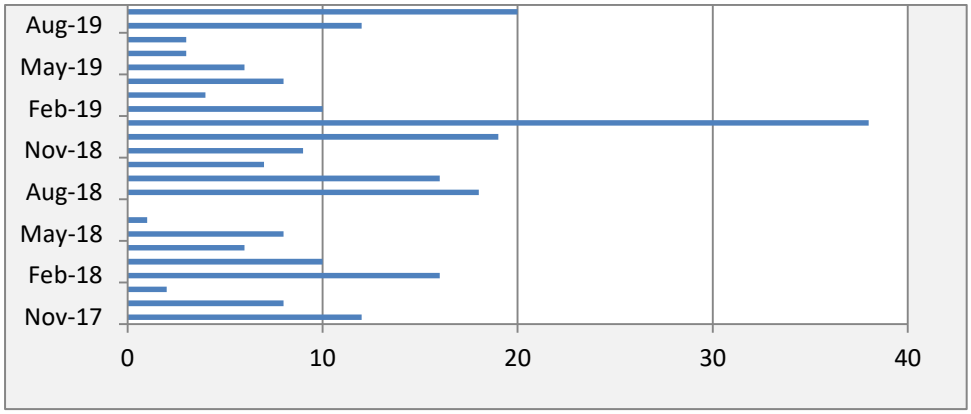
1. Number of training posts (total)	240.6 FTE budget for trainees
2. Number of doctors / dentists in training (total):	241.8 FTE in post
3. Number of LTFT trainees (total)	15.8 FTE
4. Number of training post vacancies (total)	0
5. Number of trainees by site	HRI 89.3
	CRH 89
	UK 63.5 FTE

Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns	Total hours of work and/or pattern	Educational opportunities/ support	Service support available	TOTAL
July	0	3	0	0	3
August	0	11	0	1	12
September	0	19	1	0	20
Total (Q2)	**0**	**33**	**1**	**1**	**35**

Number of monthly exception reports (2017-current)



Trends in Exception Reporting

The number of ERs increased in September (20 in total), which reflects a trend seen in previous years following on from the new foundation doctors coming into post in August. All exception reports this quarter are from junior trainees (FY1/2, CT, ST1/2), the majority from foundation doctors. The ERs have been submitted from nine different specialities within the Trust, reflecting wide engagement with the process; the majority from general surgery (10/35). There is an increasing trend of ERs reported due to inadequate time in work schedules for completing Trust or HEE (Health Education England) mandatory training.

Resolutions

Total number of exception reports per month within this quarter resulting in:

	TOIL granted	**Payment for additional hours**	**Work schedule reviews**	**Resolved - No action required**	**Unresolved/pending**	**TOTAL**
July	3	0	0	0	0	3
August	4	6	0	0	2	12
September	1	11	0	7	1	20
Total (Q2)	**8**	**17**	**0**	**7**	**3**	**35**

A higher proportion of ERs have been resolved in a timely manner this quarter (86%) compared to previously (30%) with an increasing proportion being resolved with time off in lieu (preferred option)

Exception reports split by ethnicity and gender (Workforce data)

Ethnicity	Exceptions	Trainee Doctors	Trust
White	45.88%	55.04%	78.72%
BAME	40.00%	41.18%	15.44%
Unknown	14.12%	3.78%	5.84%

Gender	Exceptions	Trainee Doctors	Trust
Female	53.53%	52.10%	81.11%
Male	46.47%	47.90%	18.89%

Disability	Exceptions	Trainee Doctors	Trust
No	98.82%	93.70%	94.75%
Yes	1.18%	0.84%	4.07%
Not Declared	0.00%	0.84%	0.87%
Unspecified	0.00%	4.62%	0.26%
Prefer Not to Answer	0.00%	0.00%	0.05%

The data above is representative of the junior doctor population in the Trust

Work schedule reviews

Nil this quarter

Fines levied

No fines have been levied in this quarter.

	TOTAL
Balance at end of last quarter	£ 1200
Fines incurred this quarter	**0**
Cumulative total	£ 1200

JDF representatives will speak to their colleagues to identify what the funding could be used for to enhance junior doctor experience at CHFT. A popular suggestion was buying a gift for all junior doctors working on Christmas day.

Rota gaps

Summary (See Appendix 1)

In medicine, majority of the registrar-level gaps have been successfully filled with Trust doctors and currently there are only 2 gaps at ST3+, both in diabetes and Endocrinology.

A high number of registrar grade gaps persist in A/E where the rota was revised from August 2019. In the new format, the rota is split into three new rotas per site (ST4+/Speciality Dr (changed from September), ST3/FY3, and FY2/GPST/CT/ACP). This seems to be working better and there are fewer registrar-level gaps.

Paediatrics have significant gaps at registrar grade which is likely to increase due to further maternity leave. At present the ACPs cover some of these and the rest are covered by locums out of hours.

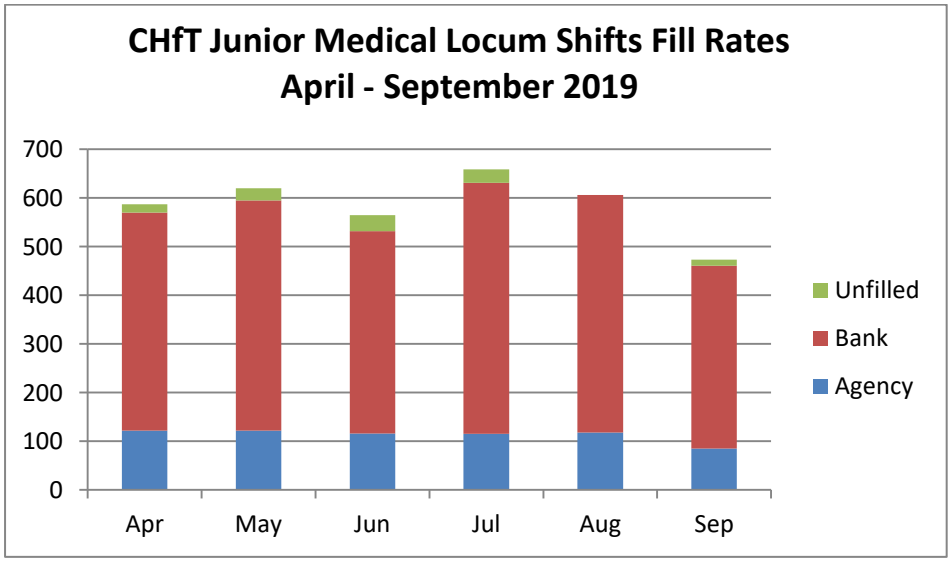
No concerns flagged up from the OBGYN rota this quarter (there is a 0.4 vacancy at ST2 level due to a LTFT trainee)

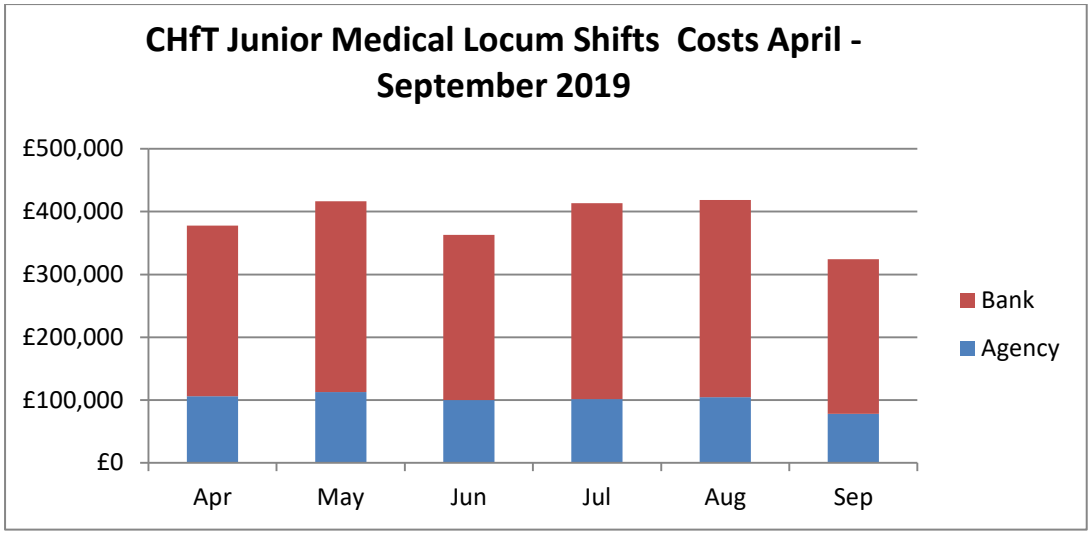
For both Urology and ENT, there is a long-term registrar gap (deanery gap and maternity leave) and a vacant Trust doctor post.

In Trauma & Orthopaedics, there are 2 trust grade vacancies (junior grade), however there are no registrar-level gaps.

Ophthalmology currently have an ongoing deanery vacancy at ST1/2 level

Locum bookings





The above data from workforce and development shows that the number of unfilled shifts has decreased and the proportional use of bank locums has increased which is a good trend and contributes to the well-being of our junior doctors.

Feedback from the regional GOSWH meeting (September 2019)

Regionally, there is a decrease in the number of exception reports. However it is not clear whether this represents fewer issues around safe working or lack of engagement with the reporting process. Most of the discussions were regarding the 2018 review of the junior doctors' contract. In the review, there is further clarity on the scope of exception reporting, the response time for ERs, safety and rest limits for junior doctors, linking the guardian fines to NHS-I rates and time frames for personalised work schedules. The review also sets down the administrative support and time required for the GOSWH role. A staggered implementation of agreed changes commenced nationally in August 2019.

All current rotas at CHFT are compliant with the 2018 review and the Trust is on-track in the implementation of the recommendations of this review

Summary from the catering survey (junior doctors)

An online survey was sent out on behalf of the service performance team to our junior doctors in June 2019. The response was poor with a minority sending free text comments. The recurring themes were the lack of hot food available out of hours, inadequate healthy/vegan/halal choices and the expensive nature of the food available . A further survey has been done in September, results are awaited. These responses were discussed at the junior doctors' forum in October.

Junior doctors' forum (JDF)

No JDF was held this quarter due to the number of apologies received.

Support for guardian role

Amount of time available in job plan for guardian to do the role: 1 PA/week

Admin support provided to the guardian (if any): Some support is provided by medical HR

Amount of job-planned time for educational supervisors: 0.125 PA per trainee

Key Issues and Summary

The current intake of foundation trainees and other junior doctor grades are familiar with the exception reporting process on Allocate software. They have had a GOSWH induction and I have been to talk to them on wards and FY1 teaching sessions as well. Although there have been no immediate safety concerns raised, staff shortages and the inability to take recommended breaks has been highlighted in some ERs. Approximately £30,000 worth of Department of Health funding is available at CHFT to support the BMA/NHS Employers "Fatigue and Facilities Charter", so there is a real opportunity in the next few months to help "enhance" junior doctors working lives whilst at CHFT.

Staff shortages continue to be flagged up as a reason for working overtime and impact on the junior doctor workload. There have been successful recruitments to Trust doctor posts in Medicine, significantly reducing the registrar-level gaps. The new three –tier rota pattern in A/E has helped fill senior trainee gaps and is working well. In paediatrics, the registrar gaps persist and are being managed in part by advanced nurse practitioners (ANPs).

Actions required by the board

The board is requested to note the 2019/20 Q2 report.

Anu Rajgopal

Guardian of safe working hours

October 2019

Appendix 1

Grade	Dept	No. of Gaps	Current Gaps	Cover arrangements	Duration of Gaps	Any anticipated concerns
ST3+	Medicine		1.4 (Maternity plus LTFT)	On-calls backfilled with locums	7 Registrar gaps till August/September. Now filled with Trust doctors or Deanery posts	None
SAS/Trust grade		1	0	Locum cover for on-calls only	Gap till Aug/mid Sept.	None
GPST		1	0	Trust doctor picking up the vacant on-calls/daytime cover	Until 7th August	None
ST3+	Surgery	1	Mat leave Deanery Gap	On-calls only covered by internal bank	22/7/10 to 1/10/19	No
ST3+	Urology	1	Deanery Gap	On-calls only covered by internal bank & Agency	3/10/18 to 1/10/19	Ongoing gap
Specialty Doc	Urology	1	Trust Vacancy	On-calls only covered by internal bank & Agency	Ongoing	Ongoing vacancy
CT 1-2	Surgery - UGI	1	Deanery Gap	On-calls only covered by internal bank	Feb 2019 to Aug 2019	No
Trust grade junior doctor	Surgery	1	Trust Vacancy	Daytime and on-calls covered by internal bank	Aug 2018 to Aug 2019	No - recruited into post.
ST3+	ENT	1	Mat leave Deanery Gap	On-calls only covered by internal bank	Feb 2019	Vacancy until April 2020
Specialty Doc	ENT	1	Trust Vacancy	On-calls only covered by internal bank	Ongoing	Ongoing vacancy
ST2	Obs and Gynae	0.4	LTFT Trainee	MTI's covering on call gap	1 year	No Concerns
ST3+	Paediatrics	3.5	2 on Mat leave 1 Reg gap 2 LTFT trainees	ACPs/locums	6-12months	further Reg gap d/t maternity
Trust grade junior	T&O	2	Trust vacancy	ACP /locums		2 trust gaps
ST1-2 level	Ophthalmology	1	Deanery	on-calls covered by trust doctor	June –May 2020	No anticipated concerns.
Speciality Doctor	A&E	3		Locums/deanery trainees if fit with the rota	July and August 2019	Rota changed
ST3+	A&E	5	Deanery gaps	Locums if needed	July 2019	
FY2/GPST/ CT	A&E	0.5	Deanery gaps	ACPs/locums if needed	July 2019	
ST3/FY3	A&E	7	4.5 deanery gaps	2 new Trust doctors going on ST3 rota from November/locums	August and September 2019	
ST4+	A&E	4	2 deanery gaps and 2 maternity leave	Locums if needed	September 2019	
FY2/GPST/ CT	A&E	0.5	Less than full time GP trainee	ACPs/locums if needed - 3 ACPs commencing from 23rd September are able to cover junior gaps	August and September 2019	
CT, SAS, ST3+	Anaesth HRI	3	Vacancy due to number of CT trainees	Extras/bank staff	August 2019 – October 2019	No gaps from Nov
SAS, MTI, CT	Anaes CRH	3	Vacancy due to trust gap	Extras/bank staff	June 2019 – present	Gap reduced to one (Nov)

10. Emergency Preparedness, Resilience and Response (EPRR) Annual Report Presented by Bev Walker, Deputy Chief Operating Officer

To Approve

NHS
Calderdale and Huddersfield
NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	Emergency Preparedness and Security Annual Report
Author:	Ian Kilroy, Resilience and Security Manager
Sponsor:	Bev Walker, Deputy Chief Operating Officer / Director of Community Healthcare Division

Actions Requested:

- To approve

Purpose of the Report

The purpose of the report is to provide the BOD an overview of CHFT Emergency Preparedness Annual Report which highlights areas of work and consolidates a resilience footprint across the wider health economy. The supporting information details are:-

- NHS England 2018-2019 - Core Standards self-review document
- Statement of Compliance against the core standards
- Agreed action improvement plan to develop the current profile to agreed standards
- CHFT Emergency Preparedness Annual Report

Key Points to Note

Background - EPRR Standards (Version 6) have developed progressively to a self-review of the changing aspects of the EPRR landscape. CHFT has routinely complied with the direction required for submission.

Overview - There have been significant improvements against the core standards since last year's submission. This year's review against current EPRR portfolio practice, identifies that there are similar significant pieces of work required going forward. The current compliance level is **Substantial** with the caveat of fully implementing the associated improvement/action plan.

EQIA – Equality Impact Assessment

The report is a look back at previous activities and completion of a declaration relation to national standards, there is no evidence of an EQIA having been undertaken previously. Activities for 19/20 will be subject to an EQIA as developed.

Recommendation

As CHFT can demonstrate:
Statement of compliance "Substantial"
NHS England EPRR Core Standards improvements/action plan
CHFT Emergency Preparedness Annual Report
EPRR strategy approach – Training, Exercises, Plans, Tests, Development

The Board is asked to **APPROVE** the Emergency Preparedness and Security Annual Report.

Calderdale and Huddersfield NHS Foundation Trust

Emergency Preparedness and Security Annual Report 2018-19

September 27
2019

1. Executive Summary

1.1. The patients and communities that we serve expect us to be there for them when they need it, irrespective of the circumstances we face. As such, we as a Trust must do all that we can to ensure we are well prepared to respond to any disruptive challenges or emergencies that we might come to face. These could be anything from extreme weather conditions, to an outbreak of an infectious disease, or a major transport accident. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR).

1.2. NHS England requires that the Board is regularly updated on its level of preparedness to deal with and manage emergency situations or periods of significant disruption to Trust services.

1.3. This report sets out, for the period April 2018 – Sep 2019:

- the Trust's governance and resource arrangements supporting EPRR;
- details of the existing EPRR Work Programme;
- incidents of note;
- tests and exercises of the Trust's emergency plans;
- training to support the EPRR work programme; and
- details of the meetings held to support EPRR

2. Governance

Accountable Emergency Officer (AEO)

2.1. The Trust's Chief Operating Officer, is the Accountable Emergency Officer with strategic responsibility for EPRR across the Trust and for providing assurance to the Trust Board that the organisation meets its statutory and legal requirements.

Non-Executive Director (NED)

2.2. The Non-Executive Director is the chair person for the Security and Resilience Governance Group with EPRR added to their portfolio.

Director of Urgent Care and Community Healthcare Division

2.3. The Director of Urgent Care and Community Healthcare Division has the tactical/operational lead responsibility for EPRR.

Emergency Preparedness Manager

2.4. The Accountable Emergency Officer is supported on a full time basis by the Trust's Resilience and Security Manager.

Emergency Preparedness Support Officer

2.4. The Resilience and Security Manager is supported on a full time basis by the Trust's Resilience and Security Support Officer.

Security, Resilience and Governance Group

2.5. The Trust has in place a Security & Resilience Governance Group (SRGG) to ensure that the Trust complies with the legal requirements of the Civil Contingencies Act; as well as fulfilling its non-statutory obligations under NHS England's Core Standards for EPRR. The SRGG routinely escalates information through the Trusts Health & Safety Committee to the Trust Board.

NHS England's Core Standards

2.7. NHS England's Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet to comply with the requirements of the NHS England's planning framework, NHS Contract and the Civil Contingencies Act 2004.

2.8. NHS England routinely writes to the Trust's Accountable Emergency Officer, setting out the expectations for the 2019/20 EPRR assurance process which NHS England used to be assured that the NHS in England is prepared to respond to an emergency and has resilience in relation to continuing to provide safe patient care.

2.9. The Trust undertook a self-assessment against the named core standards and submitted its response to NHS England and the Calderdale and Kirklees Clinical Commissioning Group. To support this, the Trust's submission was accompanied by a "Statement of Compliance" which will be signed off by the AEO in October 2019

2.10. The outcome of the self-assessment shows that of the 64 applicable standards, the Trust is:

- Fully compliant with 62 of the standards (green) (up from in 2018/19);
- Partially compliant with 2 of the standards (amber) (down from in 2018/19);
- Non-compliant with 0 of the standards (red).

2.11. Where the Trust was not compliant with a standard, work was undertaken to assess the gaps and identify what work would be required for the Trust to become fully compliant. In each of these cases, this work was included on the Trust's 18 month EPRR Work Programme, details of which are set out later in this report.

2.12. The results of the core standards will be discussed at a meeting of the Local Health Resilience Partnership (LHRP) in December 2019, which will be attended by the AEO.

HAZMAT / CBRN YAS Audit

2.13. The Hazardous Materials (HAZMAT) and Chemical, Biological, Radiological, Nuclear (CBRN) assessment, which was previously conducted by the Yorkshire Ambulance Service on behalf of NHS England was again incorporated into NHS England's Core Standards assurance process.

2.14. The Yorkshire Ambulance Service (YAS) attended Huddersfield Royal Infirmary and Calderdale Royal Hospital in Jul 2019 to carry out a "deep dive" audit of the Trust's HAZMAT/CBRNe.

2.15. The findings of the YAS audit has identified keys areas of subject to address and changes. In the main, minor changes are recommended in the report and include:.

- Arrange for Pro 2 Line 7 Decontamination Unit to be serviced by manufacture. This should be done annually
- Produce an inventory checklist for all equipment kept in decontamination store rooms. Also carry out ideally a monthly check to ensure all decontamination equipment is accounted for. Also sort and tidy C & H September 2019 decontamination store rooms to ensure all kit is easily accessible and in particular and quick access requirements for IOR/RRR kit
- Check and update staff CBRN/Hazmat Training Records to ensure they are up to date. Also include details of any CBRN/Hazmat awareness training for Reception Staff C & H September 2019
- Ensure annual CBRN/Hazmat refresher training is carried out for relevant staff

2.16. The audit concluded that:

"The visit has identified a number of recommendations that you will want to consider, however Calderdale and Huddersfield Hospitals are considered to be prepared in being able to deal with any type of CBRNe/Hazmat incidents."

Internal Audit

2.17. As part of the 2018/19 Annual Audit Plan, Internal Audit undertook a review of the Trust's emergency preparedness, resilience and response in October 2018.

2.18. Internal Audit recognised that:

Significant (Good)	The Foundation Trust has made adequate progress to ensure comprehensive emergency preparedness arrangements are in place for 2018/2019 and that major threats to business continuity are mitigated. An annual work plan has been developed as well as a training programme for Trust staff including the introduction of an introduction of an Awareness for Emergency Preparedness session within the Trust's Corporate Induction.

2.19. Internal Audit provided an overall assurance opinion rating of 'GOOD'.

2.20. Internal Audit provided the Trust with 3 recommendations to take forward and these have been incorporated into the Trust's EPRR Work Programme for 2019/20.

2.21 The Audit recommendations included;

- "The Resilience & Security Manager would only know of significant incidents if notified by the teams dealing with them.
- A review of the list of trained loggists at the Trust found this was last updated in March 2017. This should be updated annually.
- Discussions with the Resilience & Security Manager highlighted that arrangements at the Trust for Incident Control Centre rooms were a weak area as the rooms are currently not fit for purpose should a large incident occur. A gap analysis found that an initial assessment of HRI had been undertaken and found the arrangements to be insufficient to manage a long term event; the Incident Control Centre room CRH requires a review to be undertaken".

The recommendations are part on the annual work programme that is monitored for progress at the Security Resilience Governance Group.

3. Work Programme

Introduction

3.1. After joining the Trust in May 2016, the Trust's Emergency Preparedness Officer undertook a review of the Trust's emergency preparedness, security risk management and business continuity plans as well as the schedule of training and exercising which supports this work. Together with the outcomes of the Trust's self-assessment against NHS England's Core Standards for EPRR, this GAP analysis assessment was used to develop an 18-month long work programme for EPRR which concluded at the end of Apr 2019.

3.2. A copy of the 18-Month EPRR Work Programme is included under Appendix A of this report.

3.3. Details of key projects undertaken during 2018/19 are set out below.

Influenza Pandemic Preparedness

3.4. Influenza Pandemic is the top risk on the UK Government's risk register for civil

emergencies and this represents the significant impacts which could be felt by both the NHS and society at large.

3.5. The most recent outbreak of influenza pandemic, H1N1 (swine flu) in 2009, demonstrated some of the challenges that the NHS might face during a pandemic and reinforced the need for robust and flexible plans which can be scaled both up and down to meet the characteristics of the pandemic.

Influenza Pandemic Plan

3.6. A new Influenza Pandemic Plan has been developed to support staff and departments across the Trust in planning for, responding to and recovering from any future outbreak of influenza pandemic.

3.7. The new plan has been developed in line with national guidance published by the Department of Health and is intended to work alongside similar influenza pandemic plans belonging to local and regional partner organisations.

Multi Agency Influenza Pandemic Group

3.8. Coinciding with the launch of the new Influenza Pandemic Plan, the Influenza Pandemic Group was established in 2018/19 to lead on the coordination of the Trust's preparedness for, response to and recovery from an outbreak of influenza pandemic.

3.9. The main functions of the Multi Agency Influenza Pandemic Group are:

- To coordinate a work programme to improve the Trust's preparedness to an outbreak of influenza pandemic;
- To receive and review any guidance or plans on influenza and ensure the Trust's arrangements dovetail accordingly;
- To fully engage with local, regional and national partner organisations on preparing for and responding to an outbreak of influenza pandemic;
- To ensure the Trust has robust plans in place for the initial response, treatment and recovery stages of an outbreak of influenza pandemic;
- To coordinate the Trust's response and recovery to any future outbreak of influenza pandemic;
- To monitor the progress of the Influenza Pandemic Group's Work Programme and report this no less frequently than annually to the Trust's EPRR Board;

3.10. The Group is chaired by the Calderdale CCG AEO and was attended by representatives from across the Trust.

3.11 During Jun 2019, Exercise Alfonso was implemented to test Influenza Pandemic for multi agencies that are link to health. The exercise tested plans, reviewed responses, developed learning and a post exercise report categorized a work stream for the group

Business Continuity Management System

3.11. The most significant piece of work on the Trust's 18-Month EPRR Work Programme was to ensure that the Trust has in place robust and up-to-date business continuity plans. To achieve this, the Trust set out to:

- Review a new business continuity policy;
- Develop a new Trust-wide business continuity plans process;
- Develop a business continuity toolkit of e-learning package which each and every service/department could use to develop local business continuity plans

Business Continuity Policy

3.12. A business continuity policy was written, published and reviewed in May 2018. The policy sets out how the Trust will embed its programme of business continuity, enabling it during either a critical/major incident or a period of business disruption to continue to provide its critical and essential services.

Business Continuity Plans

3.13. Trust-wide business continuity high risk service plans was template was written and published in December 2015. The new plans supports the Trust's Incident Response Plans and has been developed to set out how the Trust will prepare for, respond to and recover from business continuity incidents.

3.14. The business continuity plan includes a set of specific response procedures which sets out how the Trust will manage common business disruption risks. Examples of business disruption risks include a loss of utilities, increased staff illness, industrial action, IT failure or a national fuel shortage.

Business Continuity Toolkit/E-Learning Package

3.15. A business continuity toolkit has been developed to support services and departments develop their own local business continuity plans.

3.16. The business continuity toolkit must be completed by every service and department in the Trust. To support services and departments in this work, the Trust's Emergency Preparedness Manager has been meeting with every service and department to ensure this work is completed consistently across the Trust.

Business Continuity Exercises – CHFT Divisions/Services

3.17. A multitude of Table Top Exercises has been facilitated, delivered, tested business continuity service plans and post exercise reports have been issued to divisional boards.

- THIS

- Estates and Facilities
- PFI (ISS/Engie)
- Pathology
- Radiology
- FSS
- Medical Wards
- Medical Gases
- Emergency Department
- Intensive Care Unit
- Community
- Workforce and Organisational Development

4. Incidents

Declared Incidents

4.1. The Trust did not declare any significant or major incidents however there have been some internal critical incidents where the tactical command structure was implemented.

- Winter Planning with a focus around the Emergency Care Standard (ECS)
- Lockdown Incident
- Severe Weather - Heat
- UCI – World Cycling Event in Harrogate
- EU Exit preparedness

4.2. In response to these planned and responsive incidents, the Trust has put in place arrangements to ensure that any disruption to patients, services and staff were minimal.

4.3. Internal Coordination, Command and Control processes were and have been implemented with operational support from divisional directors, service managers and the Trust's Emergency Preparedness Officer.

5. Tests and Exercises

5.1. NHS emergency planning guidance requires that the Trust regularly tests its emergency arrangements through:

- Live, or simulated live exercises at least every 3 years;
- Tabletop exercises at least every year; and
- Communication tests at least every 6 months.

5.2. The Trust has planned to hold its own tabletop/simulation based and drill exercises and the following subjects were tested against plans.

- HAZMAT Drill Exercise

- Lockdown Table Top Exercise
- ED – BCP Simulation Based Exercise
- ICU – BCP Simulation Based Exercise
- Operation Alfonso – Pan Flu Multi Agency Table Top Exercise
- THIS Counter Terrorism – Table Top Exercise
- EU Exit – Simulation Based Exercise
- CHS – Loss of Power Table Top Exercise

A Post exercise report has been issued to all Divisions, following a debrief of each exercise, to share learning.

6. Developmental Training

E-Learning

6.1. NHS guidance sets out the need for all staff to be aware of their role during an emergency, crisis and disaster event and this is especially important for the Trust following the comprehensive review of all the Trust's emergency plans.

6.2. Available for the On Call Management Team is a specialised information resource relating to

- Business Continuity
- Major Incident Response
- On Call Management – Strategic/Tactical Group
- Strategic Leadership In Crisis (SLiC) training

E-learning packages have been designed to deliver information relating to the specialist areas. It is at developmental stage of training category

6.3 Corporate Induction – Induction presentation has been implemented and EPRR booklets issued to all new staff within CHFT. In excess of +900 new delegates of CHFT have received the information and resources.

6.4 On Call Management – Face to face two training sessions and Strategic/Tactical Guidance booklets have been issued to in excess of +50 staff On Call Management.

6.5 Public Health England Emergo Senior Training has been identified as 3 identified CHFT staff are to attend in Oct 2019. Post training event will qualify staff to exercise around OPEL, Patient Flow and Discharge management processes.

Loggist Training

6.6. During any critical or major incident, the Trust must keep a comprehensive record of all events, information received, task allocations, actions taken and decisions made (including the rationales behind these decisions). In order to capture this information accurately the Trust will utilise loggists who have received specialised

training.

Chemical, Biological, Radiological, Nuclear (CBRN) Training

6.9. To ensure training competencies are maintained, refresher training was provided in March 2017 to all staff working in the Trust's emergency department as well as all porters working at CRH and HRI.

7. Meetings

Local Health Resilience Partnership

7.1. The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector and includes the private and voluntary sector where appropriate.

7.2. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, Public Health England and local authority representatives on the LRF in their role to represent health sector emergency planning, resilience and response matters.

Calderdale CCG Operational Group

7.3. The Calderdale CCG Operational Group is a local multi-agency group which is responsible for ensuring emergency plans are in place and joined up across the Calderdale and Kirklees area.

7.4. Representation at the Calderdale CCG Operational Group was made by the Trust's Emergency Preparedness Manager during 2019.

Calderdale Local Authority – Silver Group

7.5 The Calderdale Local Authority Silver Group is a multi-agency group that meets on a monthly basis to assess themes occurring in the community and shares information

8. Security Risk Management

8.1 Policies and guidelines have been developed and implemented relating to staff safety including specialized guidance around violence and aggression, counter terrorism, lone working, abduction and audio/visual recording of staff/patients. In addition staff protection action cards have been developed which include restraint techniques alongside anti-crime and counter terrorism strategies.

8.2 Physical Intervention Training has delivered targeted learning for CHFT high risk areas which were identified through the Safeguarding committee In excess of 170 staff have received this training which covers staff protection awareness , assault avoidance and initial response techniques alongside de-escalation techniques.

8.3 CHFT have been successful in securing funding for a Police Community Support Officer (PCSO) through joint working with our partners in the West Yorkshire Police force. The PCSO liaison role involves a range of interventions that will provide a safe and supportive service alongside providing a highly visible uniformed presence within the Trust. The PCSO will also proactively focus on and undertake crime prevention initiatives with Trust staff and the community. .

8.4 Action Counter Terrorism (ACT) Awareness is the national counter terrorism awareness initiative for business produced by NaCTSO (need to write out in full) to protect our communities from the threat of terrorism. The current threat from terrorism is serious and real, but it is important to keep it in perspective. The level of threat is complex and ranges from crudely planned attacks to sophisticated networks pursuing ambitious and coordinated plots. The aim of ACT Awareness is to: help understand the threat from terrorism to the UK; guide individuals on what to do if they find themselves involved in a terrorist incident or event that leads up to a planned attack; and finally to enable people to recognise and report suspicious activity

9. Conclusion and recommendations

9.1. In 2018/19 the Trust has continued to invest both time and resources in its emergency preparedness, resilience and response.

9.2. This investment has resulted in a clear improvement of the Trust's emergency preparedness, as demonstrated by the findings of:

- the Trust's self-assessment against NHS England's Core Standards;
- Internal Audit's evaluation of the Trust's EPRR arrangements; and
- Yorkshire Ambulance Service Foundation Trust's evaluation of the Trust's CBRN preparedness.

9.3. Following the completion of the Trust's 18-Month EPRR Work Programme, a new work programme is being developed for the year.

APPENDIX A: Emergency Preparedness, Resilience, and Response (EPRR) 18 Month Work Programme

Work Area	Project	Position	Action Required	Driver	Completed date	
EPRR	NHS England Core Standards	The outcome of the self-assessment showed that of the 64 applicable standards, the Trust was: • fully compliant with 62 of the standards (green) (up from in 2017/18); • partially compliant with 2 of the standards (amber) (down from in 2017/18); • non-compliant with 0 of the standards (red).	Statement of Compliance issued to WEB Core standards work plan issued to WEB Core Standards issued to NHS England by 31 Oct 2019	AEO	31 Oct 2019	To be completed
BCMS	Business Continuity Management System	Identification of Business Continuity Risk Assessments and Strategy The review found that a business continuity programme is in place to review the Trust's key areas including all critical information assets and critical processes. The work is focused on ensuring each area has the following documents in place: - Outline Business Continuity Risk Assessment - Outline Business Impact Analysis - Outline Business Continuity Plans	BC Developmental Training	Emergency Preparedness Team	Apr 2020	Implemented
			Internal EPRR Web Page			Completed
			Service BCP Database			Completed
Incident Response Plans (IRP)	Implementation and review of IRP identified areas	The vast majority of IRP are completed. The following attached IRP's have been developed, shared with multiple specialised groups. Ratification and inclusion to internal web page	Critical Incident	Emergency Preparedness Team	Apr 2020	To be ratified at SRGG – Post completion of Surge and Escalation Plan
			Pan Flu			To be ratified at H&S Committee – Nov 2019
			Electronic Patient Record (EPR)			To be ratified at SRGG
			Operational Escalated Pressures Levels (OPEL)			Awaiting clarity on Surge and Escalation Plan

Developing Training	Delivering topics relating to EPRR	EPO to develop a comprehensive training programme to follow the redevelopment of the Trust's emergency plans. Training programmes to include:	On Call Management Group identified key training packages • On Call Management • E-Learning • Loggist • Emergo • Corporate Induction • Strategic Leadership in a Crisis	Emergency Preparedness Team	Apr 2020	Implemented
Testing Exercises	Reviewed plans and exercised	Identified Exercises that took place	HAZMAT	Emergency Preparedness Team		Completed
			Lockdown			Completed
			ED – BCP			Completed
			ICU – BCP			Completed
			Alfonso			Completed
			THIS 3			Completed
			EU Exit			Completed
			CHS - Power			Completed
CBRNe	CBRNe – Training Exercise Equipment Audit	To support the Trust's CBRNe Plan, the Trust has a range of CBRNe equipment, currently stored at CRH and HRI	EPRR Officer to review the Trust's CBRNe Equipment following an external audit which is to be carried out by the Yorkshire Ambulance Service (as part of the NHS EPRR Core Standards Submission).	Civil Contingencies Act 2004 NHS Guidance EPRR Core Standards Assurance Action	Apr 2020	Continuing

11. Q2 Quality Report

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	Quarterly Quality Report – Q2 2019-2020
Author:	Anne-Marie Henshaw, Assistant Director of Quality and Safety Lisa Fox, Head of Clinical Information
Sponsor:	Ellen Armistead, Executive Nurse Director/Deputy Chief Executive
Previous Forums:	Quality Committee - 4 November 2019

Actions Requested:

- To note

Purpose of the Report

To provide an update on progress against the Trust quality priorities for quarter 2.

Key Messages

The report is structured into the five Care Quality Commission domains, with each section having a summary providing an overview of compliance with each indicator and highlights. This is followed by an update on progress with the three Quality Account priorities and the five CQUINs for 2019-2020.

Domain: Safe

Pressure Ulcers

- An overall reduction in the number of pressure ulcers in quarter 2 compared to quarter 1.
- No category 4 pressure ulcers in quarter 1 or quarter 2.
- A reduction in hospital acquired pressure ulcers caused by medical devices (17 in quarter 1 compared to 11 in quarter 2).
- A reduction in hospital acquired category 3 pressure ulcers (21 in quarter 1 compared to 8 in quarter 2).

Falls

- Improved performance against the CQUIN target.

VTE

- All 3 outcome measures were achieved in quarter 2.

Sepsis

- The most recent available 12 months HSMR figures show that as a Trust CHFT's HSMR is at 88.12 for the period April 2018 – May 2019 which demonstrates a sustained position.

Serious Incidents - Never Events

- No never events have been reported year to date.

Maternity Investigations

- Between 3 December 2018 and 31 March 2019, the Trust has referred 5 cases to HSIB. No cases were reported to HSIB in quarter 1 or quarter 2.

- 4 HSIB reports have been received during Q2 (2 final reports, 2 draft reports for factual accuracy checking) and 1 report is outstanding.

Must Do Compliance – Compliance with fundamental safety 'checks' of equipment and environment

- Most areas self-reported 100% compliance with the 'must dos' during Q1 and Q2. However, there remain issues with consistently maintaining high standards of medicines management.

Domain: Patient Experience (Caring)

Dementia Screening

- In 2018 CHFT was an outlier with performance at around 20%.
- Improvements in 2019 saw compliance reaching 60% in April. However, there has been no further improvement and performance has fallen to around 47% at the end of Q2.

Claims

- 28 new clinical negligence claims were opened.
- 4 clinical negligence claims were settled at a total cost of £28,000.
- 14 lost property claims were settled.
  - 7 claims concerned the loss of dentures.
  - 2 claims concerned the loss of a patient's glasses.
  - 1 claim concerned loss of a hearing aid.

Inquests

- 13 new inquests were opened during quarter 2.
  - 11 inquests concern patients cared for in the Medicine Division.
  - 2 inquests concern patients cared for in the Surgical Division.
- 8 inquests were closed.
- 2 Prevention of Future Deaths Reports (Regulation 28) have been received by the Trust with responses currently in process and on track to report.

Complaints

- There has been a slight increase in the number of complaints received in quarter 2 compared to quarter 1.
- 99% of complaints were acknowledged in time (3 working days)
- 36% of complaints were close in time in quarter 2, driven by poor performance in August (22%). In July 37% of complaints were closed in time, in September 47% of complaints were closed in time. Clinical and Corporate Divisions have taken a range of improvement actions to improve response. There remains variation across the Divisions.

Domain: Responsive

Outpatients and Appointments

- During quarter 2, the Trust has undertaken a significant programme of work to understand outpatients and appointments issues from the perspective of multiple stakeholders.
- A 'deep dive' was undertaken to ensure all issues related to outpatients and appointments were identified and have developed a comprehensive action plan to drive improvement.
- By way of additional assurance, the Trust commissioned an external, independent review of issues raised by the CQC and others about current outpatient provision at the Trust. This focused on identification of current risks and the consequent priorities for the Trust and the experiences of users of the outpatient service (patients and clinicians) and staff engaged in managing the service.
- Four issues were identified from the external independent review. These were
  1. Number of patient lists managed across the outpatient system
  2. Training of staff managing the outpatient system
  3. The number of cancelled appointments and;
  4. Clinics and communication with patients.

Domain: Effective

Infection Prevention and Control

- No trust assigned MRSA bacteraemia in quarter 2.
- 7 cases of C.Difficile (7 in quarter 2 against a ceiling of no more than 10 per quarter).

AKI

A new multi-disciplinary collaborative group was established in quarter 2.
The group held two meetings during the quarter and have begun to develop programme aims and a work plan for the next 12 months.

Domain: Well Led

Compliance with Essential Safety Training

Overall compliance for Essential Safety Training at the end of Q2 is 94.85%

Compliance with Role Specific Essential Safety Training

Compliance at the end of Quarter 2:

- 8 courses have 90% or more compliance
- 4 courses have between 85 and 89.99% compliance
- 21 courses have less than 85% compliance.

Of the 21 courses BRAG rated red (<84.99%) 6 are maternity courses, 2 courses are related to care and management of the sick child, 2 end of life and 1 adult resuscitation:

CQC

Of the outstanding actions from the 2018 CQC inspection:

- 2 'must do' and 3 'should' are not yet embedded, these are areas of specific focus for the CQC Response Group.
- 2 'must do' actions remain 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. Mitigation is in place and approved by the Executive Board.
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. Mitigation plans have been developed.

Activities in quarter 2 have included:

- CQC Style Invited Peer Reviews
- Launch of the new CHFT CQC Intranet Page
- Work Force & Organisational Development Well-Led Health Check
- Assessment preparation framework revised to help teams prepare for Core Service Self Assessments against the Inspection Framework
- CQC Insight Report
- Application to join the CQC Digital Triage project, this was not successful on this occasion but CHFT will contribute to next CQC Digital Project
- Scoping the well-led developmental review

Accreditation Visits

Two accreditation visits took place in quarter 2:

- Accreditation **EL (97)52 Audit of CRH Aseptic Unit.** Background: Audit of HRI Aseptic Unit (April 2017) re audit Nov 2017, May 2018 and Jan 2019. Risk rating for this site currently remains "High". Re audit carried out Jan 2019. May 2019 - The auditor has closed out the audit and acknowledges the improvements made since the previous audit, particularly in respect of Capacity Management and detailed planning to support the shutdown of the CRH unit. The overall risk level assigned to this unit is "High".
- Accreditation **Health Informatics ISO 27001** – Accredited.
- One report was received: Respiratory Services – Invited Service Review. Final report received August. Action plan devised. Governance of actions will be Quality Committee via Medicine PSQB.

Update on Progress with CQUINS
Progress is being made against CQUIN targets.
CQUIN CCG 3 Alcohol and Tobacco has seen some improvement but this remains a challenging CQUIN.

Update on Progress against Quality Account Priorities for 2019-2020
Progress has been made against all three quality account priorities.

EQIA – Equality Impact Assessment
An equality impact assessment has been undertaken. The quarterly quality report does not currently report on outcomes and performance with a breakdown for different protected groups as defined in the Equality Act 2010. This is a gap in relation to patient experience and outcomes/ incidents and work has taken place during quarter 2 to refine Datix to include detail of people's characteristics so that we can understand difference.
Matters for Escalation to the Board/Recommendation
The Board of Directors is recommended to note the content of the report and activities across the Trust to improve the quality and safety of patient care.

Quarterly Quality Report – Q2 2019-2020

Contents

Quarterly Quality Report – Q2 2019-2020

1. Introduction

The Trust aims to always treat and care for people in a safe environment and protect them from avoidable harm. The Board has a quality assurance committee which scrutinises, monitors and provides assurance on our quality programmes, and further assurance is given by our governors' quality committee through which our council of governors supports and advises on current quality and priorities for the future.

This report provides an update on progress against the Trust quality priorities for quarter 2.

The report is structured into the five Care Quality Commission domains, with each section having a summary providing an overview of compliance with each indicator and highlights.

There are three Quality Account priorities for 2019-2020:

- Improving clinical outcomes linked to waiting times in the Emergency Department (Safe).
- 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 always given (Effective).
- Mental Health in the Emergency Department - Improving psychological and social support for mental health patients in the Emergency Department (Caring).

Progress against quality account priorities is provided in section 8.

There are five CQUIN areas for 2019-2020:

- CCG 1a and b Antimicrobial resistance
- CCG 2 Staff Flu Vaccinations
- CCG 3 Alcohol and Tobacco
- CCG 7 Three high impact actions to prevent Hospital Falls
- CCG 11 Same Day Emergency Care

Progress against CQUIN targets can be found in section 7.

2. Domain Patient Safety: People are protected from abusive and avoidable harm.

2.1. Safety Thermometer

The NHS Safety Thermometer is a national point of care survey which provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients.

Teams measure harm and the proportion of patients that are 'harm free' in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide. The Trust submits data to the Classic (In Patient), Maternity, and Children and Young People's Safety Thermometers. Results and improvement priorities are reported on a monthly basis on the Trust integrated performance report.

