Public Board of Directors

Schedule	Thursday 9 January 2020, 9:00 — 12:30 GMT
Venue	HRI - Boardroom
Organiser	Amber Fox

Agenda

11:08	17.	Update from sub-committees and receipt of minutes & papers • Finance and Performance Committee – minutes from meeting held 1 November 2019 • Audit and Risk Committee – minutes from meeting held 30 October 2019 • Quality Committee – minutes from meeting held 4 November 2019 • Workforce Committee - minutes from meetings held on 5 November 2019 and 10 December 2019 • Charitable Funds Committee – minutes from meeting held 6 November 2019 • A&E Delivery Board – minutes from meetings held 10 September and 12 December 2019 To Note	284
		APP M1 - Finance and Performance Committee - Draft Minutes of Meeting held 011119.docx	285
		APP M2 - Audit and Risk Committee Minutes 30 October 2019.docx	292
		APP M3 - FINAL Quality Committee Minutes (4 Nov 2019) (Approved at QC on 2 Dec 2019).docx	301
		APP M4 - Notes of Workforce Committee Meeting 5 November 2019.pdf	310
		APP M5 - Draft Notes of Workforce Committee Meeting 10 December 2019.pdf	317
		APP M6 - Charitable Funds Committee - Minutes 6 November 2019.docx	320
		APP M7 - A&E Delivery Board Notes 10092019.docx	323
		APP M8 - A&E Delivery Board Notes 121119.pdf	332
11:18	18.	Date and time of next meeting Thursday 5 March 2020, 9:00 am Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital To Note - Presented by Philip Lewer	342

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).

1. Welcome and Introductions:

The Kings Fund

To Note

Presented by Philip Lewer

2. Apologies for absence: Richard Hopkin

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 7 November 2019

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 7 November 2019 at 9:00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Alastair Graham **(AG)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director
Richard Hopkin **(RH)**	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
Peter Wilkinson **(PW)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director

IN ATTENDANCE

Bev Walker	Deputy Chief Operating Officer **(item 118/19 and 126/19)**
Peter Keogh	Assistant Director of Performance **(item 126/19)**
Cornelle Parker	Deputy Medical Director **(item 123/19 and 124/19)**
Amber Fox	Corporate Governance Manager **(minutes)**
Andrea McCourt	Company Secretary
Kirsty Archer	Deputy Director of Finance
Dr Anu Rajgopal	Guardian of Safe Working Hours **(item 117/19)**
Asifa Ali	Research and Innovation Lead **(item 124/19)**
Caroline Gizzi	Director of Operations, Families and Specialist Services Division **(item 125/19)**
Marilyn Rogers	Registered Midwife / Infant Feeding Advisor **(item 115/19)**
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)

OBSERVERS

Emma Summerfield	Hempsons Solicitors
Jackie Ryden	Corporate Governance Manager **(covering from January 2020)**
Rhianna Lomas	Finance Admin Assistant **(shadowing)**

108/19 Welcome and introductions:

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

The Chair announced Linda Patterson and Phil Oldfield will step down as Non-Executive Directors at the end of December 2019, as they come to an end of their tenure. The Chair formally thanked Linda Patterson for all her support as Non-Executive Director over the last six years.

The Chair formally welcomed Denise Sterling and Peter Wilkinson to their first Board meeting as Non-Executive Directors. The Chair acknowledged the number of Non-Executive Directors in attendance at the Board was greater than Executive Directors and explained the new Non-Executive Directors will take no part in any voting in order to balance the Board.

109/19 Apologies for absence:

Apologies were received from Helen Barker, Mandy Griffin, Anna Basford, Gary Boothby, Phil Oldfield, John Richardson and Veronica Woollin.

110/19 Declaration of Interests

The Board were reminded to declare any interests at any point in the agenda.

111/19 Minutes of the previous meeting held on 5 September 2019

The minutes of the previous meeting held on 5 September were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 5 September 2019.

112/19 Action log and matters arising

The action log was reviewed and updated accordingly.

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

113/19 Chair's Report

The Chair reminded Board members of the Christmas tea trolley rounds and asked if they are available to offer their support.

a) Council of Governors Nominations and Remuneration Committee – Update on Non-Executive Director Appointments

The Chair confirmed the appointments of Denise Sterling and Peter Wilkinson were formally ratified at the Council of Governors meeting on 17 October 2019.

b) Outgoing Non-Executive Directors

The Chair formally thanked the two outgoing Non-Executive Directors, PO and LP for their contribution to the Trust over the last six years.

c) West Yorkshire Association of Acute Trusts (WYAAT) 2018/19 Annual Report Summary

The WYAAT 2018/19 annual report summary was circulated and noted by the Board. The full WYAAT annual report is available on the Trust website.

OUTCOME: The Board **NOTED** the update on the Non-Executive Director appointments and the WYAAT 2018/19 Annual Report Summary.

114/19 Chief Executive's Report

The Chief Executive reminded the Board about 'Purdah' and the general election guidance circulated for NHS organisations. In respect of campaign visits to NHS services and premises, NHS providers have discretion in deciding whether to allow visits from parliamentary candidates. The Chief Executive advised that he had declined a request from a prospective parliamentary candidate to spend time in the accident and emergency department based on disruption of services. The Chief Executive reported the Trust are keeping disruption to patients at a minimum.

RH added that the impact of 'Purdah' regarding the 5-year plan had been raised at a recent NHS Providers meeting.

Action: Latest NHS England/Improvement (NHSE/I) Guidance on the General Election to be circulated to the Board – Company Secretary

The Board acknowledged the engagement events regarding reconfiguration will continue during the election period and the Chief Executive confirmed the ongoing consultation regarding vascular services at the West Yorkshire level will also continue as no decisions are required between now and the election.

AN asked how WYAAT aligns with the Integrated Care System (ICS). The Chief Executive confirmed there is a System Leadership Executive Group meeting with local authority representatives, NHS Providers, Commissioners and voluntary members. This group is in

discussion regarding the 5-year plan for the Integrated Care System. The Chief Executive confirmed there is positive overlap and work is underway to develop a clinical strategy which will feed into the ICS.

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

115/19 Patient Story – 'Success of CHFT in improving breast feeding over the years'

Marilyn Rogers, Registered Midwife and infant feeding advisor attended the Board at the request of Dr Peter Bamber, to share the success of CHFT in improving breastfeeding over the years. The key achievements highlighted were:

- Calderdale Royal Hospital began working towards Baby Friendly Initiative (BFI) in 1997
- CHFT were the first accredited Baby Friendly hospital in the region in 2002
- The Trust maintained the status throughout the assessments conducted in 2004, 2007, 2011, 2015 and 2018
- Over time as services have merged Huddersfield Birth Centre, Health Visiting Services NHS Calderdale (Locala) and NHS Kirklees (Locala) have achieved Baby Friendly Initiative, BFI accreditation
- Baby Friendly Achieving Sustainability Gold Award received in April 2019

It was noted that the guardian of the Baby Friendly Initiative standards is the Chief Operating Officer.

AG asked if there are lots of baby cafés in Kirklees and Calderdale. Marilyn confirmed there is one in Halifax, Huddersfield and Birstall and there is an interactive map on the baby café website. This is a worldwide, charitable organisation which was developed with NHS funding in 2002. The Trust pay an annual license fee to the NHS Charity.

The Chief Executive passed on credit to Marilyn Rogers who has been strongly dedicated to this work and the Trust have now achieved five consecutive awards. He shared the following quote about Marilyn *"she is dedicated to the voice of women and those who don't have a voice."*

LP thanked Marilyn for sharing her presentation and great story.

OUTCOME: The Board **NOTED** the patient story and success of CHFT in improving breastfeeding.

116/19 Month 6 Financial Summary

The Deputy Director of Finance presented the month 6 financial summary, the key updates were:

Income and Expenditure

- Year to date (YTD) deficit is £9.32m in line with the plan, although there are pressures absorbed within this that impact on the forecast
- To deliver the deficit, a total of £11m of the Cost Improvement Plan (CIP) needs to be achieved, as well as the receipt of over £22m of central funding – 'provider sustainability funding' and 'financial recovery funding' which requires the Trust to stay on track to access this funding
- YTD is positive, the financial position was delivered in line with income and expenditure plan at month 6
- CIP delivered £4.41m in the year, slightly ahead of a planned £4.24m
- Underspending against agency budget with a shift into bank expenditure

Financial pressures within YTD position that impact on the forecast:

- Month 5 (August) – 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 (operationally)
- Identified a recovery and restraint plan to close the gap, subject to the necessary quality and impact assessments
- Month 6 (September) – further £0.5m stretch required due to worsening position in the Medical division 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 the Family and Specialist Services division. Extra scrutiny and escalation measures are in place.
- Forecast continues to assume delivery of the £9.7m deficit as planned with actions in place

Capital and Cash

- Borrowing less than originally planned due to timing of capital investments – capital expenditure is forecast at £14.35m for the year, £5.86m lower than planned, latest forecast is in line with plan from July 2019, the monies not spent this year will be spent next financial year

AG asked what the impact will be of the general election. The Deputy Director of Finance explained that an element of funding is still subject to confirmation from NHS Improvement (NHSI). The funding awaiting approval from NHSI is already in the late stages and no direct impact is anticipated this year. There will be a level of risk in the five-year plan. The winter reserve has been committed for investment for winter pressures this year which covers the winter plan with some allowance for contingency.

RH shared the concern from the Finance and Performance Committee with month 5 of an additional £1.2m required for recovery actions and restraint and now an additional £0.5m to be identified. This will be risk-assessed, and the risk rating will be reviewed.

KH asked about the pressure of the national medical pay award. The Deputy Director of Finance confirmed the Trust received the money and planned for pay at 2% uplift from mid-year in line with last year. The assumption was an award one year later; however, the award and timing of it was not clear. The pay award has been awarded at slightly higher than 2% and backdated to April. This was provided by extra funding from national sources and the difference was from 2% to 2.6-2.7% with no funding to backdate this award to April which is a pressure. Other Trusts have the same pressure.

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

117/19 Guardians of Safe Working Hours Quarterly Report

Dr Anu Rajgopal, Guardian of Safe Working Hours presented the Q2 report from July to September 2019. The key updates were:

- 35 exception reports from a wider range of specialities mainly due to hours worked
- Exception reports by ethnicity and gender are now included in the report
- Registrar-level gaps in medicine have been resolved, no trauma and orthopaedic gaps
- Significant gaps remain in Paediatrics and Accident and Emergency
- Funding from the Department of Health of £30k for CHFT will be discussed at the Junior Doctors forum and included in the Q3 report

AN asked what can be done at the Trust to improve the training and hospitality for junior doctors. The Guardian of Safe Working Hours confirmed the Trust undertook a catering survey, the Medical Director added there was not a large response from Junior Doctors and the Trust are trying to engage differently with this staff group. Feedback from the survey was mainly regarding food available out of hours, limited health options and no

fresh food. The results from the survey in September 2019 are yet to be received and will be included in the next report.

OUTCOME: The Board **APPROVED** the Guardians of Safe Working Hours Quarterly Report.

118/19 Emergency Preparedness, Resilience and Response (EPRR) Annual Report

The Deputy Chief Operating Officer presented the EPRR Report. The key points to note were:

- The Trust has in place a Security and Resilience Governance Group chaired by Andy Nelson
- The Trust is compliant with the NHS England EPRR 64 core standards
- Submitted self-assessment to NHS England and Internal Audit recognised the positive compliant ratings
- Large piece of work took place over 18 months to achieve this and prepare staff
- Introduction of an on-call framework, table top exercises and training (online and face to face) to review business continuity plans (BCPs)

AN explained there has been positive progress made which can be evidenced in terms of the training, policies and procedures. All audit actions have been completed and the Trust are now focused on outcome measures. The Trust will shift to embedding the learning in 2020/ 2021 and Divisions will be invited to the Security and Resilience Governance Group to provide evidence.

KH asked if there are plans to complete simulation exercises. The Deputy Chief Operating Officer confirmed a significant number of table top exercises have taken place e.g. lighting, floods etc. and re-assured the Board that the clock change downtime went smoothly. KH added it is useful to undertake these exercises periodically.

OUTCOME: The Board **APPROVED** the Emergency Preparedness, Resilience and Response (EPRR) Annual Report.

119/19 Q2 Quality Report

The Director of Nursing presented the quarter 2 quality report by CQC domain. The key points to note were:

SAFE

- Positive performance on children's safety thermometer
- Improved in falls / falls prevention
- Medicine safety remains a challenge and an external peer review has taken place
- How to evidence learning from complaints, incidents and concerns and strengthen the audit process is an area for improvement
- Ongoing vacancy in the nursing sepsis post
- Maternity investigations – Between 3 December 2018 and 31 March 2019, the Trust has referred 5 cases to the Healthcare Services Investigation Branch, HSIB, these are ongoing cases with HSIB with four reports finalised and awaiting one further report, no cases were reported to HSIB in Q1 or Q2
- Tissue Viability Specialist Nurse has been recruited and a deep dive on pressure ulcers will take place next year
- Positive Friends and Family Test (FFT) results – this is changing nationally from April 2020 and will give a more rounded view on quality
- Complaints remains a challenge, a facilitated Working Together to Get Results (WTGR) session is scheduled, there has been a reduction in the number of re-opened complaints and the quality of responses is improving, the mean number of days is reducing; however, the Trust is not closing complaints within the timeframe - an external visit/peer review has taken place
- Out patients and delivery of the emergency care standard remains challenging

LP highlighted there has been a lot of work on medication compliance with the Clinical Director for Pharmacy which has been discussed at the Quality Committee.

RH suggested the Board receive regular feedback on complaints and are kept informed. RH asked if the 90% target for dementia screening is realistic. The Medical Director confirmed the target is realistic; however, the Trust were more compliant with the target when using paper records as the field is less visible in EPR. The Trust are reviewing how to make this more visible which is a must-do for doctors.

AN highlighted performance against the four-hour target for A&E has dipped. The Director of Nursing explained that volume is an issue along with acuity of patients. Staff have been reminded of the systems and processes that are in place and an improvement plan is in place with new initiatives, including re-opening the discharge lounge. The Deputy Chief Operating Officer added there has been a 5% growth in attendances and transfer of care has hit a peak with escalation to partners. RH suggested the presentation shared at the Finance and Performance Committee by the Chief Operating Officer is circulated to the Non-Executive Directors.

Action: Circulate the Patient Flow and Emergency Care Standards Improvement Plan presentation from Finance and Performance Committee to Non-Executive Directors

The Chief Executive re-iterated the importance of addressing internal issues and enquired whether changes in acuity could be measured as well as co-morbidities.

AG highlighted attendance at complaints panels and asked if these panels can be focused on positive learning to improve attendance. The Director of Nursing explained a Working Together to Get Results (WTGR) session is scheduled which will focus on learning. It was noted there are more positive responses to serious investigations. KH highlighted that the complaints had been reviewed at the Quality Committee and it is a multi-faceted issue with a cultural element, with an opportunity to learn from complaints and more effort should be made to resolve complaints informally. She added the complexity of complaints requires some level of training.

AG asked for an update on staffing in ICU and if there has been a discussion with CQC regarding the Trust's mitigations. The Director of Nursing explained the mitigation strategy has been signed off ahead of the full reconfiguration and all safety measures are in place and are being monitored.

OUTCOME: The Board **NOTED** the Q2 Quality Report and activities across the Trust to improve the quality and safety of patient care.

120/19 Care Quality Commission (CQC) and Use of Resources Update

The Director of Nursing provided an update on the key actions which have been undertaken in the quarter in relation to care quality commission (CQC) work and priorities for quarter 3. The key points to note were:

- An ongoing must-do action relating to intensive care at CRH and medical staffing presence (Must Do 8) and should do action across the Trust (should do 9) regarding Consultant presence in the Emergency Department. Mitigation is in place for both actions.
- The Trust have strong relationships with local CQC Officers
- Reviewed terms of reference for the CQC Response Group chaired by the Director of Nursing, the purpose of this group is to remain on track with must-do and should-do actions and move from 'requires improvement' to 'good' and 'good' to 'outstanding'

- Well-led developmental review is taking place with an external provider to review gaps in the early new year in line with the national expectation that all organisations have a development review every three years, a table top assessment exercise has been completed
- A CQC portal has been introduced which is very comprehensive
- A 'Go See' visit took place to Newcastle, these findings will be reviewed
- Conversations are taking place with an outstanding Trust regarding their governance arrangements

AN stated it is positive to see peer reviews and actions arising from this, he asked if any big issues have been identified. The Director of Nursing confirmed the detail is included in the quality report and the peer reviews provided the Trust with some recommendations, particularly regarding nutrition.

AG asked if the Trust found out why the benchmarking position was better at Leeds Teaching Hospitals (LTHT) on use of resources. The Deputy Finance Director explained the assessment was a desktop exercise and there are ongoing conversations with Leeds. The Trust's agency position has improved since the point of the assessment and positive actions have been taken. RH asked if the Trust will use LTHT for the use of resources element. The Chief Executive explained the Trust will need to identify where to focus on to move from 'requires improvement' and to achieve the £9.7m deficit position. The Deputy Finance Director confirmed the use of resources element is wider than finance and includes staffing, estate and workforce. She added LTHT's ability to recruit staff helps their position. RH confirmed that use of resources will be discussed at the Finance and Performance Committee.

KH asked if a report on the Electronic Patient Record (EPR) will be received next year to understand the progress made since Go Live. This will be discussed under the Outpatient Improvement agenda item. The Director of Nursing explained there is a new Clinical Safety Officer for Information in post, this will include connections to digital and this role will be reviewed.

OUTCOME: The Board **NOTED** the progress on Care Quality Commission (CQC) must-do and should-do actions and use of resources and **CONSIDERED** the next steps for the well-led assessments.

121/19 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:

- Two new risks with mitigation action plans in place (Radiology Requests risk 7430 and Maxillofacial follow up appointment risk 7527 due to user/system issues)
- Two removed risks – risk 7062 funding for the capital programme reduced from 16 to 6 as agreed at Finance and Performance Committee and Tissue Viability Team risk 7477 reduced from 16 to 6 due to improved staffing
- Pie chart included in the report which includes an overview of risk type – 71% of risks are around quality and safety
- Deep dives will take place for risks on the high level risk register with a static risk score as part of an assurance process

PW asked if the capital programme risk score (7062) may increase due to the general election. The Deputy Finance Director confirmed risk 7062 relates to this financial year; however, it could affect long-term financial sustainability.

AN noted that there had been conversations within the Workforce Committee on the nursing and medical staffing position with positive progress noted. The Medical Director confirmed mitigation is in place and for Radiology; this includes outsourcing reporting in the UK and exploring this abroad and the Medical Director attending a recruitment fair in

London where there was focus on how to make radiology more attractive with reporting from home. The Chief Executive added there is still a challenge to attract Radiology staff interested in specific sub-specialties. It was noted that an external view of the Radiology Service by Professor Briggs had commented that the current Trust Radiology service provision was good and that the Trust model of developing skills amongst other staff groups, such as radiographers, was potentially more sustainable. There are wider discussions at the West Yorkshire Association of Acute Trusts regarding the reporting ability across systems via the Yorkshire Imaging Collaborative programme of work, which is detailed in the 2018/19 WYAAT annual report previously shared.

RH explained an annual review of risk management was presented at the Audit and Risk Committee and looked at the movement of the high-level risk register which confirmed it was dynamic and that in terms of the number of quality and safety risks on the high level risk register, the Auditors had confirmed they increasingly see more work around quality and safety risks, as opposed to finance, at other Trusts. The Director of Nursing explained the proportion of quality and safety risks on the high level risk register was as expected and the next step is for the Board to map the impact of the risks.

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

122/19 Director of Infection Prevention Control (DIPC) Quarterly Report

The Medical Director presented the quarterly DIPC report. The key points to note were:

- C.difficile is in a similar position to last year – all sporadic cases with no outbreaks
- Change in reporting for c.difficile from 1st April 2019
- MRSA – there has been one case which was deemed as unavoidable
- There have been 18 post-admission e.coli cases, a reduction of 18% YTD compared to last year – the overall target has been extended to 2024 is to reduce these cases by 50% (90% of all cases occur in community)
- Reduction in ANTT competency – all staff who undertakes ANTT will now require a re-assessment every three years

AN asked for clarity why there are no targets set for some indicators, for example the MSSA and e.coli bacteraemia. The Medical Director confirmed that this is because no national targets are set and explained that the control measures for MSSA should be the same control measures that relate to MRSA. A total of 1-2% of the population carry MRSA and 50% of population carry MSSA.

AN highlighted that flu vaccination uptake is positive compared to our peers. Vaccines are released in three batches which is different to last year and the Trust are offering front line staff the vaccine in phase one of the campaign. Compliance is currently at 38%.

AG highlighted the positive progress made to the green domains and passed on credit to the Medical Director and the team in helping the organisation respond to infection.

OUTCOME: The Board **APPROVED** the quarterly Director of Infection Prevention Control (DIPC) report.

123/19 Learning from Deaths Quarter 2 Report

The Deputy Medical Director presented the Learning from Deaths Q2 report. The key points to note were:

- National piece of work to review hospital deaths with a screening review target of 50%
- A total of 40% of hospital deaths reviewed at the Trust require a more detailed structured judgement review and there are 9 consultants who participate in this process
- 20% of hospital deaths reviewed have been through a Structured Judgement Review (SJR)

- There is a rise in trend for completion following a revised process as consultants wanted to review largely within their own specialty and less from an independent perspective
- Learning from Deaths panel is to be re-convened to prioritise learning and peer review of structured judgement reviews (SJRs)
- the new Medical Examiner role commences in January 2020 and alignment of the Learning from Death process with this role will take place, providing further scrutiny and improvements in the quality of information

RH highlighted that 5 of out 30 deaths which went through a Structured Judgement Review received a poor care score and queried whether there was a theme of lack of escalation for patients with high NEWS scores. The Deputy Medical Director explained when poor care is identified, a second structured judgement review takes place to assess the quality of care. Themed learning over 12 months will be identified within the Learning from Deaths annual report.

AG suggested including the learning from structured judgement reviews in the report e.g. failure to escalate quickly enough and what the Trust are doing differently as a result. The Deputy Medical Director stated she included 20 different elements in the original report; however, this was removed and will be included in the annual report to analyse the themes over a year. The Medical Director added a more detailed paper was presented to a previous Board meeting.

The Chief Executive asked for clarity on what is happening at a broader level. It was confirmed that 2018/19 had the lowest number of deaths since 2009 however it is difficult to establish whether learning has contributed to this reduction. The Medical Director explained it is complex with a strong focus on Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicators (SHMI) and co-morbidities and he is not confident that a lower number of deaths is related to a lower mortality rate, for example there could be more patients who are dying at home rather than in hospital. The SHMI is stable now and HSMR is better than expected and slowly increasing this year. The Chief Executive advised that we need to identify the key factors that are making a difference and the Medical Director suggested the Trust review patients with a high NEWS score to review the acuity in the organisation, now and retrospectively. The Deputy Medical Director commented that as the Trust began reviewing deaths before this was mandatory the data we have collected allows for a mature debate.

The Medical Director added that learning from death reviews will be rolled out to include community deaths.

OUTCOME: The Board **APPROVED** the Q2 Learning from Deaths report.

124/19 Update on Research and Innovation

AG requested an update on research and innovation to be presented to the Board to understand the great work being undertaken by the team and the opportunities in the future, particularly in relation to commercial research. The research work cuts across most disciplines within the Trust and there is a wider geographic context through the Clinical Research Group.

The Research and Innovation lead, together with the Deputy Medical Director, shared a presentation on the research strategy for 2019-22, the key updates were:

- Research is funded by the National Institute of Health and Research
- Recruitment to time and target open studies - currently achieving 88% on the NIHR key benchmark for performance and have consistently achieved above 80%
- Cancer is the highest number of recruitment studies by speciality and the Trust is the second in the region for cancer research studies

- 2019 achievements were noted which included CHFT being the first UK site to open and recruit to some studies including commercial studies
- Greater collaboration with Allied Healthcare Professionals (AHPs) and Physiotherapists
- Prof Felicity Astin, Professor of Nursing is working jointly with the Trust and providing introductions to the clinical academic post
- Piloting research nurse led clinics
- The first Trust wide research event, 'Be Part of Research' is taking place on Monday 25th November 2019

In response to a question from KH the Research and Innovation lead explained how the costs of research are covered for different types of studies. KH highlighted the range of areas is significant with cancer being the largest and asked if there are other areas seeking to develop in research. The Research and Innovation lead explained Paediatrics and Gastroenterology, Sexual Health and now Surgery are areas we are looking to develop our research profile

The Medical Director added there is a challenge to broaden research and it is great to see progress. The ability to access research is part of the NHS and used to be strong in Rheumatology, where they now have less interest. The Medical Director recommended the Trust continue to strive to broaden research.

The Director of Nursing explained there is an ambition for nurses to become a centre of excellence for nursing research and suggested working together with the research team to develop nursing research. The Research and Innovation lead stated the Trust are recognised for having principal investigators for nursing research.

DS asked if there are any plans or targets to increase research across the range of other professions. The Deputy Medical Director explained there is a new Head of Therapies which presents an opportunity and a new research nurse has been appointed who will be taking this forward.

OUTCOME: The Board **NOTED** the Research Strategy and supported its implementation.

125/19 Outpatient Improvement

Caroline Gizzi, Director of Operations for the Families and Specialist Services Division presented the outpatient improvement report which highlighted key actions to secure improvement in outpatient processes.

The background was given, noting that the Electronic Patient Record system which is used as the booking function was introduced in May 2017 and concerns were highlighted by clinicians, GPs and clinic reception staff about the booking processes which triggered both internal and external reviews.

Internal reviews held included a review of complaints for cancelled appointments, an in-depth review with outpatient booking managers, directorate reviews and a series of Trust-wide working together to get results session focused on response, reality and result which were used to scope the improvement plan. An external review was also undertaken which focused on risks, consequences and the patient experience.

These reviews highlighted three key themes which were digital/technology, user issues and capacity and demand. The External review also supported the expansion of the Outpatient Transformation programme. The Risk register was updated as a result of the findings and the booking centre was restructured to maximise capacity.

An outpatient action plan has been shared across the organisation and leads have been identified with a deadline of the end of March 2020 – actions will be audited to ensure they

are embedded. The Chief Operating Officer has presented the identified themes to both commissioner Governing Bodies.

AN challenged that these are not new issues and have been discussed at The Health Informatics Executive Board who had been reviewing 100 outstanding issues and over 60 have been on the list for over 100 days. The Director of Operations explained the Trust is scoping a new way of working with the booking and directorate teams and has a task and finish group to address the action plan to understand how green actions are monitored and embedded. The Trust is a field site nationally for EPR for the elective care standard and there is an overlap with the backlog of issues.

AG highlighted that equality impact assessment states there are no clear links to any protected characteristics and suggested vulnerable groups may be differentially affected and that assurance should be sought that vulnerable groups are not being overlooked. The Chief Executive shared his concern about the impact on elderly and frail patients that require support to attend appointments and patients attending on the wrong site.

Action: Review the impact of the outpatient improvement plan on vulnerable groups - Chief Operating Officer / Director of Operations, FSS

KH raised concern with the actions RAG rated red and explained this is not reported to Quality Committee as it is reviewed at Executive Board. The Director of Nursing asked for clarity on the governance and oversight to ensure there are no patients missed to a follow up or come to harm as a result and she suggested an in-depth de-brief takes place to embed learning. The Director of Nursing added Outpatients see the most patients as a core service and should be seen as important as ED.

Action: Executive Directors to review which Board Committee should have oversight for monitoring progress with the outpatient improvement plan

The Chief Executive was optimistic about understanding the scale of the problem and stated the Trust is being open and transparent and comfortable describing the reality which is a common issue across all Trusts and the opportunity this gives the Trust to accelerate the Outpatient transformation programme.

The Chair asked the Executive team to keep the Board informed.

OUTCOME: The Board **NOTED** the Outpatient improvement report and a further update will be provided in January 2020.

126/19 Integrated Performance Report – September 2019

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

- September's performance score is 74% with three green domains
- Positive performance in essential safety training (EST)
- Trust's 62-day RTT performance for the first half of the year is one of the best nationally
- Sickness levels remain green

AN asked if the 38-day referral are small numbers or if this is a challenging target. The Associate Director of Performance responded this is a combination of small numbers and reliance on other organisations transfer of care, e.g. Leeds.

RH highlighted the positive news that the Trust's key performance indicators was reported as being number 3 out of 112 Trusts.

OUTCOME: The Board **NOTED** the Integrated Performance Report and overall performance score for September 2019.

127/19 Update from sub-committees and receipt of minutes & papers

Finance and Performance Committee – minutes from the meeting 27.9.19

RH provided an update from the last meeting held on 1.11.19, the key points to note in addition to those already covered in the meeting were:

- Prof Tim Briggs – exemplar site for GIRFT (Getting it Right first time)
- First Transformation Committee meeting will Chaired by Peter Wilkinson on Monday 11 November 2019
- Discussion regarding the timetable for approval of the strategic outline case

Audit & Risk Committee – verbal update from meeting held on 30.10.19

RH provided an update from the last meeting held on 30.10.19, the key updates were:

- Approved the Board Assurance Framework, approved at Board in September
- Approved the recommended changes to the standing orders of the Council of Governors and Board
- Approved the revised Treasury Management policy
- Approved bad debt write-offs relating to £58k relating to overseas patients, there is a large debt outstanding for overseas visitors
- Risk management review over the year including review of high level risk register and benchmarking of the BAF
- Internal audit concerns regarding outstanding overdue actions (Gosport review and charitable funds, a new Fundraising Manager is now in place)
- Internal Audit progress reports - 1 limited assurance report around Medical Division governance, RH suggested this is a wider issue and is under review
- Self-effectiveness review and action plan

Quality Committee – minutes from the meeting held 3.9.19

LP, Chair of the Quality Committee provided an update from the last meeting. The key points to note were the focus on medication compliance and ongoing complaints

Workforce Committee – minutes from the meetings held 7.10.19

KH, Chair of the Workforce Committee provided an update from the last meeting.

- Made considerable progress recruiting more nurses from the Philippines
- Clinical recruitment is progressing well, including healthcare scientists
- Hot House event to promote the staff survey
- The Chief Executive asked about pastoral support for international nursing colleagues, KH confirmed support teams are arranged with recommended accommodation and a network is set up for colleagues, feedback received is positive
- AN recognised the positive statistics on workforce performance, two key strategies were discussed on recruitment and leadership development which will be presented to the Board in January 2020
- The Cupboard strategy will come back to Board

Council of Governors meeting – minutes from the meeting held 17.10.19

The Chair provided an update from the last meeting:

- Currently in the process of appointing a lead governor to conclude on 19 November 2019
- Reviewed Trust Constitution and approved recommended changes
- Ratified the appointments of Denise Sterling and Peter Wilkinson, Non-Executive Directors

Charitable Funds Committee – minutes from the meeting held 23.8.19

The Chair provided a verbal update from the last meeting held on 6.11.19:

- Positive report from external auditors
- Fundraising Manager is making positive process
- All processes were double checked and confirmed by the external auditor
- Name of the charity is 'Calderdale and Huddersfield NHS Charitable Funds'
- Medical Director added there is work to clarify what is suitable for funding and a structure
- Fundraising Manager has benchmarked against other organisations

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

128/19 Governance Report

The Company Secretary presented the Governance Report for November 2019. The key documents to note were:

- Constitution and standing orders have been reviewed with the governors and approved at the Council of Governors on 17 October 2019. The Audit and Risk Committee on 30 October 2019 reviewed the Standing Orders and the Board was asked to approve the changes
- The new Deputy Chair and Senior Independent Non-Executive Director will be Richard Hopkin from January 2020 as Phil Oldfield's tenure ends at the end of December 2019
- Updated Board of Directors workplan for 2020/21 was presented for review
- The Trust seal has been used seven times in the last quarter, five documents were related to the sale of the St Luke's hospital site

AN explained the Director of Infection Prevention Control report and learning from deaths report undergo scrutiny at the Quality Committee and suggested these are reported less often at the Board or on an annual basis. The Chief Executive raised a concern that if performance was to slip the Board would not have sight of the risk. AN suggested the Board need to ensure mechanisms are in place to escalate clearly from the sub-committees. The Director of Nursing was uncomfortable with removing these updates from the annual cycle of the Board.

OUTCOME: The Board **APPROVED** the changes to the Trust constitution and standing orders, the Board of Directors workplan for 2020/21 and **NOTED** the appointment of Deputy Chair / Senior Independent Director from January 2020 and use of the Trust Seal in the last quarter.

129/19 Any Other Business

AN suggested feedback is shared by the Non-Executive Directors and Executive Directors from 'back to the floor' week which was very eye opening. The Chief Executive suggested feedback is also shared by the staff on the floor.

Action: Experience from 'back to the floor' week to be shared at a future Board workshop – Company Secretary

LP formally thanked the Board for all their support, which she explained helped her in her role as Non-Executive Director at the Trust.

Date and time of next meeting
Date: Thursday 9 January 2020
Time: 9:00 – 12:30 pm
Venue: Boardroom, Huddersfield Royal Infirmary

The Chair closed the meeting at 12:17 pm.

5. Action log and matters arising

To Note

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 23 Dec 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
7.11.19 129/19	**AOB** Experience from 'back to the floor' week to be shared at a future Board workshop	AM	Scheduled for 2 April 2020	January 2020		
7.11.19 125.19	**Outpatient Improvement – EQIA** Assess the impact of the outpatient improvement plan on vulnerable groups Executive Directors to review which Board Committee should have oversight for monitoring progress with the outpatient improvement plan	HB/Caroline Gizzi Executive Directors	Agreement that ongoing monitoring of progress with the outpatient improvement plan will take place at the Quality Committee and not required on the Board agenda	January 2020		Dec 19
7.11.19 119/19	**Q2 Quality Report** Circulate the Patient Flow and Emergency Care Standards Improvement Plan presentation from Finance and Performance Committee to Non-Executive Directors	AM	Circulated. Action closed.	November 2019		Nov 19
7.11.19 114/19	**Chief Executive Update – 'Purdah'** Latest NHS England/Improvement (NHSE/I) Guidance on the General Election to be circulated to the Board	AM	Circulated. Action closed.	November 2019		Nov 19
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		7.11.19

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 23 Dec 2019 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
4.7.19 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 11 July 2019	September 2019		11.7.19.
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

To Note

Presented by Philip Lewer

7. Chief Executive's Report

(a) West Yorkshire and Harrogate Health and Care Partnership Memorandum of Understanding

To Note

Presented by Owen Williams

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU)
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Owen Williams, Chief Executive
Previous Forums:	West Yorkshire & Harrogate Partnership Board, 3 December 2019.

Actions Requested:
To approve the revised West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU)

Purpose of the Report

To present the first annual review of the West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU) and approve a revised MoU recommended to the Board for approval following agreement at the Partnership Board on 3 December 2019.

Key Points to Note

The West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU), which formalises ways of working across West Yorkshire and Harrogate, was signed off by all partners in December 2018.

To ensure the MoU meets the evolving requirements of the Partnership as an Integrated Care System an annual review of the MoU takes place. The first annual review has been completed and signed off by the Partnership Board on 3 December 2019 and is enclosed.

The substantive amendments to the MoU are detailed in the attached paper. In brief these relate to:

- Addition of arrangements for involving patients and the public, the role of the voluntary and community sector, the revised priorities in the five year plan and references to the role of the Primary Care Networks
- Partnership governance: addition of a summary of the role of the Quality Surveillance Group, the addition of the Finance Forum and a revised partnership governance schematic
- Decision making and resolving disagreements – updated terms of reference to allow for the Partnership Board to delegate urgent decisions and addition of a table summarising the roles and responsibilities of each Partnership Governance forum.

Enclosed with this report is:

- First annual review of the West Yorkshire and Harrogate Health and Care Partnership MoU
- Final revised MOU for approval

EQIA – Equality Impact Assessment

This MoU for the West Yorkshire and Harrogate Health and Care Partnership confirms the commitment of partners to work together to tackle health inequalities, including treating and preventing ill health as well as tackling the wider determinants of health.

Recommendation

The Board is asked to:

(i) approve the revised West Yorkshire & Harrogate Health and Care Partnership Memorandum of Understanding (MoU)
(ii) authorise the Chief Executive to sign the final version of the MoU

West Yorkshire and Harrogate
Health and Care Partnership

Summary report	
Item:	**First annual review of the Partnership Memorandum of Understanding**
Report author:	Stephen Gregg, Governance Lead, WY&H Health and Care Partnership

Executive summary

Following extensive engagement, the Partnership Memorandum of Understanding (MoU) was signed off by all partners in December 2018. The MoU describes how we organise ourselves at West Yorkshire & Harrogate level to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve. The MoU includes a requirement that it is reviewed within its first year of operation and then annually, to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System (ICS).

The MoU formalised many of our existing ways of working, such as the System Leadership Executive and the programme approach to delivery. It also established a number of new arrangements, including the Partnership Board, System Oversight and Assurance Group (SOAG), peer review process and mutual accountability framework.

Twelve months on, many of these arrangements are still in the process of 'bedding in'. In view of this, the WY&H System Leadership Executive agreed that the first review should take a 'light touch' approach, focusing on:

- Learning to date from operationalising the MoU.
- Changes in Partnership arrangements which should be reflected in the MoU.
- A gap analysis against the NHS Long Term Plan expectations for ICSs as set out in the Plan, the Implementation framework and the ICS maturity matrix.

The review found that the Partnership's arrangements align well with the NHS Long Term Plan expectations and most of the proposed changes to the MoU are administrative in nature. The main substantive changes proposed are to:

- reflect the revised priorities and programmes set out in the Partnership's five year plan.
- highlight the Partnership's arrangements for involving patients and the public.
- recognise the establishment of the Finance Forum and the Quality Surveillance Group.

At its meeting on 3rd December 2019, the Partnership Board noted the review findings and approved the revised MoU for agreement by individual Partners. The revised MoU is attached at **Annex A**. It is proposed that a more comprehensive review is carried out in Autumn 2020.

First annual review of the Partnership Memorandum of Understanding

Introduction

1. This report sets out the findings of the first annual review of the Partnership Memorandum of Understanding (MoU).

2. Following extensive engagement, the Partnership MoU was signed off by all partners in December 2018. The MoU describes how we organise ourselves at West Yorkshire & Harrogate level to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

3. The MoU includes a requirement that it is reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. Following that, it will be subject to an annual review by the Partnership Board

Approach

4. The MoU formalised many of our existing ways of working, such as the System Leadership Executive and the programme approach to delivery. It also established a number of new arrangements, including the Partnership Board, System Oversight and Assurance Group (SOAG), peer review and mutual accountability framework. Many of these arrangements are still in the process of 'bedding in' and the WY&H System Leadership Executive agreed at its meeting on 5th November that the first review of the MoU take a 'light touch' approach and be followed by a more comprehensive review in Autumn 2020.

5. The review was been carried out by seeking comments on the MoU from a representative group of partners from across our places, sectors and programmes. Staff from the Partnership core team supplemented this with a 'desk top' review.

6. The review focused on:
   - Learning to date from operationalising the MoU.
   - Changes in Partnership arrangements which need to be reflected.
   - The NHS Long Term Plan expectations for Integrated Care Systems as set out in the Plan itself, the Implementation framework and the ICS maturity matrix.

7. The next section presents the findings of the review against each of the main chapters of the MoU and includes comments by the Partnership Board at its meeting on 3rd December 2019.

Introduction and context

8. This section sets out the context for Partnership working and includes the following key paragraph:

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

9. The context for why we work as a Partnership remains unchanged, as does our commitment to promote integration and collaboration.

Substantive amendments to the MoU
• *None.*

How we work together in WY&H

10. This section outlines the Partnership's vision, values and leadership principles together with its objectives and approach to delivery improvement.

11. The Partnership's broad vision and values and its approach to leadership remain unchanged and continue to guide all of our arrangements. To support delivery improvement, the 'check and confirm' process has been established successfully and has sought to ensure rigour and delivery focus in all of our programmes.

12. The Partnership's ambitions for improving health outcomes have been reviewed as part of the development of our five year plan and we will have a refreshed set of objectives once the plan has been formally agreed.

13. The Partnership team carried out a gap analysis of the Partnership's arrangements against the expectations for ICSs as set out in the Long Term Plan, the Implementation framework and the ICS maturity matrix. The analysis showed that the Partnership's arrangements align well with the NHS Long Term Plan expectations, but that the MoU did not include a clear enough statement of the Partnership's approach to involving patients, service users and the public and the role of key governance groups in this. There is also a need to recognise Primary Care Networks in the MoU.

14. Discussion at the Partnership Board highlighted the need to recognise the role of the voluntary and community sector in the MoU.

Substantive amendments to the MoU

- *Arrangements for involving patients and the public added at paragraphs 3.4–3.8. New responsibility added to Terms of Reference of Partnership Board (3.1.iii) and System Leadership Executive (3.1.ii).*
- *Paragraphs 3.9-3.10 outline the role of the voluntary and community sector.*
- *Paragraph 3.12 reflects the revised priorities set out in the five year plan.*
- *References to the role of Primary Care Networks added at 2.9 and 4.32.*

Partnership Governance

15. This section formalises the governance arrangements at place, programme, sector and Partnership level, including the role of groups such as the System Leadership Executive, Clinical Forum and sector collaborative forums. It also established the Partnership Board and System Oversight and Assurance Group (SOAG) as new forums.

16. The Partnership Board had its first meeting in June 2019 and the SOAG in October 2018. Whilst these governance structures are the right ones to meet our Partnership's needs, at this relatively early stage there is still work to do to refine how they operate in practice. To inform a more comprehensive review of the operation of the MoU in Autumn 2020, it is proposed that each Partnership governance forum will undertake a self-assessment.

17. The Finance Forum was established in 2019 to replace the Directors of Finance group and strengthen the governance of financial matters. The MoU has been updated to reflect this. The WY&H Quality Surveillance Group (QSG) convened by NHS England, has been established to bring together a range of partners from across the health and care system, to share intelligence about risks to quality. NHS England and NHS Improvement came together to act as a single organisation in April 2019. The MoU has been updated to reflect these organisational and administrative changes.

Substantive amendments to the MoU

- *Summary of the role of the Quality Surveillance Group added at paragraph 4.27.*
- *Paras 4.28-4.31 added to reflect the establishment of the Finance Forum.*
- *Partnership governance schematic at Annex 2 updated to reflect revised structures.*

Mutual accountability framework

18. This section establishes a consistent approach for assurance and accountability between partners on WY&H system-wide matters.

19. The agreed approach has been operationalised by monitoring performance against key standards and plans in each place and across programmes. The arrangements for ensuring this include SOAG, Peer Review and the check and confirm process.

20. As with wider Partnership governance, these arrangements are still 'bedding' in and work is ongoing to ensure that they operate effectively in practice.

Substantive amendments to the MoU

- *None.*

Decision making and resolving disagreements

21. This section sets out the Partnership's overall approach to making decisions, following the principle of subsidiarity. It also sets out the Partnership's dispute resolution process. The Partnership Board aims to make decisions by consensus. The Chair will seek to resolve the disagreement, but if a consensus decision cannot be reached, the matter will be referred to the dispute resolution process. Financial matters will be decided on a 75% majority vote.

22. Comments from some partners and questions from members of the public have highlighted a lack of clarity about the relationship between the Board, other Partnership forums and statutory organisations. Discussion at the September Partnership Board on transformation funding highlighted the lack of an agreed mechanism for taking urgent decisions in between meetings of the Board.

Substantive amendments to the MoU

- *Partnership Board Terms of Reference updated to make provision for the Board to delegate urgent decisions (5.4).*
- *Table appended to the MoU at Annex 3, which summarises the roles and responsibilities of each Partnership governance forum and sits alongside the Partnership governance schematic at Annex 2.*

Financial Framework

23. The establishment of the Finance Forum has strengthened financial management arrangements and is reflected in paras 4.28-4.31.

Substantive amendments to the MoU

- *None.*

West Yorkshire and Harrogate
Health and Care Partnership

Memorandum of Understanding

December 2019

Version 2 20.12.19

Contents

Foreword

Since the creation of West Yorkshire and Harrogate Health and Care Partnership in March 2016, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 2.7 million people living in our area.

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

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

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

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

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

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

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

1. Parties to the Memorandum

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

Local Authorities

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

NHS Commissioners

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

NHS Service Providers

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

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

Heath Regulator and Oversight Bodies

- NHS England and NHS Improvement

Other National Bodies

- Health Education England
- Public Health England

Other Partners

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

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

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

Definitions and Interpretation

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

Term

1.5. This updated Memorandum replaces the previous version agreed by partners in December 2018 and shall commence on the date of signature of the partners. It will be subject to an annual review by the Partnership Board to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System.

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

Local Government role within the partnership

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

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

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

Partners in Local Places

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

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

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

2. Introduction and context

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

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

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

2.4. We published our high level proposals to close the health, care and finance gaps that we face in November 2016. In January 2020 we will agree our five year plan, setting out our ambitions for the next five years. We have already made significant progress to build our capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our aims.

Purpose

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

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

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

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

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

2.8. The Memorandum should be read in conjunction with the Partnership five year Plan, due to be agreed in January 2020, and the six local Place plans across West Yorkshire and Harrogate.

Developing new collaborative relationships

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

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

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

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

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

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

Promoting Integration and Collaboration

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

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

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

3. How we work together in West Yorkshire and Harrogate

Our vision

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

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

Overarching leadership principles for our partnership

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

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

Our shared values and behaviours

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

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

Involving the public

3.4. We are committed to meaningful conversations with people and value highly the feedback that people share with us. Effective public involvement, particularly with those with lived experience and who are seldom heard, ensures that we make the right decisions together about our health and care services.

3.5. We use a wide range of ways to involve the public. These include public and patient reference groups, engagement events, independent co-opted members on our Partnership Board, lay members on our Programme Boards and community champions. We seek assurance about the effectiveness of public and patient involvement in our decisions through the co-opted members on our Partnership Board and other mechanisms, including the Joint Committee of CCG's Patient and Public Involvement Assurance Group.

3.6. We are committed to learning from and refining our approach to involving people; we want to understand the best ways to engage with people and we consistently challenge ourselves to improve. We aim to involve people and understand their perspectives at the earliest possible point when taking decisions, as people have the greatest scope to influence the change if their views are considered from the outset

3.7. We aim to learn from feedback from all our communications and engagement networks without duplicating effort and cost. We publish on our website information about all of the involvement and engagement activity that we have been involved in, and are planning.

3.8. Our communications and engagement plan, involvement framework and digital strategy are available on our website at: https://www.wyhpartnership.co.uk/engagement-and-consultation.