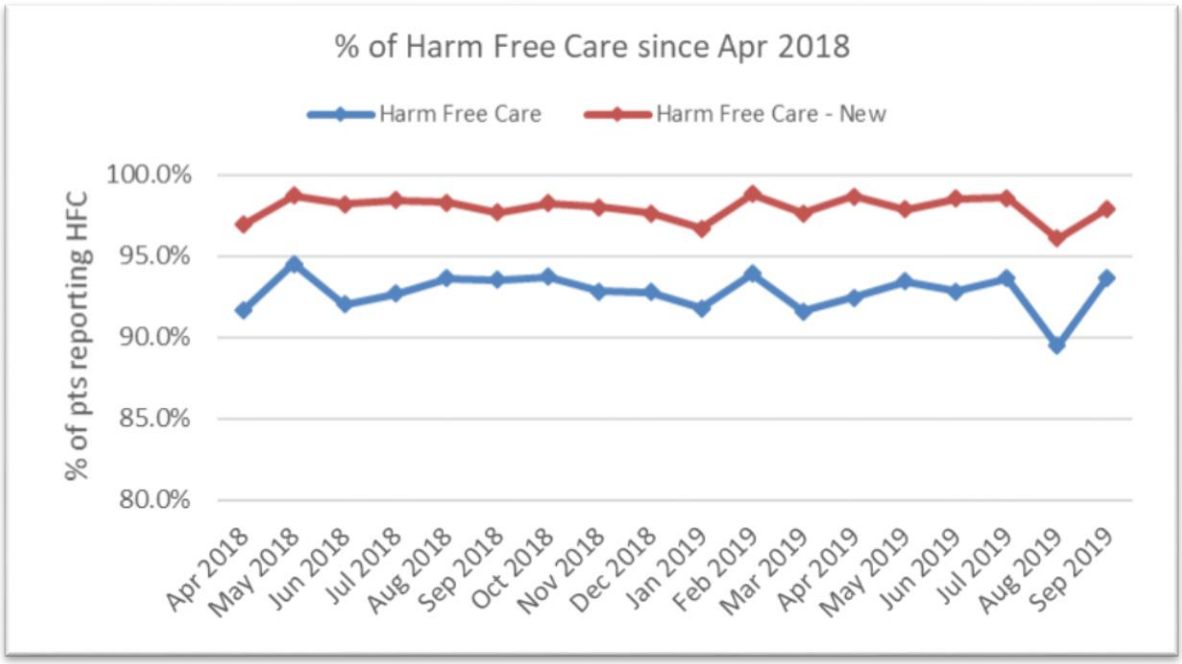
Table 1: Summary of Harm Free Care from 2018-2019 Quarter 1 to 2019-2020 Quarter 2

	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Q1 19-20	Q2 19-12
Inpatient All Harm	92.73%	93.28%	93.10%	92.44%	92.90%	92.23%
Inpatient New Harms Only	97.96%	98.14%	97.96%	97.70%	98.37%	97.51%
Maternity (Physical and perceptions of safety)	77.8%	73.2%	83.1%	78.4%	80.2%	80.5%
Children and Young People	93.4%	97.6%	96.4%	100%	95%	99%

Inpatient (Classic) Safety Thermometer

The Inpatient Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs.

Figure 1: Inpatient Survey April 2018 to September 2019



Pressure Ulcer, Falls and VTE improvement work is provided in more detail in sections 2.2 to 2.4.

Maternity Safety Thermometer

The Maternity Safety Thermometer is a measurement tool for improvement that focuses on perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The survey is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women's homes and community postnatal clinics.

During quarter 2, the maternity service has focused on improving women's experiences of care in relation to:

- Proportion of women with concerns about safety during labour and birth not taken seriously.
- Proportion of time women in labour were left alone at a time that worried them.

Achievements in quarter 2 include:

- Implementation of a compliment, comment or query poster to encourage escalation of concerns.
- Sharing Maternity Safety Thermometer data with staff to explore their understanding of women's perception of safety.
- All postpartum haemorrhages continue to be reviewed at weekly MDT and learning is shared with all clinical colleagues.

Improvement priorities for quarter 3 are:

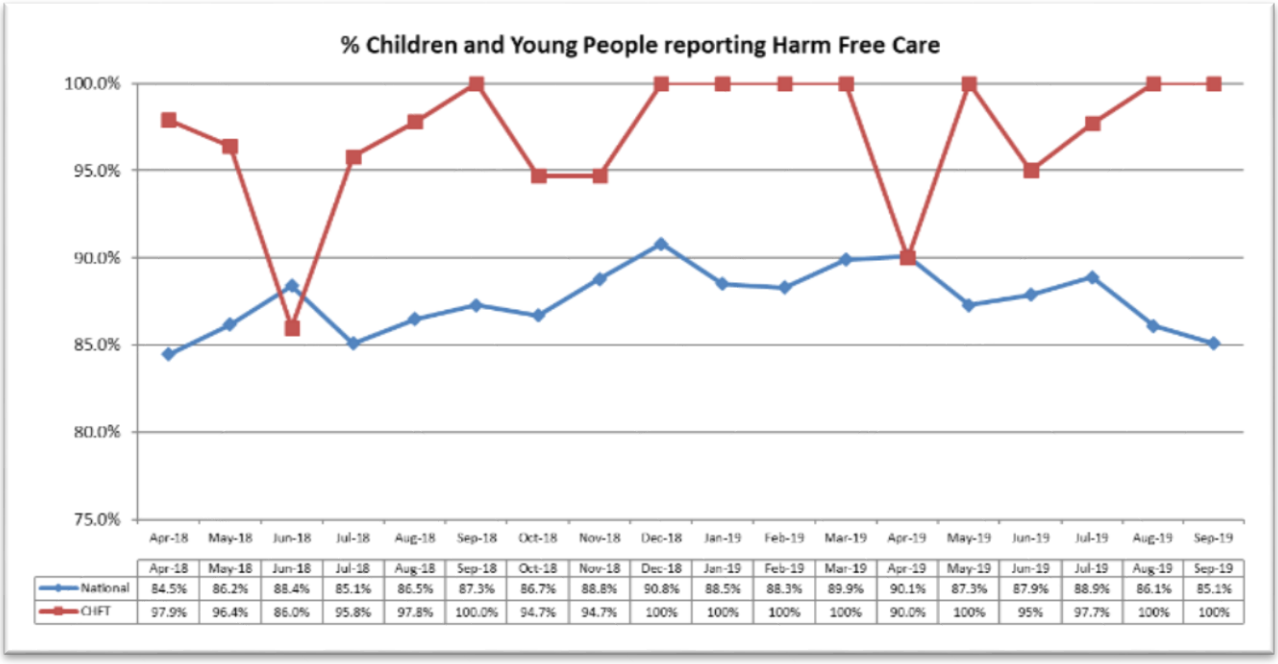
- Relaunch the ATAIN (avoiding term admissions to neonatal unit) project on the 21st October 2019.

Children and Young People's Survey

The Children and Young People's Services Safety Thermometer focusses on deterioration, extravasation, pain and skin integrity.

The Children's Service has consistently performed at a higher level than the national data. The team has undertaken an exercise to validate data, no areas for improvement in data quality were identified.

Figure 2: Children and Young People's Survey April 2018 to September 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
National	84.5%	86.2%	88.4%	85.1%	86.5%	87.3%	86.7%	88.8%	90.8%	88.5%	88.3%	89.9%	90.1%	87.3%	87.9%	88.9%	86.1%	85.1%
CHFT	97.9%	96.4%	86.0%	95.8%	97.8%	100.0%	94.7%	94.7%	100%	100%	100%	100%	90.0%	100%	95%	97.7%	100%	100%

2.2. Pressure Ulcers

Pressure ulcers are a key indicator of the quality and experience of patient care. We know that many pressure ulcers are preventable, so when they do occur, they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating. Preventing them will improve care for all vulnerable patients.

Achievements in quarter 2 include:

- An overall reduction in the number of pressure ulcers in quarter 2 compared to quarter 1.
- No category 4 pressure ulcers in quarter 1 or quarter 2.
- A reduction in hospital acquired pressure ulcers caused by medical devices (17 in quarter 1 compared to 11 in quarter 2).
- A reduction in hospital acquired category 3 pressure ulcers (21 in quarter 1 compared to 8 in quarter 2).
- Successful recruitment to the tissue viability lead nurse role and other clinical posts with the team has led to renewed focus on delivery of the Trust wide and divisional pressure ulcer reduction action plans.
- The Pressure Ulcer Collaborative Group (medical and surgical division) continues to meet although there is at times limited attendance and this is being addressed with support from the senior nursing team.
- During quarter 2 refinements to the Datix Incident Reporting system for pressure ulcers took place. Going forwards this will improve the identification of key themes and trends of investigations.
- The PUSH (pressure ulcer safety huddle tool) for rapid review of pressure ulcer incidents within 48 hours has been implemented.

Improvement priorities for quarter 3 are:

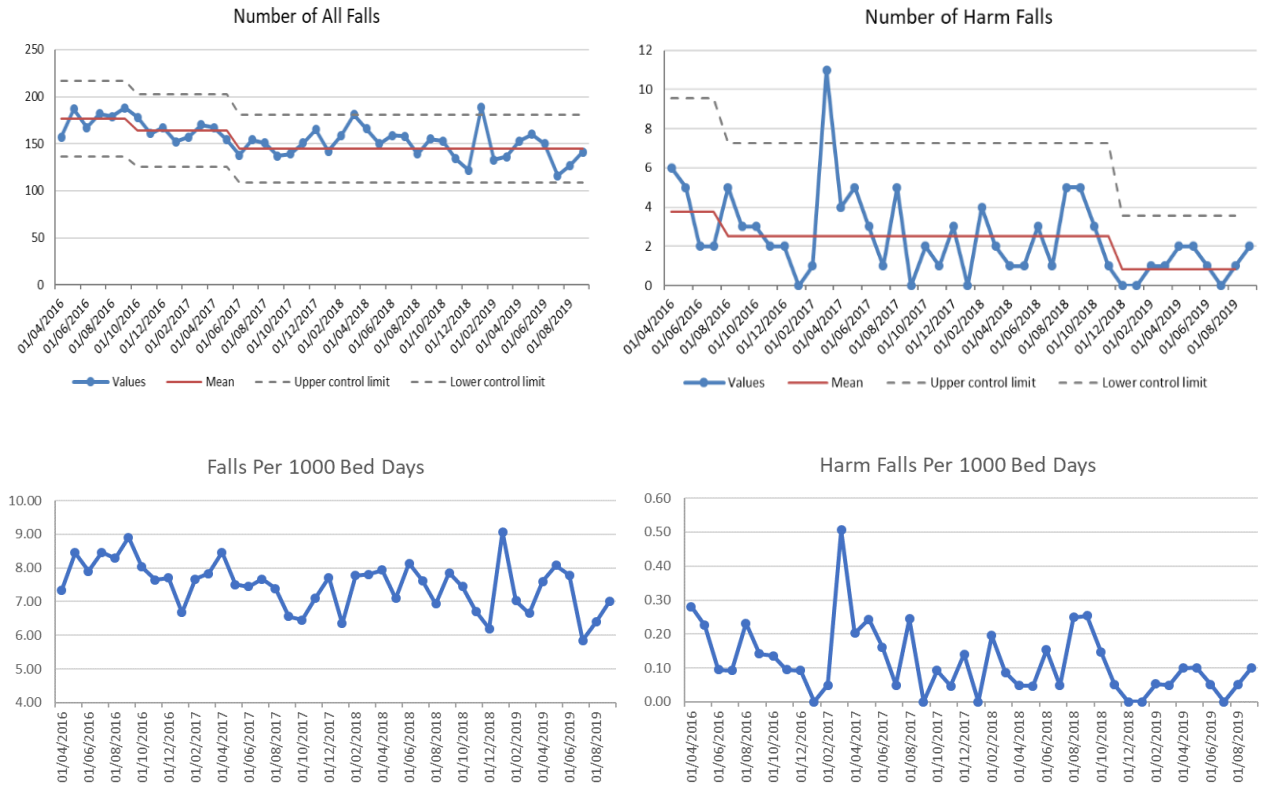
- Improve the effectiveness of communication in safety huddles to highlight patients at increased risk of pressure ulcers.
- Improve the quality of clinical documentation in relation to preventative care and actions (Gaps in documentation have been highlighted by Divisional Orange Incident Panels).
- Due to reduce resource with the TVN team formal education was temporarily cancelled. This provided an opportunity for bite size learning within the clinical areas which has been well received by clinical teams, but the education programme needs to be restarted.
- Sharing learning - The importance of a 24-hour approach to ensuring the correct equipment is used to ensure prevention or minimising deterioration.
- In some areas there are opportunities to improve knowledge of the PUSH Tool and safeguarding related to tissue viability.

2.3. Falls

Falls cause distress and harm to patients, families and their carers. The Trust has a trust-wide Falls Reduction action plan delivery of which is overseen by a monthly Falls Collaborative chaired by our dedicated clinical falls lead who is a consultant within Older Peoples services. The action plan is based on some aspects of the previous National Audit which highlighted some areas for improvement including lying and standing BP, medication review and vision.

Since September 2018 we have seen an overall decrease in the total number of falls.

Figure 3: Number of Falls (All Falls and Harm Falls) and the Rate of Falls per 1,000 bed days



There has been a marked improvement in the number of falls where patients have sustained harm as a result of a fall.

Table 2: Total Number of Falls (Wards and Community) October 2018 to September 2019)

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Average
No. of Ward Falls	153	134	122	189	133	136	153	160	150	116	127	141	143
Medical	119	105	86	129	106	106	112	120	115	83	97	98	106
Surgical	30	23	29	49	18	21	33	26	25	25	24	21	27
FSS	2	1	4	7	6	1	2	3	3	2	2	5	3
No. of Community Falls	2	5	3	4	3	8	6	11	7	6	4	17	6
Total Falls	155	139	125	193	136	144	159	171	157	122	131	158	149

Falls CQUIN

Since April 2019, the trust is working towards achieving the inpatient Falls Reduction CQUIN. The three high-impact actions measured to achieve the CQUIN are:

- lying and standing blood pressure.
- mobility assessment within 24 hours.
- medication review re anxiolytics rationale for prescribing/administering.

Overall Falls Reduction CQUIN performance in quarter 1 was 12%, this has improved in quarter 2 to 64%.

Table 3: Performance against the Three High Impact Action Quarter 1 and Quarter 2

80% of older inpatients receiving key falls prevention actions

Sample: Admitted patients aged of 65 years with a length of stay at least 48 hours

Exclusions: Patients who were bedfast and/or hoist dependant through their stay. Patients who die during their hospital stay.

	Q1 TOTAL			July			August			September			Q2 TOTAL		
	No. of patients where all 3 actions are met and recorded	No. of patients audited	%	No. of patients where all 3 actions are met and recorded	No. of patients audited	%	No. of patients where all 3 actions are met and recorded	No. of patients audited	%	No. of patients where all 3 actions are met and recorded	No. of patients audited	%	No. of patients where all 3 actions are met and recorded	No. of patients audited	%
Overall	**12**	**100**	**12.0%**	**21**	**32**	**65.6%**	**22**	**35**	**62.9%**	**21**	**33**	**63.6%**	**64**	**100**	**64.0%**

	No. of patients where specified action is met and recorded	No. of patients audited	%	No. of patients where specified action is met and recorded	No. of patients audited	%	No. of patients where specified action is met and recorded	No. of patients audited	%	No. of patients where specified action is met and recorded	No. of patients audited	%	No. of patients where specified action is met and recorded	No. of patients audited	%
Lying/standing BP recorded at least once	17	100	17.0%	30	32	93.8%	35	35	100.0%	32	33	97.0%	97	100	97.0%
No Hypnotics/ antipsychotics/ anxiolytics given OR rationale documented	91	100	91.0%	32	32	100.0%	34	35	97.1%	31	33	93.9%	97	100	97.0%
Mobility Assessment documented within 24 hours of admission OR walking aid provided within 24 hours of admission.	70	100	70.0%	23	32	71.9%	23	35	65.7%	23	33	69.7%	69	100	69.0%

Achievements in quarter 2 include:

- Ward managers from the Acute Floors in CRH and HRI have shared learning about how to embed 3 times a day falls prevention safety huddles as part of the Elderly Care Strategy Improvement Plan. There is ongoing work with the Engagement Support team and Enhanced Care team to provide staff skilled in the care and management of patients with cognitive impairment and those at risk of falling.

- The Trust submits data to the National Audit of Inpatient Falls Causing Fractured Neck of femur (January 2019) with focused work based on the findings. This has now been expanded to include all femur fractures and the data is being included in the national database (FFFAP- The Falls and Fragility Fracture Audit Programme).

Improvement priorities for quarter 3 are:

- A Falls Prevention week is planned during October, in conjunction with Kirklees Falls Prevention Group. The trust organises a quarterly falls reduction workshop (Last held on 26 September 2019, next planned for February 2020).

2.4. Venous Thromboembolism

Venous Thromboembolism (VTE) is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a significant cause of mortality, long-term disability and chronic ill-health problems, many of which are avoidable. It has been estimated that the management of hospital associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long-term care. Long term complications that reduce the quality of life add to the human cost and overall burden of VTE. VTE Prevention is supported by national standards that facilitate high quality care and NICE guidelines for reducing risk in patients admitted to hospital.

The VTE Committee met all 3 outcome measures in quarter 2.

Table 4: VTE Achievements in Quarter 2

Outcome	Description	Achievement in Q2
Outcome 1:	To meet the 95% target of patients being risk assessed for developing a VTE	Overall trust compliance at the end of Q2 was 95.7%.
Outcome 2:	Maintain the level of Hospital acquired VTE episodes, not more than 20% of all VTE episodes	Total of 91 VTEs recorded with 10 confirmed as Hospital acquired (**11%**).
Outcome 3:	No Avoidable hospital acquired VTE Deaths	There was no avoidable hospital acquired VTE deaths in quarter 2.

Achievements in quarter 2 include:

- The VTE Group report improved engagement with divisions over the quarter through better channels of escalation via the Patient Safety Group and improved risk screening reporting. The Committee chair continues to liaise directly with Clinical Leads within areas of concern.

Audit activity has increased with 3 audits presented to the committee in Quarter 2:

- Pharmacy audit of VTE risk assessment and prescribing of thromboprophylaxis.
- 'Is VTE (Venous Thromboembolism) prophylaxis being correctly prescribed for all postpartum women upon discharge?'
- Management of suspected PE in pregnant patients.

Improvement priorities for quarter 3:

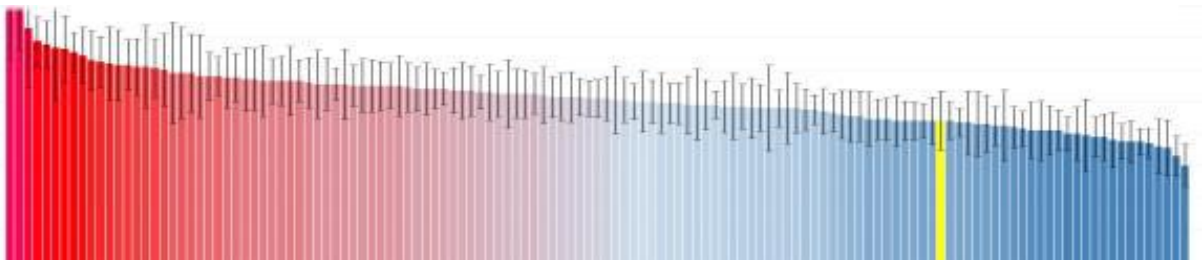
- To continue to monitor the progress of audit actions plan and schedule of re audit.

2.5. Sepsis

The most recent available 12 months HSMR figures show that as a Trust CHFT's HSMR is at 88.12 for the period April 2018 – May 2019 which has been steady for the last few months.

The Trust is ranked 31st out of 132 Trusts.

Figure 4: HSMR Sepsis Deaths April 2018 – May 2019



The Sepsis Collaborative continues to meet on a monthly basis, reporting to the Clinical Improvement Group on a quarterly basis.

Main areas of concern for the sepsis bundle relate to measurement and recording of urine output and prescribing of oxygen. Work is ongoing to use Nerve centre functionality to address this issue, but this is not likely to be ready to use until the end of the year.

The focus of work in quarter 2 has been delivery of the June 2019 WTGR to Improve Early Recognition and Treatment of Sepsis Breakthrough action plan which includes

Achievements include:

- Revisions of the Sepsis EPR power chart.
- Joint review with Bradford on sepsis alert.
- Patient/family information leaflet now available on repository.

Priorities for quarter 3 are:

- Appoint to the Lead Nurse for Sepsis role. Recent interviews for the Sepsis lead nurse 0.6wte role were unsuccessful and so further interviews have been planned for November 2019.
- Progress work to improve delivery of the sepsis bundle (urine output and oxygen).

2.6. Medicine Safety

The Medication Safety and Compliance Group aims to ensure that medicines are managed in a safe manner throughout the Trust and that risks in relation to medicines are effectively mitigated. The group meet on a monthly basis to review current medication issues and concerns and consider recommend and, where relevant, implement actions to be taken to reduce risks and maximise patient safety.

Work is progressing to support Trust wide solutions to safe storage of medication wastage and temperature monitoring of medication storage areas, however both internal and external audits indicate we still have further work and focus to improve the safe management of medicines on our wards.

Achievements in quarter 2 include:

- Ward based medicines peer review was undertaken.

The purpose of the review was to test out the progress made against the 2016 & 2018 CQC recommendations for medicines management and to ensure the actions remained embedded. The focus of the review was:

- Safe storage and administration of medicines on wards.
- Management of CDs including the findings of the internal audit report.
- Review the Trust Response to CQC inspection recommendations.
- Delayed and omitted doses e.g. pain relief, critical medicines.

The Trust invited a team from Mid Yorkshire Hospitals NHS Trust to review the service as part of CHFTs CQC style Peer Review Programme. Wards were visited across both HRI and CRH sites and the visits were unannounced ensuring the peer review mirrored the approached taken by CQC. A timetabled schedule was used for the onsite inspection.

It was agreed by the CQC Response Group that the following actions would be taken in response to the findings from both the External and Internal Peer Reviews:

i. Full report to be shared with Assistant Directors of Nursing for consideration and action planning within their Divisions.

ii. Full findings report to go to Medicines Safety Group and Controlled Drug Subgroup for awareness.

iii. A Work Together Get Results event took place at the end of August to identify ways in which improvements could be embedded.

iv. Updates regarding action plans and progress on improvement work to be presented at the September CQC Response.

Priorities for quarter 3 are:

- To continue to improve safe storage and administration of medicines across the Trust.

2.7. Serious Incidents

a) Patient Safety Incidents and Serious Incident by month reported

Serious incidents account for 0.27% of all Patient Safety Incidents reported.

The section below analyses the timeliness and trends in external reporting and highlights outliers.

Table 5: Summary of Patient safety Incidents and Incidents with Severe Harm or Death April 2018 to September 2019

Month reported	No of Patient Safety Incidents	No of Patient Safety Incidents with severe harm or death	* StEIS by month externally reported
Apr 2018	954	8	5
May 2018	1011	3	4
Jun 2018	946	7	1
Jul 2018	969	2	3
Aug 2018	955	4	1
Sep 2018	973	3	4
Oct 2018	1106	3	3
Nov 2018	993	3	3
Dec 2018	942	3	1
Jan 2019	1117	2	3
Feb 2019	952	0	2
Mar 2019	1037	2	2
Apr 2019	1031	4	0
May 2019	1049	6	6
Jun 2019	929	3	3
Jul 2019	1053	2	2
Aug 2019	981	4	1
Sep 2019	964	3	7

b) Timeliness of declaring Serious incidents (SIs)

From April 2018 there were on average three serious incidents reported each month.

For Q1 and Q2 of 2019/20, the mean SIs declared per month was 3.16 cases, and range was 0 – 7 cases per month.

c) Serious Incidents by Division

Table 6: Types of SI Declared in Q1 and Q2 by Division

	COMM	FSS	MED	SAS	Total
Safeguarding child		1			1
Apparent/actual/self-inflicted harm			1		1
Diagnostic incident, incl delay or failure to act on test results			2	2	4
Maternity/Obstetric: Mother and baby		1			1
Maternity/obstetric: Mother only		1			1
Medication incident				1	1
Slips/trips/falls	1		3		4
Sub-optimal care of the deteriorating patient			1		1
Treatment delay			4	1	5
Grand Total	1	3	11	4	19

d) Never Events
e) There have been no never events reported in 2019/20. See the Learning from Safety Incidents section below for a summary of the learning from the SIs: Unintentional connection of a patient requiring oxygen to an airflow meter.
f) Progress with SI actions (Summary position)

The status of open actions associated with serious incident investigations is reported to Quality Committee on a quarterly basis. In summary, as of 30th September 2019, there were 79 open actions against serious incident investigations, compared with 148 open actions as of June 2019. This is an improved position compared with the end of Quarter 1.

g) Learning from Safety Incidents in 2019-1920 Quarter 1 and Quarter 2

Learning from incidents unintentional connection of a patient requiring oxygen to an airflow meter.

Summary of Incident: Connection of nasal cannula to Air instead of oxygen

Learning:

- The Trust should establish a robust process to cascade Safety Alerts and Never Event recommendations and actions through a variety of methods to reach all staff groups;
- There should be timely and continuous review to ensure that all actions from clinical incidents/SI's and alerts are being undertaken in clinical practice by testing clinical staff knowledge and observing practice;
- Developing a system for dissemination of safety messages and learning from incidents for junior medical staff using Social Media should be considered;
- The Medical Division should review their processes for two-way communication of clinical governance information to ensure this is effective.

Learning from incidents related to sepsis

There have been two incidents related to sepsis in quarter 1 and quarter 2.

Learning to Share

- Ensuring staff are aware of sepsis policy and the triggers for sepsis and importance of early intervention;
- Ensuring staff escalate when unable to obtain IV access and consider alternate routes of accessing blood such as femoral stab;
- Ensure staff are reminded of the importance of communication including handovers, referring to other teams and recording in EPR and the use of the SBAR tool.
- Timely, contemporaneous record keeping is essential to provide an accurate record of patient care.

An event to share learning in respect of recognition and appropriate response to NEWS2 and commencement of sepsis pathway has been proposed by CHFT to the regional learning group in context of the recent HSIB report into the deteriorating patient and the SI's.

2.8. Maternity Safety - Transformation and Improvement

a) Update on cases referred to HSIB and Learning

The Healthcare Safety Investigation Branch (HSIB) investigates maternity incidents that meet the Each Baby Counts[1] criteria or the HSIB criteria for maternal deaths. Eligible babies for HSIB investigations include all term babies (at least 37+0 completed weeks of gestation) born following labour, who have one of the below outcomes:

- Intrapartum stillbirth where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death when the baby died within the first week of life (0-6 days) of any cause.
- Severe brain injury diagnosed in the first seven days of life, when the baby was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE), was therapeutically cooled (active cooling only) or had decreased central tone and was comatose and had seizures of any kind.

Between 3 December 2018 (when HISB commenced investigations in the region) and 31 March 2019, the trust has referred 5 cases to HSIB. No cases were reported to HSIB in quarter 1 or quarter 2.

4 HSIB reports have been received during Q2 (2 final reports, 2 draft reports for factual accuracy checking). 1 report is outstanding.

Learning from the HSIB reports, locally and regionally, and a review of Orange and Red incidents between March 2017 –March 2019 has identified the following key themes:

- Recognition of risk and escalation/ action.
- Review of previous situation and care.
- Interpretation of CTG monitoring.
- Quality of information (verbal and written) given to women.

[1] Each Baby Counts is the Royal College of Obstetricians & Gynaecologists' national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

- Quality of communication and handover.
- Record keeping of telephone conversations.

Actions have been put in place to address learning, progress is being monitored via the Divisional Patient Safety Quality Board, Performance Review Meetings and Quality Committee.

b) Training

Most maternity role specific training rates are below 90% (Section 5.3). The Directorate have reviewed data quality and cleansed ESR and are awaiting a further update on quarter 2 compliance.

The Head of Midwifery is working closely with clinical managers to improve compliance.

A training needs analysis is planned for quarter 3 to confirm role specific training requirements for 2020-2021.

The Maternal Acute Illness Management course is now established in the Trust and a showcase event is planned for 5 December 2019. The course enhances the knowledge, confidence and performance of maternity staff dealing with acutely ill women and encourages teamwork and improved communication.

Interpretation of CTG monitoring has been highlighted as an area of concern. The Saving Babies Liver Care Bundle v.2 recommends a 0.4wte lead for CTG training, this role is not yet established at the Trust, but funding has been identified for the next year from the Local Maternity System.

c) Staffing

Maternity staffing has been particularly challenging during quarter 2 with significant vacancy over the summer months. Ongoing recruitment continues and a substantial number of newly qualified midwives commenced with the Trust 14 October 2019. The number of incidents; 1:1 care in labour; MAC triage times and induction delays were closely monitored with no adverse effects noted.

d) Continuity of Carer

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.

The national trajectory is for 35% of women to be booked onto a Continuity of Carer pathway by March 2020. The trust has appointed a Band 7 Project Midwife to support implementation of Continuity of Carer. Achieving the 35% will present a significant challenge to the trust, a detailed implementation plan is being developed during quarter 3.

2.9. ‘Must Do’ Compliance

The ‘must dos’ are ward and departmental safety checks that must be completed each 24 hour period to ensure the safety of patients in that area. ‘Must do’ safety checks include:

- Leadership checks.
- Environmental safety checks.
- Vital safety equipment (e.g. resuscitation trolleys).
- Controlled drugs.
- Medication fridge temperatures.

Table 7: Combined Performance in Q1 and Q2

	April	May	June	July	Aug	Sept
HRI	99.7%	99.5%	99.3%	99.9%	99.9%	99.3%
CRH	99.8%	99.9%	99.9%	99.9%	99.9%	99.8%

Most areas self-reported 100% compliance with the 'must do's' during Q1 and Q2. However there remains issues in terms of compliance with medicine safety Must Do's.

The Medication Safety and Compliance Group have agreed a series of actions with Divisional and Senior Nursing colleagues to:

- Share Best Practice and Learning to Make Continuous Improvements.
- Assess and manage capacity and capability issues.
- Embed and test processes to provide assurance about the safe storage and management of medicines.

A new medication fridge temperature monitoring sheet was introduced for use on wards from 1st September. The Medicines Code has been updated accordingly. Screensavers and email communications to ward managers has been issued regarding use of these new forms.

Progress of the replacement programme of fridge temperature monitoring is being overseen on a monthly basis by the Medication Safety and Compliance Group, this is on the risk register.

3. Domain Patient Experience (Caring): Staff involve and treat people with compassion, kindness, dignity and respect

3.1. Assessment and Dementia Screening

The cognitive assessment process is an essential part of medical clerking for patients aged 75 and over. The assessment is crucial to the patient receiving excellent care. It includes:

i. an assessment for delirium; followed by
ii. a screen for depression; and if the delirium assessment is negative it is followed by
iii. the dementia screen.

If delirium is diagnosed, the cognitive assessment does not progress to the dementia screen.

The dementia screen is a nationally monitored standard requiring 90% compliance. The dementia screen is not intended to be an indicator for investigation whilst the person is in hospital. Its function is to prompt a message for the GP to be aware that a positive screen may lead them to refer the patient to mental health memory services for full investigation.

In 2018 CHFT was an outlier with performance at around 20%. In April 2019 this was at 60% however, there has been no further improvement and performance has fallen to around 47% at the end of Q2.

Achievements in quarter 2 include:

- A dedicated clinically led task and finish group continue to monitor progress against an action plan which aims to ensure that:
    i. Clinical staff understand the importance of early identification of cognitive impairment in patients aged 75 and over.

ii. Early identification of Delirium is the priority and should the Delirium assessment be positive, the patient will not be screened for Dementia.
iii. All patients aged 75 and over, other than those who are exempt, will be screened for Dementia during clerking.
iv. All sections of the Dementia screen will be completed on EPR as relevant.

Improvement priorities for quarter 3 include:

- Working collaboratively with ward teams and the frailty team to inform changes required, make further enhancements to EPR to simplify, guide and prompt the screen.
- Continue to work collaboratively with ward teams to explore opportunities and solutions.
- Deliver person-centred dementia care training to clinical colleagues as priority.

3.2. Nutrition & Hydration

During quarter 2, a mock CQC style nutrition and hydration peer review took place. The purpose of this review was to test out the Trusts compliance with Nutrition and Hydration standards. The focus of the review was:

- Parenteral and enteral care of nutritional complex patients, reviewing the co-ordination of service provision.
- Nutrition and hydration standards compliance for all patients of different ages.
- Decision making and End of Life Care relating to nutrition and hydration.

The Trust invited a team from Leeds Teaching Hospitals NHS Trust to support this review. Wards were visited across both HRI and CRH sites and the visits were unannounced ensuring the peer review mirrored the approached taken by CQC. A timetabled schedule was used for the onsite inspection. A full comprehensive report was published to ADNs and Directors post review.

In response to the external peer review findings the following actions have been taken to date:

- Consultant Gastroenterologist was present at initial feedback back session and findings escalated to the team via the Gastroenterology Team Meeting.
- The report has been shared with the Divisional Assistant Directors of Nursing, Nutritional Steering Group and Artificial Nutrition Steering Group.
- A bite sized learning in relation to recording MUST scores on EPR was published 19.09.19.

It has been recommended that the following actions are taken in response to the findings from the External Peer Review:

- The Nutritional Steering Group and Artificial Nutrition Steering group to be accountable for progressing Action plans to address issues.
- Response required from the Gastroenterology Team about recommendations for enteral and parental nutrition
- A review to take place of the current CHFT audit programme in relation to artificial nutrition to ensure this meets the best practice audit standards.
- Full report to be shared with wider teams for consideration.
- Updates regarding action plans and progress on improvement work to be presented by the Divisional ADNs at the October CQC Response.
- Internal Peer Review to be organised to check progress of actions.

3.3. Claims

A summary of activity in quarter 2 is provided in this report; further detail can be found in the more detailed Legal Services Quarter 2 Report to the Risk and Compliance Committee.

a) Clinical Negligence

28 new clinical negligence claims were opened.

- 10 clinical negligence claims were linked to incidents (36%) - 1 Community Division claim, 4 FSS Division claims, 2 Medicine Division claims and 3 Surgical Division claims.
- 8 clinical negligence claims were linked to a complaint (25%) – 1 Community Division, 0 FSS Division, 4 Medicine Division and 3 Surgical Division.

4 clinical negligence claims were settled. Excellent, or poor, standards of clinical documentation meant that:

- 2 claims were upheld with a total cost of £28,000.
- 1 claim was repudiated.
- 1 claim was withdrawn.

b) Lost Property

14 lost property claims were settled.

- 7 claims concerned the loss of dentures
- 2 claims concerned the loss of a patient's glasses
- 1 claim concerned loss of a hearing aid.

Divisional senior nursing teams have been updated on these cases and asked to put in place actions to improve care of essential patient property.

3.4. Inquests

13 new inquests were opened during quarter 2.

- 11 inquests concern patients cared for in the Medicine Division.
- 2 inquests concern patients cared for in the Surgical Division.

During quarter 2 8 inquests were closed.

The Trust received two Prevention of Future Death Reports (Regulation 28) from Her Majesty's Coroner. The trust is in the process of responding to the Coroner and remain on-track to deliver relevant actions plans by the due dates. Action plans will be received into the Quality Committee.

3.5. Legal Services Improvement Programme

The trust had identified issues in terms of inconsistency in the timeliness of reporting into the coroner's office. The team held a Work Together, Get Results Breakthrough meeting to agree improvement actions and develop an implementation plan.

Improvement priorities for quarter 3 include:

- DATIX system upgrade to enable use of action module to alert colleagues to required actions and timeframes.
- Weekly escalation meeting with Head of Legal Services and new escalation process.
- Legal Services Team Leader works 1 day a week in Bradford Coroner's Officers Office to facilitate timely transfer of information.

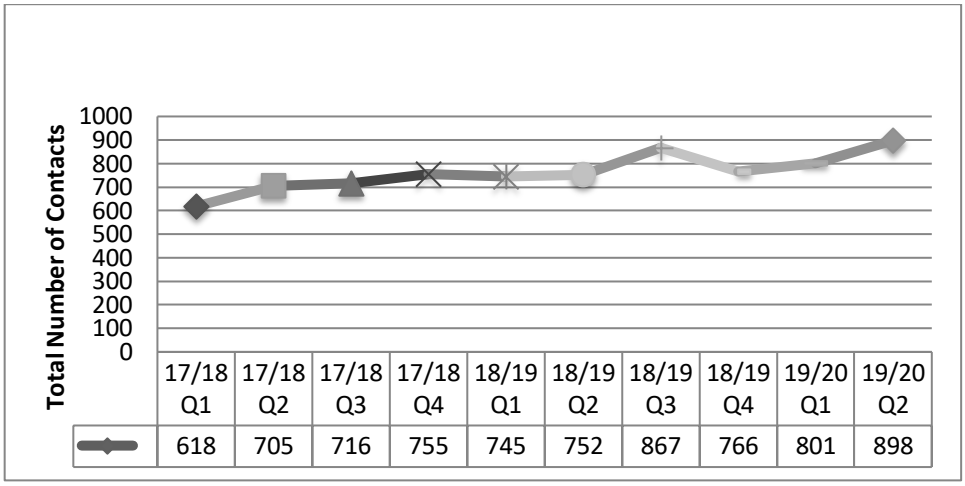
- Assistant Director of Quality and Safety meets every 4 weeks with Coroner's Services Manager, HM Coroner's Office Bradford, to build relationships and monitor improvement from HM Coroner perspective.

3.6. Complaints

Patient Advice and Liaison (PALS) Contacts

During quarter 2 the PALS team had 898 contacts, an increase of 12% from Q1 2019-2020.

Figure 5: PALS Contacts by Quarter from Q1 2017-2018 to Q2 2019-2020



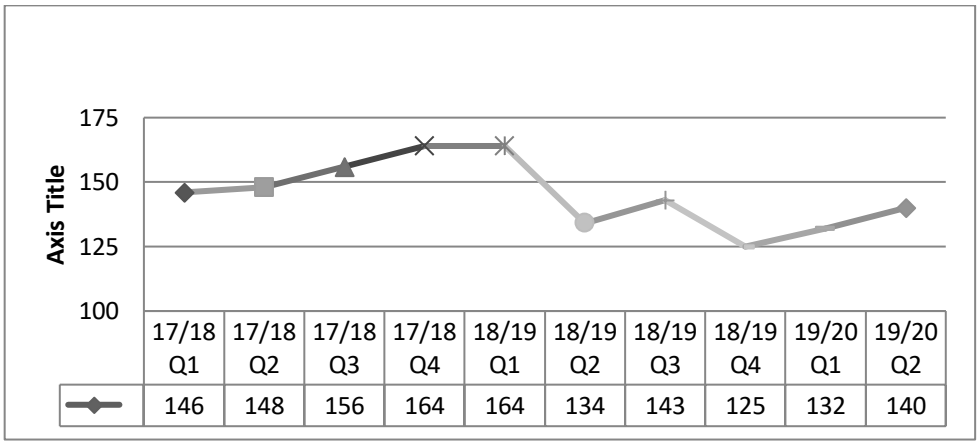
There was a slight increase in the number of PALS concerns escalated to a formal complaint in the Medicine Division during quarter 2, but this is consistent with percentages for the last year, and an improvement on previous years.

Themes from PALS contacts:

- Appointments (including delays and cancellations) were the top subjects of concerns raised during quarter 2, representing 39% of contacts.
- The second highest subject of concern was Communication representing 32% and the third highest subject was Access to Treatment or Drugs, representing 11% of all concerns.

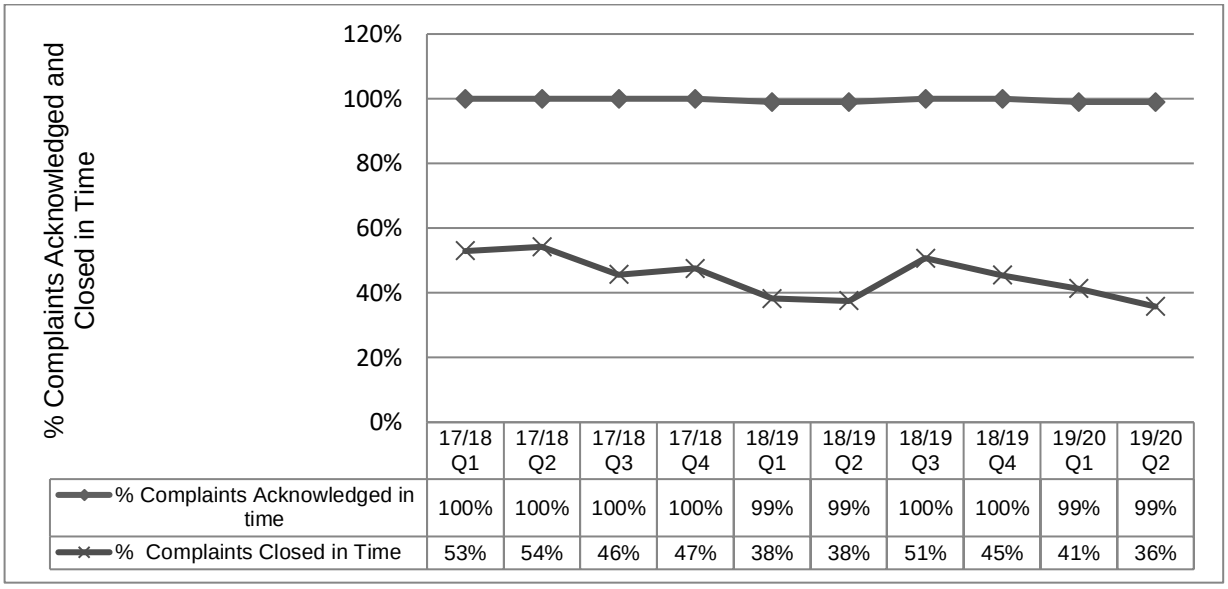
There has been a slight increase in the number of complaints received in quarter 2 compared to quarter 1.

Figure 6: Complaints Received by Quarter (2017- 2018 Quarter 1 to 2019-2020 Quarter 2)



- 99% of complaints were acknowledged in time (3 working days)
- 36% of complaints were close in time in Quarter 2.