The voluntary and community sector

3.9. The voluntary and community sector (VCS) is an important part of our Partnership, working across all our places and programmes of work. The Harnessing the Power of Communities (HPOC) programme acts as the co-ordinating point and provides a strong voice into the Partnership.

3.10. The HPOC Group includes infrastructure organisations from each of our 6 places. These organisations connect into the much wider and diverse voluntary and community sector.

Partnership objectives

3.11. Our ambitions for improving health outcomes, joining up care locally, and living within our financial means were set out in our STP plan (November 2016, available at: https://wyhpartnership.co.uk/meetings-and-publications/publications). This Memorandum reaffirms our shared commitment to achieving these ambitions and to the further commitments made in *Next Steps for the West Yorkshire and Harrogate Health and Care Partnership*, published in February 2018 and the Partnership 5 Year Plan, due to be agreed in January 2020 .

3.12. We have agreed the following big ambitions for our Partnership:

- increase the years of life that people live in good health and reduce the gap in life expectancy by 5% in our most deprived communities by 2024.
- reduce the gap in life expectancy for people with mental ill health, learning disabilities and autism by 10% by 2024.
- reduce health inequalities for children living in households with the lowest incomes, including halting the trend in childhood obesity.
- increase early diagnosis of cancer, ensuring at least 1,000 more people have the chance of curative treatment.
- reduce suicide by 10% overall by 2020/21 and achieve a 75% reduction in targeted areas by 2022.
- reduce anti-microbial resistance infections by 10% by 2024, reducing antibiotic usage by 15%.
- reduce stillbirths, neonatal deaths, and brain injuries by 50%, and reduce maternal morbidity and mortality by 2025.
- have a more diverse leadership that better reflects the broad range of talent in our area.
- become a global leader in responding to the climate emergency.
- strengthen local economic growth by reducing health inequalities and improving skills.

i. To enable these transformations, we will work together to:

- Secure the right workforce, in the right place, with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff,
- Engage our communities meaningfully in co-producing services,

- Use digital technology to drive change, ensure systems are inter-operable, and create a 21st Century NHS,
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the strategic capital and estates plans across West Yorkshire and Harrogate, maximising all possible funding sources and ensuring our plans support the delivery of our clinical strategy,
- Strengthen leadership and organisational development, and;
- Develop our commissioning arrangements.

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

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

iv. Act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

Delivery improvement

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

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

3.14. Each programme has undergone a peer review 'check and confirm' process to confirm that it has appropriate rigour and delivery focus.

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

4. Partnership Governance

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

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

4.3. A schematic of our governance and accountability relationships is provided at **Annex 2,** a summary of the roles and responsibilities of the Partnership Board, System Leadership Executive, System Oversight and Assurance Group, Clinical Forum and Finance Forum is provided at **Annex 3** and their terms of reference at **Annex 4**.

Partnership Board

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

4.5. The Partnership Board is made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils and senior representatives of other relevant Partner organisations, including the voluntary and community sector. It also has four independent co-opted members. The chair of the Partnership Board will be a chair of a Health and Wellbeing Board, and the vice-chair will be nominated from among the chairs of NHS bodies. It will meet at least four times each year in public.

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

System Leadership Executive

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

4.8. Each organisation is represented by its chief executive or accountable officer. Members of the SLE are responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE are expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

4.9. The System Oversight and Assurance group (SOAG) provides a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It:

- is chaired by the Partnership Lead;
- includes representation covering each sector / type of organisation;
- regularly reviews a dashboard of key performance and transformation metrics; and
- receives updates from WY&H programme boards.

4.10. The SOAG is supported by the Partnership core team.

West Yorkshire and Harrogate programme governance

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

4.12. Programmes provide regular updates to the System Leadership Executive and System Oversight and Assurance Group.

Other governance arrangements between Partners

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

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

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

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

4.16. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs. To provide assurance about the effectiveness of public and patient involvement in its commissioning decisions, the Joint Committee has established a Patient and Public Involvement Assurance Group.

West Yorkshire Association of Acute Trusts Committee in Common

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

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

West Yorkshire Mental Health Services Collaborative

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

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

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

Local council leadership

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

- Local authority chief executives meet and mandate one of them to lead on the health and care partnership;
- Health and Wellbeing Board chairs meet;
- A Joint Health Overview and Scrutiny Committee
- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

Clinical Forum

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

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

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

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

Quality Surveillance Group

4.27. The WY&H Quality Surveillance Group (QSG) brings together a range of partners from across the health and care system, to share intelligence about risks to quality. Convened by NHS England, the QSG is a supportive forum for collaboration and intelligence sharing. By triangulating intelligence from different organisations, it provides the health economy with a shared view of risks to quality, and opportunities to coordinate actions to drive improvement. Members of the QSG include CCGs, Councils, Healthwatch, CQC, PHE, and HEE. It covers all NHS-commissioned services, and services jointly commissioned by the NHS and Councils.

Finance Forum

4.28. The Finance Forum has been established to strengthen financial governance and leadership for the Partnership. Financial leadership is built into each of our work programmes and governance groups, and our Finance Forum provides financial advice to all of our programmes.

4.29. The Finance Forum leads on enabling the Partnership to deliver the financial principles that are set out in paragraphs 7.1-7.3. It is the primary forum for financial leadership, advice and challenge and will support the Partnership Board and System Leadership Executive Group to lead and direct the Partnership. It will also support the System Oversight and Assurance Group to ensure robust mutual financial accountability across the Partnership.

4.30. The Finance Forum is a forum for sharing knowledge and intelligence. It works by building agreement with financial leaders across Partner organisations to drive action around a shared direction of travel.

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

Local Place Based Partnerships

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

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

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

5. Mutual accountability framework

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

Current statutoryrequirements

5.2. NHS England and NHS Improvement were brought together to act as one organisation in 2019, but each retains its statutory responsibilities. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

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

A new model of mutual accountability

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

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

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

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

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

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

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

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

Taking action

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

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- co-ordination of formal intervention and improvement support; and
- agreement of restrictions on access to discretionary funding and financial incentives.

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

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;

  co-ordination of formal intervention and improvement support;

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

The role of Places in accountability

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

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

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

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

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

Implementation of agreed strategic actions

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

National NHS Bodies oversight and escalation

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

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

6. Decision-Making and Resolving Disagreements

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

Collective Decisions

6.2. There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- **Decisions delegated to collaborative forums** - some partners have delegated specific decisions to a collaborative forum, for example the CCGs have delegated certain commissioning decisions to the Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the respective Joint Committee and not this Memorandum. There are also specific dispute resolution mechanisms for WYATT and the WYMHC.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in Paragraphs 6.3-6.5 below.

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

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

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

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

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

Dispute resolution

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

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

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

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

6.10. The key stages of the dispute resolution process are

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

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

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

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

7. Financial Framework

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

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

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

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

Living within our means and management of risk

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

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

NHS Contracting principles

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

Allocation of Transformation Funds

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

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

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

Allocation of ICS capital

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

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

Allocation of Provider and Commissioner Incentive Funding

7.11. The approach to managing performance-related incentive funds set by NHS planning guidance and business rules is not part of this Memorandum. A common approach to this will be agreed by the Partnership as part of annual financial planning.

8. National and regional support

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

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

9. Variations

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

10. Charges and liabilities

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

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

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

11. Information Sharing

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

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

12. Confidential Information

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

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

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

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

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

13. Additional Partners

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

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

14. Signatures

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

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

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

Kersten England
Chief Executive

Robin Tuddenham
Chief Executive

Paul Shevlin
Chief Executive

Wallace Sampson
Chief Executive

Jacqui Gedman
Chief Executive

Tom Riordan
Chief Executive

Richard Flinton
Chief Executive

Merran McRae
Chief Executive

Helen Hirst
Accountable Officer

Matt Walsh
Accountable Officer

Carol McKenna
Accountable Officer

Amanda Bloor
Accountable Officer

NHS Leeds Clinical Commissioning Group

Tim Ryley
Accountable Officer

NHS Wakefield Clinical Commissioning Group

Jo Webster
Accountable Officer

NHS Airedale NHS Foundation Trust

Brendan Brown
Chief Executive

NHS Bradford District Care NHS Foundation Trust

Brent Kilmurray
Chief Executive

NHS Bradford Teaching Hospitals NHS Foundation Trust

Mel Pickup
Chief Executive

NHS Calderdale and Huddersfield NHS Foundation Trust

Owen Williams
Chief Executive

NHS Harrogate and District NHS Foundation Trust

Steve Russell
Chief Executive

NHS Leeds and York Partnership NHS Foundation Trust

Sara Munro
Chief Executive

NHS Leeds Community Healthcare NHS Trust

Thea Stein
Chief Executive

NHS The Leeds Teaching Hospitals NHS Trust

Julian Hartley
Chief Executive

NHS The Mid Yorkshire Hospitals NHS Trust

Martin Barkley
Chief Executive

NHS South West Yorkshire Partnership NHS Foundation Trust

Rob Webster
Chief Executive

Colin Martin
Chief Executive

Rod Barnes
Chief Executive

Karen Jackson
Chief Executive

Richard Stubbs
Chief Executive

Anthony Kealy
Locality Director, NHS England and NHS Improvement

Mike Curtis
Local Director, Yorkshire & the Humber

Mike Gent
Deputy Director

Gary Jevon
Chief Officer, Wakefield

Sarah Hutchinson
Manager

Helen Hunter
Chief Executive

Hannah Davies, **Chief Officer**
Dr John Beal, **Chair**

Nigel Ayre,
Operations Manager

Schedule 1 - Definitions and Interpretation

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

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

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

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

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

Glossary of terms and acronyms

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

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

GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Paragraph 1.1
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better.
HWB	Health and Wellbeing Board
ICS	Integrated Care System
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and "Laws" shall be construed accordingly
LWAB	Local Workforce Action Board sub regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	One of c.50 geographical areas which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people.
NHS	National Health Service
NHSE and NHSI	NHS England (formally the NHS Commissioning Board and NHS Improvement (the operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions) now working together as a single organisation.
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS

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

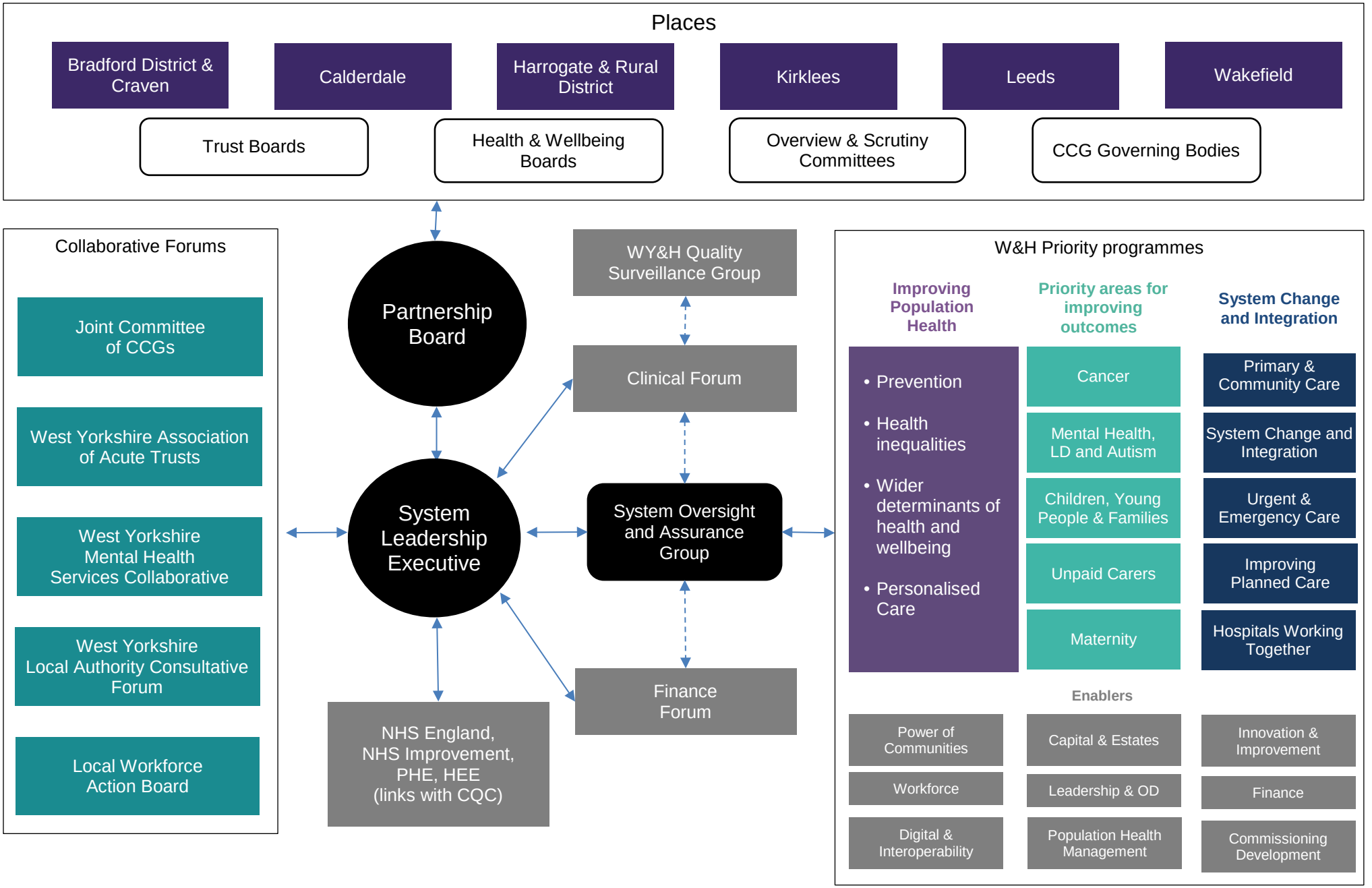
Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association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

Annex 1 – Applicability of Memorandum Elements

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

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

Annex 2 – Schematic of Governance and Accountability Arrangements



Annex 3 Partnership governance forums – roles and responsibilities

Issue	Roles and responsibilities	Partnership Board	System Leadership Executive Group	System Oversight and Assurance Group	Clinical Forum	Finance Forum
Strategy and planning	Agree broad objectives for the Partnership.	✓				
Strategy and planning	Agree the objectives of priority Partnership work programmes and work streams.	✓	Recommend		Recommend	
Strategy and planning	Executive responsibility for delivery of the Partnership plan.		✓			
Mutual accountability	Oversee a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners.	✓	✓	✓		Support development and implementation
Mutual accountability	Overview of system performance and transformation at whole system, place and organisation levels. Overview of programme delivery.			✓	Support through review	Oversee, scrutinise and monitor financial performance
Mutual accountability	Lead the development of a dashboard of key performance, quality and transformation metrics for the Partnership			✓		
Mutual accountability	Receive reports from WY&H programmes and workstreams on issues which require escalation. Develop and maintain connections with other key groups			✓		
Mutual accountability	Lead the development of a framework for peer review and support and oversee its application.			✓		
Mutual accountability	Reach agreement in relation to recommendations made by other governance groups within the Partnership on the need to take action in relation to managing collective performance, resources and the totality of population health.	✓	✓ (or Recommend to Board, depending on circumstances)	Recommend	Recommend	Recommend
Mutual accountability	Agree common actions when systems become distressed.	✓	Recommend			Develop financial frameworks

Issue	Roles and responsibilities	Partnership Board	System Leadership Executive Group	System Oversight and Assurance Group	Clinical Forum	Finance Forum
Health improvement	Build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for healthcare services.		✓			
Health improvement	Ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.	✓	✓	✓	✓	✓
Clinical Leadership	Lead the development of a clinical strategy and narrative for WY&H. Ensure that all plans are clinically led, evidence based and improve patient outcomes Provide oversight and alignment of all clinical initiatives across WY&H Maintain and embed clinical co-production, support collaboration, exhibit clinical leadership, champion change and innovation, support transition to new models of care. Provide innovative solutions to system-wide challenges				✓ ✓ ✓ ✓ ✓	
Patient and public involvement	Ensure that the voice of patients, service users and citizens is heard and reflected in all plans.	✓ **NEW**	✓ **NEW**		✓	
Quality and safety	Ensure a robust framework for quality impact assessment of change is established and implemented				✓	
Quality and safety	Review system performance on the quality of health and care services and provide a mechanism for partner organisations to hold each other to account.				✓	

Issue	Roles and responsibilities	Partnership Board	System Leadership Executive Group	System Oversight and Assurance Group	Clinical Forum	Finance Forum
Finance	Oversee financial resources of NHS Partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget.	✓	Manage			Support
Finance	Agree the apportionment of transformation monies from national bodies.	✓	Recommend			Develop financial frameworks
Finance	Agree priorities for capital investment across the Partnership.	✓	Recommend			Develop financial frameworks
Finance	Agree the operation of the single NHS financial control total (for NHS bodies).	✓	Recommend			Develop financial frameworks
Finance	Action in relation to managing collective financial performance and resources					Develop financial frameworks
Finance	Ensure that Partnership plans are underpinned by robust financial evidence and support the financial sustainability of the health and care system					✓
Finance	Identify opportunities and risks relating to the financial sustainability of the health and care system					✓
Finance	Provide advice on the delivery of financial plans by Partnership programmes and contribute to the benefits realisation of each programme					✓

Issue	Roles and responsibilities	Partnership Board	System Leadership Executive Group	System Oversight and Assurance Group	Clinical Forum	Finance Forum
Finance	Provide advice on the deployment of financial management capacity, resources and expertise in support of Partnership programmes;					✓
Finance	Share best practice and provide advice on the delivery of efficiency gains and value for money improvements;					✓
Finance	Support the financial review of any proposals or business cases which have resource implications and require a decision by the Health and Care Partnership (either directly or through financial leadership at programme or place level)					✓
Partnership development	Act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.	✓	✓	✓	✓	✓
Partnership development	Support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place.	✓	✓	✓	✓	✓
Values and behaviours	Make joint decisions and resolve any disagreements by following the principle of subsidiarity, in line with the shared values and behaviours of the Partnership.	✓	✓	✓	✓	✓
Values and behaviours	Provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale.	✓	✓	✓	✓	✓

Annex 4 - Terms of Reference

The following sets of terms of reference for partnership governance groups are appended to this Memorandum:

- **Part 1: Partnership Board**
- **Part 2: System Leadership Executive**
- **Part 3: System Oversight and Assurance Group**
- **Part 4: Clinical Forum**
- **Part 5: Finance Forum - NEW**

West Yorkshire and Harrogate
Health and Care Partnership

Partnership Board

Terms of Reference

December
2019

Contents

1. Introduction and context

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

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

1.3. The Partnership Board is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

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

1.5. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.

1.6. The Partnership Board will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

1.7. These Terms of Reference describe the scope, function and ways of working for the Partnership Board. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

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

Principles for our partnership

2.2. The Partnership Board operates within an agreed set of guiding principles that shape everything we do through our Partnership:

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

Our shared values and behaviour

2.3. Members of the Partnership Board commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

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

3. Role and Responsibilities

3.1. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction and providing strategic oversight for all Partnership business. It will make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

i. agree the broad objectives for the Partnership;

ii. consider recommendations from the System Leadership Executive Group and make decisions on:

- The objectives of priority HCP work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership
- Operation of the single NHS financial control total (for NHS bodies)
- Common actions when systems become distressed

iii. ensure the voice of the patients, service users and citizens is heard and reflected in all plans

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

v. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;

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

vii. support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;

viii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;

ix. oversee a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;

x. reach agreement in relation to recommendations made by other governance groups within the Partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;

xi. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership.

4. Membership

4.1. The membership will comprise:

- A Chair, who will be a Health and Wellbeing Board chair
- the Partnership lead CEO
- CCG Clinical Chairs
- CCG Accountable Officers
- Chairs of Health and Wellbeing Boards of each Place
- A second elected member for each Council
- Council chief executives
- Chairs of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum
- Three representatives of the voluntary and community sector
- Four independent Co-opted members.

4.2. The Co-opted members will be a 'critical friend' to the Board and will provide independent, strategic challenge to the Partnership's work. In particular, they will champion the public, service user, patient and carer perspective, providing assurance that people's needs are at the centre of the Board's decisions. Co-opted members will be able to participate on all issues but will not have a vote.

4.3. A vice Chair will be agreed from among the chairs of NHS bodies.

4.4. A list of members is set out at **Annex 1**.

Deputies

4.5. If a member, other than a co-opted member, is unable to attend a meeting of the Partnership Board, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their organisation, place or group effectively. Deputies will be eligible to vote.

Additional attendees

4.6. Additional attendees will routinely include:

- The WY&H Partnership Director
- The WY&H Partnership Finance director.

4.7. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The Partnership Board will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The Partnership Board will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.2. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding set out at 5.3 below) it may be referred to the dispute resolution procedure under Paragraph 6.6 of the Partnership Memorandum of Understanding by any of the affected Partners for resolution.

5.3. In respect of priorities for capital investment or apportionment of transformation funding from the Partnership, then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members present at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote

5.4. By exception, and with its prior approval, the Partnership Board shall authorise members of the Board to take decisions on its behalf. The nature and scope of the delegation shall be recorded in the minutes and any such decisions shall be reported to the Board as its next meeting.

6. Accountability and reporting

6.1. The Partnership Board has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.

6.2. The Partnership Board has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements). The minutes, and a summary of key messages will be submitted to all Partner organisations after each meeting.

7. Conduct and Operation

7.1. The Partnership Board will meet in public, at least four times each year. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees and made available to the public no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any Partnership Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

7.8. The secretariat function for the Partnership Board will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

8.1. These terms of reference and the membership of the Partnership Board will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Annex 1 – Members

Health and Wellbeing Board Chairs

Bradford , Airedale and Wharfedale	✓
Calderdale	✓
Kirklees	✓
Leeds	✓
North Yorkshire	✓
Wakefield Council	✓

Local Authorities

	Leader	Chief Executive
City of Bradford Metropolitan District Council	✓	✓
Calderdale Council	✓	✓
Craven District Council	✓	✓
Harrogate Borough Council	✓	✓
Kirklees Council	✓	✓
Leeds City Council	✓	✓
North Yorkshire County Council	✓	✓
Wakefield Council	✓	✓

CCGs

	Chair	Accountable Officer
NHS Airedale, Wharfedale and Craven CCG	✓	✓
NHS Bradford City CCG	✓	✓
NHS Bradford Districts CCG	✓	✓
NHS Calderdale CCG	✓	✓
NHS Greater Huddersfield CCG	✓	✓
NHS Harrogate and Rural District CCG	✓	✓
NHS Leeds CCG	✓	✓
NHS North Kirklees CCG	✓	✓
NHS Wakefield CCG	✓	✓

NHS Service Providers

	Chair	Chief Executive
Airedale NHS Foundation Trust	✓	✓
Bradford District Care NHS Foundation Trust	✓	✓
Bradford Teaching Hospitals NHS Foundation Trust	✓	✓
Calderdale and Huddersfield NHS Foundation Trust	✓	✓
Harrogate and District NHS Foundation Trust	✓	✓
Leeds and York Partnership NHS Foundation Trust	✓	✓
Leeds Community Healthcare NHS Trust	✓	✓
The Leeds Teaching Hospitals NHS Trust	✓	✓
Locala Community Partnerships CIC	✓	✓
The Mid Yorkshire Hospitals NHS Trust	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓
Tees, Esk, and Wear Valleys NHS Foundation Trust	✓	✓
Yorkshire Ambulance Service NHS Trust	✓	✓

Heath Regulator and Oversight Bodies

NHS England	✓
NHS Improvement	✓

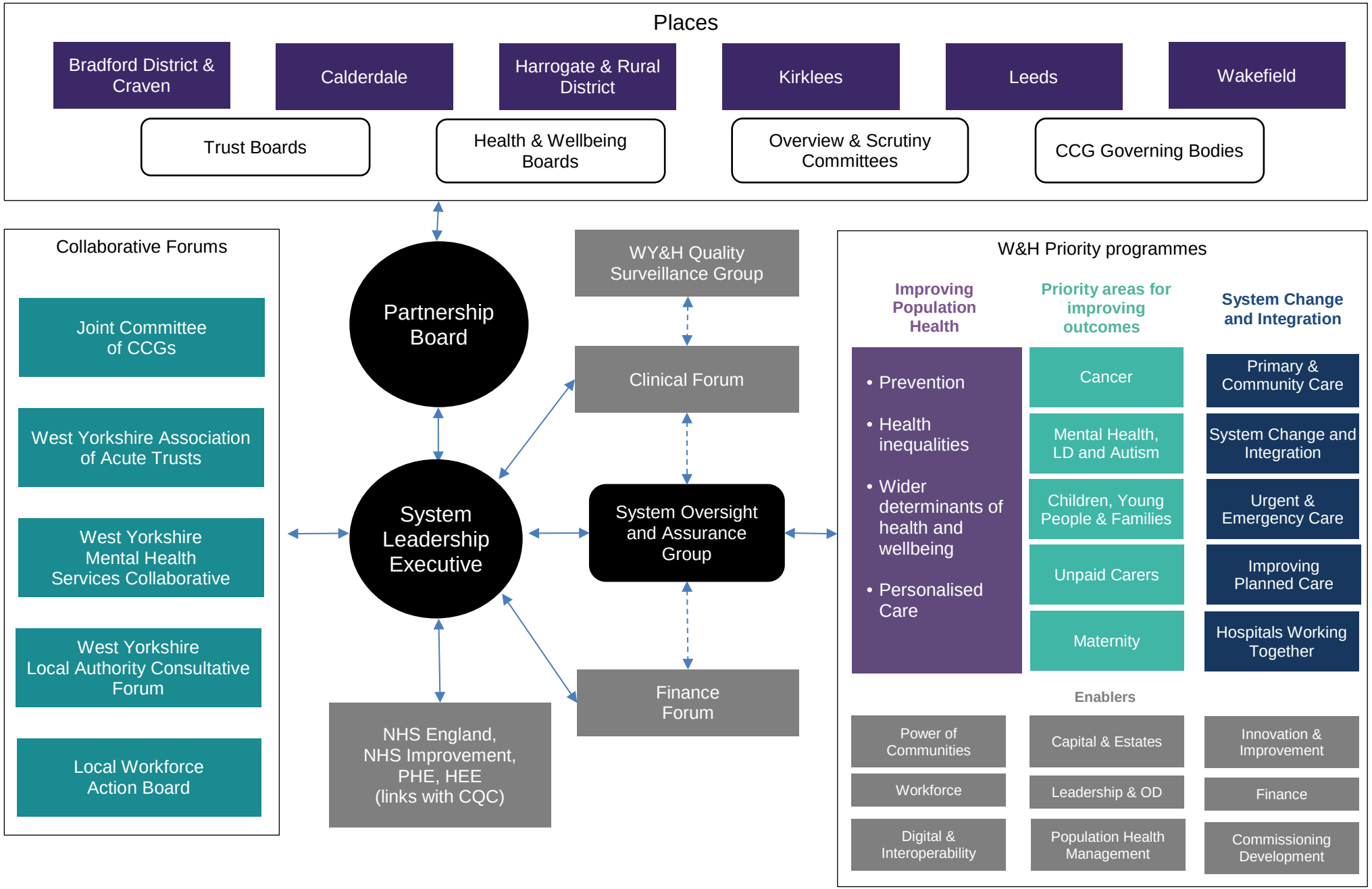
Other National Bodies

Health Education England	✓
Public Health England	✓

Other Partners

Healthwatch representative	✓
Yorkshire & Humber Academic Health Science Network	✓
Three representatives of the voluntary and community sector	✓
Four independent co-opted members	✓

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

System Leadership Executive Group

Terms of Reference

June 2018

Contents

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

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

1.3. The System Leadership Executive Group ('the Executive Group') is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

1.4. The Executive Group will support the Partnership Board to lead and direct the Partnership and will have overall executive responsibility for delivery of the Partnership plan.

1.5. The Executive Group will make decisions and recommendations to the Partnership Board on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum. .

1.6. The Executive Group has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.

1.7. The Executive Group will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

1.8. These Terms of Reference describe the scope, function and ways of working for the Executive Group. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

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

Principles for our partnership

2.2. The Executive Group operates within an agreed set of guiding principles that shape everything we do through our Partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible

  We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

Our shared values and behaviour

2.3. Members of the Executive Group commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

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

3. Role and Responsibilities

3.1. The Executive Group will take overall executive responsibility for delivery of the Partnership plan. It will make recommendations to the Partnership Board and make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

i. make recommendations to the Partnership Board on:

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

ii. ensure the voice of the patients, service users and citizens is heard and reflected in all plans

iii. progressively build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for healthcare services;

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

v. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;

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

vii. support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;

viii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;

ix. oversee the development and implementation of a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;

x. reach agreement in relation to recommendations made by other governance groups within the partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;

xi. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

4. Membership

4.1. The membership will comprise:

- A Chair – the partnership lead CEO
- CCG Accountable Officers
- Council chief executives
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum

4.2. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

Deputies

If a member is unable to attend a meeting of the Executive Group, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively. Deputies will be

eligible to vote.

Additional attendees

4.3. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.4. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The Executive Group will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The Executive Group will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.2. Members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus cannot be reached, then decisions will be made by 75% majority of the Group present and voting at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

6. Accountability and reporting

6.1. The Executive Group will be accountable to the Partnership Board, which provides the formal leadership of the WY&H Partnership. The Executive Group has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.

6.2. The Executive Group has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements). The minutes will be submitted to each meeting of the Partnership Board. The minutes, and a summary of key messages will also be submitted to all Partner organisations after each meeting.

7. Conduct and Operation

7.1. The Executive Group will normally meet monthly. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any Executive Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

7.8. The secretariat function for the Executive Group will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

8.1. These terms of reference and the membership of the Group will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Annex 1 – Members

Local Authorities

City of Bradford Metropolitan District Council	
Calderdale Council	
Craven District Council	
Harrogate Borough Council	
Kirklees Council	
Leeds City Council	
North Yorkshire County Council	
Wakefield Council	

NHS Commissioners

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

Healthcare Providers

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

South West Yorkshire Partnership NHS Foundation Trust	
Tees, Esk, and Wear Valleys NHS Foundation Trust	
Yorkshire Ambulance Service NHS Trust	

Heath Regulator and Oversight Bodies

NHS England	
NHS Improvement	

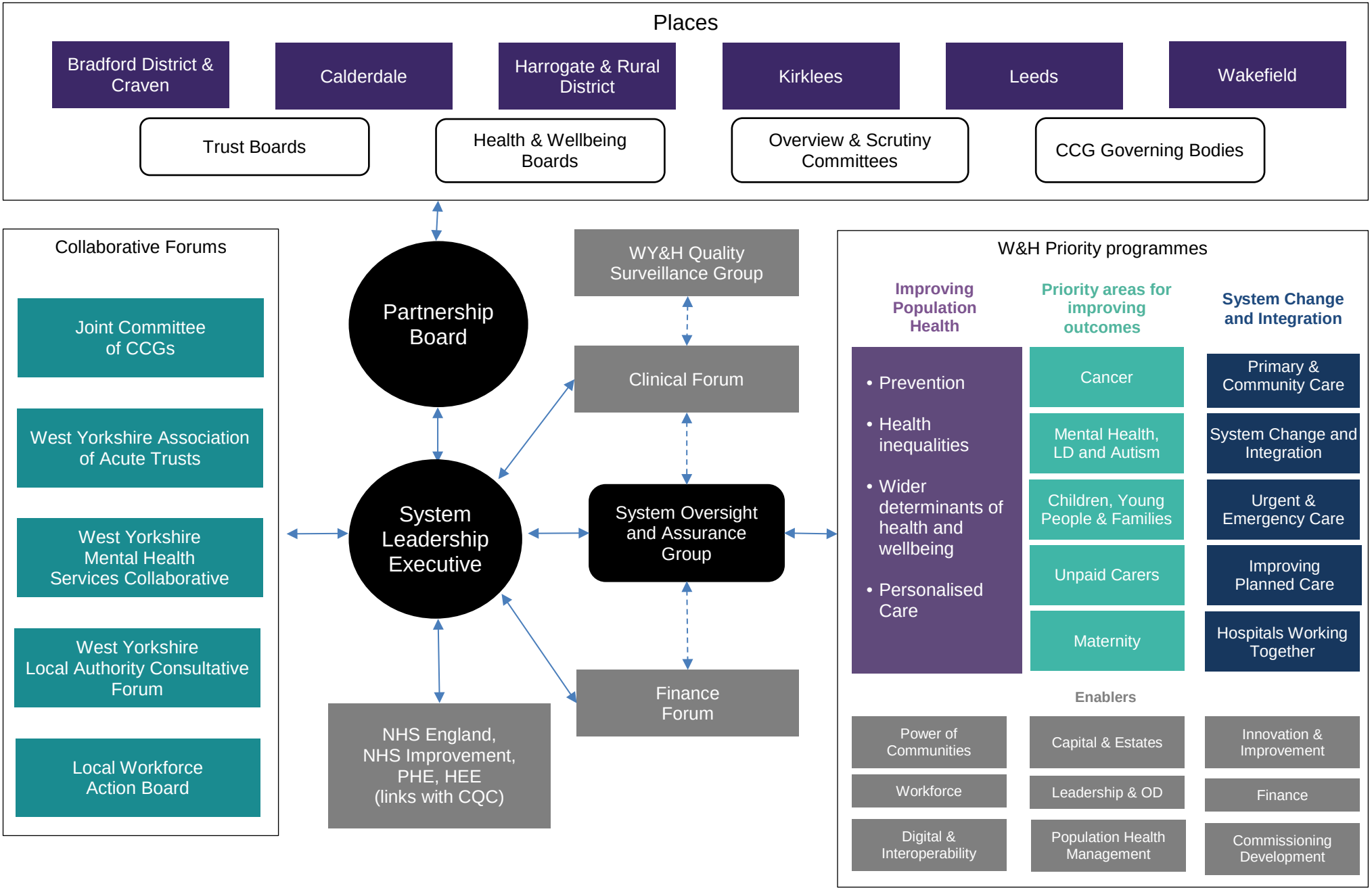
Other National Bodies

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

Other Partners

Clinical Forum Chair	
Healthwatch representative	
Yorkshire and Humber Academic Health Science Network·	

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

System Oversight and Assurance Group

Terms of Reference

October 2018

Contents

1. Introduction and context

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

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

1.3. The System Oversight and Assurance Group is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care partnership.

Purpose

1.4. The Partnership has agreed to adopt a new integrated approach to leading performance development and culture change, encompassing operational performance, quality and outcomes, service transformation, and finance.

1.5. This new approach will feature:

- a single framework, covering individual places, and West Yorkshire and Harrogate as a whole;
- an increasing focus on making judgements about a whole place, while understanding the positions of individual organisations;
- a strong element of peer review and mutual accountability;
- a clear approach to improvement-focused intervention, support and capacity building.

1.6. The purpose of the System Oversight and Assurance Group is to be the primary governance forum to oversee the Partnership's mutual accountability arrangements. It will take an overview of system performance and progress with delivery of the partnership's plan

1.7. These Terms of Reference describe the scope, function and ways of working for the System Oversight and Assurance Group. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

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

Principles for our partnership

2.2. The System Oversight and Assurance Group operates within an agreed set of guiding principles that shape everything we do through our partnership:

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

Our shared values and behaviour

2.3. Members of the System Oversight and Assurance Group commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

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

3. Role and Responsibilities

3.1. The System Oversight and Assurance Group will provide oversight, and challenge to the delivery of the aims and priorities of the Partnership. In support of this, its responsibilities are to:

i. lead the development of a dashboard of key performance, quality and transformation metrics for the partnership;

ii. take an overview of performance and transformation at whole system, place and organisation levels in relation to partnership objectives and wider national requirements;

iii. take an overview of programme delivery;

iv. receive reports from WY&H programmes and enabling workstreams on issues which require escalation;

v. develop and maintain connections with other key groups and organisations which have a role in performance development and improvement, including:

- Care Quality Commission
- Quality Surveillance Groups
- Place-based transformation boards
- A&E Delivery Boards
- WY&H Directors of Finance Group
- WY&H Clinical Forum;

vi. lead the development of a framework for peer review and support for the partnership and oversee its application;

vii. make recommendations to the System Leadership Executive, in consultation with WY&H programme boards, and national NHS bodies, on the deployment of improvement support across the partnership, and on the need for more formal action and interventions. Actions will include the requirement for:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- co-ordination of formal intervention and improvement support;
- agreement of restrictions on access to discretionary funding and financial incentives.

4. Membership

4.1. The membership of the System Oversight and Assurance Group will include representation from each sector of the partnership, i.e. providers, commissioners, Councils, national bodies, Healthwatch. Members will be nominated so as to reflect appropriate representation from each place.

4.2. The membership will comprise:

- A Chair – the partnership lead CEO
- Acute sector – chair of WYAAT (and nominated WYAAT deputy)
- Mental health sector – chair of Mental Health Services Collaborative (and nominated MHSC deputy)
- CCGs – nominated lead accountable officer (and nominated deputy)
- A representative of community / primary care providers
- Local authorities – lead CEO for health (and nominated CEO deputy)
- The chair of the WY&H Clinical Forum (and nominated deputy)
- One representative of NHS England / NHS Improvement
- One representative of Healthwatch

4.3. A deputy Chair will be agreed from among nominated members. A list of members and nominated deputies is set out at **Annex 1**.

Deputies

4.4. If a member is unable to attend a meeting of the System Oversight and Assurance Group, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group

effectively. Nominated sector deputies will be invited to attend SOAG meetings, either in place of, or in addition to the nominated sector lead).

Additional attendees

4.5. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The System Oversight and Assurance Group will not be a formal decision making body. The Group will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. The Group will not take votes and will not require a quorum of members to be present to consider any business.

5.2. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.3. Under exceptional circumstances any substantive difference of views among members will be reported to the System Leadership Executive Group.

6. Accountability and reporting

6.1. The Group does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations. However, NHS England and NHS Improvement will, where appropriate, enact certain regulatory and system oversight functions through the group.

6.2. The Group has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

6.3. The System Oversight and Assurance Group will formally report, through the Chair, to the System Leadership Executive Group. It will make recommendations, where appropriate to the System Leadership Executive Group.

7. Conduct and Operation

7.1. The Group will normally meet monthly. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

7.8. The secretariat function for the System Oversight and Assurance Group will be provided by the NHS England operations and delivery team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

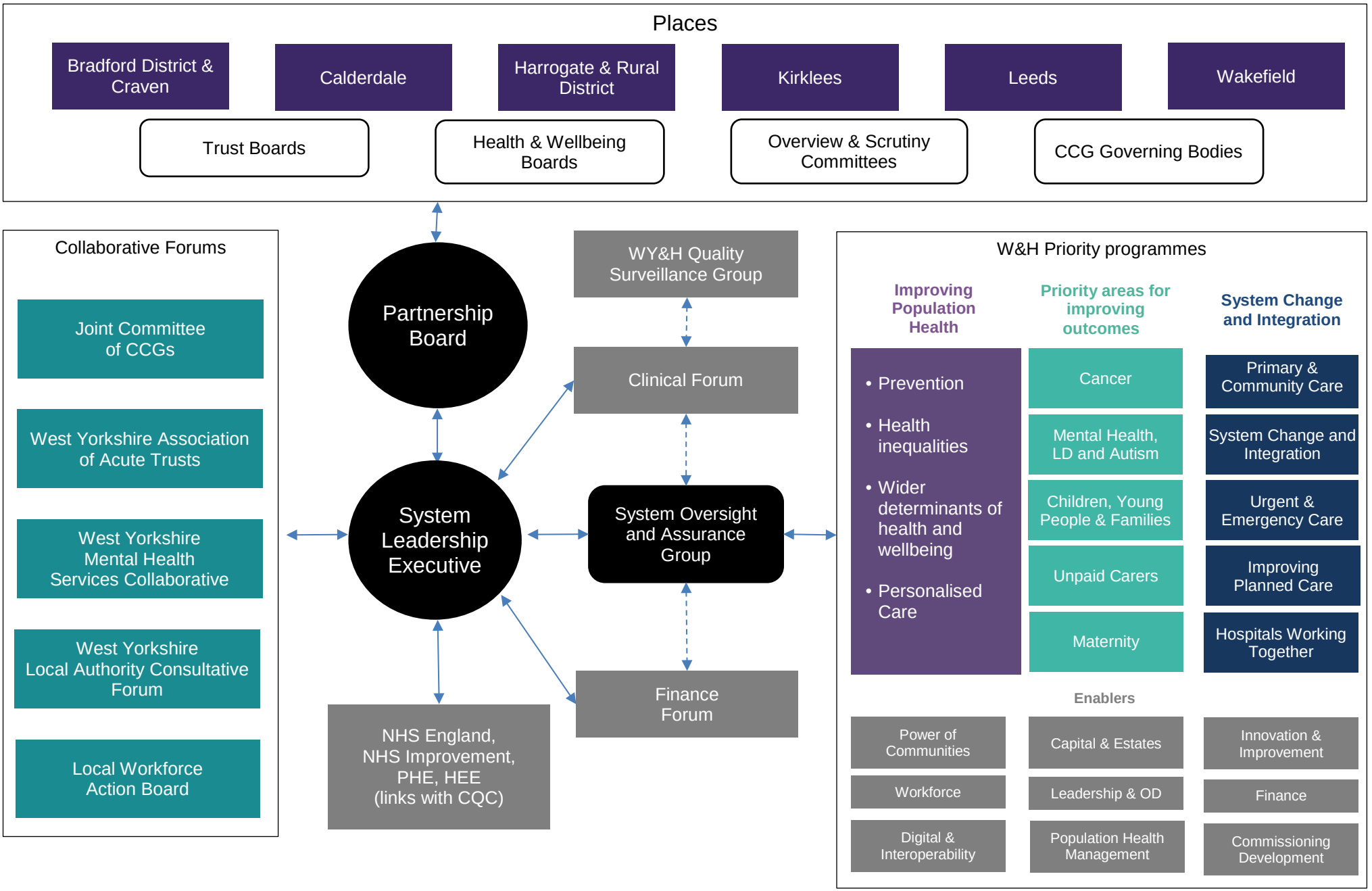
8. Review

8.1. These terms of reference and the membership of the Group will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Annex 1 – Members

Sector	First representative	Second representative
Chair		
Acute Provider		
Mental health provider		
CCG		
Local Government		
Primary and Community provision		
Clinical leadership		
NHS England / NHS Improvement		
Healthwatch		

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

Clinical Forum
Terms of Reference

April 2018

Contents

1. Introduction and context

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

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

1.3. The Clinical Forum is a key element of leadership and governance arrangements for the West Yorkshire and Harrogate health and care partnership.

Purpose

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

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

1.6. These Terms of Reference describe the scope, function and ways of working for the Clinical Forum. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership [**forthcoming],** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.

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

Principles for our partnership

2.2. The Clinical Forum operates within an agreed a set of guiding principles that shape everything we do through our partnership:

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

Our shared values and behaviour

2.3. Members of the Clinical Forum commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honestly and integrity, and trust each other to do the same
- We challenge constructively when we need to

- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The Clinical Forum will provide clinical leadership, oversight, and challenge to the development and delivery of the aims and priorities of the partnership. In support of this, its responsibilities are to:

i. lead the development of a clinical strategy and narrative for West Yorkshire and Harrogate

ii. ensure that all plans within the West Yorkshire and Harrogate health and care partnership are clinically led, evidence based, and configured to improve patient outcomes;

iii. ensure the voice of the patients, service users and citizens is heard and reflected in all plans;

iv. maintain and embed clinical co-production as a core principle of the partnership;

v. support collaboration and strengthen partnerships between clinical colleagues;

vi. exhibit clinical leadership and galvanise professional colleagues and partner organisation to agree models of care which support delivery to close the three gaps (health, care and finance) in West Yorkshire and Harrogate

vii. champion change and evidence-based innovation within their own organisations and Place, with peers, professional colleagues and networks;

viii. support transition to new models of care, where appropriate.

ix. make recommendations to the System Leadership Executive Group on proposals developed by priority workstreams and local place-based partnerships;

x. provide oversight and alignment of all clinical initiatives across West Yorkshire and Harrogate;

xi. support regular communication and engagement with all stakeholders;

xii. support through review the evaluation and impact of all workstreams and plans

xiii. provide innovative solutions to system-wide challenges, particularly where there are dependencies between workstreams (including enablers) and local plans;

xiv. provide input and assurance to the clinical representation on each of the workstreams;

xv. ensure a robust framework for quality impact assessment of change is established and implemented;

xvi. review system performance on the quality of health and care services and provide a mechanism for partner organisations to hold each other to account on quality, making appropriate links with the Quality Surveillance Forum.

3.2. Members of the group should ensure that all groups of clinicians within their organisations are engaged with the work of the Clinical Forum as appropriate.

4. Membership

4.1. The membership of the Clinical Forum will reflect the engagement of all Places and partner organisations.

4.2. Members will be senior clinicians (normally clinical commissioners, provider GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.

4.3. The membership will comprise:

- A Chair
- One clinical commissioner representative from each of the six places
- One representative from each mental health and community trust
- One representative from each acute Trust
- One representative from Yorkshire Ambulance Service
- One medical representative from NHS England and NHS Improvement
- One Nursing and Quality Lead
- One Allied Health Professional representative
- One Community Pharmacist representative
- Two representatives of primary care federations
- One Director of Adult Social Services
- One Director of Public Health
- The Clinical Director for the West Yorkshire Association of Acute Trusts
- One representative from Yorkshire Academic Health Science Network

4.4. A deputy Chair will be agreed from among nominated members.

4.5. A list of current members is set out at **Annex 1**. (Arrangements for future changes to the role of Chair and nominated members will be confirmed with the Forum).

4.6. Additional representatives may be requested to attend meetings of the Clinical Forum from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- clinical leads for each of the West Yorkshire and Harrogate priority programmes and enabling workstreams
- Local Medical Committee representatives.

Additional attendees

4.7. A representative of Healthwatch, members of the WY&H partnership core team, external advisers, and other individuals may be invited to attend for all or part of any meeting as and when appropriate, at the discretion of the Chair.

Deputies

4.8. If a member is unable to attend a meeting of the Clinical Forum, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

5. Accountability and reporting

5.1. The Clinical Forum will not be a formal decision making body. It does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations.

5.2. The Clinical Forum has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

5.3. The Clinical Forum will formally report, through the Chair, to the System Leadership Executive Group. The Chair will be a core member of this group.

5.4. The Forum will make recommendations, where appropriate to the System Leadership Executive Group.

6. Conduct and Operation of the Clinical Forum

6.1. The Forum will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members.

6.2. The Forum will not take votes and will not require a quorum of members to be present to consider any business.

6.3. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

6.4. Under exceptional circumstances any substantive difference of views among members will be reported by the Chair to the System Leadership Executive Group.

Secretariat

6.5. The secretariat function for the Clinical Forum will be provided by the WY&H partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

6.6. The secretariat will collate papers and circulate them to members and attendees no less than five days before the meeting. Late papers will be permitted in exceptional circumstances at the discretion of the Chair.

7. Frequency of meetings

7.1. The Clinical Forum will usually meet each month. An annual schedule of meetings will be confirmed by the secretariat.

7.2. Additional or extraordinary meetings may be called for a specific purpose at the discretion of the Chair.

7.3. Members will normally be given a minimum of six weeks' notice of any meeting of the Forum.

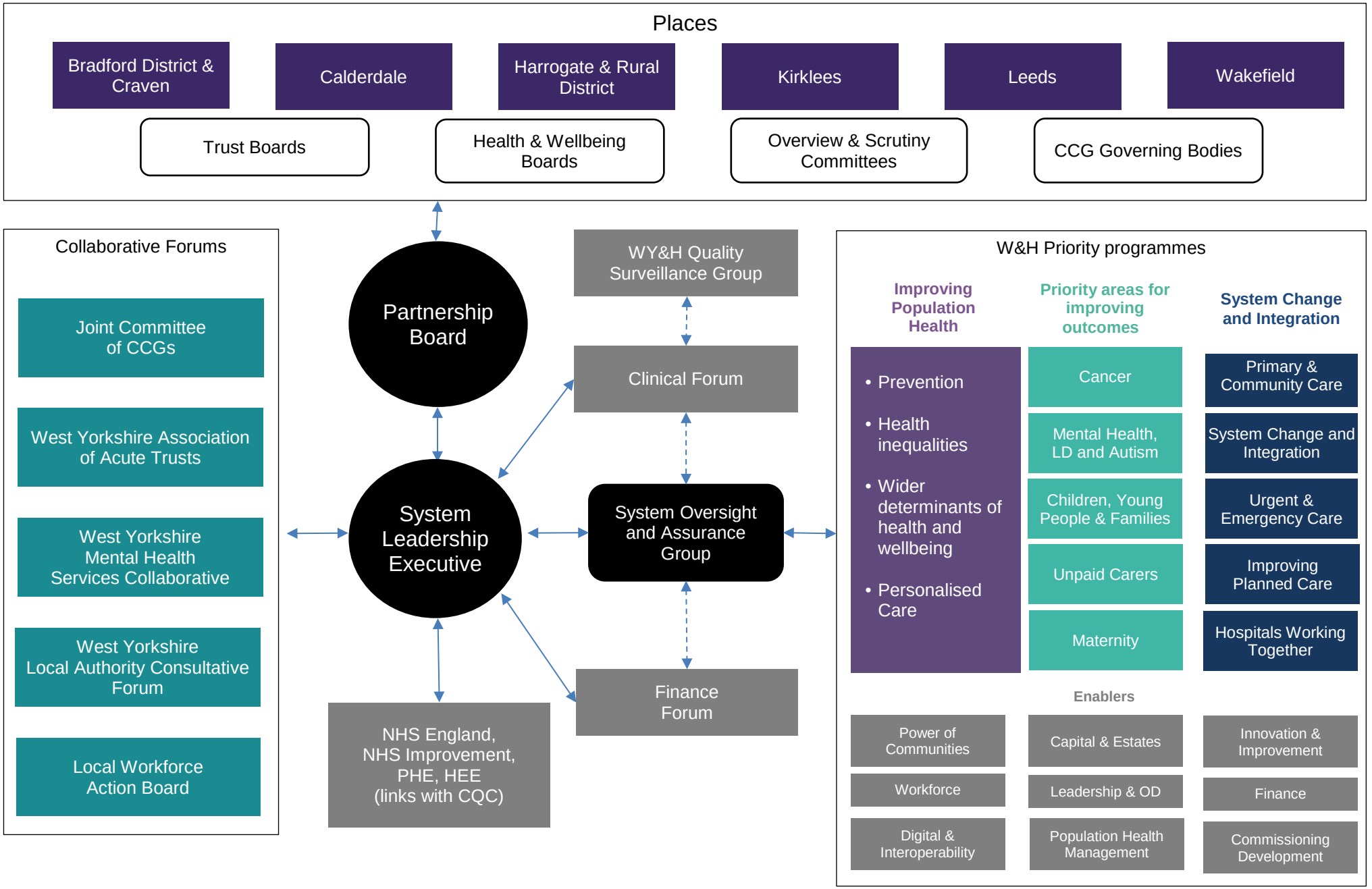
8. Review

8.1. These terms of reference and the membership of the Forum will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Annex 1 – Members of the Clinical Forum

	Nominee
Chair	
CCGs / Places	
Bradford District and Craven	
Calderdale	
Harrogate and Rural District	
Leeds	
North Kirklees and Greater Huddersfield	
Wakefield	
Acute Trusts	
Airedale NHS Foundation Trust	
Bradford Teaching Hospitals NHS Foundation Trust	
Calderdale and Huddersfield NHS Foundation Trust	
Harrogate and District NHS Foundation Trust	
The Leeds Teaching Hospitals NHS Foundation Trust	
The Mid Yorkshire Hospitals NHS Foundation Trust	
Mental Health and Community Providers	
Bradford District Care NHS Foundation Trust	
Leeds and York Partnership NHS Foundation Trust	
South West Yorkshire Partnership NHS Foundation Trust	
Leeds Community Healthcare NHS Trust	
Others	
NHS England / NHS Improvement	
Allied Health Professional	
Community Pharmacist	
GP Providers x 2	
Social Care	
Public Health representative	
WYAAT Clinical Lead	
Yorkshire Ambulance Service	
Nursing & Quality Lead (and QSG link)	
AHSN	

Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire and Harrogate
Health and Care Partnership

Finance Forum

Terms of Reference

July 2019

Contents

1. Introduction and context

1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services. To enable this, Partners are committed to working collaboratively to achieve financial sustainability and live within our resources.

Purpose

1.3. The Finance Forum is a key element of the governance arrangements for the Partnership. It will be the primary forum for financial leadership, advice and challenge and will support the Partnership Board and System Leadership Executive Group ('the Executive Group') to lead and direct the Partnership. It will also support the System Oversight and Assurance Group to ensure robust mutual accountability across the Partnership.

1.4. The Finance Forum will lead on enabling the Partnership to deliver the financial principles that are set out in its Memorandum of Understanding (MoU). These confirm that we will :

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

1.5. The Finance Forum will be a forum for sharing knowledge and intelligence. It will work by building agreement with financial leaders across Partner organisations to drive action around a shared direction of travel.

1.6. These Terms of Reference describe the scope, function and ways of working for the Finance Forum. They should be read in conjunction with the MoU for the West Yorkshire and Harrogate Health and Care Partnership**,** which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

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

Principles for our partnership

2.2. The Finance Forum operates within an agreed set of guiding principles that shape everything we do through our Partnership:

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

Our shared values and behaviour

2.3. Members of the Finance Forum commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

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

2.4. The Forum will act as a financial leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

3. Role and Responsibilities

3.1. The Finance Forum will provide financial leadership, oversight, challenge and advice to the Partnership. It will support the Partnership to manage the financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations, and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget. It will:

i. develop financial frameworks (as part of wider decision-making) in the areas of:
   - the allocation of transformation monies from national bodies;
   - priorities for capital investment across the Partnership;
   - operation of the single NHS financial control total (for NHS bodies) and the development of incentive schemes;
   - action in relation to managing collective financial performance and resources; and
   - agreeing common action when systems become financially distressed.

ii. ensure that Partnership plans are underpinned by robust financial evidence and support the financial sustainability of the health and care system;

iii. oversee, scrutinise and monitor the financial performance of the health and care system;

iv. identify opportunities and risks relating to the financial sustainability of the health and care system;

v. provide advice on the delivery of financial plans by Partnership programmes and contribute to the benefits realisation of each programme;

vi. provide advice on the deployment of financial management capacity, resources and expertise in support of Partnership programmes;

vii. share best practice and provide advice on the delivery of efficiency gains and value for money improvements;

viii. support the development and implementation of a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;

ix. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

x. support the financial review of any proposals or business cases which have resource implications and require a decision by the Health and Care Partnership (either directly or through financial leadership at programme of place level);

xi. support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;

xii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings; and

xiii. provide a focus for financial issue which impact on the WY&H Health and Care Partnership, which require lobbying of regional or national bodies, and co-ordinate any actions related to this.

4. Membership

4.1. The membership will comprise:

- The Chair – the Director of Finance Lead for the Health and Care Partnership
- CCG Chief Financial Officers
- Directors of Finance of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of each sector network/collaborative forum
- All Local authority Chief Financial Officers
- One representative of NHS England/NHS Improvement (specialised commissioning)
- One representative of NHS England/NHS Improvement (regulatory functions)
- One WY&H Partnership Board Co-opted Member

4.2. A Vice Chair will be agreed from among the members listed at **Annex 1**.

Deputies

4.3. Members will be responsible for identifying a designated deputy to attend on their behalf if they are unable to attend a meeting. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their organisation or place effectively.

Additional attendees

4.4. At the discretion of the Chair, representatives may be requested to attend meetings from time to time to discuss or report on particular issues. Such additional representatives may include:

- The WY&H Partnership Director
- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. Members of the Finance Forum commit to make every effort to attend meetings or to send their designated deputy. Meetings will not be quorate unless at least one representative from each place is present.

5.2. The Forum will operate on the basis of forming a consensus on issues on a 'best for WY&H' basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.3. In exceptional circumstances, if a consensus cannot be reached, any substantive differences of view among members will be reported by the Chair to the Executive Group or System Oversight and Assurance Group, as required.

6. Accountability and reporting

6.1. The Finance Forum has a key role within the wider governance and accountability arrangements of the Partnership (see **Annex 2** for a description of these arrangements). It does not have any powers or functions delegated by the Boards or Governing Bodies of its constituent organisations. The Finance Forum will be accountable to the Executive Group and will formally report, through the Chair, to the Executive Group. The Chair will be a core member of the Executive Group. The Forum will also make recommendations and provide advice to the System Oversight and Assurance Group.

6.2. The Forum has established a Finance Steering Group to advise on particular aspects of its roles and responsibilities

7. Conduct and Operation

7.1. The Finance Forum will normally meet monthly. An annual schedule of meetings will be published by the secretariat.

7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days' notice will be given when calling an extraordinary meeting.

7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

7.6. Where any member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

7.8. The secretariat will be provided by the Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

8.1. These terms of reference and the membership will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

8.2. Furthermore, an annual review of effectiveness of the Finance Forum will be undertaken.

Annex 1 – Members

NHS Commissioners

NHS Airedale, Wharfedale and Craven CCG
NHS Bradford City CCG
NHS Bradford Districts CCG
NHS Calderdale CCG
NHS Greater Huddersfield CCG
NHS Harrogate and Rural District CCG
NHS Leeds CCG
NHS North Kirklees CCG
NHS Wakefield CCG
NHS England/Improvement (specialised commissioning)

Healthcare Providers

Airedale NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Community Healthcare NHS Trust
The Leeds Teaching Hospitals NHS Trust
Locala Community Partnerships CIC
The Mid Yorkshire Hospitals NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Tees, Esk, and Wear Valleys NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Sector networks/collaborative forums

West Yorkshire Association of Acute Trusts
Mental Health Provider Collaborative

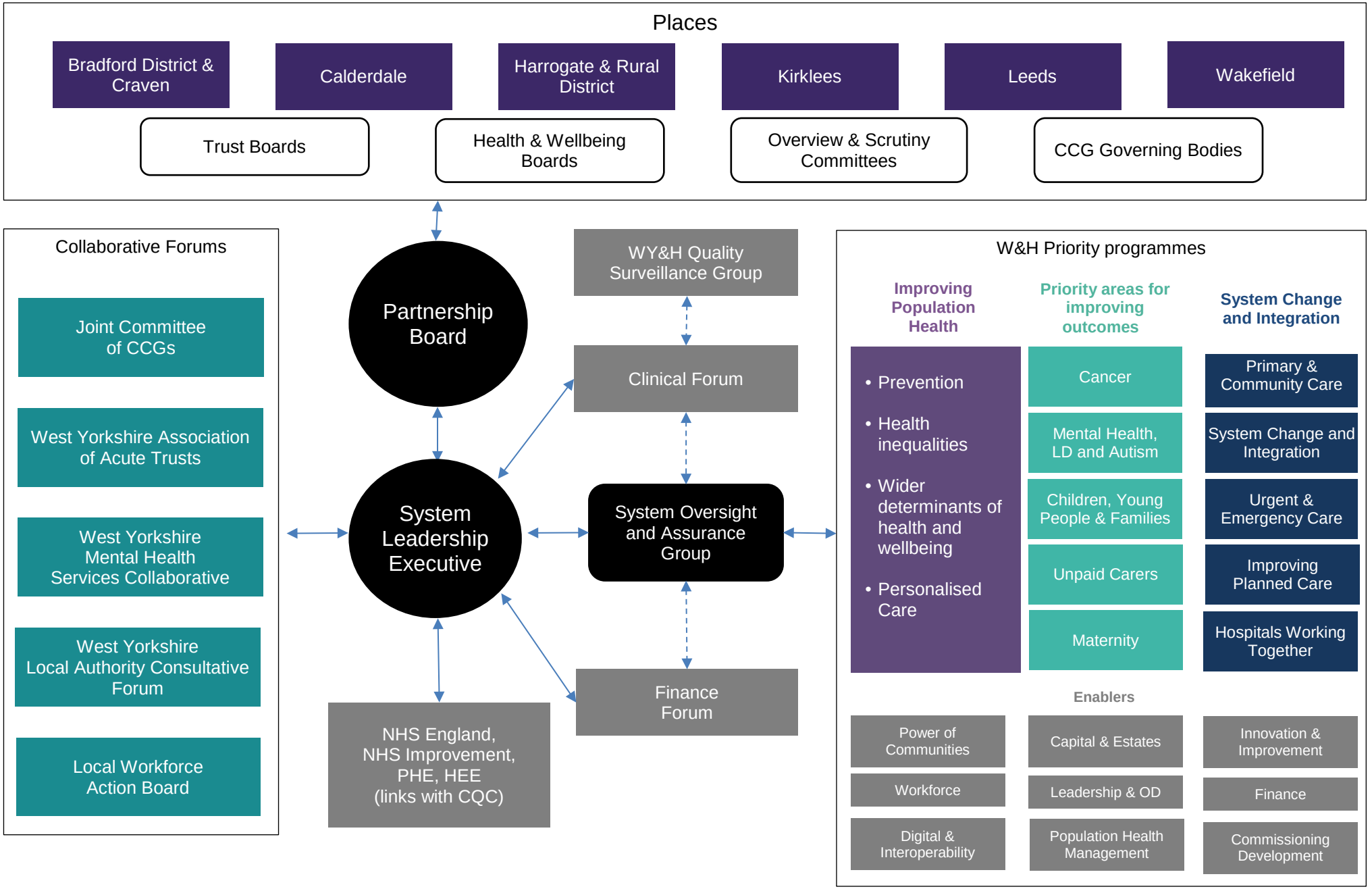
Heath Regulator and Oversight Bodies

NHS England/ Improvement

Local Authorities:

City of Bradford Metropolitan District Council
Calderdale Council
Craven District Council
Harrogate Borough Council
Kirklees Council
Leeds City Council
North Yorkshire County Council
Wakefield Council

Annex 2 – Schematic of Governance and Accountability Arrangements



A Workforce for the Future

8. The Cupboard Update

(i) Recruitment Strategy

(ii) Leadership Development Strategy

(iii) Equality, Diversity and Inclusion Strategy

To Approve

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	The Cupboard – an update
Author:	Ruth Mason, Associate Director of Organisational Development
Sponsoring Director:	Suzanne Dunkley, Executive Director Workforce and Organisational Development
Previous Forums:	The Cupboard Board of Directors March 2019. Recruitment Strategy, Leadership Development Strategy, ED&I Strategy: Workforce Committee various dates 2019
Actions Requested: To note	
Purpose of the Report	
To update the board on developments in The Cupboard (the Trust's people strategy) since launch in April 2019	
Key Points to Note	
The Cupboard is a dynamic tool to help everyone understand their role in delivering compassionate care. This presentation highlights key developments since launch in April 2018	
EQIA – Equality Impact Assessment	
The Cupboard encapsulates our key priorities and expectations of behaviour for everyone employed by the Trust. The principles of equality, diversity and inclusion are intrinsic to The Cupboard, and are captured and explored in one of the seven component recipe cards	
Recommendation	
The Board is asked to note these developments	

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care

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NHS Foundation Trust

The Cupboard - an update

Board of Directors

Thursday 9 January 2020

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What we'll cover

- What's happened since launch
- 3 key developments
- 2020…

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Since April 2019…

- Trust 1 year plan
- Partnerships info: Local Authorities; CHS
- Photos and quotes refreshed
- Apprenticeship Strategy
- Succession Planning tool
- 3Rs electronic canvas
- Events: Wimbledon; NHS 71st birthday; Candy Dance
- IIP assessment
- Leadership Conference

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3 Key Developments

- Recruitment Strategy
- Leadership Development Strategy
- Equality, Diversity & Inclusion Strategy

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Recruitment Strategy

- Hot House event July 20th 2018
- Helping to inform the WYAAT approach
- Recruitment microsite under development

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RESULTS

- Be a known as a Centre of Excellence for recruitment by hiring and retaining talented people not just for how good they are at the job, but for their values too
- Create an inclusive environment providing one culture of care – looking after the people who look after the people
- Make sure people know what's expected of them in their role
- Give opportunities for promotion and progression to enable people to achieve their potential
- Support managers to recruit the right people to the right place at the right time
- Ensure the policies and procedures for recruitment are clear, concise and up to date
- Be recognised as an employer of choice and contribute to achieving Outstanding Status from CQC

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OUR RESPONSE – RECRUITMENT STRATEGY ON A PAGE

Result	Response
Marketing To be a known as a Centre of Excellence for recruitment by hiring and retaining talented people not just for how good they are at the job, but for their values too To create an inclusive environment providing one culture of care – looking after the people who look after the people	• Increased social media presence • Creation of a brand to demonstration the CHFT culture, values and four pillars, including a library of promotional material • Publicising and promoting flexibility through our adverts • Increased presence at local events and schools/colleges/university • Consistent and accurate job description and person specification templates • Advertising and promoting our Rewards and Recognition package • Promotion of Bank vs Agency • Attendance at the 'Step into Health' Network to attract Armed Force colleagues and Reservists • Working toward achieving silver status in the Armed Forces Covenant • Opt-out for bank rather than opt-in • Promote Health and Wellbeing through recruitment
New Starter Experience & Retention We will make sure people know what's expected of them in their role	• Review of the Corporate Induction and survey to understand the experience of the new starters • Ensure new starters only commence employment on the agreed fixed start dates • Review of the recruitment survey • Working in partnership with the Nursing Workforce department to have a collaborative approach to newly qualified nurse recruitment • Start a support group to help and keep overseas colleagues with us
Talent Management We will give opportunities for promotion and progression to enable people to achieve their potential	• Develop career clinics to help improve communications to staff around the opportunities for career progression • Internal opportunities for promotion/progression using agreed career ladders • Capture promotions within ESR when they occur • Build a talent pool of people who are interested in and ready to apply for new opportunities in our organisation – including people who want to step up into leadership roles • Utilising Apprenticeships to not only attract new people, but to develop our existing people for a workforce fit for the future as per the Apprenticeship Strategy
Training & Development We will support managers to recruit the right people to the right place at the right time	• Revision of the recruitment and selection training course for managers • Creation of a 3 year refresher course for managers in recruitment and selection • 'Go See' and support managers as and when required with the recruitment process
Policies, Processes & Reporting We will ensure the policies and procedures for recruitment are clear, concise and up to date. We will make our processes more attractive, easier and shorter 	• Work with colleagues across the region and nationally on the Streamlining agenda, for example acceptance of factual references only • Ensure that the Vacancy Control Panel are supporting the Apprenticeship Strategy • Create visible process maps for managers • Monitor and measure vacancy numbers; staff turnover and retention rates • Review of Information Change Forms • Refresh the relocation policy to support overseas doctors arriving in the UK

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Leadership Development Strategy

- Engagement across the Trust
- Hot House ‘Management Essentials’ August 12th 2019
- Leadership Conference Oct 2019 and follow up Hot House Feb 2020

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The Leadership Offer

Core

Bespoke 'CLIP +'

- Nursing & Midwifery Leadership
- Consultants' Leadership
- Need To Lead Modules
- Technical Masterclasses

Underpinned by

COACHING ACTION LEARNING SETS LEADERS' NETWORK

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Equality, Diversity & Inclusion Strategy

- Crucial element of One Culture of Care
- Hot House October 5th 2018
- Growing network of Inclusion Champions and interest groups

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Plan on a Page

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2019/20

Laying the Foundations

-Compliance

-Equality Groups

-Activities

-Education

2020/21

Strategic

-EDI Strategy developed, consulted and published

-KPI's Developed and achievement tracked

2021/22

Inclusive Leaders

-Role Modelling

-Capability to authentically communicate the EDI strategy

-Accountable – each leader has a EDI objective

2022/23

Cohesive 360 degree Approach

-Life Cycle of an Employee

-Work Environment

-Patients

-Vision

2023/24

Positive Disruption

-Diversity of thought

-Innovative

-Leading

-Bottom Up Challenge

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2020 - Activity & Measurement

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Best Practice Activity

Internal

- Top Down/Bottom Up Approach – colleague toolkits developed by colleagues (along with patients)
- Inclusion Roadshows / Empower Programme / 'Step in Their Shoes' – Unconscious Bias
- More accountability for Equality Group representatives

External

- Working with the Community – Cross Sector 'Working Together' Workshops with Calderdale Police
- Collaboration between BAME Steering Groups YAS/CHFT
- Sponsorship of a National Diversity Award
- Inclusion Conference

Measurement

Activity

- Grow the numbers of the equality groups and monitor their impact
- 'Step in Their Shoes' Unconscious Bias Workshop – 70% of key decision makers attending the programme by December 2020
- Inclusion Roadshow – Attending 50% of the CHFT footprint by December 2020

Data

- Employee Survey/Freedom to Speak up/Datix/Tell Owen/PALs
- Workforce Metrics (Selection, Recruitment, Disciplinary, Grievance, Development, Mobility & Exit)

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Inclusive Leaders /Embedding/Innovation

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Grow authentic inclusive leaders who walk the talk every day

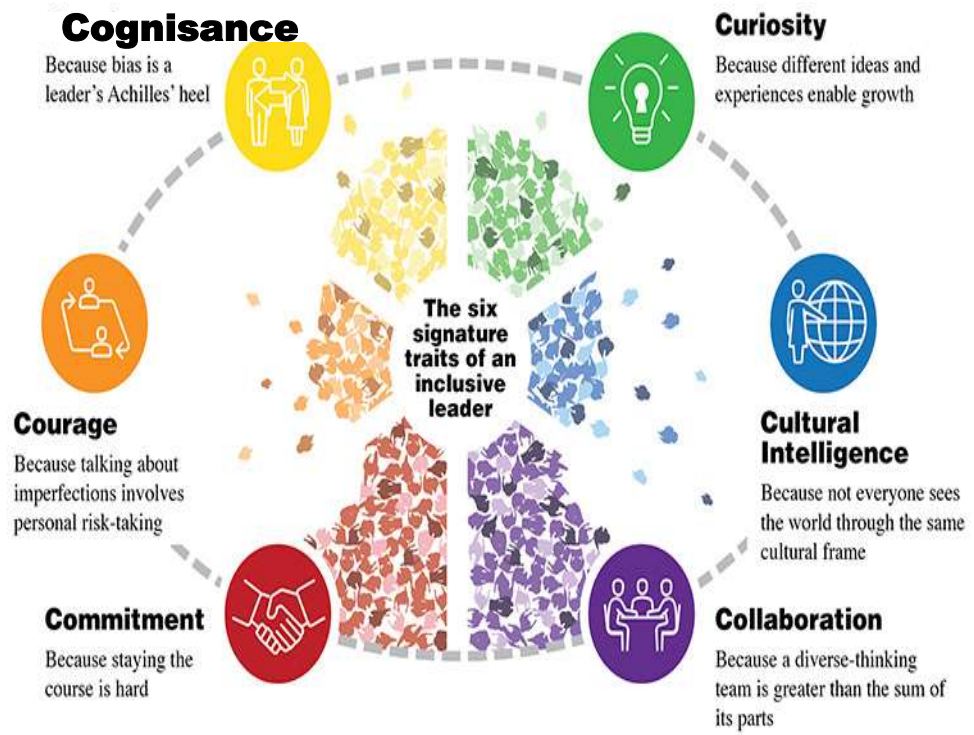

*Image taken from Deloitte six signature traits of an inclusive leader

'This is the way we do things around here' –

E,D &I will be embedded into everything we do

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2020…

- Chefs keeping ingredients fresh, dynamic, and tasty!
- New metrics facility
- New search facility

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Financial Sustainability

9. Month 8 Financial Summary

To Note

Presented by Kirsty Archer

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	Month 8 Financial Summary
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance and Performance Committee

Actions Requested:
To note

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 8 (November 2019)

Key Points to Note

The year to date deficit is £8.67m, a £0.24m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding.

- There is some pressure year to date due to higher than planned non pay expenditure including utilities, maintenance contracts, outsourced services and lower than planned VAT recovery.
- These pressures have been offset year to date by lower than planned pay expenditure, although for the last three months pay has been slightly overspent due to Medical pay awards and pressure from additional capacity.
- Clinical income performance (contract and other) is below plan by £1.56m. The Aligned Incentive Contract (AIC) protects the income position by £2.15m resulting overall in a favourable variance of £0.59m, an improvement compared to the position in Month 7. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services.
- CIP achieved year to date is £6.34m, £0.17m more than planned.
- Agency expenditure year to date is £5.35m, £2.16m below the planned level.
- The key focus in the final four months needs to be on containing overall winter expenditure within the earmarked funding available.

Appendix: Finance Report Month 8

EQIA – Equality Impact Assessment
All cost improvement and recovery plans will need to undergo both QIA and EQIA on an individual basis prior to implementation.
Recommendation
The Board is asked to note the attached summary

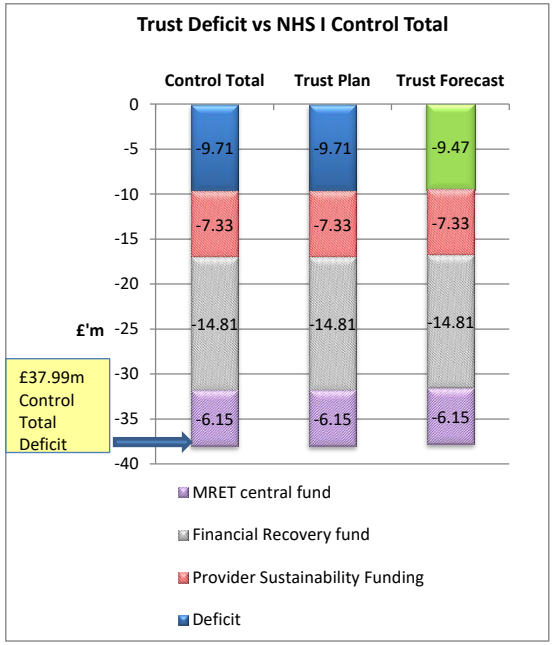
Signed off by: Kirsty Archer

Date signed off: 19/12/19

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Nov 2019 - Month 8

KEY METRICS

	M8				YTD (NOV 2019)				Forecast 19/20			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.57)	(£0.34)	£0.23		(£8.91)	(£8.67)	£0.24		(£9.71)	(£9.47)	£0.24	
Agency Expenditure	(£0.81)	(£0.58)	£0.23		(£7.51)	(£5.35)	£2.16		(£11.56)	(£7.27)	£4.28	
Capital	£1.04	£0.46	£0.58		£7.68	£4.59	£3.09		£20.21	£14.35	£5.86	
Cash	£1.91	£4.91	£3.00		£1.91	£4.91	£3.00		£1.91	£1.90	(£0.01)	
Borrowing (Cumulative)	£156.74	£159.71	£2.97		£156.74	£159.71	£2.97		£168.40	£162.06	(£6.34)	
CIP	£0.96	£1.07	£0.11		£6.17	£6.34	£0.17		£11.00	£11.00	£0.00	
Use of Resource Metric	3	3			3	3			3	3		



Year to Date Summary

The year to date deficit is £8.67m, a £0.24m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding.

- There is some pressure year to date due to higher than planned non pay expenditure including utilities, maintenance contracts, outsourced services and lower than planned VAT recovery.
- These pressures have been offset year to date by lower than planned pay expenditure, although for the last three months pay has been slightly overspent due to Medical pay awards and pressure from additional capacity.
- Clinical income performance (contract and other) is below plan by £1.56m. The Aligned Incentive Contract (AIC) protects the income position by £2.15m resulting overall in a favourable variance of £0.59m, an improvement compared to the position in Month 7. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services.
- CIP achieved year to date is £6.34m, £0.17m more than planned.
- Agency expenditure year to date is £5.35m, £2.16m below the planned level.

Key Variances

- Clinical income is now above plan overall, but only as a result of the £2.15m protection offered by the Aligned Incentive Contract (AIC), with lower than planned activity levels across all points of delivery with the exception of A&E. However, AIC protection has reduced further in month by £0.20m.
- Surgical Division continue to show a favourable variance to plan, reflective of lower expenditure linked to lower activity levels. However, the Medicine position has worsened further in month primarily due to capacity pressures, staff sickness and pressure on A&E services.
- 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, clinical waste and utilities.
- There is an adverse variance on Medical staffing expenditure of £0.21m, although this includes £0.54m pressure due to pay awards. Some additional funding has been allocated by DH, but this is insufficient to fully cover the planning gap (a net pressure of £0.37m year to date).
- Nursing pay expenditure is lower than planned year to date by £0.17m, despite the opening of additional capacity, supported in month by a reduction in both agency usage and average hourly rate.

Forecast

In the round the recovery and restraint requirement reported last month remains at £1.7m. This recovery requirement is largely driven by additional non pay costs linked to the estate and maintenance and the additional capacity requirements seen over the last few months that are very likely to continue.

£0.5m additional ICS winter funding has been materially committed to additional capacity and discharge facilities. There remains some uncommitted winter reserve that is assumed to be spent to manage any winter pressures that continue into Quarter 4, but general contingency reserves are now fully committed.

Total Group Financial Overview as at 30th Nov 2019 - Month 8

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M8

CLINICAL ACTIVITY

	M8 Plan	M8 Actual	Var
Elective	3,699	3,657	(42)
Non-Elective	40,142	39,175	(967)
Daycase	28,132	27,710	(422)
Outpatient	244,267	238,617	(5,651)
A&E	103,802	105,474	1,672
Other NHS Non-Tariff	1,211,316	1,200,355	(10,961)
Other NHS Tariff	87,080	87,111	31
Total	**1,718,439**	**1,702,099**	**(16,340)**

TOTAL GROUP: INCOME AND EXPENDITURE

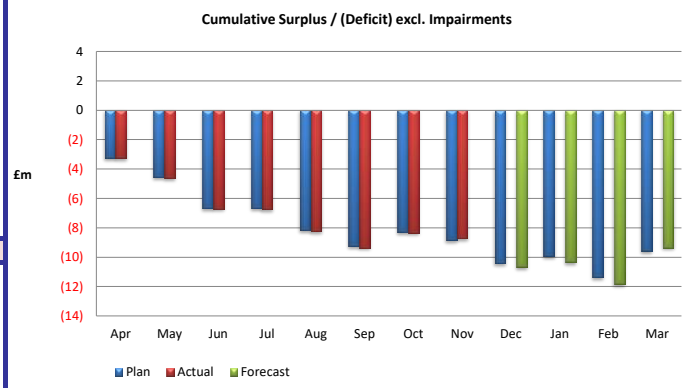
	M8 Plan	M8 Actual	Var
	£m	£m	£m
Elective	£11.92	£11.56	(£0.37)
Non Elective	£73.51	£72.41	(£1.10)
Daycase	£19.94	£19.15	(£0.79)
Outpatients	£31.43	£31.01	(£0.41)
A & E	£15.01	£15.27	£0.26
Other-NHS Clinical	£67.36	£70.17	£2.81
CQUIN	£2.44	£2.41	(£0.03)
Other Income	£31.72	£33.26	£1.55
Total Income	**£253.33**	**£255.24**	**£1.91**
Pay	(£174.59)	(£173.39)	£1.20
Drug Costs	(£24.37)	(£26.47)	(£2.10)
Clinical Support	(£19.86)	(£19.91)	(£0.06)
Other Costs	(£34.36)	(£35.53)	(£1.17)
PFI Costs	(£8.72)	(£8.72)	£0.00
Total Expenditure	**(£261.89)**	**(£264.02)**	**(£2.13)**
EBITDA	**(£8.57)**	**(£8.78)**	**(£0.21)**
Non Operating Expenditure	(£16.62)	(£16.17)	£0.45
Surplus / (Deficit) Control Total basis*	**(£25.19)**	**(£24.95)**	**£0.24**
Conditional Funding (MRET/PSF/FRF)	£16.27	£16.27	£0.00
Surplus / Deficit*	**(£8.91)**	**(£8.67)**	**£0.24**

* Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M8 Plan	M8 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£9.22	£10.20	£0.97
Medical	£27.47	£26.32	(£1.16)
Families & Specialist Services	(£3.11)	(£3.27)	(£0.16)
Community	(£1.91)	(£1.52)	£0.39
Estates & Facilities	(£0.00)	(£0.02)	(£0.02)
Corporate	(£28.84)	(£28.34)	£0.50
THIS	£1.60	£1.29	(£0.31)
PMU	£2.04	£2.23	£0.20
CHS LTD	£0.24	£0.32	£0.09
Central Inc/Technical Accounts	(£14.78)	(£14.84)	(£0.06)
Reserves	(£1.06)	(£1.04)	£0.02
Unallocated CIP	£0.21	£0.00	(£0.21)
Surplus / (Deficit)	**(£8.91)**	**(£8.67)**	**£0.24**

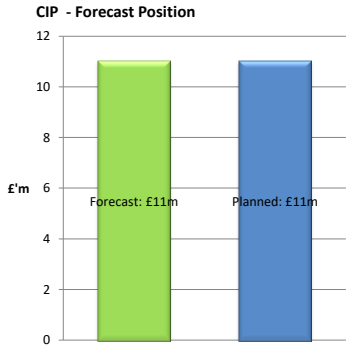
TOTAL GROUP SURPLUS / (DEFICIT)

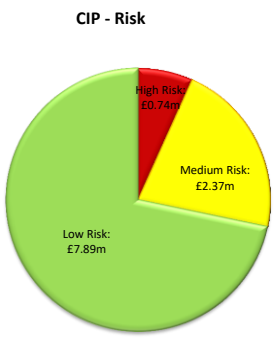


KEY METRICS

	Year To Date			Year End: Forecast		
	M8 Plan	M8 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£8.91)	(£8.67)	£0.24	(£9.71)	(£9.47)	£0.24
Capital	£7.68	£4.59	£3.09	£20.21	£14.35	£5.86
Cash	£1.91	£4.91	£3.00	£1.91	£1.90	(£0.01)
Loans	£156.74	£159.71	£2.97	£168.40	£162.06	(£6.34)
CIP	£6.17	£6.34	£0.17	£11.00	£11.00	£0.00
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £11m

Total Forecast £11m

YEAR END 19/20

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,459	5,490	31
Non-Elective	60,256	59,484	(771)
Daycase	41,813	40,867	(946)
Outpatient	362,551	356,832	(5,719)
A&E	153,542	156,532	2,990
Other NHS Non- Tariff	1,798,704	1,781,960	(16,744)
Other NHS Tariff	129,454	130,030	576
Total	**2,551,779**	**2,531,195**	**(20,584)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.64	£17.27	(£0.37)
Non Elective	£110.17	£109.33	(£0.84)
Daycase	£29.65	£28.48	(£1.17)
Outpatients	£50.52	£44.10	(£6.42)
A & E	£22.21	£22.68	£0.47
Other-NHS Clinical	£97.06	£105.79	£8.73
CQUIN	£3.63	£3.61	(£0.02)
Other Income	£48.55	£50.37	£1.83
Total Income	**£379.42**	**£381.63**	**£2.21**
Pay	(£262.18)	(£261.14)	£1.04
Drug Costs	(£36.42)	(£39.04)	(£2.63)
Clinical Support	(£29.62)	(£29.81)	(£0.18)
Other Costs	(£51.31)	(£51.99)	(£0.68)
PFI Costs	(£13.07)	(£13.17)	(£0.09)
Total Expenditure	**(£392.61)**	**(£395.14)**	**(£2.52)**
EBITDA	**(£13.19)**	**(£13.51)**	**(£0.32)**
Non Operating Expenditure	(£24.80)	(£24.25)	£0.56
Surplus / (Deficit) Control Total basis*	**(£37.99)**	**(£37.75)**	**£0.24**
Conditional Funding (MRET/PSF/FRF)	£28.28	£28.28	£0.00
Surplus / Deficit*	**(£9.71)**	**(£9.47)**	**£0.24**

* Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

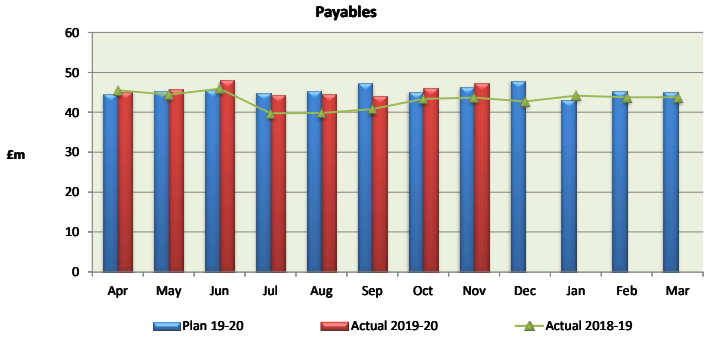
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£13.90	£15.08	£1.18
Medical	£40.37	£39.56	(£0.81)
Families & Specialist Services	(£4.90)	(£5.21)	(£0.31)
Community	(£2.92)	(£2.58)	£0.34
Estates & Facilities	(£0.00)	(£0.02)	(£0.02)
Corporate	(£43.15)	(£42.87)	£0.28
THIS	£2.43	£2.23	(£0.20)
PMU	£2.99	£3.15	£0.16
CHS LTD	£0.62	£0.58	(£0.03)
Central Inc/Technical Accounts	(£17.39)	(£18.10)	(£0.71)
Reserves	(£2.08)	(£1.71)	£0.37
Unallocated CIP	£0.41	£0.41	£0.00
Surplus / (Deficit)	**(£9.71)**	**(£9.47)**	**£0.24**

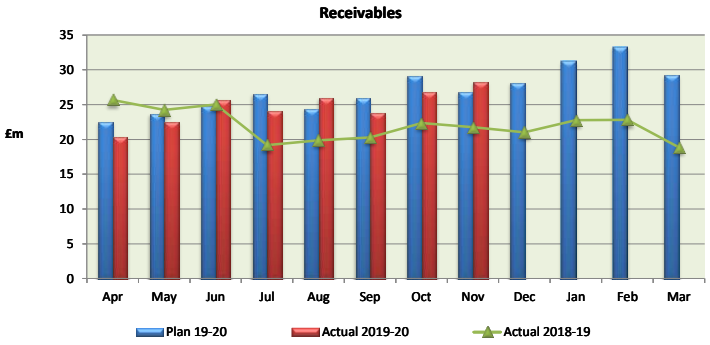
Total Group Financial Overview as at 30th Nov 2019 - Month 8

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

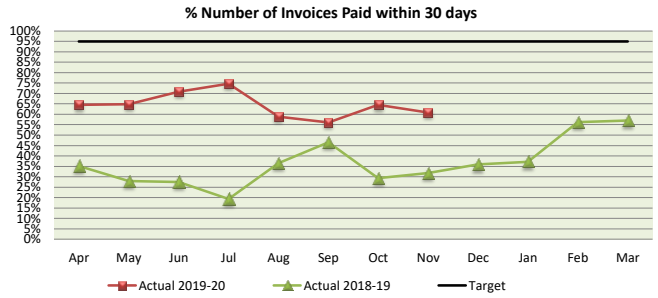
WORKING CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Payables (excl. Current Loans)	(£46.48)	(£47.44)	£0.96	
Receivables	£26.86	£28.22	(£1.36)	



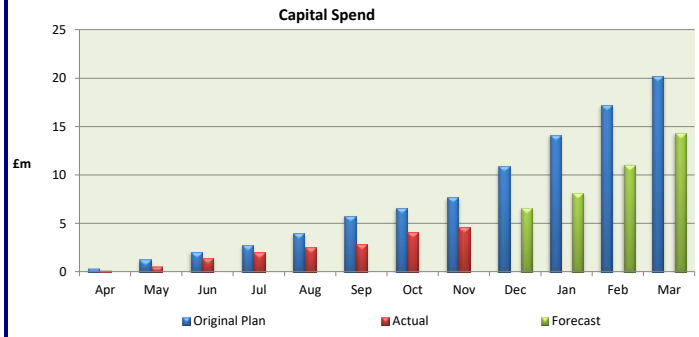


BETTER PAYMENT PRACTICE CODE



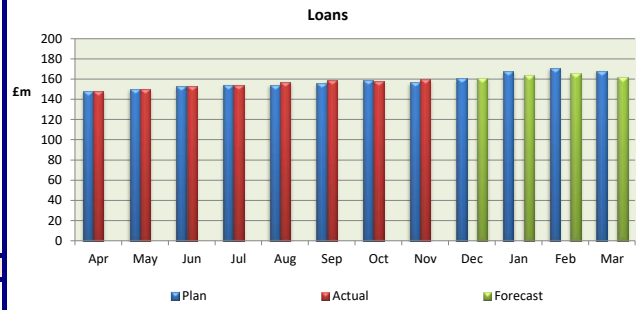
CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Capital	£7.68	£4.59	£3.09	

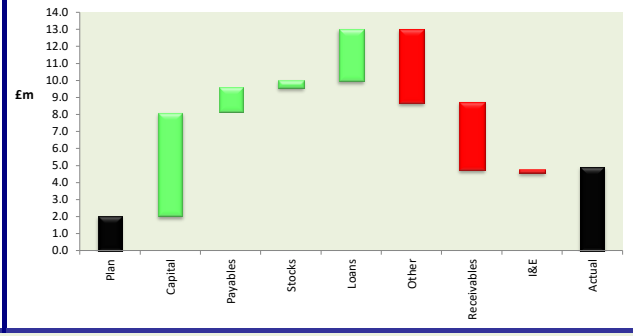


CASH

	M8 Plan £m	M8 Actual £m	Var £m	M8
Cash	£1.91	£4.91	£3.00	
Loans (Cumulative)	£156.74	£159.71	£2.97	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £8.67m, a £0.24m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding. This position excludes the I&E impact of the reversal of an impairment (£0.9m favourable variance) and donated assets (£0.06m adverse variance) which are excluded for control total purposes.
- Income position assumes that the Trust will is eligible to receive full year to date allocation of Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) totalling £9.96m year to date, given that the Control Total has been achieved as planned.
- Year to date activity is below plan for all points of delivery with the exception of A&E and overall Clinical Contract Income is below plan by £0.34m, an improvement compared to Month 7.
- Year to date Capital expenditure was lower than planned at £4.59m against a planned £7.68m.
- Cash balance is £4.91m, £3.0m higher than the planned £1.91m.
- Year to date the Trust has borrowed £17.77m to support the deficit and PSF / FRF funding that will be paid in arrears.
- Year to date CIP schemes have delivered £6.34m of savings, £0.17m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 against a planned level of 3. Of the five metrics that make up the UOR, all are as planned.

NOTES

- The Trust is forecasting to achieve Control Total as planned with a £9.71m forecast deficit.
- The Forecast position includes conditional funding of £28.28m, (£6.147m MRET central funding, £7.33m Provider Sustainability Funding and £14.807m Financial Recovery Fund). 15% of the Trust's Provider Sustainability Funding (£1.10m) is reliant on the Integrated Care System (ICS) delivering Control Total overall and this is also currently forecast to deliver.
- The Trust is forecasting Agency expenditure of £7.27m, considerably below the NHSI ceiling of £14.96m, but offset by an increase in expenditure on Bank staff.
- The Trust is forecasting full delivery of the £11.00m 19/20 CIP target.
- 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 £6.34m due to slippage on emergency capital plans
- The total loan balance at year end is forecast to be £162.06m, £6.34m lower than planned. Two Revenue loans were due for repayment this year: £12.9m loan due for repayment in February 20 has now been extended until August 20 and a further loan for £26.9m due for repayment in January 20 has been extended until July 20. These loan extensions have now been confirmed.
- Capital expenditure is forecast at £14.35m, £5.86m lower than planned. The latest plan submitted to NHSI on 15th July detailed forecast expenditure of £15.01m. This reduced further following confirmation of a revised profile for the 2 year PDC funded Energy Efficiency Scheme. Other amendments have been made to the capital forecast since that last submission, but whilst these impact on the make-up of the forecast, total forecast remains within the agreed envelope.