Figure 7: Percentage of Complaints Acknowledged and Closed in Time (2017- 2018 Quarter 1 to 2019-2020 Quarter 2)



	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
% Complaints Acknowledged in time	100%	100%	100%	100%	99%	99%	100%	100%	99%	99%
% Complaints Closed in Time	53%	54%	46%	47%	38%	38%	51%	45%	41%	36%

Complaints Themes

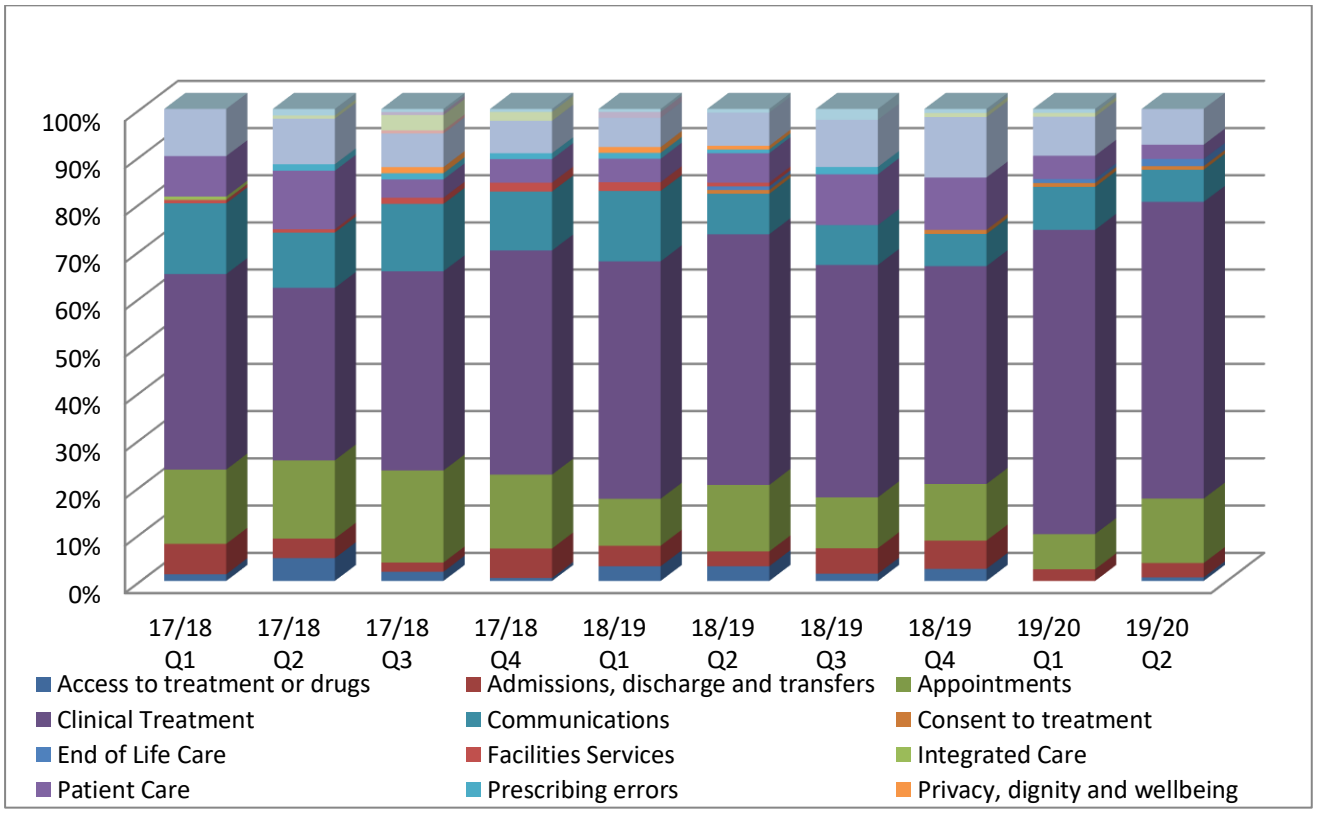
During Quarter 2 there was an increase in complaints related to:

- Appointments (n=18 vs n=9 in Q1)
- Clinical treatment (n=83 vs n=78 in Q1)

There was a small reduction in complaints related to:

- Communication (n=9 vs n=11 in Q1).

Figure 8: Complaint theme by Quarter (2017- 2018 Quarter 1 to 2019-2020 Quarter 2)



Reopened Complaints

Complaints are reopened when:

- The response failed to address all issues and concerns raised by the complainant.
- Parliamentary and Health Service Ombudsman open an investigation into our handling of a complaint

Figure 9: Percentage of Complaints Reopened (2017- 2018 Quarter 1 to 2019-2020 Quarter 2)

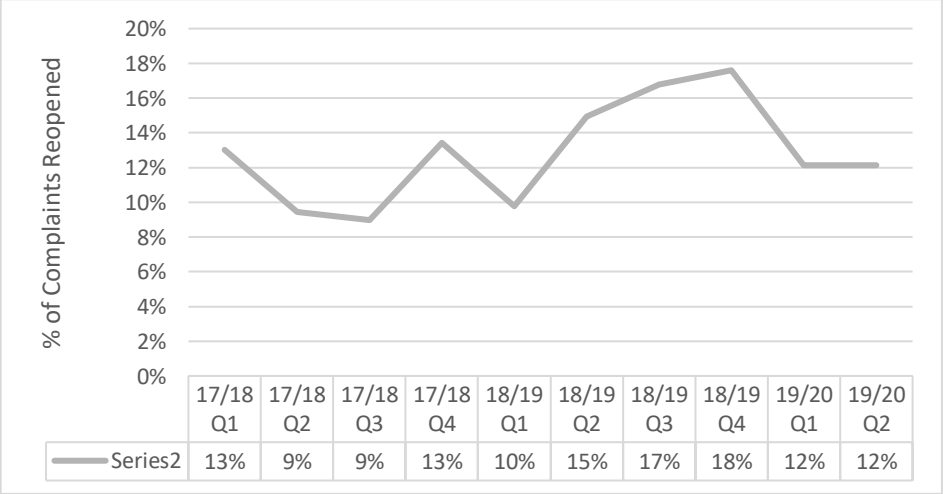
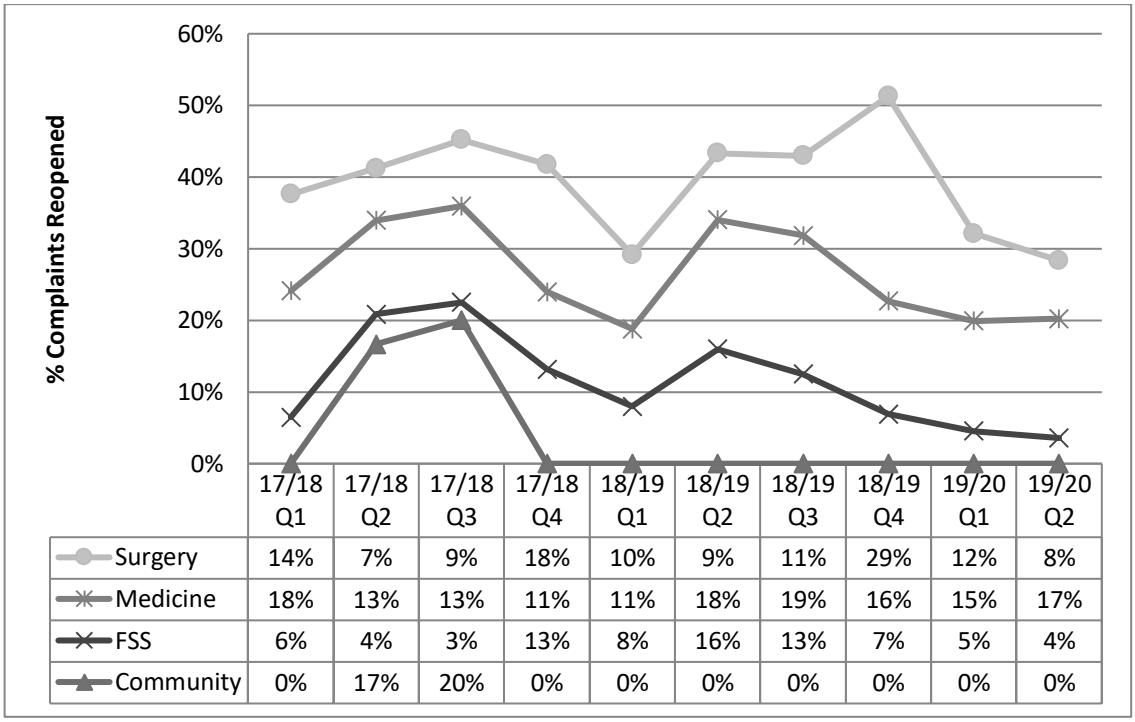


Figure 10: Percentage of Complaints Reopened by Division (2017- 2018 Quarter 1 to 2019-2020 Quarter 2)



	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Surgery	14%	7%	9%	18%	10%	9%	11%	29%	12%	8%
Medicine	18%	13%	13%	11%	11%	18%	19%	16%	15%	17%
FSS	6%	4%	3%	13%	8%	16%	13%	7%	5%	4%
Community	0%	17%	20%	0%	0%	0%	0%	0%	0%	0%

Surgery and FSS Divisions have had a quarter by quarter reduction in the % of complaints reopened for the last three quarters suggesting improvement in the quality of complaint investigations.

Medicine Division have had similar % of complaints reopened in each of the last three quarters suggesting there needs to be a focus on improving the quality of the Divisions investigations and report writing.

Parliamentary and Health Service Ombudsman

Table 8: Summary of Parliamentary and Health Service Ombudsman Cases in Quarter 2

	Q2 2019-20
Number of New PHSO Cases	0
Number of Closed PHSO Cases	3
Number of PHSO Cases UPHELD	0
Number of PHSO Cases NOT UPHELD	2
Number of PHSO Cases PARTIALLY UPHELD	1

Update on work to improve complaints handling

New intranet site

The PALS and Complaints Team have developed and launched a new intranet site to support staff undertaking complaint investigations. The intranet site provides a range of resources including the master class investigator training slides and the complaints process flowchart as well as contact details for all team members.

Additional Capacity in the Emergency Directorate

Additional capacity was funded for the Emergency Directorate during quarter 2 to enable front line nursing and medical staff to focus on clinical care whilst still ensuring a timely response to complaints. A new nursing model has been put in place and so this post has been discontinued from the middle of November.

Bank administrative hours have been used whilst the vacant Patient Advice and Complaints Administrator post has been recruited to.

Sharing Learning

In response to requests for more bespoke support and supervision, the Complaints Team started a weekly 'drop in' session from 9am -10am each Thursday for complaint managers to discuss any issues about the investigative process or report writing. Uptake of the session, called 'Coffee, croissants and complaints', has been good, especially from the Medical Division.

Investigator Checklist

Whilst considering various ways to support and assist investigators, it was highlighted that there is an 'investigator checklist' uploaded to the template section on Datix. This checklist was recirculated to the Divisional leads to share with both new and existing investigators so that they may use this as a helpful tool to assist in their investigations (see appendix 1).

Complaints improvement priorities for Quarter 3 are:

Reduce the number of formal complaints received

From 1 October the PALS team will be working with colleagues in all clinical areas to improve front line resolution and improve the quality of clinical documentation about conversations related to patient care. The project ('Everyone's a PAL - Speak to Sister, Meet with Matron') is being supported by the Associate Directors of Nursing.

Increase the number of complaints closed per week.

Changes to PALS/ complaints administrative team aimed at streamlining processes by up skilling colleagues across all areas of the service to provide flexibility at times of peak activity.

Reduce the number of complaints awaiting response and number of complaints breaching agreed timescale

Medicine Division have engaged a temporary member of staff to help create capacity to manage complaints in a timely manner.

Complaints panels take place in Medical and Surgical Division. Colleagues are scheduled to attend Panel to enable quality and progress monitoring, and ensure colleagues are appropriately supported throughout the process. Attendance is variable with some colleagues choosing not to attend despite delayed and poor-quality responses. During Quarter 3 and 4 the Divisions will move to a more formal process to invite colleagues to attend panel and follow up if they do not attend.

Evaluation of colleague's experiences of receiving feedback about their complaint's responses

A formal evaluation of colleague's experiences' of receiving feedback will be undertaken during quarter 3.

4. Domain Responsive: Services are organised so that they meet people's needs

4.1. Outpatients Improvement

During quarter 2, the Trust have systematically sought to understand outpatients and appointments issues from the perspective of patients (through concerns, complaints and feedback) and stakeholders including clinical colleagues, Divisions and services, general practitioners and administrative staff. The trust has been in communication with CQC throughout quarter 2 about issues raised to CQC by anonymous GP/s.

A 'deep dive' was undertaken. The purpose of the deep dive was:

- To ensure all issues related to outpatients and appointments were known.
- To ensure clarity of the issues i.e. do we all understand them and the associated risks.
- To agree the priorities for resolution and associated timelines.

Three key issues were identified from the deep dive:

- Issues related to EPR and digital patient communications
- User Issues
- Access issues - Capacity / Demand

In addition, the Trust commissioned an external, independent review of issues raised by the CQC and others about current outpatient provision at the trust. The external, independent review focused on:

- Identification of current risks and the consequent priorities for the Trust.
- The experiences of users of the outpatient service (patients and clinicians) and staff engaged in
- managing the service.

Four issues were identified from the external independent review:

- The number of patient lists managed across the outpatient system.
- Training of staff managing the outpatient system.
- The number of cancelled appointments and clinics.
- Communication with patients.

Priorities for quarter 3:

- Ongoing delivery and assurance monitoring of the combined action plan developed to address recommendations emerging from the findings of the deep dive and the external independent review. Progress with action is being monitored by the Weekly Executive Board.
- A key solution to many of the issues is Outpatient transformation which needs to be accelerated however there is also a requirement to align this clinical pathway work with the administrative system to ensure data quality is not compromised.
- Some solutions require agreement with Bradford Teaching Hospitals NHS Trust and there are some delays occurring as a consequence. There is a planned Cerner upgrade scheduled for 2020, at this point it is unclear how many of the issues this solution may resolve, and early confirmation is required which will support prioritisation and upgrade timeline.
- There is a clear connection between the outpatient deep dive and the RTT diagnostic/field testing work and the 3 workstreams are being managed together. A visit from the national team is scheduled for 11th October.

5. Effective: Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

5.1. Infection and Prevention Control

Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI).

Table 9: Quarter 2 Update against Key Performance Indicators

Indicator	Update
MRSA bacteraemia (Trust assigned)	1 MRSA case attributed to the organisation. The case was deemed as unavoidable following investigation.
C.difficile (Trust assigned)	At the end of Q2 there have been 13 cases- Of the 4 preventable cases there are some antimicrobial prescribing issues, the areas are being supported by the Microbiologists and pharmacy to improved prescribing in line with guidance. The Deep clean and HPV of high-risk wards. This has been approved again for the forthcoming year and the programme commenced on the 1st June 2019 and will be complete at the end of October.
MSSA bacteraemia (Post admission)	There have been 10 post-admission MSSA bacteraemia cases during Q1 and Q2. A review of cases has been undertaken, there is no common theme, and ongoing cases will be reviewed on a monthly basis.
E. coli bacteraemia (Post admission)	There have been 18 post-admission E-coli bacteraemia cases since the 1st April 2019. New guidance is due to be published within the next couple of months to aid organisations on how to achieve reductions, with the date for reductions being extended to 2024.
ANTT Competency assessments	*As of the 1st September 2019, all staff who undertake ANTT will require re-assessment every three years. This will have an initial impact on the ANTT performance matrix as staff ESR records will automatically lapse to RED if their previous assessment was more than 3 years ago (before 1st September 2016).

Indicator	Update
	To counteract this all staff that have not been assessed during the last 3 years are advised to undertake an ANTT re-assessment as soon as possible. Trust compliance on 14 October 2019 is 54%.
Isolation breeches	There have been 253 isolation breaches since 1st April 2019 compared to 164 breaches for the previous year. Most breaches are patients with a previous history of MRSA or ESBL at the time of admission to MAU or attending ED, or patients being transferred, and their infection status not being handed over, although this information is all clearly visible within the EPR. The Infection Prevention and Control team will continue to monitor isolation breaches; actions to reduce breaches have been included in the HCAI annual action plan, this includes ongoing work within the medical division where the majority of breaches occur.
Influenza Vaccination 	The 2019-2020 Health and Social Care Workers Influenza Vaccine Campaign 'Time to get your flu jab' started on 30 September 2019. The campaign led by Public Health England in partnership with and NHS England & NHS Improvement focuses on the protective benefit of the flu vaccination using a "Shield" motif. Influenza vaccination is recommended for all frontline NHS staff. This year's campaign aims to offer vaccination to 100% of frontline staff with at least 80% of staff taking up the offer. At CHFT frontline staff working in direct admissions areas including ED have been offered the vaccine during phase one of the campaign.
Quality Improvement Environmental Audits	26 Quality improvement environmental audits have been carried out since the beginning 1st April 2019 to 31st July 2019. Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating. 15 of the areas achieved a green rating. 10 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified. 1 area was deemed as a Red rating; the Diabetic centre at CRH, an action plan is being developed and a re-audit took place in September and scored a Green rating.

5.2. Acute Kidney Injury

A new multi-disciplinary collaborative group was established in quarter 2.

The group held two meetings during the quarter and have begun to develop programme aims and a work plan for the next 12 months.

Improvement priorities for quarter 3 are:

- Confirmation of programme aims and workplan.
- AKI Bundle and EPR: Orientation to where it is in EPR and what it contains.
- Finalise AKI dashboard and measurement for improvement metrics.
- 'Go see' to trusts with well-established programmes.
- Leadership - AKI nurse post being advertised in October.
- Improvement work around referral processes – currently these are predominantly paper based so the aim is to ensure all referrals are via EPR.

6. Well Led: The Leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

6.1. Staffing Fill Rates

Average fill rates are monitored and reported to Board each month.

The report has been developed within the last quarter to clearly identify key areas of concern and mitigating action taken. Average fill rates have maintained through Q2 (see Table 20 below).

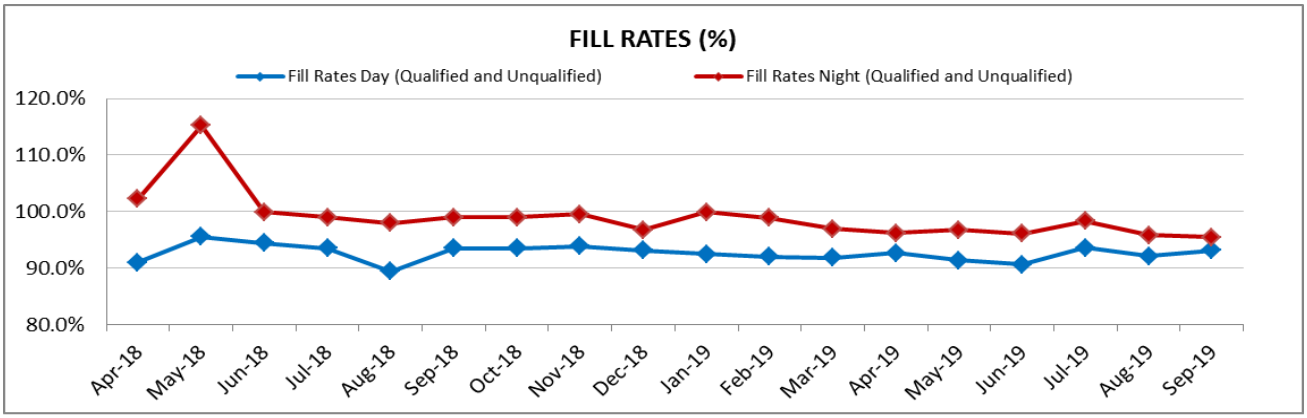
Care hours per patient day (CHPPD)[2] rates for the Trust have also maintained through Q2 but are slightly below the planned position (See Table 20 below). Areas with less than 75% fill rate for both registered nurses (RN) and care staff has remained a challenge in certain areas.

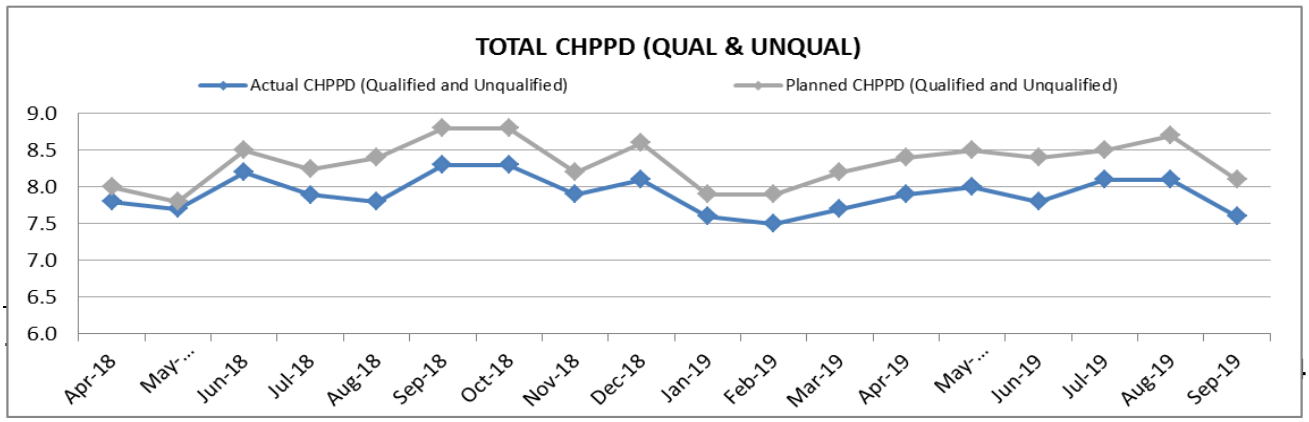
- Evidence of fill rates in excess of 100% for RN reflects areas achieving supervisory status; new recruits to the trust within their supernumerary period and additional staffing in flexible capacity areas.
- Fill rates of less than 75% have been attributed to: increased bed capacity demand Sickness; Vacancies; Increased long days (resulting in the right number of nurses on shift but reduced total nursing hours per day).

For care staff fill rates of over 100% reflect the additional shifts required to support 1-1 care, and increased care staff hours to support reduced fill rate for qualified nurses.

The actual staffing position can be reviewed by the senior nursing team at any point in the day utilising safe care live. This innovative technology is now used in the daily staffing meeting to:

- Review utilisation of the nursing workforce.
- Support effective deployment of the workforce to meet patient demand.
- Ensure staffing levels are appropriate to the acuity and dependency needs of the patients.





6.2. Essential Safety Training

In order to have a workforce which delivers safe and compassionate care, the trust has identified 9 core subjects of essential safety training applicable to all colleagues in the Trust and role specific training compliance. All subjects are always required to be at a consistent compliance rate of 90%.

a) Essential Safety Training

Overall compliance for Essential Safety Training at the end of Q2 is 94.85%, please see Appendix 1 for breakdown by core subject.

b) Role Specific Training

There are 34 Role Specific Training Courses (Appendix 2).

Compliance at the end of Quarter 2:

- 8 courses have 90% or more compliance
- 4 courses have between 85 and 89.99% compliance
- 21 courses have less than 85% compliance.

Of the 21 courses BRAG rated red (<84.99%) 6 are maternity courses, 2 courses are related to care and management of the sick child, 2 end of life and 1 adult resuscitation. The Divisional Patient Safety Quality Boards have been asked to provide an update on local action plans to address training deficits to the November Patient Safety Group.

6.3. External Agency Visits, Inspections and Accreditations

The Trust regularly receives visits, either invited or as part of an inspection or accreditation process. It is important that the Trust is appropriately prepared in order to get the most value from the visit; to ensure that any actions are completed in a timely manner; any risks are identified and that any learning is shared across the Trust.

The 'External Agency Visits, Inspections and Accreditations Policy' provides the framework to support colleagues to prepare for and manage external visits and to monitor the governance processes that provide assurance about progress against any actions or gaps identified pre- or post-visit are addressed in a timely manner.

During quarter 2 the Trust received the final report of the Royal College of Physicians Invited Services Review into the Trust management of the four Never Events and respiratory Services. The report concluded that:

- There were missed opportunities in terms of the trusts to respond to patient safety alerts.
- Overall, the response of the Trust to the two Never Events which occurred in early 2019 has been thorough. Senior managers reacted immediately and realised that education alone would not be sufficient to avoid a reoccurrence of the problem. Ahead of the root cause analysis took place, air outlets were closed off and were checked several times a day and at regular intervals during the night to ensure they were no longer accessible. The purchase of 15 nebulizers was also commissioned so that there would no longer be a need to use the air from wall outlets and, to prevent their use, flowmeters were locked away.
- There appears to be a good culture of incident reporting at CHFT. However, improvements could have been made to overview of key themes relating to NIV.

The Medical Speciality Directorate have developed an action plan in response, this is being monitored via Medicine Division Patient Safety and Quality Board, reporting to Quality Committee.

Table 9: External agency visits, inspections and accreditations during Quarter 2.

Assurance Type	External agency visits, inspections and accreditations	Position Statement and Governance Arrangements
Accreditation	EL (97)52 Audit of CRH Aseptic Unit	Background: Audit of HRI Aseptic Unit (April 2017) re audit Nov 2017, May 2018 & Jan 2019. Risk rating for this site currently remains "High". Re audit carried out Jan 2019. May 2019 - The auditor has closed out the audit and acknowledges the improvements made since the previous audit, particularly in respect of Capacity Management and detailed planning to support the shutdown of the CRH unit. The overall risk level assigned to this unit is "High".
Accreditation	Health Informatics ISO 27001	Accredited.
Invited Service Review -	Respiratory Services – Invited Service Review	Final report received August. Action plan devised. Governance – Quality Committee via Medicine PSQB.

Table 10: External agency visits, inspections and accreditations planned for Quarter 3.

Assurance Type	External agency visits, inspections and accreditations	Position Statement and Governance Arrangements
Peer Review	Neonatal Service Review	Visit Date: 21 October 2019
Accreditation	National Bowel Cancer Screening Programme	Visit Date: 4 and 5 November 2019
Accreditation	QSI (ISAS –Radiology Accreditation Scheme)	Visit Date: 13 December 2019
Accreditation	Pathology UKAS ISO 15189	Visit Date: December 2019

6.4. Care Quality Commission Response Group Update

a) Relationship Meetings

No relationship meetings took place during quarter 2 (Meetings held in May 2019 and October 2019), although there were a few contacts from the CQC relationship manager to update on the outcomes of serious incident investigations and HSIB investigations.

b) Update on CQC Exceptions Action Plan – Update on 'Must Dos' & 'Should Dos'

At the end of quarter 2, a further 3 ‘must do’ and 5 ‘should do’ had been completed and embedded in relevant core service areas.

2 ‘must do’ and 3 ‘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.

Table 11: Summary of achievements in quarter 2

Title	Update
CQC Style Invited Peer Reviews	Two CQC style invited peer reviews took place in quarter 2. These were Medicines Management Peer Review and Nutrition & Hydration Peer Review (Findings and actions discussed in sections 2.6 and 3.2 of this report).
Launch of the new CHFT CQC Intranet Page	In July the CHFT CQC Intranet pages where updated and re-launched as a ‘Resource Centre for Everything CQC’. The aim was to be able to provide colleagues with all information relating to CQC in one place. The pages are updated as a minimum of a monthly basis and include: - Links to past CHFT CQC Reports - Links to CQC reports from outstanding rated trusts - All CQC Core Service Frameworks - Assurance Tools i.e. health checks - Escalation process if CQC arrive unannounced - Important communication published by CQC i.e. updated guidance, newsletters, annual reports.
Work Force & Organisational Development Well-Led Health Check	A representative from WOD presented the findings from their Well-Led review at the August CQC Response Group. The review identified numerous examples of opportunities to be Outstanding across the Well-Led domain including: i. Use Succession planning toolkit in the Directorate ii. Mental Health Lead in the Directorate iii. The Cupboard can be further developed to incorporate the performance targets and/or key outcomes for our two local authorities iv. The Senior WOD Team now meet each year to set out priorities that align with the One-year plan on a page. These are cascaded at Time-Outs so that team plans are also working towards the same performance measures, which will provide an opportunity for outstanding. v. The 5-year Vision and strategy on a page, includes a column on workforce for the future. The directorate also identified and presented clear priorities for the next quarter.
Assessment preparation framework	Revise core service self-assessment documents following feedback about health check documents from clinical team
CQC Insight Report	The CHFT CQC Insight Summary Report was presented at the August CQC Response Group. A new approach to managing the monthly Insight report

	published by CQC was agreed. The group requested that position statements were submitted from the governance forums with oversight of anything flagged red on the report. This included any area flagged as a drop in performance since the last report or anything in which CHFT is flagged as being below the nation average. Work is ongoing to collate all position statements. A new monitoring template has been developed to include the position statements and eventually a trust response. The report is a standing item at the CQC Response Group and is presented quarterly at the Risk and Compliance Group.
CQC Digital Triage Sandboxing	In August the Care Quality Commission invited innovators and services using digital clinical triage to join its regulatory sandbox. Trialing 'sandboxing' is part of CQC's work to encourage innovation, quality and safety. This first round looked at how NHS providers are working with industries to digitise clinical triage. CHFT submitted an expression of interest to showcase its Nerve Centre clinical triage system. Unfortunately, on this occasion CHFT was not selected to partake in trailing the sandboxing. There is an opportunity to remain involved in the work remotely and to meet participants in December.

Improvement priorities for quarter 3 are:

- PIR preparation – all narrative sections to be complete, quality checked and ready for submission.
- CQC inspection preparation CQC Core Service Self Assessments for:

a) End of Life Care, Children and Young Peoples Services and Gynaecology.

b) Surgery, Urgent & Emergency Services and Outpatients.

- Go See to Outstanding Trusts arranged for November 2019 (Newcastle) and October 2019 (Gateshead).
- To create an external CQC focused "Go See planning guide" to ensure the Trust gets the most out of every external Go See visit – to include proforma of generic questions.
- Learning Portal to be live on the CHFT Intranet page.
- Sharing Learning Guide to be available for all colleagues.
- How to achieve Outstanding – focused work looking at what is Outstanding for each domain.
- To raise awareness about CQC across the trust as part of the preparation for the next inspection – tea trolley rounds, CQC information drop in sessions.

7. CQUIN Update

The Trust and Clinical Commissioning Group agreed five CQUINs for 2019-2020. Progress against all five CQUINS is presented in Table 19.

Table 12: Quarter 2 Update on Progress with CQUINs

CQUIN	Target	Quarter 2 Update
CCG 1a and b Antimicrobial resistance	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment. Achieving 90% of antibiotic surgical prophylaxis prescriptions	Target 90% (partial achievement 60-90%) Q1 compliance 8% - Q1 data is being officially discounted nationally Q2 compliance 43% M6 compliance 76% Q1 compliance – 85%

	for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	Q2 compliance – 86%
CCG 2 Staff Flu Vaccinations	Achieving an 80% uptake in staff flu vaccinations of frontline staff	The national flu vaccination campaign got underway at the end of Quarter 2 – week commencing 23rd September and as of 15th October, uptake was 15%. The campaign will run until Feb 2020, when it is anticipated over 80% of frontline staff will have had their vaccination. Over quarter three, there will be: • Weekly flu strategy group meetings to maintain campaign plan and monitor progress • Weekly data reports to Divisional leads and WEB • Flu CHFT campaign launch / prizes and comms in November once all vaccine stock is received
CCG 3 Alcohol and Tobacco	Achieving at least 80% of inpatients who are inpatients for at least one night are screened for alcohol and tobacco use. Achieving 90% of identified smokers given brief advice. Achieving at least 90% of patients identified as drinking above low risk levels, given brief advice or offered specialist referrals.	Overall CQUIN at 30% for Q2 which is an improvement from Q1 which was at 27.2%.
CCG 7 Three high impact actions to prevent Hospital Falls	Achieving 80% of older inpatients patients receiving key falls preventions interventions	Q1 Performance – 12% Q2 Performance – 64%
CCG 11 Same Day Emergency Care	Achieving 75% of patients with stated diagnosis being managed in a same day setting where clinically appropriate.	Complete quarter 2 audit results are not available at the time of this report, however indications from the CQUIN lead are that it is expected that performance will be in line with quarter 1 performance: CCG 11a Pulmonary Embolus Q1 – 100% CCG 11b Tachycardia with Atrial Fibrillation Q1 – 91.4% CCG 11c Community Acquired Pneumonia Q1 - 97.7%

8. Quality Account Priorities

The Trust identified three quality priorities for 2019-2020. Progress has been made against all three priorities during quarter 1 and quarter 2 with further improvement actions planned for quarters 3 and 4.

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

Table 13: Summary of Progress in Quarter 1 and Quarter 2 Priority 1

What did we plan to do during 19/20?	Summary of Progress in Quarter 1 and Quarter 2
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. The new band 7 'streaming nurses' are now in place so it is anticipated further improvements will be seen from November
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. A dashboard has been developed which breaks down time to triage and length of stay in ED so that patient experience and outcomes can be analysed.
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.

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.

Table 14: Summary of Progress in Quarter 1 and Quarter 2 Priority 2.

What did we plan to do during 19/20?	Summary of Progress in Quarter 1 and Quarter 2
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. 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, supported by the Dementia Task and Finish Group.
Analyse outcome data from patients with raised NEWS.	Action continues, with reports due from Q3.

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.

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

Table 15: Summary of Progress in Quarter 1 and Quarter 2 Priority Three

What did we plan to do during 19/20?	Summary of Progress in Quarter 1 and Quarter 2
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 is a core member 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.

9. Recommendations to Board of Directors

The Board of Directors is recommended to note the content of the report and activities across the Trust to improve the quality and safety of patient care.

Appendix 1: Essential Safety Training Compliance

Subject	Renewal Period	1 Oct 2019	Rating[3]
Dementia Awareness	Once only	98.72%	
Health & Safety	3 years	97.86%	
Equality & Diversity	3 years	97%	
Conflict Resolution	2 years	95.65%	
Fire Safety	Annual	94.92%	
Infection Control	Annual	93.90%	
Moving and Handling	3 years	93.17%	
Data Security Awareness	Annual	92.53%	
Safeguarding Children	3 years	92.86%	
Safeguarding Adults	3 years	91.89%	

[3] As at 1 April 2019 the EST targets have changed as follows:

95% + Stretch Target	
90% - 94.99%	
85% - 89.99%	
-84.99%	

Appendix 2 Role Specific Training Compliance

Subject	Renewal Period	Required	Outstanding	1 October 2019	Rating
Anti D training	Once Only	182	3	98.35%	
Preventing Falls	3 years	2872	71	97.11%	
Oxygen Knowledge & Knowledge Assessment	3 years	1381	60	95.57%	
Breastfeeding Update	2 years	228	11	95.20%	
New2 Self Declaration	Once Only	993	56	94.92%	
Food Hygiene & Safety	3 years	1210	77	93.98%	
Waste Management	Once Only	3697	295	92.49%	
Female Genital Mutilation	Once Only	484	39	93.26%	
Deprivation of Liberty Safeguarding Level 2	3 years	3075	271	91.10%	
Safer Insulin Awareness Training	Once Only	2250	226	90.24%	
Pressure Ulcer Care	2 years	2508	306	87.59%	
Blood Transfusion – Registered Staff	2 years	1194	161	87.11%	
MUST	3 years	829	115	86.17%	
SABINE	Annual	198	30	84.85%	
Moving & Handling for Inanimate Load Handlers	2 years	13	2	84.62%	
Medicines Management Awareness	2 years	1543	238	84.80%	
Deprivation of Liberty Safeguarding Level 3	3 years	740	131	83%	
Antenatal Newborn Screening	Annual	178	36	80.90%	
Moving & Handling for People Handlers	2 years	2967	611	79.91%	
Safeguarding in Athena	Once Only	279	58	81.36%	
End of Life Care Level 3	3 years	1287	280	76.53%	

Infection Control – Level 2	2 years	3568	802	76.48%	
Maternity Obstetric Emergency Training (PROMPT)	Annual	268	62	73.98%	
NGT	Once Only	488	124	76.74%	
Clinical Pathways for Sick Children	Once Only	155	53	64.94%	
Resuscitation – Adult Basic Life Support	Annual	3085	1113	64.58%	
Perinatal Mental Health	3 years	182	68	62.64%	
Aseptic Non Touch Technique (ANTT)	3 years	3074	1319	54.47%	
Fetal Monitoring Programme (K2)	Annual	215	96	54.42%	
Blood Transfusion – Collecting Blood (Non-qualified staff)	Once Only	540	248	53.85%	
Resuscitation – Paediatric Basic Life Support	Annual	498	235	52.32%	
Resuscitation	2 years	526	255	51.53%	
Fire Warden Training	3 years	916	450	50.22%	
End of Life Care Level 2	3 years	349	183	46.41%	

12. Care Quality Commission (CQC) and Use of Resources Update

To Note

Presented by Ellen Armistead

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	CQC Update Quarter 2 2019/20
Author:	Shelley Rochford, CQC Compliance Manager Anne-Marie Henshaw, Assistant Director of Quality and Safety
Sponsor:	Ellen Armistead, Executive Nurse Director/ Deputy Chief Executive
Previous Forums:	Quality Committee - 4 November 2019

Actions Requested:

- For information

Purpose of the Report

This paper provides a summary of the key actions which have been undertaken in the quarter 2 2019 in relation to CQC work and priorities for quarter 3.

Key Points to Note

During quarter 2 there has been a focus on:

- Continuous monitoring of the 2019/20 CQC Exceptions Action plan.
- Self-Assessments to ensure compliance against CQC Core Service Frameworks.
- Preparation of the PIR document.
- Identifying Outstanding practice across the Trust and opportunities for sharing learning.
- Benchmarking core services against Outstanding rated trusts.
- Preparation for the developmental well-led review.

EQIA – Equality Impact Assessment

An equality impact assessment has been undertaken. In terms of the actions within the paper there would not be any potential equality impact.

Recommendation

The Board of Directors is requested to:

- Note progress with must do and should do actions.
- Be aware of the should do actions which are not progressing to plan.
- Be aware of the continuous work to ensure regulatory compliance across the Trust.
- Consider the next steps re Well-led assessments.
- Note the updated Terms of Reference for the CQC Response Group.
- Be aware of the key priorities/work streams in relation to CQC preparation in quarter 3.

compassionate care

CQC Update Quarter 2 2019/20

1. Introduction

This paper provides a summary of the key actions which have been undertaken in the quarter 2 2019 in relation to CQC work. This work includes:

- Continuous monitoring of the 2019/20 CQC Exceptions Action plan
- Self-Assessments to ensure compliance against CQC Core Service Frameworks
- Identifying Outstanding practice across the Trust and opportunities for sharing learning.
- Benchmarking core services against Outstanding rated trusts.

The CQC Response Group has met twice in quarter 2, July & August.

The September meeting was cancelled due to the 'Back to the Floor Week'.

2. 2019/20 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

At the end of quarter 2, a further 3 'must do' and 5 'should do' actions from the 2018-2019 Post CQC Inspection Action Plan had been completed and embedded in relevant core service areas.

2 'must do' and 3 'should do' actions 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.

MD1	The trust must improve its financial performance to ensure services are sustainable in the future	BRAG rating from **Amber** to **Green**
MD2	The trust must ensure they have robust systems for checking equipment and consumables and identifying and disposing of expired items.	BRAG rating from **Green** to **Blue**
MD4	The trust must ensure that they meet environmental audit targets for cleanliness or infection control.	BRAG rating from **Green** to **Blue**
MD5	The trust must ensure that deviations to appropriate fridge temperatures are escalated in line with internal policies.	BRAG rating from **Green** to **Blue**
SD3	The trust should develop processes to measure the outcomes of mental health patients in order to identify	BRAG rating from **Amber** to **Green**
SD6	The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	BRAG rating from **Amber** to **Green**.
SD10	The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.	BRAG rating from **Green** to **Blue**

SD21	The trust should continue to monitor transfer rates from Huddersfield Birth centre to the Calderdale site, and review why rates appear high compared to national averages.	BRAG rating from **Green** to **Blue**
SD28	The trust should ensure that arrangements are in place to monitor when band five staff are in charge of ward 18 without the advanced paediatric nurse practitioner (APNP) being present being present.	BRAG rating from **Green** to **Blue**
SD37	The trust has opportunity to improve exists in the pay cost / WAU at the trust, particularly in regards to agency staffing. The trust needs to demonstrate an improvement path towards at least a median cost per WAU.	BRAG rating from **Green** to **Blue**
SD38	In 2017/18 the trust is forecasting to save £2 million less than the £20 million target described in its CIP, with 50% being recurrent. The trust needs to improve its identification of recurrent opportunities for savings and productivity in line with the opportunities identified in this report so that it can reduce its underlying financial deficit and bring financial performance back in line with its 5 year recovery plan.	BRAG rating from **Green** to **Blue**
SD39	The trust needs to ensure it delivers the return on investment and maximises realisation of the benefits of the innovative technologies it has implemented, including a plan to maximise the opportunities provided by the EPR implementation and the overall digital maturity.	BRAG rating from **Green** to **Blue**
SD40	Whilst the trust has provided evidence of investment in a number of initiatives it was not always clear that the impact was fully understood or that sufficient evidence was available to be able to demonstrate the return on investment. The trust must ensure that it has robust systems of measurement in place to track investments and enable timely decision making about their effectiveness.	BRAG rating from **Green** to **Blue**

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.

SD21 HRI: The trust should continue to monitor transfer rates from Huddersfield Birth centre to the Calderdale site, and review why rates appear high compared to national averages was signed off as embedded following presentation of an in-depth review of the Huddersfield Birth Centre undertaken by the Reader in Midwifery. The review did not identify any significant areas of concern in relation to transfer rates or practices from HBC.

There was some indication that there is currently a low threshold for risk in relation to decision to transfer, this may be appropriate, and recommendations were made to help provide support and confidence to midwives working on HBC.

The CQC inspection included a separate assessment of Use of Resources (UoR) which is a review carried out by NHS Improvement. At the last review CHFT was rated as Requires Improvement for UoR which is reflective of the Trust's deficit position and reliance upon cash borrowing.

Following the UoR review the Trust developed an action plan which formed part of the overall CQC action plan and associated monitoring. The formal recommendations from this visit were crystallised into just one 'Must Do' action and four 'Should Do' actions. The Trust has taken the pro-active approach of also drawing out from the inspection report a number of further observations where action could usefully be pursued. All of these actions were reviewed by Finance and Performance Committee in July and ratified with expanded measurable outcomes described in September 2018. Further updates on progress have and continue to be scheduled for reporting to the Finance and Performance Committee.

In addition, the Trust has benchmarked its position against Leeds Teaching Hospitals (LTH) who were assessed as Outstanding during their use of resources assessment. The comparison has been undertaken to learn from the LTH position but also to support and track progress being made by CHFT in its journey to outstanding. At time of assessment there were a number of metrics in CHFT that were better than those at LTH, however, the key metrics where LTH were favourable related to their overall surplus and cash position. Additionally, their staff costs per Weighted Activity Unit (WAU) were significantly better which contributes to their overall healthier financial position. Staff cost per WAU is seen as a key efficiency indicator which can either be used to suggest greater volume of work per Whole Time Equivalent (WTE), or less cost per WTE and more efficient skill mix.

The challenge for CHFT remains to improve the deficit in line with agreed plans and SOC, and to continue to deliver the plans recurrently as per the recent track record.

3. CQC Update and Engagement Meetings

In line with the new CQC strategy, scheduled engagement meetings have taken place between the trust and the CQC in March, May and October 2019.

The Trust have been advised by the CQC that from 1 September 2019 we have a new Inspection Manager. Ruth Dixon has been replaced by Ruth Sadler. There is no change to CHFT Relationship Manager, Catherine Robson.

From 7 November 2019, services operating from Todmorden Health Centre and Broad Street Plaza will transfer to the CQC mental health directorate. An early meeting has been arranged to understand what the implications of the transfer might be on inspection approach.

During quarter 2, the CQC Relationship Manager spent a day visiting critical care in HRI and CRH, and visits are planned for a visit to the Emergency Departments at both sites in November 19.

CQC have attended the following trust meetings during quarter 1 and quarter 2:

- Quality Committee June 2019
- Patient Safety Group May 2019

At the end of quarter 2 the Trust has 13 open enquiries with CQC:

- Serious Incidents n=6.
- Invited Service Review – Respiratory.
- Outlier Alert n=2 (Cardiac Pacemaker and National Paediatric Diabetes Audit).
- Complaint n=3 (2 maternity cases that are also inquests, complaint from GP about outpatient appointments and letters).
- Prevention of Future Deaths Report (Regulation 28) – Hard collar.

4. Achievements in Quarter 2

4.1. Updated Terms of Reference for CQC Response Group

Terms of Reference (ToR) for the CQC Response Group have been reviewed. Current ToR focus on trust response and management of an inspection action plan rather than preparation for an upcoming visit. Proposed changes to TOR include:

- Monitoring of compliance against the CQC fundamental standards of quality and safety ensuring that the trust is in a state of continuous readiness for announced and unannounced regulatory inspection.
- Setting direction for the achievement of an overall rating of outstanding.
- Monitoring progress with action plans developed in response to commissioned Invited Service Reviews and external peer reviews.

4.2. CQC Core Service Framework Self-Assessment Toolkit

A CQC Core Service Framework Self-Assessment Toolkit has been developed and approved by the CQC response Group. The toolkit is a core service specific self-assessment tool that will bring together the findings from the Health Checks; ward level, directorate and divisional assurance tools and findings from internal and external reviews which together will be used to self-assess and rate services against each of the 5 domains. The toolkit will allow services to identify practice that may require improvement and opportunities to showcase outstanding.

A work plan has been created for services to present findings to the CQC Response Group for assurance and oversight.

Core services scheduled to update the CQC Response Group in quarter 3 are:

- November Response Group: End of Life Care, Children and Young Peoples Services and Gynaecology.
- December Response Group: Surgery, Urgent & Emergency Services and Outpatients.

4.3. Provider Information Return (PIR) Preparation

There has been ongoing preparation for the next PIR submission throughout quarter 2. Narrative sections of the PIR have been completed by key contacts within divisions and services. This is now a priority piece of work for quarter 3 with the aim that all narrative sections will be complete, quality checked and ready for submission when the formal request is received by CQC.

4.4. Testing compliance with fundamental standards through peer review

Two CQC style peer reviews took place in quarter 2: a ward-based medicines peer review and a nutrition and hydration peer review.

Medicines Management Peer Review

The purpose of the review was to test out the progress made against the 2016 & 2018 CQC recommendations for medicines management and to ensure the actions remained embedded. The focus of the review was:

- Safe storage and administration of medicines on wards.
- Management of CDs including the findings of the internal audit report.
- Review the Trust Response to CQC inspection recommendations.
- Delayed and omitted doses e.g. pain relief, critical medicines.

The Trust invited the Director of Pharmacy from Mid Yorkshire Hospitals NHS Trust to review the service as part of CHFTs CQC style Peer Review Program. Mid Yorks have undertaken a significant improvement programme in relation to ward based medicines and so the review created opportunity to share learning.

Wards were visited across both HRI and CRH sites and the visits were unannounced ensuring the peer review mirrored the approached taken by CQC. A full timetabled schedule was used for the onsite inspection. A full comprehensive report was published to ADNs and Directors post review.

It was agreed by the CQC Response Group that the following actions would be taken in response to the findings from both the External and Internal Peer Reviews:

- Full report to be shared with Assistant Directors of Nursing for consideration and action planning within their divisions.
- Full findings report to go to Medicines Safety Group and Controlled Drug Sub Group for awareness.
- A WTGR event to be organised for pharmacy, to take place end of August.
- Updates regarding action plans and progress on improvement work to be presented at the September CQC Response.

Nutrition & Hydration Peer Review

The purpose of the review was to test out the Trusts compliance with Nutrition and Hydration standards. The focus of the review was:

- Parenteral and enteral care of nutritional complex patients, reviewing the co-ordination of service provision.
- Nutrition and hydration standards compliance for all patients of different ages.
- Decision making and End of Life Care relating to nutrition and hydration.

The Trust invited the lead Consultant Gastroenterologist and team from Leeds Teaching Hospitals NHS Trust to review standards of care. A comprehensive toolkit was provided by CHFT to use to assess the areas.

Wards were visited across both HRI and CRH sites and the visits were unannounced ensuring the peer review mirrored the approached taken by CQC. A full timetabled schedule was used for the onsite inspection. A full comprehensive report was published to ADNs and Directors post review.

In response to the external peer review findings the following actions have been taken to date:

- Consultant Gastroenterologist was present at initial feedback back session and findings escalated to the team via the Gastroenterology Team Meeting.
- The report has been shared with the Divisional Assistant Directors of Nursing, Nutritional Steering Group and Artificial Nutrition Steering Group.
- A bite sized learning in relation to recording MUST scores on EPR was published 19.09.19.

CQC Response Group have recommended that the following actions are taken in response to the findings from the peer review:

- The Nutritional Steering Group and Artificial Nutrition Steering group to be accountable for progressing Action plans to address issues.
- A response required from the Gastroenterology Team about recommendations for enteral and parental nutrition.
- A review to take place of the current CHFT audit programme in relation to artificial nutrition to ensure this meets the best practice audit standards.
- Full report to be shared with wider teams for consideration.
- Updates regarding action plans and progress on improvement work to be presented by the Divisional ADNs at the October CQC Response.
- Internal Peer Review to be organised to check progress of actions

4.5. New CHFT CQC Intranet Page

In July the CHFT CQC Intranet pages where updated and re-launched as a 'Resource Centre for Everything CQC'. The aim was to be able to provide colleagues with all information relating to CQC in one place. The pages, updated as a minimum on a monthly basis and include:

- Links to past CHFT CQC Reports.
- Links to CQC reports from outstanding rated trusts.
- All CQC Core Service Frameworks.
- Assurance Tools i.e. health checks.
- Escalation process if CQC arrive unannounced.
- Important communication published by CQC i.e. updated guidance, newsletters, annual reports.

The new page can be found at: https://intranet.cht.nhs.uk/non-clinical-information/chft-cqc-homepage/

4.6. Well-led Review

An essential element of any future CQC inspection will be the well-led assessment and plans are in place to assess our level of compliance with the CQC key lines of enquiry. A table top assessment has been undertaken in order to provide an analysis of any potential gaps in compliance. This will be used to inform the Developmental well-led Assessment all trusts are expected to commission every three years. The

developmental review will be a focussed review, the aim of which is to build on the table top exercise and provide analysis of those key areas the board will need to focus on going forward.

4.7. CQC Insight Report

The CHFT CQC Insight Summary Report was presented at the August CQC Response Group. A new approach to managing the monthly Insight report published by CQC was agreed. The group requested that position statements were submitted from the governance forums with oversight of anything flagged red on the report. This included any area flagged as a drop in performance since the last report or anything in which CHFT is flagged as being below the national average.

Work is ongoing to collate all position statements. A new monitoring template has been developed to include the position statements and eventually a trust response. The report is a standing item at the CQC Response Group and is presented quarterly at the Risk and Compliance Group.

5. Priorities for Quarter 3

Key priorities for quarter 3 are:

Priority	Action	Lead
PIR preparation	All narrative sections to be complete, quality checked and ready for submission by the end of quarter 3.	ADQS/ DON
CQC inspection preparation	CQC Core Service Self Assessments to be presented at the CQC Response Group for: - End of Life Care - Children and Young Peoples Services - Gynaecology. - Surgery - Urgent & Emergency Services - Outpatients	Divisional Teams
Go See to Outstanding Trusts	A 'go see' visit to Newcastle upon Tyne Hospitals NHS Foundation Trust is planned to take place 8th November 19. The focus of the 'Go See' is: - Pediatrics - flow of patients to theatres and managing pediatric patients in ED. - Quality assurance mechanisms. - CQC inspection preparation. - Learning from Patient Experience - handling complaints and learning.	CQC Compliance Manager
To create a CQC focused 'Go See planning guide'	To ensure colleagues and the Trust get the most out of every external Go See visit – will include proforma of suggested generic questions.	CQC Compliance Manager
Learning Portal to be live on the CHFT Intranet page.	-	CQC Compliance Manager
Sharing Learning Guide to be available for all colleagues.		Governance Administrator

How to achieve Outstanding	Focused work looking at what is Outstanding for each domain.	CQC Compliance Manager
To raise awareness about CQC across the trust as part of the preparation for the next inspection	Organize a range of communications activities, for example tea trolley rounds, CQC information drop in sessions.	CQC Compliance Manager

6. Recommendations to Board of Directors

The Board of Directors is requested to:

- Note progress with must do and should do actions in section 2.
- Be aware of the should do actions which are not progressing to plan.
- Be aware of the continuous work to ensure regulatory compliance across the Trust.
- Consider next steps re Well-led assessments.
- Note the updated Terms of Reference for the CQC Response Group.
- Be aware of the key priorities/work streams for quarter 3 to prepare for CQC inspection.

13. High Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	High Level Risk Register
Author:	Andrea McCourt, Company Secretary
Sponsor:	Ellen Armistead, Executive Director of Nursing/Deputy Chief Executive
Previous Forums	Risk and Compliance Group - 7 October 2019 Quality Committee - 4 November 2019

Actions Requested:

- To approve

Purpose of the Report

A key element of risk management is to clearly understand the risks pertinent to the Trust and ensure effective governance is in place to support a consistent and integrated approach to risk management.

The purpose of this report is to present an update of the risks on the high level risk register and to assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks as at 25 October 2019.

Key Points to Note

The Trust has 21 risks on the high level risk register.

In terms of movement there are two new risks added to the risk register since last reported to the Board on 5 September 2019 and two risks that have been removed from the high level risk register due to reduction in risk scores. The removed risks will be managed within local risk registers:

NEW RISKS

- 7430 (Score 15) Radiology Requests Risk - Risk of being in breach of IRMER (Ionising Radiation (Medical Exposure) Regulations due to the way roles are set up within EPR, with non-medical staff, who are not permitted to request Radiology exams, being allowed to make such requests.
- 7527 (Score 15) Maxillofacial follow up appointment risk due to user / system issues

REMOVED RISKS

- 7062 Funding for Capital Programme Risk - Corporate Finance - risk reduced from 16 to 6 as agreed at the Finance and Performance Committee due to easing of national capital funding pressures and assurances regarding external elements of capital funding.
- 7477 - Tissue Viability Team Risk - Corporate Nursing- risk reduced from 16 to 6 capacity in the Tissue Viability Team due to Improved staffing

EQIA – Equality Impact Assessment
The purpose of this document is to take all reasonable steps to ensure that risks are identified and recorded on the appropriate agreed database as per the Risk Management Policy and to minimise risk and maximise quality of service to patients and stakeholders. The risk owner is accountable to determine any proposed actions to mitigate any equality impact arising from a risk.
Recommendation
The Board is asked to: i. consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed ii. approve the current risks on the risk register iii. advise on any further risk treatment required

High Level Risk Register - October 2019

Risks at 25 October 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

7430 (Score 15) Family and Specialist Services (FSS) (Impact 3 x Likelihood 5)
Radiology Requests Risk

Risk of being in breach of IRMER (Ionising Radiation (Medical Exposure) Regulations due to the way roles are set up within EPR, with non-medical staff, who are not permitted to request Radiology exams, being allowed to make such requests.

7527 (Score 15) – Surgery and Anaesthetics (SAS) (Impact 5 x Likelihood 3)
Maxillofacial follow up appointment risk

There is a risk that patients will not receive appropriate follow up care for their clinical pathway due to user issues with the EPR system and a lack of assurance that failsafe processes are in place to detect any errors or delays. This could result in patients not being seen as requested by the clinical team, delays in their diagnosis and an alternative and potentially more extensive treatment required.

INCREASED RISKS

None

RISKS WITH DECREASED SCORE

7062 Funding for Capital Programme Risk ↓6 (16) - Corporate Finance

Risk that the Trust will have insufficient funding available to complete its planned capital programme

Rationale for Reduction

The capital forecast has been reduced to £14.35m based on an assessment of 2019/20 requirements, this is still £6.41m more than internally generated. The risk was reduced from a risk score of 16 to 6 (likelihood 2 x impact 3) and agreed at the Finance and Performance Committee on 30 August 2019. The reason for the reduction in the risk score was due to easing of national capital funding pressures and assurances that external elements of capital funding, eg funding for national pathology exchange, energy efficiency scheme,emergency capital and an element of funding from

the Strategic Outline Case will flow this financial year.

This risk will be continued to be managed with the Finance risk register.

7477 ↓6 (15) - Tissue Viability Risk - Corporate Nursing

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.

Rationale for Reduction

Improved staffing with Band 7, Band 6 and lead nurse now in post. Mitigation in place over the last few months has supported the anticipated risk.

This risk will continue to be managed on the Corporate Nursing risk register.

October 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 25/10/2019

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead/ Divisional Director						
					May 19	June 19	July 19	Aug 19	Sept 19	Oct 19
Quality and Safety Risks										
10a/19	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=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
10a/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	Essential Safety 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	Divisional Director of FSS (JO'R)	=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	=16
08/19	6493	Keeping the base safe	Complaints Quality and performance Risk	Director of Nursing (EA)	!15	=15	=15	=15	=15	=15
10a/19	7454	Keeping the base safe	Radiology service provision staffing risk	Divisional Director of FSS (JO'R)	!15	↑20	=20	=20	=20	=20
06/19	7474	Keeping the base safe	Medical Devices Risk	Director of Finance (GB)		!15	=15	=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	=15	=15
08/19	7430	Keeping the base safe	Radiology Requests risk	Divisional Director of FSS (JO'R)						**!15**
05/19	7527	Keeping the base safe	Maxillofacial follow up appointment	Divisional Director of SAS (WA)						**!15**
FINANCE RISKS										
13/19	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
WORKKFORCE RISKS										
10b/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
10a/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
ESTATES / SAFETY RISKS										
09/19	5806	Keeping the base safe	Urgent estate work not completed	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
09/19	7414	Keeping the base safe	Buidling safety risk	Director of Finance (GB)	=15	=15	=15	=15	=15	=15
09/19	7413	Keeping the base safe	Fire compartmentation at HRI	Director of Finance (GB)	=15	=15	=15	=15	=15	=15

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 resource, capacity and capability of full optimisation of the EPR system due to lack of optimisation of the system does not continue to further enhance quality and safety
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.
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.
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
11/19	Risk of not attracting or retainng colleagues who are confident and competent to provide compassionate care to patients and inclusive leadership to colleagues.
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
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longert term and meet safety and regulatory standards resulting in patient harm and regulatory intervention

Sept 2019 updated BAF references

TRUST RISK PROFILE AS AT 25/10/2019

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 =7315 Appointment Risk !7430 Radiology Requests Risk	= 6345 Nurse Staffing = 7078 Medical Staffing =7454 Radiology staffing	=7278 Financial sustainability
Likely (4)				=7223 Digital IT systems risk =7248 Essential Safety Training =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity =7345 District Nurse Referral Risk	= 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 !7527 Maxillofacial follow up appointment
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE Approved October 2018

Risk Category	This means	Risk Level Appetite	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to delvier high quality patient care (despite greater inherent risk)	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**

High Level Risk Register

25 October 2019

NHS
The Health Informatics Service
Informing Healthcare

Risk No	Div	Dir	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	RC	Lead Exec/ Div Dir	
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). Development of five year plan underway in line with Strategic Outline Case assumptions.	October update 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 yearlong term plan for the Integrated Care System is due to be submitted in November 19. Draft fiveyear plan has been submitted to the ICS in line with Strategic Outline Case assumptions, adjusted for current DH guidance. Deficit trajectory is not materially different from the SOC, although some key elements including control total and access to Financial Recovery Funding, are still awaiting confirmation.	Novt-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	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.	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. - Existing consultants	**October update 2019** - we have recruited an overseas NHS locum due to commence Nov/Dec and we have an overseas global fellow (junior consultant) starting at the same time however 2 consultants have resigned and will be leaving the department at the end of November.	Nov-2019	Dec-2019		PSQB	JUlie O'Riordan / Caroline Gizzi	Sarah Clenton

							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.	Impact on the general on-call rota.				accommodating different work to cover gaps - Outsourcing increased to free up capacity where possible - Locum support employed when available e.g. breast radiologists						
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	July/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. **September 2019 Update** 25 newly qualified staff nurse commences in post on the 23 September with another staff nurse open day planned for the 13 October. The event is set to attract student nurses due to graduate in 2020 plus those who will be offered a band 2 HCA bank role until they qualify. 18 Nursing Associate were invited to interview on 28 September for the next Trainee Nurse Associate programme in December 2019. 4 international nurses are due to start in post in October **October 2019** Recruitment Fair held 12 October by Clinical Education team	Nov-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	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	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	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 from today. **Sept / October Update 2019** New rotas working well. To date there has been a reduced requirement for ad hoc locums.	Nov -2019	Aug-2020		WEB	David Birkenhead	Dr Mark Davies

						unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	level with no guarantee of retention Inability of School of EM to allocate trainees.									
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 key strategic objectives	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	**October 2019** A new cohort of specialty trainees commenced in post in October, all of whom were cleared and commenced without delays. The majority were higher trainees who were given a doctor specific induction by the Medical Education Team on Monday 7 October. In addition to the trainees there are also two new Trust doctors due to commence in post within Emergency Medicine. One is a Medical Training Initiative (MTI) doctor arriving from overseas and the second has previously worked within the NHS. Both doctors will be working at ST3 level and hoping to progress further. All our current rotas for doctors in training have been tested for compliance against the new rules set out in the contract. There were 2 rotas that required changes. These have now been agreed and implemented so both of these rotas are now fully compliant. There is a new joint BMJ advert in print which has all our current Consultant opportunities from across all divisions. These include; Anaesthetics, Radiology, Trauma & Orthopaedics, Emergency Medicine, Urology, Stroke Medicine, Respiratory Medicine, Neurology, Haematology, Acute Medicine , Gastroenterology and Geriatric Medicine. Early October, there were also Trust representatives at the BMJ Careers Fair in London where the Trust had a stand. There were approximately 70 visitors to the stall who gave their details as they may be interested in a role here at CHFT. These people will be put in touch with the relevant divisional teams so that opportunities can be progressed.	Nov-2019	Mar-2020		WF	David Birkenhead	Pauline North
5806	Calderdale and	Estates	Estates Department	May-2015	Keeping the base	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.	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	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.	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	**September Update** - The estates strategy / sustainable development plan continues to progress with external help. October Update – HRI estates safety strategy continues to be developed	Nov-2019	Mar-2020		RC	Stuart Sugarman	Paul Gilling / Chris

						This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks identified within the Estates Risk Register being • 7220 Flooring: • 6734 Pipework: • 6735 Structural: • 6736 Air Handling Units: f • 6737 Windows: • 6739 Roofs: • 6761 Ward Upgrade Programmes: • 6762 Day Surgery: • 6763 Environmental Condition: • 6766 Road Surfaces: • 6767 Staff Residences: • 6769 Electrics: • 6770 Plantroom: • 6332 Asbestos: • 6771 Emergency Lighting: • 5963 Equality Act: • 6764 Fire Detection: • 6860 Electrical 3rd substation • 5511 Fire Compartmentation: • 6897 BMS heating controls • 6997 Structural Cladding - • • 6848 Water Safety:	work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	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.										
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	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.	**Sept 19 update.** Issues with purchase of ready to use TPN due to national supply issues causing increase in capacity at HR unitI. Enabling work tender has been awarded to separate company to that for aseptic build work (Bassaire). Bassaire are now stating that they will need to charge by the hour for the validation work now required for them to validate the enabling work. Estates / Engie and Pharmacy to meet as a matter of urgency to understand contracting and finical implications of this. **October 2019 update.** CRH unit due to close 29th November and enabling work planned to commence 2nd Dec 2019. Planned repairs (vinyl in HRI unit , remove sink in HRI unit) late October /early November. Engie/ Bassaire reached agreement regarding validation work and responsibilities.. New CRH unit still planned to be open mid/ end June 2020	Nov-2019	Jun-2020		DB	Ellen Armistead	Elisabeth Street

							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)										
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 and loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold	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).	**Sept19 update**: The BCP work across the trust led by Emergency Planning team has progressed well. There have been a number of table top exercises as well as some planned downtime giving the opportunity to test. This mitigates the risk to some extent. During Oct/Nov this year scheduled maintenance windows need to be agreed in order to close the remaining gaps listed in this risk, at this point the score can be amended and the risk re-assessed. **October 19 update:** Following the initial internal review against the Data Security Protection Toolkit a number of contributing risks have been identified that require addressing prior to the formal submission in March 2020. This results in some technical configuration changes being required and a plan is being pulled together in order to have these completed prior to submission. This plan of action has some overlap with this risk and therefore, in addition to the Business Continuity Plan point raised in the last update, the score remains the same.	Nov-2019	March 2020		RC	Mandy Griffin	Rob Birkett

							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	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. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. Resulting in: - Colleagues practice without a basic, or higher depending on role/service, understanding of our essential safety training subjects. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 essential safety training subjects alongside the 29 role specific essential skills training. This approach strengthens the importance of completing the essential skills designated to specific roles and by combining the two areas into one enhances the Trust's requirement to reach 95% across all the competency offerings. Risk:- There have been issues with ESR and the consequences of not being able to undertake e-learning. ESR was down for 15 days from 31 December 2018 - 14 January 2019. Impact:- Employees have been unable to access ESR to undertake e-learning and in turn affects our ability to reach and maintain 95% compliance.	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.	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. **September / October 2019** - The core 9 subjects are consistently attaining a compliance of over 90%. Focussed activity is taking place on the role specific subjects where compliance is below 85%. This includes contacting Subject Matter experts to ensure the target audiences are correct and working with HR business partners to share non-compliance with relevant departments.	Nov 2019	Mar-2020		WF	Suzanne Dunkley	Charlotte North

3793	Surgery & Anaesthetics	Head and Neck	Ophthalmology	May-2017	Keeping the base safe	Risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 3 x 2	16 4 x 4	3 1 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) Appointment made, anticipated start date July 2019 - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	August 2019 - 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. **October Update** Over the last 12 months additional capacity provided for longest waiters on the holding lists - now have 120 between 13-26 weeks overdue (primarily general ophthalmology - 47, and oculoplastics- 27, orthoptics - 16, glaucoma - 7). Additional capacity clinics will now be identified to ensure these patients are validated and appointments identified by the ophthalmology failsafe team. 2187 patients are overdue 0-12 weeks, including 596 requiring visual field tests - we are aware that as soon as this test is requested it is showing as overdue to the lack of ability to schedule them e.g 6/12 months in advance on EPR (appointments centre senior team informed). 454 are general ophthalmology and 208 retina f/up. The department has identified to the appts centre team there is capacity for these patients and to ensure vacant slots are reviewed daily to maximise use of capacity. New specialty doctor due to start 18th November 19, interviewing for Glaucoma Consultant in Nov 19 and the nurse practitioners are training in macular injections and in Dec 19 5 Trust/Specialty doctor sessions will be released for additional follow-up capacity in key areas.	Nov-2019	Dec-2019		DB	Will Ainslie	Prit Laloe
7345	Community Healthcare	Community Nursing	District Nursing / Matrons	Oct-2018	Transforming and improving patient care	Patient Safety Risk There is a risk of patients with a nursing need not being referred on discharge to the District Nursing service. Due to lack of referral facility on EPR and the discontinuation of the PASWEB referral pathway prior to the implementation of EPR. Resulting in patients not receiving district nursing care deteriorating at home and being re admitted to hospital.	Wards have been advised to contact the DN teams via telephone to make referrals on discharge. Community Division to work with the other division to test out if this process is being followed and understood. Community Division are reporting incidents of non referral on to Datix to enable monitoring	System has not yet been tested	16 4 x 4	16 4 x 4	2 1 x 2	Directory of Community services circulated to wards and departments Ward staff encouraged to refer to District nurse via telephone E referral option being scoped Wards and discharge coordinators encouraged to invite District nurse to MDT	August 2019 EPR referral now active. Wards slow to roll out but reinforcing with all refers to use EPR. Communication circulated **October Update** EPR now in use. Wards now more familiar in using but still some referrals not via EPR. Further Comms to be sent out to remind staff to use EPR. Spoke with Matron Elderly care and will cascade to other hospital matrons/ward managers. Risk score reduction to 4 to be discussed at Risk and Compliance Group 11 November 2019	Nov-2019	Dec-2019		PSC	Ellen Armistead / Andrea Dauris / Liz Morley	Caroline Lane

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	May 2019: Delivery of fire training June 2019: Fire risk assessments, installation of sockets July 2019: NHSI capital bid for 19/20	JULY 2019 UPDATE Chief Operating Officer appointed as Exec Lead for Trust Fire Safety. CHS briefing COO with an update on fire safety. **SEPT 19** Independent Fire Engineer to provide fire risk assessments for CHS (Trust) CHS provided with “reasonableness” view on work carried out on fire safety infrastructure to date Fire Safety Committee established to understand current position / gaps / next steps CHS Fire Safety SLA to be reviewed to ensure suitable & sufficient for Trust purposes. Transfer of Fire Officer back into Trust Fire Safety Committee gathering all external / internal information to provide an overarching view of fire safety and provide an update of the risk **October 2019** 60 minute fire compartmentation building works has commenced through CHS that will ensure that 60 minute compartmentation is in place across the HRI building by Spring 2020. The approach and management of fire risk has also been considered within the HRI Strategic Development Plan that is being developed. Furthermore, the Trust has commissioned a Fire Strategy review that will provide a position statement on the works completed to date along with identifying the key investments required over the future years. The strategy will also cover the Trust’s overall responsibilities e.g. Fire Risks Assessments, Evacuation Strategy and Training. This will be reported to Board once complete in early 2020.	Nov-2019	Dec-2019		FC	Gary Boothby	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 carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 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 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	**August / Sept 19** CHS confirmed that over-cladding is recommended. Due to go to CMG to align with Business Case **October 2019 Update** The approach to cladding is being determined as part of the HRI Strategic Development Plan (SDP) This SDP will propose an estates strategy for the site and provide the Trust with an investment strategy to address the cladding risk in the short and longer term. A design solution will be developed following approval of the SDP.	Nov-2019	Dec-2019		FC	Gary Boothby	C Davies / A Wilson

7430	Family & Specialist Services	Radiology	All Radiology	Mar-2019	Keeping the base safe	There is a risk of being in breach of IRMER regulations due to the way roles are set up within EPR, as this allows non medical staff who are not permitted to request Radiology exams as part of their role. Under IRMER 17 regulations a non medical health care professional can refer for radiological examinations but only under a clearly defined agreed protocol and only after receiving the appropriate irmer training. therefore access to radiology requesting should be restricted to these groups only.	There is an approval process within radiology to allow access to non medical referring that require access to this for their role. A register of all non-medical referrers is accessible to all staff. It is fully up to date and updated daily. Radiology staff can check unknown referrers against this list. When requests from inappropriate staff are noticed they are taken up with the staff in question. All radiology requests are vetted for appropriateness and justified in accordance with IRMER 2017. Please note this also includes requests that do not involve ionising radiation e.g. ultrasound and MRI. A quarterly audit is done of request made, and any prolific requestors are contacted.	Despite this gatekeeping the volume of requests that come into radiology mean this manual checking is ineffective. These requests will come through into the Radiology systems and although the name of the referrer is present with the request unless each one is individually checked staff would be unsure if an unrecognised name is a new FY1 or non medical referrer, thus there is a good chance the exam will be done. The numbers of requests received mean the controls in place can never be 100% effective There is no way to stop the problem at source without the creation of extra EPR requesting groups which would add to an admin burden to the system or potentially affect other systems within EPR.	15 3 x 5	15 3 x 5	15 3 x 5	- To audit quarterly and contact referrers concerned - To continue to raise issue via digital board - To ensure Radiology record of approved requesters continues to be up to date - At last audit some 6707 (12% of total) requests were made by inappropriate referrers.	**September / October 2019** - Radiation protection advisors are checking other similar Cerner sites for solutions - Re-audit undertaken which has shown a deterioration in position	Nov-2019	Mar-2020		PSQB	Julie O'Riordan / Caroline Gizzi	Mark Williams
6493	Corporate	Corporate Quality	Governance and Risk Quality	Nov-2015	Keeping the base safe	Complaints Management - quality and performance risk There is a risk that the Trust does not respond in a timely way to complaints and breaches NHS Complaints Regulations 2009 Due to complaints responses not being investigated and drafted within agreed timescales, staff not recording all complaints investigations on Datix and not updating complainants in a timely way. Resulting in dissatisfaction for complainants due to poor communication, delays in responses, poor performance on complaints responsiveness identified within the integrated performance report, reputational damage, increasing number of complaints referred to the Ombudsman	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 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	Medical division complaints position continues to be challenging - to be addressed through performance route also following lack of assurance to Quality Committee on 30 July 2018 re: sustained improvements. Quarterly meetings with senior complaints team and Assistant Directors of Nursing to be introduced. Investigators not routinely contacting complainants within 7 days. Quality of responses received variable Further WEB report on complaints and tracking of individual cases for September 2018	12 3 x 4	15 3 x 5	4 2 x 2	Continue to monitor overdue complaints via weekly tracker and revise risk score and actions required if improved position is not sustained. Position escalated to Chief Nurse and Chief Operating Officer and discussed with divisional teams through PRM route. External review of complaints being planned by Chief Executive.	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. **October 2019** - Improvement noted across all Divisions with 47% of complaints closed in time in September. Work continues to focus on responding to overdue complaints and reducing the number of complaints raised by service users and their families.	Nov-2019	Dec-2019		QC	Ellen Armistead	Anne-Marie Henshaw

							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.												
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	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. **September / October 2019** Dates to be confirmed for visit to Leeds in relation to Digital Champions in clinical areas. Engagement with the acute floor taking place currently looking at all aspects of record keeping. Digital Ward Assurance available through the Knowledge Portal for all ward managers to be able to monitor their own ward progress. Clinical Records Group formulating an E Cras Audit Tool - currently being trialled in 2 ward areas.	Nov-2019	Nov-2019		WEB	Ellen Armistead	Carol Gregson/Graham Walsh
7315	Family & Specialist	Appointment and Records	Appointments Service	Aug-2018	Keeping the base safe	There is a risk of delay to patient care, diagnosis and treatment Due to insufficient outpatient appointment capacity to meet current demands Resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints	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	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	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	August 2019 Capacity and demand tool on knowledge portal has been developed. Being shown to all ops managers during 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	Nov-2019	Jan-2020		PSQB	Julie ORiordan / Caroline [illegible]	Kimberley Scholes

						and possible claims. Currently there are in excess of 11,000 patients awaiting appointments. circa 3500 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 8,000 follow up patients that have all exceeded the appointment due date. Please refer to following individual risks: 4050 6078 6079 7199 7202	date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..	appointment.					detail and root cause analysis. **October 2019** There is still a lack of capacity for new and f/up patients. Total ASI's currently stand at 2,161 and f/ups overdue stands at 9,859. Discussions have taken place at WEB and agreed a focused piece of work needs to be done. OP Transformation is helping clinical divisions optimise technology to reduce waiting times. WTGR session outcome to revamp customer contact meeting to include higher accountability of capacity issues with clinical divisions. Recent audit of new patient ASI's showed inaccuracy between ERS and the APP. From November the new patient ASI's will be managed directly on ERS instead of the app to give greater accuracy and reduce admin work. Paper referrals and long waiters will still need to be managed via the app as there is no current alternative.						
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	August 2019 Update: Position remains as per update above. **October 2019** update - MYT consultant working at HRI 1 day per week, 2 locums booked in rotation until the end of the first week in January. NHS locum working with rotational support from the other 3 consultants.	Nov-2019	Mar-2020		DB	Julie ORiordan / Caroline Gizzi	Sarah Clenton
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	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	2019/05/21-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.	2019/08/02-Update-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. **September 2019 Update**-High Risk numbers rose High risk (490 to 511), Medium fell (2244 to 2172), Low rose (1775 to 1825), a total of (4509 to 4508). We are finding more devices that are End of Life or end of support these are being added to CHS risk 7516 & CHFT 7478, these risks are being reduced due to allocation of funding to replace devices. **October 2019 Update** High Risk numbers rose High risk (511 to 524), Medium rose (2172 to 2184), Low rose (1825 to 1860), a total of (4508 to 4568). Impact has	Nov-2019	March 2020		RC	Ellen Armistead	Robert Ross

						harm CHS Risk 7438 –(Rating 20) CHFT Risk 7474 (Rating 15)						slowed this month, due to staff leave and training this should aid in decreasing the shortfall next month.						
7527	Surgery & Anaesthetics	Head and Neck	All wards/departments Head & Neck	Aug-2019	Keeping the base safe	There is a risk that patients will not receive appropriate follow up care for their clinical pathway Due to user issues with the EPR system and a lack of assurance that failsafe processes are in place to detect any errors or delays. This could result in patients not being seen as requested by the clinical team, delays in their diagnosis and an alternative and potentially more extensive treatment required.	A failsafe process has been implemented for the post cancer patients , ? recurrent cancer / Surveillance through the cancer head and neck services. The validation team are prioritising the maxillofacial validation of 591 patients. Checks that all orders at placed following outpatients attendance Added onto careplans of review of follow ups dates required for all cancer diagnosed patients	EPR system (Lists) Lists of patients Failsafe Escalation process to implemented within appointment centre, secretaries. Appropriate training within the department	15 5 x 3	15 5 x 3	4 2 x 2	Review outstanding validations Develop process with appointment centre (Validation team) Develop escalation process with appointment centre , secretaries for cashing up of clinics, and process to add further requests if appointments are cancelled. Communication plan within the head and neck services. High level process to roll out within the division.	September 2019 51 patients validated as of 17th September 2019. Meeting arranged Friday 20th September 2019 with appointment centre Update to be given at red panel Friday 20th September 2019. Met with validation team 18th September to confirm 519 patients on the IO (Incomplete order list) - Actions: * To start validating Maxfax patients , approx. timescale for completion is 3 days . K Fletcher to update L Cooper daily of progress * Ensure 2017 patients have all been completed of any outstanding validations still in circulation * L Cooper and S Turner to produce clinical validation SOP and share across the division team. * Division to discuss priority of specialities to be validated in high risk order and send to the validation team with rationale *L Cooper exploring how to RAG rate surveillance patients with S Beeley in IT. **October update** - Validation almost complete. review and drill down to patients pathways that have been delayed.	Oct-2019	Dec-2019		PSQB	Will Ainsle / Mel Addy	Laura Cooper
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	- 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	- Use of second floor OCT requires patients to travel between 2 floors during their visit - Patient's pathology still require OCT in many instances	15 5 x 3	15 3 x 3	1 1 x 1		**October 2019** Risk score lowered to 9 following Divisional Management team - all new OCT machines are installed within the department, linked across site so scans can be accessed across site. Training currently underway to ensure all nursing and AHP staff competent to perform basic scans. Training needs analysis produced for the department, and senior staff highlighted for advanced training to act as super users and disseminate training further across the teams. The	Nov-2019	Nov-2019		PSQB	Will Ainslie	Louise Corp

						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.	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.					machines are currently not performing to full capacity due to training required. Medical staff still require scan interpretation training - to be organised as part of training needs analysis. Review of risk removal from high level risk register at Risk and Compliance Group 11 November 2019.						

14. Director of Infection Prevention Control (DIPC) Quarterly Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 September 2019
Meeting:	Board of Directors
Title:	Quarterly DIPC report
Author:	Jean Robinson, Senior Infection Control Nurse
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report
To provide the Board a report on the position of Healthcare Associated Infections (HCAIs).
Key Points to Note
Improving position on E-coli bacteraemia.
EQIA – Equality Impact Assessment
This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. Information on flu uptake has been analysed by ethnic group and reportedly separately.
Recommendation
The Board is asked to **NOTE** the performance against key IPC targets and **APPROVE** the report.

APPENDIX I

Calderdale and Huddersfield NHS Foundation Trust

Quarterly DIPC
1st April 2019 to 30th September 2019

1. Introduction

This report covers the period from 1st April 2019 – 30th September 2019 (Q1 & 2). Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). Assurance against key performance and quality indicators is provided in the report.

2. Performance targets

Indicator	End of year ceiling 18/19	Year-end performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**1**	1 post case
C.difficile (trust assigned)	40	**13**	Non Preventable = 8 Preventable = 4 Pending = 1
MSSA bacteraemia (post admission)	None set	**10**	
E.coli bacteraemia (post admission)	None set	18	
MRSA screening (electives)	95%	96%	
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.59	Rolling 12 months
ANTT Competency assessments (doctors)	90%	87.53%	
ANTT Competency assessments (nursing and AHP)	90%	54%	As of the 1st September all staff undertaking ANTT need to be re-assessed on a 3yrly basis, this now is reflected in the overall compliance. Divisions are working hard to ensure staff are updated with an aim to have 75% compliance by end of March 2020.
Hand hygiene	95%	99%	

3. Quality Indicators

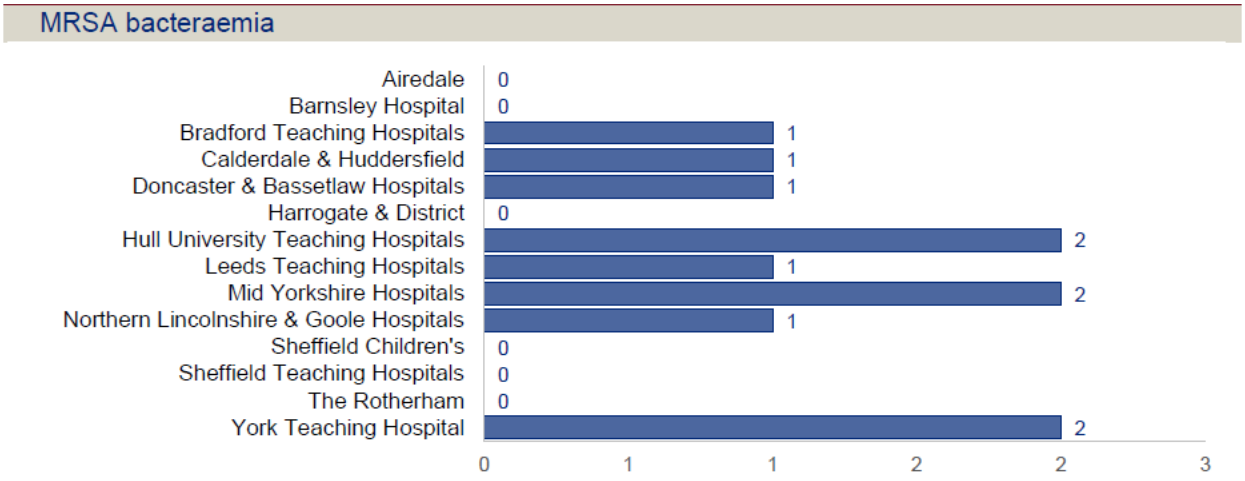
Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	90%	
Isolation breaches	**Non set**	253	Compared to 194 for same period time last year.
Cleanliness	Non set	96.4%	

4. MRSA bacteraemia:

There has been 1 MRSA cases attributed to the organisation: -
This was a patient who was admitted to the Emergency Department on the 26 March 2019 complaining of back pain. On investigation the patient was found to have a hairline fracture to the lumbar spine (L2). On the 14 April in the morning the patient started to have rigors, however they remained stable – with a recorded NEWS of 1. Staff noted that evening that the patient had started to become increasingly confused and at this stage had started to complain of bilateral knee pain (new change). Blood cultures were taken and found to be MRSA positive.

Aspiration of synovial fluid from the knee has grown MRSA. The medical notes indicate that this is almost certainly the cause of the MRSA bacteraemia. The case was deemed as unavoidable.

The chart below compares total numbers of attributed MRSA bloodstream infections to each organisation in Yorkshire and The Humber.



5. MSSA bacteraemia:

There have been 10 post-admission MSSA bacteraemia cases during 1st April to 30th September 2019. A review of cases has been undertaken, there is no common theme, ongoing cases will be reviewed on a monthly basis.

Calderdale and Huddersfield NHS Foundation Trust

6. Clostridium difficile:

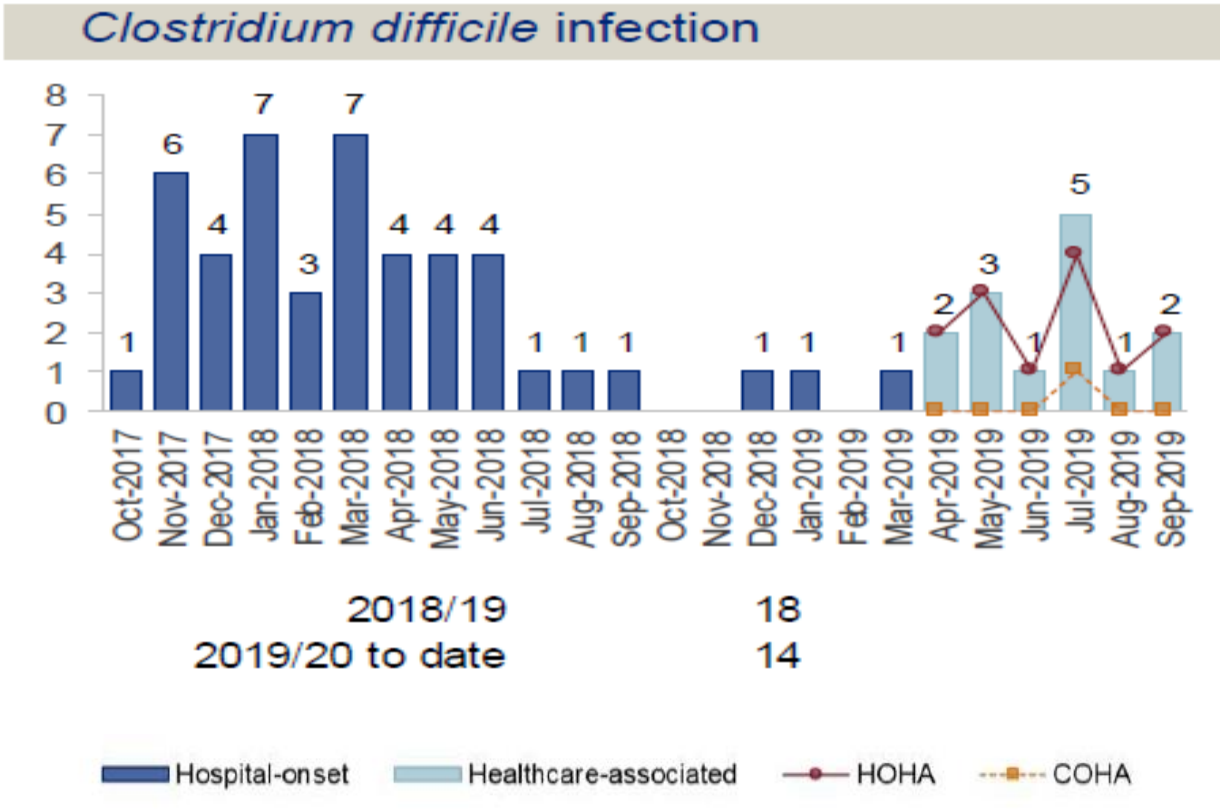
The ceiling for 2019/20 is for no more than 40 Trust attributable cases. At the end of September there have been 13 cases: -

- The deep clean and HPV of high-risk wards has been approved and commenced on the 1st June 2019 and will be complete at the end of October.
- Of the 4 preventable cases there are some antimicrobial prescribing issues, the areas are being supported by the Microbiologists and pharmacy to improve prescribing in line with guidance.

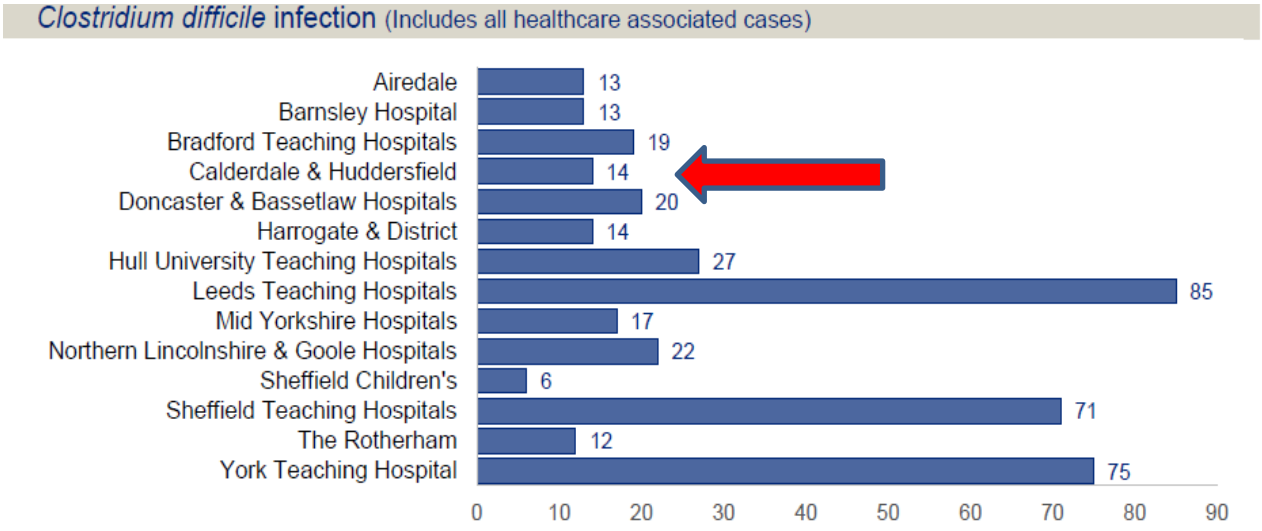
New national criteria for the reporting of C-difficile cases commenced on the 1st April 2019 as follows: -

a) **Healthcare onset healthcare associated (HOHA)**: cases detected in the hospital ≥2 days after admission,
b) **Community onset healthcare associated (COHA):** cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,

The chart below shows CHFT cases 2017/18 and 2018/19



The chart below compares total numbers of attributed C. difficile infections to each organisation across the Yorkshire & Humber region:-



7. E. coli bacteraemia:

There have been 18 post-admission *E. coli* bacteraemia cases since the 1st April 2019, a reduction in 18% compared to last year, of these 8, primarily associated with Urinary tract infections were potentially avoidable.