RAG KEY: (Excl: UOR)	
	Actual / Forecast is on plan or an improvement on plan
	Actual / Forecast is worse than planned by <2%
	Actual / Forecast is worse than planned by >2%

NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

RAG KEY: UOR	
	All UOR metrics are at the planned level
	Overall UOR as planned, but one or more component metrics are worse than planned
	Overall UOR worse than planned

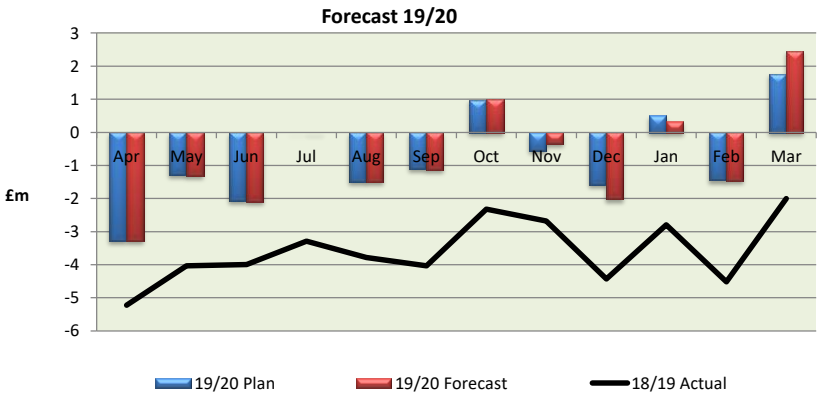
FORECAST

YEAR END 19/20

	Plan £m	Forecast £m	Var £m	
Elective	£17.64	£17.27	(£0.37)	
Non Elective	£110.17	£109.33	(£0.84)	
Daycase	£29.65	£28.48	(£1.17)	
Outpatients	£50.52	£44.10	(£6.42)	
A & E	£22.21	£22.68	£0.47	
Other-NHS Clinical	£97.06	£105.79	£8.73	
CQUIN	£3.63	£3.61	(£0.02)	
Other Income	£48.55	£50.37	£1.83	
Total Income	**£379.42**	**£381.63**	**£2.21**	
Pay	(£262.18)	(£261.14)	£1.04	
Drug Costs	(£36.42)	(£39.04)	(£2.63)	
Clinical Support	(£29.62)	(£29.81)	(£0.18)	
Other Costs	(£51.31)	(£51.99)	(£0.68)	
PFI Costs	(£13.07)	(£13.17)	(£0.09)	
Total Expenditure	**(£392.61)**	**(£395.14)**	**(£2.52)**	
EBITDA	**(£13.19)**	**(£13.51)**	**(£0.32)**	
Non Operating Expenditure	(£24.80)	(£24.25)	£0.56	
Surplus / (Deficit) Control Total basis*	**(£37.99)**	**(£37.75)**	**£0.24**	
Conditional Funding (MRET/PSF/FRF)	£28.28	£28.28	£0.00	
Surplus / Deficit*	**(£9.71)**	**(£9.47)**	**£0.24**	

*Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

Forecast



The Trust is forecasting a favourable variance of £0.24m against the planned £9.7m deficit, although this includes a £0.23m benefit from a gain on disposal, excluded for the purposes of allocation of Provider Sustainability Funding / Financial recovery Funding. The forecast deficit assumes the full allocation of conditional funding available as a result of accepting the 19/20 Control Total, (a £37.99m deficit).

Key Assumptions:

- Efficiency challenge is £11m CIP. The forecast assumes full delivery including high risk elements with a value of £0.74m.
- Aligned Incentive Contract (AIC) with two main commissioners reduces risk of income loss, but for all other commissioners contracts remain on a payment by results basis and are therefore subject to variability based on actual activity levels.
- Agency plan of £11.56m against the NHS I ceiling of £14.96m. At Month 8 forecasting agency expenditure of £7.27m, £4.28m lower than plan but offset by an increase in bank / locum expenditure.
- Contingency Reserves of £2m held, including £1m Winter Reserve, the majority of which has now been committed.
- Further Growth /Winter reserve of £1.6m, plans are now in place for the allocation of this funding.

Key Variances:

- Medical staffing pay awards have been awarded, backdated to April with arrears paid in September. The cost of these awards is higher than the value planned and are driving a pressure in the forecast of £0.54m (£0.81m pay pressure less additional central funding received of £0.27m).
- The recovery and restraint requirement has stabilised at £1.7m (£1.2m initially identified plus £0.5m worsening in Month 6). This recovery requirement is the result of a combination of: forecast pressures in Medicine, FSS and Health Informatics and higher than planned maintenance and utilities costs that fall within the CHS contract with the Trust. Recovery plans of £1.2m identified in October are materially on track to deliver and the Medicine position now recognises £0.45m further recovery actions as discussed at TE, but this has only served to hold their position at last month's level rather than drive an improvement, due to continuing additional capacity requirements.
- £0.5m additional ICS winter funding has been materially committed to additional capacity and discharge facilities.
- The Medicine forecast assumes that current additional capacity is required until late December and there remains some uncommitted winter reserve that is assumed to be spent to manage any winter pressures that continue into Quarter 4 with the exception of £0.3m previously committed to recovery and £0.1m now included within the Medical Division forecast.

Risks and Opportunities:

- The cost of unrecoverable VAT on goods and services purchased outside of the CHS Managed Service at HRI has been higher than expected year to date by £0.75m. The likely pressure as a result of this VAT recovery issue is fully mitigated in the forecast, but some of this mitigation is non-recurrent in nature. There is further work to do the ensure that VAT recovery has been maximised, but there remains a risk that this is a recurrent cost pressure.
- Impact of changes to VAT rules relating to the Brookson agency contract are expected to be c.£0.2m - to be covered through contingency reserve. If HMRC sought to recover the VAT retrospectively the cost could increase to close to £2m.
- Changes to pension rules resulting in unplanned costs - the Trust has now received three invoices from the pensions agency totalling £0.31m relating to members of staff that have already retired. It is likely that further charges will follow.
- Fees relating to the Reconfiguration Business Case (Architect, legal and professional fees) of up to £1m, in order to progress the case to OBC stage, are assumed to be funded through draw down of DH Capital loan funding. This funding has not yet been received, but the Trust has had assurances that emergency loan funding will be made available this year. Revenue funding to cover this cost will need to be identified if Capital funds are not made available.
- 15% of Provider Sustainability Funding (PSF) worth £1.10m is dependant on the Integrated Care System (ICS) as a whole achieving its control total. Whilst this is a risk to the Trust, additional funding has been secured by the ICS as a result of accepting this control total, some of which is likely to be allocated to the Trust in due course.

Transforming and Improving Patient Care

10. Climate Change Report

To Note

Presented by Stuart Sugarman

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	CHFT Climate Change report
Author:	Emma Clarke, Environment Manager
Sponsoring Director:	Stuart Sugarman
Previous Forums:	CHS Board

Actions Requested:
To note contents and approve the contents of the report

Purpose of the Report

Introduction
The scientific evidence of climate change is well documented, as are the health consequences, as detailed in publications such as The Lancet. The Government has committed to net zero by 2050, which goes beyond the obligations of the Climate Change Act 2008. Further obligations are expected in 2020 as a result of the Environment Bill 2019. Significant progress by all nations is needed by 2030 if irreversible damage to the environment is to be avoided. This paper outlines how CHS and CHFT propose to meet our own obligations to mitigate the impacts of climate change and adapt our services to protect residents and the environment now and for the future.

CHFT has a significant role in leading and supporting action to realise the co-benefits for public health that actions to reduce greenhouse gas emissions can bring, in addition to leading the way in reducing our own greenhouse gas emissions within the health sector. As an anchor institution we are expected to demonstrate good practice. We already have a Sustainable Development Management Plan and a Sustainable Development Action Plan to implement this, but a ten-year climate change plan would enable us to monitor and evaluate progress and demonstrate to patients, colleagues and the wider public how we are doing against our climate change targets on an annual basis.

Climate emergency
Our climate change plan could be facilitated by declaring a climate emergency. As a public declaration, it would send a clear message to colleagues, patients and the wider public that CHFT recognises and give weight to the impact of climate change on public health. Many local authorities including both Calderdale and Kirklees have committed to net zero by 2038 and have declared a climate emergency. A CHFT declaration will support the Councils, and the West Yorkshire Combined Authority's pledge for the Leeds City Region to become carbon neutral by 2038. We should have ambitions to lead, together with other healthcare organisations (and local businesses) in committing to plans to achieve carbon neutrality, which will improve the health of the population immediately.

What is carbon neutrality?
An organisation's 'carbon footprint' is the amount of carbon dioxide (or carbon dioxide equivalent) released into the atmosphere as a result of its activities. Emissions are separated into those that the organisation has management control over (i.e. emissions from owned boilers, owned vehicle fleet and purchased electricity) and emissions from activities where we have less control (i.e. purchased goods & services, waste disposal and all other colleague/patient/visitor travel). 2018-19 is the first year that we have calculated our carbon footprint. Our impact was more than 52,000 tonnes of CO2 equivalent for 2018-19 and we are working to develop comparative data to understand where we are in relation to other Trusts.

Declaring a climate emergency and committing to net zero emissions or carbon neutral activities, means we need to adapt our activities to reduce our carbon footprint year on year, and commit to plans to reduce our emissions to zero. We would align our ambitions with the West Yorkshire Combined Authority and our local authorities by aiming for net zero by 2038.

What if we don't?
Failure to act now will result in continued health impacts on our local and global population. There could be impacts on our health and wellbeing including more extreme weather events such as higher summer temperatures, colder and icier winters, more rain resulting in flooding. Such events could affect our colleagues and patients as well as affecting us indirectly as a result of crop failure (and food shortages) and disruption to our local infrastructure and economy.

What have we already done?
We have:

- Developed a Sustainable Development Management Plan and Action Plan (however more resource are required to complete the actions) and a future report will be presented with a business case to support additional staffing requirements.
- Established a Sustainable Development Group and volunteer Green Champion network.
- Secured funding to begin a LED lighting programme at HRI and CRH (replacing light fittings with energy efficient LED) to reduce consumption by more than 3 megawatts at both sites.
- From April 2020, we have agreed with our supplier that all electricity for HRI, Acre Mill, Broad Street, and PMU will be from renewable sources and we will receive Renewable Energy Guarantees of Origin (REGO) certificates to prove this.
- Improve waste segregation, reducing reliance on financially and environmentally costly high temperature incineration (on-going).

What is the plan?
Building on what we have done, the immediate opportunities in 2020 are detailed below. Some are the responsibility of senior Trust and CHS staff, others require the support of colleagues and patients (with the support of the Environment Manager and wider CHS staff) in order to realise our ambitions:

- Increase communication with all colleagues to raise awareness of sustainability and our impact as individual and a Trust and facilitate behaviour change (by June 2020).
- Declare a Climate Emergency (or Health Emergency linked to Climate Change) to show the Trust takes the scientific evidence and climate change threat seriously; and enabling sustainability to become embedded in our activities (by June 2020).
- Include sustainability as a requirement in Board papers and in business case applications (update template documentation by June 2020).
- Work with Engie to source 100% renewable electricity for CRH (by April 2021).
- Evaluate with a full quality and equality impact assessments a new fleet tender specifying an electric or hybrid vehicles option (by February 2020).
- Promote the use of Warp-it, an online platform for reuse of items such as office equipment, furniture, telecoms, computers and stationery within the Trust and with external parties (by June 2020).
- Install electric car charging points at HRI and CRH (by March 2021), expanding depending on demand by fleet vehicles, colleagues and patients (this could involve the Trust being reimbursed for electricity consumed by the user).

- Senior Trust and CHS colleagues to work and co-produce with Calderdale and Kirklees Councils, a Climate Commission (as meetings dictate).
- Identify and investigate viability of alternative solutions for specific clinical waste streams, e.g. reusable sharps containers, theatre waste and endoscopy waste.
- Work with our partners, suppliers and patients to implement the NHS Plastic Pledge. To support this, investigate feasibility of offering colleagues and patient discounts for using reusing cups and food containers in our restaurants.
- Consult with our patients and suppliers to investigate the viability and trial 'Meatless Mondays' with our patient menus and our catering partners by offering more meat free alternatives (Compass, ISS and Tillery Valley for our patient meals).
- Annual sustainability reporting (including carbon calculations) to publicise our achievements to date and future ambitions (coincide with CHFT annual report).

Our long-term opportunities for 2021-2025 will include:

- Develop a more detailed plan to reduce carbon emissions between 2021-2025 (by June 2020)
- Commission a feasibility study for installation of Combined Heat and Power at HRI (by March 2021).
- Work with Workforce and Organisational Development (WOD) and Occupational Health to encourage sustainable (colleague) travel through cycle scheme and public transport discounts (by April 2022)
- Target of recycling over 40% of non-clinical waste (by April 2022).
- Work with our suppliers and Procurement to develop, co-produce and embed sustainable procurement practices through inclusion of sustainability standards, specification and evaluation criteria in all procurement contracts.
- Work with WOD and THIS to increase agile working opportunities to reduce unnecessary travel to a specific place of work (by March 2021 onwards).
- Work with THIS and our suppliers to recycle and or refurbish our digital hardware as it gets close to or beyond its sell by date (by March 2022).
- Work with THIS to increase digital services to reduce the requirement for patients to travel to outpatient appointments (by June 2021 onwards).
- Embed BREEAM (building sustainability assessment) in reconfiguration plans for CRH and HRI (at initial design stage and during construction). Include rainwater harvesting for use in non-clinical areas (timing dictated by reconfiguration meetings).
- Develop a strategy as part of our reconfiguration plans to review transport and the use of digital technology to reduce car miles (timing dictated by reconfiguration meetings).
- Develop a strategy with Pharmacy to reduce use of most harmful anaesthetic gases (strategy written and agreed by March 2021)
- Increase repair and reuse of equipment such as crutches and walking frames (by March 2022).
- Investigate the opportunities to generate electricity onsite, e.g. via photovoltaic cells, to ensure resilience against future changes in global energy markets (by March 2023).
- Plant 6,000 trees (one for every colleague member) on our estate, within the local authority and as part of the NHS National Forest to help mitigate the impacts of carbon in the atmosphere. Target of planting 1,200 per annum.
- Work with Occupational Health, other Councils, patients and voluntary group to form a 'Green Gym' for colleagues, patients and residents to volunteers to tree planning, local clean-ups etc (by June 2020).
- Review in 2025 for new five-year plan.

What will be the results?

Our Climate Change business continuity plan is reactive and ensures we can maintain services in the event of extreme weather events as a result of climate change, whilst a Climate Change Plan demonstrates how we will be proactive and lead by example to help reduce the quantity and severity of climate change induced weather events.

A commitment to reduce carbon emissions (and declare a climate emergency) would demonstrate we are committed to reducing the impact of our activities in the short, medium and long term as our Plan progresses. By demonstrating commitment, we will work with colleagues, patient groups, the CCG, local authorities, the voluntary sector and other public

sector bodies to ensure that by 2030 residents feel the health benefits of noticeably improved air quality, and prevention of localised extreme weather events.

As part of the plan we will develop key performance indicators, working with patients, colleagues, suppliers and our partners so we can measure the impact of the work we are doing. We will develop overall carbon reduction targets per annum and report our progress.

Key Points to Note

Infographic below demonstrating how we encourage, engage and enable colleagues to consciously manage their (the Trust's) impact and how the Trust can exemplify good practice.

Data and graph breaking illustrating our carbon impact by category.

EQIA – Equality Impact Assessment

At present it is not possible to identify how specific groups will be impacted by the plans until individual changes are developed.

Some groups will be more affected by climate change, or by action (or non-action) taken. The main groups most likely to be impacted by climate change and action to reduce emissions are those in rural communities; children and future generations; poor or deprived communities and fuel poor households. The impacts will depend on the recommendations for change.

The Sustainable Development Management Plan and accompanying Action Plan will be the vehicle to implement our Climate Change Plan. Individual policies and actions will be discussed and assessed with the Sustainable Development Group, which will include an ED&I representative to ensure we highlight and address (socio-economic) inequalities.

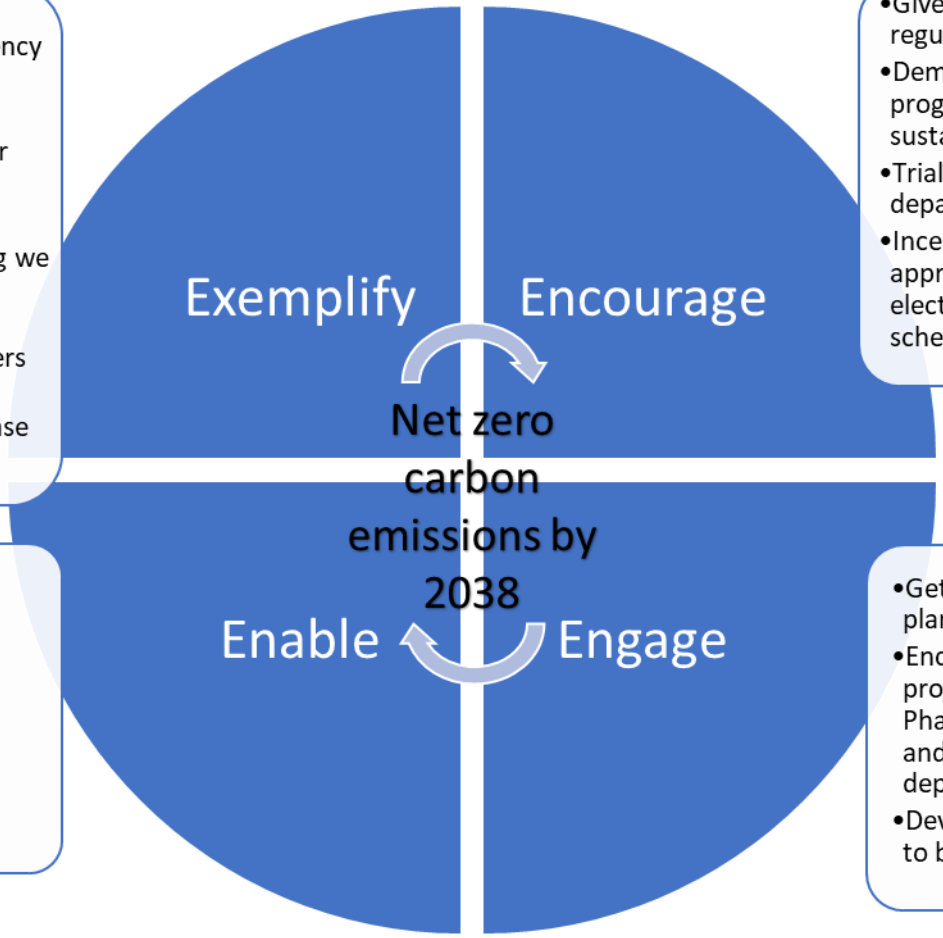
Recommendation

The Board is asked to:

- Commit to an ambition of net zero carbon emissions by 2038 in line with our local authorities.
- Support this climate change report.

CHFT Climate Change Plan:

Work together to get results: Net zero carbon emissions by 2038



- Lead by example
- Declare a Climate Change Emergency
- New waste contracts to reduce carbon impacts
- Source renewable electricity on or off-site
- Report on progress
- Embed sustainability in everything we do:
  - Include a sustainability assessment in Board papers
  - Include a sustainability assessment in business case applications

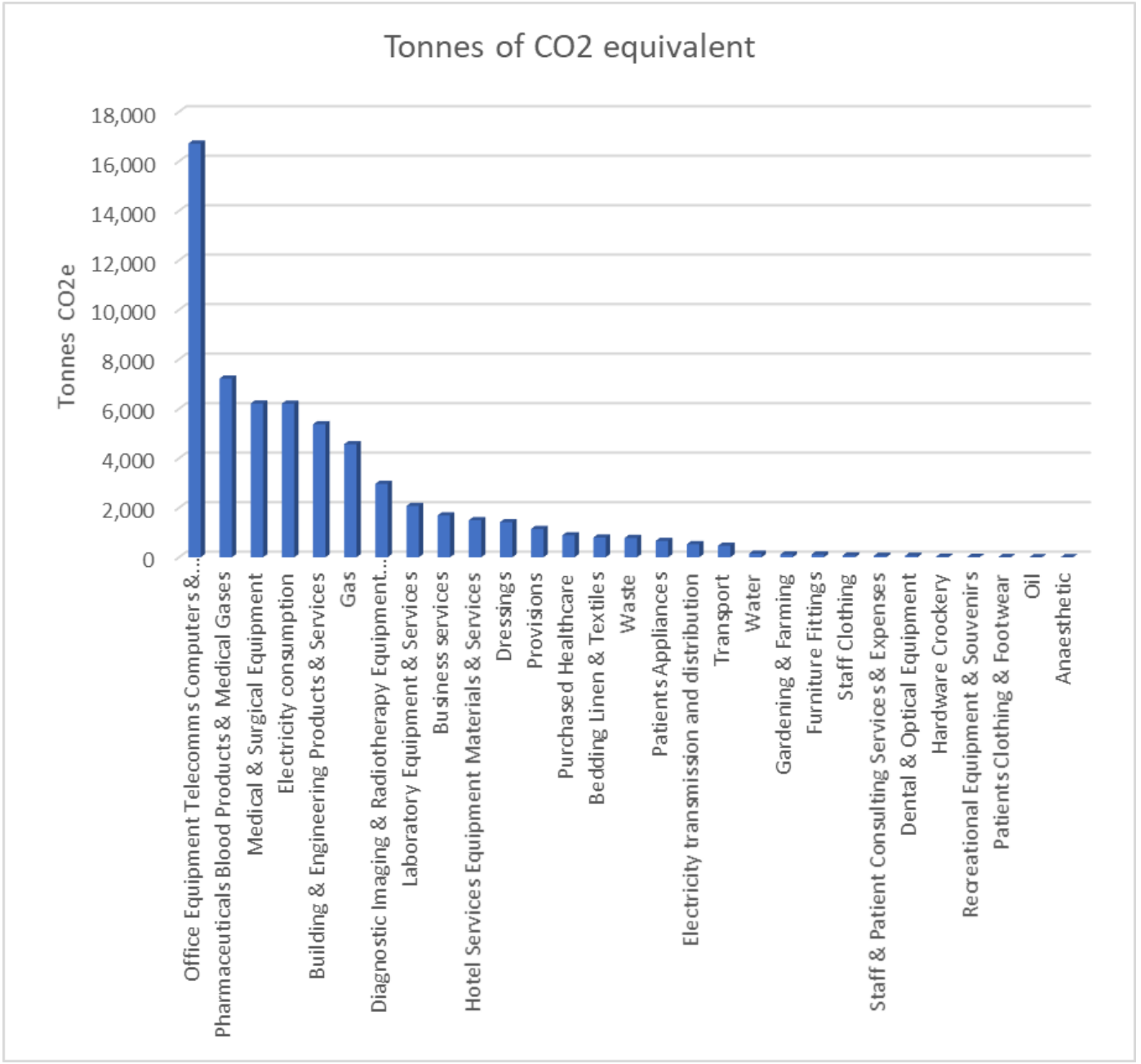
- Give positive feedback through regular communication
- Demonstrate good practice and progress against targets in an annual sustainability report
- Trial innovation with wards and departments
- Incentivise (and disincentivise if appropriate), e.g. free charging for electric vehicles or via staff benefit scheme.

- Make it easy
- Provide facilities e.g. recycling bins
- Expand the Environment Team to achieve the aim of the Plan
- Provide support (training and education) to enable responsible choices

- Get people involved, e.g. tree planting programme and green gym
- Encourage specific carbon reduction projects with Procurement, WOD, Pharmacy, Catering, Transport, THIS and individual wards and departments
- Develop 'social norms' to enable staff to be more conscious of our impact

Carbon impact

Category	Tonnes CO2 equivalent
Office equipment, telecoms, computers and stationery	16,716
Pharmaceuticals, blood products	7,220
Medical and surgical equipment	6,210
Electricity consumption	6,206
Building and engineering products and services	5,376
Natural gas	4,569
Diagnostic imaging and radiotherapy equipment and services	2,967
Laboratory equipment and services	2,076
Business services	1,694
Hotel services, equipment materials and services	1,496
Dressings	1,418
Provisions	1,144
Purchased healthcare	886
Bedding, linen and textiles	798
Waste	778
Patients appliances	662
Electricity transmission and distribution	529
Transport	466
Water	149
Gardening	113
Furniture and fittings	112
Colleagues clothing	75
Colleagues and patient consulting services	61
Dental and optical equipment	57
Hardware crockery	25
Recreational equipment and souvenirs	18
Patients clothing and footwear	9
Oil	5
Anaesthetic gases	3
TOTAL	**61,838**


Tonnes of CO2 equivalent
Tonnes CO2e
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Office Equipment Telecomms Computers &...
Pharmaceuticals Blood Products & Medical Gases
Medical & Surgical Equipment
Electricity consumption
Building & Engineering Products & Services
Gas
Diagnostic Imaging & Radiotherapy Equipment...
Laboratory Equipment & Services
Business services
Hotel Services Equipment Materials & Services
Dressings
Provisions
Purchased Healthcare
Bedding Linen & Textiles
Waste
Patients Appliances
Electricity transmission and distribution
Transport
Water
Gardening & Farming
Furniture Fittings
Staff Clothing
Staff & Patient Consulting Services & Expenses
Dental & Optical Equipment
Hardware Crockery
Recreational Equipment & Souvenirs
Patients Clothing & Footwear
Oil
Anaesthetic

Keeping the Base Safe

11. Health and Safety Review

Health and Safety review and 2019/20 Workplan

(i) 2018/2019 Annual Report

(ii) Strategic Review of Health and Safety

(iii) Board Assurance Framework Risk of Health and Safety

To Approve

Presented by Suzanne Dunkley

Date of Meeting:	**9 JANUARY 2020**
Meeting:	**BOARD OF DIRECTORS**
Title:	**STRATEGIC REVIEW OF HEALTH & SAFETY BY QUADRIGA HEALTH & SAFETY LIMITED**
Author:	**ALISON WILSON, CONTRACTS AND COMPLIANCE MANAGER/** **SUZANNE DUNKLEY, CHFT Health and Safety Champion**
Presented By:	**ALISON WILSON, CONTRACTS AND COMPLIANCE MANAGER**
Previous Forums:	**HEALTH & SAFETY COMMITTEE 18 DECEMBER 2019**

Actions Requested:

- To approve

Purpose of the Report

The paper updates the Board following a strategic review of the health and safety management arrangements in CHFT with a particular focus on the health and safety arrangements between the Trust and Calderdale and Huddersfield Solutions Ltd (CHS). The paper includes:

Health and Safety Review and 2019/20 Workplan
Appendix1 H&S Annual Report 2018/19
Appendix 2 Quadriga Strategic Review of Health and Safety Management
Appendix 3 Health and Safety risk proposed for Board Assurance Framework

Key Points to Note

Under the Health and Safety at Work Act our Trust Board have overall responsibility for the health and safety of colleagues and those who use our premises. All colleagues within the organisation have specific health and safety responsibilities.

The report from the external review undertaken by Quadriga concludes CHFT faces a number of health, safety and fire related safety issues which require close scrutiny by the Board and a review at senior level to ensure the issues are effectively managed and reduced.

The formation of CHS has resulted in the provision of operational health and safety support to CHFT but no independent strategic health and safety advice. The current arrangements give rise to a conflict of interest with professional monitoring of health and safety standards coming from within CHS. A similar issue was noted relating to strategic fire safety advice however, arrangements are now in place to resolve this issue.

A number of prioritised recommendations have been made to manage and reduce the risks identified which include:-

- The provision of a professional health and safety manager to provide support and advice to the Health and Safety Champion, Board of Directors and all colleagues
- A review of the Trust's Health and Safety Policy which will clearly identify roles and responsibilities of all colleagues within the Trust and identify the arrangements between any third parties (i.e. CHS / PFI)
- A review of the Construction (Design & Management) Regs 2015 ensuring the appropriate appointment of third parties (i.e. CHS)

- A review of the Reporting of Injuries, Diseases & Dangerous Occurrence Regs (RIDDOR) 2015 to ensure the Trust has a robust reporting process to the Health & Safety Executive for all RIDDOR injuries, diseases and dangerous occurrences
- A review of the risk assessment probability matrix
- Development and implementation of specific policies for specific risks
- A review of the fire safety arrangements and plans
- Early warning, visibility and clarity on joint risks between CHS and CHFT complete with mitigation and actions

It is recommended the Board approve the report and its recommendations which will reduce the issues highlighted and provide greater assurance the Trust is meeting its legal requirements.

It is recommended the action plan is managed and monitored through the Trust's Health and Safety Committee who report directly to the Audit and Risk Committee.

Health and Safety Risk

The Trust five-year strategy, within the keeping the base safe objective, identifies the intention to be fully compliant with health and safety standards.

The Board Assurance Framework identifies risks to the achievement of strategic objectives. It has been previously reported to the Board that a risk relating to this strategic objective for health and safety was being identified and would be presented to the Board once the external health and safety review was complete.

The following categories of the Board risk appetite are relevant to a risk relating to health and safety:

Harm and safety – minimal risk appetite "*we will take minimal risk, or as little as reasonably possible, when it comes to staff/patient safety and harm and clinical outcomes for patients."*

Legal – minimal risk appetite *"we will comply with the law"*

A health and safety risk has been developed and is enclosed at Appendix 3 for review and approval by the Board. The risk is described below and a risk score of 9 has been identified using the Trust risk scoring matrix.

BAF ref: 16/19
Risk of not being compliant with the Health and Safety at work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.

EQIA – Equality Impact Assessment

The equality impact of this paper has been considered. All health and safety (including fire) policies, guidelines and processes will be written in plain English. All health and safety (including fire) staff learning modules and patient instructions will be delivered via multiple learning/communication channels to ensure colleagues know (for example) what to do in the event of a fire – this includes colleagues with a hearing impairment and patients whose first language is not English or are neuro diverse.

A further EQIA will be carried out on the Health and Safety action plan (which will include contribution from service users, colleagues from the equality networks and Equality, Diversity and Inclusion Manager which will be presented to a future Board.

Recommendation
The Board is asked to APPROVE the report and its recommendations. Note the 2018/19 Health and Safety Annual report and 2019/20 action plan Approve the recommendations from the external review of H&S as described in this paper Approve the Health and Safety risk, 16/19 for addition to the Board Assurance Framework

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

9 JANUARY 2020

HEALTH & SAFETY REVIEW

1. Introduction

This review takes account of previous health and safety recommendations and workplans prior to and following the formation of Calderdale and Huddersfield Solutions (CHS) Ltd. It also takes into account the work carried out by the Trusts Health and Safety Committee, the Trust's 5 year strategy and recommendations made by Quadriga Health and Safety Limited who are the Trusts external advisor.

2. Aim

The aim of this review is to provide:-

- an update and assurance to Trust Board of the health and safety work and plans shared in the Annual Report (1st April 18 – 31st March 19)
- detail relating to health and safety work delivered between 1st April 19 to 31st October 19).
- a clear and concise health and safety workplan for the remainder of CHFTs financial year (Nov 19 – March 20) which takes account of existing and new recommendations identified by Quadriga; this will be monitored by the Health and Safety Committee.

3. Review

3.1 Background

Prior to the formation of CHS the Executive Director with accountability for Health and Safety resided in Estates and Facilities. The responsibility for providing health and safety support, advice and guidance to the Trust and to work partnership with its PFI provider resided in the Estates and Facilities Division. On the formation of the wholly owned subsidiary the health and safety advisor role was retained within CHS and a service level agreement (SLA) developed whereby operational health and safety services were provided to CHFT.

However, concerns were raised regarding the robustness of health and safety arrangements between CHS and CHFT resulting in recommendations for an external review.

3.2 Health and Safety Activities during 1st April 18 – 31st March 19

The Trusts annual health and safety report is detailed in Appendix 1 and illustrates work carried out during a 12 month period and includes recommendations. Health and Safety training was provided by CHS and external providers. The training focussed on:- -

- Trust Induction – 24 sessions per annum (via CHS)
- Risk Assessment Training – 21 sessions provided with availability to 270 staff and 140 attendees (52%) via CHS
- COSHH Super User Training – 2 sessions delivered by Alcumus to 10 Super Users with further cascade training delivered however, the latter not monitored
- IOSH Leading Health & Safety – 1 session provided to Trust Board

Trust induction and risk assessment training sessions have continued to be provided however, a review of the effectiveness of both Risk Assessment training and the Trust COSHH arrangements is recommended and captured within this report.

Significant efforts have been focussed on training in the use of medical devices and identifying and completing planned preventative maintenance on medical devices. CHS, with the support of the Trust and its capital programme, have carried out a planned programme of work identifying the location of

devices and, where appropriate, maintaining such devices. A number of devices have been replaced resulting in a much improvement towards the management of equipment.

3.3 Health & Safety activities between 1st April 19 & 31st Oct 19

A strategic review of Health and Safety was carried out by Quadriga Health and Safety Limited in July 2019 with a final report submitted in October 2019 (Appendix 2).

A number of Quadriga recommendations aligned with the Trusts however a number of new recommendations were made to ensure compliance with Health and Safety legislation. These were:-

- Compliance with the Construction (Design and Management) Regulations 2015 (CDM 2015) and relationships between Trust and CHS
- Introduction of new policies to ensure legislation applicable to the Trust was managed accordingly
- A review of fire safety arrangements between the Trust and CHS which, following the appointment of the Trust Chief Operating Officer and the transfer of the Fire Officer from CHS to the Trust, has commenced.
- The appointment of a competent and skilled Health and Safety Manager to support the CHFT Executive Health and Safety Champion and provide strategic advice to CHFT.
- Clarity on shared risks between the Trust and CHS at Joint Liaison Committee with a focus on reviewing the effectiveness of any mitigation / controls.

During this period the Health and Safety Committee continues to be proactive and, following changes in the leadership, meets on a bi-monthly basis as opposed to a monthly basis. The Committee forms part of a robust governance structure feeding into the Risk and Audit Committee via a SOAP. The Committee is made up of Trust Management, Divisional Reps, Staff Side Reps, CHS, HPS and PFI colleagues and continues to provoke a healthy debate and sharing amongst colleagues. The Committees TORs are due to be reviewed with the expectation of Divisional Reps taking on a more proactive role in sharing and learning from incidents. Health and Safety related policies continue to be approved via this committee.

The Trusts Health and Safety policy requires a review and, following an external review by Quadriga Health and Safety Limited in June 2019, is required to give clarity on the arrangements, roles and responsibilities between CHFT and CHS. A number of stand-alone policies will be required which currently reside within the Trusts Health and Safety Policy.

4. Joint Quadriga / Trust Health & Safety Workplan 2019/20

The following 2019/20 workplan captures a combination of both Trust and Quadriga recommendations which has been discussed with the Trust Health and Safety Committee. Whilst there are some short-term actions which are complete there are a number of recommendations that require progressing. This Committee will ensure the workplan is closely monitored on a bimonthly basis and provide regular updates to the Audit and Risk Committee.

HEALTH AND SAFETY WORKPLAN NOVEMBER 2019/MARCH 2020

The workplan captures all recommendations relating to health and safety. The workplan will be monitored at bi-monthly Health & Safety Committee meetings.

- AP – CHFT Health & Safety Annual Plan Recommendations
- Q – Quadriga Recommendations

	Action	Tasks	Recs	Who	Target Date
1	**Review of Health and Safety Arrangements**	Assess and review health and safety governance arrangements between CHFT and CHS	AP & Q	MD CHS and CHFT Executive Health and Safety Champion Quadriga	30/9/19
		Advertise and appoint Trust Health and Safety Manager	AP	CHFT Executive Health and Safety Champion	31/3/20
		Review Trust Health and Safety Policy to create clarity on roles and responsibility within CHFT (referencing relevant support from CHS) stating how competent support is provided at strategic level.	AP & Q	CHFT Executive Health & Safety Champion and Manager	31/3/20
2.	**Review of Risk Assessments**	Introduce Risk Assessment Policy	Q	Health & Safety Manager	31/3/20
		Review Risk Assessment scoring matrix	Q	Health &Safety Manager/ Risk Management	31/3/20

	Action	Tasks	Recs	Who	Target Date
		Review effectiveness of Risk Assessment Training	AP	Health & Safety Manager /Health & Safety Advisor	30/9/20
3	**Develop Specific Risk Related policies**	Review and, where appropriate, create individual policies on specific risk areas namely:- • Dangerous Substances and Explosive Atmosphere Regs (2002) • Control of Noise at Work Regs (2005) • Control of vibration at Works Regs (2005 • Control of Electromagnetic Fields at Work Regs (2006)	Q	Health & Safety Manager /Health & Safety Advisor	30/9/20
4	**Ensure compliance with Construction (Design & Management) Regs 2015**	CHFT to appoint, in writing, CHS as the Principal Contractor and Principal Designer for all such minor works and obtain a written acceptance of this appointment. Appointment letter must identify expectations and reporting structure.	Q	CHFT FD, CHFT Executive Health & Safety Champion and CHS MD	31/1/19
5.	**Ensure compliance with the Fire Safety (Regulatory Reform) Order and supporting HTM 05**	Appoint Director with overall responsibility for Fire Safety	Q	Chief Exec / CHFT Executive Fire Safety Champion	31/8/19
		Review Fire Safety Service Level Agreement between CHFT and CHS.	Q	CHFT Executive Fire Safety Champion / CHS	31/12/19

	Action	Tasks	Recs	Who	Target Date
		Review Trust Fire Policy ensuring clarity on roles, responsibilities and arrangements with CHS and clarity on training requirements.	Q	CHFT Executive Fire Safety Champion / CHS	31/12/19
		Develop 5 year Fire Strategy taking into account capital works / reconfiguration and compartmentation.	Q	CHFT Executive Fire Safety Champion	30/6/20
6	**Reduce the number of Needle-stick, Sharps and Splash incidents.**	Update Health & Safety Committee terms of reference incorporating the role and responsibility of Divisional Reps.	AP	CHFT Executive Health and Safety Champion / H&S Committee	31/3/20
		Measure the number of incidents on a bi-monthly basis	AP	Occ. Health / H&S Committee	31/3/20
		Develop and share innovative learning across Trust	AP	H&S Committee	31/3/20
7	**Provide a robust COSHH management system Trust wide**	Carry out a review of current COSHH system within Trust recognising:- • No of Super users • No of Staff Trained • Up to date COSHH folders available • Knowledge of colleagues in Divisions	Q & AP	CHS Health & Safety Advisor / Divisions	30/9/20

	Action	Tasks	Recs	Who	Target Date
8	**Monitor reporting of Slips, Trips & Falls**	Monitor the number of incidents on a bi-monthly basis.	AP	CHS Health & Safety Advisor / H&S Committee	31/12/19
		Encourage accurate reporting and learning via Datix	AP	Risk Management	31/3/20
9	**Review Health and Safety Training**	Monitoring mandatory 3 yearly training	AP	H&S Advisor / CHFT Executive Fire Safety Champion	31/1/20
		Measure numbers of colleagues receiving risk assessment training	AP	CHS H&S Advisor	31/1/20
		Reviewing effectiveness of risk assessment training	AP	CHS H&S Advisor	31/3/20
10	**Wards / Departments to achieve Medical Devices training target**	Monitor and report medical device training statistics at health and safety committee	AP	CHS Medical Devices Trainer	31/8/19
		Escalate areas of concern to Audit & Risk Committee	AP	Health & Safety Committee	31/3/20

	Action	Tasks	Recs	Who	Target Date
11.	**CHS & CHFT Risk Registers**	Cross reference CHS and CHFT applicable risks	Q	CHFT/CHS	
		Ensure Joint Liaison Committee (CHS/CHFT) periodically review whether risk controls in place are considered acceptable and are actually working.	Q	JLC Chair	
		Where risks are registered as falling into the significant risk category on either CHS or CHFT register, and are reported to the JLC Committee, that the immediate actions being taken to mitigate the risk are also outlined in the same report. This should be supplemented by the planned timescale for implementation.	Q	CHFT/CHS	
12.	**Improvement of reporting arrangements of RIDDORs incidents to HSE**	Review RIDDOR reporting arrangements for interfacing with the Health and Safety Executive and submitting reports under RIDDOR to the HSE	AP & Q	Health and Safety Manager/H&S Committee/Risk Management	31/3/20
		Monitor and report RIDDOR incident and trends at health and safety committee	AP	CHS H&S Advisor	31/8/19

Alison Wilson
Contracts & Compliance Manager
9 January 2020

Appendix 1

Health & Safety Annual Report
1st April 2018 – 31st March 2019

1. INTRODUCTION

The Health and Safety annual report has been prepared by Calderdale & Huddersfield Solutions (CHS) on behalf of Calderdale and Huddersfield NHS Foundation Trust (CHFT). CHS was formed in September 2018 as a wholly owned subsidiary of CHFT. The report forms part of the CHFTs 5 year strategy with a goal of "delivering the annual health and safety action plan" which underpins the result of "Keeping the Base Safe". The report provides a retrospective review of the previous 12 months health and safety performance and makes recommendations to improve future performance.

2. BACKGROUND

Prior to the formation of CHS the Executive Director with accountability for Health and Safety resided in Estates and Facilities. The responsibility for providing health and safety support, advice and guidance to the Trust and to work partnership with its PFI provider resided in the Estates and Facilities Division. On the formation of the wholly owned subsidiary the health and safety advisor role was retained within CHS and a service level agreement (SLA) developed whereby operational health and safety services were provided to CHFT.

However, concerns were raised regarding the robustness of health and safety arrangements between CHS and CHFT resulting in recommendations for an external review.

3. REPORT

3.1 Policies

CHFT's Health and Safety Policy is under review and aims to be completed following the external health and safety review and subsequent recommendations. On completion the policy will be presented to the Trust board for approval.

3.2 Risk Assessments

The Management of Health and Safety at Work Regulations MHSWR) 1999 place a requirement on organisations to undertake suitable and sufficient risk assessments to identify significant risks to the health, safety and welfare of employees and anyone that may be affected by their activities. Regulation 3 states it is an "absolute" duty that employers must carry out suitable & sufficient risk assessments, the risk assessments must be recorded, reviewed and staff must be suitably trained to undertake them.

The organisation has specific risk assessments for specific risk eg: Fire Safety, Moving and Handling, Estates Engineering Tasks and Substances that may be hazardous to health, however, there is a gap with regards to the general risk assessment process. Following a review of health and safety training our Trust Executive Board agreed to replace the one day IOSH Managing Safety with more focussed bite sized Risk

Frances Brocklehurst
Health & Safety Advisor
CHS

Assessment training; this continues to be provided by CHS Health and Safety Advisor. A total of 21 sessions have been provided with spaces for 270 staff and an uptake of 140 staff (52%). Training has been well received by Trust colleagues however, the effectiveness of the training remains unclear.

3.3 Incidents reported via The Reporting of Incidents Injuries and Dangerous Occurrence Regulations (2013) (RIDDOR)

RIDDOR places a legal requirement on employers, and others in control of work premises, to report, investigate and maintain records for certain types of injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE). These are classed as work related incidents and fall under the following categories:-

- Work-related accidents which cause death
- Work-related accidents which cause certain serious injuries ('specified injuries') or result in employees being away from work for more than 7 days
- Diagnosis of certain industrial diseases
- Dangerous occurrences (incidents with the potential to cause harm)

During the reporting period a total of 8 staff RIDDOR incidents were reported to the HSE, this is a reduction of 34% on 2017/2018. Given the size of the organisation there is further work required to ensure RIDDOR incidents are being reported accurately through Datix, Occupational Health Department and Managers.

A breakdown of the causes of these incidents is illustrated in table 1 with 2018/19 comparator of the previous year.

Table 1 – STAFF RIDDOR INCIDENT CAUSES

	2017/2018	2018/2019
Slips, trips, falls and collisions	8	4
Lifting accidents	2	1
Abuse on Staff by patients	0	0
Accident caused by some other means	2	3
TOTAL	12	8

Whilst table 1 illustrates a 34% reduction in RIDDOR incidents concerns remain over the accuracy of reporting. Upgrading to the Datix incident reporting system has taken place by Risk Management within 2018/19 allowing ease of use for staff when reporting a RIDDOR incident and a step by step guide available on the Trust intranet under the Health & Safety. RIDDOR incident reporting is also covered within the risk assessment training.

Slips, trips and fall incidents remain the main cause of RIDDOR incidents with an increase of 1 on the previous year. Table 2 illustrates the type of RIDDOR incidents reported to the HSE.

Table 2 – RIDDOR INCIDENT INJURIES

Type of RIDDOR Incident	2018/2019	Injury cause
Specified injuries	3	Fall (2 x fractures) Burn x1
Injuries causing over 7 days absence	5	Slips, trips or falls (3) Lifting Incident (1) Driving Accident (1)

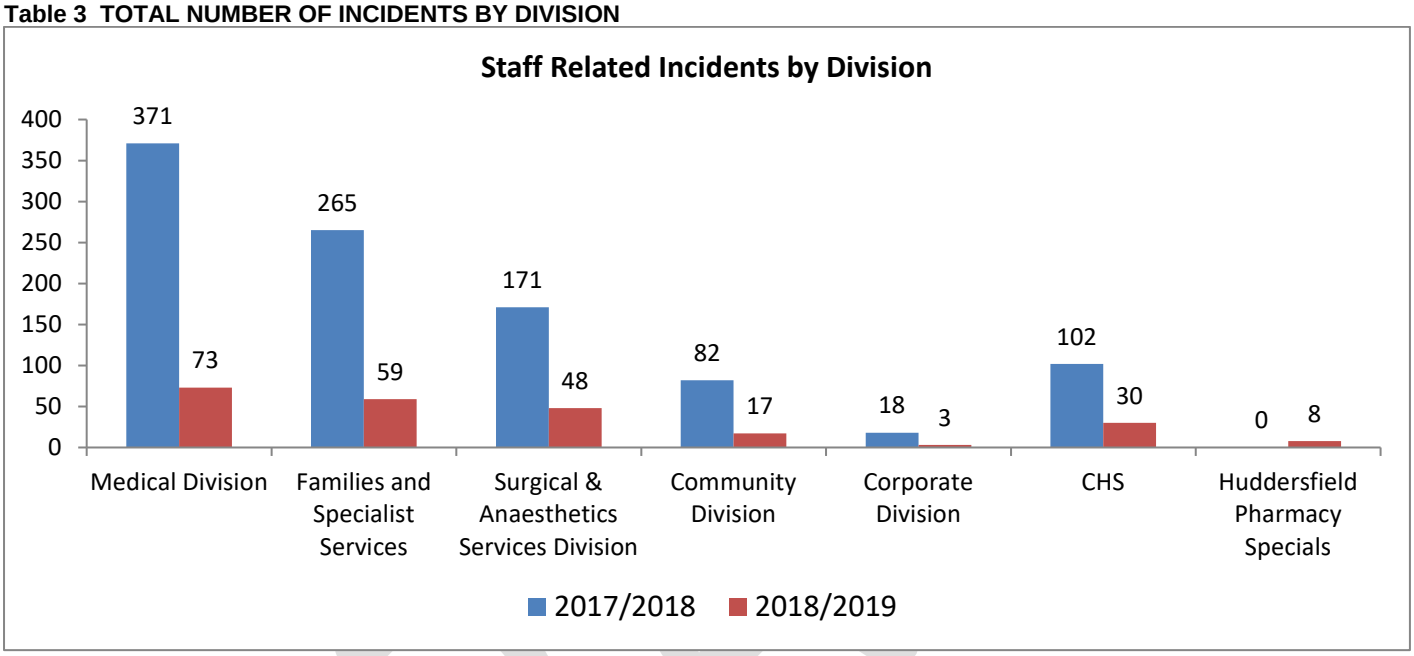
Frances Brocklehurst
Health & Safety Advisor
CHS

3.4 Staff Related Incidents Reported on Datix

Incident reporting has decreased significantly by 45% in 2018/2019 despite there being a continual effort to raise awareness of the importance of reporting incidents at both Corporate Induction and Health and Safety Training.

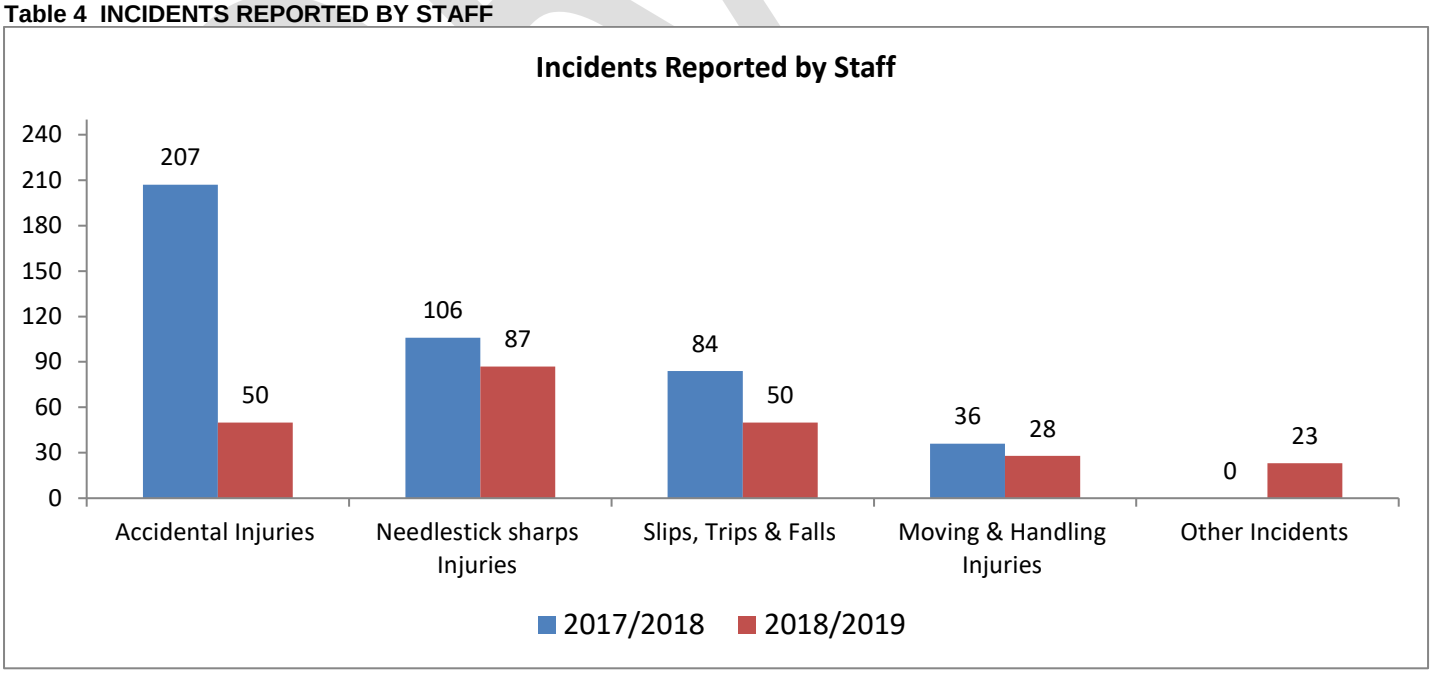
A total of 238 staff incidents were reported in 2018/19 which is a 45% decrease compared with the 2017/2018 total (433)

Table 3 TOTAL NUMBER OF INCIDENTS BY DIVISION



The main incidents indentified / sustained by staff in 2018/2019 are outlined in Table 4:

Table 4 INCIDENTS REPORTED BY STAFF



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- **Accidental Injuries** shows a decrease in numbers by 76% in 2018/2019. The Datix incident reporting system has been streamlined in 2018/2019 to capture significant incident details to monitor trends and identify areas for inprovement.

- **Needlestick/Sharps Injuries** shows a 18% decrease in numbers in 2018/2019. An overview is detailed in section 3.5 and the recognition that further work is necessary in 2019/20.

- **Slips, Trips & Falls** shows a derease in numbers of 40% in 2018/2019, incident reporting is essential to capture a true reflection of incidents and how they occur, this area will continue to be monitored and promoted.

- **Moving & Handling Injuries** reported on Datix within 2018/2019 llustrate a 22% reduction from the previous year. The Moving & Handling training and policy was transferred to Workforce and Organisational Development in 2018 and the Specialist Advisor regularly reports into the Health and Safety Committee.

3.5 Needle-stick and Splash Injuries

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 concentrates on the prevention of sharps injuries in the hospital and healthcare sector and apply to employers, contractors and workers in this sector. On reflection of the 2016 national HSE inspections of 40 healthcare providers, the Trust is continuing with the proactive approach to protect all staff from exposure to blood borne viruses. The Sharps Injury Task and Finish Group (Health and Safety committee sub-group) continues to:

- Ensure accurate reporting of such incidents
- Investigate needle-stick / splash related incidents
- Observe and inspect the workplaces with high numbers of incidents
- Provide support / advice to areas
- Ensure shared learning across the Trust

The sub-group consists of the CHS Health and Safety Advisor, Lead Infection and Prevention Control Matron, Lead Occupational Health Advisor, Staff Side and BBraun Contracts Manager. A number of needle-stick / sharps audits have been completed with audit findings and recommendations shared with Heads of Departments and General Managers. The recommendation of the sub group is the Divisional audits are shared with Divisions at the health & safety committee, the divisional leads with return with their recommendations and subsequent actions to ensure learning from incidents with a view to reducing injuries to all staff. Divisional engagement is essential in order to protect all staff.

Table 5 illustrates a total of 87 Needle-Stick / Sharps injuries reported on Datix which has decreased by 18% 2018/2019. A total of 149 Needle-Stick/ Sharps injuries were reported to Occupational Health in the same reporting period illustrating a discrepancy of 62 incidents. The promoting of Datix incident reporting is continuing with Occupational Health colleagues and promotional information.

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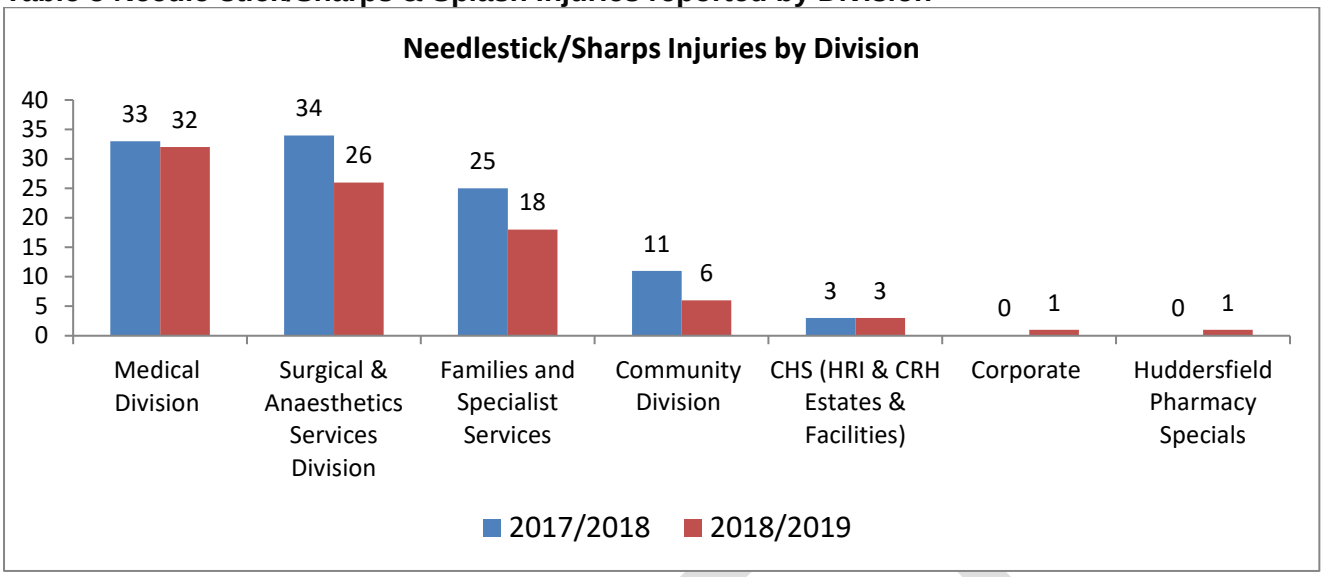
Table 5 Needle-stick/Sharps & Splash Injuries reported by Division



3.6 Employee & Public Injury Claims

Risk Management provide quarterly updates to the Health and Safety Committee of Employers and Public Liability claims (EL/PL) made against the Trust. During the reporting period of 2018/2019 a total of 11 EL/PL claims were lodged against the Trust, showing a decrease 3 claims since 2017/2018. A total of 23 claims were closed in 2018/2019,

EL/PL Cost to the Trust:

Claimant cost	£63,210
Damages	£74,368
Defence Cost	£24,885

3.7 Health and Safety Training

The mandatory Health & Safety awareness training is continuing for all Trust staff on a 3 yearly basis via ESR and the Trust is currently 94% compliant at the end of March 2019. This training package is a national package and cannot be changed locally, however in 2019/2020 attention will be paid to updating the ESR health and safety training package with the assistance of Workforce & Organisational department.

CHS Health and Safety Advisor provides face to face health & safety training at Trust induction which is held twice monthly and continues to receive positive feedback from attendees.

In 2018/2019 CHS Health & Safety advisor provided face to face risk assessment training, the training last for 1 hour 30 mins and targets Managers, Supervisors, Team Leaders and anyone responsible for carryout a risk assessment, the training has received positive attendance figures with over 100 staff members attending and completing the face to face interactive session, the training will continue on an on-going basis throughout 2019/2020.

Trust Board of Directors received “Leading on Health and Safety Training” in February 2019 which was well received.

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4. GOVERNANCE ARRANGEMENTS

4.1 Reporting Arrangements

Following the creation of CHS and the transfer of previous Executive lead for health and safety the Trust Health and Safety Committee is chaired by the Director of Workforce Organisational Development. The Committee meet on a bi monthly basis and report into the Quality Committee (a sub-committee of Trust Board) escalating any areas of concern or significant risk. Each topic specialist provides regular reports to the Committee providing assurance that specific risks are being managed.

4.2 Health and Safety Committee Attendance

The membership of the Committee includes topic specialists, Staff Side Reps, Divisional Reps and guest speakers as and when required. The Committee ensures that the Trust consults its employees on health and safety matters, allows the exchange of information, indicates potential areas of safety concern highlighted through the presentation of incident data and provides legislative updates.

However, further work is required to ensure Divisional reps attend as this will provide assurance that information discussed is disseminated to Divisional staff including any shared learning.

5. SPECIFIC RISKS

5.1 **Control of Substances Hazardous to Health (COSHH)**

Under the COSHH Regulations 2002 the Trust must either prevent or reduce employees' exposure to substances that are hazardous to their health. The Trust aims to achieve this by:-

- finding out what the health hazards are,
- deciding how to prevent harm to health via COSHH risk assessments,
- providing control measures to reduce harm to health (eg: ventilation / personal protective equipment)
- making sure the control measures are used accordingly
- keeping all control measures in good working order;
- providing information, instruction and training for employees and others;
- providing monitoring and health surveillance in appropriate cases;
- planning for emergencies

An external Company, Alcumus Sypol, provide the Trusts COSHH risk assessments which are available via a COSHH Management System (CMS). They are reviewed at regular intervals or when safety data sheets indicate any changes in the hazards associated with the substance. The CMS enables staff to download and print electronic COSHH risk assessments for hazardous substances used in their area. In 2018/2019 Alcumus Sypol provided the Trust with a number of "train the trainer" sessions and a number of nominated Divisional staff were trained to become CMS "Super Users". The plan being that Super Users would train colleagues within their division. Additionally, CHS Health and Safety Advisor has provided COSHH training to over 30 Trust colleagues.

Further work is essential ensure COSHH requirements are understood and embedded within Divisions with up to date risk assessments, trained staff and an understanding of requirements.

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CHS

5.2 Manual Handling

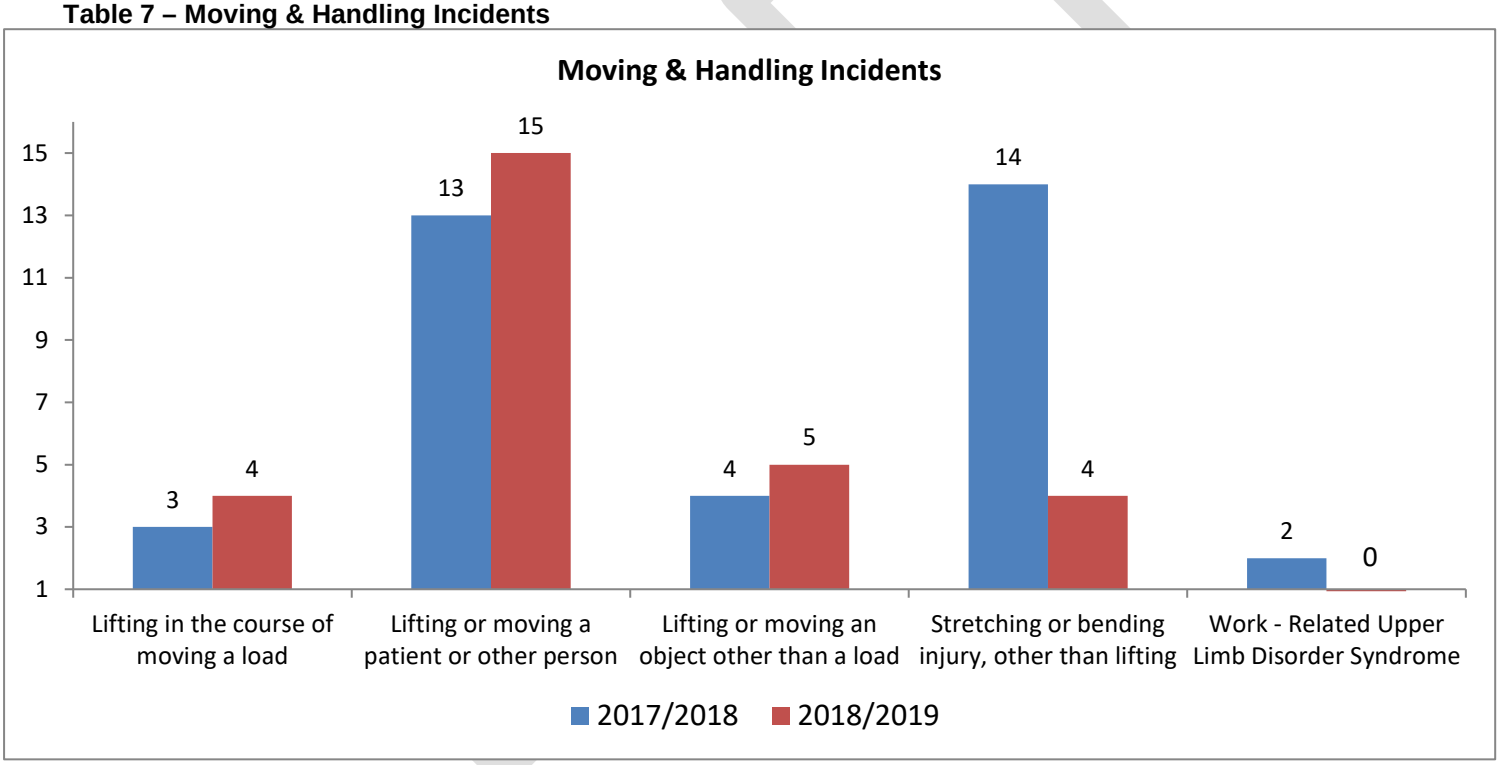
Manual Handling Operations Regulations 1992 (as amended) (MHOR) define manual handling as: "...any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force. The Trust must comply with the risk assessment requirements set out in the Regulations 1999 as well as the requirement in the Manual Handling Operations Regulations 1992 (MHOR) to carry out a risk assessment on manual handling tasks.

The Trust saw a total of 28 staff related manual handling incidents reported via Datix during 2018/2019 which has decreased by 22% on 2017/2018 figures; however, lifting or moving a patient/person has increased by 13%.

The Moving & Handling training sits within the Workforce and Organisational Development and the Specialist Advisor provides regular informative reports into the Health and Safety Committee. CHFT is currently 92.2% complaint with manual handling training.

Table 7 below shows Manual Handling incidents from 2017/2018 – 2018/2019

Table 7 – Moving & Handling Incidents



5.3 Medical Engineering

The Medical Devices Regulations 2002(11) require all medical devices to carry the CE marking which is captured within the Medical Devices Management Policy. The Medical Engineering department provide an important service to the Trust and follow the MHRA document "Managing Medical Devices Guidance for healthcare & social services organisations – April 2015" which includes:

- Checking equipment for compliance with appropriate regulations
- Managing the provision of appropriate maintenance and repair for medical devices

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- Providing proactive advice on the procurement of suitable medical devices ensuring that devices are of good quality, comply with appropriate standards and are cost efficient, resulting in safe and appropriate equipment for healthcare use.
- Co-ordination & provision of medical devices training
- Monitoring and recording training on the 'Medical Devices Training Database'
- Management of the Medical Equipment library on two

The safe and correct use of medical equipment is important to obtain the right diagnosis so that appropriate treatment can be delivered to the patient. The incorrect use of equipment can result in patient harm, staff injuries and damage to equipment which can impact further patient diagnoses. It is essential that suitably authorised staff receive appropriate competency-based training **before** using the medical equipment.

In 2018/2019 it was identified that throughout the Trust there were a number of medical devices that were out of service date, unavailable for use and still in use. The Chief Medical Engineer (CHS) escalated the risks and identified a prioritised action plan which aimed to minimise the risk as quickly as possible, working on the high-risk devices first:

- Identifying/locating high risk devices, focusing on surgical/theatre devices as a priority.
- Introduce monthly medical devices checks by departments/divisions to identify devices that are due for servicing.
- Controlling maintenance contracts to ensure contractual obligations are met.
- Controlling the procurement of medical devices.
- Introducing a software system within the procurement process to monitor & control access of contractors and sales representatives.

During 2018/2019 there were 257 incidents involving medical equipment reported via Datix which is a 23% increase in reporting from the reporting period in 2017/2018, Incident reporting is continuing to improve within divisions as is shown in the reporting figures. Table 9 below details Medical Device incidents reported by Division.

Table 9

Medical Device Incidents Division	2017/2018	2018/2019
Surgical & Anaesthetics	64	89
FSS	58	84
Medical Division	59	70
Community	10	5
Estates & Facilities	6	9
Corporate	2	0
Total	**199**	**257**

Medical Devices Training

The Trust has a target of 70% of authorised staff being trained in the use of a new device prior to clinical use and a 95% target for permanent staff sufficiently trained on current devices. In 2018/2019 the Trust compliance figures were 77% which was significantly below target. Medical device training has been added to the 2019/2020 action plan and support is needed to raise the training compliance figures.

Table 11 below illustrates medical device training compliance. The medical devices training department have put an action in place to identify staff that are non-compliant with medical devices training, wards/departments are requested to carry out risk assessments associated to the non-complaint staff, put an action plan in place and capture this information on their departmental risk register.

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This will be reported through the Health & Safety Committee however, support is needed by Divisions to ensure CHFT staff are compliant with medical device training throughout 2019/2020

Table 11 - Medical Device Training by Divisions

Division	Average % of staff trained 2017/2018	Average % of staff trained 2018/2019	Decrease/Increase
FSS	90%	81%	Decrease
Surgery & Anaesthetics	78%	62%	Decrease
Medical	74%	69%	Decrease
Corporate	66%	65%	Decrease
Community	75%	85%	Increase

A total of 80% of Divisions are showing a decrease in relation to staff receiving medical devices training therefore urgent work is needed to ensure CHFT are compliant with medical devices training. Well done to Community Division who have made improvements on the previous year.

The Medicines and Healthcare Regulatory Agency (MHRA) provides the key compliance document in relation to the management of medical devices, "Managing Medical Devices Guidance for healthcare and social services organisations" (April 2015). The MHRA issues Medical Device Alerts (MDAs) that notify organisations about safety issues with medical equipment and actions that need to be taken to remove or reduce the risks identified. The MHRA issued 49 Medical Device Alerts (MDAs) in the 2018/19 financial year relating to medical devices, all of which were actioned appropriately in accordance with Trust policy.

6. WORKPLAN AND RECOMMENDATIONS 2019/2020

The following work-plan illustrates actions to be incorporated into the 2019/2020 work plan.

	Action	Tasks	Who	Target Date
1	**Review of Health and Safety Arrangements**	Assess and review health and safety governance arrangements between CHFT and CHS	WOD Exec Director / Quadriga	30/9/19
		Review Trust Health and Safety Policy ensuring clarity on key roles and responsibilities within CHFT and arrangements with CHS.	WOD	31/3/20
2	**Reduce the number of Needle-stick, Sharps and Splash incidents.**	Update Health & Safety Committee terms of reference incorporating the role and responsibility of Divisional Reps.	WOD Exec Director / H&S Committee	31/3/20
		Measure the number of incidents on a bi-monthly basis	Occ. Health / H&S Committee	31/3/20

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		Develop and share innovative learning across Trust	H&S Committee	31/3/20
3	**Provide a robust COSHH management system Trust wide**	Carry out a review of current COSHH system within Trust recognising:- • No of Super users • No of Staff Trained • Up to date COSHH folders available • Knowledge of colleagues in Divisions	WOD / CHS Health & Safety Advisor / Divisions	30/9/20
4	**Monitor reporting of Slips, Trips & Falls**	Monitor the number of incidents on a bi-monthly basis.	CHS Health & Safety Advisor / H&S Committee	31/12/19
		Encourage accurate reporting and learning via Datix	Risk Management	31/3/20
5	**Review Health and Safety Training**	Monitoring mandatory 3 yearly training	H&S Advisor / WOD Director	31/1/20
		Measure numbers of colleagues receiving risk assessment training	CHS H&S Advisor	31/1/20
		Reviewing effectiveness of risk assessment training	CHS H&S Advisor / WOD	31/3/20
6	**Wards / Departments to achieve Medical Devices training target**	Monitor and report medical device training statistics at health and safety committee	CHS Medical Devices Trainer	31/8/19
		Escalate areas of concern to Audit & Risk Committee	Health & Safety Committee	31/3/20
7.	**Ensure accurate RIDDOR reporting**	Review reporting of RIDDOR incidents	WOD/Risk Management	31/3/20
		Monitor and report RIDDOR incident and trends at health and safety committee	CHS H&S Advisor	31/8/19

Frances Brocklehurst
Health & Safety Advisor
CHS

Strategic Review of Health and Safety Management For Calderdale and Huddersfield NHS Foundation Trust

July 2019

Undertaken by Quadriga Health & Safety Ltd
318 Kings Road, Reading, Berkshire RG1 4JG

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Strategic Review of Health and Safety Management

Contents

Strategic Review of Health and Safety Management

Executive Summary

Quadriga Health and Safety Ltd, was commissioned by the Calderdale and Huddersfield NHS Foundation Trust to undertake a strategic review of health and safety management arrangements in the Trust. In particular, the review considered the way in which the Trust exercised oversight of its subsidiary company providing estates services for the Trust in respect of the Huddersfield Royal Infirmary.

The scope of the review did not include a review of the oversight of the separate PFI hospital operated by the Trust. The scope of the review also did not include any detailed inspections of the facilities and the actual systems of work on-site, as opposed to the overall health and safety management arrangements. However, an opportunity was taken during the site visits to see some areas of the hospital in particular some plant and boiler rooms, basement areas, roof spaces and areas of roof access.

The review involved a two day site visit during early July 2019 and discussions with key directors and senior members of staff and a review, before and after the site visit, of key health and safety documentation and policies. The review also included attendance at the Joint Liaison Committee between CHFT and CHS as an observer. Following this review, a draft report was issued in August 2019 and this final report has been issued following some comments and further information supplied by CHFT in October 2019 after the original draft was issued.

The conclusions of the report are summarised in the Conclusions section at the end of this report.

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Strategic Review of Health and Safety Management

Introduction and Aims

Quadriga Health and Safety Ltd, was commissioned by the Calderdale and Huddersfield NHS Foundation Trust to undertake a strategic review of health and safety management arrangements in the Trust. In particular, the review considered the way in which the Trust exercised oversight of its subsidiary company providing estates services for the Trust in respect of the Huddersfield Royal Infirmary.

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The review involved a two day site visit to the Huddersfield Royal Infirmary, on 1st and 2nd July 2019, discussions with key members of staff from both the Calderdale and Huddersfield NHS Foundation Trust (CHFT) and Calderdale and Huddersfield Solutions Ltd (CHS) and a detailed review of key health and safety documentation. The review also included attendance at the Joint Liaison Committee between CHFT and CHS on the 2nd July as an observer.

The author would like to thank all those involved in the review for their time, and useful and informative discussions. All those involved in the review were, without exception, very open and informative. The author would particularly like to thank Alison Wilson, Head of Performance and Compliance, for her efficient organisation of the site visits and meetings and for the provision of detailed information and hospitality and assistance during the visit.

It was quite clear from all the discussions that all those involved were committed to achieving high health and safety standards.

A number of recommendations have been made arising from the review and these are summarised in Appendix 1 of the report.

Strategic Review of Health and Safety Management

1. Background

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) delivers patient care from two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary, as well as in community sites, health centres and in patients' homes. The Calderdale Royal Hospital is a PFI hospital where the provision of hard and soft facilities management and responsibility for the fabric of the building rests with the PFI project company. However, the Huddersfield Royal Infirmary is a conventional hospital where all estates and facilities management is the responsibility of the Trust or its wholly owned subsidiary Calderdale and Huddersfield Solutions Ltd (CHS). The Trust employs over 6,000 staff.

The scope of this review focussed on the health and safety management arrangements at the Huddersfield Royal Infirmary and, in particular, the health and safety management arrangements between the CHFT and CHS.

2. Activities Undertaken by CHS

The transfer of services and personnel from CHFT to CHS took place on 1st September 2018. This involved the estates, facilities, medical engineering and procurement services being transferred to the newly formed subsidiary company. Around 450 staff are now employed by CHS.

There is a formal contractual arrangement between CHFT and CHS with supporting service level agreements (SLAs) and Key Performance Indicators (KPIs). There are also a number of reverse SLAs between the CHFT and CHS where services such as HR and Associated Services, Finance, IT and Information Governance are provided by CHFT to CHS.

Within the services transferred were the Trust Fire Officer and a Health and Safety Adviser. A Service Level Agreement between CHFT and CHS now includes a health and safety service with a separate SLA covering fire safety support.

In addition, the arrangement has involved a lease between CHFT and CHS, where CHS lease the buildings from CHFT with a schedule of condition, with CHS responsible for maintenance of the facilities and CHFT responsible for capital spends. It is understood that the schedule of condition and the lease had not been finalised at the time of this review. However, a 6 facet buildings and premises survey was commissioned by CHS that provided a broad status of condition. Both the medical equipment and medical equipment maintenance have also been transferred to CHS.

Clearly the Trust buildings at the Hospital are dated, and it is understood that there is a considerable back log of maintenance that, including necessary asbestos removal, is understood to be in excess of £85m. Some of this maintenance relates to safety related matters such as required fire and electrical safety improvements as well as the asbestos removal. There have also been programmes of improvement particularly relating to fire alarm and detection systems and emergency lighting and upgrades to edge protection arrangements and access on external roofs and walkways.

3. Structure of the Health and Safety Function and Implications

Prior to the formation of CHS, the Trust had a compliance team. Within the remit of this team was waste and energy management, health and safety, security specialist, fire safety and emergency planning. Following the formation of CHS and the transfer of staff, the health and safety, fire safety and operational security transferred to CHS and security policy and emergency planning remained with the Trust residing with Central Operations Team.

The Health and Safety function, prior to the transfer, consisted of the involvement of Alison Wilson approx. one day per week with a full time Health and Safety Adviser Frances Brocklehurst. Alison Wilson is a Chartered Member of the Institution of Occupational Safety and Health (CMIOSH), the recognised standard for a full time Health and Safety Adviser.

Frances has two years' experience in health and safety and achieved an entry level NEBOSH (National Examining Board in Occupational Safety and Health) Certificate in December 2018 and is following a structured development plan to complete NEBOSH Diploma. Frances is a Tech SP member of the Institution of Occupational Safety and Health. Frances successfully achieved the IOSH Managing Safely certificate in 2016 and was appointed to the role of Health and Safety Advisor in September2017.

Frances also has 12 years' experience working in a healthcare estates setting and her responsibilities have included Authorised Persons for LOLER (Lifting Operations and Lifting Equipment Regulations), COSHH (Control of Substances Hazardous to Health) competent person and the administration of the fire risk assessment process for the Estates Department. Prior to the formation of CHS Frances received guidance and direction from her Manager in support of her health and safety development plan.

This background and experience is relevant for a developing health and safety practitioner supported by an experienced Chartered professional to assist with the strategic input and to oversee a professional development plan.

Since the transfer, Alison Wilson, as Head of Performance and Compliance, does not have any direct responsibility for health and safety and does not have managerial responsibility for Frances. However, on an informal basis, Alison does provide guidance to Frances and also provides health and safety input and advice to executives in the Trust. This, however, is not part of Alison's current role. Therefore the necessary support for Frances role is now provided only on an informal basis.

The only formal and appointed source of health and safety advice is now through CHS as part of an SLA.

It should be noted that there is a specific legal requirement under the Management of Health and Safety at Work Regulations 1999 for an employer to appoint one or more competent persons to assist the employer to comply with their duties. Specifically the Regulations require that: *"The number of competent persons, the time available for them to fulfil their functions and the means at their disposal are adequate having regard to the size of his undertaking, the risks to which his employees are exposed and the distribution of those risks throughout the undertaking".*

The Regulations also require that a person should be regarded as competent where they have *"sufficient training and experience or knowledge and other qualities to enable him properly to assist…"*

It is quite acceptable and legal to have an external source of health and safety advice to fulfil this role (for example from a third party provider or consultancy). However, the employer still retains the obligation for ensuring that the source of that advice is competent and sufficiently resourced to fulfil the function and therefore meet the above requirements.

The Regulations also require that *"Where there is a competent person in the employer's employment, that person shall be appointed… in preference to a competent person not in his employment".*

In practical terms, an arrangement of having external health and safety advice (or in this case health and safety advice and support provided through a wholly owned subsidiary company) is unlikely to be subject to any challenge provided that there is sufficient role clarity, resourcing, competence and an adequate level of oversight and monitoring. It is also necessary, with such an arrangement, that the specialist adviser, or advisers, have clear access and input to the senior executives of the relevant organisation receiving the advice. These points are addressed in the sections below.

4. Adequacy of the Current Health and Safety Function, Service Level Agreement and Resourcing

In order for health and safety to be effectively managed, there needs to be clear leadership on health and safety matters from the senior executives in the organisation and adequate support from specialist advisers. Such advisers need to have the required resourcing, training and competence. These principles are outlined in the HSE publication Managing Health and Safety (HSG65) and in the IOD/HSE guidance on Leading Health and Safety at Work. Whilst neither of these publications are legal requirements, a jury can consider them in any prosecution under the Corporate Manslaughter and Corporate Homicide Act 2005.

Clearly there are also specific statutory requirements relating to the provision of competent health and safety advice, as outlined in the section above. In practice, an organisation and its directors will be vulnerable to prosecution if offences committed by that organisation under health and safety legislation, can be linked to arrangements that are less than robust in relation to health and safety advice and support. These key points are addressed in the following subsections.

a. Health and Safety Service Level Agreement

The current arrangement for the Trust is that the entirety of the professional health and safety support (and hence the competent advice required under the Management of Health and Safety at Work Regulations 1999) is provided through the Health and Safety Service Level Agreement with CHS (SLA 003). Whilst the objective section of this SLA is broad, the actual scope and associated KPI are very narrow in scope and relate to carrying out specific (and limited) activities.
The overall objective states:

> The objective of this agreement is to:
>
> - Provide a comprehensive health and safety management and advisory service to meet the Trusts requirements
> - Present a clear, concise and measurable description of service provision to the Trust.
> - Match perceptions of expected service provision with actual service support & delivery.
> - Give advice to the Trust on future health and safety strategies

However the scope which is covered by the SLA limits the services to:

1.1 Scope of SLA

The following detailed service parameters are the responsibility of CHS in the on-going support of this Specification.

The following services are covered by this Specification:

- CHS will comply provide with the standards and requirements set out in this Specification.
- CHS manage the provision of health and safety services
- CHS will be responsible for overseeing the compilation and submission of:-
  - Annual Health and Safety Report
  - Health & Safety Policy
  - Provision of health and safety analysis of incidents
  - Specific health and safety training (risk assessment / COSHH)
  - Manage, maintain and display the Health & Safety at Work Law Poster

The SLA indicates that the service is only available Monday to Friday in normal working hours, and there is no content on accident or incident investigation nor liaison with the HSE, for example following a RIDDOR incident. It is not clear whether the reference to risk assessment and COSHH training refers to the totality of training provided or whether this is an example of the training provided.

The responsibilities section further narrows the scope by giving the following responsibilities:

Head of Estates Services is responsible for the implementation of the Health and safety policy ensuring compliance with legislation.

Health and Safety Advisor is responsible for:

- Upkeep of relevant Health & Safety Policies
- Provision of COSHH training for Trust staff
- Provision of risk assessment training for Trust staff
- Provision of health & safety induction training for Trust new starters
- Provision of monthly statistical analysis of Trusts incidents
- Provision and compilation of the annual health and safety report for Trust Board

It is not clear here whether the Head of Estates Services is responsible for implementing the policy for the Trust or just for CHS, to comply with legislation.

If the former, this is inappropriate and if the latter then it is not clear how the Trust Policy is implemented.

The H&S Adviser responsibility seems very narrow and the relevant health and safety policies are not listed. The SLA is silent on the provision of new policies or indeed effective review of existing ones. There is no reference to the aim of the SLA to this being the Trust's appointed source of competent health and safety advice and no reference to the level of qualifications, experience or resourcing to provide it.

There is also no reference to providing strategic health and safety advice or high level liaison with the Trust's directors and senior management team. There is also no part of the content that relates to changed external circumstances, identification of changed health and safety legislation etc.

The only KPI is as shown below, in relation to H&S training on a monthly basis. This is a binary measure with no indication of what the training is, its duration, the training of those delivering it or the method of delivery and no indication of quality, quantity or content.

Weighting	KPI description	Performance Output Range		
		Green	Amber	Red
Monthly	Provision of Health & Safety Training on a monthly basis	Yes	N/A	No

b. Structure and Resourcing of the Health and Safety Function

As indicated above, the health and safety function within CHS, to provide the entirety of the service to the Trust, consists of a Health and Safety adviser of relatively limited experience, qualifications and training who has been separated from the professional oversight in support of the role. There is, however, a training programme going forward and further development is planned. However, such a role is only tenable with professional oversight, mentoring and support which is now only being provided on an informal basis.

As the line responsibility for the Health and Safety Adviser has now changed, the arrangement is also likely to result in a progressively increasing conflict of interest. This is particularly the case as the aim is for CHS to provide support services to other organisations other than CHFT. The likely result of this is that the Health and Safety Adviser will get drawn into supporting the health and safety aspects or bids for other work, and supporting the work undertaken at other organisations, and away from support to the Trust.

In addition, the reporting line within CHS could also create a conflict in the Health and Safety Adviser raising risk issues with the Trust that may adversely impact on the CHS meeting other targets or impact on financial KPIs.

c. Operation of the Health and Safety Function in Practice

As part of this review, discussions were held with both the Health and Safety Adviser and others in regard to the practical role being performed by the function. It is clear that at an estates operational level, the function is supporting CHS in meeting health and safety requirements. However, there are a range of issues that, due to lack of clarity or lack of a coordinated approach between CHS and CHFT, are not being addressed, or are not within the overall visibility of the health and safety function within CHS. For example:

i. There is no coordinated approach to reporting under RIDDOR to the Health and Safety Executive with staff making direct reports and the CHS Health and Safety Adviser not being involved in any RIDDOR reports relating to, or linked to, patient safety issues.

ii. There is no clarity of who is the main point of contact for the HSE. For example, if the HSE were investigating a number of RIDDOR incidents it would be wise to have one point of contact that is familiar with handling such an inspection.

iii. Whilst there is a software based system for COSHH assessments, the Health and Safety Adviser was unaware of the arrangements for controlling exposure to anaesthetic gases or diathermy fume. Both of these types of exposures fall within the requirements of the Control of Substances Hazardous to Health Regulations 2002.

iv. There is no noise policy in place for CHFT. Noise exposure issues not only arise in estates functions, they are also relevant in relation to orthopaedic surgery for example.

v. Whilst the Construction (Design and Management) Regulations 2015 (CDM 2015) are applied in relation to significant projects, many routine elements of more minor work (such as painting and decorating, minor building repairs, installation of electrical and computer cabling), undertaken by CHS staff and their contractors, come within the Regulations. CHFT will be the Client for these works and will commit an offence if CHS have not been appointed as Principal Contractor and Principal Designer or if there is no Construction Phase Plan in place. Indeed CHFT, by not making such an appointment of CHS, will legally become by default the Principal Contractor and Principal Designer for such works and commit a number of offences. It is important therefore that these appointments under the requirements of CDM 2015 are made on a default basis in writing as outlined in Recommendation 2 below.

In terms of health and safety inspection and auditing there is reportedly no structured system in which the Health and Safety Adviser is involved. In summary, the current arrangements for providing health and safety advice and support to CHFT cannot be considered adequate for meeting the requirements of the Management of Health and Safety at Work Regulations 1999 and significant areas of the necessary input are not being covered by CHS, nor is the SLA adequate.

In addition, the Health and Safety Adviser within CHS does not have sufficient role clarity, training, experience or support, to fulfil the role that is needed if this is to include strategic advice to the CHFT in addition to the operational aspects of CHS. There is also no formal role within CHFT to provide strategic advice and guidance on health and safety matters to the Board.

Recommendations are provided later in this report on how the above situation could be improved.

5. Overall Health and Safety Policy

Under the requirements of the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999, there is a requirement for CHFT to prepare a general statement of health and safety policy and the organisation and arrangement for putting it into effect. The organisation part of the policy should cover individual responsibilities of different roles, and the arrangements should cover the specific policies and procedures for managing health and safety. The specific requirements of the above Regulations include an obligation to have arrangements for the planning, organisation, control monitoring and review of health and safety measures. This approach is also recommended in the HSE publication HSG 65 where the "Plan, Do, Check, Act" approach is advocated.

In line with the above approach, CHFT have developed an updated draft Health and Safety Policy that was reviewed as part of preparing this report. Whilst the draft policy follows a sound general framework, it contains large areas of detail relating to procedures that should sit separately from the policy and organisation. For example, a risk assessment matrix is introduced which contains evaluations of risk unrelated to health and safety, and mixes matters such as incidents purely involving cost with those that have a statutory implications.
The likelihood matrix used in this risk assessment process shows levels of likelihood of risk which are completely inappropriate for a health and safety risk assessment (see section on Risk Assessment below).

In addition, the CHFT policy containing details of the management of CHS that go beyond the services that CHS provide to CHFT.

Given the separation of the organisations and, in particular, that CHS will be likely to undertake work for other organisations, it would be appropriate to contain in the CHFT policy purely what services are provided by CHS and how CHFT monitor them, as opposed to creating responsibilities, in the CHFT policy, for CHS employees. CHS should then have a clear health and safety policy which relates to its organisation, but in particular, that outlines how it discharges its obligations in providing services in a safe and adequate way to CHFT and others.

Recommendation 1

It is recommended that the Health and Safety Policy is reviewed so as to create clarity on the responsibilities within CHFT (referencing the relevant support from CHS) and that individual policies on specific areas such as COSHH, risk assessments, and supporting guidance and toolkits are developed and cross referenced in the policy. The policy should clearly state how competent health and safety support is provided at a strategic level within CHFT and specify Director with overall responsibility for health and safety. (Recommendations on these points are contained in Section 8 below).

Recommendation 2

It is recommended that, in order to ensure that CHFT does not inadvertently commit offences under the Construction (Design and Management) Regulations 2015 (CDM 2015) due to routine minor works, that fall within the definition of construction, being undertaken by CHS, then CHFT should appoint in writing CHS as the Principal Contractor and Principal Designer for all such minor works and obtain a written acceptance of this appointment. Such an appointment should contain limitations requiring CHS to notify the Trust in advance of any of the higher risk work falling within Schedule 3 of the Regulations or any larger scale work which is notifiable to the HSE. CHFT should then ensure that CHS has produced a Construction Phase Plan covering such routine minor works. This approach will avoid CHFT assuming, by default, the positon of Principal Contractor and Principal Designer and committing an offence of allowing such work to proceed without a Construction Phase Plan.

Recommendation 3

It is recommended that arrangements for interfacing with the Health and Safety Executive and submitting reports under RIDDOR to the HSE should be clarified so there is one central point of contact for the HSE and submitting reports to the HSE for any incidents involving CHFT or matters for which CHFT are responsible.

6. Approach to Risk Assessment

As outlined above, the Health and Safety Policy contains a risk assessment process which uses a risk grading matrix. The CHFT Risk Management Policy Strategy for 2019/2020 contains a similar risk grading matrix. However, the probability score element of this matrix is inappropriate and accepts risks as low, which from a health and safety perspective would be considered intolerable.

For example, the matrix suggests that a risk of 1 in 1,000 per annum is extremely unlikely. Where this is combined with a catastrophic level event (detailed as an incident involving a death for example) then the overall risk rating would be evaluated as 5 and thus regarded as low and unlikely to lead to any further action.

However, if this is applied at a risk assessment level in relation to the risk of a fatal accident from an activity to an employee, this results in a totally unacceptable result. In terms of accepted risks to employees at work then a risk of death per annum is considered trivial at a probability of 1 in a million per annum and tolerable at a risk level of 1 in 100,000 per annum. Put another way, exposing Trust employees to a risk of death of 1 in a 1,000 per annum would result in an average of 6 fatalities a year amongst the approximately 6,000 employees.

It should be noted that the legal purpose of a health and safety risk assessment, as outlined in the Management of Health and Safety at Work Regulations 1999, is to establish the actions the employer needs to take to comply with the relevant legal requirements. Therefore, where risk assessments are undertaken for health and safety purposes, they need to be related back to the legal framework and accepted standards of good practice in guidance and Approved Codes of Practice that support them.

Recommendation 4

It is recommended that the risk assessment probability matrix is reviewed to realistically relate probabilities of events to an acceptable standard. The recognised publication on this is the HSE publication "Reducing Risks, Protecting People" which outlines the boundary between an acceptable risk and a tolerable risk as outlined above. Annual risks of death from accidents and incidents at work of 1 in 1,000 per year are regarded as intolerable and require cessation of an activity or immediate action to remove the risk. It is generally accepted for risks to employees at work, that a risk of death per annum is considered trivial at a probability of 1 in a million per annum and tolerable at a risk level of 1 in 100,000 per annum. An extremely unlikely risk in the risk matrix should therefore be regarded as a risk of 1 in a million per annum and the remainder of the risk matrix changed accordingly.

Recommendation 5

The health and safety risk assessment process should be separated from the health and safety policy and the format for undertaking risk assessments should identify specific legal requirements. For example, it is not possible to undertake a noise and vibration assessment by using a 5 x5 risk matrix. The assessment has to take account of the statutory limits which relate to employee noise exposure. The same point applies to other risks such as those related to exposure to electromagnetic fields or hazardous substances. There should then be a clear identification as to who is trained and competent to undertake the more complex risk assessments and a clarity given to those required to undertaken departmental risk assessments of the scope of the risk assessments required.

Recommendation 6

Specific policies and risk assessment formats should be put in place to enable CHFT to have adequate policies and risk assessments in place for areas such as noise and vibration, hazardous and dangerous substances (COSHH and DSEAR), and exposure to electromagnetic fields. Specifically the arrangements for exposure to hazardous materials should include exposure to generated fumes in clinical operations such as diaththermy fume. Noise and vibration assessments should include assessment of such exposure to those involved in orthopaedic surgery.

7. Fire Safety Management

CHFT have had a number of challenges relating to fire safety management which are difficult to address given the age of the buildings. CHS provide the Trust Fire Officer and there is also an SLA on fire safety matters. This SLA (SLA 012) outlines that CHS will provide, and review every two years, a fire safety strategy for the Trust and the SLA indicates that, if the Trust complies with the strategy, it will ensure compliance with HTM and legal requirements.

The SLA reviewed seems to have a missing section in so far that the index shows a section on responsibilities whereas there is no such section in the SLA.

The only KPI against this SLA relates to ensuring the CHFT achieve an 80% compliance in fire training in the year, which since the original drafting has been changed to 90%. There are no other KPIs, although clearly some aspects of fire safety system maintenance and inspection would fall into other SLAs.

This change is a wise one as it would not be appropriate to set up a KPI accepting that 20% of staff will not be adequately trained, or not receive adequate refresher training as this could imply a breach of legal requirements even when the target is achieved. Indeed, even a target of 90% could be regarded as falling short of an acceptable standard. In addition, the focus on just fire safety training would seem an insufficient KPI given the fact that other key matters such as fire safety audits and inspections, maintenance of fire risk assessments, and monitoring the implementation of the strategy should all be key matters that should be addressed.

It is understood that there have been some historical problems with enforcement action having been taken against CHFT by the fire authority arising from a fire authority inspection in 2013. These particularly related to inadequate fire compartmentation in clinical areas and inadequacy of fire alarm and detection systems.

The Notice resulted in an action plan being developed and WY Fire Authority were content with the approach; improvements being made in some areas. Following the issue of the Notice, the Trust appointed a full-time fire safety adviser with operational fire safety experience and formally appointed an Authorising Engineer (Fire) (AE (Fire)) as recommended in Health Technical Memorandum 05:01 as an external specialist whose specialism was in fire safety in healthcare premises.

A number of ward upgrades were carried out in 2013 and 2014 which included improving fire compartmentation and fire detection. Thereafter, complete ward upgrades did not continue but capital funding was provided to continue with fire compartmentation and the upgrading of fire detection.

Compliance with the enforcement notice was accepted by the Fire Authority in June 2013 and a joint concordat agreed between the Trust and West Yorkshire Fire Authority for the purpose of improving fire safety and ensuring compliance with legislation.

The Trust has recently engaged with Fire Safety consultant to appraise the approach taken by the Trust relating to fire safety improvements with the initial outcome endorsing the approach taken. A further report is expected recommending next steps to prioritise fire safety actions across HRI.