A total of 191 *E. coli* infections have been identified in total. New guidance is due to be published within the next couple of months to aid organisations on how to achieve reductions, with the date for reductions being extended to 2024.

8. Outbreaks & Incidents

There have been no reportable outbreaks this quarter.

9. Influenza:

The staff flu immunisation campaign for 2019/20 started on the 30th September. There is an ambition to offer the vaccine to 100% of front-line health care workers and achieve an 80% uptake.

We have had to amend how the campaign is being delivered this year due the vaccines been delivered in 3 batches over a 6-week period. Frontline staff working in direct admission areas including ED have been offered the vaccine during phase one of the campaign.

10. Isolation Breaches

There have been 253 isolation breaches since 1st April 2019 compared to 164 breaches for the previous year. The majority of breaches are patients with a previous history of MRSA or ESBL at the time of admission to MAU or attending ED, or patients being transferred, and their infection status not being handed over, although this information is all clearly visible within the EPR.

The IPCT will continue to monitor isolation breaches; actions to reduce breaches have been included in the HCAI annual action plan, this includes ongoing work within the medical division where the majority of breaches occur.

11. Audits:

Quality Improvement Audits:

26 Quality improvement environmental audits have been carried out since the beginning 1st April 2019 to 31st July 2019.

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

- 15 of the areas achieved a green rating.
- 10 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- 1 area was deemed as a Red rating which was the Diabetic centre at CRH, an action plan is being developed and a re-audit took place in September and scored a Green rating.

CJD risk assessment audit: - is carried out on a quarterly basis by randomly selecting surgical patient records to check; Average compliance is 93%.

12. ANTT:-

As of the 1st September 2019, all staff who undertakes ANTT will require re-assessment every three years. This will have an initial impact on the ANTT performance matrix as staff ESR records will automatically lapse to RED if their previous assessment was more than 3 years ago (before 1st September 2016). Current Trust compliance is 54%.

13. CQUIN CCG1a (UTI) 2019-20

Aim: To improve the treatment and diagnosis of simple lower UTIs in patients over 65years in line with NICE and PHE guidance.

The target compliance is for 90% of all audited patients to comply individually with all four aspects of the CQUIN:

- Diagnosis according to PHE guidance
- No dipsticks to be used to diagnose UTIs in the over 65s
- Antimicrobials to be prescribed in line with NICE or Trust Guidance
- MSU sent to lab in line with guidance

CQUIN progress to date

Measure	Q2 overall	Q1 overall	Month 4	Month 5	Month 6
number of patients	76	75	39	16	21
1 patient represents %	1.31	1.33	2.56	6.25	4.76
Diagnosis % compliance	75	63	69	69	90
Dipstick % compliance	66	23	54	69	86
Abx choice % compliance	83	69	82	81	86
MSU sent % compliance	80	73	77	69	95
Overall % compliance	43	8	31	31	76
trimethoprim number	36	43	20	9	7
%	47.4	57.3	51.3	56.3	33.3
nitrofurantoin number	27	15	12	4	11
%	35.5	20.0	30.8	25.0	52.4

There has been a marked increase in overall compliance between Q1 and Q2, mainly due to improved compliance with the dipstick element, although the compliance with choice of antibiotic has improved significantly also.

The rate of compliance with each individual aspect does not necessarily reflect the overall result.

Data from PHE shows that the majority of Trusts were scoring low across the country, with nobody achieving the CQUIN target in Q1. The average for England was 29% compliance. This reflects the scale of the challenge proposed by the CQUIN.

On 11/10/19 it was announced that Q1 data would no longer be counted towards the CQUIN target.

Improvement Strategies to date

The first interventions were released on 1st July. These included: -

- An educational screensaver and poster campaign (see below).
- A number of targeted educational visits were performed, in key areas A&E, care of the elderly, acute floor to educate healthcare assistants, nurses and medical staff.
- Initiative being discussed in ward huddles and handovers.
- Opportunistic activities included building teaching into the pharmacy induction talks for new medical staff and microbiology teaching sessions. The campaign was also brought into scheduled CPD teaching days for non-medical prescribers from across the Trust.
- An EPR shortcode has been developed in order to facilitate decision making and documentation of the treatment of simple lower UTIs (.LUTI). It was agreed that that although this is already available, it needs further development and then promotion to encourage uptake.
- Removal or restricting access to urine dipsticks capable of being used to diagnose UTIs in key areas and a costing document was produced based on what was currently available in the Trust.

- A 'to dip or not to dip' tea trolley round was undertaken week beginning 23rd September. This was led by the infection control nurses at supported by the microbiologists and antimicrobial pharmacist. This was very well received and was featured on anther screensaver and in the Trust Newsletter.

Next Steps: - Further interventions are grouped around the four criteria:

Diagnosis

- Working on an acronym to help clinical staff remember the diagnostic criteria for UTIs. This will then be worked into another screensaver and other educational materials.
- LUTI to be reviewed and made more user friendly.

Dipstick Avoidance

- To pursue removal and restriction of Combiscreen dipsticks in key areas, and the introduction of Labstix (or similar).

Correct Antimicrobials: - Compliance in this area is very good at 83%, but still needs to improve if we are to achieve 90% for the whole CQUIN.
Ongoing education, ongoing selective reporting, rewording of trust guidelines and moving from normal release (QDS) to modified release (BD) nitrofurantoin are anticipated to further help this element of the CQUIN.

Send a MSU: - Compliance in this area is consistent in the 70-80%. The EPR team are building powerplans (automated forms) for each area in the antimicrobial guidelines which will include ordering an MSU automatically as the prescription is generated. This would be following completion of the new sepsis bundle, which is a Trust priority.

The AMT are also exploring with EPR colleagues whether the prescription of certain antibiotics (such as nitrofurantoin, trimethoprim and pivmecillinam) could automatically trigger the request for a MSU.

CQUIN CCG1b (surgical prophylaxis) 2019-20
Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.

Q1 compliance – 85%
Q2 compliance – 86%

Continue to audit and on-going discussions with surgery to make improvements and agree consistent recording for administration of antibiotics. Q3 - Identify individual patients who aren't compliant and agree further actions with surgery to improve compliance.

Other work:
The Antimicrobial Team (AMT) have continued to support on the use of gentamicin as first line antibiotic in general surgery and urology within the trust. Pharmacy review of prescriptions, education of clinical teams, adaptation to gentamicin level selection within EPR, the development of prescribing resources (including advising on the gentamicin video) and negotiating additional phlebotomy support are some of the interventions put in place. Following on from the work done at The Royal Free Trust, we are now working

with EPR colleagues to improve the gentamicin calculator within EPR. A further gentamicin audit is planned for November 2019.

The trust antimicrobial guidelines are now hyperlinked to the safety advice for fluoroquinolones wherever these antibiotics appear within guidance. Inpatient fluoroquinolone use has been audited and the results fed back to key areas. As a result of the audit, multidisciplinary stewardship ward rounds focussing on the appropriate use of these agents have been put in place across sites. A re-audit is underway.

The AMT continue to promote and educate on the appropriate use of antimicrobials within the trust. Recent work has included bite-sized teaching within ED, presenting CQUIN and quinolone work at elderly grand round, an antibiotic masterclass for FY1 doctors, an antimicrobial resistance session for link practitioners, an antimicrobial stewardship session for non-medical prescribers as well as core sessions at junior doctor induction.

14. IPC Team:

Portfolio's within the Trust team have been reviewed.

One member of the team has successfully completed the Diploma in IPC

The IPC Team continue to work both proactively and reactively.

15. Recommendation

The Board is asked to note the performance against key IPC targets and approve the report.

15. Learning from Deaths Q2 Quarterly Report

To Approve

Presented by Cornelle Parker

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title:	Learning from Deaths Report Quarter 2 2019/2020
Author:	Gemma Pickup – Quality Governance Lead
Sponsoring Director:	Cornelle Parker, Deputy Medical Director
Previous Forums:	None

Actions Requested:
To approve

Purpose of the Report

To provide the Board of Directors with assurance of mortality reviews and identified learning.

Key Points to Note

1. Speciality specific initial screening reviews (ISR's) are in place and ICU, Acute Medicine a nd Orthopaedics are all achieving review rates of approximately 80%
2. There is a trend across the last 3 quarters of rising completion rates in ISR's respectively 24%, 34% and 42% against a target of 50%
3. The Learning from Deaths panel is to be reconvened and will prioritise learning and peer review of Structured Judgement Reviews (SJR).
4. A priority for the 3rd and 4th quarters will be alignment of the LfD process with the new Medical Examiner role

EQIA – Equality Impact Assessment

Deaths of those with learning difficulties aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does not replace out internal process. All deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group (MSG).

Child deaths: Whilst all deaths are notified to the JCDOP and a core data set collected, not all deaths will be reviewed in detail and are therefore considered for SJR review. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention.

Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the MSG.

Still born and perinatal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. Stillbirths and neonatal deaths are reviewed by a multidisciplinary team and reported nationally via the Perinatal Mortality Review Tool.

Recommendation

The Board is asked to approve the learning from deaths Q2 quarterly report.

Calderdale and Huddersfield NHS Foundation Trust

Learning from Deaths Report
Quarter 2 2019/2020

Initial Screening Reviews (ISR)

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

In the last 12 months (Oct 18 – Sept 19), there have been 1454 adult inpatient deaths. Of these, 430 (30%) have been reviewed using the initial screening tool (ISR). The quality of care was assessed as follows:

Quality Care Score	Number	Percentage of all deaths
5 – Excellent Care	143	10%
4 – Good Care	209	14%
3 – Adequate Care	64	4%
2 – Poor Care	13	1%
1 – Very poor	1	0.06%

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

The table below shows the number of adult inpatient deaths reviewed by ISR by month

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Total deaths	124	126	131	148	124	119	126	111	99	120	110	96
Total reviewed	25	27	39	46	43	44	53	43	45	29	17	8
% reviewed	20	21	30	31	35	35	42	39	45	24	15	8

Figures for Jul – Sept are provisional and will increase as the reviews are completed

Speciality focused Initial Screening Reviews

In Q3 of 18/19 the Trust made the decision to support speciality specific reviews with the understanding that consultants would not be allocated reviews outside of their speciality if they committed to completing reviews within their speciality. This approach appears initially to have been successful with overall review percentages increasing from 24% in Q3 18/19 to 34% in Q4 18/19 and then to 42% in Quarter 1 of 19/20. Below is a breakdown for participating specialities:

Speciality	April		May		June		Total		Percentage reviewed
	Total	Reviewed	Total	Reviewed	Total	Reviewed	Total	Reviewed	
Acute Medicine*	25	19	16	14	13	11	**54**	**44**	**81%**
Cardiology	7	3	1	1	4	2	**12**	**6**	**50%**
Elderly**	9	4	9	7	9	6	**27**	**16**	**59%**
Gastro	10	7	8	2	1	0	**19**	**9**	**47%**
Haematology	3	3	4	1	3	0	**10**	**4**	**40%**
ICU	12	12	10	9	15	12	**37**	**33**	**89%**
Oncology	2	1	3	3	6	3	**11**	**7**	**64%**
Orthopaedics	1	1	5	3	3	3	**9**	**7**	**78%**

Dr Cornelle Parker, Deputy Medical Director & Gemma Pickup, LfD Coordinator

Respiratory	6	1	8	4	9	3	**23**	**8**	**35%**
Stroke	7	0	1	0	5	4	**13**	**5**	**38%**
Surgery	5	0	6	0	8	0	**19**	**0**	**0%**
	87	**51**	**70**	**42**	**76**	**35**	**233**	**166**	

* The Acute Medicine team have agreed with the LfD team that as a minimum they will review deaths for patient who were admitted to the acute floors and died within 72hrs. If capacity allows more deaths will be reviewed.

** Due to the complexity of their patients and potential for extended admission the Elderly Care team have agree to review 1 death per consultant a month prioritising any deaths referred to the coroner or where they have existing concerns. The speciality average approx.30 deaths per month resulting in a third of their deaths being reviewed.

Excellent rates of review at or around 80% are noted for ICU, acute medicine and orthopaedics.

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

In addition to adult inpatient services, reviews also take place in the Emergency Department, Maternity, Paediatrics and Calderdale Community (30 days post-discharge). These deaths are also presented 6 monthly to the Mortality Surveillance Group.

Structured Judgement Reviews

In the last 12 months, 122 deaths have been escalated for SJR. The table below shows the reason for escalation.

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Total
Escalated from ISR	0	0	0	1	2	5	2	3	1	1	1	**2**	**18**
Complaint	0	1	1	1	0	1	0	1	1	2	2	**1**	**11**
Serious Incident Panel	1	1	1	3	0	0	2	0	0	0	0	**0**	**8**
Elective	0	0	0	1	1	0	1	0	0	0	0	**0**	**3**
Learning difficulties	1	0	1	1	2	2	0	1	0	1	3	**0**	**12**
2nd Opinion SJR								5	3	2	2	**0**	**12**
Coroner								13	4	0	2	**2**	**21**
Other	0	0	9	0	1	4	6	0	8	0	0	**9**	**37**
Total Requested	**2**	**2**	**12**	**7**	**6**	**12**	**11**	**23**	**17**	**6**	**10**	**14**	**122**

A total of 30 SJRs were requested in Quarter 2 19/20. The quality care scores for these are below

Quality Care Score	Number	Percentage
5 – Excellent Care	5	17%
4 – Good Care	4	13%
3 – Adequate Care	16	53%
2 – Poor Care	5	17%
1 – Very poor	0	0%

Thematic analysis of SJRs

A recent theme that has been highlighted through SJR is failure to escalate despite patients having high NEWS scores. This has been brought to the attention of the Clinical Directors for ED and ICU who are considering the findings.

Future Plans and Sharing Learning

- SJR to be transferred to online portal by beginning of Quarter 4
- Planned meeting with LFD panel to co-design forward plan for peer review & disseminating learning
- Meeting with Coroner's office, Complaints and Serious Incidents teams to reassess how SJRs can be utilised to effectively support investigations.
- Clarity on purpose and scope of SJR to be communicated with consultants and where relevant SAS doctors utilising SJR reviewers
- 'Lead' SJR reviewer to be considered to provide clinical oversight of SJRs, support consistency and assurance around SJR process
- Align LfD processes to the new Medical Examiner role

16. Outpatient Improvement

Presented by Caroline Gizzi, Director of Operations, Families and Specialist Services Division

To Note

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title:	Outpatient Issues and improvement plan
Author:	Caroline Gizzi – Director of Operations, Families and Specialist Services Division (FSS)
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 a briefing on the issues that have been identified in relation to Outpatient processes and highlight the key actions that have been agreed to secure improvement.

Key Points to Note

Concerns were raised around the access to outpatients, the booking processes and overall capacity. These have been internally and externally reviewed.

In response a 3Rs process has taken place with a range of clinicians and managers, a deep dive review was undertaken which was shared with the Executive Board and all Directorates have met with the Chief Operating Officer to discuss specialty specific issues. For further assurance an external review was commissioned.

Three key themes were identified from the Outpatients deep dive:

- Digital/technology
- User Issues
- Capacity and Demand

The external review made several recommendations in 4 areas:

- The number of patients lists managed cross the organisation
- Training of staff managing the outpatient system
- The number of cancelled appointments and clinics
- Communication with patients

In addition, the review strongly advocates the expansion of the Outpatient Transformation programme as the key vehicle for the resolution of the Capacity & Demand Challenge.

From the reviews and recommendations, a detailed action plan has been agreed which describes the required improvement journey between now and March 2020. This has been as signed to senior organisational leaders with completion dates reflective of the risk identified and will be monitored via the trusts existing governance architecture.

EQIA – Equality Impact Assessment
There is no direct impact on current policies and no clear link to any protected characteristics from the administrative issues identified to date however there are concerns around safeguarding connections and the communications with patients within clinic which will need to be addressed. As responses are implemented advice will be taken on which elements require an EQIA before closure.
The Board is asked to note the depth of the review undertaken, the external review and the action plan subsequently developed. The Board is asked to agree to receive further updates in January and April reflecting the main closure dates within the plan.

Outpatient Issues and Improvement Plan

1.0 Background

Annually, the out-patient function at CHFT manages over 440,000 patient contacts which, acknowledging that there will be some seasonal variation, is circa 36000 contacts each month.

The booking function is managed using the Electronic Patient Record (EPR) digital solution (Cerner) which was introduced in May 2017 via a single booking centre with Divisional management teams responsible for the identification of capacity.

Internally some clinicians highlighted concerns around the booking processes which were also highlighted by some GPs and clinic reception staff who were concerned about the patient experience. In recognition of the concerns a series of actions were initiated to better understand the concerns and associated risks including both an internal and external review process.

The initial internal deep dive identified three key themes:

- Digital/technology
- User Issues
- Capacity and Demand

The external review corroborated the internal outputs and built on this with further observations which included:

- The number of patients lists managed cross the organisation
- Lack of ownership of issues by colleagues outside of the Booking Centre
- The structure within the Booking Centre
- Training of staff, including clinical colleagues using the outpatient system
- The positive work of the Outpatient Transformation programme and the opportunity to address the capacity and demand issues by further stretch

The key themes are being taken forward via a detailed action plan and progress against each has been assigned to a senior organisational leader and is being monitored via a robust governance arrangement, with direct accountability to the Trust weekly executive board.

2.0 Identification of issues

In Summer 2019, concerns were raised by local GPs, internal clinicians and outpatient staff describing the impact on patient experience of current outpatient service provision at CHFT. In response, the organisation has undertaken an in-depth review.

Review Process

- A review of complaints and comments made by users e.g. GP's relating to outpatients indicated that the vast majority were related to cancelled appointments and difficulty in making bookings. At the same time, the ratings for outpatients services through friends and family tests were consistently high.

- A deep dive review with Outpatient and booking managers was undertaken by the Chief Operating Officer and 2 extraordinary Executive Boards were established to work through all identified issues, confirm agreement and identify any further concerns.

- A series of 3Rs sessions focused upon listening to the current reality of service provision across the breadth of outpatient services, the required improvement response and the associated results that the organisation and its staff wanted to take forward to improve patient and stakeholder experience.

- A multi disciplinary team from all Directorates met with the COO and planned access team to review their planned access position, understand the Outpatient related issues by specialty and identify any additional issues or risks of which several were identified

- A meeting with medical secretary leads took place to further explore the deep dive issues

- An external review of outpatients was commissioned with a focus upon two areas: -

    - Current risks and the consequent priorities for the Trust
    - The experiences of users of the outpatient service (patients and clinicians) and staff engaged in managing the service

3.0 Review findings

The review provided a rich source of intelligence and drew several specific conclusions as follows: -

3.1 Internal

There were three key themes identified from the internal deep dive

- Digital/Technology
- User Error
- Capacity & Demand

Within each theme there are numerous different issues and each have been logged, where required added to the risk register, a result and response agreed.

3.2 External

The external review corroborated with the internal findings as described above and were related to patient safety and experience. In addition, the review made some further observations and recommendations.

There is a requirement to refocus the relationship between Divisional teams and the Booking Centre.

The Booking Centre needs to restructure around specialties/Divisions not tasks and contact meetings need to be uniform in attendance and agenda.

The Divisional teams need to take full ownership of the issues around capacity and demand, hospital-initiated clinic cancellations and clinical validation.

All lists currently held outside of the Cerner system should be removed as this duplication poses a risk.

In addition, the external review advocated an acceleration and further stretch to the Outpatient transformation programme reflecting the success to date however there is also a requirement to align this clinical pathway work with the administrative system to ensure data quality is not compromised.

This report is attached;

OPD review CHFT.pdf

The full list of issues, results and responses can be found in Appendix A.

4.0 Next steps

Information from the review and the associated action plan has been shared across the organisation, leads have been identified and deadlines set reflective of the identified level of risk.

Presentation of the key issues has been made to both CCG Governing Bodies and both Calderdale and Greater Huddersfield LMCs.

A patient involvement group will be established to ensure key responses are developed through co-production.

A weekly task and finish group has been established to oversee the delivery of the plan, the timeline for completion of this work plan is 31.03.19. Assurance for progress and escalation will be managed via the existing organisational governance infrastructure via CHFT weekly Executive Board.

A review of the various risks on the risk register is underway with an overarching risk to be added to the Corporate Risk Register.

A proposal to accelerate the Outpatient Transformation programme has been presented to the System Recovery Group and is currently being considered.

Appendix A

Item	Result	Reality	Response	Timescale for Completion	Added to Risk register	RAG
	EPR / Digital Patient Communications					
1	Letters - Ability to confirm that 100% of patients receive the letter that has been generated about their appointment	Bookings made by several areas Unable to confirm if all patients are included in the extract	Production of reconciliation report	31/10/2019	Yes - Outpatient **RISK ID 7201**	
2	Letters - patients with Multiple Appointment receive correspondence on all attendances	Booking staff can perform 3 different actions – booking, cancelling and rescheduling. When more than one action is performed on the same encounter on the same day, only the letter for the last action makes it into the extract. This has been investigated there are 2 different issues that need to be resolved	Technical solution required to ensure all actions have a letter included in the extract as required	31/10/2019	Yes - Outpatient **RISK ID 7201**	
3	Letters - Full data required in the extract so that 100% of letters can be processed by 3rd party provider	• Cohort of patients with missing specialty code which prevents processing of the letter. • 40 – 80 bookings being returned to Appointment Centre to be manually actioned. • Patient receives appointment but 24hours later than planned	Technical deep dive required to understand source of issue and rectify	26/09/2019	No - issue resolved	

		• Additional WTE required to manually process the letters (in place) • Unclear yet on source of error as full dataset believed to be in the system. Issue specifically relates to specialty code 0. Address field missing this being reviewed.				
4	Reminders - Suppression of SMS reminder at day 1 where appointment has been cancelled between day 7 and day 1	If a patient is cancelled at 7 days notice or less patients are still receiving a SMS reminder. This has resulted in some patients attending the hospital in the believe that the appointment is going ahead.	There are 2 options to progress/test to resolve: 1. Change the extract entirely to produce 2 daily extracts which only contain future 7 day appointments and future 1 day appointments. This would negate reprocessing against cancellations for HCC as only valid appointments would be passed. 2. Look at converting rescheduled appointments into cancellation flags such that HCC then remove future appointments for these also (as well as cancelled).	31/10/2019	Yes - outpatients **RISK ID 7201**	
5	Reduction on patient generated cancellation	The reminder and digital letter system offer patients the opportunity to cancel their appointment via SMS response. Patients may not be aware of the delays this could incur and impact on treatment, and increased admin workload.	Switch off the SMS cancellation functionality. Patients would be required to cancel via the appointments line.	31/10/2019		

6	Location - All appointment letters have the correct clinic location	Patients have been receiving letter stating HRI or CRH rather than a specific site. Patients booked for a telephone appointment were receiving letters with a hospital location.	This issue has been resolved and is to be monitored.		No - issue resolved	
7	IO List - Process required to sort/store information from Incomplete Order list into separate cohorts	Within Cerner the current configuration places all cohorts in the one file. Cancelled with Request Open Appointments (not to be seen but not discharged) Outcomed as Appointment Given/later Date but no order placed Patient cancelled and not rebooked Patient DNAs Incomplete transactions - e.g. system error This file is large and increasing making visibility of cohorts unmanageable. If patients are booked/discharged outside of the list, they remain on the list. All validation requires the extraction of data onto a pivot table as system does not sort.	Validation process in place but using manual data extract, additional validation capacity deployed Ongoing work to extract information from IO list into separate cohorts. Change request for development of Open Appointment category to differentiate between patients on Open Pathway and other cohorts. System solution required.	25/10/2019	Yes - Planned Access & DQ Risk ID 7532	

8	Post Ward Discharges can be received by receiving specialty electronically to triage for appointment, advice or discharge to GP	All staff can request an outpatient appointment following inpatient stay with any specialty and no ability to clinically validate. This results in patients being booked into New Appointment slots when they do not require an appointment. This is causing capacity issues in particular specialties e.g. cardiology.	Establish a triage process for PWD that returns to GP or redirects prior to appointment being allocated.	29/11/2019	Yes - Cardiology ID	
9	Cancelled Follow-up Appointment with Request - Patients cancelled and not rescheduled should be added back to the Holding List so that the trust has a complete picture of the number of patients waiting for an appointment	Hospital and patient cancellations where possible are rescheduled at the point of cancellation. If the appointment cannot be rescheduled the patients drop into 2 categories: Cancelled Appointment with Request Modified Users should modify a cancelled appointment in order for the request to be added back to the follow-up ASI list. This is a worklist in EPR for booking of all appointments and cannot be filtered to identify patients who have been cancelled. This cohort of patients does not filter through to the Holding List, but instead land on the Incomplete Order List and can be filtered to identify those patients cancelled with a request to book. Cancelled Appointment with Request not modified	Solution required within EPR to automatically reinstate the original request. Electronic solution required to replace Consultant A with Consultant B without manual intervention. The CAWR list is continually validated in line with the process for management of the Holding List. Duplicates and discharges are removed and clinical assessment/booking process in place for the remainder. Require automated process to adding CAWR patients back onto the Holding List.	30/11/2019	Yes - Planned Access & DQ: Risk ID 7525	

		If a user fails to modify a cancelled appointment, the patient is added to the Incomplete Order list. This list cannot be filtered and leaves the appointment in a cancelled state. The CAWR currently stands at over 4000 patients. The Holding List position is under-stated due to not including this cohort of patients. Duplicates and discharges are removed through manual validation.				

10	ERS Clock Starts - the clock start for all new referrals on EPR should be based on the date an appointment was booked or if slots are not available at the time of booking, the clock start should be the date the patient was deferred to provider	Currently EPR is capturing the date the appointment was booked as the clock start. This means that patients on the ASI list who have been deferred to provider due to no appointments being available at the point of booking and booked at a later date have an incorrect clock start. As at the end of July there were approx. 5500 patients with an incorrect clock start in EPR - The inaccurate dates ranged from 1-179 days. This impacts on delivery of RTT targets and the 52 week standard. 2 patients breached in August due to correction of the clock start and a further 4 in September 1 at month end.	A fix is required in EPR to record ASI clock starts from the date the referral was deferred to provider. Cerner have confirmed that a fix is available. This will be added to cert and tested. In the meantime clock starts up to the end of July are being manually corrected by the Validation Team. The work has been broken down into 3 categories: Clock start is under 18 weeks and will remain under 18 weeks following revision Clock start is currently under 18 weeks, will move to over 18 weeks following revision. It is anticipated that the manual correction (5500) will be completed by end of September. Once August data is available this will be added to the revision/validation process and will continue until the technical solution is in place. Clock start is over 18 weeks and will remain over 18 weeks following revision - priority group.	31/10/2019	Yes - Planned Access & DQ: Risk ID 7533	

11	Open Appointment - EPR should include the option of Open Appointment to allow open access to appointments if required	When outcoming a patient from Clinic the clinician would like to offer an Open Appt where appropriate. As this is not available on EPR Clinicians are selecting "appointment later date" but not placing an order. This action is adding the patient to the Incomplete Order List amongst other IO categories.	A change request was submitted a number of months ago for "Open Appointment".	04/10/2019		
12	Next appointment timeframes - The clinician should be able to select the timescale for next appointment and this should be clearly understood by the booking team	Users are confused with some requesting the next appointment based on the start date of the request, (patient to be seen in 6 weeks, clinician selecting 6-12 weeks), and some requesting the appointment based on the end date (patient to be seen in 6 weeks selecting 60-12 weeks). This has resulted in some patients being given an appointment date sooner than required, and other delayed.	A change request submitted some months ago to move to fixed timeframes e.g. 1 week, 1 month. The development is currently in the test system. Bradford have agreed the breach rules. Update on testing / go live required.	25/10/2019		
13	All patients who cancel or have appointment cancelled by the Trust should drop into a cancelled patient list so waiting time and cancellation volume can be tracked	Currently no data capture of cancellations hospital or patient.	Requires an automatic solution to identify cancellation data on the system and for this to be able to be extracted for reporting and a process for review and action when cancelling a clinic.	22/11/2019		
14	An automatic report sent to safeguarding for children who DNA	Currently requires reception staff to manually note DNA and refer to safeguarding if felt appropriate. For children's clinics outside of Children's Directorate no clear process.	Requires an automatic solution that alerts safeguarding to Children's DNA where appropriate	31/10/2019		

15	All referral data to be recording to facilitate full understanding of demand	Currently only GP referrals recorded as demand, paper referrals, ward discharges and Consultant to Consultant are all absent.	reporting solution required. This information is available. Page to be added to the weekly report.	18/10/2019		
16	The Correct Lead Clinician to be assigned to patients	many patient records have wrong clinician assigned resulting in incorrect information on correspondence, potentially results etc allocated to incorrect message centre. Lead clinician must be manually changed in PM Office and cannot be applied to a group of patients.	Electronic solution required to transfer group of patients from Consultant A to Consultant B. Explore possibility of using Pooled Clinician to set up locum clinic templates. Need to understand how lead clinicians are assigned. Paeds - ALL babies born at CHFT assigned the on call Neonatal consultant as Lead clinician. Unclear as to rationale and causing significant issues for Children's services. Discussion with DQ team has confirmed that paediatrician consultant is required at birth for activity and financial purposes. Bradford use a mixture of treatment functions (Neonatology, well babies, Paediatrics) this would need some clinical input and a wider discussion to decide if these were appropriate to assign to our clinicians / activity.	18/11/2019		
17	All admin staff to be able to have a 'Favourites' set up removing the risk of incorrect appointment location selection. EPR should prevent a user booking an appointment	Currently the booking system defaults to alphabetical clinic listing and includes all clinics even if not frequented by the Clinician increasing risk of incorrect selection.	Change request to link the site requested in the Work in Progress box, with the clinic location.	31/12/2019	Outpatients ID	

	on a site that the clinic does not run.					
18	All patients to be assigned to correct treatment function and single treatment function per specialty	Respiratory medicine is showing as Respiratory Medicine and Resp Med on the holding list. This is causing confusion to users.	patients to be merged into one cohort.	11/10/2019		
19	Bulk changes to lead clinician managed automatically with no requirement to cancel and reappoint clinic activity	Currently when there is a change of consultant e.g. retirement or locum then all patient records have to be changed manually and outpatient appointments have to be cancelled and reappointed driving up cancelled appointment numbers.	Change request to be submitted to EPR BAU to enable change of clinician on a template.	31/12/2019		
20	No patients are incorrectly cancelled as a consequence of a joint pathway	If patients have 2 appointments on 1 pathway e.g. Audiology and ENT if discharged from Audiology also discharges them from the ENT system increasing risk of 'lost to follow up'.	Could EPR ask the user if future appointments should be cancelled and show the appointment types. Users to be given further training on encounters and pathways.	30/11/2019		
21	All referrals to be received electronically and automatically registered	Currently Cons to Cons, Optometry and dental referrals still on paper.	Explore possibility of using ERS or alternative electronic platform for internal and external referrals that are currently paper.	31/12/2019		
22	Electronic request process for leave	Variation on A/L request and authorisation timeline for all clinic cancellations.	Requires an electronic application process and ability to report weekly on compliance e.g. ESR.			
	User Issue					

23	Failure to Print - All users to select print if the intention is to send a booking/cancellation letter to the patient	Not all users are clicking `send to print', resulting in some patients not being informed that appointment has been booked or cancelled.	Message to all users to highlight the importance of completing the print action. Test that users understand the print process.	04/10/2019		
24	Wrong Consultant/Specialty - All requests should be linked to the correct encounter to ensure that activity is linked to the correct pathway and patients receive the correct information in appointment related correspondence	Some requests are being ordered against the wrong encounter. This occurs outside of the clinic setting, when a user is required to place a request for another activity (appointment) and selects the wrong pathway ID. As a result, the patient will receive incorrect information on the appointment letter e.g. wrong consultant or wrong specialty. The booking clerk only see the request (not the linked encounter) so is not aware that the request is linked to the wrong encounter. This could also result in the patient being discharged from a pathway e.g. discharged from Specialty A but pathway should continue for pathway B.	Algorithm required to identify incorrect encounter. This would need to be generated daily to prevent an appointment being booked against an order linked to an incorrect encounter. Process needs to include identification of user to enable further training.	TBC	Yes - Planned Access & DQ Risk ID 7530	
25	No patients booked outside of agreed polling range	Some Consultants are insisting on booking patients into clinics outside of the 6week A/L rule and managed by individual secretaries.	Communication to clinicians highlighting the importance of following trust booking rules.	04/10/2019		

26	Time of Appointment - Patient should only be informed of appointment change of time if it exceeds 20 minutes	Letters are being generated for appointment changes of a few minutes	Receptionist to highlight on sitrep if an issue Reminder to booking Teams	13/09/2019	No	
27	Hospital initiated appointment cancellations should only occur at less than 6 weeks notice for exceptional circumstances	Approximately 11000 appointments are cancelled each month either by the patient or by the hospital. Ratio is about 50:50. Of the hospital cancellations 72% are within 6 weeks of the appointment and 10% of these within 7days of the appointment. There is approximately a 50:50 split between new and follow up Some specialties have a polling range, i.e. offer appointments on Choose & Book, longer than 6weeks. This does not align with Trust Medical Staff Annual Leave Policy of 6/52 notice increasing risk of patient cancellation The Trust has an electronic request process for A/L but there are different view about where the breakdown is occurring. Rota management does not align with 6week rule and regular changes are made impacting on availability.	A report is required from the cancellation system that shows when the request was made, authorised and actioned. > 6 weeks requests - seek agreement and process to automatically cancel on request (without going through approval process) when the requester is giving more than 6 weeks' notice. OPs managers confirmed prefer to approve as not all leave approved prior to submission to cancel. < 6 week requests - implement a Divisional Director only authorisation process for all Consultant annual leave and study leave. Task and Finish Group be developed to resolve issues relating to requests as a result of rota changes.	31/10/2019	Yes - outpatients **RISK ID 4050**	
28	Multiple Cancellations (hospital initiated)- Clinic lists should be reviewed prior to cancellation to ensure that patients are	If a clinic that has patients booked is cancelled then the clinician should agree when and where to relocate patients on the cancellation form. The Appointment Centre process the	Process required to enable clinical assessment of every patient to be cancelled prior to submission of cancellation request. Alternative capacity to be included	31/10/2019	Yes - Outpatient **RISK ID 4050**	

	clinically assessment and multiple appointment cancellation avoided.	cancellation and batch cancel the clinic, which actions the cancellation for all patients on the clinic code without the need to cancel patient level. At the point clinic is cancelled patients are reappointed as per Consultant instruction. If there is no capacity within the required timescale, new patients are returned to ASI list and f/u patients onto the Cancelled with Request list. Not all clinicians are reviewing the clinic list on EPR prior to instruction to cancel. There is currently no way of highlighting previously cancelled patients at the point of cancellation without looking at each patient appointment history. This means that some patients may be cancelled multiple times and cannot be tracked. The cancellation form asks for an indication of when the patient(s) should be seen, e.g. next available, additional clinic in x weeks. Usually "next available" is selected. This results in the patient being added back to the ASI list as there is no capacity.	in cancellation request where assessment has highlighted clinical risk or previous cancellation. Task & Finish Group required to agree process linked to item 16.			
29	All users understand the system and are fully trained to maximise the potential of the system	External review suggests users are looking for the system to deliver historical practice and have not been	Refresher training linked to job roles.	TBC		

		sufficiently trained on the system to maximise the potential.				
30	All patients accessing information via E Portal	Not all patients are aware of or signed up for the patient portal to access letters and test results. This has resulted in increased calls to medical secretaries from patients seeking information, and increased admin for the Subject Access Team.	Information hubs required in outpatients to inform and enrol patients as they attend clinics. Communications in GP practices to inform patients of digital letters and patient portal at point of referral.	30/11/2019		
31	Booking centre teams based around Divisions and single TOR for contact meetings	Appointment Centre works on task-based teams. Whilst this improves productivity it does not allow for specialist knowledge.	Review of workforce model with a view to introducing failsafe officers and specialty teams.	31/10/2019		
32	No waiting lists held manually, all patients to be registered on correct EPR list and managed accordingly	Currently several secretaries, Consultants and CNS's holding waiting lists of patients and appointing patients from this outside of Appointment centre process	To work through Operational team to identify all patient lists, cross check with central system to confirm on record and then destroy individual list.	31/12/2019		
	Access - Capacity / Demand					
33	New Referrals - Appointment Slots Issues. ASIs should be minimal and no more than 1 week beyond the set polling range (maximum waiting time for specialty)	**Process** Slot Polling – slots are released in line with set waiting time e.g. 6 weeks GP Electronic Referrals - Patients are given a unique booking reference number (UBRN) and book the appointment on line or via the national booking line. Referrals from other referrers (Optometrists/Dentists) are received in paper format and registered/booked via the appointment centre.	A review of the Customer Contact Meeting agenda to provide more detailed ASI information with focus on balance of new / follow-up capacity/demand. Meeting to be chaired by DD or DOP and to include Appts Manager and Operational Managers as appropriate. Discussion re local AL policy if longer polling than 6 weeks leave rules.	16/11/2019	Yes - Outpatient **RISK ID 6078**	

		Patients who can't access a slot are referred to the booking centre automatically and added to the ASI list **Issues** Polling range is set with capacity or RTT pathway in mind. E.g. 6 weeks GS, 11 weeks Ophthalmology – this could result in patients being cancelled as a consequence of A/L policy Insufficient slots resulting in some patients being unable to book. Increase in defer to provider in some specialties, as other demand e.g. follow up and ward discharge is taking all slots. Some new patients are waiting beyond 18 weeks for a first appointment.				

34	Follow Up Appointments - Priority/urgent Patients should be seen within the timeframe selected by the Clinician. Any delays should be minimal and with the Clinicians knowledge.	Lack of clarity of definition of priority patient Inconsistent application of clinical assessment following admin validation Insufficient capacity to meet demand	A review of process for Urgent appointment ASIs is required to develop a process that ensures that the capacity is agreed as a priority. Data in clinic to inform clinician of next available slots. Clear escalation process where solution is not identified in Clinic. Outpatient transformation to reduce Face to Face visits Clear description of priorities Validation against above Identify capacity gaps	01/12/2019	Yes - Outpatient **RISK ID 6079**	
35	Follow-up Appointments - Routine There should be sufficient capacity to enable the patient to be offered an appointment nearer the appointment due date and the appointment should not be cancelled by the hospital	**Process** Clinician requests next appointment and timescales. Receptionist informs Patient that the appointment will be booked nearer the due date. Patient is added to the holding list and approx. 4 weeks prior to appointment due date appointment is booked **Issues** Clinics cancelled at <6 week notice with no alternative slots provided Insufficient capacity for routine patients – previously patients received an invite to book, this has been switched off due to insufficient slots available. Patients contacted when	Capacity / demand modelling required in advance of appointment due date to determine available capacity. A review of the Customer Contact Meeting agenda to provide more detailed ASI information with focus on balance of new / follow-up capacity/demand. Attendees to include lead clinician / GM / Ops Manager as agreed with Directorate. Specialty level agreement of next steps e.g. flexing new /urgent capacity as appropriate. Clinician input required to determine best way to utilise the clinician template	25/10/2019	Yes - Outpatient **RISK ID 6079**	

		capacity identified this can means delays in excess of >12 weeks beyond the appointment due date.	information available on Clinic Diary. Outpatient transformation to reduce Face to Face visits			
36	All clinicians to identify patients for the priority list to the same criteria	4 different understandings of the priority list criteria Use for those patients that must be seen in the timescale requested. Patients that need to be seen <8 weeks Patients clinically urgent e.g. cancellation Cancer pathway	Consensus required on use of this field, followed by communication to all users Following consensus review booking and validation processes as appropriate.	31/10/2019		
37	Only patients who comply with Directory of Services should be accepted for an appointment	No all referrals are reviewed prior to patient attending clinic resulting in some patients being seen in the wrong specialty/clinic or being seen unnecessarily.	Deployment of Ardens system for all referrals Review of DOS	31/03/2020		
38	Only patients who require face to face are offered appointments in the hospital setting	Only a limited number of specialties offer non face to face appointments	Need to accelerate pace of outpatient transformation.	31/03/2020		
39	All staff to fully comply with Access Policy	Not all staff fully aware of Access Policy key points.	Access Policy key points to be included as part of essential training requirements.	31/12/2019		
40	All clinics to have a stop moment to ensure all information in place for safe and effective clinic and a post clinic safety huddle	Clinicians are not fully informed of DNAs, cancellations and next available appts. This could result in delays to essential patient care, and difficulty in managing patient expectations and care.	Removal of last appointment to support team huddles, cash up process and clinician decision making on next steps for patients that have cancelled or DNA'd Dashboard of relevant information to support clinician decision making and group huddle.	30/11/2019		

41	All clinic template changes to be authorised by CD & GM	Ad hoc changes being made to templates without appropriate approval.	Review of access levels to restrict removal of slots to appropriate personnel only. Review of start / finish times cross referenced with template.	31/12/2019		
42	Under 6 week cancellations to require DD authorisation	Currently <6 week cancellations are approved by the Operational Manager who may not be aware of the impact to patients from a clinical perspective.	Electronic system to be adapted to enable DD authorisation for all requests under 6 weeks.	31/12/2019		
43	Single clinic session time & template for all clinics and weekly report on clinic utilisation	The Master template can only be viewed by looking into the future on EPR. A list of all master templates by clinician/specialty is not currently available.	Directory of master templates by consultant/specialty and weekly report of utilisation against master template.	30/11/2019		
44	Full dataset on all issues as they pertain to outpatients on a weekly basis	Currently inconsistent information available on issues with booking and waiting issues.	Establish a trigger list for all staff involved in outpatients for Datix completion and weekly sitrep. Establish a proactive communication with patients at booking to capture concerns	31/10/2019		
45	Maximised clinic capacity by effective use of workforce	Generic nursing model is restricting capacity due to inexperience and inability to undertake extended roles. Opportunities for increased pharmacy role in clinic.	Review of workforce model and succession planning to enable flexing of roles.	31/03/2020		
46	Have a clear succession plan for all known Consultant leavers for next 3 - 5 years	Loss of capacity due to consultant turnover and absence of succession planning.	Specialty level plans for replacement of consultants - forward thinking and use of CNS roles where appropriate.	31/03/2020		
47	Reduce impact on clinic cancellations of junior doctor rota	Middle rota changes are resulting in last minute clinic cancellations due to conflicting clinical priorities e.g. theatres, and on call.	Rotas should be locked down at 6 weeks. Any changes required after this time should consider impact on patients attending OPD.	31/11/2019		

48	Business model for visiting Consultant specialties	Different arrangements in place for Visiting consultants with some managing their own waiting list making it difficult for CHFT to deliver against national targets.	Standard approach to employment and clinic activity for visiting consultants.			
49	All patients requiring an urgent follow up from clinic leave with agreed date	There is insufficient short notice capacity available in some clinics. These means that some patients instructed to book their next appointment are unable to do so.	Clinicians should be provided with information on next available appointment to support decision making. Shortfalls in capacity should be addressed via the customer contact meetings, and clinical assessment of all patients waiting for additional capacity. Linked to Item 26.	30/11/2019		

17. Integrated Performance Report – August 2019

Presented by Bev Walker, Deputy Chief Operating Officer

To Note

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	Quality and Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsor:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee, Quality Committee

Actions Requested:

- To note

Purpose of the Report

To provide the Board of Directors with the performance position for the month of September 2019.