Following the formation of CHS, is it is understood this service is supplied by CHS. The SLA review provides that the AE (Fire) will undertake an independent annual audit to ensure the management arrangement and strategic direction of the "subsidiary" which is understood to be a reference to CHS. However, with the changes introduced by the formation of CHS, if, as is understood to be the case that the AE (Fire) is provided through CHS (and the only reference in the SLA reviewed to the AE (Fire) is to this annual audit), then this would again seem to create a conflict of interest similar to that outlined above in relation to health and safety.

In particular, CHFT is not provided with truly independent advice on an ongoing basis to enable it to properly oversee the adequacy of the services and support supplied by the subsidiary CHS.

A draft Fire Action Plan, dated February 2019, was provided for this review and outlined the actions necessary in achieving further compartmentation and other improvements. At present, the lack of compartmentation and sub-compartmentation in some areas would result in the need for a much larger evacuation of patients than would be necessary if the compartmentation was in place. Such an evacuation could be difficult to achieve in the required timescales, particularly at night times when staffing levels are lower. There was some concern expressed during this review by the MD of CHS, that the implications of this lack of fire compartmentation were not fully understood by the CHFT Board.

However, it should be noted that fire safety training for fire wardens and fire safety in general has been provided across the Trust with evacuation exercises carried out in some clinical areas.

It is recognised that in buildings of this age, and with the cost pressures on the Trust, progressing these compartmentation improvements can be challenging. However, there is a need for a clearly monitored Action Plan that is agreed at Board level with regular reports on progress and improvements.

Since the issue of the initial draft report in August CHFT are planning to commission Mott McDonalds to review the Trust's whole approach to managing the risk of fire within the Trust and in particular to produce a fire strategy for ten Trust buildings including the HRI.

In discussions and arising from the draft action plan, it is clear that there are differing views on the methods and frequency of fire safety training, with the CHS Fire Office emphasising the need for face to face fire safety training. This is understandable as it is a particular requirement of the HTM for the training not to be exclusively undertaken by e learning. Indeed, there has been recent high profile enforcement action against an NHS Trust, which purely relied on e learning on exactly this point.

However, a substantial number of CHFT staff are located in offices separate from the main hospital location, or in premises which can be immediately evacuated and do not have non ambulant patients present. These staff would also not be involved in a patient evacuation.

There would, therefore, be considerable advantage in undertaking more intensive practical training and drills for those members of staff located in parts of the premises that would be involved in the evacuation of non-ambulant patients. These staff need to fully understand the progressive horizontal evacuation strategy and the true state of the compartmentation in their area (and therefore what areas need to be fully evacuated and to what extent). This could be resourced by reducing the training requirements for those staff in premises that could be immediately evacuated and limiting this to on line training plus evacuation drills with more detailed training for fire wardens. Fire wardens could then also be used to ensure that first day fire safety briefing and walking of escape routes is undertaken for staff in such areas.

Recommendation 7

It is recommended that if the Draft Action Plan has not yet been issued for Board approval it should be finalised and issued and a clear plan agreed and monitored by the Board.

Recommendation 8

Whilst it is recognised that there are considerable challenges in improving fire compartmentation in these older buildings, it is recommended that a very high priority is placed on improving compartmentation and ensuring, in the interim, that evacuation procedures are based on the actual areas that may need to be evacuated. This is especially the case in the where the existing compartmentation has not been upgraded and is known to not being fully effective. The training and evacuation procedures need to recognise this. However, ensuring training and evacuation procedures recognise the actual level of compartmentation can only be regarded as a temporary solution whilst essential fire compartmentation improvements are made.

Recommendation 9

It is recommended that the current SLA for fire is reviewed to include the responsibilities section and a wider range of KPIs and that there is clarity on the role and independence of the Authorising Engineer (Fire). In particular, it is recommended that the direct appointment of the Authorising Engineer (Fire) should be made by CHFT so that there is independent oversight of the performance of CHS on fire safety matters and independent advice on fire safety matters to the Trust.

Recommendation 10

It is recommended that the fire training approach should focus resource on practical training for those staff working in patient areas that are subject to a progressive horizontal evacuation strategy. This should be resourced by undertaking more basic training (by e learning and drills) for those in office areas and areas that can be immediately evacuated with more detailed training for fire wardens. All staff should of course have first day fire induction briefing that could be carried out in office areas by a fire warden using a checklist.

8. Board Oversight and Leadership on Health and Safety and Appointment of a Health and Safety Director

As outlined above, the overall Health and Safety Policy has not yet been finalised and there are a number of issues that are subject to internal discussion. One of these is the appointment of a Health and Safety Director (sometimes called a Health and Safety Champion). It is also understood that the Board attended executive level health and safety training during February 2019 and this triggered some of the discussion on this point.

The current draft of the Policy also places particular responsibilities on the Director of Workforce and Organisational Development, including chairing the Trust's Health and Safety Committee. The responsibilities also include ensuring the provision of a competent occupational health a service for all staff and ensuring that professional health and safety advice is available for the Trust. The comments and notes on this draft document indicates that this advice is provided through the SLA with CHS and through Alison Wilson on a part time basis.

It is clear that Alison Wilson has the qualifications, knowledge, experience and familiarity with CHFT to perform this role, but it is also understood that this is not part of the current Head of Performance and Compliance role.

The queries and issues identified in the draft Health and Safety Policy are to some extent symptomatic of the issues identified above in the split in the structure and, in particular, the split in the health and safety function identified above. This would seem to have put CHFT in a position where there is the requisite health and safety expertise but this is not available (in terms of time and allocated responsibility) to provide the required independent input and strategic support to the Trust Board.

There was a concern expressed by the Director of Workforce and Organisational Development that to be appointed as the Health and Safety Director required a level of specialist expertise and significant time to discharge this function. It was also understood that the Board had received varying advice on the exact nature of this role.

However, the role of the Health and Safety Director as envisaged by the HSE/IOD guidance on Leading Health and Safety, is not that of a health and safety specialist, but one of a Board lead and Champion on the issue to ensure that the Board is aware of its responsibilities and addresses them.

It is not, therefore, necessarily (or indeed usually) a health and safety specialist. It is also clear, both in guidance and as a matter of law, that the Health and Safety Director does not take responsibility for health and safety on behalf of the Board as this is a collective responsibility of all Directors.

What, however, is essential, as outlined in Section 3 above, is that the Board has access to competent health and safety advice and that there is at least a strategic health and safety function within CHFT capable of assisting the Health and Safety Director and the Board in driving the health and safety agenda and monitoring progress.

It would be appropriate and logical for the professional providing that advice and support to report to the Health and safety Director.

Following the initial draft issue of this report, CHFT have requested advice on respective health and safety roles and leads and the interaction with the Health and Safety Function and this has been provided by a separate advice letter of advice.

Recommendation 11

It is recommended that a review is undertaken of the role of the Head of Performance and Compliance to establish if it is possible to release time for Alison Wilson to have a formal role as the professional high level source of health and safety advice to the CHFT and to the Director of Workforce and Operational Development or to create a Head of Health and Safety role within the Trust. This would also support the Trust with professional oversight of the operational health and safety support provided by CHS. By introducing professional health and safety support in a formal context to support the Director of Workforce and Operational Development, and by clarifying the role of Health and Safety Director explicitly in the Health and Safety Policy, this would enable this role to be taken by the Director of Workforce and Operational Development. It would also address the concerns expressed of this role needing significant time, input or detailed professional health and safety expertise.

9. CHS and CHFT Joint Risk Register

As part of the CHFT/CHS Joint Liaison Committee, a joint risk register is reviewed and reported to the Committee with a process for escalation. Whilst a collaborative approach is clearly important, it would aid clarity if it were made clearer which party was exposed to the relevant risk.

It is unlikely that most of these risks will actually be joint ones or expose both parties to the same level of risk. For example, if CHS is working to a fire strategy agreed by the Trust, maintaining the fire safety systems and procedures in a competent way, and meeting obligations under the contract and SLAs, then CHS will have met its obligations. The risks for example, associated with inadequate fire compartmentation which has not yet been upgraded would then rest with CHFT not CHS.

One of the risks listed on the risk register related to medical devices and maintenance. This was as noted, has having a risk rating of 20. During the review, a discussion was held with the CHS Chief Medical Engineer as to the background to this issue.
The issue would appear to have been raised quite suddenly and arisen due to the system for identifying equipment falling due for maintenance, reaching the end of its useful life, or being no longer supported by the manufacturer, not operating effectively. The background issues of whether the system was working effectively had not seemed to have been identified as an emerging issue.

Recommendation 12
It is recommended that the CHFT/CHS joint risk register is modified so that it clearly indicates the risk to the respective organisations. It is further recommended that, if not already the case, the whole of the risk register is periodically reviewed at the JLC meeting to consider whether the controls in place for the risks that are considered acceptable are actually in place and what monitoring is undertaken to confirm this. This would assist in gaining some early warning of control measures breaking down and risks escalating.

Recommendation 13

It is recommended that, where risks are registered as falling into the significant risk category on either risk register, and are reported to the Committee, that the immediate actions being taken to mitigate the risk are also outlined in the same report. This should be supplemented by the planned timescale for implementation and who is accountable for overseeing this implementation.

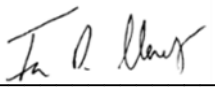
Conclusions

CHFT faces a number of challenges related to high profile health and safety and fire safety issues which require close Board scrutiny and review at senior level to ensure that these are effectively managed and reduced. The age of the buildings and the backlog of necessary building improvements and repairs contributes significantly to this challenge.

The recent formation of CHS and the transfer of part of the original health and safety function to CHS, with the consequent change in the role of Alison Wilson, has left CHFT with no independent strategic health and safety advice. In addition, the only provision of operational health and safety support is now from a relatively inexperienced and developing health and safety practitioner with no formal role being in place for professional mentoring and support. The arrangement also gives rise to a conflict of interest with the only professional monitoring of health and safety standards of the service provided by CHS to CHFT coming from within CHS. There are also some similar conflicts of interest with the arrangements for fire safety advice and support.

Similarly, whilst it is realised that the service level agreements have been quickly established and need further review, those related to health and safety and fire safety do not fully cover the areas that should be addressed and have limited and very narrow KPIs.

The above points, and others identified in this report, could be considerably improved by implementing the recommendations outlined above and summarised below.

Signed:  Date: 22nd October 2019

Ian Clements BSc MSc CEng MIET CMIOSH FIoD CDir
Managing Director
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Calderdale and Huddersfield NHS Foundation Trust

Appendix 1

Summary of Recommendations

Recommendation Number	Recommendation	Suggested Priority	Legal Requirements
1	The Health and Safety Policy should be reviewed so as to create clarity on the responsibilities within CHFT (referencing the relevant support from CHS) and that individual policies on specific areas such as COSHH, risk assessments, and supporting guidance and toolkits are developed and cross referenced in the policy. The policy should clearly state how competent health and safety support is provided at a strategic level within CHFT and specify Director with overall responsibility for health and safety. (Recommendations on these points are contained in Section 8 below).	High	The Health and Safety at Work etc. Act 1974- Section 2(2)(c) The Management of Health and Safety at Work Regulations 1999
2	It is recommended that, in order to ensure that CHFT does not inadvertently commit offences under the Construction (Design and Management) Regulations 2015 (CDM 2015) due to routine minor works, that fall within the definition of construction, being undertaken by CHS, then CHFT should appoint in writing CHS as the Principal Contractor and Principal Designer for all such minor works and obtain a written acceptance of this appointment. Such an appointment should contain limitations requiring CHS to notify the Trust in advance of any of the higher risk work falling within Schedule 3 of the Regulations or any larger scale work which is notifiable to the HSE. CHFT should then ensure that CHS has produced a Construction Phase Plan covering such routine minor works. This approach will avoid CHFT assuming, by default, the positon of Principal Contractor and Principal Designer and committing an offence of allowing such work to proceed without a Construction Phase Plan.	High	The Construction (Design and Management) Regulations 2015 (CDM 2015)
3	Arrangements for interfacing with the Health and Safety Executive and submitting reports under RIDDOR to the HSE should be clarified so there is one central point of contact for the HSE and submitting reports to the HSE for any incidents involving CHFT or matters for which CHFT are responsible.	Medium	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Calderdale and Huddersfield NHS Foundation Trust

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Summary of Recommendations

Recommendation Number	Recommendation	Suggested Priority	Legal Requirements
4	The risk assessment probability matrix should be reviewed to realistically relate probabilities of events to an acceptable standard. The recognised publication on this is the HSE publication "Reducing Risks, Protecting People" which outlines the boundary between an acceptable risk and a tolerable risk as outlined above. Annual risks of death from accidents and incidents at work of 1 in 1,000 per year are regarded as intolerable and require cessation of an activity or immediate action to remove the risk. It is generally accepted for risks to employees at work, that a risk of death per annum is considered trivial at a probability of 1 in a million per annum and tolerable at a risk level of 1 in 100,000 per annum. An extremely unlikely risk in the risk matrix should therefore be regarded as a risk of 1 in a million per annum and the remainder of the risk matrix changed accordingly.	Medium	The Management of Health and Safety at Work Regulations 1999
5	The health and safety risk assessment process should be separated from the health and safety policy and the format for undertaking risk assessments should identify specific legal requirements. For example, it is not possible to undertake a noise and vibration assessment by using a 5 x5 risk matrix. The assessment has to take account of the statutory limits which relate to employee noise exposure. The same point applies to other risks such as those related to exposure to electromagnetic fields or hazardous substances. There should then be a clear identification as to who is trained and competent to undertake the more complex risk assessments and a clarity given to those required to undertaken departmental risk assessments of the scope of the risk assessments required.	Medium	The Management of Health and Safety at Work Regulations 1999

Calderdale and Huddersfield NHS Foundation Trust

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Recommendation Number	Recommendation	Suggested Priority	Legal Requirements
6	Specific policies and risk assessment formats should be put in place to enable CHFT to have adequate policies and risk assessments in place for areas such as noise and vibration, hazardous and dangerous substances (COSHH and DSEAR), and exposure to electromagnetic fields. Specifically the arrangements for exposure to hazardous materials should include exposure to generated fumes in clinical operations such as diaththermy fume. Noise and vibration assessments should include assessment of such exposure to those involved in orthopaedic surgery.	High	The Management of Health and Safety at Work Regulations 1999 The Control of Substances Hazardous to Health Regulations 2002 The Dangerous Substances and Explosive Atmospheres Regulations 2002 The Control of Noise at Work Regulations 2005 The Control of Vibration at Work Regulations 2005 The Control of Electromagnetic Fields at Work Regulations 2016
7	It is recommended that if the Draft Action Plan has not yet been issued for Board approval it should be finalised and issued and a clear plan agreed and monitored by the Board.	Medium	The Health and Safety at Work etc. Act 1974 The Management of Health and Safety at Work Regulations 1999

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Summary of Recommendations

Recommendation Number	Recommendation	Suggested Priority	Legal Requirements
8	Whilst it is recognised that there are considerable challenges in improving fire compartmentation in these older buildings, it is recommended that a very high priority is placed on improving compartmentation and ensuring, in the interim, that evacuation procedures are based on the actual areas that may need to be evacuated. This is especially the case in the where the existing compartmentation has not been upgraded and is known to not being fully effective. The training and evacuation procedures need to recognise this. However, ensuring training and evacuation procedures recognise the actual level of compartmentation can only be regarded as a temporary solution whilst essential fire compartmentation improvements are made.	High	The Regulatory Reform (Fire Safety) Order 2005
9	It is recommended that the current SLA for fire is reviewed to include the responsibilities section and a wider range of KPIs and that there is clarity on the role and independence of the Authorising Engineer (Fire). In particular, it is recommended that the direct appointment of the Authorising Engineer (Fire) should be made by CHFT so that there is independent oversight of the performance of CHS on fire safety matters and independent advice on fire safety matters to the Trust.	Medium	The Regulatory Reform (Fire Safety) Order 2005
10	The fire training approach should focus resource on practical training for those staff working in patient areas that are subject to a progressive horizontal evacuation strategy. This should be resourced by undertaking more basic training (by e learning and drills) for those in office areas and areas that can be immediately evacuated with more detailed training for fire wardens. All staff should of course have first day fire induction briefing that could be carried out in office areas by a fire warden using a checklist.	Medium	The Regulatory Reform (Fire Safety) Order 2005

Calderdale and Huddersfield NHS Foundation Trust

Appendix 1

Summary of Recommendations

Recommendation Number	Recommendation	Suggested Priority	Legal Requirements
11	A review should be undertaken of the role of the Head of Performance and Compliance to establish if it is possible to release time for Alison Wilson to have a formal role as the professional high level source of health and safety advice to the CHFT and to the Director of Workforce and Operational Development or to create a Head of Health and Safety role within the Trust. This would also support the Trust with professional oversight of the operational health and safety support provided by CHS. By introducing professional health and safety support in a formal context to support the Director of Workforce and Operational Development, and by clarifying the role of Health and Safety Director explicitly in the Health and Safety Policy, this would enable this role to be taken by the Director of Workforce and Operational Development. It would also address the concerns expressed of this role needing significant time, input or detailed professional health and safety expertise.	Medium	The Management of Health and Safety at Work Regulations 1999
12	It is recommended that the CHFT/CHS joint risk register is modified so that it clearly indicates the risk to the respective organisations. It is further recommended that, if not already the case, the whole of the risk register is periodically reviewed at the JLC meeting to consider whether the controls in place for the risks that are considered acceptable are actually in place and what monitoring is undertaken to confirm this. This would assist in gaining some early warning of control measures breaking down and risks escalating.	Medium	The Management of Health and Safety at Work Regulations 1999
13	Where risks are registered as falling into the significant risk category on either risk register, and are reported to the Committee, that the immediate actions being taken to mitigate the risk are also outlined in the same report. This should be supplemented by the planned timescale for implementation and who is accountable for overseeing this implementation.	Medium	The Management of Health and Safety at Work Regulations 1999

TRUST GOAL: 2. KEEPING THE BASE SAFE			Appendix						
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING DECEMBER 2019**	
								Initial	**Current**	**Target**
16.19 27/11/19	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	• SLA in place for CHS to provde Health and Safety Training for CHFT colleages. • Director and Non-Executive Director Health and Safety Champion identified (to be approved by the Board) • Proactive health & safety committee • Annual report on Health and Safety to Board • Health and Safety action plan • Training: 'Leading Safely' IOSH training for Board members February 2019 • Health and Safety mandatory training for staff (3 years) • Health and Safety training on staff induction • COSHH training • Risk assessment training	<u>First line</u> Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and securitry information . s and shared learning, health and safety incidents / learning. <u>Second line</u> Board joint responsibility for risk understood following the Board IOSH training in February 2019 WEB reports on mandatory training, health and safety training compliance currently at target levels <u>Third line</u> External health and safety review (Quadriga) 2019 (reference also to fire safety)	• Director and Non-Executive Director champions for Health and Safety to be confirmed at the Board meeting on 9 January 2020 • Health and Safety Policy to be revised to include statement of intent with supporting policy / procedural guidance and provide clarity on roles and responsibilities - Need for specific policies for Risk Assessment, Noise Policy and others (as detailed in Quadriga report) • Lack of identified and competent resource to recruit to Head of Health and Safety and secure an appropriate candidate • Inability to progress recommendations from external review of health and safety due to finance, people, time and current infrastructure at CHFT • Explore models of independent and professional external provison of technical health and safety advice (similar to Authorised Engineer role)	• 2020 January external Health and Safety review to be presented to Board (last review 2017) • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 • Lack of health and safety input to Audit and Risk Committee - need to review reporting arrangements • As detailed in Quadriga review: update Health & Safety Policy, Review RIDDOR reporting, Develop Risk Assessment Policy & matrix, ensure compliance with fire safety, share and discuss joint CHS & Trust risks & mitigation at Joint Liaison Committee meetings.	**3x3 = 9**	**3x3 = 9**	**2x2 = 4**

Action	**Timescales**	**Lead**
Reframe the current 5 Year Strategy objective on health and safety	April 2020	SD / A Wilson
- Implementation of 2019/20 action plan (including Health and Safety Policy review)	31 March 2020	As per plan
- Review Board/Committee reporting on health and safety	31 March 2020	SD / AM
- Plan 2021 internal audit review of health and safety	2021 internal audit plan	AM / GB

Links to risk register:
7413 fire compartmentation, 7414 building safety, 7474 medical devices

12. Q3 Guardian of Safe Working Hours Report

Dr Anu Rajgopal

To Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	Q3 report: (Oct-December 2019) from the Guardian of safe working hours, CHFT
Author:	Anu Rajgopal, Guardian of Safe Working
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	none

Actions Requested:
To note and approve

Purpose of the Report

To provide an overview and assurance of the Trust's compliance with safe working hours for junior doctors across the Trust and to highlight and detail any areas of concern.

Key Points to Note

- Increased number of exception reports from Paediatrics and Orthopaedics
- Improved engagement of trainees at the junior doctor forum with allocation of funding received to enhance junior doctor working at the Trust
- Plans to progress with assessing Trust compliance with the BMA fatigue and facilities Charter and monitoring progress through the junior doctor forum.

EQIA – Equality Impact Assessment

The medical workforce is ethnically diverse and exception reports submitted by our junior doctors have been split by ethnicity and gender. The analysis shows that the data is representative of the junior doctor population in the Trust.

Recommendation

The Board is asked to note and approve the report.

Q3 report: (Oct-December 2019)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

The number of exception reports (ERs) submitted this quarter is similar to Q3 last year however there are significantly fewer reports from FY1 trainees and increased reporting from higher grades (FY2s, CTs, ST1-2). Exceptions submitted from general surgery have reduced with an increase seen in paediatrics and Orthopaedics. There have been no safety concerns.

There was improved engagement of trainees at the junior doctor forum (JDF) in October providing better insight into common day-to day problems faced by them and suggestions on how the organisation could improve their working lives. The Trust has signed up to the BMA fatigue and facilities charter led by the DME with support from the GOSWH. Monies received, £30,000, to support the improvement of facilities for junior doctors with particular regard to fatigue issues is welcomed and work is currently underway to engage with trainees and allocate the funding according to their needs.

Implementation of the revised 2016 TCS is underway and it is agreed that compliance will be monitored at subsequent JDFs. This will empower junior doctors to work with the Trust proactively and constructively in improving their working conditions in line with the TCS.

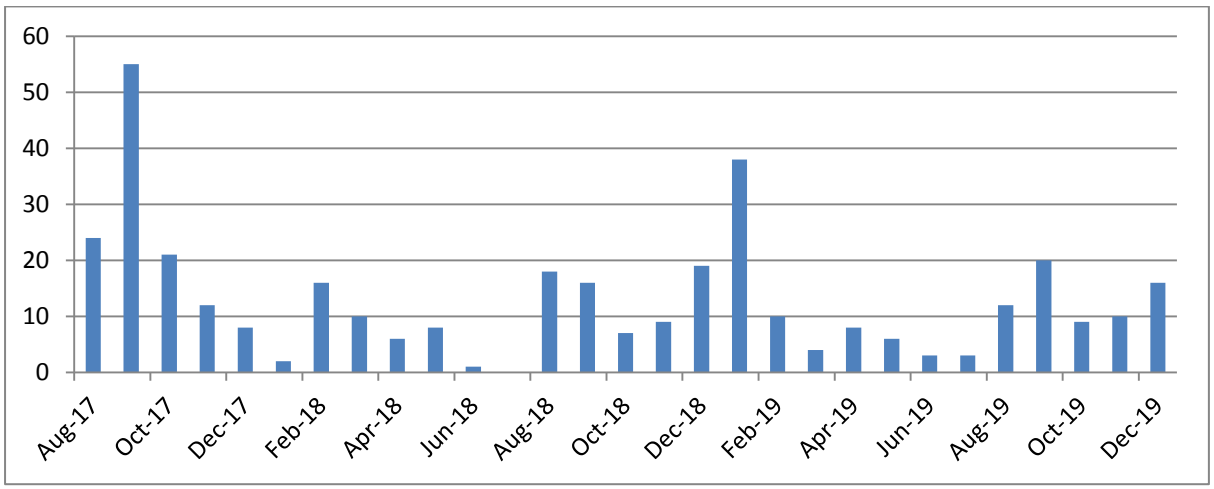
There are still some supervisors and trainees that remain unclear about the exception reporting process. I have met with some and have a schedule to meet with others as a group and hopefully clarify issues raised.

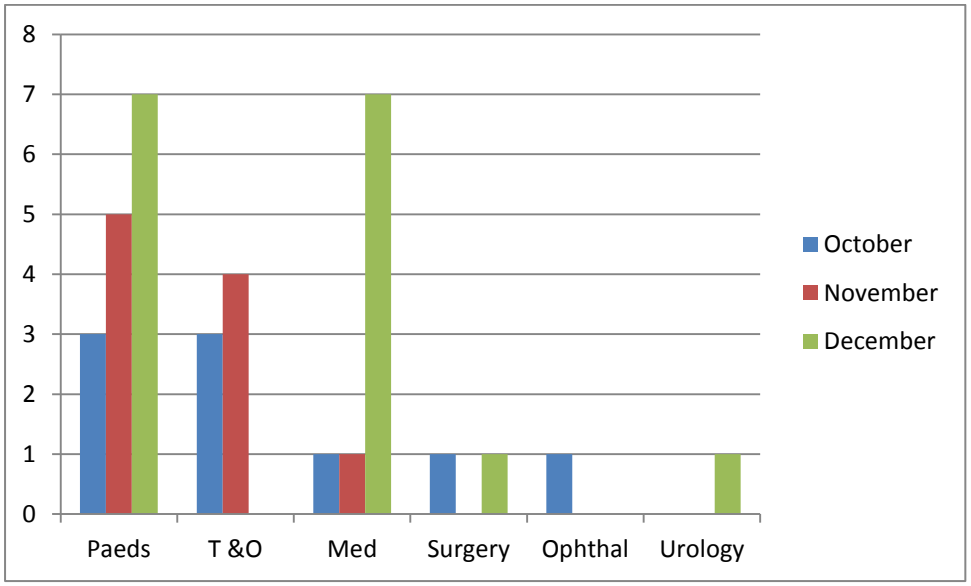
a. Exception reports

	Immediate safety concerns	Total hours of work and/or pattern	Educational opportunities/ support	Service support available	TOTAL
October	0	9	0	0	9
November	0	10	0	0	10
December	0	16	0	0	16
Total (Q2)	**0**	**35**	**0**	**0**	**35**

Trends in exception reporting

There have been a higher number of exceptions submitted in December reflecting increased activity in the Trust. The report only includes ERs submitted till 19/12/19, there may be further reports submitted by the end of the month.





The majority of exceptions this quarter have been from 3 main specialities; Paediatrics, Trauma & orthopaedics and General medicine.

In paediatrics, these were submitted mainly because of overtime due to sick patients and/or busy wards. A couple of ERs were due to missed breaks. Two thirds were from foundation year trainees. I have requested a work-schedule review of the FY1 trainee.

All exceptions from T & O were due to the number of hours worked and submitted by foundation and junior trainees. One of the junior trainees has submitted majority of these exceptions and is currently being supported by their educational supervisor and the department.

In medicine, the ERs were submitted mainly from MAU due to busy wards and sickness in colleagues.

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
October	2	6	1	1	0	9
November	2	7	0	0	1	10
December	5	1	1	0	10	16
Total (Q3)	**9**	**14**	**2**	**1**	**11**	**35**

There were a couple of ERs resulting in compensation plus a work schedule review. There are a large number of pending ERs, some of which have been submitted this week and some have had a verbal agreement but not signed off on Allocate. I have escalated this to the relevant supervisors.

b. Rota gaps- Areas of concerns

Paediatrics
Some further gaps due to maternity leave. Recent recruitment of a trust grade in paediatrics may help in bridging some of the gaps.

Emergency medicine

The gaps on the FY3/ST3 rota have increased from 7 to 8 and there is reliance on locums to fill these vacancies. This is due to recruitment problems and deanery gaps.

c. Guardian fines

No fines were levied this quarter.

d. Junior doctor forum (JDF)

Trainee attendance at the JDF in October has improved compared to prior meetings. The main discussion was around £30,000 allocated to CHFT to be spent in agreement with junior doctors for improving their working conditions at the Trust. This is following the BMA fatigue and facilities charter published in 2018. CHFT has signed up to the charter with the DME as nominated lead supported by the medical director, GOSWH and Medical HR. There will be a baseline assessment against the charter and an action plan in the coming year.
A junior doctor poll was requested to ascertain their needs at work in order to best allocate the above funding.

Results from the junior doctor poll (Oct-Nov'19, 40 responders)
The survey was around trust facilities, the exception reporting process and improving the working lives of our junior doctors.

Facilities:

- 65% of juniors do not know how to access the mess
- 95% of juniors think the mess facilities are currently unsuitable
- 77.5% said they would use the facilities if they were improved.
- 83% of people would use the mess if it was in a better location
- 60% believe the mess should be functional, 40% think it should be comfortable.

The most pressing issues were the quality of the mess, the lack of computers/phones and lack of comfort.

Improving JD working life:

Main themes were;

- Increasing availability of computers in wards and offices- I have escalated this to the clinical director in medicine
- Difficulty in car parking
- Inadequate time given in work schedules to update portfolios and complete mandatory training-Medical education and HR are aware and dedicated time has been allocated.
- Availability of 'doctor's office/space' near clinical areas for administrative work
- Improving catering options and facilities
- The need for a confidential waste bin in the doctor's handover room (HRI) was flagged up and resolved

Majority of the above will be reviewed as part of our compliance with the BMA charter. Progress against it will be monitored through the JDF.

Engagement with the exception reporting process

One third had filled in an exception report.

Reasons for not submitting ERs

- N/A for a lot of people
- People do not know how to
- "Pointless, nothing is ever rectified, no one cares to be fair"
- Being dissuaded from other members of staff to exception report
- Consultants aren't receptive to reported reasons for leaving late

I have already raised awareness around exception reporting at induction days and departmental audit days. I will continue to do that on a rolling programme next year and will get some GOSWH slots at the trainee forums.

e. Other matters arising in Q3

1) Post-shift rest facilities for junior doctors

The BMA rep has raised an issue with the provision of post-shift rest facilities for junior doctors in the Trust. The 2016 TCS states that where a trainee feels too tired to drive home following a night shift, a long late shift or attending work at night when non-resident on-call, employing Trusts are already required to cover the cost of an appropriate rest facility or alternative arrangements for the trainee's safe travel home. This revised TCS states that Trusts will now also provide for reasonable expenses to be paid for the trainee's return journey to work, either to begin their next shift or, where they have left their personal vehicle at work, to collect the vehicle.

At CHFT we do have rest facilities available. However if these are full, there is no clarity on the process for booking and payment for alternative facilities and no baseline figures on how often this happens. This will be a piece of work that we need to do in 2020.

2) Vouchers for junior doctors working on-site on Christmas day

Following support at the JDF, some of the GOSWH fine money has been used in Q3 to present vouchers to all junior doctors working in the Trust on Christmas day as a token of our appreciation. This has been very well received.

3) Junior doctor awards 2020

Planning has commenced. I will update the board in my further reports.

Summary

This quarter has seen an increase in exceptions from Paediatrics and Orthopaedics submitted mainly for overtime work. Vacancies on the paediatric rota are expected to increase in early 2020 and we may continue to see more exceptions from that area.

Trainee engagement with the JDF has improved. CHFT compliance with the BMA fatigue and facilities charter and our progress with the revised 2016 TCS will be assessed and monitored via the JDF. A review of the use of post-shift rest facilities by trainees is required.

As GOSWH, I am planning further face-to face sessions with junior doctors and supervisors to help improve engagement with and clarify the exception reporting process.

Matters for the board to consider

i. I recommend a review of our assessment against the BMA fatigue and facilities charter especially the rest facilities available to our junior doctors at night.

ii. Potential adjustments to the terms and conditions of service for doctors in training may need some support during the next few months.

Anu Rajgopal

Guardian of safe working hours

December2019

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

To Approve

Presented by Ellen Armistead

Date of Meeting:	9 January 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 & Safety
Sponsor:	Ellen Armistead, Executive Nurse Director/ Deputy Chief Executive
Previous Forums:	None

Actions Requested (please delete as required):

- For information

Purpose of the Report

This paper provides a summary of the key actions which have been undertaken in the quarter 3 2019 in relation to CQC work and priorities for quarter 4.

Key Points to Note

During quarter 3 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

Board of Directors is requested to:

- Note progress with must do and should do and must do actions.
- Be aware of the should do actions which are not progress to plan.
- Be aware of the continuous work to ensure regulatory compliance across the Trust.
- Note progress with Well-led assessments.
- Be aware of the key work streams in relation to CQC preparation in quarter 4.

1. Introduction

This paper provides a summary of the key actions which have been undertaken in the quarter 3 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 3, October & December.

The November meeting was cancelled due to the clinical pressures across the trust.

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

At the end of quarter 3, 2 'must do' and 3 'should do' actions are still not yet embedded; these continue to be 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.

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.

MD1	The trust must improve its financial performance to ensure services are sustainable in the future	BRAG rating remains **Green** **End of Q3 update:** The Trust has submitted a five year financial plan through the Integrated Care System and onward to regulators in line with the defined challenging Financial Improvement Trajectory. This trajectory sees a projected reduction in the deficit position but continues to require external funding support to achieve breakeven.
MD8	The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.	BRAG rating remains **Red** **End of Q3 update:** Further work is needed to make the proposal more palatable financially. Consideration is been made within the trusts planning cycle for 20/21. There is still no mitigation and therefore the risk remains red.
SD3	The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	BRAG rating remains **Green** **End of Q3 update:** Work has progressed with the strategy which is now going Trust approval and governance processes.

SD6	The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	BRAG rating remains **Green**. **End of Q3 update:** Discussed at nursing huddles to strengthen staff knowledge. Plan to test staff knowledge in Q4. To remain Green.
SD9	The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	BRAG rating remains **Red** **End of Q3 update:** We are non-compliant with this standard given our current consultant workforce numbers. We are continuing with attempts to recruit to consultant numbers to deliver this standard.

3. Use of Resources

The Trust is exploring options to progress an external review of Use of Resources in order to proactively identify areas for improvement. In addition a workshop is to be held in late January to raise awareness and engagement with the Use of Resources process with colleagues from a range of functions. An invitation to this workshop will also be extended to Non-Executive Directors to get a breadth of input.

4. 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 October and December 2019.

From 7 November 2019, services operating from Todmorden Health Centre and Broad Street Plaza transferred to the CQC mental health directorate. The new relationship manager Joanne White visited Broad Street Plaza on 17th December 19 to meet the team and to discuss what the implications of the transfer might be on inspection approach.

During quarter 3, the CQC Relationship Manager spent a day visiting the Emergency Departments at both HRI and CRH.

The CHFT Inspection Manager attended a Workforce and Organisation Development Hot House event with a focus on Health & wellbeing.

5. Achievements in Quarter 3

5.1. Roll out of the CQC Core Service Framework Self-Assessment Toolkit

The CQC Core Service Framework Self-Assessment Toolkit has now been rolled out to all CQC Core Services. 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.

During quarter 3 all core services were provided with the service specific template to undertake the self-assessment. Continuous work is ongoing within divisions to work through each domain and providing a rating for each Key Line of Enquiry (KLOE).

A decision was made by both Medicine and Surgery divisions to self-assess per directorate and not as a core service whole due to the size of the services and to ensure that ratings can be ratified.

Core services which presented at the CQC Response Group in quarter 3 Group were Children and Young Peoples Services and Gynaecology and ToPs. The services self-assessed and rated as:

	Domain				
Core Service	Safe	Effective	Caring	Responsive	Well-Led
Gynaecology & ToP Services	Good - Dec 19	Good - Dec 19	Good - Dec 19	Good - Dec 19	Good - Dec 19
Children & Young People Services	Good - Dec 19	Good - Dec 19	Good - Dec 19	Good - Dec 19	Good - Dec 19

Opportunities for outstanding included:

Gynaecology & ToP Services

CQC Ref:	Ward / Area	Detail of Outstanding Practice
C1/ 2/3	4c	Working with families on the bereavement pathway resulting in the purchasing of a Cuddle cot – which provides compassionate support families following a miscarriage
S1	4c	Gold Exemplar accreditation for infection control practise
S3	TOP	TOP mobilisation following recent AQP award for Kirklees
E1	4c	Nurse led enhanced recovery programme
E1	Gynae OPD	Looking at nurse led services delivery for the future
C1/ 2/3	4c	Patients feedback and compliments very good

Children & Young Peoples Services

CQC Ref:	Ward / Area	Detail of Outstanding Practice
C1/ 2/3	All services	Capturing the child and young persons voice in planning and developing services
C1/ 2/3	CDS	NHSI transition collaborative – supporting journey
	Directorate	System wide working for pathways for CYP
C1/ 2/3	Directorate	Utilisation of technology to communicate with our service users and staff
All	All	CHKS – successful Accreditation first children's service to be accredited
		Innovation funding and Joint working with ED to strengthen pathways
		Continuous learning from other providers who are rated as outstanding

Both services have key priority work streams over the next quarter which includes:

Gynaecology & ToP Services

Ward / Area	Priorities
4c and OPD	Set up and deliver safeguarding supervision within Gynae services
All service	Relaunch and audit the usage of the trigger list and closing the loop on incidents
All services	Further engagement with the wider team to disseminate understanding of CQC processes and high quality evidence
OPD	Devise and peruse secession planning for nurse colp and hysteroscopists
Gynae ward	Skills mapping exercise needs to be completed to identify any training needs

Children & Young Peoples Services

Ward / Area	Priorities
WARD 3	Mental health knowledge and training – a significant number of staff trained in MAYBO further work regarding compliance with ESR training
Ward 3	Reviewing further training in sepsis – to ensure all new starters have completed the ESR module
Ward 3	Ensuring policy's and procedures are clear and fit for purpose when caring for complex mental health pts This being led by a multi disciplinary group
CDS	Strengthening Transition pathways – bid to be submitted Jan 2019

Core services scheduled to present at the CQC Response Group in Quarter 4 are:

- End of Life Care, Surgery: January 2020
- Community Services: February 2020
- Medical Division (inc. Elderly Care) March 2020

5.2. Provider Information Return (PIR) Preparation

There has been ongoing preparation for the next PIR submission throughout quarter 3. Narrative sections of the PIR have been completed by key contacts within divisions and services.

The Innovations sections of the PIR were discussed at all December divisional PSQBs to ensure continuity and sign off at a divisional level.

The PIR will remain an ongoing priority piece of work with review and updates been requested on a quarterly basis. The aim is that all narrative sections will be complete, quality checked and ready for submission when the formal request is received by CQC.

5.3. CHFT CQC Intranet Page

The CHFT CQC Intranet pages are regularly updated to ensure colleagues have access to all information relating to CQC. The pages, continue to be updated as a minimum on a monthly basis, recent updates have included:

- Links to CQC reports from outstanding rated trusts.
- Core service specific recognised Outstanding Practice from published CQC reports.
- Core Service Self –Assessment Tools
- Updated escalation process if CQC arrive unannounced.
- Communication published by CQC i.e. updated guidance, monthly newsletters, annual reports.
- Findings from 'Go See' visits to Outstanding Trusts.

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

5.4. 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 was undertaken in quarter 2 in order to provide an analysis of any potential gaps in compliance. This was then used to inform the Developmental well-led Assessment all trusts are expected to commission every three years. The developmental review is 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.

An external Well-Led Developmental review has been commissioned and will be led by AQuA. Quarter 3 actions were:

Next steps for quarter 4 are:

5.5. CQC Insight Report

The new CHFT CQC Insight Summary Report was presented at the November Risk and Compliance Group. The new approach to managing the monthly Insight report published by CQC was well received.

Service position statements and a Trust response are now in place for all flagged indicators. Submissions were received from the service leads as well as details of the governance forums with oversight. This also includes any area flagged as a drop in performance since the last report or any area in which CHFT is performing below the national average.

A process is now in place so each monthly updated published Insight Report is analysed and reviewed. If any new indicators are flagged as a drop in performance or underperformance the core services are updated and a position statement and trust response is requested via divisional PSQBs.

Any indicators which show CHFT have improved in performance or are performing better than the nation average are also included in the Summary Report and shared with divisions.

Going forward all assigned leads will be asked to review and update the submitted position statement for each flagged indicator on a quarterly basis, in line with the quarterly update report to Risk and Compliance Group. The next updates are due for submission by 31st January 2020.

The report will remain as a standing agenda item at the CQC Response Group.

5.6. Go See to Outstanding Trust

Representatives from across the trust visited Newcastle upon Tyne Hospitals NHS Foundation Trust on 8th November 19. The focus of the 'Go See' was:

- Peadiatrics - flow of patients to theatres and managing peadiatric patients in ED.
- Quality assurance mechanisms.
- CQC inspection preparation.
- Learning from Patient Experience - handling complaints and learning.

Key learning in which the team brought back from the Go See visit included:

- Theatre's using volunteers to collect and transfer patient pre and post op where clinically appropriate.
- All departments such as surgical admissions theatre and recovery on the same floor and building which helps in terms of efficiency and through put.
- Flexible bed numbers through children's day surgery unit dependant on clinical need.
- The Complaints Team sits under the umbrella of Patient Experience whilst the PALS service is currently run by an external company.
- Staff well prepared for CQC visits especially around celebrating the positives and being able to identify outstanding practice. Outstanding evidence files are continuously updated.
- All directorates are internally peer reviewed annually. The peer review mirrors a CQC Inspection and consists of an inspection team of approx. 15 staff members all from key roles and specialities within the organisations i.e. pharmacist, infection control nurse, outpatient's manager.
- Findings from the internal peer reviews formed one centralised action for the directorate.
- Positive culture and can do attitude. Happy and content work force.
- The estate - lots of space in wards
- Utilised staff across all services – multi skilled workforce
- Clear visible leadership on the ground
- Clear roles and responsibilities understood

6. Priorities for Quarter 4

Key priorities for quarter 4 include:

Priority	Action	Lead
PIR preparation.	Ongoing quarterly review and updates of all submissions.	ADQS/ DON
CQC inspection preparation.	CQC Core Service Self Assessments to be presented at the CQC Response Group for: - End of Life Care - Community - Medical Division	Divisional Teams
Internal Peer Review	To create a proposal of how the trust can test compliance with fundamental standards through internal peer review. Considering all forms of assurance tool i.e. Ward Exemplar, Assurance Fridays; and bench mark to the systems used in outstanding organisations such as Newcastle and Salford NHS Trusts.	Assistant Director of Quality & Safety

Learning Portal to be live on the CHFT Intranet page.	Launch of new CHFT “Learning Portal”.	CQC Compliance Manager
Sharing Learning Guide to be available for all colleagues.	To be available to all staff at the same time “Learning Portal” is launched.	Governance Administrator
Go See to Outstanding Trusts.	To arrange at least 1 Go See visit to an Outstanding CQC rated Trust	CQC Compliance Manager
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	Organise a range of communications activities, for example tea trolley rounds, CQC information drop in sessions.	CQC Compliance Manager

7. Recommendations to Board of Directors

Board of Directors is requested:

- To note progress with must do and should do and must do actions in section 3.
- To be aware of the should do actions which are not progress to plan.
- To be aware of the continuous work to ensure regulatory compliance across the Trust.
- To be aware of the key priorities for quarter 4 to prepare for CQC inspection.

14. High Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing, Deputy Chief Executive
Previous Forums:	Risk and Compliance Group – 9 December 2019 Weekly Executive Board - 12 December 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 20 December 2019.

Key Points to Note

The Trust has 21 risks on the high level risk register as at 20 December 2019.

In terms of movement on the high level risk register two new risks have been added since this was last reported to the Board on 7 November 2019, two risks that have been removed from the high level risk register due to reduction in risk scores and will be managed within local risk. Registers. One risk is proposed for closure.

New Risks

- 7615 (risk score 15, Medical Division) risk of not meeting the four hour emergency care standard due to multiple factors resulting in poor patient experience, delivery of fundamental care standards and reputational risk.

- 2830 (risks core 16, Medical Division) risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department, due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability.

Risks with Reduced Score

The following risks have been removed from the high level risk register following a reduction in risk score:

- 7345 Referral to District Nursing Service on EPR system – Community Healthcare – risk score reduced from 16 to 4 due to EPR referral being active.

- 7251 Optovue OCT machine risk – Surgery and Anaesthetics Division - risk reduced from 15 to 9 due to new machines having been installed.

To Note
The risks below are currently being reviewed in detail by the relevant risk owners:

- Risk 5806 urgent estates risk – this is a collective risk regarding multiple estates issues, all of which have individual risks captured on the risk register – it has been agreed at the Joint Liaison Committee with Calderdale and Huddersfield Solutions Ltd (CHS) on 20 December 20210 that an assurance piece of work will take place during January 2020 to check that all risks are adequately captured and have appropriate controls in place, The risk will then be reviewed and a recommendation made to the Risk and Compliance Group on 17 February 2020 and the decision regarding risk 5806 will be shared with the Board in March 2020.

- Risk 3793, Opthalmology out patients – further testing of assurance regarding this risk in January 2020

- Risk 6715, poor documentation, will undergo a full review including a review of the risk description, controls and gaps as this has been a risk on the risk register for a number of years.

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

compassionate care

NHS

Calderdale and Huddersfield

NHS Foundation Trust

High Level Risk Register – December 2019

Risks at 20th December 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

7615 (15) – Medicine (Impact 3 x Likelihood 5)

ED Four Hour Standard Risk

Risk of not meeting the four hour emergency care standard due to multiple factors (demand, workforce and workforce model, patient flow, ability to discharge patients) resulting in poor patient experience, delivery of fundamental care standards and reputational risk

2830 (16) – Medicine (Impact 4 x Likelihood 4)

ED Mental Health Risk

Risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department, due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability.

This risk had previously been on the Medical division risk register and the score was increased from 12 to 16 following a patient incident and agreed as a high level risk register risk.

INCREASED RISKS

None

RISKS WITH DECREASED SCORE

These risks have therefore been removed from the high level risk register and will be managed within divisional risk registers

7345 Referral to DN service on EPR Risk ↓4 (16) – Community Healthcare

Risk patients with a nursing need not being referred on discharge to the District Nursing Service due to the lack of referral facility on EPR – risk score reduced from 16 to 4.

Rationale for Reduction
EPR referral now active

7251 9↓ (15) - SAS
Optovue OCT Machine Risk

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. Risk score reduced from 15 to 9.