Key Points to Note

September's Performance Score is 74% with 3 green domains continuing the Trust's excellent performance for 2019/20. The SAFE domain and the EFFECTIVE domain have both maintained their green performance with EFFECTIVE now at 91% with the latest SHMI score at < 100. The CARING domain remains amber however further focus on both of the FFT A%E metrics could see this improve. The RESPONSIVE domain remains amber with cancer 62 day screening missing target for the 3rd month. 2 of the 4 stroke indicators have missed target again and the 6 weeks Diagnostics target remains a challenge. The Trust's 62 day referral to treatment performance for the first half of the year is one of the best nationally. WORKFORCE remains green with sickness levels and EST continuing their strong performance which is a great achievement. EFFICIENCY & FINANCE remains amber.

EQIA – Equality Impact Assessment

The Integrated Performance report is a retrospective review of Key Performance Indicators and as a document does not have an EQIA. Actions within each domain, where required, will be subject to EQIA.

Recommendation

The Board of Directors is asked to note the contents of the report and the overall performance score for September 2019.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

September 2019

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

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

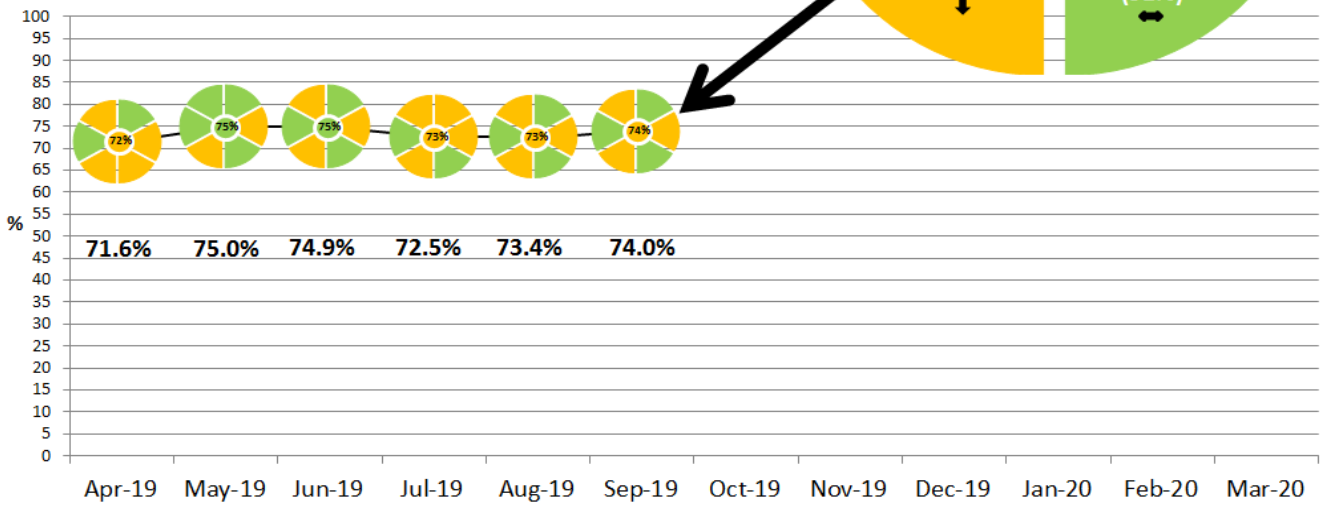
62 Day Referral From Screening to Treatment for July had a late breach and therefore missed target resulting in an overall reduction in the Responsive domain and Trust Summary for July.

Performance Summary

September

RAG Movement

September's Performance Score is 74% with 3 green domains continuing the Trust's excellent performance for 2019/20. The SAFE domain and the EFFECTIVE domain have both maintained their green performance with EFFECTIVE now at 91% with the latest SHMI score at < 100. The CARING domain remains amber however further focus on both of the FFT A%E metrics could see this improve. The RESPONSIVE domain remains amber with cancer 62 day screening missing target for the 3rd month. 2 of the 4 stroke indicators have missed target again and the 6 weeks Diagnostics target remains a challenge. The Trust's 62 day referral to treatment performance for the first half of the year is one of the best nationally. WORKFORCE remains green with sickness levels and EST continuing their strong performance which is a great achievement. EFFICIENCY & FINANCE remains amber.



SINGLE OVERSIGHT FRAMEWORK

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

RESPONSIVE	
Diagnostics 6 weeks	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	Aug-19	Sep-19	YTD	Performance Range		
SAFE									Green	Amber	Red
Never Events	4	0	0	0	0	0	0	**0**	0		>=1
CARING									Green	Amber	Red
% Complaints closed within target timeframe	42.00%	29.0%	38.0%	58.0%	37.0%	22.0%	**47.0%**	**38.0%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - Response Rate	36.39%	34.35%	36.50%	32.61%	33.58%	26.59%	**30.68%**	**32.45%**	>=24.5%		<24.5%
Friends & Family Test (IP Survey) - % would recommend the Service	97.46%	97.29%	97.56%	96.91%	97.40%	96.40%	**97.31%**	**97.19%**	>=96.7%	93.8% - 96.6%	<93.8%
Friends and Family Test Outpatient - Response Rate	10.75%	7.93%	9.25%	9.93%	10.11%	7.71%	**5.62%**	**8.15%**	>= 4.7%	2.3% - 4.6%	<2.3%
Friends and Family Test Outpatients Survey - % would recommend the Service	90.92%	91.13%	90.36%	91.81%	92.11%	92.31%	**91.92%**	**91.63%**	>= 96.2%	93.4% - 62.1%	<93.4%
Friends and Family Test A & E Survey - Response Rate	13.03%	11.56%	11.48%	14.46%	11.37%	11.10%	**9.03%**	**11.88%**	>= 11.7%	4.2% - 11.6%	<4.2%
Friends and Family Test A & E Survey - % would recommend the Service	83.80%	83.88%	84.79%	85.60%	82.29%	86.82%	**80.28%**	**84.65%**	>=87.2%	82.8% - 87.1%	<82.8%
Friends & Family Test (Maternity Survey) - Response Rate	36.51%	30.84%	41.78%	52.54%	38.29%	34.61%	**32.27%**	**32.25%**	>=20.8%	10.4% - 20.7%	<10.4%
Friends & Family Test (Maternity) - % would recommend the Service	98.64%	100.00%	99.19%	99.43%	99.53%	98.61%	**98.66%**	**99.34%**	>=97.3%	94.3% - 97.2%	<94.3%
Friends and Family Test Community - Response Rate	4.91%	3.38%	5.74%	2.15%	2.48%	2.46%	**4.31%**	**3.53%**	>=3.2%	1.7% - 3.1%	<1.7%
Friends and Family Test Community Survey - % would recommend the Service	94.64%	96.69%	95.48%	97.96%	98.15%	98.21%	**97.07%**	**96.92%**	>=96.7%	94.4% - 96.6%	<94.4%
EFFECTIVE									Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	2	1	0	0	0	0	**0**	**1**	0		>=0
Preventable number of Clostridium Difficile Cases	5	0	0	0	3	1	**0**	**4**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.25							**99.43**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	84.51							**86.84**	<=100	101 - 109	>=111
RESPONSIVE									Green	Amber	Red
Emergency Care Standard 4 hours	91.29%	90.19%	92.30%	89.32%	91.44%	91.37%	**86.82%**	**90.25%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	64.00%	46.55%	50.88%	63.41%	55.36%	58.21%	**62.50%**	**55.59%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.46%	96.56%	96.92%	98.00%	98.75%	98.24%	**99.16%**	**97.98%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.56%	98.34%	94.01%	93.56%	97.87%	100.00%	**99.26%**	**97.01%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.63%	100.00%	99.40%	100.00%	99.40%	100.00%	**100.00%**	**99.79%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	99.04%	100.00%	100.00%	100.00%	100.00%	100.00%	**96.00%**	**99.31%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	52.42%	31.58%	31.58%	55.56%	84.21%	42.31%	**44.44%**	**48.44%**	>=85%		<=84%
62 Day GP Referral to Treatment	88.37%	88.51%	91.76%	89.16%	89.58%	93.69%	**91.76%**	**90.82%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	94.42%	91.30%	96.30%	100.00%	88.46%	87.50%	**89.47%**	**92.06%**	>=90%		<=89%
WORKFORCE									Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.69%	3.67%	3.64%	3.61%	3.61%	3.63%	*	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.39%	2.37%	2.36%	2.33%	2.33%	2.35%	*	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.30%	1.29%	1.28%	1.28%	1.28%	1.28%	*	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.45%	93.18%	93.40%	93.36%	94.68%	94.58%	95.22%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff		16.52%	50.88%	96.43%	97.63%	96.97%	96.11%	-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	92.85%	87.23%	86.89%	85.28%	86.21%	85.27%	86.71%	-	>=95%	>=90%	<90%
FINANCE									Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	0.01	**0.01**	**0.01**	**0.01**	**0.01**	**0.00**	**0.00**	**0.01**			

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Latest SHMI figures are now < 100.	Friends and Family Test A & E Survey - Response Rate/Would Recommend. Further drop in Response Rate to 9% lowest rate in over 12 months. % Would Recommend lowest rate in over 12 months at 80%.	Work is ongoing in the department to improve the response rate to ensure we are receiving as much patient feedback as possible. There is a go-see visit to Newcastle planned in November to see how they maintain a good response rate. We are implementing more communication re: waiting times etc. which should improve the % would recommend.
Emergency Readmissions Within 30 Days are now better than expected for the Trust as a whole and for Greater Huddersfield CCG patients.		
	% Diagnostic Waiting List Within 6 Weeks - now at 91.2%.	Echocardiography ICS outsourcing company are providing scanning capacity but not the numbers they originally predicted. We are exploring additional weekend lists with ICS to increase their capacity. CHFT staff are also performing extra weekend lists through September/October to maximise the number of scans available. We are currently working to a revised trajectory which will see the over 6 week backlog cleared by the end of October. Neurophysiology - An options appraisal was developed to look at clearing the backlog including an option to use outsourcing and maintain the required capacity whilst we continue to recruit substantively. We made a decision not to outsource and to treat the patients within CHFT.

Executive Summary

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

Domain	Area
Safe (80%)	• **% PPH ≥ 1500ml - all deliveries** - rate increased to 3.98% in month but still within normal variation. • **% Complete EDS - performance** at 94.42% against 95% target. Communication to all doctors regarding standard and increased performance monitoring across clinical divisions.
Caring (67%)	• **Complaints closed within timeframe** - Complaints performance has improved in September to 47% responded to within time. Divisional Senior Management Teams and Corporate Complaints Team colleagues continue to work together to improve responsiveness. A number of strategies are in place including increased capacity to manage ED complaints twice weekly divisional meetings to review complaints and additional timetabled supervision meetings to improve the quality of complaint responses. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 92% against the 96.2% target. Outpatient improvement and transformation work includes the Trial of paper FFT in Orthopaedic Outpatients at CRH which has shown a significantly higher response rate and a decrease in "wouldn't recommend" however it has not consistently shown significant improvement in the "would recommend rate". Plan to role out paper capture to HRI and ENT. • **Friends and Family Test A & E Survey - Response Rate/Would Recommend**. Further drop in Response Rate to 9% lowest rate in over 12 months. Work is ongoing in the department to improve the response rate to ensure we are receiving as much patient feedback as possible. There is a go-see visit to Newcastle planned in November to see how they maintain a good response rate. % Would Recommend lowest rate in over 12 months at 80%. We are implementing more communication re: waiting times etc. which should improve the % would recommend. • **% Dementia patients screened following emergency admission aged 75 and over** - performance remains at 46% and is a long way from the 90% target. Medicine - The delirium team have now assigned dementia champions for each ward area to raise the profile of the importance of the delirium and dementia screen with clinical colleagues The butterfly scheme relaunch has taken place in September across both sites. The nurse consultant for older people has undertaken a go-see to other cerner sites during September to learn from their response rate. Surgical division are focussing on improved communication within directorates to support improvement.
Effective (91%)	• **% Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - performance has fallen to 76% still below the 85% target. RCA undertaken for all organisational breaches with patient outcomes monitored. Joint working with Theatres to consider alternative options for planned trauma. Performance is still challenging as a result of previous trauma surges, as those patients were not fit for discharge in July and August and have featured in this month's performance figures.

Background Context

AED attendances remain a pressure and despite great work to minimise non-elective admissions the increased acuity at both sites during September has added to a challenging operational situation. LOS has increased along with increased numbers of patients medically fit for discharge resulting in the opening of some additional capacity and associated Divisional cost pressures. Some of the Urgent Care developments are not yet in place and therefore a step change in capacity is expected during November and December.

Senior leadership has been reviewing the flow position with an improvement plan developed as a result of further pressures in October. There has been an improvement in medical cover in the department since the implementation of the new junior doctors' rotas, with much fewer unfilled slots. We continue to work closely on the rota daily to ensure robust cover is in place. Lead nurses and matron providing daytime and evening cover during the busiest shifts to support flow throughout the department.

The CAS trial in Gastroenterology is continuing and will see the CAS open up to GPs for them to select directly in the coming months.

A new elderly care consultant started in post in September and a succession planning exercise is underway to mitigate against expected retirements in the near future.

Ambulatory care (2A) and the Acute Floor CRH (2BCD) both saw huge improvements in their FLO audits in month and were sent Trust "thank you" cards in recognition of their hard work and achievements.

Executive Summary

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

Domain	Area
Responsive (60%)	• **Emergency Care Standard 4 hours** - deteriorated further to 87% in September, (88.44% all types) - 1. The band 7 streaming nurses have started in ED from 14th October. 2. We have seen an improvement in medical cover in the department since the implementation of the new junior doctors rotas, with much fewer unfilled slots. We continue to work closely on the rota daily to ensure robust cover is in place. 3. Lead nurses and matron providing daytime and evening cover during the busiest shifts to support flow through the department. The Patient Flow & ECS Improvement plan was signed off at WEB 24th October. • **Stroke targets** - % Stroke patients spending 90% of their stay on a stroke unit is now at 77.5% against the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival has improved to 62.5% against the 90% target. Reviewed escalation protocol as in hours we found the escalation was happening too close to the 4 hour – Bed team is now escalating as soon as patient is identified as query stroke rather than when a bed is requested. A comprehensive action plan has been developed to ensure an improvement in performance against the 4 hour admittance and 90% stay targets which includes a number of detailed actions. • **% Diagnostic Waiting List Within 6 Weeks** - now at 91.2%. Echocardiography ICS outsourcing company are providing scanning capacity but not the numbers they originally predicted. We are exploring additional weekend lists with ICS to increase their capacity. CHFT staff are also performing extra weekend lists through September/October to maximise the number of scans available. We are currently working to a revised trajectory which will see the over 6 week backlog cleared by the end of October. Neurophysiology - An options appraisal was developed to look at clearing the backlog including an option to use outsourcing and maintain the required capacity whilst we continue to recruit substantively. We made a decision not to outsource and to treat the patients within CHFT. • **Cancer 38 Day Referral to Tertiary** - performance was 44% in September. Urology proves to be a challenge and on review 2 out of the 5 breaches could have been avoided if appropriate treatment plans had been implemented. This has led to a discussion with the clinician involved and further training offered on CWTv9. All Urology pathways are shared with the substantive consultant body with a demand for recommendations to avoid further breaches. • **Cancer 62 Day Referral From Screening to Treatment** - performance just missed target at 89.5%. There are still ongoing issues with the low numbers for treatment against the breached numbers, the programme manager is authoring a service plan as it appears the initial increase in demand through FiT has stabilised. • **Appointment Slot Issues on Choose & Book** - performance has improved to 25% 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 sessions continue to improve performance within those specialties where it has been implemented.
Workforce (86%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total small increase to 3.63% due to increase in long term sickness in month which is highest in over 12 months at 2.59%. RTWI performance has improved to 74.5% but remains • **Essential Safety Training** - overall at 95%.
Finance (70%)	• **Year to Date Summary** The year to date deficit is £9.32m, 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, maintenance contracts and lower than planned VAT recovery. • These pressures have been offset year to date by lower than planned pay expenditure, although in month pay was overspent due to Medical pay awards and some pressure from additional capacity. • Clinical income performance (contract and other) is below plan by £3.03m. The Aligned Incentive Contract (AIC) protects the income position by £2.78m in the year to date leaving a residual pressure of £0.25m, an improvement compared to the position in Month 5. • CIP achieved year to date is £4.41m, £0.17m more than planned. • Agency expenditure year to date is £4.16m, £1.72m below the planned level. **Key Variances** • Clinical income is below plan overall despite £2.78m 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 the Medical Division, clinical divisions continue to show favourable variances to plan, reflective of lower expenditure linked to lower activity levels. However, the Medicine division are over budget on pay expenditure having experienced high levels of acuity leading to the opening of additional unplanned capacity in month. • 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 an adverse variance on Medical staffing expenditure of £0.14m, although this includes a £0.41m in month pressure due to the backdating of pay awards. Some additional funding has been allocated by DH, but this is insufficient to fully cover the planning gap (a net pressure of £0.27m year to date). • Nursing pay expenditure is lower than planned year to date by £0.21m, despite an increase in costs in month due to the opening of additional capacity. **Forecast** Divisional forecasts improved this month following the identification of £1.3m of recovery actions. However, non-pay costs linked to the estate and maintenance continue to grow and the additional capacity requirements seen in month are likely to continue throughout October, driving a further increase in the recovery requirement. Achieving the planned deficit will now require further recovery actions of circa £0.50m. This recovery requirement assumes that, £0.50m earmarked for reconfiguration is fully committed in year; the winter planning reserve is spent in full, with the exception of £0.3m already earmarked for recovery; and that contingency reserves are exhausted. The majority of these reserves are already committed.

Background Context

Safe Care within the Community Healthcare division remains a focus due to a number of areas where a deterioration in month has been seen. Learning through Orange panel is shared throughout the division and the organisation.

The division now has a well established, strong, cohesive senior management team and are looking forward and focusing on improving patient experience through co-design with patients and a number of other strategies.

We are reviewing the Community Service offered within the newly established Primary Care Networks, looking at opportunities through working with colleagues from across the system to enhance care closer to home.

CHFT have been added to the framework of providers for TOP following successful tender submission. Working to be mobilised by 1st November.

HSIB reports for Maternity triangulated with Serious Incidents and complaints to consider themes and audit trail to ensure lessons learned and embedded. 5th HSIB report received in draft form - positive report for CHFT with many examples of good practice evidenced.

Maternity WTGR - a number sessions undertaken with follow-up arranged to ensure workforce well being and flow of patients.

Middle grade cover in Paediatrics continues to be a challenge with division utilising Nurse Practitioners to support gap fill and budgetary spend.

Radiology Consultant staffing continues to be a challenge with really positive commitment from remaining Consultants but service remains fragile and work to convert the agreements from WYAAT colleagues into reality requires pace

Within Surgery Divisional Management and Matron teams are all now in place and fully operational. the division have taken on a 'ward Buddy' approach providing support to staff around flow and MDT working. Delays in complaints response times are reducing although numbers closed in time are still below target.

Activity has improved across Points of Delivery for most specialties with reductions in longest waits realised in Urology and Plastics Day Cases. The ASi and Holding list positions are improving with longest waits reduced in addition to volume of patients waiting.

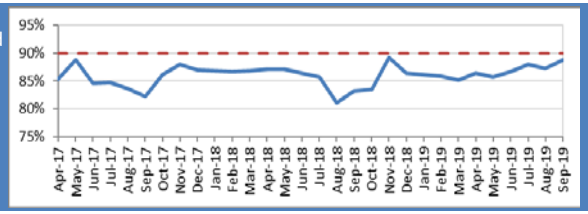
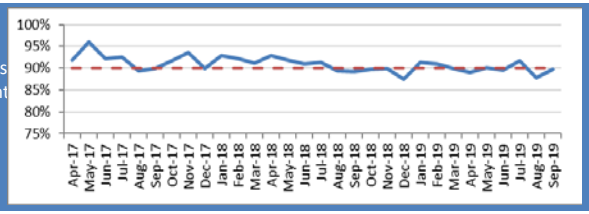
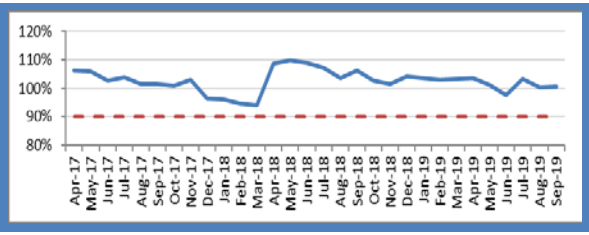
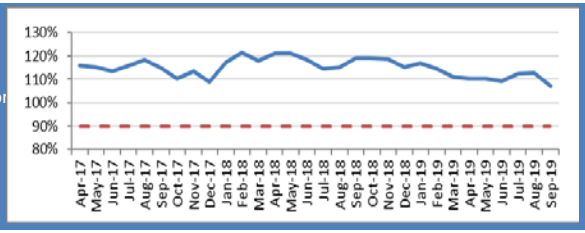
Long term sickness continues to have an impact upon the already challenged Ophthalmology capacity, masking the appointment of the new Corneal Consultant. Activity continues to be provided via a small number of WLI and Ophthalmic LLP.

Newly refurbished theatres at CRH have reopened mid-month and have enabled access to T&O LLP lists .

Upper GI continues to have long term sickness which has impacted upon ASI position and DC/IP capacity with short term sickness in Urology causing cancelled operations and clinic cancellations.

Trust wide ERS challenges have added in pathways across specialties with history of ASIs (Urology, General Surgery, Ophthalmology in particular) this has added to the long waits (>26 and >40 weeks RTT) and require individual tracking to ensure treatment as promptly as possible.

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.	88.70% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 15 72.9%	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.	89.82% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - 7a/d 69.9%	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.	100.59% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - LDRP 73.6%% - NICU 47.7%	The low HCA fill rates in September 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 workload. 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.	107.17% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - NICU 52%	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 nurse. 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

		DAY						NIGHT						Care Hours Per Patient Day				
Ward	Main Specialty on Each Ward	Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual							
CRH ACUTE FLOOR	GENERAL MEDICINE	2,736.87	2,693.00	2,237.83	2,224.17	98.4%	99.4%	2,436.50	2,320.50	1,969.00	1,945.75	95.2%	98.8%	7.3	7.1		4	14
HRI ACUTE FLOOR	GENERAL MEDICINE	3,021.42	2,633.25	2,610.50	2,500.58	87.2%	95.8%	2,629.00	2,354.75	1,980.00	1,969.00	89.6%	99.4%	8.2	7.6		5	23
WARD 5	GERIATRIC MEDICINE	1,464.20	1,124.08	1,124.52	1,629.33	76.8%	144.9%	990.00	957.00	990.00	1,235.50	96.7%	124.8%	6.1	6.6		0	7
WARD 15	GENERAL SURGERY	1,730.50	1,262.00	1,495.00	1,834.17	72.9%	122.7%	1,318.00	1,012.00	1,320.00	1,582.50	76.8%	119.9%	7.3	7.1		1	8
RESPIRATORY FLOOR	GENERAL MEDICINE	3,351.58	2,889.58	2,352.00	2,377.83	86.2%	101.1%	2,629.00	2,273.67	990.00	1,320.00	86.5%	133.3%	5.7	5.4		2	9
WARD 6	GENERAL MEDICINE	745.25	741.17	1,161.83	1,149.92	99.5%	99.0%	660.00	660.00	660.00	614.00	100.0%	93.0%	5.5	5.4		0	0
WARD 6C	GENERAL MEDICINE	1,080.17	846.83	708.50	622.17	78.4%	87.8%	660.00	660.00	330.00	330.00	100.0%	100.0%	5.9	5.2		0	0
WARD 6AB	GENERAL MEDICINE	1,318.33	1,298.75	1,080.00	1,085.00	98.5%	100.5%	990.00	1,111.00	990.00	1,124.00	112.2%	113.5%	5.3	5.6		1	4
WARD CCU	GENERAL MEDICINE	1,350.17	1,282.17	360.67	339.00	95.0%	94.0%	990.00	990.00	0.00	0.00	100.0%	-	8.7	8.4		0	2
WARD 7AD	STROKE MEDICINE	1,315.33	1,414.77	1,155.67	1,298.03	107.6%	112.3%	979.50	682.00	660.50	858.00	69.6%	129.9%	10.5	10.8		0	2
WARD 7BC	STROKE MEDICINE	2,385.67	1,858.00	1,612.00	1,701.28	77.9%	105.5%	1,980.00	1,737.00	660.00	770.00	87.7%	116.7%	10.3	9.4		0	0
WARD 12	MEDICAL ONCOLOGY	1,487.70	1,135.50	731.00	1,042.50	76.3%	142.6%	984.00	874.00	330.00	473.00	88.8%	143.3%	8.9	8.9		0	2
WARD 17	GASTROENTEROLOGY	1,859.33	1,484.32	1,099.50	1,114.33	79.8%	101.3%	1,309.00	952.00	660.00	660.00	72.7%	100.0%	6.9	5.9		0	5
WARD 20	GERIATRIC MEDICINE	1,614.50	1,337.05	1,511.00	1,586.42	82.8%	105.0%	1,320.00	1,052.50	1,320.00	1,419.00	79.7%	107.5%	7.3	6.8		1	7
WARD 21	TRAUMA & ORTHOPAEDICS	1,463.17	1,239.82	1,262.33	1,199.00	84.7%	95.0%	1,035.00	865.50	915.00	908.00	83.6%	99.2%	7.9	7.1		0	6
ICU	CRITICAL CARE MEDICINE	3,878.50	3,439.25	777.50	693.30	88.7%	89.2%	4,128.50	3,420.00	0.00	0.00	82.8%	-	37.2	32.0		0	0
WARD 3	GENERAL SURGERY	910.75	870.58	566.32	553.98	95.6%	97.8%	690.00	690.00	502.50	564.00	100.0%	112.2%	7.5	7.5		0	1
WARD 8A	TRAUMA & ORTHOPAEDICS	862.50	668.50	608.50	558.00	77.5%	91.7%	690.00	552.00	345.00	305.50	80.0%	88.6%	10.6	8.8		1	0
WARD 8D	ENT	739.13	727.30	563.50	527.42	98.4%	93.6%	685.50	667.00	157.50	191.00	97.3%	121.3%	6.6	6.5		0	0
WARD 10	GENERAL SURGERY	1,271.97	1,116.15	784.50	883.50	87.7%	112.6%	1,035.00	909.50	690.00	704.48	87.9%	102.1%	6.4	6.1		0	2
WARD 11	CARDIOLOGY	1,617.42	1,542.28	1,083.17	1,019.00	95.4%	94.1%	1,192.50	1,133.00	685.02	895.02	95.0%	130.7%	6.0	6.0		0	0
WARD 19	TRAUMA & ORTHOPAEDICS	1,572.00	1,353.25	1,235.67	1,252.83	86.1%	101.4%	1,035.00	989.00	1,035.00	1,173.00	95.6%	113.3%	13.2	12.9		0	6
WARD 22	UROLOGY	1,137.50	1,094.25	1,086.25	1,037.25	96.2%	95.5%	690.00	690.00	690.00	690.00	100.0%	100.0%	5.6	5.4		0	2
SAU HRI	GENERAL SURGERY	1,372.17	1,245.67	695.33	701.00	90.8%	100.8%	1,605.00	1,520.25	345.00	382.50	94.7%	110.9%	8.8	8.5		0	1
WARD LDRP	OBSTETRICS	3,974.42	3,619.88	916.00	674.33	91.1%	73.6%	3,782.25	3,384.83	690.00	686.50	89.5%	99.5%	24.1	21.5		0	0
WARD NICU	PAEDIATRICS	2,419.00	2,086.67	813.00	387.50	86.3%	47.7%	2,058.50	1,898.50	690.00	359.00	92.2%	52.0%	11.5	9.1		0	0
WARD 3ABCD	PAEDIATRICS	3,356.83	3,089.50	690.00	632.50	92.0%	91.7%	3,507.50	3,129.50	345.00	337.00	89.2%	97.7%	9.8	9.0		0	0
WARD 4ABD	OBSTETRICS	2,300.00	2,271.38	690.00	609.50	98.8%	88.3%	1,725.00	1,717.80	684.50	674.00	99.6%	98.5%	4.6	4.5		1	0
WARD 4C	GYNAECOLOGY	1,205.67	1,124.33	380.00	343.67	93.3%	90.4%	690.00	698.00	345.00	312.00	101.2%	90.4%	7.8	7.4		0	3
TRUST		**53,542.03**	**47489.28**	**31392.08**	**31577.5**	**88.70%**	**100.59%**	**44424.75**	**39901.3**	**20979.02**	**22482.8**	**89.82%**	**107.17%**	**8.1**	**7.6**			

Hard Truths: Safe Staffing Levels (3)

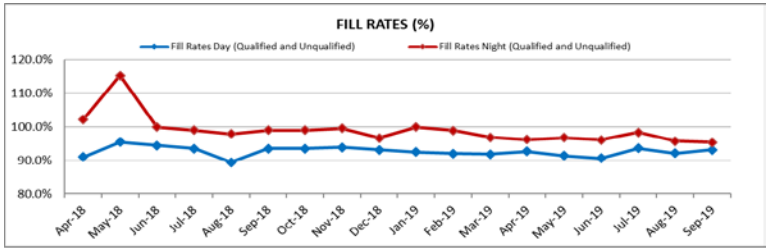
Care Hours per Patient Day

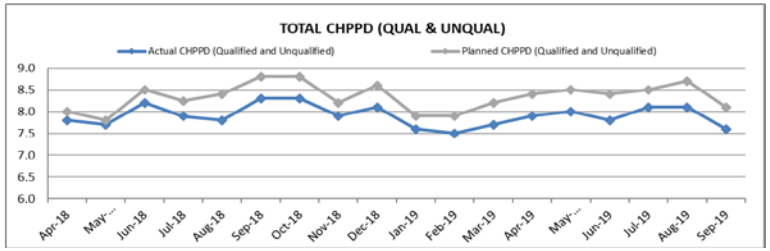
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Jul-19	Aug-19	Sep-19
Fill Rates Day (Qualified and Unqualified)	93.6%	92.1%	93.1%
Fill Rates Night (Qualified and Unqualified)	98.3%	95.8%	95.4%

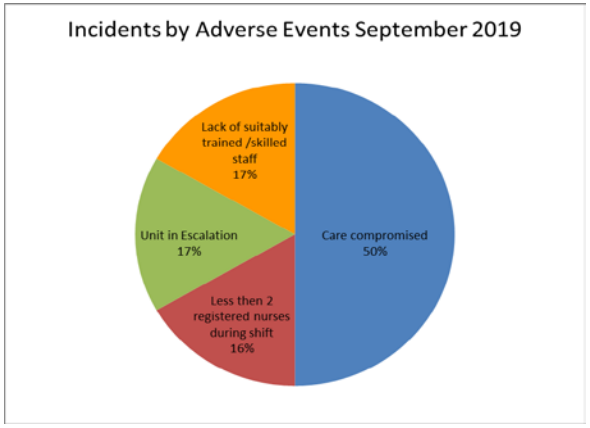
Planned CHPPD (Qualified and Unqualified)	8.5	8.7	8.1
Actual CHPPD (Qualified and Unqualified)	8.1	8.1	7.6

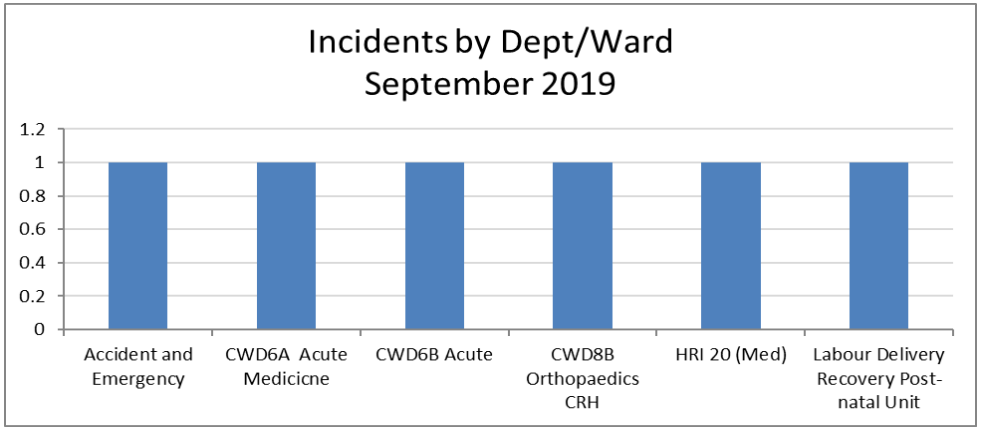
A review of September data indicates that the combined (RN and care staff metrics) resulted in 22 l clinical areas or the 28 reviewed having CHPPD less than planned. 3 departments reported CHPPD slightly in excess of those planned and 3have CHPPD at planned levels. Areas with CHPPD greater than planned 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 correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There were **6 Trust Wide Red shifts** declared in September
No datix's reported in September have resulted in patient harm

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area and the Trust are expecting 49 new graduates through September/October.
2. Monthly recruitment initiatives continue, and a planned recruitment fair will take place on Saturday 12th October.
3. Applications from international recruitment projects are progressing well and the first 35 nurses have arrived in Trust, with a further 4 planned for deployment in late December 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 & 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

Data available at quarter end

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 resistance - Lower urinary tract infections in older people	90%	Data available at quarter end			8%	Data available at quarter end											
			CCG1b: Antimicrobial resistance - Antibiotic prophylaxis in colorectal surgery	90%	Data available at quarter end			85.40%	Data available at quarter end											
	Acute & Community	CCG2: Staff Flu Vaccinations	CCG2: Staff Flu Vaccinations	80%	Data collection starts 1st September 2019				Data collection starts 1st September 2019											
	Acute & Community	CCG3: Alcohol and Tobacco	CCG3a: Alcohol and Tobacco - Screening ACUTE	80%	Data available at quarter end			64.5%	Data available at quarter end											
			CCG3a: Alcohol and Tobacco - Screening COMMUNITY		Data available at quarter end			25.3%	Data available at quarter end											
			CCG3a: Alcohol and Tobacco - Screening TRUST (combined)		Data available at quarter end			57.8%	Data available at quarter end											
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice ACUTE	90%	Data available at quarter end			13.8%	Data available at quarter end											
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice COMMUNITY		Data available at quarter end			92.0%	Data available at quarter end											
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice TRUST (combined)		Data available at quarter end			25.1%	Data available at quarter end											
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice ACUTE	90%	Data available at quarter end			29.0%	Data available at quarter end											
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice COMMUNITY		Data available at quarter end			22.2%	Data available at quarter end											
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice TRUST (Combined)		Data available at quarter end			28.7%	Data available at quarter end											
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%	Data available at quarter end											
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%	Data available at quarter end											
			CCG11b: SDEC - Tachycardia with Atrial Fibrillation	75%	100.0%	70.0%	100.0%	91.4%	Data available at quarter end											
			CCG11c: SDEC - Community Acquired Pneumonia	75%	100.0%	97.1%	96.2%	97.7%	Data available at quarter end											

18. Update on Research and Innovation

Presented by Cornelle Parker and Asifa Ali

To Note

Presented by Cornelle Parker

NHS
Calderdale and Huddersfield
NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	Research Strategy Update
Author:	Asifa Ali, Research and Development Lead
Sponsor:	Cornelle Parker, Deputy Medical Director
Previous Forums	The Research Strategy was ratified by the Weekly Executive Board in October 2018. The implementation of this is overseen by the Research & Innovation Committee on a quarterly cycle. This research strategy update has been prepared solely for the Board on request from Alastair Graham, Board member and member of the Research & Innovation Committee.

Actions Requested:

- To note

Purpose of the Report

The research strategy is being shared as a supporting document to the research presentation to the Board.

The supporting document provides a complete overview of the strategic objectives and actions for implementation. Where actions are in progress or achieved, this is highlighted with a 'tick'.

Key Points to Note

- Progress on the implementation of the strategy
- The challenges for recruitment targets and on-going funding
- Importance of increasing our research capability to remain competitive and current

EQIA – Equality Impact Assessment

All research studies undertaken are ethically reviewed and approved for equality, data protection and access to research, by the National Research Ethics Service prior to commencement at CHFT.

Recommendation

The Board is asked to note the update provided on the research strategy and give its continued support for its implementation.

Calderdale and Huddersfield
NHS Foundation Trust

RESEARCH STRATEGY
2018-2021

UPDATE PREPARED FOR TRUST BOARD
November 2019

compassionate care

Research Strategy & Implementation Plan 2018 - 2021

Transforming and Improving Patient Care *'Increase our research capability'*	
Strategic Objective	***Action***
Achieve yearly increase in CHFT patients participating in research studies	- Deliver 20% annual increase in recruitment. ✓ - Achieve annual Recruitment to Time and Target (RTT) at 80% or above ✓
Develop a communication and engagement strategy to inform, promote and disseminate research across the Trust and public domain	- Disseminate published research undertaken at CHFT and link to Trust quality improvement initiatives. - Provide research information on Trust website for patients and public.✓ - Engage in social media to promote research activity.✓ - Create Trust research newsletter for staff.✓ - Undertake annual patient research experience survey (PRES).✓ - Recruit 2 patient research ambassadors with annual plan for engagement activities.✓ - Thank-you coffee mornings/events for research patients and staff.
Clinical Leads to champion and support research within their specialty area	- Implement electronic system for sharing and responding to new research study information. ✓ - Clinical Leads to represent and facilitate research at departmental/specialty meetings.
Create research link nurses and AHPs across the Trusts acute and community divisions	- Identify nurses/AHPs/community staff through local forums to become research representatives to increase Trust research activity awareness among peers. - Support AHP and community staff to engage and participate in delivering research.✓
Achieve a balanced research portfolio for greater equity of access and choice for patients to research	- Identify and facilitate new areas for research within specialties.✓ - Disseminate new study information via specialty leads.✓ - Robust feasibility of new research to ensure capacity and capability to deliver.✓ - Ensure research nurses suitably trained to support new areas.
Open research in 3 new specialty areas	- Fast-track new studies in new specialty areas.✓ - To include commercial research studies✓ - Increase the number of Principal Investigators by 20% by 2021 and Chief Investigators by 3.

Keeping the base safe *'Improve research delivery and systems'*	
Strategic Objective	***Actions***
Achieve year on year improvements to NIHR High Level Objectives	- Achieve and maintain improvements to study RTT at 80%.✓ - 80% of eligible studies to achieve set up within 40 calendar days (from 'Date Site Selected' to 'Date Site Confirmed).✓ - Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies (max 30 days). - Meet national indicators for timely, reliable and consistent delivery of commercial research contracts.✓
Identification of new studies in an efficient and timely manner to maximise opportunities	- Set up robust electronic process for early identification of new studies and logging outcome.✓ - Ensure research grants are adequately costed within a timely manner. - Fast track commercial research set-up and delivery to within 10 days.✓
Greater collaborations with regional partners and academia in developing, leading and implementing research ideas	- Develop strong academic engagement with local Universities, with aim to submit joint research grant submissions. - Further research and innovation opportunities with CHFT Huddersfield Pharmacy Specials; AHSN; YHARC; YH CRN; STP.✓ - Develop & deliver research training on student nurse courses with University of Huddersfield✓
Workforce for the Future ***'Create opportunities for our research workforce'***	
Strategic Objective	***Actions***
Identify dedicated research personnel to optimise commercial research opportunities	- Establish an industry research post within R&D to focus on generating new study opportunities – aim to open 2 new commercial studies per year.✓ - Undertake a customer experience survey with past and present commercial partners.✓
Recognise contribution of clinicians, nursing and allied health professionals through job planning/role.	- Appropriate recognition for significant research contributions for staff undertaking research. - Staff reward and recognition for exemplar practice and research contribution. - Provide summary activity data to Principal Investigators for annual appraisals.✓
Create incentives to keep research workforce engaged and feel valued	- Comprehensive training programme for all research staff.✓ - Study delivery programme for PI /CNS groups.✓ - Establish secondment/placements for Ward staff and students (Uni). - Establish links with community staff/social enterprise/care homes.

Capacity build clinical and non-clinical research workforce through reinvestment of research income e.g. DH RCF; NIHR grants; local funding	- Create a £5k funding call for potential projects open to staff with ideas for research. - Offer support and guidance for any funding calls. - Set up review panel. - Advertise across the Trust. - Explore collaborative initiatives with external partners with matched funding.
Explore opportunities for research and innovation through the Trusts digital strategy	- Create links with Trust digital strategy and identify opportunities for research.
Financial Sustainability ***'Effective utilisation of research funds'***	
Strategic Objective	***Action***
Robust implementations of income under policy for commercial research distribution	- Ensure implementation of commercial research income policy.✓ - Report research funding allocation to each Division based on activity and performance every 6 months.
Monitor research funding to departments against output to ensure best use of funding	- R&I Committee to oversee Divisional allocation of funding against performance to ensure outputs are delivered.✓
Develop Divisional research KPIs in consultation with each Division	- Ensure appropriate oversight of research activity, funding and performance within each division. - Quarterly performance reports to Divisions on research activity.✓

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

• Finance and Performance Committee – minutes from meeting held 27.9.19

• Audit and Risk Committee – verbal update from meeting held 30.10.19

• Quality Committee – draft minutes from meeting 3.9.19 and verbal update from meeting held 30.9.19 and 5.11.19

• Workforce Committee - minutes from meeting held 7.10.19

• Council of Governors – draft minutes from meeting held 17.10.19

• Charitable Funds Committee – minutes from meeting held 23.8.19

To Note

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

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 27 September 2019, 9.30am – 11.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Chief Operating Officer (In part)
Owen Williams	Chief Executive
Phil Oldfield	Non-Executive Director (Chair)
Richard Hopkin	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA (Minutes)
Kirsty Archer	Deputy Director of Finance
Philip Lewer	Trust Chair
Sian Grbin	Governor

ITEM

149/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

150/19 APOLOGIES FOR ABSENCE

Apologies from Gary Boothby were noted

151/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

152/19 MINUTES OF THE MEETING HELD 30 August 2019

The Draft Minutes of the meeting held 30 August 2019 were approved following two small amends.

153/19 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as follows: -

Matters Arising

010/19: CQC Recommendations – ED Workforce Staffing – HB updated the Committee and stated that assurance was missing from the report and this was deferred to the next meeting – **HB, 1/11/19**

125/19: Performance Review Meeting (PRM) Deep-Dives – HB presented the key themes within the report which have been discussed at recent PRMs. It was noted that all divisions have monthly PRMs except for Community which are bi-monthly which reflects their good performance metrics. The following areas were highlighted:-

Data Quality is high priority across the organisation, HB requested that she should bring back a further deep-dive on RTT next month. Looking at some of the data

issues it has highlighted some 52 week risks and NHS I have been informed. In addition, there is a national issue and all Trusts have been notified that the National Electronic Referral systems has been deleting patients after six months, Cerner has a fix and this is being followed up.

Vacancy Hotspots – We have nursing gaps, the main area of concern being Respiratory at CRH and both EDs. Within ED we have a large cohort starting with us next month and a comprehensive induction has been established for them.

Model Hospital CIP Portfolio Opportunities – All divisions have presented to TE to discuss in more detail their findings and associated plans. In terms of transformation/ reconfiguration it was noted that as part of the work for the Outline Business Case (OBC) there is an opportunity to look at all services. OW explained that we may need to appoint a Transformation Programme Director sooner than what was first thought who can challenge clinical decisions. It was also noted that we are looking to extract some clinical colleagues to become part of a bespoke group to focus on transformation and job descriptions are being worked up.

ACTION: A further verbal update around Transformation will be presented at the next meeting – **OW/AB, 1/11/19**

It terms of complaints, OW confirmed that an action plan will be going to the next Quality Committee. It was noted that it is unfortunate that we are regressing, and it is not satisfactory. If things do not improve, key individuals will be asked to attend Quality Committee to explain why we are not on plan.