Rational for Reduction

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 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

December 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 20th December 2019

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead/ Divisional Director						
					July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 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
10a/19	7454	Keeping the base safe	Radiology service provision staffing risk	Divisional Director of FSS (JO'R)	=20	=20	=20	=20	=20	=20
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	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
06/19	**2830**	**Keeping the base safe**	**ED Mental Health Breach**	**Associate Director of Nursing (MM)**					**!15**	**=15**
06/19	7315	Keeping the base safe	Out patient appointments capacity risk	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
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	6493	Keeping the base safe	Complaints Quality and performance Risk	Director of Nursing (EA)	=15	=15	=15	=15	=15	=15
06/19	7474	Keeping the base safe	Medical Devices Risk	Director of Finance (GB)	=15	=15	=15	=15	=15	=15
08/19	7430	Keeping the base safe	Radiology Requests risk	Divisional Director of FSS (JO'R)				**!15**	=15	=15
05/19	7527	Keeping the base safe	Maxillofacial follow up appointment	Divisional Director of SAS (WA)				**!15**	=15	=15
06/19	**7615**	**Keeping the base safe**	**Emergency Care Standard**	**Chief Operating Officer / Director of Nursing**						**!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 safety risk 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 17/12//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 =7315 Appointment Risk =7430 Radiology Requests Risk !7615 Emergency Care Standard	= 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 !2830 ED Mental Health Breach	= 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 December 2019 (for approval at 9 January 2020 Board meeting)

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, equality and patient safety, which will be subject to rigorous impact assessments. The balance of price, value and benefits will be considered. We will allocate resources to capitalise on opportunities.	**CAUTIOUS**	**MODERATE**
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 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**
Legal	We will comply with the law.	**MINIMAL**	**LOW**
Innovation / Technology	The risk appetite for innovation / technology is high 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.	**OPEN**	**HIGH**
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.	**OPEN**	**HIGH**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to staff/patient safety and harm and clinical outcomes for patients.	**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. .	**MINIMAL**	**LOW**
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. 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**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**

High Level Risk Register

20 December 2019

The Health Informatics Service
Informing Healthcare

Risk No	Div	Dir	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
7278	Corporate	Finance and Procurement	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: Strategic Outline Case submitted in April; starting to develop Outline Business Case. 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 £0.5m 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 - due for submission 23rd Oct 19.	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. Trust is currently on plan and forecasting to achieve this planned deficit. A five year long term plan for the Integrated Care System is due to be submitted in October 19. Draft five year 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 and access to non recurrent Financial Recovery Funding for 20/21 has been confirmed at a level that will bring the Trust back to a balanced position, which will reduce borrowing requirements.	Jan -2019	Mar-2020		FPC	Gary Boothby	Philippa Russell

7454	Family & Specialist Services	Radiology	Apr-2019	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in consultant capacity resulting in gaps in some specialist areas, a reduction in overall general capacity and the potential for breaching national targets.	- Agency locum cover. - NHS Locum cover. - Additional support from external providers. - Head and neck: Additional support from external providers and short term support was provided up until end June 2019 from adjacent Trust. - Lung and chest: Additional support from external providers and temporary change to job plans. - IR: Agency locum cover. - Neuro: Additional support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in: - Head and neck: No vetting of requests . No on-site cover. - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap during annual leave/other leave of one remaining Consultant. - Breast: Reduced capacity and no capacity during annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave. Impact on the general on-call rota.	15 3 x 5	20 4 x 5	1 1 x 1	- 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 accommodating different work to cover gaps - Outsourcing increased to free up capacity where possible - Locum support employed when available e.g. breast radiologists	October and November 2019 Update: We have recruited an overseas NHS locum (commenced November 2019) 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. **December 2019 Update**: ,Introduction of a named Consultant each morning/afternoon who is assisting with prioritisation of requests/challenging which could be done as outpatient requests or unnecessary requests.	Jan-2020	Mar-2020		PSQB	Caroline Gizzi	Sarah Clenton
2827	Medical	Emergency Care	Apr-2011	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	20 5 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	Sept 2019 New rota's working well. To date there has been a reduced requirement for ad hoc locums. **November/December update 2019** New rotas working well. To date there has been a reduced requirement for ad hoc locums	Jan-2020	Aug-2020		WEB	David Birkenhead	Dr Mark Davies

6345	Corporate	Workforce & Organisational Development	Jul-2015	Keeping the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing	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	October 2019 Update Recruitment fair held 12 October by clinical education team November 2019 Update: New graduates now in post and going into shift fill - on new preceptorship programme International recruits progressing well (35 in post - 5 going through the OSCE training programme) Next TNA programme due to start on the 6th of Jan 2020 **December 2019 Update:** New graduates now in post and going into shift fill - on new preceptorship programme International recruits progressing well (35 in post - 5 going through the OSCE training programme) Next TNA programme due to start on the 6th of Jan 2020	Feb-2020	Feb-2020		WF	Ellen Armistead, Suzanne Dunkley	Rachael Pierce

7078	Corporate	Workforce & Organisational Development	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 2020 Further work to introduce the new rota rules for doctors in training which were agreed over summer 2019 by NHS Employers and the BMA.	**December 2019** A number of interviews have been arranged at Consultant level during December. There are strong applicants for substantive posts at Consultant level for Urology, Respiratory Medicine, Rheumatology, Care of the Elderly, Acute Medicine, Neurology, Ophthalmology and Renal Medicine. In addition, interviews are scheduled for fixed term appointments at Consultant level in Anaesthetics Haematology and Radiology. Current Vacancy data shows that there are 21 consultant level vacancies so if these applicants are appointed then we will be able to reduce this vacancy rate further. A recent paper regarding consultant recruitment has been presented to the Workforce Committee. This showed that consultant level vacancies have reduced from 31 gaps in October 2018 to 20 in October 2019. The changes to the pay arrangements for doctors in training with regards to their weekend allowances have all been applied and updates completed. Invites for the Local Clinical Excellence Awards have been sent out and all applications are to be submitted by the end of December for consideration by the Awards Panel. Briefing sessions for the panel are being delivered throughout December so that scoring can commence in January without delay. The Awards panel are due to meet Wednesday 12 February 2020.	Jan -2020	Mar-2020		WF	David Birkenhead	Pauline North

5806	Calderdale and Huddersfield Solutions	Estates	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks identified within the Estates Risk Register being: • 7220 Flooring • 6734 Pipework: k • 6735 Structural: • 6736 Air Handling Units: • 6737 Windows: • 6739 Roofs: • 6761 Ward Upgrade Programmes • 6762 Day Surgery: • 6763 Environmental • 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:	The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. Each of the risks above has an entry on the risk register and details actions for managing the risk.Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.	16 4 x 4	20 5 x 4	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. **December Update** - The reconfiguration plan is now currently being developed including the estates strategy / sustainable development plan which will address some of these risks. Assurances regarding individual estate risks to be reviewed by CHS during January 2020 and risk to be reviewed and update provided to Risk and Compliance Group on 17 February 2020	Jan-2020	Mar-2020		RC	Stuart Sugarman	Paul Gilling / Chris Davies

7223	Corporate	THIS	Mar-2018	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data andCyber Security	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 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).	Oct 19 update: Following the initial internal review against the DSP 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 BCP point raised in the last update, the score remains the same. **November/December 2019 update** - As per Octobers update, the Data Security Protection Toolkit Plan is still being pulled together with resource being identified for a Jan 2020 start. There is a separate risk logged for potential non-compliance of the toolkit (7617) however the overlap with this risk is significant enough to maintain (and potentially increase) the score.	Jan-2020	Mar-2020		RC	Mandy Griffin	Rob Birkett

7248	Corporate	Workforce & Organisational Development	Apr-2018	Developing our workforce	The risk: Not all colleagues will complete their designated core 'Essential Safety Training' (EST) subjects. In addition not all colleagues will complete their role specific training. Resulting in: Colleagues practicing without the recorded required knowledge or understanding of core EST subjects. This could lead to unsafe practice, potentially leading to incidents involving colleagues and/or patients. EST consists of 10 'core' subjects which all colleagues must be consistently 100% compliant in. There are a further 35 subjects which are 'role specific' – subjects which are dependent on the role the colleague has. The Trust has a compliance target of 90%. Our core subjects have been consistently above this target since April 2019, with an average of 95.22%. The focus therefore is on the compliance of the 35 role specific subjects. Compliance for these subjects range from 97.60% to 50.04%. We expect all role specific training to be on target by August 2020.	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.	November 2019 - The core 9 subjects remain at over 90% compliance, with 5 subjects consistently over 95%. Fire Warden training has been assigned to all Band 6 Nurses which has seen a reduction in compliance, work is under way to review the target audience and increase capacity. **December 2019** - Of the 34 role specific subjects, 19 are at below 85% compliance. Each of these is being scrutinised this month with a plan in place to increase compliance by end of March 2020.	Jan-2020	Mar-2020		WF	Suzanne Dunkley	Charlotte North
6829	Family & Specialist Services	Pharmacy	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 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 and July 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 . Potentially when CRH closes, will open HRI unit earlier at 7.30am to prepare those doses required at CRH and ensure timely transport. Delay in project- new unit not now due to open until Aug 20	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 November 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in .. Phasing in of ready to use chemo batches also underway.	**December 19 update**. Delay due to lease agreements with lenders solicitors being reviewed. CRH unit now due to close Jan 20 and enabling work start mid- Jan but awaiting confirmation from Associate Director of Finance re outcome of lease sign off debate. This is likely to delay opening of new unit to Aug 20 and reliance on HRI aseptic unit until that point.	Jan-2020	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 June 2020 -outsource radiopharmacy (buy in MDVs of radioisotopes from Bradford)											
2830	Medical	Emergency Care	Apr-2011	Keeping the base safe	There is a risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department. Due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability. Resulting in a lack of supervision and care provided in the wrong place	Appropriate assessment from nursing team to identify high risk patients. (ReACT self-harm risk assessment at triage.) Nurse in visible areas use 1-1 nursing if deemed appropriate. Referral to Mental Heath Liaison Team, service available over 24 hours. Use of security service as necessary. Referral to CAMHS for children and adolescents. Missing Persons Policy for escalation if patients abscond	Delays in timely assessment from the CAMHS service. Mental health inpatient capacity limited locally and nationally. Absence of departmental guideline for rapid tranquilisation of mentally disturbed patients No clear pathway between SWYFT and the Local Authority in terms of the timeliness of Mental Health Assessments, Gatekeeping assessments and securing a bed in a MH facility Lack of additional resource availability to provide 1:1 when required.	3 3 x 1	16 4 x 4	9 3 x 3	Develop clear escalation process to support nurse staffing in the ED when demand exceeds capacity.	October 2019 Discussed at Risk and Compliance, and agreed for inclusion onto the high level risk register update to wording shared with matron **December 2019:** Continuing to review all mental health long waits within the department and evaluate care in the department and appropriate escalation.	Jan-2020	Jun-2020		NA	Maggie Metcalfe	Louise Croxall
3793	Surgery & Anaesthetics	Head and Neck	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	- 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)	**December update** 3/12/19 reviewed risk score with Clinical Director - holding list numbers reducing from 2200 to 1300 and only 28 patients over 12 weeks overdue. Discussions on reducing the likelihood to 3 (reducing risk score to 12) at Risk and Compliance Gorup, however following discussion at Weekly Executive Board on 12 December 2019 assurance to be tested and risk score reviewed with Opthalmologists at Working Together to Get results session in Jnauary 2020.	Jan-2020	Jan-2020		DB	Will Ainslie	Pnt Laloe

						validation and slot utilisation in Ophthalmology (happened in summer 2018)											
6493	Corporate	Corporate 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 line with PHSO clinical standard. Divisional Directors or Assistant Director of Nursing reviewing complaints in before sending to complaints team for review. . Complaints Policy details process for managing all complaints including cross divisional complaints. Quality assurance process in division and central team to ensure complaint is responded to appropriately. Escalation process of 10% complaints by division overdue highlighted to Director of Nursing. Complaints Investigation training reiterates key timescales and investigator responsibilities. complaints improvements within Governance and Risk action plan.	Medical division complaints position continues to be challenging - to be addressed through performance route also following lack of assurance to Quality Committee on 30 July 2018 re: sustained improvements. Quarterly meetings with senior complaints team and Assistant Directors of Nursing to be introduced. Investigators not routinely contacting complainants within 7 days. Quality of responses received variable Further WEB report on complaints and tracking of individual cases for September 2018	12 3 x 4	15 3 x 5	4 2 x 2	Continue to monitor overdue complaints via weekly tracker and revise risk score and actions required if improved position is not sustained. Position escalated to Chief Nurse and Chief Operating Officer and discussed with divisional teams through PRM route. External review of complaints being planned by Chief Executive.	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. November 2019 - 40% of complaints closed in target timeframe. WTGR event held to refocus improvement actions. Chief Nurse taking paper to Quality Committee in December to outline recommendations and actions for improvement. Complaints Team leader has secured an internal promotion to another team and so work taking place to review structure and roles in the team before advertising role. **December 2019** - 41% of complaints closed in target timeframe. Band 6 post awaiting Trust Exec sign off before advertising. Improvement actions continue.	Jan-2020	Feb-2020		QC	Ellen Armistead	Anne-Marie Henshaw

6715	Corporate	Corporate Nursing	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience Due to inconsistently completed documentation on EPR Resulting in a potential 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	Establishment of clinical documentation group	**December 2019** Date arranged for visit to Leeds - 17th December with engagement from ED, Acute Floor and Training. E Cras Audit Tool being audited on Ward 6 CRH. Engagement nationally with counterparts who use the same electronic system looking at alternatives to improving digital clinical record. Continue to support the Discharge Quality Group factoring in digital clinical record. Full review of risk to take place	Jan-2020	Mar-2020		WEB	Ellen Armistead	Carol Gregson/Graham Walsh
5747	Family & Specialist Services	Radiology	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1wte substantive consultant in post - Ad-hoc locums supporting the service - Continue to try to recruit to vacant posts	- Failure to secure long term locum support. - Lack of clarity on regional commissioning arrangements relating to vascular services	16	4 x 4	15	5 x 3	6	2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response	October and November 2019 update: Mid Yorkshire Trust 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. **December 2019 Update**: We now have a Vascular Radiologist from MYT/LTHT working at HRI one day per week. This will assist with stabilisation of the service and support for our new NHS Locum, in particular in relation to EVAR (Endo Vascular Aneurism Repair) provision. We continue to work with WYVAS. Actions underway from regional Chief Operating Officers meeting held in early October 2019 regarding Radiology. Looking to create regional contingency.	Jan-2020	Mar-2020		DB	Caroline Gizzi	Sarah Clenton

7474	Trustwide	All Divisions	May-2019	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and use across CHFT due to the lack of assurance of the Trust Asset Register being up to date including equipment which has been gifted or bought without CHS involvement resulting in potential patient harm. CHS Risk 7438 –(Rating 20) - There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, resulting in potential patient harm CHS Risk 7438 –(Rating 20) CHFT Risk 7474 (Rating 15)	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.	Failure to manage, maintain and service medical devices.	5 5 x 1	15 5 x 3	1 1 x 1		**December update** 2019/12/02-Update-High Risk numbers fell High risk (524 to 408), Medium fell (2184 to 1722), Low fell (1860 to 1325), a total of (4568 to 3455). The audit carried out with community has greatly reduced the number of devices we are looking for this in conjunction with contracts management and training has had a positive impact on compliance.Related CHS risk has reduced risk score from 20 to 15.	Jan-2020	Mar-2020		RC	Ellen Armistead	Robert Ross
7527	Surgery & Anaesthetics	Head and Neck	Aug-2019	Keeping the base safe	There is a risk that patients will not receive appropriate follow up care for their clinical pathway which can cause delays for diagnosis and treatment.	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- Completed Develop process with appointment centre (Validation team) Completed Develop escalation process with appointment centre , secretaries for cashing up of clinics, and process to add further requests if appointments are cancelled. Completed Communication plan within the head and neck services. Completed High level process to roll out within the division. - Ongoing , process map developed, awaiting sign off by division.	**12 December update** - All validation for Maxfax completed and monitored weekly . Development of surveillance patients portal digitally is being worked by information management. Progressing well for all patients identified no commencing date as yet. To be sent to DMT to reduce risk	Jan-2020	Mar-2020		PSQB	Mel Addy	Laura Cooper

7315	Trustwide	All Divisions	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 and possible claims. Please refer to following individual risks: 4050 6078 6079 7199 7202	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3	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	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. **December 2019 update** There is still a lack of capacity for new and f/up patients. Total ASI's currently stand at 2,368 and f/ups overdue stands at 8,478. Discussions around the action plan continue to take place at WEB. 2020/21 Planning discussions have detailed capacity and demand plans. 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. We have now switched off the ASI app for ERS refs and reporting is going through KP+ which gives greater accuracy and reduce admin work. Paper referrals and long waiters are still managed via the app as there is no alternative currently. Risk moved from Family and Specialist Services risk register and discussions to agree whether this risks should sit within Medical or Surgical Division risk register to take place.	Feb-2020	Mar-2020		PSQB	Helen Barker	Asif Ameen, Mel Addy, Caroline Gizzi

7413	Corporate	Finance and Procurement	Feb-2019	Keeping the base safe	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. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety 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 1 X 1	Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard. Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. May 2019: Delivery of fire training June 2019: Fire risk assessments, installation of sockets July 2019: NHSI capital bid for 19/20 Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks.	October 2019 Update 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 will be presented to Trust Board in November. 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. **November/December update 2019** CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trust's reconfiguration plans.	Jan-2020	Mar-2020		NA	Helen Barker	C Davies
7414	Corporate	Finance and Procurement	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 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	October 2019 The approach to cladding is being determined as part of the HRI Strategic Development Plan (SDP) to be presented to Board in November. 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. **December 2019 update** - CHS carrying out re-inspection 12 months on, any remedial works will be carried out from the re-inspection. CHS awaiting finalisation of the SDP but continue to explore over cladding option following an option appraisal.	Jan-2020	Mar-2020		FC	Gary Boothby	C Davies / A Wilson

7430	Family & Specialist Services	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	9 3 x 3	- 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.	November 2019 -We have met with Wirral and the EPR team and Wirral have a solution to this problem that could work at this trust. -We need to meet with EPR to discuss a pilot of this and how it could work. This meeting will take place in the next few weeks. **December 2019** - Setting up a meeting to look at a pilot in one area. Possibly A&E. Some key staff are on AL which has delayed a date.	Jan-2020	Mar-2020		PSQB	Gill Harries	Mark Williams
7615	Medicine	All Directorates Medical	Dec-2019	Keeping the base safe	There is a risk of not meeting the four hour emergency care standard Due to increasing demand on Emergency Care (approximately 5% above plan) meaning significant workload above workforce model, inappropriate use of ED. ED team factors including medical and nurse staffing (Risk ID 2827 and 6044), not triaging, patient flow, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community Resulting in poor patient experience, potential risks to delivery of fundamental care standards and potential harm to the patients, increased scrutiny and reputational risk to the organisation	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - eg gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and teams Skill mix- training for newly qualified nurses Streaming from the front door and admission avoidance services - frailty, streaming,	Partners not being able to deliver YAS - transport - escalation and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams	15 3 x 5	15 3 x 5	1 1 x 1	Patient Flow action plan in place Governance - reported monthly at WEB Patient Flow action plan owner – Deputy COO, Accountability- Directors	**December 2019** Discussed at Risk and Compliance Group and WEB and agreed as new risk. Need to also record new risk relating to transfer of care and work with local authority partners – lead Rachel Rae	Jan-2020	Mar-2020		WEB	Helen Barker/ Ellen Armistead	Bev Walker

15. Integrated Performance Report – Month 2019

To Note

Presented by Helen Barker

Date of Meeting:	**9th January 2020**
Meeting:	**BOARD OF DIRECTORS**
Title of report:	**QUALITY & PERFORMANCE REPORT**
Author:	**Peter Keogh, Assistant Director of Performance**
Sponsor:	**Helen Barker, Chief Operating Officer**
Previous Forums:	**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 November 2019.

Key Points to Note

November's Performance Score is 75% 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. The CARING domain remains amber although FFT A&E, Community and Outpatients 'would recommend' need improvement. The RESPONSIVE domain remains amber with all key cancer metrics achieving target. 2 of the 4 stroke indicators are still missing target and the 6 weeks Diagnostics only just missed target. WORKFORCE remains green with sickness levels and EST continuing their strong performance which is a great achievement. FINANCE remains green although a deterioration in EFFICIENCY metrics means that the domain is now amber.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

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

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

November 2019

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

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

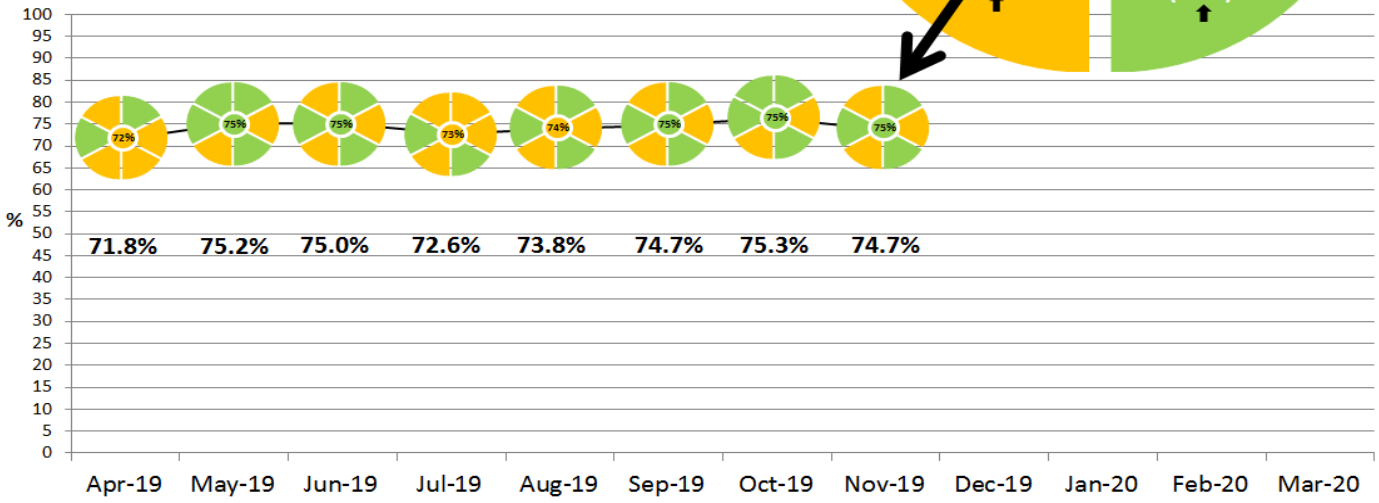
There have been no changes to note since the October report.

Performance Summary

November

RAG Movement

November's Performance Score is 75% 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. The CARING domain remains amber although FFT A&E, Community and Outpatients would recommend need improvement. The RESPONSIVE domain remains amber with all key cancer metrics achieving target. 2 of the 4 stroke indicators are still missing target and the 6 weeks Diagnostics only just missed target. WORKFORCE remains green with sickness levels and EST continuing their strong performance which is a great achievement. FINANCE remains green although a deterioration in EFFICIENCY metrics means that the domain is now amber.



OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT OP FFT A&E
FFT IP FFT Maternity	FFT Community
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	Oct-19	Nov-19	YTD	Performance Range		
SAFE											Green	Amber	Red
Never Events	4	0	0	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%	40.0%	**41.0%**	**39.0%**	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%	31.51%	**29.82%**	**32.02%**	>=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%	97.63%	**96.78%**	**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%	6.25%	**6.52%**	**7.60%**	>= 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%	91.70%	**92.80%**	**91.79%**	>= 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%	10.28%	**11.12%**	**11.24%**	>= 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%	85.86%	**81.84%**	**83.96%**	>=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%	33.65%	**37.10%**	**32.90%**	>=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%	99.60%	**98.70%**	**99.20%**	>=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%	6.10%	**9.11%**	**3.97%**	>=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%	96.20%	**94.66%**	**96.75%**	>=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	0	**0**	**1**	0		>=0
Preventable number of Clostridium Difficile Cases	5	0	0	0	3	1	0	0	**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%	84.19%	**82.68%**	**88.55%**	>=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%	41.82%	**47.37%**	**52.76%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.46%	96.56%	96.92%	98.00%	98.75%	98.24%	99.09%	99.15%	**99.40%**	**98.29%**	>=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%	99.27%	96.77%	**98.41%**	**97.17%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.63%	100.00%	99.40%	100.00%	99.40%	100.00%	100.00%	98.47%	**100.00%**	**99.61%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	99.04%	100.00%	100.00%	100.00%	100.00%	100.00%	96.00%	100.00%	**100.00%**	**99.47%**	>=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%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	52.42%	31.58%	31.58%	55.56%	84.21%	41.67%	38.10%	56.52%	**66.67%**	**50.00%**	>=85%		<=84%
62 Day GP Referral to Treatment	88.37%	88.51%	91.76%	89.16%	89.58%	93.69%	91.76%	87.56%	**92.17%**	**90.50%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	94.42%	91.30%	96.30%	100.00%	88.46%	86.67%	89.47%	77.50%	**100.00%**	**89.50%**	>=90%		<=89%
WORKFORCE											Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.69%	3.67%	3.64%	3.61%	3.61%	3.63%	3.66%	3.71%	*	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.39%	2.37%	2.36%	2.33%	2.33%	2.35%	2.39%	2.41%	*	-	<=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%	1.27%	1.30%	*	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.45%	93.18%	93.40%	93.36%	94.68%	94.58%	95.22%	95.30%	95.32%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff		16.52%	50.88%	96.43%	97.63%	96.97%	96.11%	95.21%	94.65%	-	>=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%	83.81%	88.42%	-	>=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**	**0.00**	**0.23**	**0.24**			

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - At 91.89% best monthly performance to date.	% Stroke patients spending 90% of their stay on a stroke unit is now at 67% against the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival has improved to 47% against the 90% target. The quarter 2 SSNAP score has been received and has unfortunately been downgraded to a B.	Following a challenging October and November a full action plan has been drawn up to ensure performance does not worsen and also improve our two most challenging areas; 90% stay and admittance to stroke within 4 hours. It is encouraging that both of these indicators have seen improved performance in month which hopefully will lead to an improvement in the SSNAP score for quarter 3.
3 months' running overall green performance for CHFT.	RTT Waits over 52 weeks - there were 3 at month end.	As part of the RTT Diagnostic project and agreed trajectory with NHSI/E we have been reviewing 3,000 patients on a Non-Planned Waiting list that were not on a current RTT Pathway. The Validation team started this work in November and have been through over 1,500 patients on the list so far. Of these 625 pathways have been reopened and are now showing in the reported RTT Position. At month end, 3 of these were found to have been waiting over 52 weeks for treatment. All 3 were treated by the 19th December 2019.
Cancer performance back on track with all key performance targets achieved.	Emergency Care Standard 4 hours - deteriorated further to 82.68% in November, (85% all types). A&E Trolley Waits (From decision to admission) - We reported 9 over 12 hour trolley waits in November.	We have seen an increase in activity and prolonged length of stay for those patients waiting for beds. We have escalated where appropriate and the introduction of the matron and operational manager on each site has made sure that patients are moved through as quickly as possible. Those patients with prolonged waits are written to in order to give them an opportunity to provide us with feedback. We escalated the 12 hour trolley waits appropriately and they are currently being externally investigated. A new line is now in place on EPR so all teams can be clear about the time a 12 hour breach is due.

Executive Summary

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

Domain	Area
Safe (80%)	• **Maternal smoking at delivery -** Performance was 14.5% in November, the highest level in over 12 months against the 12.9% target. Provision of a 'risk perception' intervention following dating scans for women who smoke has not been taking place due to staffing issues in Antenatal clinics. • **Health & Safety Incidents (RIDDOR) -** 1 in month, incident under investigation.
Caring (63%)	• **Complaints closed within timeframe** - Complaints performance remains at 41% in November. Divisional Senior Management Teams and Corporate Complaints Team colleagues continue to work together to improve the quality and timeliness of complaint responses, and training and supervision of colleagues responding to complaints. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 93% against the 96.2% target. Changes are expected as the Trust continues to work through its outpatient transformation plan. • **Friends and Family Test A & E Survey - Would Recommend**. Deteriorated in month to 81.84%, below 87.2% target. The comments continue to be reviewed and the themes related to both medical and nursing issues. This has been taken through directorate QI and one of the ED consultants is now leading on improving behaviours and therefore patient feedback. Work has started to improve the environment at HRI consisting of re-laying the flooring and re-painting the cubicles. All colours will be dementia friendly and will brighten up the environment.
	• **Friends and Family Test Community Survey - % would recommend the service**. Performance dropped again to 94.66% in month. The division has reviewed the responses. These have been fed back to the relevant teams for local action.
	• **% Dementia patients screened following emergency admission aged 75 and over** - performance is at 35% and is a long way from the 90% target. Medicine - Dementia champions are in place in the Medicine divison, raising the profile of the importance of the dementia screen with clinical colleagues. The Task & Finish group have met and are supporting the introduction of large touch-screen patient information boards to include essential assessments, including dementia. This is being led by the Associate Medical Director. This will be tested on one of the acute floors initially.
Effective (95%)	**All metrics are within normal variation.**

Background Context

November has been a challenging month due to the norovirus outbreak which has seen several wards restricted throughout the month resulting in additional escalation areas opening.

Staff sickness has been particularly challenging due to the 48 hour sickness bug.

We had 9 x 12 hour breaches in ED which are currently being investigated externally to the organisation.

The full impact of the Urgent Care Board funding has not yet been realised.

The 8th Respiratory consultant (winter bid) has been recruited to within Acute Medicine. The benefits of this will be to reduce the number of Respiratory patients requiring admission to hospital and for those that do, we will be able to reduce the length of stay for these patients.

The SSNAP score for quarter 2 has been received and has decreased to a B. The Stroke team are working to recover this following a particularly challenging 2 months in September and October.

November has seen the start of the Same Day Emergency Care (SDEC) Unit co-located in CDU in HRI. KPI's are in place to monitor performance. There have been some really positive stories from the first two weeks with examples of outstanding patient care.

Acute Floor consultants started cross site working on 11th November.

Focussed work has started in all divisions on RTT trajectories for patients waiting over 32 weeks.

Executive Summary

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

Domain	Area
Responsive (65%)	• **Emergency Care Standard 4 hours** - deteriorated further to 82.68% in November, (85% all types) - We have seen an increase in activity and prolonged length of stay for those patients waiting for beds. We have escalated where appropriate and the introduction of the matron and operational manager on each site has made sure that patients are moved through as quickly as possible. Those patients with prolonged waits are written to in order to give them an opportunity to provide us with feedback. • **A&E Trolley Waits (From decision to admission)** - We reported 9 over 12 hour trolley waits in November. We escalated these appropriately and they are currently being externally investigated. A new line is now in place on EPR so all teams can be clear about the time a 12 hour breach is due. • **Stroke targets** - % Stroke patients spending 90% of their stay on a stroke unit is now at 67% against the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival improved to 47% against the 90% target. The quarter 2 SSNAP score has been received and has unfortunately been downgraded to a B. Following a challenging October and November a full action plan has been drawn up to ensure performance does not worsen and also improve our two most challenging areas; 90% stay and admittance to stroke within 4 hours. It is encouraging that both of these indicators have seen improved performance in month. • **RTT Waits over 52 weeks** - As part of the RTT Diagnostic project and agreed trajectory with NHSI/E we have been reviewing 3,000 patients on a Non-Planned Waiting list that were not on a current RTT Pathway. At month end, 3 of these were found to have been waiting over 52 weeks for treatment. All 3 were treated by the 19th December 2019. • **% Diagnostic Waiting List Within 6 Weeks** - CHFT just missed the November target due to a small number of Echo cases not seen. • **Cancer 38 Day Referral to Tertiary** - performance was improved to 67% in November. • **Appointment Slot Issues on Choose & Book** - performance has deteriorated to 31% against the 20% target following 3 months of improvement from the introduction of CAS clinics and action plans in place at specialty Level.
Workforce (86%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness rolling 12 month total continues to increase although October saw a decrease in long term sickness in month. RTWI performance has peaked at 85% just below the 90% target. • **Essential Safety Training -** overall at 95%.
Finance (68%)	• **Year to Date Summary** The year to date deficit is £8.67m, a £0.24m favourable variance from plan due to a gain on the disposal of property. This benefit is excluded for the purposes of allocation of Provider Sustainability Funding/Financial recovery Funding. • There is some pressure year to date due to higher than planned non-pay expenditure including utilities, maintenance contracts, outsourced services and lower than planned VAT recovery. • These pressures have been offset year to date by lower than planned pay expenditure, although for the last three months pay has been slightly overspent due to Medical pay awards and pressure from additional capacity. • Clinical income performance (contract and other) is below plan by £1.56m. The Aligned Incentive Contract (AIC) protects the income position by £2.15m resulting overall in a favourable variance of £0.59m, an improvement compared to the position in Month 7. This position includes some additional income allocated by the Integrated Care System (ICS) to support winter pressures and cancer services. • CIP achieved year to date is £6.34m, £0.17m more than planned. • Agency expenditure year to date is £5.35m, £2.16m below the planned level. **Key Variances** • Clinical income is now above plan overall, but only as a result of the £2.15m protection offered by the Aligned Incentive Contract (AIC), with lower than planned activity levels across all points of delivery with the exception of A&E. However, AIC protection has reduced further in month by £0.20m. • Surgical Division continue to show a favourable variance to plan, reflective of lower expenditure linked to lower activity levels. However, the Medicine position has worsened further in month primarily due to capacity pressures, staff sickness and pressure on A&E services. • 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, clinical waste and utilities. • There is an adverse variance on Medical staffing expenditure of £0.21m, although this includes £0.54m pressure due to pay awards. Some additional funding has been allocated by DH, but this is insufficient to fully cover the planning gap (a net pressure of £0.37m year to date). • Nursing pay expenditure is lower than planned year to date by £0.17m, despite the opening of additional capacity, supported in month by a reduction in both agency usage and average hourly rate. **Forecast** In the round the recovery and restraint requirement reported last month remains at £1.7m. This recovery requirement is largely driven by additional non pay costs linked to the estate and maintenance and the additional capacity requirements seen over the last few months that are very likely to continue. £0.5m additional ICS winter funding has been materially committed to additional capacity and discharge facilities. There remains some uncommitted winter reserve that is assumed to be spent to manage any winter pressures that continue into Quarter 4, but general contingency reserves are now fully committed.

Background Context

Whilst Safe Care remains a priority domain for the Community Healthcare division, there are a number of areas within each domain where an increase in focus through deep-dives /investigations or scrutiny and analysis of processes and impact are being undertaken. This is to either improve performance/patient safety/or data quality. First results will be back 23rd December.

National Community Benchmarking results are now available and a review of community performance nationally will be shared through the PRM Process.

We are now collaborating closely with the Clinical Directors in the newly established Primary Care Networks and have secured agreement to be the primary provider for the new First Contract Practioners working within the PCNs. This promotes Care closer to home.

Pressures in Paediatrics have been extremely high with very large numbers of children with high acuity requiring admission. There have been significant staffing gaps in nursing and middle grade doctors.

Pathology - work continues accross WYAAT some initial conversations with staff on proposals for whole system working across the WYAAT.

Pharmacy - discussions continue re: well pharmacy reprovision and associated contractual issues (including potential financial penalties). Aseptics business case continues to progress and workforce redesign in pharmacy pending.

We have maintained elective activity during November despite challenges with Flow, Flu and Norovirus.

We have seen on day cancellations by on day Consultant sickness absence (ENT and Colorectal), high levels of sickness absence in Ops services and the surge in Paediatrics emergency capacity requirements.

Complaints position anticipated to improve further due to continued SMT review/ involvement at an early stage and we will introduce a feedback and monitoring form which describes the standards required from the investigator through every stage of the complaint process. The process will facilitate a targeted approach to addressing training and performance issues and ensure that individuals are clear on what is required to improve.

Activity has improved across all Points of Delivery for most specialties with reductions in longest waits realised in Urology and Plastics Day Cases.

Transformation work across several specialties continues to produce benefits demonstrated by reduced ASIs and holding list position.

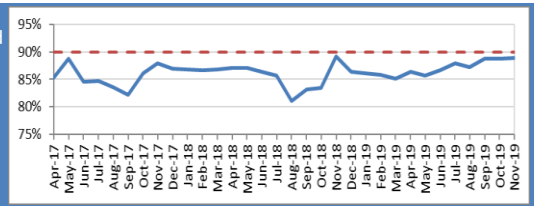
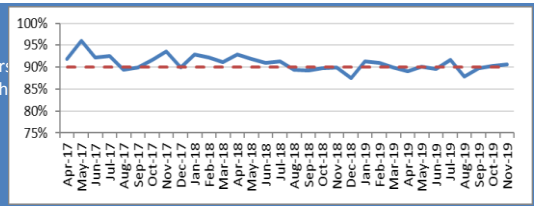
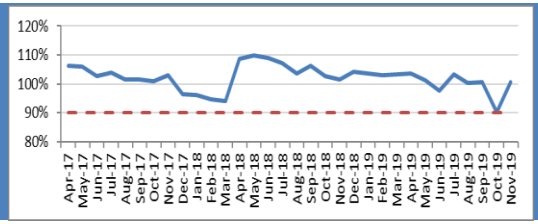
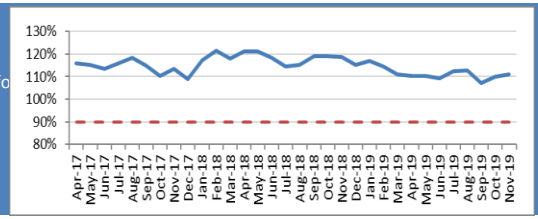
Long term sickness continues to have an impact upon the already challenged Ophthalmology capacity, masking the appointment of the new Corneal Consultant and additional Locum capacity. Additional DC cataract activity continues to be provided via a small number of WLIs on additional weekend operating lists.

Upper GI continues to have long term sickness which has impacted upon ASI position and DC/IP capacity with short term sickness in ENT and Max/Fax contributing to cancelled operations and clinic cancellations.

Theatre Productivity project continues with transactional CIP supporting delivery with a requirement to undertake more transformational work to impact in 2020/21.

The appointment of an additional Elderly Care Consultant in September will enable the commencement of a Proactive care for Older People undergoing Surgery (POPS) service in December – Consultant Physician reviewing acute elderly surgical patients to provide an additional level of care for this client group. This will include assessment and treatment before surgery, as well as individualised care in the days/ weeks post operatively. Impact of this post will be reviewed via SAFER Board with particular KPIs regarding LoS, Readmissions, AKI, post op complications.

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.	88.93% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 5 67.5% - Ward 6c 73.3%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy. CHPPD has been maintained by using skill-mix opportunities and supported by acuity data on safe care live.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	90.71% of expected Registered Nurse hours were achieved for nigh shifts.		Staffing levels at night <75% - 7a/d 66.7%	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.	100.71% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - 6C 67.4% - LDRP 72.3% - NICU 44.7%	The low HCA fill rates in November 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.	110.99% of expected Care Support Worker hours were achieved fo night shifts.		Staffing levels at night <75% - NICU 65.2%	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	2,754.68	2,756.50	2,238.67	2,225.67	100.1%	99.4%	2,434.00	2,359.00	1,980.00	1,946.50	96.9%	98.3%	7.2	7.1		6	19
HRI ACUTE FLOOR	GENERAL MEDICINE	3,013.17	2,687.53	2,613.50	2,363.25	89.2%	90.4%	2,640.00	2,360.42	1,980.00	2,026.00	89.4%	102.3%	8.2	7.6		4	32
WARD 5	GERIATRIC MEDICINE	1,484.07	1,001.55	1,106.00	1,503.78	67.5%	136.0%	990.00	936.33	990.00	1,107.00	94.6%	111.8%	6.1	6.1		0	11
WARD 15	GENERAL SURGERY	1,683.00	1,447.67	1,493.08	1,869.98	86.0%	125.2%	1,331.00	1,056.00	1,320.00	1,765.00	79.3%	133.7%	7.3	7.7		0	2
RESPIRATORY FLOOR	GENERAL MEDICINE	3,357.10	2,765.02	2,369.60	2,243.50	82.4%	94.7%	2,640.00	2,336.00	1,001.00	1,024.50	88.5%	102.3%	6.7	6.0		1	6
WARD 6	GENERAL MEDICINE	1,488.67	1,127.08	1,181.50	1,396.67	75.7%	118.2%	990.00	946.25	990.00	935.00	95.6%	94.4%	7.2	6.9		0	0
WARD 6C	GENERAL MEDICINE	1,088.40	797.50	726.73	489.83	73.3%	67.4%	660.00	660.00	330.00	330.00	100.0%	100.0%	6.0	4.9		2	7
WARD 6AB	GENERAL MEDICINE	1,411.97	1,487.47	1,110.50	1,243.92	105.3%	112.0%	1,001.00	1,177.00	1,012.00	1,342.50	117.6%	132.7%	4.9	5.7		2	13
WARD CCU	GENERAL MEDICINE	1,360.42	1,227.58	360.00	280.50	90.2%	77.9%	989.25	990.00	0.00	0.00	100.1%	-	8.2	7.6		0	1
WARD 7AD	STROKE MEDICINE	1,287.00	1,338.13	1,152.53	1,058.87	104.0%	91.9%	990.00	660.00	660.00	660.00	66.7%	100.0%	7.6	6.9		0	1
WARD 7BC	STROKE MEDICINE	2,370.05	2,009.67	1,640.33	1,705.33	84.8%	104.0%	1,969.00	1,870.00	660.00	759.00	95.0%	115.0%	8.7	8.3		0	3
WARD 12	MEDICAL ONCOLOGY	1,475.00	1,263.50	738.25	1,048.95	85.7%	142.1%	990.00	946.00	330.00	595.00	95.6%	180.3%	6.0	6.5		3	8
WARD 17	GASTROENTEROLOGY	2,007.67	1,607.83	1,102.33	1,179.33	80.1%	107.0%	1,309.00	990.00	660.00	770.00	75.6%	116.7%	7.1	6.4		0	5
WARD 20	GERIATRIC MEDICINE	1,595.33	1,356.00	1,502.00	1,883.00	85.0%	125.4%	1,320.00	1,145.00	1,320.00	1,730.00	86.7%	131.1%	6.5	7.0		2	10
WARD 21	TRAUMA & ORTHOPAEDICS	1,480.17	1,318.67	1,259.50	1,175.50	89.1%	93.3%	1,035.00	943.00	914.50	1,083.00	91.1%	118.4%	7.8	7.5		0	5
ICU	CRITICAL CARE MEDICINE	3,834.00	3,512.50	767.00	728.00	91.6%	94.9%	4,140.00	3,462.50	0.00	0.00	83.6%	-	34.1	30.1		1	0
WARD 3	GENERAL SURGERY	904.58	847.17	573.50	590.17	93.7%	102.9%	690.00	678.50	499.50	546.92	98.3%	109.5%	5.9	5.9		0	1
WARD 8A	TRAUMA & ORTHOPAEDICS	844.23	743.67	555.92	496.33	88.1%	89.3%	690.00	561.50	345.00	333.50	81.4%	96.7%	8.6	7.5		0	0
WARD 8D	ENT	778.98	775.15	573.08	562.92	99.5%	98.2%	690.00	691.00	157.50	172.50	100.1%	109.5%	6.3	6.3		0	0
WARD 10	GENERAL SURGERY	1,268.33	1,220.08	788.00	786.50	96.2%	99.8%	1,035.00	977.50	690.00	759.00	94.4%	110.0%	6.5	6.5		0	3
WARD 11	CARDIOLOGY	1,606.50	1,510.08	1,085.00	991.02	94.0%	91.3%	1,192.50	1,121.00	690.00	734.50	94.0%	106.4%	6.0	5.7		0	4
WARD 19	TRAUMA & ORTHOPAEDICS	1,568.83	1,413.65	1,324.50	1,395.00	90.1%	105.3%	1,035.00	1,000.08	1,035.00	1,207.50	96.6%	116.7%	7.6	7.7		2	3
WARD 22	UROLOGY	1,144.50	1,102.17	1,073.50	1,079.17	96.3%	100.5%	690.00	690.00	690.00	953.50	100.0%	138.2%	5.4	5.7		0	2
SAU HRI	GENERAL SURGERY	1,394.00	1,305.42	690.00	746.50	93.6%	108.2%	1,600.50	1,504.75	345.00	525.00	94.0%	152.2%	8.6	8.7		0	4
WARD LDRP	OBSTETRICS	3,978.92	3,658.30	916.00	661.83	91.9%	72.3%	3,779.25	3,433.50	690.00	580.00	90.9%	84.1%	26.6	23.7		0	0
WARD NICU	PAEDIATRICS	2,602.98	2,013.47	810.00	362.17	77.4%	44.7%	2,047.00	1,654.25	690.00	450.00	80.8%	65.2%	16.4	12.0		0	0
WARD 3ABCD	PAEDIATRICS	3,859.67	3,436.33	678.50	627.50	89.0%	92.5%	3,908.50	3,442.00	514.00	533.00	88.1%	103.7%	8.1	7.2		0	0
WARD 4ABD	OBSTETRICS	2,380.00	2,248.17	690.00	647.50	94.5%	93.8%	1,719.50	1,710.00	690.00	667.00	99.4%	96.7%	5.2	5.0		0	0
WARD 4C	GYNAECOLOGY	1,209.17	1,142.08	346.83	346.83	94.5%	100.0%	690.00	696.50	345.00	358.50	100.9%	103.9%	7.3	7.1		0	0
TRUST		**55,231.38**	**49119.93**	**31466.37**	**31689.5**	**88.93%**	**100.71%**	**45195.5**	**40998.1**	**21528.5**	**23894.4**	**90.71%**	**110.99%**	**7.8**	**7.4**			

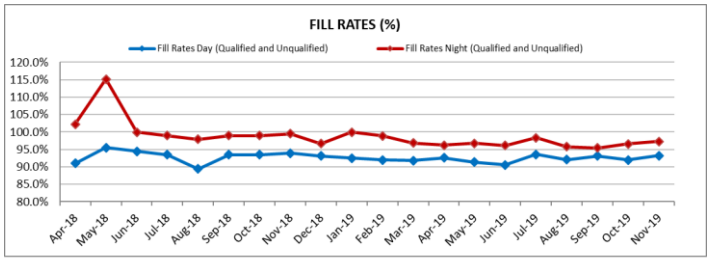
Hard Truths: Safe Staffing Levels (3)

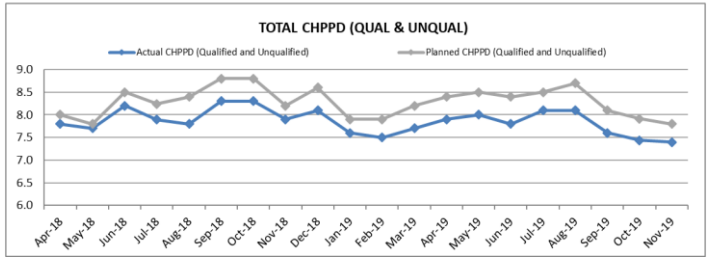
Care Hours per Patient Day

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

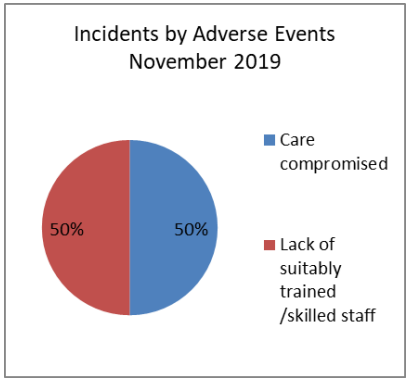
	Sep-19	Oct-19	Nov-19
Fill Rates Day (Qualified and Unqualified)	93.1%	92.0%	93.2%
Fill Rates Night (Qualified and Unqualified)	95.4%	96.6%	97.3%
Planned CHPPD (Qualified and Unqualified)	8.1	7.9	7.8
Actual CHPPD (Qualified and Unqualified)	7.6	7.4	7.4

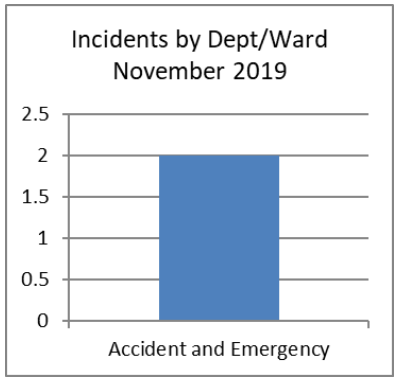
A review of November data indicates that the combined (RN and care staff metrics) resulted in 18 clinical areas having CHPPD less than planned. 6 departments reported CHPPD slightly in excess of those planned and 24have CHPPD at planned levels. Areas with CHPPD greater than planned is attributed to 1-1 enhanced care requirements.