The progress with the budget holder accountability agenda was discussed. It was agreed that engaging with budget holders had raised the profile and the importance, however, what has been highlighted is that the Budget Holders perceive that they have not previously been actively involved in budget setting and this should be a focus for next year's budget setting. Finance support is also being reviewed and new ideas are being implemented, this includes launching a video explaining how budgets are agreed and set, also introducing a 'budget setting season' much like the appraisal season.

ACTION: The Committee agreed that the level of content had been incredible useful and that the PRM Review would become a Quarterly Review on the F&P Agenda – **BS/HB, quarterly timings to be aligned for the Workplan.**

130/19: HPS – A report updating the Committee regarding the progress of the actions originating from the HPS Staff Survey results was received and noted. It was felt that the action plan should be expediated to ensure that the priority areas are being addressed and that it should be an item on the HPS Board agenda in November.

ACTION: To update the Committee in January with regard to the outcomes following implementation of the Action Plan **- GB/RH, 6/1/2020**

141/19: Holiday Pay – The Deputy Director of Finance presented a briefing paper which described the risk to the revenue position that exists as a result of recent court cases relating to the payment of holiday. The paper also made recommendations as regards the inclusion of this risk on the Risk Register.

The Committee discussed the implications for the Trust and agreed to place this on the Risk Register as an individual risk at a Risk Level 4. This risk will be reviewed on an annual basis.

ACTION: To ensure this risk is placed on the Risk Register for annual review – **KA/AMcC**

The Committee **RECEIVED** and **NOTED** the report.

FINANCE & PERFORMANCE

154/19 INTEGRATED PERFORMANCE REPORT - AUGUST

The Chief Operating Officer reported the following headlines:-

- Slight deterioration on performance which relates to the 52 week issue and the Cancer 62 day referral to treatment from a screening perspective.
- The Committee were asked to note that for the purposes of the IPR it is being assumed that RTT is being delivered. The national team from the field test site will be coming in a couple of weeks and a paper relating to the average waiting times will be provided through Private Board.
- A couple of detailed Outpatient deep-dives have been through WEB and HB has spent time as part of the Back to the Floor week meeting with various colleagues and the work plan and prioritisation will be discussed at the next Executive Board.
- From an Emergency Care Standards (ECS) perspective, we performed well in August and September, however, October has been tough, therefore we will miss our trajectory for September. Discussions with our Regulators confirm that this is the national picture. The ECS 3 month improvement plan was outlined to the Committee.

<u>Back to the Floor</u>

The Chief Executive gave examples of his observations regarding the Back to the Floor week. It was felt that from a diversity perspective, we need to be more aware of questions being asked to patients. There are process opportunities, for example, within blood clinics who are still manually booking appointments, there are a couple of issues around GDPR which still need working through. From an Executive Team point of view there needs to be more 'buddying' with General Managers and operating staff to review process which not only would help patients but also colleagues.

It was acknowledged that there is no doubt our clinical colleagues, particularly our nurses, have a good rapport with our patients, however, work is required with regard to how we move to a more personalised care approach.

The Director of Transformation & Partnerships spent the week in the Outpatient Services and saw some great innovation first hand, for example:-

- Fertility Clinic are using apps for clinical leaflets which can be shared.
- Video links - a couple had elected to have a home consultation which worked well with no lack of compassion.
- Prescriptions still need to be printed out for a physical signature – hopefully a solution will be found via our new pharmacy provider.

- Colorectal services – telephone assessment clinic, the interaction via the phone was very personal.
- Virtual Fracture Clinic – where patients get a response instantly.

AB felt that she had been humbled by the experience and the compassionate care was very impactful.

The Committee **NOTED** the IPR for August.

155/19 MONTH 05 FINANCE REPORT

The Deputy Director of Finance reported that the year to date position is in line with planned deficit. The main change this month is that whilst we are continuing to forecast to deliver our planned deficit of £9.7m, this is now reliant on recovery plans to the scale of £1.20m. Divisions have been asked to scope out recovery plans and these will be discussed during the next round of PRMs. The ideas and suggestions will then be fed back to TE and WEB.

It was noted that as part of the West Yorkshire & Harrogate Health Care Partnership ICS a portion of the Trust's Provider Sustainability Fund (PSF) is also subject to the ICS achieving its Control Total. The risk to achieving this would be likely to fall in Qtr. 4.

The Committee **RECEIVED** and **NOTED** the report.

156/19 LONG TERM PLAN

The Deputy Director of Finance presented to the Committee slides which outlined our Draft Long Term Plan. It was noted that the Indicative Control totals for the next 4 years have been informally shared by NHSI and that the 20/21 Control Total is largely in line with the Strategic Outline Case (SOC) as expected. The Indicative Control Total for the years 21/22, 22/23 & 23/24 are less challenging than that assumed in the SOC and reflect revised national funding expectations.

Following discussions with NHSI, the draft plan submitted reflects this less challenging picture and assumes a lower efficiency requirement than that modelled in the SOC. It was acknowledged by NHSI that this would impact the unsupported breakdown point in future years.

It was also noted that the efficiencies within the Long Term Plan have been assumed to be recurrent and therefore the cumulative impact on the financial position is larger.

The Committee **NOTED** the presentation.

STRATEGIC ITEMS

157/19 CIP UPDATE

The Director of Transformation & Partnership reported that we are slightly ahead of YTD at Month 5 and we are still forecasting full delivery of CIP. The main focus at Turnaround Executive is identifying different recurrent savings to help reduce the CIP plan for next year. There is a programme of work to hold Star Chamber events and deep-dive reviews over the next few weeks.

Discussions took place with regard to the possible change in the political landscape and it was felt that until the fiscal position changes we must stay on track with our cost improvement programme.

GOVERNANCE

158/19 REFERENCE COSTS & PATIENT LEVEL COST SUBMISSIONS 2018/19 SIGN OFF

The Committee **NOTED** the paper which will go to Audit & Risk Committee.

159/19 DRAFT MINUTES FROM SUB-COMMITTEES

- Draft Commercial Investment & Strategy Committee held 18 July 2019
- Draft Huddersfield Pharmacy Specials (HPS) Board held 9 September 2019
- Draft Capital Management Group held 11 September 2019

The Minutes were **RECEIVED** and **NOTED** by the Committee.

160/19 WORK PLAN

The Committee **NOTED** the Work Plan which will be updated to reflect the actions from this meeting.

161/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following points for cascading to the Board:

- Received a report which was a good insight into the Divisional PRMs
- Holiday Pay was discussed, it was agreed to keep as an individual risk on the Risk Register which will be reviewed annually.
- IPR – Overall a good performance, issues around ECS and an improvement plan is being worked up
- Finance – on plan recognising in-year pressures. It was recognised that the ICS is under pressure and this may impact our PSF 4th Qtr. Payment.
- Long-term Financial Plan received by the Committee.
- CIP – on plan, continue to monitor non-recurrent schemes
- Reference Costs will be presented to the Audit Committee
- Back to the Floor had been well received by colleagues and had provided good intelligence.

147/19 REVIEW OF MEETING

The Committee agreed that there had been good discussions.

148/19 ANY OTHER BUSINESS

There were no items raised under AOB.

DATE AND TIME OF NEXT MEETING:
FRIDAY 1 November 2019, 9.30am – 12.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Tuesday, 3 September 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

151/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Dr Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public Governor
Maxine Travis **(MT)**	Senior Risk Manager
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Andrea Dauris **(AD)**	Associate Director of Nursing – Community **(item 158/19)**
Lucy Pittaway **(LP)**	General Manager for ED **(item 164/19)**
Maggie Metcalfe **(MM)**	Associate Director of Nursing – Medical **(item 156/19)**
Joanne Middleton **(JMidd)**	Associate Director of Nursing – Surgical (item 157/19)
Karen Spencer **(KS)**	Associate Director of Nursing – FSS (item 159/19)
Elisabeth Street **(ES)**	Clinical Director of Pharmacy **(item 143/19)**

152/19 APOLOGIES

Jason Eddleston **(JE)**	Deputy Director of Workforce and Development
Karen Heaton **(KH)**	Non-Executive Director
Dr Cornelle Parker **(CP)**	Associate Medical Director
Lindsay Rudge **(LR)**	Deputy Chief Nurse

153/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

154/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 29 July 2019 were approved as a correct record.

155/19 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

Medication Safety and Compliance Update

Elisabeth Street (Clinical Director of Pharmacy) was in attendance to provide a summary of progress following July's Medication Safety and Compliance Group Quality Committee report:

- *Work Together Get Results (WTGR) Medicines Management Event* - A WTGR nursing and pharmacy event took place on 22 August 2019 to review how to improve compliance with medication management standards. A summary of this session is being reported to the CQC response group. The Group has been tasked with providing a summary of suggestions and options to standardise the process for managing such issues to the chief nurse by the end of September.

- *Medication key security* - A review of medication key security across the Trust has been undertaken. The total costs for all areas requiring digilocks (to ensure a lockable room for medical waste containers) and also key safes for the storage of medication keys out of hours, has been collated and a paper is to be submitted to the October Commercial Investment and Strategy Committee to request funding for this estates work.

- *Temperature monitoring* - A new temperature monitoring sheet was introduced on 1 September 2019, with communication details issued to wards regarding the use of the new forms. An update from medical engineering regarding recalibration of Trust fridge thermometers is due for completion by end of September 2019.

- *Safe storage of waste medication* - New medication waste bins are to be available from 1 September 2019, with communications being issued to colleagues

- *Controlled Drugs assurance* - A controlled drug focussed Medicines Management Newsletter was issued in August 2019 to clinical staff (copy included in report).

- *Medication shortages* - Shortages of medication continue to be an issue. Throughout August, there was an increase in IV medication shortages, which had no impact on patient care. The pharmacy procurement team work closely with the regional procurement team to manage such shortages and source alternatives where appropriate. A specific issue with shortage of parenteral nutrition bags for community patients has received national media coverage. Patients in our locality requiring long term total parenteral nutrition (approximately six in the locality) are not managed directly by CHFT; they are under the care of specialist centres at Leeds and Salford. A risk has been escalated that these patients may present at our emergency department suffering from dehydration and electrolyte imbalance, and our community nursing team is aware of the issue, and our specialist gastro nurse is liaising directly with the specialist centres. As yet we have not had any patients admitted.

- *Pharmacy staffing* - Current issues with pharmacists on maternity leave and delays in recruitment for pharmacist's posts have resulted in a reduced pharmacist clinical serve to wards. This issue is recorded on the Pharmacy risk register. Mitigation work is taking place which includes:

  - a pharmacist workforce review which will benchmark our pharmacy service against other organisations and identify gaps in our service model;
  - a review of pharmacy staff skill mix and utilisation of new band 3 assistants to free up band 5 technicians from dispensing operational processes to be clinical-facing on the wards
  - the recruitment and training of two new bank pharmacists to support and fill some recruitment gaps
  - pharmacists being asked (as a temporary measure) if they are able to work additional hours

Discussion took place on the expectations to carry out the 'must-dos' as demonstrated by one of the Trust's four pillars of behaviours, and the pressing actions needed due to current systems and processes not having the desired impact.

OUTCOME: The Quality Committee received and noted the content of the report.

156/19 MEDICAL DIVISION QUARTER 1 PATIENT SAFETY AND QUALITY BOARD REPORT

Maggie Metcalfe (Associate Director of Nursing) presented Appendix D summarising the quality and safety issues identified in the quarter:

- Nurse staffing on Acute Floor at HRI, Respiratory floor at CRH and ward 6AB at CRH – nine new starters were expected, but unfortunately, this has reduced to five, and jobs have now been re-advertised.

- *Hydrogen Peroxide Vapour (HPV) impact* – the HPV cleaning programme is now underway. Ward 6B opened for 'additional' beds when this occurred to absorb the 'lost' capacity at HRI.

- *Pressure ulcers* – these have increased in the Acute directorate compared to the previous three months with 26 - six of which were category 3 pressure ulcers. This is of particular concern as the tissue viability team will shortly be under-resourced. A deep dive may be required into why there has been an increase in pressure ulcers and falls as this is likely to be multi-factorial.

- *Improvement work in emergency department* – the emergency network are reviewing initial assessment processes including streaming pathways to other services, increasing number of triage nurses to reduce time to assessment and senior cover at the front door from the second consultant from 11:00 am and the band 7 triage nurse between 8:00 am and 8:00 pm. The doctor workforce in the emergency department has been reviewed and now implemented new, more robust rotas. Two sisters, Janet Sagaitis and Sarah Watson, have taken the lead on patient experience and been focussing their time on developing and providing learning from complaints training to the team and redesigning department huddles to include learning from positives and patient compliments.

- *Positives from the division*
  - Acute directorate - undertaking some quality improvement work on sepsis and also an elderly care strategy for the wards focussing on falls, pressure ulcers, nutrition and Electronic Patient Record.
  - Gastroenterology - the Clinical Assessment Service continues to have a positive impact on the appointment slot issues, which have dropped from 306 to 199.
  - Cardiology – Clinical Assessment Service in development
  - Dynamic mattresses to be purchased for HASU (Hyper-Acute Stroke Unit) and patients assessed to downgrade mattress, rather than upgrade.

Discussion ensued on complaints and it was stated that the division has had support from the quality team and an external locum working on emergency department complaints. The backlog is currently 27 overdue complaints out of a total of 73.

OUTCOME: The Quality Committee received and noted the content of the report.

157/19 SURGICAL DIVISION QUARTER 1 PATIENT SAFETY AND QUALITY BOARD REPORT

Joanne Middleton (Associate Director of Nursing) presented Appendix E summarising the quality and safety issues identified in the quarter:

- *Complaints* - performance remains variable in terms of timeliness of responses. The year-to-date position reported in quarter 1 demonstrated the most improvement in the Trauma and Orthopaedics Directorate with 50% of complaints closed in time frame. The most challenged directorate continues to be General and Specialist surgery with 14% of complaints closed in time. This directorate receives the highest number of complaints and the division has implemented a standard operating procedure to support capacity and capability in this directorate.

- *Chairperson* - The division has introduced rotational chairs at the Patient Safety and Quality Board meeting following feedback that this approach was improving engagement across the Medical Division.

- *Care Quality Commission (CQC)* – the 'should-do' action for critical care regarding medical staffing had an options appraisal presented to the Weekly Executive Board in July 2019, and an option was agreed to move this forward to move to a position of partial compliance and mitigate the risks. A further piece of work was commissioned to improve the incidence of near-miss reporting regarding access to anaesthetists on the CRH site.

- *Staffing* – This has been a particular challenge in operating services through quarter 1 due to vacancy levels and sickness. An improvement plan is in place which includes the development of speciality-specific competencies to increase capacity and capability and minimise the impact on patient experience. A Work Together Get Results (WTGR) session was held with theatre teams and an action plan is in place.

- *Orthopaedics* – 23-hour knee replacements have received excellent feedback from patients as well as excellent clinical outcomes. This has also been shortlisted for a 2019 HSJ (Health Service Journal) award in the category of Digitising Patient Services Initiative.

- *Orthopaedics* – The Virtual Fracture Clinic (VFC) was reported as progressing well and has had some excellent patient feedback. A service evaluation is planned for quarter 2. An upgrade of monitors to support the Virtual Fracture Clinic (VFC) to enable better clarity of images was also added to the risk register.

- *General Surgery* - surgery school commenced for colorectal patients, which is an enhanced recovery programme for patients. The impact of this was evaluated through quarter 1 and was found to be positive. Psychological support for patients and pain management is also being looked into.

- *Operating Services* – The post of matron for the service has been appointed to Fiona Kaye.

OUTCOME: The Quality Committee received and noted the content of the report.

158/19 COMMUNITY HEALTHCARE DIVISION QUARTER 1 PATIENT SAFETY AND QUALITY BOARD REPORT

Andrea Dauris (Associate Director of Nursing) presented Appendix F summarising the quality and safety issues identified in the quarter:

- Demand for community-based therapy services continues to increase, and the level of risk associated. There is work to be done on the smaller services, such as speech and language, and work on outpatient clinic settings.

- The division continue to experience issues with the quality of discharges. These include lack of referrals, issues with medication and equipment not being arranged for patients on their arrival home. This is being addressed through the Quality Discharge Group.

- Risk in management of medical devices - The divisional teams are working alongside the medical devices team in relation to high to low risk medical devices that are overdue their inspection date. The division have also taken a slightly different approach and done a divisional amnesty. All information has been submitted to the medical devices team and working through the list and describing an improving picture.

- Quality and safe discharges – the division have leadership for the time-limited Quality Discharge group which met for the first time in August. A Work Together Get Results event has been scheduled for September to shape the work plan.

- Electronic referral – The e-referral system into community services in Calderdale went live in July 2019 with a view to offering equitable referral processes across the Trust patch and standardising the process to promote safe and quality discharges

- Additional division colleagues are attending Cohort 2 of the Trust's Work Together 2 Improve training scheme. There are now seven colleagues currently working on improvement projects for their areas

- A decision was made to integrate in-patient therapy services into the Community Healthcare Division, to move towards a single professional and leadership model.

- The division has now recruited to the new post of Head of Therapies, who will be starting next month.

OUTCOME: The Quality Committee received and noted the content of the report.

159/19 FAMILIES AND SPECIALIST SERVICES DIVISION QUARTER 1 PATIENT SAFETY AND QUALITY BOARD REPORT

Karen Spencer (Associate Director of Nursing) presented Appendix G summarising the quality and safety issues identified in the quarter:

- Diabetes external peer review and self-assessment – A peer review by the Royal College of Paediatrics and Child Health on 5 June 2019 resulted in two serious concerns identified; Understanding of clinical leadership by the team and the amount of psychologist input into the service. A Work Together Get Results meeting took place where an action plan was developed, and a response submitted to the Peer review Team. Since the peer review, there has been a successful recruitment to band 7 nurse lead. Lead clinician has contacted regional lead to understand the amount of psychologist support available in neighbouring organisations.

- Paediatric medical rota - Since April 2019, there have been 5.5 gaps in an 11-person paediatric medical rota, due to Deanery gaps. High proportions of gaps were covered with bank and agency staff. An improved tier 2 allocation from the Deanery has improved the staffing position along with the recruitment of a trust doctor in paediatrics.

- *CAMHS (Children and Adolescent Mental Health Services)* – There is an increasing number and complexities of young people with mental health needs on ward 3. Nationally there is a lack of tier 4 beds and therapeutic social housing placements for young people. An action plan has been developed to review current service provision, and the directorate team are linking with CAMHS and the new care models lead which includes scoping potential for involvement in a new regional training initiative.

- *Aseptic Dispensing Unit (ADU)* - Capacity of the HRI ADU during temporary closure of the CRH ADU. Completion of new ADU facilities at CRH delayed, and currently likely to be open in April 2020.

- *Gaps in radiology service* - There was a risk to radiology service provision due to a reduction in consultant capacity, however, a new interventional radiologist commenced in June 2019, a breast radiologist started in August 2019, and a new head and neck radiologist started at the end of July 2019.

- *Patient letters* – Issues continue with some patients not receiving cancellation letters, many of which have impacted on the increase in DNA's (do not attend) in May 2019 which reduced again in June 2019. Joint investigation undertaken with supplier and team working closely with the IT department to resolve the issues.

- *Blood Transfusion Team* – There is an increased risk within the team with a colleague retiring in November 2019, and sickness due to work-related stress. A further colleague was referred to Occupational Health for the same reason. A colleague from the laboratory has been transferred to support Bloodtrack and using bank staff in Blood transfusion.

- Paediatric staff survey – Local action plan being developed in line with Trust action plan with focus on involving colleagues in decision-making through use of survey monkey, and senior staff back to the floor.

- *Baby Friendly Initiative (BFI) Gold accreditation awarded* - Seven other maternity services in the UK have the gold award, and CHFT's award was received in conjunction with Locala Calderdale Health Visiting Service which makes the Trust the first joint accreditation of maternity and health visiting service in England.

- *Transformation of the outpatient department services* - Good work is being undertaken utilising video conferencing and telephone clinics.

- *PACS* - The new system has gone live, and whilst there have been some issues in relation to linking with external organisations; the project was extremely successful internally.

- *Duty of candour* – The division achieved 100% compliance with in quarter 1

- *Healthcare Safety Investigation Branch (HSIB)* – There have been no new cases and two draft reports have been received into the organisation.

Discussion ensued on the HSIB reports and due to the level of concern and high-profile nature of HSIB investigations, it was requested that any related actions from serious incidents, other national guidance and HSIB recommendations are amalgamated into one action plan, and monthly progress reported into the Quality Committee in the first instance, then move to quarterly reporting.

Action: To amalgamate all actions relating to serious incidents, HSIB recommendations, and other guidance, into a monthly action plan.

OUTCOME: The Quality Committee received and noted the content of the report.

160/19 SERIOUS INCIDENTS – OUTSTANDING ACTIONS

Maxine Travis (Senior Risk Manager) presented an update on the outstanding actions from completed serious incidents up to 20 August 2019.

- *Medical* - In June 2019, the division had 97 open actions. 53 have been evidenced and closed and 44 remain open. A further 43 actions have been added, of which 11 are completed and 32 remain open. The division's position is currently 76 open actions, of which 48 are overdue.
- *Families and Specialist Services* - the division had 36 open actions in June 2019, and of these, 22 have been completed with 14 remaining open. A further 12 actions were added, of which seven remain open and five have been completed. The division in total have 21 open actions of which 15 are overdue.
- *Surgery and anaesthetics* - In June 2019, the division had 8 outstanding actions, seven of which have been completed. A further 11 actions were added of which seven were already completed. In total, the division have five open actions, of which one is overdue.
- *Community Healthcare* - the division had seven outstanding actions in June 2019 of which three have been completed and active progress is being made on the remaining four. One of these actions is being led by Corporate Division.

The previous report to Quality Committee in June 2019 summarised a total of 148 open actions, and as of 20 August 2019, 85 of those actions have been delivered. A further 66 new actions have been added since the last report, of which 23 have been delivered.

Work is progressing on the triangulation of action themes to identify actions that are repeated across a number of incidents, in order to collectively and consistently address these. Actions from maternity cases are being collated by the Families and Specialist Services into one overarching action plan, along with alignment of existing assurance processes and quality improvement work. Falls-related and sepsis-related activity is feeding in to the appropriate forums to ensure that actions are aligned with improvement

work and that risks identified are being captured and mitigated in the workplans of the collaboratives. Required amendments to policies, procedures and guidelines are being collectively considered and implemented.

The report demonstrates that actions arising from serious incident investigations are being implemented by divisions with evidence collated to verify their delivery and that the focus on delivery of actions is having an impact in terms of closure. The volume and complexity of work required to complete action plans to mitigate risk presents a continuous challenge to divisions and is being proactively supported by the Risk Team.

OUTCOME: The Quality Committee received and noted the content of the report.

161/19 HIGH LEVEL RISK REGISTER

Andrea McCourt (Company Secretary) presented the high level risk register (appendix I) highlighting risks as at 19 August 2019, which included:

- Six top risks:
  - 7278: longer-term financial sustainability risk
  - 7454: radiology staffing risk
  - 2827: over-reliance on locum middle-grade doctors in the emergency department
  - 6345: nurse staffing risk
  - 7078: medical staffing risk
  - 5806: urgent estates schemes not undertaken
- One new risk:
  - 7477: Corporate nursing tissue viability – risk of reduced capacity in the Tissue Viability Team due to vacancy.
- One increased risk:
  - 7454: Radiology staffing - risk to Radiology service provision due to a reduction in consultant capacity.
- Two decreased risks:
  - Electronic Patient Record Risk
  - Paediatric staffing risk

This report will also be submitted to the Board of Directors on Thursday, 5 September 2019.

OUTCOME: The Quality Committee received and noted the content of the report.

162/19 QUALITY REPORT

Dr Anne-Marie Henshaw (Associate Director of Quality and Safety) presented appendix J, giving an overview of assurances on quality and highlighting areas where ongoing improvement work is taking place. During quarter 1:

- The first bi-annual report on external agency visits, inspections and accreditations was received by the Quality Committee.
- Nine serious incidents were reported to the commissioners. Five 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.
- Two 'must do' and seven '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.

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.

Discussion ensued on the very detailed report and it was stated that this will be presented to the Board of Directors on Thursday, 5 September 2019.

OUTCOME: The Quality Committee received and noted the content of the report.

163/19 INTEGRATED PERFORMANCE REPORT

July's performance score is 74% with three green domains. The safe domain continues to be green, the caring domain remains amber, however, further focus on both of the Emergency Department's Friends and Family Test metrics could see this improve. The effective domain remains green, with Fractured Neck of Femur yet to improve. The responsive domain is amber and has improved with the cancer 38-day target being achieved for the first time. Unfortunately, two of the four stroke indicators have worsened in month and the 6-week diagnostics target remains a challenge. Workforce remains green with sickness levels continuing their strong performance. All essential skills training areas are now green. Efficiency and finance is amber with a small deterioration in efficiency metrics in month.

- *Friends and Family Test* – Outpatients have seen a reduction in people who would recommend, and this is part of a wider piece of work which will be presented to the Board of Directors in detail.

- *Falls* is in the most improved position since June 2018.

- *Pressure ulcers* – triangulation work is needed as there are the same numbers of category 3 and category 4 pressure ulcers.

- *Requirements for children awaiting a CAMHS bed* – this is a capacity issue, and a meeting is taking place with the mental health provision partner. This will form part of the mental health strategy.

- *Fractured Neck of Femur* – discussion ensued on performance, which has improved although still some distance from the 85% target. A summary of a presentation provided by colleagues on fractured neck of femur in relation to harm to patients was provided.

OUTCOME: The Quality Committee received and noted the content of the report

164/19 EMERGENCY DEPARTMENT QUALITY ACCOUNTS

Lucy Pittaway (General Manager for ED) was in attendance to present a report (appendix L) on discrepancies in patients not being discharged in real time.

Following a recent quality accounts audit, it became apparent that patients are not always removed from the FirstNet system at the time they leave the department. From working with the teams in both departments it is understood that this happens when the department is particularly busy due to doctors prioritise assessing and treating the next patient before fully completing the previous patients records, meaning those patients cannot be removed from the FirstNet system; and the nurse in charge prioritising supporting with clinical care of patients in the department over removal of patients from the FirstNet system. This leads to

the nurses changing the checkout time retrospectively, which is not consistently making a permanent log in the patient records.

A multidisciplinary working group was assembled, and different patient journeys were followed through the system. A full review of the process for checking patients out the Emergency Department was completed, and it was identified where each stage leaves a permanent timestamp in the patient records. It was found that the only patients that risk not having clear documentation of the discharge time, were those where the checkout time is different from the time the discharge letter is generated (as this is created at the time the patients is checked out on FirstNet, but the checkout time itself can be amended retrospectively).

What this highlighted were significant glitches in the current clinical system relating to amendments made retrospectively to departure times. However, if the patient is discharged straight from the Emergency Department, there should be no opportunity for the time to be removed from the Emergency Department administration summary at a later time in that patient encounter. Based on this, a working hypothesis is that the only patients whose notes do not have the timestamp are those whose checkout time is different to the time the discharge letter is completed and are subsequently discharged from hospital after an onward journey from the Emergency Department. However, a report on First-Net under the emergency medicine tab titled “patient summary report search” was identified, which showed the time the patient was back-timed to. Therefore, any patients where a timestamp couldn’t be found in the records should be found there.

To further test out the hypothesis, an audit of 350 patient records for one week was carried out, where the time the discharge letter was generated was different to the checkout time reported externally, to ensure adequate documentation in the notes. If the audit proved the hypothesis, the admitted cohort of patients would continue to be reviewed to ensure a clear timestamp in the records which corresponds with the discharge time in the back of the system. If the audit disproved the hypothesis, the findings would be reviewed to decide which cohort of patients wold need to continue to be reviewed and amended.

There is now assurance that the timestamps can be found in the patient summary report, and this has been submitted to external auditors, who have been invited back to carry out a repeat audit. Work is taking place to ensure there is capacity in order to report discharges in real time.

The Chair stated that this was also discussed at the Annual General Meeting in July, where no issues or concerns were raised.

OUTCOME: The Quality Committee received and noted the helpful assurance included in the report

165/19 INFECTION CONTROL COMMITTEE MINUTES

Dr David Birkenhead (Medical Director) provided a summary of items discussed at the Infection Control Committee meeting in April 2019 (Appendix M).

- *Influenza* – the southern hemisphere is experiencing high flu rates, and the target is for 80% of all colleagues to be vaccinated. 75% was achieved last year. Vaccines will be available from October.

- *Decontamination manager* – this has been challenging for the last six months with no manager in post. Processes are to be established which will ensure compliance.

- *Antimicrobial stewardship* - work ongoing

- *Resistant infections* – this is currently sporadic, with periodic admission of patients. There have been no transmissions in the organisation.

166/19 ANY OTHER BUSINESS

British Medical Journal

The Chair mentioned two recent articles in the BMJ on preventable harm – see below:

- Preventable harm: getting the measure right - **https://www.bmj.com/content/366/bmj.l4611**
- Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis - **https://www.bmj.com/content/366/bmj.l4185**

167/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- All divisional Patient Safety and Quality Board reports received
- Work ongoing to improve medication safety across the Trust

168/19 EVALUATION OF MEETING

What went well……
- Very good, triangulated discussions

Would be better if……
- There was consistency on what is reported here and what is reported up to Board.

169/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix N) was accepted.

NEXT MEETING

Monday, 30 September 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Monday 7 October 2019, 1pm – 2pm, Meeting Room 1, Learning Centre, Huddersfield Royal Infirmary

PRESENT:

Ellen Armistead	(EA)	Director of Nursing/Deputy Chief Executive
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(KH)	Non-Executive Director (Chair)
Andrea McCourt	(AMC)	Board Secretary
Andy Nelson	(AN)	Non-Executive Director
Alison Schofield	(AS)	Governor
Sharon Senior	(SS)	Staff Side Representative

IN ATTENDANCE:

Nikki Hosty	(NH)	FTSU/ED&I Manager
Adam Matthews	(AM)	Workforce BI Manager – Analytical Lead
Sal Uka	(SU)	Associate Medical Director (for DB)

66/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

67/19 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
David Birkenhead, Medical Director
Gary Boothby, Director of Finance

68/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

69/19 **MINUTES OF MEETING HELD ON 6 AUGUST 2019:**

The minutes of the Workforce Committee meeting held on 6 August 2019 were approved as a correct record.

70/19 **ACTION LOG (items due this month)**

The action log was reviewed and updated accordingly.

71/19 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – AUGUST 2019**

AM presented the highlights of the report.

Performance on workforce metrics continues to be high but the Workforce domain score dropped slightly to 86.2% in August 2019. This is now 5 consecutive months of a 'Green' domain.

Only 3 of the 17 metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', 'Medical Appraisals' and 'Safeguarding EST'.

Workforce - August 2019

The Staff in Post increased by 33.46 FTE, which, despite a slight increase to establishment (2.67 FTE), resulted in just a decrease in vacancies (30.79 FTE).

Turnover improved again to 8.09% for the rolling 12 month period September 2018 to August 2019. This is the lowest turnover on record beating the previous lowest achieved in July 2019.

The highest turnover remains within the Healthcare Scientists staff group at 9.89%. This is an improvement from 10.79% reported in July 2019. Plans to change career progression in Healthcare Scientists to mirror neighbouring Trusts has been approved which should aid retention of this staff group.

Sickness absence – July 2019

The in-month sickness absence increased to 3.45% in July 2019. However, the rolling 12 month remained at 3.61%. This equates to an average of 13.18 FTE days lost per FTE. This remains the lowest rolling sickness absence rate recorded on ESR and equates to an additional 1.5 FTE days worked per employee since July 2018.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 29.21% of sickness absence in July 2019, dropping slightly from 30.41% in June 2019.

The RTW completion rate deteriorated slightly to 73.15% in July 2019.

Essential Safety Training – August 2019

Performance has improved in 4 of the 9 core suite of essential safety training. 8 of the 9 remain above the 90% target with 4 achieving the 95% 'stretch' target (Dementia Awareness, Equality & Diversity, Fire Safety and Health & Safety). Overall compliance deteriorated slightly to 94.58% but remains above the 90% target.

Workforce Spend – August 2019

Overall spend increase by £0.03M. Bank increased by £0.05M and substantive reduced by £0.03M. Agency spend remained static at £0.73M.

Employee Relations – August 2019

There were 16 open disciplinary, grievance or harassment cases at the end of August 2019.

Recruitment – August 2019

2 of the 5 recruitment metrics reported improved in August 2019. The time to hire for colleagues starting in August 2019 was just under 16 weeks.

The Committee further discussed the data and associated activities attributed to the Trust's positive position and agreed the following actions to be brought back to the November Committee meeting.

ACTIONS:

- **Present 2018/2019 Model Hospital workforce data (AM)**
- **Describe the activities put in place to effect the reduction in Healthcare Scientist turnover (AM)**
- **Complete a review of time to hire targets (Charlotte North/Rachael Pierce)**
- **Provide a summary of consultant appointments over the last 2 years (Charlotte North/Pauline North)**
- **Provide an explanatory note in the 'Workforce Plan' graph for agency (AM)**

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

72/19 **UPDATE ON 2018/2019 CQC ACTION PLAN AND FUTURE IMPROVEMENT WORK**

JE advised that consideration was still being given to scheduling an external peer review for Workforce and OD led activity.

KH noted staff pensions and holiday pay were identified as areas of concern for Workforce and OD. JE advised the Committee both issues were technical in nature and that the Trust is maintaining a 'watching brief' in relation to each.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

73/19 **WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY STANDARD (WDES)**

The two action plans had been shared with papers. NH provided an insight into the activities and approach taken to further embed actions and highlighted the areas requiring more focus.

<u>WRES</u>

NH confirmed the action plan had been published on the Trust's website. BAME colleagues agreed the BAME Network has been a useful support resource. Improvements have been made in respect of BAME colleague experience. NH highlighted that more BAME engagement is required to increase the Trust's workforce profile along with the Unconscious Bias programme 'Step in our shoes' to be incorporated into management essentials and inclusive leadership programmes to support BAME career progression.

KH noted that bullying/harassment by patients had increased. NH advised that in response a patient awareness programme focusing on fairness and respect and embedding the one culture of care mechanism is being developed. KH asked if the results identified specific areas. NH advised the data can be provided by staff groups.

ACTION: Provide an analysis of 2018 staff survey results in relation to patient bullying/harassment of staff (NH)

<u>WDES</u>

In 2019 a comms programme to highlight the importance of the WDES commenced alongside the Colleague Disability Action Group established to raise concerns and remove barriers in the workplace for disabled colleagues. NH added that engaging and building trust with colleagues is essential to addressing concerns about representation of disabilities.

KH stated that disability under-reporting is common and acknowledged the steps being taken to promote self declaration rates.

The Inclusion Strategy will be presented at the November Committee meeting.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

74/19 **ANY OTHER BUSINESS**

There was no other business.

75/19 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will take the following to Board:-

- Work continuing to further reduce Healthcare Scientist turnover
- Committee's support to the WRES/WDES

76/19 **DATE AND TIME OF NEXT MEETING:**

5 November 2019, Workforce Committee Deep Dive, 9.30am – 11.30am, Room 3, Acre Mill Outpatients

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 3:30 PM ON THURSDAY 17 OCTOBER 2019 IN THE BOARDROOM, CALDERDALE ROYAL HOSPITAL

PRESENT:

Philip Lewer	Chair

Public Elected Governors

Alison Schofield	Public Elected - North and Central Halifax
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
Paul Butterworth	Public Elected - East Halifax and Bradford
Brian Richardson	Public Elected - Skircoat and Lower Calder Valley
Jude Goddard	Public Elected - Calder and Ryburn Valleys
Chris Owen	Public Elected – South Kirklees
John Gledhill	Public Elected – Lindley and the Valleys

Staff Elected Governors

Linzi Smith	Staff Elected – Management / Admin / Clerical
Dr Peter Bamber	Staff Elected – Drs / Dentists
Sian Grbin	Staff Elected – Nurses/ Midwives
Sally Robertshaw	Staff Elected – Allied Healthcare Professionals (AHPs)
Rosie Hoggart	Staff Elected – Nurses/ Midwives

Appointed Governors

Prof Felicity Astin	University of Huddersfield
Chris Reeve	Locala
Jayne Taylor	Calderdale and Huddersfield Solutions Ltd (CHS)
Cllr Lesley Warner	Kirklees Metropolitan Council

IN ATTENDANCE:

Owen Williams	Chief Executive
Andy Nelson	Non-Executive Director
Richard Hopkin	Non-Executive Director
Karen Heaton	Non-Executive Director
Andrea McCourt	Company Secretary
Helen Barker	Chief Operating Officer
Kirsty Archer	Deputy Director of Finance
Anne-Marie Henshaw	Assistant Director of Quality and Safety
Amber Fox	Corporate Governance Manager (minutes)
Jackie Ryden	Shadowing Corporate Governance Manager
Mr. Smith	Halifax, Member of the Public (Observer)

44/19 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Dianne Hughes	Public Elected - North Kirklees (Reserve Register)
Sheila Taylor	Public Elected - Huddersfield Central
Christine Mills	Public Elected - Huddersfield Central
Veronica Woollin	Public Elected - North Kirklees
Cllr Megan Swift	Calderdale Metropolitan Council
Helen Hunter	Healthwatch Kirklees and Calderdale

45/19 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors and staff colleagues to the meeting and introductions were made around the table.

46/19 DECLARATIONS OF INTEREST

The Chair reminded the Council of Governors and staff colleagues to declare their interest at any point in the agenda.

47/19 MINUTES OF THE LAST MEETINGS HELD 18 JULY 2019

The minutes of the previous minutes held 18 July 2019 were approved as a correct record subject to the following amendments:

- 33/19 – confirmation on the specialty of ward 11
  UPDATE POST MEETING: This ward has been confirmed as a General Surgery ward.
- 34/19 – The Non-Executive Director interactive session was a **20-minute** session

OUTCOME: The minutes of the previous meeting held 18 July 2019 were **APPROVED** as a correct record, subject to the amendments above.

48/19 MATTERS ARISING / ACTION LOG

Update on the complaints policy and procedure – The Director of Nursing to provide a response. The Company Secretary confirmed the Chief Executive is attending the Council of Governors meeting in January 2020 to provide a presentation on complaints. Sian commented that the reduction in performance may be related to a level of sickness absence in the complaints team.

49/19 INTERACTIVE SESSION WITH NON-EXECUTIVE DIRECTORS

The Chair asked the Non-Executive Directors in attendance to provide an overview of which Committees they attend and what they are involved in.

Richard Hopkin explained he has been a Non-Executive Director for 3.5 years and is in his second term. Richard's background is in finance, largely in the private sectors but recently, more extensively in voluntary and public sector e.g. Age UK, Housing Association. Richard sits on the finance related committees and has attended the Audit and Risk Committee since the beginning of his tenure and took over the chair 18 months ago. Dr Peter Bamber and Brian Moore have both been a member on the Committee which meets quarterly. Andy Nelson and Linda Patterson also attend the Audit and Risk Committee. The purpose of the Audit and Risk Committee is to monitor risk, the performance of internal and external audit and counter fraud. Richard also attends the Finance and Performance Committee

which meets monthly and is chaired by Phil Oldfield. The Finance and Performance Committee reviews financial and operational performance. Sian Grbin has been an active member on this Committee, which was previously attended by Brian Moore. In addition, Richard is a Non-Executive Director on the Pharmacy Manufacturing Unit or Huddersfield Pharmacy Specials (HPS) Board, chaired by the Executive Director of Finance. This effectively operates as a Division of the Trust. In addition, Richard attends Turnaround Executive which meets weekly and focuses on performance against the Cost Improvement Programme (CIP), agency performance, workforce and wider financial performance. Three Non-Executive Directors attend Turnaround Executive on a monthly basis, Richard Hopkin, Phil Oldfield and Andy Nelson.

Dr Peter Bamber asked which Committee monitors clinical risk and performance. Richard confirmed the Audit and Risk Committee focuses on corporate risk and performance; clinical risk and performance is monitored by the Quality Committee, although the Audit and Risk Committee do receive the Clinical Audit Programme. The Quality Committee chair also attends the Audit and Risk Committee.

Andy Nelson explained he has been a Non-Executive Director for two years. Andy's background is in leading information technology and major change projects in the private and public sectors. Andy was a Chief Information Officer in charge of IT for major UK government departments and for a year for the UK government as a whole. He is a Non-Executive Director for the Disclosure and Barring Service (Safeguarding and CRB checks) and he is also a Board Advisor to the Law Society of England and Wales. In addition to Audit and Risk, Andy attends the Workforce Committee which focuses on performance, turnover, recruitment and retention and hot house sessions and deep dives into subjects. Andy will also be a member of the Transformation Programme Board as a Board sub-committee for reconfiguration. Andy is involved in The Health Informatics Service and attends the monthly Executive Board and meets with the Managing Director for Digital Health on a 1-1 basis. He has recently been on a day-long tour through the hospital looking at all aspects of use of technology. Andy chairs a small committee called the Security and Resilience Governance Group which reports into the Health and Safety Committee. All the Non-Executive Directors are involved in chairing consultant recruitment panels. Andy has also spent time in the Community shadowing district care nurses and looking at care closer to home.

The Non-Executive Directors felt the back to the floor experience was very enlightening as it puts things into focus on the clinical floor. All the Board and Non-Executives were involved in back to the floor week.

Karen Heaton explained she is chair of the Workforce Committee and chair of the Clinical Excellence Award panels. She also attends Quality Committee. Karen is a Human Resources Director for the University of Manchester. From her current role, she sees very similar challenges in the Trusts Workforce Committee around well-being and there are lots of deep dive debates focused on topics such as equality and diversity. Karen is looking forward to seeing the equality and diversity strategy this calendar year. The Hot House events are well attended and feed into 'The Cupboard'. The results of the staff survey reached 51% last year and the Trust is looking to increase this significantly. Karen is a Board champion for diversity and inclusion.

50/19 UPDATE FROM COUNCIL OF GOVERNORS SUB-COMMITTEE

Nominations and Remuneration meeting held on 15.8.19

The Chair reported there was a meeting held on 15 August 2019 where it was agreed Phil Oldfield and Linda Patterson's tenure was extended for three months to the end of December 2019, to assist with a smooth handover and transition.

OUTCOME: The Council of Governors **APPROVED** the minutes of the Nominations and Remuneration Committee meeting held on 15.8.19.

51/19 CHAIR'S REPORT

Ratify decision at the Nominations and Remuneration Committee on Non-Executive Director Recruitment

The Chair asked the Council of Governors to ratify the appointments of two new Non-Executive Directors, Peter Wilkinson and Denise Sterling as detailed in the supporting paper.

OUTCOME: The Council of Governors **APPROVED** the appointments of the new Non-Executive Directors, Peter Wilkinson and Denise Sterling.

52/19 PERFORMANCE AND STRATEGY

a) Performance Report

The Chief Operating Officer reported a positive position for August 2019, the main highlights from the report were:

- Solid position with all amber or green domains, no red domains
- Struggled with complaints and FFT in August 2019
- There is an ongoing piece of work focused on the patient experience in Outpatients and booking procedures, a session of workshops with consultant staff, admin staff and managers are scheduled to understand what successful looks like, meetings have taken place with each specialty and further updates will be provided following the weekly Task and Finish Group
- 4-hour care emergency standard benchmarks well compared to nationally
- Cancer performance continues to be strong
- Bowel screening process – there are 10 patients per month that need treating and if one patient refuses treatment being offered, this KPI doesn't meet the target
- Diagnostics target remains challenging – patients waiting over 6 weeks for a test in cardiology (echo) and neurophysiology relating to workforce capacity in these hard to recruit to specialties
- No longer reporting on RTT, CHFT are one of the 12 organisations testing the new clinical standards focused on average waiting time rather than 92% of patients seen within 18 weeks
- Staff do exceptionally well in terms of the 4 pillars and putting the patient first, there is a positive balance of performance delivery

Dr Peter Bamber asked why there has been a reduction in staff appraisals at 93% last year and 85% this year. The Chief Operating Officer explained medical staff appraisals are managed differently and take place within a 12-month period. There is always an up and down trajectory throughout the year to meet the target by March,

she explained the position is no worse or better than 12 months ago and a robust process is in place.

Cllr Lesley Warner raised concern about focus on targets and short staffing in ED and the wellbeing of staff. She asked if there is a high rate of staff illness through stress and overwork. The Chief Operating Officer responded that the Trust has some of the best attendance nationally and this has improved over the last 18 months. There has been a focus on staff wellbeing at a series of workshops over the last few days which were well attended and have positive actions.

Jude Goddard highlighted that the governors asked for staff wellbeing as one of the subjects at a future workshop. She highlighted staff work so hard throughout the year and this is not recognised enough and wondered how governors could come up with suggestions. The Chief Operating Officer explained volunteers and non-clinical staff brought a tea trolley to ED last week to thank staff for their hard work, she added there is a good ability to respond to hard work in the Trust. The Chair noted screensavers are used across the Trust to thank staff, particularly when the emergency department is under pressure.

Linzi Smith asked why dementia care is struggling in terms of assessments. The Chief Operating Officer explained this is likely to be reporting related since the electronic patient record. There used to be a clear robust process on paper, and staff now need to remember to enter this in a certain field in the electronic system where there is no reminder or alert to do this. There is currently no robust solution for this and some organisations have moved this to a nursing action, CHFT need to find a solution for a medic.

Lynn Moore highlighted a concern regarding medication when patients are referred to their GP when medication can only be provided by a hospital. The Chief Operating Officer clarified ‘amber’ or ‘red’ classified drugs need to be provided by the hospital and this is being managed as part of the Outpatient Transformation Programme.

Dr Peter Bamber explained the general view from doctors is that the training received at go live for the electronic patient record and subsequent training was minimal. They feel they are not getting the best out of the system as they don’t know how to use it. The Chief Operating Officer explained this was part of the external review and was one of the pieces of work on the workplan. Dr Peter Bamber clarified that this includes doctors at the Trust for 6, 12, or 18 months. The Chief Operating Officer and Medical Director attended a recent junior doctors induction training and are working with the team to refine this. Dr Sue Crossland has contacted all junior doctors for their feedback. Dr Peter Bamber asked that progress on this is brought back in three months’ time.

Action: Chief Operating Officer to report back on progress on doctors training on the electronic patient record - 23 January 2020

The Chief Executive suggested governors attend induction sessions with new staff, normally 25% of the room are returning staff and one reason for this is the digital agenda (tracking blood electronically, echocardiogram, electronic patient record). The Chief Executive reminded colleagues that CHFT were only the second Trust in the country with a ‘Big Bang’ go live, as much as clinically possible, whereas most Trusts do a modular go live. There is an opportunity to compare the degree to which clinical colleagues use the system compared to other Trusts and CHFT are by far the

most advanced. The patient portal has on average nationally 3,000 users, whereas there are over 20,000 users at CHFT.

Dr Peter Bamber said the Trust must acknowledge the lack of training caused problems, for example, thousands of letters not reaching GPs and entries in records not visible in the system due to lack of training. The Chief Executive confirmed that all these problems have been acknowledged and the Trust have been open and transparent.

Sian Grbin asked what concerned the Trust the most following the staff survey results from 2018. Alison Schofield shared leaflets from the Workforce Committee which shows findings and actions from last year and how they are promoting the survey next year.

b) Financial Position and Forecast – Month 5

The Deputy Director of Finance summarised the key points from the Month 5 position;

- The Trust is forecasting to achieve Control Total as planned with a £9.71m forecast deficit
- The Trust has spent considerably less on agency staffing than the trajectory set by NHS Improvement (NHSI)
- Year-end forecast required identifying recovery and restraint measures – a total of £1.2m has been identified in these measures which will be subject to a quality and equality impact assessment
- The Trust is forecasting full delivery of the £11m 19/20 CIP target, if this delivers, the Trust will have a planned deficit of £9.71m

Dr Peter Bamber asked if the finance report can include figures for agency plus bank by Division. The Deputy Director for Finance confirmed this information is available by Division and will be included in the report. She confirmed agency plus bank is in line with planned overall spend.

Action: Deputy Director of Finance

Alison Schofield asked the Deputy Director of Finance to clarify how the reduction in the deficit position to £9m has improved. The Deputy Director of Finance confirmed the Trust have moved, in reality, from a deficit of £43m last year to a £38m deficit this year before new funding. The rules around income and the marginal rate emergency tariff (MRET) have changed this year and the Trust now receive money back and a refund for penalty previously taken off, which totals £6m. The Trust previously did not receive income for an increase in emergency activity. This brings the deficit down to £9.7m.

Sian Grbin asked why agency expenditure is seeing a variance of £1.32m year to date and if this means the Trust don't need to use this money. The Deputy Director of Finance confirmed rather than spending on agency, the Trust are spending on bank staff, which will see a £1.32m (or similar) overspend.

Sian Grbin asked for clarity on the £2.47m planned income and expenditure against the actual income and expenditure of £2.49m in the Families and Specialist Service Division in month 5. The Deputy Director of Finance clarified the figure of £2.47 versus the £2.49 is effectively the profit loss. The Surgery and

Anaesthetics Division are planning to deliver a surplus profit £5.6m against the aligned incentive contract. This is almost a fixed guaranteed level of income which is not impacted by the volume of work. The aligned incentive contract allows for innovation e.g. frailty model can be reviewed to see if care can be delivered in the community.

c) Q1 Update on Quality Account Priorities

Anne-Marie Henshaw, Assistant Director of Quality and Safety presented an update on the three quality account priorities. Each quality account priority has been BRAG rated on progress which is provided within the report.

Alison Schofield asked what the ligature free room has been named in the Emergency Department (ED). The Assistant Director of Quality and Safety confirmed all the rooms are numbered, there is no specific name. Alison provided praise that there is now a specific room for mental health.

The funding for 24/7 1-1 support in ED for patients in distress 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. An NHS Trust with a strong focus on patient experience in ED has been identified and a 'Go See' visit is taking place in November 2019. Alison Schofield suggested the staff in ED may need to take a turn at supporting these shifts and South West Yorkshire Partnership Foundation Trust should also provide support. The Assistant Director of Quality and Safety explained the mental health team have supported the education for the teams in ED and are beginning to work on standard operating procedures.

Cllr Lesley Warner highlighted the need for more money put into mental health. The Assistant Director of Quality and Safety explained additional 1-1 support is being prioritised and a robust Director on call rota is in place to escalate through all routes, this continues to be a national challenge. There is a short-term facility on the children's ward which is more appropriate; however, this is not long term and the Trust do not provide mental health inpatient beds for children. A fortnightly quality improvement forum takes place where these issues are discussed. The priorities in ED have provided an opportunity to review the workforce models.

Mr. Smith joined the meeting, an observer from the Halifax constituency.

OUTCOME: The Council of Governors **NOTED** the performance and finance report for August 2019 and the Q1 update on the quality account priorities.

d) Membership and Engagement Strategy

The Company Secretary explained there was a requirement to refresh the membership engagement strategy which will be available on the public website. The Council of Governors are asked to identify the top three priorities from the Membership Strategy to progress.

Linzi Smith asked for the budget to support the membership engagement strategy.
Action: Company Secretary to confirm the budget

Prof Felicity Astin suggested the patient panel should be top priority. Jayne Taylor agreed that the youth membership and patient panel should be one of the top three priorities.

Andy Nelson asked what the timeframe was and overall targets to be achieved. The Company Secretary confirmed it is a three-year strategy with an accompanying one-year action plan which will be brought back each year. The key targets are how to represent members and the community we serve.

Chris Reeve suggested the Trust need to look at getting new members with a focus on people who want to take part, this will also be more cost effective. He suggested the Trust utilise volunteers and asked if there is a role as a governor for a volunteer and if all volunteers are Trust members. The Company Secretary explained the patient panel will include the volunteer's manager. Chris Reeve suggested it would be best to focus on a few aspects in year one.

The Company Secretary will update the strategy based on feedback from the governors and will present an update in January 2020.

Prof Felicity Astin passed on credit for the updated membership strategy to the Membership Engagement Manager, Vanessa Henderson.

OUTCOME: The Council of Governors **NOTED** the draft Membership and Engagement Strategy and that the final strategy will be presented to the Council of Governors meeting in January 2020.

53/19 COMPANY SECRETARY'S REPORT

a. Review of Constitution

A review of the constitution took place during October 2019 with the aim to have a current and clear constitution for the Council of Governors and Board of Directors. The changes that were discussed in these sessions are captured in Appendix I1.

Sian Grbin asked if staff governors reduced from 6 to 5 is being reviewed. The Company Secretary confirmed during the workshops it was identified there is a whole category of staff in the ancillary staff group (HCA's, phlebotomists) which was removed as CHS are an appointed governor. This staff group will be re-instated and will be included in the elections for next year. Sian explained Oxford Trust have a total of 9 staff governors and asked if the number at CHFT can be increased. The Company Secretary will review the ratios of staff and stakeholder governors compared to other Trusts; however, public elected governors need to be in the majority.

Prof Felicity Astin suggested Psychologists are added in with Allied Healthcare Professionals as members. She suggested under non-attendance at meetings, that the word 'normally' is added with regard to the governor losing their position if they do not attend the required meetings as this allows some flexibility.

b. Appointment of Lead Governor

Subject to approval, the lead governor process will begin from 17 October 2019 and the voting will close on 19 November 2019. A formal announcement will be made at an extra-ordinary Council of Governors meeting on Friday 22 November 2019 after the joint Board of Directors and Council of Governors workshop. The appointment

will be effective from 22 November 2019 until the Annual General Meeting on 15 July 2020.

c. Council of Governors Self-Effectiveness Feedback and Action Plan
This paper describes the findings from the review from the summer of 2019 and identifies areas for continual improvement. It was noted that no feedback was received from appointed governors and this will be included in next year's feedback.

d. Review Council of Governors Declarations of Interest Register
The Council of Governors declarations of interest register is attached for review. Any changes to current declarations are to be notified to the Corporate Governance Manager.

e. Review Annual Council of Governors Business Cycle 2020
The annual workplan for the Council of Governors for 2020 was attached for review. Comments are to be sent to the Corporate Governance Manager.

f. Receive allocations of governors on Board sub-committees and Divisional Reference Groups
The governor allocations for Divisional Reference Groups and Board Sub-Committee from November 2019 were attached with upcoming dates of meetings. Governors who are unable to attend any of Board Sub-Committee dates are asked to contact the Deputy allocated to that meeting, to attend in their absence.

g. Senior Independent Non-Executive Director/Deputy Chair Appointment
Phil Oldfield's tenure as a Non-Executive Director ends at the end of December 2019. It is recommended that Richard Hopkin takes on the role as Deputy Chair and Senior Independent Non-Executive Director from January 2020.

OUTCOME: The Council of Governors **APPROVED:**

1. Changes to the constitution and noted the changes will go to the Board of Directors for approval on 7 November 2019
2. Process for appointment of lead governor
3. Actions identified from the Council of Governors self-effectiveness questionnaire
4. Declarations of interest register

OUTCOME: The Council of Governors **NOTED:**

1. Council of Governors Workplan for 2019
2. Findings of the 2019 Council of Governors self-effectiveness questionnaire
3. Annual business cycle for 2020
4. Allocations of governors on Board Sub-Committees and Divisional Reference Groups
5. Senior Independent Non-Executive Director / Deputy Chair Appointment from January 2020

54/19 UPDATES FROM SUB-COMMITTEES

Quality Committee

Christine Mills provided written feedback following the last Quality Committee. The key updates were:

- Safe storage of drugs – a new system for keys is being implemented and financial details for this should be available this month, most areas are complying

with the new arrangements; however, there are still one or two areas to reach 100%, further training is being implemented
- Complaints has increased last month, the Chief Executive is looking into this, there was discussion around whether more complaints are being received or more are not being responded to in time, working to different challenges

Finance and Performance Committee

Sian Grbin reported on the last Finance and Performance Committee. The key updates were:

- 7,000 patients are seen in the Radiology Department per week - under resourced and under staffed
- Training a senior house officer to become a radiologist – £150k has been invested into the radiology plan, £60k invested into equipment to invest in an MRI scanner which costs up to £1m
- Interventional Radiologist has been appointed, update on radiologist recruitment will be provided in December 2019
- Use of resources is rated amber – Leeds General Infirmary have agreed to a peer review to look at the Trust's use of resources
- Cost Improvement Plan (CIP) – looking at reducing the deficit and working with budget holders who are supporting this and looking at exemplar wards
- Budgets are set between Finance and Divisions

Workforce Committee

Alison Schofield reported on the last Workforce Committee:

- Number of areas highlighted by staff that they are struggling with
- Following negative feedback from disabled colleagues, the Trust have employed an Equality and Diversity Officer and Alison is assisting with the Colleague Disability Action Group
- Freedom to Speak Up Guardians are included on the staff survey leaflet where staff can raise confidential issues
- Lots of engagement with staff over last year to make them feel more valued – including pets therapy dogs
- 2019 staff survey is being launched beginning of October 2019, the Trust are aiming for an increase in responses

Sian Grbin reported that staff morale is low, and she can't see a benefit of the initiatives arising from the staff survey; she asked what tangible things can be expected in response to the staff survey. Karen Heaton responded some of the issues highlighted are staff not being listened to and not being valued. The Trust are trying to fill vacancies and are reviewing sickness levels which are currently at the lowest they have been in a long time. More engagement will be taking place with staff with a focus on Managers Essentials Training to look at managers development.

OUTCOME: The Council of Governors **RECEIVED** the updates from the Board Sub-Committees.

55/19 INFORMATION TO RECEIVE

a. Council of Governors Register 2019

The updated Council of Governors Register as of 10 October 2019 was circulated for information.

b. Council of Governors Calendar 2019-2020

The Council of Governor's calendar of meetings for 2019 and 2020 was circulated for information. This includes all governor meetings, workshops and Divisional Reference Groups.

OUTCOME: The Council of Governors **RECEIVED** the updated Council of Governors Register and Calendar for 2019 – 2020.

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 17:51 pm and invited members to the next meeting.

Council of Governors Meeting
Date: Thursday 23 January 2020
Time: 3:30 – 5:30 pm (private meeting 2:00 – 3:15 pm)
Venue: Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Friday, 23 August 2019

Present: Philip Lewer, Gary Boothby, David Birkenhead, Ellen Armistead

In attendance: Emma Kovaleski, Carol Harrison, Antonia Cavalier (CCLA), S Duncan , R Billson (Calderdale Community Foundation), D Corbyn , D Darby (Healthy Minds) Lyn Walsh (minutes)
Apologies: Asif Ameen, Linda Patterson, Sheila Taylor

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Investment Performance review (CCLA)
Antonia Cavalier presented a very informative review of the investment portfolio in which the charitable funds are invested. There is some concern that a global recession is on the horizon where things could be more volatile with more fluctuations going forward.

There was a discussion on how ethical the funds are that we invest in. G Boothby asked if any investments were held in fracking. It was confirmed that CCLA don't invest in this area. E Armistead questioned the 10% invested in tobacco; this was explained that it wasn't invested with tobacco producers but covered investments held with hotels chains that possibly sell tobacco.

We now have a new contact Heather Lamont. It was suggested a video conference would be better next year to save travel time for the CCLA representative.

The Committee agreed that it was happy to recommend to the Board that we have ethical investments. Action Check Details of CCLA contract.

3. Minutes of the last meeting
The minutes of the last meeting held on 22 May 2019 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

4. Action Log
Brand Launch & promotion of Charitable funds - Jan-20.
Risk register & strategy update - papers are being written and audit will support governance.
Review of consolidating smaller funds - not discussed - ongoing.
Todmorden premium cost - the Committee decided that this should be addressed by the Outpatient Transformation Group - Action closed.

5. Todmorden Health Centre Premium update.
It was agreed that this was not for the Finance Director to decide and this would be pushed back to the Outpatient Transformation Group outside of the Charitable Funds Committee.
Action closed.

6. Quarter 1 SOFA & Balance Sheet 2019/20
C Harrison reported on the Quarter 1 position. The bulk of the income had come from donations but it should be noted that a legacy of £70k has been received in August for the General Purpose fund. The Q1 investment gain was £173k.
Action Noted.

7. Quarter 1 2019/20 Expenditure Summary
C Harrison reported on the major items of expenditure incurred in Q1.
Action Noted.

8. Charity & Fundraising Strategy & Objectives update.
E Kovaleski shared a presentation that had been seen at WEB the previous day; this will go back to WEB in six months for an update. It was well received.

It outlined the activities and strategy which mirror others in the Trust. Papers are currently being written with consultation from health & safety, audit and risk.

The name of the Charity is currently being reviewed. Staff were asked for suggestions and these were shared with the Committee who were also asked for theirs. This needs to be decided by the end of September as it affects everything going forward.

A funding income summary was shared and Emma explained that this would help form KPI's.

A budget proposal was shared and discussed, with approval given for £6,750.
A bespoke fundraising CRM was to be discussed at a later date it was asked that a business case be produced for this.
Action – EK to do a business case for the CRM and present at next meeting.

9. Calderdale Community Foundation (Healthy Minds).
D Corbyn, D Darby from Healthy Minds accompanied by S Duncan, R Billson from Calderdale Community Foundation presented an update of what the Trust's previous

grants had been spent on. They were requesting another grant of £37.5k that would be matched by CCF to continue and improve services for the Todmorden area.

P Lewer encouraged them to find a more sustainable source of funding.
D Birkenhead asked if value had been added to the client group and what were the views of local GP's and CCG's. The response was that there were some referrals from GP's but also self-referrals. It may be necessary for them to report back at the February 2020 meeting.
Action- DB to email the lead area GP for feedback.

E Armistead asked how outcomes were monitored. This was being done from forms containing questions linked to wellness indicators. E Kovaleski suggested working together to raise the profile going forward.
Action - Approved grant of £37.5k to be matched by CCF, subject to outcome data being provided. It was agreed that this was the last time a grant would be given.

Fast track not reported at this meeting (staff lottery minutes).

10. Any other business
None.

11. Date and time of next meeting
The next meeting will be on Wednesday, 6 November 2019 at 3.00pm-4.30pm in Meeting Room 3, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING

23 August 2019

Action Log - 2019/20

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Brand launch and promotion of Charitable Funds.	**PL/GB**	Jan-20	ongoing
Risk Register & Strategy update	28.08.18	Papers are being written and audit will support governance.	**GB/ EK**	Nov-19	ongoing
AOB	27.02.19	EK to bring review of options to consolidate smaller accounts alongside merits of both options	**EK**	Nov-19	
Investment Performance Review	23.08.19	Check details of CCLA contract.	**LW/CH**	Nov-19	
Calderdale Community foundation (Healthy Minds) Presentation	23.08.19	Healthy Minds to provide outcome data prior to approved £37.5k funding being released.	**PL**	Nov-19	
Calderdale Community foundation (Healthy Minds) Presentation	23.08.19	Email Lead GP in Todmorden area for feed back on Healthy Minds.	**DB / PL**	Nov-19	
Charity Fundraising Strategy & Objectives	23.08.19	Decide on the name of the Charity.	**CFC**	Sep-19	
Budget Proposal	23.08.19	Business case for fundraising CRM	**EK**	Nov-19	

20. Governance Report

a) Constitution Changes for approval

b) Appointment of Deputy Chair / Senior Independent Non-Executive Director

c) Board of Directors Workplan 2020/21

d) Use of Trust Seal

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	Governance Report - November 2019
Author:	Amber Fox, Corporate Governance Manager
Sponsor:	Andrea McCourt, Company Secretary
Previous Forums:	Council of Governors meeting - 17 October 2019 Audit and Risk Committee - 30 October 2019 (Standing Orders, Council of Governors, Board of Directors)

Actions Requested:

- To approve

Purpose of the Report

To ensure effective corporate governance, and in line with the Trust Code of Governance, this report provides updates to the Board on current governance issues and presents key documents that form part of the Trust's governance framework for review and approval in November 2019.

Key Points to Note

a) Constitution Changes

The Trust's constitution and standing orders have been reviewed during workshops with the Company Secretary and governors in October and the changes have been approved by the Council of Governors on 17 October 2019.

The Board is asked to **APPROVE** the changes to the constitution and standing orders which are highlighted in the supporting paper.

b) Appointment of Deputy Chair / Senior Independent Non-Executive Director (SINED)

NHS Foundation Trusts are strongly encouraged to take full account of the best practice provision in the Code of Governance. NHS Foundation Trusts must either comply with the Code or explain non-compliance.

The Code states that:
"The Board of Directors should appoint one of the Non-Executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to members and Council members if they have concerns which contact through the normal channels of the Chair, Chief Executive or Director of Finance, has failed to resolve or for which such contact is inappropriate. The Senior Independent Director could be the Deputy Chair."

Phil Oldfield's tenure as a Non-Executive Director ends at the end of December 2019. Phil's contribution as the Deputy Chair and Senior Independent Non-Executive Director is noted. It has been agreed that Richard Hopkin takes on the role as Deputy Chair and Senior Independent Non-Executive Director from January 2020.

The Board is asked to **NOTE** that Richard Hopkin will take on the role as Deputy Chair / Senior Independent Non-Executive Director (SINED) from January 2020.

c) Board of Directors Workplan 2020/21
The Board of Directors Workplan for 2020/21 is presented to the Board for review.

The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and **APPROVE** the workplan.

d) Use of Trust Seal
The Trust Seal has been used seven times in the last quarter relating to the lease of Allan House for Community Division clinics and the sale of the St Luke's hospital site (5 documents).

The Board is asked to **NOTE** the use of the Trust Seal in the last quarter.

EQIA – Equality Impact Assessment
Consultation with governors has led to a proposed revision to extend the eligibility criteria for lead governor to all governors including staff and appointed governors, having previously been limited to publicly elected governors.
Recommendation
The Board is asked to **APPROVE** the changes to the Trust's constitution and Board of Directors Workplan for 2020/21 and **NOTE** the appointment of Deputy Chair / Senior Independent Non-Executive Director from January 2020 and the use of the Trust Seal in the last quarter.

Update to the Trust's Constitution and Council of Governors Standing Orders

Purpose:
This report summarises recommended changes made to the Trust's Constitution, following two workshops held with the governors during October 2019 with the Company Secretary.

Background/Overview:
The proposed changes to the Trust's Constitution and Council of Governors and Board Standing Orders are described in the table below. These have been agreed by the Council of Governors on 17 October 2019.

Document	Section	Current Version	Recommendation
Constitution	All	The document currently refers to the following titles throughout the document: • Company Secretary • Board Secretary • Trust Secretary	Use of Secretary throughout the document, with the exception of cover sheets. Definition of Secretary confirms this means Company Secretary.
Constitution / Council of Governors Standing Orders	All	Currently refers to Council Member	Remove any remaining references to Council Member and change to Governor.
Constitution	All	Throughout the document, three terms are used for appointed governor: • Stakeholder • Partnership • Appointed Code of Governance uses term appointed governor.	Agreed to name **appointed** governor (this can include stakeholders or partnerships)

Constitution	Addition of a version control history table at the start of document	There was no version control history on the constitution.	Addition of a version control table has been added at the start of the constitution for a clear audit trail of changes.
Constitution	7.2.1 **Minimum age of members and governors**	Age of Members - Currently age **16** or over Governors – Currently age **18** or over	Agreed to retain at age **16** or over for members and consider this in 12 months' time once a Youth Forum has been in place. Agreed to retain at age **18** or over for governors.
Constitution	7.5 **Defining staff constituency roles**	7.5. There is one staff constituency for staff membership. It is to divide into five classes as follows with five seats: 7.5.1. doctors or dentists (x1); 7.5.2. Allied Health Professionals, Health Care Scientists or Pharmacists (x1); 7.5.3. Management, administration and clerical (x1); 7.5.4. Nurses and midwives (x2). 7.5.5 Ancillary staff	7.5.1 Doctors or dentists – fully registered with General Medical or Dental Council 7.5.2 Allied Health Professionals, Health Care Scientists, Psychologists or Pharmacists - regulatory body Council for Regulation of Healthcare Professionals 7.5.4 Nurses / midwives – registered with Nursing and Midwifery Council Agreed need to re-instate ancillary staff governor during 2020 elections.
Constitution	7.11 **Restriction on** M**embership**	**Additions regarding:** **-** no dual membership	Additions to include: An individual who is a member of a constituency, or a class within a constituency, may not while membership

			of that constituency or class continues, be a member of any other constituency class.
		- 12 month gap between a staff member leaving Trust employment and applying to be a public member (this follows discussion at the workshop with governors on moving between staff and public member roles and confirms the current procedure) - if a member moves to an address outside of the constituency area they are no longer a member of the constituency	Addition to Annexe 3 – Further Provisions termination of membership Where a staff member leaves the employment of the Trust and wishes to become a public member, there should be a period of 12 months from the date of ceasing their employment before they apply to be a public member If a public member moves address within the Trust boundaries but outside of their previous constituency area and notifies the membership office, they will be re-allocated to the new constituency in which they reside. Where a public member moves out of the Trust boundaries and notifies the Trust they are no longer eligible for membership and will be removed as a public member.
Constitution	9.1 / 17.2 **Termination of membership**	A Member shall cease to be a Member if: 9.1.1 they resign in writing by notice to the Company Secretary; 9.1.2 they die;	A Member shall cease to be a Member if: 9.1.1 they resign ~~in writing~~ by informing the Membership Office~~ notice to the Company Secretary;~~

		9.1.3 they are disqualified from Membership by paragraph 7; 9.1.4 they cease to be entitled under this Constitution to be a Member of any of the public constituencies or the staff constituency.	9.1.2 they die; 9.1.3 they are disqualified from Membership by paragraph 7; 9.1.4 they cease to be entitled under this Constitution to be a Member of any of the public constituencies or the staff constituency 9.1.5 they are expelled pursuant to paragraph 17.2.
Constitution	11. **Council of Governors - composition**		Addition 11.3.3. The Council of Governors shall at all times be constituted so that governors elected from the public constituency are in the simple majority.
Constitution	17. **Council of Governors - termination of office and removal of Governors**	17.1. A person holding office as a Council Member shall immediately cease to do so if: 17.1.2. they fail to attend two meetings in any 12 month period Clarity on which two meetings this means needed. 17.2 Alignment with Nomination and Remuneration Committee terms of reference	Governors to cease in office if they fail to attend: • two public Council of Governor meetings (this includes the Annual Members Meeting) • two Board Committee or one Divisional Reference Group meetings, based on allocations in a 12 month period from the date the governor is eligible to start attending such meetings (i.e. appointment confirmed in July, next meeting is October).

			17.2.2 the Nomination and Remuneration Committee makes a recommendation about the conduct of a governor
Constitution	18. **Council of Governors – duties of Governors**	18.2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.	18.2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge and the opportunity to hold the Non-Executive Directors to account which they require in their capacity as such.
Constitution	18. **Council of Governors – duties of Governors**	18.3 Lead Governor Currently states the Council of Governors appoints one of its **public** members to be lead governor.	Broaden to include all governors eligible to propose themselves as lead governor, this includes public, staff, appointed governors. Brings in line with Code of Governance.
Constitution	**19.2 Council of Governors meetings – public / press**	Clarification of why an exclusion may occur	19.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, for example consideration of confidential business by resolution of the Council of Governors.
Constitution	24 **Board of Directors - Composition**	Board Composition 24.1 Addition re: Non-Executive majority	24.1 and shall at all times be constituted so that the number of Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

		(reduced from 7 NEDs) 24.2 • Up to 7 Non-Executive Directors (excluding Chair) • Up to 7 Executive Directors	24.2 In the Board Composition to reduce 7 Non-Executive Directors to 6: • Up to 6 other Non-Executive Directors (excluding Chair) • Up to 6 Executive Directors
Constitution	30 **Board of Directors - meetings**	Governor attendance at public Board meetings	Addition 30.4 The Lead Governor (or nominated deputy) and an elected/appointed governor are invited to attend the public Board meeting on a rotation basis.
Constitution	33 **Board of Directors - Remuneration**	33.2 Chair and Non-Executive Director remuneration decided by the Council of Governors	33.2 Chair and Non-Executive Director remuneration decided by the Council of Governors – addition: "on the recommendation of and ratification by the Council of Governors Nomination and Remuneration Committee"
Constitution	**37.1 Auditors**	37.1. The Trust is to have an auditor and is to provide the auditor. Completed the sentence.	The Trust is to have an auditor and is to provide the auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of part 2 of the 2006 Act.
Constitution	**44. Amendment of the constitution**	Addition of 44.6 for clarity on dealing with constitution related queries	44.6 Questions of interpretation of constitution determined by Chair, taking into account view of the Senior Independent Non-Executive Director / Chief Executive and Lead Governor.

Constitution Annexe 4	**Annual Members Meeting (AGM)**	Currently states the Council of Governors presents to members the annual accounts, auditor reports, forward planning	Agreed change to the Board of Directors presents to members the approved annual accounts etc. The Council of Governors presents elections and members.
Constitution Annexe 6	**Composition of the Council of Governors**	1.2. up to six Staff Governors from Staff Constituencies from the following classes: 1.2.1. doctors and dentists (1 member); 1.2.2. Allied Health Professionals, Health Care Scientists and Pharmacists (1 member); 1.2.3. Management, Administration and Clerical (1 member); 1.2.4. Ancillary Staff (1 member); 1.2.5. Nurses and Midwives (up to 2 members)	Discussion on removing reference to 1.2.4 ancillary staff given estates now managed by Calderdale Huddersfield Solutions which has an appointed governor. Governors advised the ancillary staff group is broader than CHS and includes healthcare assistants. Reference to remain and Company Secretary to review which staff groups are covered by the ancillary staff reference prior to elections in 2020. Addition of a summary table which details governor composition showing 16 public, 5 staff and 7 appointed governors.
Council of Governors Standing Orders	**SECTION A Conduct of Meetings**	Addition Admission of Public and Press	1.1 The right of attendance referred to in para 1.1. of these standing orders carries no right to ask questions or to otherwise participate in the meeting.

Council of Governors Standing Orders	**3 Quorum**	3.1. Ten Council of Governors members (including not less than six Public Council Members, not less than two Staff Council Members and not less than two Appointed Council Members – in line with the Constitution)	3.1 Any 10 Council of Governors members – but a minimum of **4** public governors. Addition 3.2 Quorum if conflict of interest declared If a governor has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of the declaration of a conflict of interest in according with paragraph 21 of these Standing Orders they shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. The meeting must then proceed to the next business on the agenda.
Council of Governors Standing Orders	**5. Chairing Meetings** **11. Voting** **Casting vote**	Minor revision to para 5.2 and addition of paras 5.3 and 5.4 to make standing orders explicit about the Chair or Deputy Chair having a casting vote.	5.2 At any meeting of the Council of Governors, the Chair, if present, shall preside and shall exercise the right to a casting vote where the number of votes for and against a motion is equal. 5.3 – Being explicit about Deputy Chair having casting vote if Chair absent – as above – Where votes are equal, Deputy Chair has casting vote

			5.4 – Any Non-Executive Director chairing due to absence/conflict of interest of chair or deputy chair has casting vote. 11.6 In the case of an equality of votes, the Chair of the meeting shall have a second or casting vote, refer to 5.2 11.7 – Removal of Chair / Non-Executive Director shall require the approval of three-quarters of governors (staff, public or appointed) – Section 25 of the Constitution
Council of Governors Standing Orders	**12 Minutes**	Clarification reflecting current practice	Addition 12.4 The minutes should record the chair, governors' names present, and Trust staff present
Council of Governors Standing Orders	**SECTION B** **13 Appointment of Committees**	Addition	Addition to state 13.2 the Nominations and Remuneration Committee of the Council of Governors is a standing committee of Council of Governors. 13.3 Confirm Council of Governors Chair is the Board Chair.

Council of Governors Standing Orders	**SECTION C** **16.1 Register and Interests**	16.1. If Council Members have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or the Secretary.	Add details of paragraph 21 of the constitution which gives context for this section.
Council of Governors Standing Orders	**SECTION D** **18 Removal of a governor**	Addition re: Nomination and Remuneration Committee	18.1 d – addition that recommendation from Nominations and Remuneration Committee about the conduct of a governor is grounds for removal. (in addition to existing grounds of serious breach, not acting in interest of Trust)
Council of Governors Standing Orders	**Lead Governor definition**	Addition SECTION H: on the responsibilities of the lead governor	The Lead Governor responsibilities should be included in the standing orders as an appendix / annexe and reference the role of all governors in shaping the lead governor role. Section H added with responsibilities of the lead governor
Board Standing Orders	**1.2 Composition of the Board of Directors** **7.1 Standards of Business Conduct**	Alignment with Constitution Standards of Business Conduct	1.2 amended to show up to 6 Non-Executive Directors rather than 7 (excluding Chair) Updated reference to 2017 Conflicts of Interest guidance

Recommendation

The Board is asked to **APPROVE** the above changes to the Trust's constitution, following the approval given by the governors at the Council of Governors meeting on 17 October 2019.

DRAFT BOARD WORK PLAN 2020-2021 - WORKING DOCUMENT – UPDATED 29.10.19

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Date of agenda setting/Feedback to Execs	2 April 2020	4 June 2020	5 August 2020	5 October 2020	7 December 2020	1 February 2021
Date final reports required	28 April 2020	23 June 2020	25 August 2020	27 October 2020	5 January 2021	23 February 2021
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
REGULAR ITEMS						
Board Assurance Framework (Quarterly)	✓		✓		✓	
Care Quality Commission Update (CQC)	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) report (See annual items)	✓				✓	
High Level Risk Register	✓	✓	✓	✓	✓	✓
Learning from Deaths – Quarterly Report		✓ Q2		✓Q3		✓ Q1
Guardian of Safe Working Quarterly Report		✓		✓		✓
Quarterly Quality Slide Report + Presentation focused on one topic (NB – Quality Account in Annual Report)	Quality A/cs		✓ Q1	✓Q2		✓
Staff Survey Results		✓		✓		✓
Nursing and Midwifery Staffing Hard Truths Requirement			✓ (Bi-annual)			✓ (Bi-annual)
Safeguarding update – Adults & Children			✓ (Annual report)			✓

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Financial Update	✓	✓	✓	✓	✓	✓
Plan on a Page Strategy Update	✓ (Annual report)					
MINUTES FROM SUB-COMMITTEES						
Quality Committee update & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & Minutes	✓	✓	✓	✓	✓	✓
F&P Committee update & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee update & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
A&E Delivery Board Minutes	✓	✓	✓	✓	✓	✓
GOVERNANCE REPORT						
Standing Orders/SFIs/SOD review	✓					
Non-Executive appointments			✓	✓ (SINED/Deputy Chair)		✓
Board workplan		✓		✓		✓
Board skills / competencies					✓	
Board meeting dates		✓			✓	
Committee review and annual report		✓				
Annual review of NED roles			✓			
Use of Trust Seal		✓		✓		
Declaration of Interests - BOD (annually)						✓
Attendance Register – (annually)	✓					
BOD Terms of Reference						✓
Sub Committees Report & Terms of Reference	✓					
Constitutional changes (+as required)	✓					
Compliance with Licence Conditions	✓					

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Assurance (Quality) Friday Visits Feedback		✓		✓		✓
ANNUAL ITEMS						
Annual Plan						✓
Capital Plan					✓	
Council of Governors Elections		✓ (results)	✓			✓ (timetable)
Digital Health Update		✓		✓		
Emergency Planning Annual Report			✓			
Fit and Proper Person Self-Declaration Register						✓
HPS Annual Report	✓					
Health and Safety Annual Report		✓		✓ (update)		
Public Sector Equality Duty (PSED) Annual Report		✓ (update)				✓ (Annual Report)
DIPC Annual Report (ALSO SEE REGULAR ITEMS)		✓ (Annual Report)				
Fire Safety Annual Report	✓ (Annual Report)					
Medical revalidation & appraisal			✓ (Annual Report)			
Freedom to Speak Up Annual Report						✓ (Annual Report)
Review of Board Sub Committee TOR	✓					
Risk Appetite Statement				✓		
Risk Management Strategy					✓	
Winter Plan			✓	✓		
Workforce OD Strategy						✓
LHRP Core Standards			✓			✓
Performance management update				✓		

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
4-19	02.08.19	02.08.19	Section 106 legal agreement between the local authority (Kirklees) and the development partnership Pennine Property Partnership, which comprises Calderdale and Huddersfield Foundation Trust and Henry Boot, which details planning delegation relating to the development of the St Luke's site and amends this through a variation.	NAME: Ellen Armistead TITLE: Director of Nursing NAME: Andrea McCourt TITLE: Company Secretary
	05.08.19	05.08.19	Joint venture signatory – as above, signatory by Trust as landowner	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
5-19	23.08.19	23.08.19	Lease of Allan House Annex for community division clinics This is a lease for Allan House Annex which is currently used by the Trust to deliver a number of community clinics. The lease has been agreed following negotiations between Tom Donaghey (CHS on behalf of the Trust), NHS Property Services (Landlord) and Trust legal representatives Hempsons. The lease is for 5 years and has an initial rent of £8248k per year.	NAME: Ellen Armistead TITLE: Director of Nursing NAME: Andrea McCourt TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
6-19	28.8.19	28.8.19	Lease of Allan House for community division clinics. This is a lease for Allan House which is currently used by the Trust for community division offices housing administration bases for district nurses and respiratory nurses. The lease has been agreed following negotiations between Tom Donaghey (CHS on behalf of the Trust), NHS Property Services (landlord) and Trust legal representatives Hempsons. Allan House is split into two buildings (main house and annex) hence why we have two separate leases. Leases have been agreed as part of the NHS Property Services lease regularisation programme to formalise all undocumented tenancies. The lease is for 5 years and has an initial rent of £7878.66 per annum (inc of communal area proportion).	NAME: Ellen Armistead TITLE: Executive Director of Nursing NAME: David Birkenhead TITLE: Executive Medical Director

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
7-19	22.10.19	22.10.19	Agreement for Sale of property between Pennine Property Partnership and Avant Homes for the former St Luke's Hospital and buildings.	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
8-19	22.10.19	22.10.19	TR1 – transfer of whole registered title for St Luke's from Trust, CHFT, to Pennine Property Partnership	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
9-19	22.10.19	22.10.19	Legal Charge between Avant Homes and Pennine Property Partnership in relation to St Luke's Hospital	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
9-19	22.10.19	22.10.19	Legal Charge between Avant Homes and Pennine Property Partnership LLP in relation to St Luke's Hospital	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
11-19	22.10.19	22.10.19	License between Pennine Property Partnership and Avant Homes relating to land at Blackmoor Foot Road, Huddersfield (former St Luke's site)	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

21. Month 6 Financial Summary

To Note

Presented by Kirsty Archer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 7 November 2019
Meeting:	Board of Directors
Title of report:	Month 6 Financial Summary
Author:	Philippa Russell, Assistant Director of Finance
Sponsor:	Kirsty Archer, Deputy Director of Finance
Previous Forums:	Turnaround Executive

Actions Requested:

- To note

Purpose of the Report

To outline the headline financial messages for Month 6.

Key Points to Note

The year to date deficit is £9.32m in line with the plan, although there are pressures absorbed within this that impact on the forecast.

EQIA – Equality Impact Assessment

The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

Recommendation

The Board is asked to note the attached month 6 financial summary.

MONTH 6 FINANCIAL SUMMARY

Year to Date Summary

- **The year to date deficit is £9.32m in line with the plan although there are pressures absorbed within this that impact the forecast.**
- The CIP delivered in the year to Month 6 is £4.41m slightly ahead of a planned £4.24m.
- There is an under spend of £1.74m against the budgeted agency trajectory.

Clinical income (contract and other) is £0.25m below plan overall after £2.78m protection offered by the Aligned Incentive Contract reflecting lower than planned activity levels. Surgery Division benefits from £1.2m protection from the AIC. Accordingly the division's favourable variance to plan is driven by lower expenditure linked to lower activity levels. The Community underspend is slowing as staffing vacancies are filled. The Medicine position has worsened quite significantly in month primarily due to capacity pressures.

The HIS position has improved from prior months following identification of some recovery actions however, the adverse variance to plan continues. 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). This pressure has increased from previous months following completion of the validation exercise on the transfer maintenance budgets. Pressure is also seen from utilities and clinical waste spend.

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 6		
	Plan	Actual	Variance
	£'000	£'000	£'000
Corporate	(21,669)	(21,268)	401
FSS	(2,811)	(2,720)	91
THIS	1,194	958	(236)
Medicine	20,449	19,668	(780)
Surgery	6,496	7,430	934
Community	(1,430)	(1,094)	336
PMU	1,528	1,563	35
Divisional Operating Position	**3,757**	**4,538**	**781**
CHS Ltd	144	144	0
Technical Accounting & Reserves[1]	(13,232)	(14,004)	(772)
Total Trust Surplus / (Deficit)	**(9,332)**	**(9,322)**	**9**

Forecast

Last month a recovery and restraint requirement of £1.2m was identified as a result of pressure from the medical pay award and divisional forecasts. Sufficient recovery plans have been identified in month to close this gap subject to the necessary quality and equality impact assessments.

In the meantime there has been an underlying worsening in the forecast of c. £0.5m. This is due to a worsening in the Medicine forecast based primarily on capacity pressure and the finalisation of the validation work on maintenance contracts driving a further forecast pressure which will be passed on to FSS, mainly linked to PACS maintenance contracts.

This recovery requirement assumes that, £0.5m earmarked for reconfiguration is fully committed in year; the remaining winter reserve is spent with the exception of £0.3m committed to recovery; and that contingency reserves are exhausted. The majority of these reserves are already committed.

As ever there is a list of further risks and opportunities. We are closely monitoring a risk on the scale of VAT recovery, this is just a watching brief at the moment as it is very complex so work is ongoing.

Division	Expected Recovery (TE 8 Oct 2019) £'000	Expected Forecast Variance including Recovery £'000	Forecast Variance from Plan reported Month 6 £'000	Movement from Expected £'000	Notes
Central & Technical / Central income	0	(961)	(1,219)	(258)	Includes CHS Variation to contract increased by £250k in forecast
Reserves	300	396	841	444	Assumed additional recovery to bring back to plan
Corporate	35	171	217	46	
FSS	220	(165)	(77)	88	
THIS	370	(301)	(350)	(49)	
Medicine	200	(547)	(863)	(316)	
Surgery	200	1,186	1,188	3	
Community	30	337	301	(36)	
PMU	0	0	0	0	
CHS	0	46	(31)	(77)	
Total Variance from Plan	**1,355**	**161**	**7**	**(155)**	

- **The forecast continues to assume delivery of the £9.7m deficit on the basis that £0.5m of <u>additional</u> recovery and restraint will be required.**

<u>Cash and Capital</u>

- Cash balance at the end of September was £4.96m, higher than the £1.90m planned, pending repayment of a loan due early October.
- Year to date the Trust has borrowed £16.10m to support the deficit and Provider Sustainability Fund (PSF) / Financial Recovery Fund (FRF) payments that will be paid in arrears.
- The Trust planned to borrow £26.46m in 19/20 to support Capital and Revenue plans; £9.71m deficit funding, £7.75m advance to cover PSF & FRF funding that will not be paid until next year and £9m Emergency Capital loan. Forecast loan requirements have now reduced by £5.20m due to slippage on emergency capital plans.
- Capital expenditure is forecast at £14.35m, £5.86m lower than planned. The revised plan submitted to NHSI on 15th July detailed forecast expenditure of £15.01m. This has reduced further following confirmation of a revised profile for the 2 year PDC funded Energy Efficiency Scheme. The Trust has received assurances that forecast emergency and reconfiguration loan funding of £3.8m will be made available this year, but final confirmation is still pending. The £5.2m slippage on these costs compared to plan will be carried forward into 20/21 and are reflected in the Trust's five year capital plan.

22. Date and time of next meeting

Thursday 9 January 2020, 9:00 am

Venue: Boardroom, Huddersfield Royal Infirmary

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).