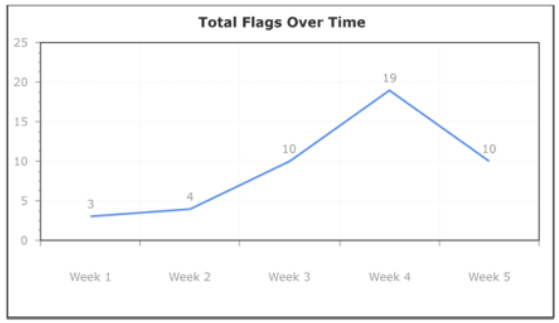


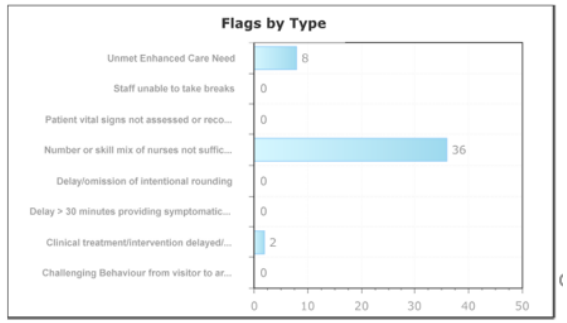


RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correc t but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the e scalation process staff are asked to record any staffing concerns through Safe care live. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.
There were 48 **Trust-Wide Red shifts** declared in November. This is a significant increase and links to greater accuracy as the reporting framework is now via safecare live.
No datix's reported in November have resulted in patient harm.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.
2. The Trust recruited 49 new graduates through September/October 2019.
3. Monthly recruitment initiatives continue.
4. Applications from international recruitment projects are progressing well and the first 35 nurses have arrived in Trust, with a further 5 planned for deployment in late December.
5. 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 with 20 recruits
6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce
7. A new module of E roster called safe care has been introduced across the clinical divisions. Benefits will include, better reporting of red flag event and, real-time data of staffing position against acuity.

CQUINS - Key messages

Area	Reality	Response	Result
CCG1a: Antimicrobial resistance - Lower urinary tract infections in older people **CCG1b: Antimicrobial resistance - Antibiotic prophylaxis in colorectal surgery**	CCG1a: Q2 performance was 43% compared to 8% in Q1. CCG1b: Q2 performance was 86% compared to 85.40% in Q1.	A consultant and matron have been identified to work with AMT. UTI guidelines to mirror PHE for diagnosis and treatment. Posters and screensavers have been created for teaching and to raise awareness of not using dipstick in > 65 years. Dip-stick learning trolley rounds are now in place. Exploring options to use dipsticks which exclude markers of infection. Dip-stick learning trolley rounds	Improvement is expected with an expectation of be on track by Q4. Accountable: Clinical Director of Pharmacy
CCG3a: Alcohol and Tobacco - Screening **CCG3b: Alcohol and Tobacco - Tobacco Brief Advice** **CCG3c: Alcohol and Tobacco - Alcohol Brief Advice**	CCG3a - Q2 performance was 58.3% compared to 57.8% in Q1. CCG3b - Q2 performance was 21.2% compared to 25.1% in Q1. CCG3c: Q2 performance was 28.8% compared to 28.7% in Q1.	Challenge with attendance at the internal CQUIN meetings – New clinical champion identified to drive the requirements of the CQUIN forward within the Trust. **CCG3a** – Trust clinical lead identified and working with the CQUIN group to embed the requirement of this CQUIN into business as usual. **CCG3b and c** –Brief advice training request taken to the NMC Meeting in September for approval and a request has been made for training to be made available through ESR for all staff groups.	Month on month improvement is expected, with an expectation to be on track during Q4 Accountable: Associate Director of Nursing - Community
CCG7: Three high impact actions to prevent Hospital Falls	Overall performance for Q2 was 13%, a slight improvement from Q1 but below target so no payment will be achieved. Lying and standing BP being recorded at least once is the area that requires the most improvement, there was some improvement from 12% in Q1 to 20% in Q2 but further improvement is required. Mobility assessment within 24 hours is at 69% compared to 70% in Q1 so this area also requires improvement.	To improve compliance the clinical team are starting to carry out engagement work with staff ensuring they understand the importance of recording lying and standing blood pressure, initially focusing on the elderly care wards, with a view to roll out to other areas in the Trust. The information team will provide weekly data to support and inform this work to see if there has been any improvement.	Month on month improvement is expected in Q3. Accountable: Consultant lead for Falls.

CQUIN - Key Measures

	Services in Scope	Indicator Name		Target	Apr-19	May-19	Jun-19	Q1	Jul-19	Aug-19	Sep-19	Q2	Oct-19	Nov-19	Dec-19	Q3	Jan-20	Feb-20	Mar-20	Q4
Prevention of Ill Health	Acute	CCG1: Antimicrobial Resistance	CCG1a: Antimicrobial resistance - Lower urinary tract infections in older people	90%	Data available at quarter end			8%	Data available at quarter end			43%								
			CCG1b: Antimicrobial resistance - Antibiotic prophylaxis in colorectal surgery	90%	Data available at quarter end			85.40%	Data available at quarter end			86.00%								
	Acute & Community	CCG2: Staff Flu Vaccinations	CCG2: Staff Flu Vaccinations	80%	Data collection starts in Q3				Data collection starts in Q3											
	Acute & Community	CCG3: Alcohol and Tobacco	CCG3a: Alcohol and Tobacco - Screening ACUTE	80%	Data available at quarter end			64.5%	65.8%	66.5%	64.6%	65.7%								
			CCG3a: Alcohol and Tobacco - Screening COMMUNITY		Data available at quarter end			25.3%	Data available at quarter end			19.3%								
			CCG3a: Alcohol and Tobacco - Screening TRUST (combined)		Data available at quarter end			57.8%	Data available at quarter end			58.30%								
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice ACUTE	90%	Data available at quarter end			13.8%	10.7%	9.7%	12.1%	10.8%								
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice COMMUNITY		Data available at quarter end			92.0%	Data available at quarter end			91.1%								
			CCG3b: Alcohol and Tobacco - Tobacco Brief Advice TRUST (combined)		Data available at quarter end			25.1%	Data available at quarter end			21.2%								
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice ACUTE	90%	Data available at quarter end			29.0%	30.1%	27.1%	31.9%	29.7%								
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice COMMUNITY		Data available at quarter end			22.2%	Data available at quarter end			7.7%								
			CCG3c: Alcohol and Tobacco - Alcohol Brief Advice TRUST (Combined)		Data available at quarter end			28.7%	Data available at quarter end			28.8%								
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%	15.6%	8.6%	15.2%	13%								
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			98.3%								
			CCG11b: SDEC - Tachycardia with Atrial Fibrillation	75%	100.0%	70.0%	100.0%	91.4%	Data available at quarter end			94.6%								
			CCG11c: SDEC - Community Acquired Pneumonia	75%	100.0%	97.1%	96.2%	97.7%	Data available at quarter end			92.0%								

16. Governance Report

a) Risk Appetite Statement

b) Board meeting dates – 2020 – 2021

c) Well-Led Governance Review

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 9 January 2020
Meeting:	Board of Directors
Title:	Governance Report – January 2020
Author:	Andrea McCourt, Company Secretary
Previous Forums:	N/A

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 January 2020.

Key Points to Note

1) Risk Appetite Statement

Risk appetite is the amount of risk that the Trust is prepared to accept in the pursuit of its strategic objectives. The Trust has had a risk appetite statement in place for a number of years, which is based on the Good Governance Institute briefing on risk appetite for NHS organisations. An annual review of the risk appetite takes place to consider whether changes to the risk appetite categories or changes to the level of risk appetite are needed to reflect current circumstances.

The risk appetite statement was reviewed by Board members at a Board workshop on risk management on 5 December 2019. Following this the Chief Executive, Director of Nursing an d Deputy Director of Finance and Company Secretary met to review the risk appetite in detail following the Board discussion.

The revised risk appetite is enclosed for review and approval by the Board. The changes to the risk appetite, highlighted in red at Appendix 1, are summarised below:

- Reduction in risk appetite for the risk categories of financial and assets, innovation and technology, commercial, workforce
- Increase in risk appetite for Quality and Innovation risk category, (with workforce el ement relating to new roles removed from the workforce category and added to the Quality and Innovation category)
- Addition of legal category and removal of reference to legal services from the regul ation category, with a minimal / low risk appetite.

The revised risk appetite is enclosed at Appendix 1.

2) Board meeting dates 2020 – 2021

The Board meeting dates for 2020 – 2021 are enclosed for information.

3) Well-Led Governance Review

NHS England / NHS Improvement guidance advises NHS Trusts to carry out an external governance review every three years to support the effectiveness of leadership and gover nance arrangements. The review is based around the eight key lines of enquiry for a well-led organisation identified by the Care Quality Commission and is a developmental review of leadership and governance. The first phase of this review commenced during December 2019 and is expected to conclude during February 2020.

Following completion of the review actions will be developed in response to the recommen dations.

EQIA – Equality Impact Assessment

The risk appetite supports decision-making across the organisation and impact assessments on specific projects or service changes will be completed where necessary.

Recommendation

The Board is asked to **APPROVE** the Risk Appetite Statement and **NOTE** the Board meeting dates for 2020 – 2021 and the Well-Led Governance Review.

compassionate care

RISK APPETITE December 2019 (red text denotes changes) Appendix 1

Calderdale and Huddersfield NHS Foundation Trust

Risk Category	This means	Risk Level Appetite	Risk Appetite	Change (no change unless indicated)
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, equality and patient safety, which will be subject to rigorous impact assessments. The balance of price, value and benefits will be considered. We will allocate resources to capitalise on opportunities.	**CAUTIOUS**	**MODERATE**	Reduced from OPEN and 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 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**	
Legal	We will comply with the law.	**MINIMAL**	**LOW**	New
Innovation / Technology	The risk appetite for innovation / technology is high 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.	**OPEN**	**HIGH**	Reduced from SEEK and 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.	**OPEN**	**HIGH**	Reduced from SEEK and SIGNIFICANT
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to staff/patient safety and harm and clinical outcomes for patients.	**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. .	**MINIMAL**	**LOW**	Reduced from SEEK and 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. 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**	Reduced from OPEN and HIGH
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**	

Calderdale and Huddersfield NHS Foundation Trust

Public Board of Directors / Workshop Dates
Proposal for 2020/2021 – Agreed on 4th July 2019

Public Board of Director Meeting Dates – 2020

Date	Time	Location
Thursday 7 May 2020	9:00 – 12:30 pm	Boardroom, Huddersfield Royal Infirmary
Thursday 2 July 2020	9:00 – 12:30 pm	Large Training Room, Calderdale Royal Hospital
Thursday 3 September 2020	9:00 – 12:30 pm	Boardroom, Huddersfield Royal Infirmary
Thursday 5 November 2020	9:00 – 12:30 pm	Large Training Room, Calderdale Royal Hospital
Thursday 14 January 2021	9:00 – 12:30 pm	Boardroom, Huddersfield Royal Infirmary
Thursday 4 March 2021	9:00 – 12:30 pm	Large Training Room, Calderdale Royal Hospital

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

• Finance and Performance Committee – minutes from meeting held 1 November 2019

• Audit and Risk Committee – minutes from meeting held 30 October 2019

• Quality Committee – minutes from meeting held 4 November 2019

• Workforce Committee - minutes from meetings held on 5 November 2019 and 10 December 2019

• Charitable Funds Committee – minutes from meeting held 6 November 2019

• A&E Delivery Board – minutes from meetings held 10 September and 12 December 2019

To Note

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 1 November 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

Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Philip Lewer	Trust Chair

ITEM

164/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

165/19 APOLOGIES FOR ABSENCE

Apologies from Gary Boothby, Peter Wilkinson, Stuart Baron and Sian Grbin were noted.

166/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

167/19 MINUTES OF THE MEETING HELD 27 SEPTEMBER 2019

The Draft Minutes of the meeting held 27 September 2019 were approved subject to the amendment of typos on Page 2, and Page 4. In addition, on Page 3 the 4th bullet point under Item 154/19 to be replaced with the following wording:

- From an ECS standard perspective, we performed well in August and early September however since that time the position has deteriorated internally which reflects the national picture. This means that we have missed the trajectory in September and October. Discussions with our Regulators confirm that this is the national picture. The ECS 3 month improvement plan was outlined to the Committee.

168/19 ACTION LOG AND MATTERS ARISING

The Action Log was noted and updated as follows: -

010/19: ED Workforce Staffing - HB confirmed that the detailed report is still not available and that discussions will take place at the Medicine PRM this afternoon. It was suggested that the Division should attend to present, a decision will be taken following discussions outside this forum – **HB/OW**

009/19: Use of Resources – Discussions to take place at Turnaround Executive and the action log will be updated accordingly – **KA/OW**

056/19: Patient Flow & EC Improvement Plan – HB provided the Committee with a more detailed briefing reflecting the Emergency Care Standard perspective since mid-September there has been a significant deterioration in performance which is reflective of the national picture. It was reported that a recent Executive Board was devoted to a review of the issues, helpfully steered by Ellen Armistead, the new Chief Nurse, who was able to provide a fresh lens. The following key themes emerged from the review from which a detailed improvement plan has been developed:-

- Length of Stay and discharge planning
- Real time data and escalation
- Behaviours and adherence to policies and procedures
- Staff availability and competence
- Visible leadership

The key to the plan is to ensure that there is a good spread of leaders to get implementation at pace in addition to getting the word out to the organisation that this is an agreed priority.

RH asked about the action to provide a new Operations Room at HRI and the action to re-visit discharge lounges at both sites. It was noted that the investment required for the Operations Room would be £6.5k and would be provided out of 'winter' monies. In terms of the discharge lounges, it was noted that with some different clinical criteria we could free up beds earlier in the day, however, this would require a step-change by ward staff in terms of utilisation.

In relation to the Facilities and Diagnostics actions, OW suggested that they are crucial groups and they should be involved in the conversations around patient flow and this Committee needs to challenge to ensure their view is heard.

It was suggested that the 7 outcomes from the actions should be the KPIs and that a baseline should be identified as of September and that these should be measured monthly. Following discussions, HB agreed to look at how this could be reported with an internal and external split.

ACTION: To include 'Winter' as an Agenda item going forward at which Patient Flow will be reviewed - **HB**

125/19: **Data Quality – ECS Pilot Site Update** – Due to the confidential nature of this item it was recorded in the Private Section of this Committee.

FINANCE & PERFORMANCE

169/19 INTEGRATED PERFORMANCE REPORT - SEPTEMBER

The Chief Operating Officer reported the following headlines:-

Diagnostics remains a challenge from both an Echocardiography (Echo) and Neurophysiology (Neuro) perspective. It was explained that for diagnostics reporting it is based on the number of patients waiting over 6 weeks on the last day of the month as a % of the total number of patients waiting for diagnostics, this is a snapshot and is not performance tracked externally.

From an Echo perspective as at 31/10/19 we had less than 1% waiting over 6 weeks by the 30/11/19 we should not have any patients waiting and this specialty will be

compliant. It was noted that compliance should be sustainable now that it is managed internally via bank, internal training and re-skill mixing.
From a Neuro perspective, outsourcing has been discounted and we will be looking at the same kind of resolution internally, however, it is likely that we will not be compliant until February 2020.

Stroke – SSNAP 'A' has been achieved again this Quarter, however, the direct admission number is still problematic with two main issues having an impact on the stroke timings:-

1. Patients who are referred with non-typical stroke symptoms.
2. Yorkshire Ambulance Service are still taking a high number of patients to HRI when they should be taken to CRH.

Cancer – all targets are performing well.

Overall there is a strong performance with only Amber and Green domains.

The Chief Executive added that Professor Tim Briggs, the national lead for GIRFT had visited the Trust yesterday and he was very impressed with how the organisation has embraced his vision. Nationally, he would like ourselves and Plymouth to work together to produce a National Template which will be known as the Calderdale & Plymouth National Template for GIRFT. Looking at Performance in a broader context and looking at the latest data-set, we are 3rd out of 112 organisations which is an exceptional position to be in. It was recognised, however, that we do still have some data quality issues which are a concern.

RH asked if the Stroke and Cancer targets are realistic, HB recognised that there is still more to do to get to a sustainable 85%, however, the organisations who are higher than us are still not at that target from a Day 38 perspective. It was noted that by March 2020 we need to move to a Day 28 from referral to confirmed diagnosis. Targets have not yet been set, however, the assumption is 85%, the focus will be on the 0 to 7-day intervention and the Outpatient Transformation work will be critical to help decision making.

RH also asked if a sustainable target had been set to respond/close complaints. It was noted that there is a focus by the Chief Nurse, however, there is a concern that the slight improvement of the turnaround time and quality of response is due to a small cohort of individuals who are influencing this improvement and that a total cultural change is required. The Quality Committee are due to review Complaints within the next 3 to 6 months.

The Committee **NOTED** the IPR for September.

170/19 MONTH 06 FINANCE REPORT

The Deputy Director of Finance reported the headlines as follows:-

YTD – the year to date deficit is £9.32m which is in line with the plan, pressures have been absorbed which are impacting on the forecast position.
Agency – continues to be below plan and the NHS I trajectory. From a Use Of Resources (UOR) point of view, we have switched to bank which is a positive, however, this has had no impact to the overall pay costs.

CIP – we are over-delivering in the year to date, but we are not forecasting a full-year over-delivery.
Capital – year to date is underspent to the original plan as opposed to the re-submission of the plan made to NHS I during the course of the year, which has pushed back some of our Emergency Capital expenditure.

It was noted that NHS I have informed organisations that capital funding for imaging equipment over 10 years old will be made available and that we have been ear-marked to receive funds for the MRI kit, this will not include any building works, therefore, we still require confirmation of emergency capital funds to cover these costs. We have also expressed an interest in additional funding to replace other imaging kit over 10 years old which may fall into this category including any available funding for a second MRI which would be beneficial for our capacity for growth.

Cash – year to date we have more cash than planned pending repayment of a loan due early October.

Forecast – Good progress has been made in relation to the recovery actions, however, non-pay costs linked to the estate and maintenance continue to grow. Pay pressures due to the opening of additional capacity in month are likely to continue throughout October, driving a further increase in the recovery requirement of circa £0.5m. Quality Impact Assessments (QIA) will be carried out on recovery actions in line with existing governance procedures. The Medicine PRM is taking place today and this will focus around their forecast and their grip, if there is no resolution an Escalation Forum will take place.

Discussions took place regarding the assumptions of the national guidance for the Pay Awards within the West Yorkshire region. It was noted that from an ICS position, leads have collated the combined pressure across West Yorkshire for this to be lobbied to NHS I.

ACTION: It was suggested that we should try to sense-check the understanding out of the region as part of the learning – **KA**

The Deputy Director of Finance stated that we are looking at Divisions, which includes Corporate, to close the gap as any pressure on-going through expenditure will have a greater impact into next year. Further discussions took place with regard to our recovery plans and it was agreed that we need to meet our targets whatever it takes, and that the prioritisation conversation may need to be re-visited

In terms of our contingencies, the provision for bad debt was discussed, it was confirmed that Account Managers have been allocated against all the significant accounts and progress is being made and that the majority of bed debt is not high risk.

ACTION: It was agreed that there should be a Bad Debt Review to take place at the next meeting – **KA, 29/11/19**

ACTION: The income position was also discussed, and it was agreed to re-visit the detail at the next meeting – **KA/HB, 29/11/19**

ACTION: Pay Profiling was discussed for the latter part of the year, this will be tested outside this meeting, it was agreed to discuss further at the next meeting – **KA, 29/11/19**

ACTION: Based on the conversations which have taken place at the meeting today it was noted that a Risk Review of the delivery of the 2019/20 Financial Plan will be discussed next month. The Risk for 2020/21 will also be reviewed and discussed – **KA, 29/11/19**

The Committee **RECEIVED** and **NOTED** the report.

STRATEGIC ITEMS

171/19 CIP UPDATE

The Committee discussed CIP as part of the Finance Report.

172/19 FINANCIAL IMPROVEMENT TRAJECTORIES/LONG-TERM PLAN

The Deputy Director of Finance presented an update of the Long-Term Plan submitted to the Integrated Care System (ICS) on the 23rd October 2019. The key points to note from the presentation are as follows:-

I&E

- Final 5-Year Plan submitted to the ICS 23rd October 2019 in line with Financial Improvement Trajectories (FIT).
- Efficiency assumptions adjusted to reflect national modelling expectations per FIT, reducing the financial risk from 2021/22.
- Efficiency assumption for 2020/21 increased to £14.1m to reflect 2019/20 recurrent pressures and impact of non-recurrent CIP.

Capital

- 2020/21 Capital Plan amended to reflect slippage on 2019/20 plans.
- Capital Plan for years 1-5 reduced by £1.4m versus Strategic Outline Case (SOC) due to reduction in internally generated funding (depreciation).

Cash

- Assumes Financial Recovery Funding (FRF) will be received from 2020/21, short term borrowing still required to bridge timing difference on receipt of FRF cash payments.

It was noted that the Trust and our Commissioners' submissions are aligned with income and expenditure and that assurance can be gained by the fact that the CCGs' submissions for next year assumes the continuation of our Aligned Incentive Contract (AIC).

In terms of the FIT, it was noted that the submission is not materially different from the SOC. It was noted that increased efficiency is required for next year and that the financial recovery funding gets us to break-even every year post-2020. The

challenges for CIP reduces over the course of the plan and pushes out the break-even of SOC.

The Committee **NOTED** the paper and retrospectively **RECOMMENDED** the Long-Term Plan for **APPROVAL** by the Board.

173/19 TRANSFORMATION UPDATE

The Director of Transformation & Partnerships reported the progress of the Outline Business Case (OBC). It was noted that architects are working with us around the design principles and the proposed plan for HRI will be formally presented to Trust Board on the 7th November 2019. We are also holding 19 staff involvement events, which will involve the architects and 4 public events have been arranged for local community organisations and targeted groups to give them the opportunity to have input into the plans. The first formal meeting of the Transformation Programme Board will be held on the 11 November 2019 to be Chaired by Peter Wilkinson, Non-Executive. Along-side this the SOC approval is progressing and the final gateway for approval is the Delivery Performance and Quality Committee on the 28th November 2019 at which regional colleagues will present the case.

The Chief Executive reported that we are looking to secure a Project Director with experience of developing similar schemes, in addition to this, as part of the transformation agenda Health Informatics are recruiting a Digital Transformation Lead who could offer more than a digital view. This has resulted in the decision to have a more flexible approach and buy-in additional external resource who can help stimulate discussions when required. Also, once a process to 'keep the base safe' has been agreed clinical colleagues will be extracted from clinical duties to cover roles.

The Committee **NOTED** and **SUPPORTED** the decision.

GOVERNANCE

174/19 DRAFT MINUTES FROM SUB-COMMITTEES

- THIS Executive Meeting held 31 July 2019

ACTION: The Committee agreed that there should be more focus and rigour on the fiscal agenda within these Minutes.

- Draft Commercial Investment & Strategy Committee held 4 October 2019
- Draft Cash Committee held 10 October 2019

ACTION: To review Aged Debt as part of the next F&P Committee.

- Draft Capital Management Group held 17 October 2019

HB commented that the rigorous process at the start of the year for capital schemes seems not to be there when Business Cases are submitted part way through the year and this should be reviewed.

The Minutes were **RECEIVED** and **NOTED** by the Committee.

175/19 WORK PLAN

The Committee **NOTED** the Work Plan which will be updated to reflect the actions from this meeting.

176/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following points for cascading to the Board:

- Emergency Care Standards – targeting the 7 criteria
- RTT Pilot/Data Quality
- IPR
    - Echo improvement and Neuro by February
    - Benchmarking GIRFT and the Plymouth initiative
    - Overall Stroke and Cancer performance
- Finance
    - On plan
    - Emergency Capital Bid for MRI
    - Forecast on plan but there are emerging risks which will be reviewed this month
    - To recommend the approval of the Long-Term Plan and Financial Improvement Trajectories to the Board
    - Transformation Update / Project resource outlined

177/19 REVIEW OF MEETING

The Committee agreed that once again there had been good discussions.

As the Chair of the Committee will be relinquishing his tenure at the end of the year, the Chief Executive took the opportunity to thank Phil Oldfield, both personally and on behalf of the Trust, for his valued contribution to the Committee.

178/19 ANY OTHER BUSINESS

It was agreed that the date for the meeting scheduled for the 6 January 2020 should be reviewed as both the new Chair and the Non-Exec representative will be on annual leave and the meeting would not be quorate.

DATE AND TIME OF NEXT MEETING:
FRIDAY 29 November 2019, 9.30am – 12.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 30 October 2019 in Room 3, Acre Mills Outpatients commencing at 11:00 am

PRESENT

Richard Hopkin (RH)	Chair, Non-Executive Director
Denise Sterling (DS)	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Adele Jowett	Local Counter Fraud Specialist
Kirsty Archer	Deputy Finance Director
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Amber Fox	Corporate Governance Manager (minutes)
Mandy Griffin	Managing Director, Digital Health
Clare Partridge	External Audit Partner, KPMG

OBSERVERS

Peter Wilkinson (PW)	Non-Executive Director
John Richardson	Public Elected Governor, South Kirklees

48/19 APOLOGIES FOR ABSENCE

Apologies were received from Gary Boothby, Andy Nelson, Linda Patterson and Philip Lewer.

The number of apologies were noted which has resulted from the change of date as the original date clashed with an Executive Leadership two-day event.

49/19 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

50/19 MINUTES OF THE MEETING HELD ON 17 JULY 2019

The minutes of the meeting held on 17 July 2019 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the meeting held 17 July 2019.

51/19 ACTION LOG AND MATTERS ARISING

RH addressed the length of papers and ongoing action to condense them, he acknowledged that several papers were circulated separately to reduce the papers.

The action log was reviewed and updated accordingly.

RH asked the Managing Director for Digital Health for an update on ICODD, the care pathway for someone who is dying. The Managing Director for Digital Health confirmed this is ongoing and is being escalated and will be carried forward with a further update in January 2020.
Action: Update on ICOD – Managing Director, Digital Health

An update was provided on overdue recommendations in the internal audit report. The Deputy Finance Director confirmed the tender is being finalised for patient appliances with Procurement following several technical queries. She explained Orthotics have bespoke products which will be purchased through the NHS catalogue, this is a new approach in design.

(i) Salary Overpayments

The Deputy Finance Director reported the Trust are a slight outlier in a couple of the elements benchmarked. The Trust did not accept the control total last year and the turnover was suppressed compared to our peers as there was no access to funding i.e. provider sustainability funding. The

controls already in place have been reviewed and an audit on payroll has taken place which provided significant assurance. Additional work has taken place to review the change forms process which has been updated to be more user-friendly. Ongoing reminders are still required to submit timely termination forms. There is a new focus on budget holder accountability and 'Managing our Money' training is now essential for budget holders to attend.

Debt Management Process – The Trust continue to chase outstanding invoices which had lapsed due to the upgrade to the ledger system. This is now back on track and is being passed onto debt collection agencies as appropriate. A review of the current position is taking place.

Denise Sterling (DS) asked if there was an issue with the end point of payroll at Leeds Teaching Hospitals. The Deputy Finance Director explained the recent change to move to Leeds was to improve controls and the service has improved from where it was previously. There has been some challenge to recruit to key posts in the payroll department. This action is now closed and will be kept under review.

(ii) Self-Effectiveness Action Plan

The Company Secretary presented the self-effectiveness action plan which has been updated following discussion with RH and the Deputy Finance Director.

RH confirmed action 3.3 is complete around the performance of external audit.

A proposal on third party assurance mapping will be brought to the Audit and Risk Committee in January 2020. This has not been brought to the committee before and suggestions are welcome.
Action: Third party assurance mapping – January 2020

A review of whether a need for an annual report to Board from all the sub-committees was discussed. RH explained the meeting of Committee Chairs discussed this as an item and concluded there is no need for formal reports to the Board and the Chairs will continue to provide a verbal update with the minutes from the meetings shared.

An annual report for the Committee will still be completed which details a 12-month review of the Committee, how many meetings were held and what items were discussed. The External Audit Partner from KPMG stated that this is good practice.

Action: Committee annual report for 2019/20 to be added to the workplan

52/19 Risk Management Review (12 month look-back)

RH confirmed in future deep dive topics will be agreed for the Committee and the topic in January 2020 will be on cyber security (data security toolkit). The Managing Director for Digital Health explained the deadline for submission of the data security toolkit is March 2020 and the Trust are currently non-compliant. A final update will be provided as the submission progresses in March 2020.
Action: Cyber Security Deep Dive, January 2020 (Managing Director – Digital Health)

The Company Secretary presented a risk management review, a 12 month look back. It was noted that the 5-year strategy refresh will change the Board Assurance Framework at the end of the year.

RH asked to confirm his understanding of the distinction was between the Board Assurance Framework and the High-Level Risk Register. The Company Secretary explained the Board Assurance Framework details the longer-term strategic risks and is therefore inevitably more static. The high-level risk register is concentrated on shorter term risks with more dynamic movement.

Out of the top 10 BAF risks identified by internal audit in the 2018 benchmarking, a total of 8 are included on the current BAF. The two risks that not included on the BAF are 'Strategy and

Partnership Working' and 'Governance and Strategic Leadership'. CP pointed out the top risk from the benchmarking was Governance and Strategic Leadership and was surprised this wasn't included on the current BAF. The Company Secretary confirmed this is likely to feature on the BAF in future.

The review confirmed that during the 12-month period there had been risks added to and removed from the high level risk register, ensuring it remains a dynamic document, however 10 static risks during the 12 month period were identified which reflected national staffing issues or matters that would be addressed as part of the reconfiguration of services.

It was noted that within the high-level risk register there was a clear focus on quality and safety risks (71% of the total). The Head of Internal Audit re-iterated that the general focus in Trusts used to be on finance, and it is now moving towards quality and safety.

The review also confirmed that a separate risk register and governance process is in place for Calderdale Huddersfield Solutions (CHS). information on serious incidents and links with future planned audits was also shared.

The Managing Director for Digital Health clarified the Capital Programme risk has been removed for the November 2019 update to Board. The Deputy Finance Director added this risk has been removed specifically related to this year's plan as opposed to long-term and a new risk may be added on the BAF.

The Head of Internal Audit will make clearer links to the BAF and the high-level risk register in next year's report.

The External Audit Partner from KPMG felt that the presentation was useful and included relevant questions.

The BAF will be reviewed at the next Board workshop on Thursday 5 December 2019 and the feedback will be shared.

Action: Company Secretary to circulate the Risk Management Review presentation to Committee members, Board and the Council of Governors

OUTCOME: The Committee **RECEIVED** the Risk Management Review 12 month look back.

53/19 Compliance Report

The Company Secretary presented a compliance report which was identified from the self-effectiveness action plan. We have been unable to identify similar reports like this in other Trusts.

The assurances are listed by five key themes:

1. Quality of Care
2. Finance and Use of Resources
3. Operational Performance
4. Strategic Change
5. Leadership and Improvement Capability

The Company Secretary confirmed a quarterly meeting takes place with NHS Improvement.

The report detailed the current position on routine reporting of compliance for the risk appetite statement, NHS Improvement Single Oversight Framework (SOF), Provider License and CQC.

The Company Secretary highlighted this report does not include the Corporate Compliance Register which details CQC visits and which will be circulated to members to understand if there

are any gaps. All Divisions present their own compliance registers at the Risk and Compliance Group.
Action: Company Secretary to circulate Corporate Compliance Register

There was an agreement that 'compliance' in this context is covered by the annual governance statement and included in the annual report; therefore, there is unlikely to be a requirement for future additional reports, particularly given that the scope could potentially be very broad ranging.

OUTCOME: The Committee **NOTED** the compliance report and **CONSIDERED** the need for future reports.

54/19 COMPANY SECRETARY'S BUSINESS

1. Review of the Board Assurance Framework

The Company Secretary presented the updated Board Assurance Framework which was approved at the Board meeting in September 2019. The next update will be provided to the Board in January 2020. There was discussion about the sequence of reporting and receiving feedback from the Audit and Risk Committee prior to the Board.

The Company Secretary confirmed the risk regarding the West Yorkshire Programme delivery has been removed from the Board Assurance Framework. All the remaining changes are highlighted in red from the Executive Directors and the detail has been thoroughly reviewed. Comments have also been picked up from learning on the internal audit benchmarking report.

A further review of the Board Assurance Framework is scheduled for the Board workshop on Thursday 5 December 2019.

OUTCOME: The Committee **APPROVED** the updated Board Assurance Framework (BAF).

2. Declarations of Interest Update (June – October 2019)

The Company Secretary presented a report which details the current position on declarations of interest and the progress made since 1 June 2019.

It has been established from other Trusts that most decision-making staff will make a nil declaration at year end, as opposed to part way through the year. Reminders to all decision-making staff have been sent from the relevant Executive Directors. Further reminders will be sent during December 2019 and at financial year end.

The Committee noted the progress in reporting and compliance over previous years since the new system went live but noted that there is still improvement to be made and will continue to monitor this.

The Company Secretary reported Leeds Teaching Hospitals (LTHT) developed the system for declarations of interest and it has taken about three years to achieve 70% compliance.

OUTCOME: The Committee **NOTED** the progress made on declarations of interest and further reminders to submit an annual declaration will be issued at financial year end to decision making staff.

3. Updates to the Board of Directors and Council of Governors Standing Orders

A review of the Trust Constitution has taken place with governors during September and October 2019. The Constitution also includes Standing Orders for the Council of Governors and the Board and these were reviewed at the same time, with the approval Committee for both Standing Orders shown as the Audit and Risk Committee.

The changes to the Board of Directors and Council of Governors Standing Orders were noted by the Committee. These changes had been approved by the Council of Governors on 17 October 2019 and will go to Board on 7 November 2019, together with the amended Constitution for approval.

OUTCOME: The Committee **APPROVED** the updates to the Board of Directors and Council of Governors Standing Orders.

4. Audit and Risk Committee Meeting Dates – 2020

The Audit and Risk Committee dates for 2020 were circulated for information. An additional meeting in May 2020 will be arranged to sign off the annual report and accounts and this will be confirmed once the national guidance on annual accounts is issued in late December 2019.

RH highlighted the change in membership going forward and the new Chair from January 2020 will be Andy Nelson. The Non-Executive Directors on the Committee will be Richard Hopkin and Denise Sterling.

OUTCOME: The Committee **APPROVED** the Committee meeting dates for next year and **NOTED** the change in membership from January 2020 and that an extra-ordinary meeting will be arranged in May 2020 to sign-off the annual report and accounts.

55/19 DEPUTY DIRECTOR OF FINANCE'S BUSINESS

1. Review Waiving of Standing Orders

The Deputy Director of Finance reported over the quarter, a total of £424k standing orders have been waived. There had been a total spend of £14m through the Procurement department.

The Deputy Finance Director explained it has been a relatively even spread across the three months between £100k-£200k per month.

RH highlighted that the report has been updated and now includes the number of times waived and more detail in terms of reference to tenders etc.

The External Audit Partner from KPMG asked if there is a risk of breaching procurement rules if the Trust go over the limits. The Deputy Finance Director clarified that the procurement team are aware of the limits and review these waivers in detail.

OUTCOME: The Committee **APPROVED** the Q2 waiving of standing orders report.

2. Review of Losses and Special Payments

The Deputy Finance Director reported the losses and special payments over last quarter, which is lower than first quarter. There have been no bad debt write-offs in quarter 2 and the subsequent paper on debts write-off focused on quarter 3.

It was noted Pharmacy losses are higher and a deep dive has taken place to gain a greater understanding of the processes on pharmacy stock management. This was taken through the Cash Committee which confirmed robust processes are in place.

OUTCOME: The Committee **NOTED** the content of the losses and special payments report.

3. Proposed Debt Write-Offs

The proposed debt write-off paper was presented for approval by the Committee. The Deputy Finance Director clarified that approval is required by the Audit and Risk Committee if more than £1k needs to be written off. The paper details a total of £58k debt write-off.

A total of £55k relates to overseas visitors and £3.3k related to a salary overpayment. This was effectively a 'clean up' of the ledger relating to old items, where debt recovery procedures had been exhausted.

The Deputy Finance Director confirmed there was no adverse impact to income and expenditure has these items were covered by provisions.

RH asked how much is billed to overseas in a year. The Deputy Finance Manager responded there is currently a risk over £100k in overseas billing from one patient in ICU last year. However, the numbers are usually £40-50k per year although there is a potential that this will increase as a result of Brexit.

The Deputy Finance Manager explained risk sharing with commissioners is being discussed. The procedure for collecting overseas payments is changing and the overseas team at NHS Improvement have been making recommendations based on what takes place at other Trusts. This will include in future billing 'up front' based on an estimate of costs.

OUTCOME: The Committee **APPROVED** the proposed debt write-offs for a total of £58k.

4. St Luke's Accounting Transactions

The Deputy Finance Director presented a paper following an update shared at the Board in September 2019. The Board did not review the accounting treatment due to the length of discussions and asked that this was delegated to the Audit and Risk Committee.

The purpose of the paper is to provide an overview of the accounting treatment of both the disposal of the land at St Luke's that was approved at Trust Board in August and the existing accounting treatment for the investment in the Joint Venture, Pennine Property Partnerships (PPP).

The disposal transaction was expected between October and November 2019 and the Deputy Finance Director confirmed the transaction completed last week.

The External Audit Partner from KPMG was due to meet with the Associate Director of Finance shortly to review this.

OUTCOME: The Committee **NOTED** the Pennine Property Partnerships and St Luke's Disposal Accounting treatment, which is subject to input from KPMG.

5. Reference Costs

The Deputy Finance Director presented the Reference Costs and Patient Level (PLICS) Cost submissions for 2018/19 which has been discussed at the Finance and Performance Committee and asked to be received at the Audit and Risk Committee.

The submission was made within the submission window set out by NHS Improvement and in line with approved costing guidance. There were no variations from the healthcare costing standards for England that would materially impact the submission.

Appendix A detailed the comparison between 2018/19 data and the previous Reference Costs submission in terms of both cost and activity.

RH explained that this paper first came to the Audit and Risk Committee 12 months ago to approve the submission. There was some initial concern regarding this, and internal audit completed an exercise. RH asked if this can be picked up in the Internal Audit 2020/2021 plan as part of a recurring programme.

Action: Internal Audit to include a review in the 2020/21 plan of reference costs submission

OUTCOME: The Committee **NOTED** the Reference Costs and Patient Level (PLICS) Cost submissions for 2018/19.

6. Treasury Management Policy

The Deputy Finance Director presented the proposed changes to the Treasury Management Policy for approval. It was noted that these changes were relatively minor and included the impact of CHS bank balances.

OUTCOME: The Committee **APPROVED** the changes to the Treasury Management Policy.

54/19 INTERNAL AUDIT

1. Review Internal Audit Q2 Follow-up Report

The Internal Audit Manager confirmed that there are seven outstanding recommendations from 2016/17 which was previously eight. A total of five out of the seven relate to charitable funds. A Fundraising Manager is now in place and the new deadline for these recommendations is 31 January 2020, although it is planned that these will be followed up earlier than the due date. DS also agreed to pick up the outstanding points from the Gosport Review audit at Quality Committee.

There has been no movement on 2017-2018 recommendations. However, the Internal Audit Manager confirmed that subsequent to finalisation of the report, there has been one further completed recommendation.

OUTCOME: The Committee **APPROVED** the Internal Audit Q2 Follow-up report.

2. Review Internal Audit Progress Report

The Internal Audit Manager confirmed there are six final reports, which are as follows:

- 4 significant
- 1 high assurance
- 1 limited assurance

The Internal Audit Manager explained they are slightly behind with number of days due to audits moving and delays in starting a few, but there is no overall concern regarding progress with the plan. The Internal Audit team now have EPR access.

Three audits in the planning stage have now moved to field work and therefore an improvement in Q3 is expected.

The KPI regarding the timing of final issuance of reports is not within target; however, there were 'one off' factors affecting this and these should be above target going forward.

RH asked for the background regarding the limited assurance report on Governance in the Medical Division. The Internal Audit Manager explained this was not originally in the plan and was requested by the Head of Governance and Risk/Company Secretary. This was focused on matrons as a result of the Division having lots more formal and informal meetings; therefore, there was a need to review escalation channels. The findings were that many meetings did not have terms of reference, agendas or minutes. Lots of work has taken place in the Surgical Division to reduce the number of meetings and Medicine were advised to speak to the Surgical Division. RH highlighted that this is still an ongoing project across the Divisions. The management responses were detailed in the report but the target date for completion of 20 November 2019 is likely to change and there will be a follow-up report in the 2020/21 plan, with another Division included in the audit. RH suggested a wider review takes place at the Board. The Company Secretary confirmed the Director

of Nursing is reviewing the reporting under Quality Committee and the Chief Operating Officer is reviewing this from an operational perspective.

The Company Secretary stated it is positive to see the A&E 4 hour waiting time indicator assurance following KPMG's qualified report at year end.

RH highlighted that the follow up report on RTT data quality is positive. The Internal Audit Manager explained this may come back at a later stage.

OUTCOME: The Committee **APROVED** the internal audit Q2 progress report.

55/19 LOCAL COUNTER FRAUD

1. Local Counter Fraud 2018/19 Annual Report and Self-Review Tool

The Local Counter Fraud Specialist presented the annual report for 2018/19 and the results of applying self-review tool to the service.

It was noted there has been no external review or inspections and the last one took place five years ago.

OUTCOME: The Committee **APPROVED** the Local Counter Fraud 2018/19 Annual Report and self-review tool results.

2. Local Counter Fraud Progress Report

The Local Counter Fraud Specialist (LCFS) provided an update on current investigations. One case was discussed relating to a fraudulent payment request (which had been actioned by Finance), using an e-mail purporting to be from the Chief Executive, as well as the learnings to prevent a recurrence in future.

RH highlighted that there is an ongoing national fraud initiative in which CHFT is participating. The Local Counter Fraud Specialist explained Audit Yorkshire have appointed a counter fraud analyst who is experienced in this type of work. It was noted that Cabinet Office have always been involved in the national fraud initiative.

DS shared her feedback from attending the Corporate Induction, she explained the 10-minute session on counter fraud is very eye opening and it is good to have awareness that the Trust have a fraud investigator. The message was well-received.

OUTCOME: The Committee **NOTED** the internal audit progress up report.

56/19 EXTERNAL AUDIT

1. Sector Update

The External Audit Partner from KPMG presented the sector update. The key points to note were:

- Update to the DHSC Group Accounting Manual. It was noted that there were no immediate concerns as a result, but the Deputy Finance Director added there is focus on IFRS 16 and work is ongoing. This involves a change to the way the Trust account for items which are held on a lease or maintenance agreement
- External Audit plan will be received in January 2020

RH highlighted the good progress with the Trust on 'freedom to speak up' initiatives.

OUTCOME: The Committee **NOTED** the sector update and **NOTED** the External Audit plan will be received in January 2020.

57/19 ITEMS TO RECEIVE

Risk & Compliance Group Minutes – 8.07.19, 5.08.19, 9.09.19

The minutes of the previous meetings were received.

Information Governance & Records Strategy Committee Minutes – 10.10.19

The minutes of the previous meeting were received.

Health & Safety Committee – 18.06.19

The minutes of the previous meeting were received. It was highlighted no one from this committee attends the Audit and Risk Committee. The External Audit Partner from KPMG suggested a health and safety representative is invited to attend a meeting in the annual cycle and there was discussion regarding a possible deep dive session.

OUTCOME: The Committee **NOTED** the minutes received of the various meetings.

58/19 ANY OTHER BUSINESS

There was no other business.

59/19 MATTERS TO CASCADE TO BOARD OF DIRECTORS

It was agreed to bring the following items to the attention of the Board:

- Self-effectiveness review - updated action plan
- Risk management review – benchmarking of Board Assurance Framework, changes with CHS, SI process and well-led review
- Approved the Board Assurance Framework which went to Board in September 2019
- Approved the recommended changes to the standing orders
- Approved the bad-debt write-offs
- Approved the revised Treasury Management Policy
- Internal Audit progress reports – 1 limited assurance report around Medical Division governance

60/19 DATE AND TIME OF THE NEXT MEETING

The next meeting is scheduled on Wednesday 29th January 2020, 10:00 – 12:00 pm in Room 3, Acre Mills Outpatients.

REVIEW OF MEETING

Feedback from the meeting was positive with good discussion and coverage.

The Company Secretary formally thanked Richard Hopkin on behalf of the Committee for all his support in his last meeting as Chair. Richard will continue to be a member of the Audit and Risk Committee from January 2020.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 4 November 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

187/19 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
Jason Eddleston **(JE)**	
Karen Heaton **(KH)**	Non-Executive Director
Dr Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Andrea McCourt **(AMcC)**	Company Secretary
Dr Cornelle Parker **(CP)**	Associate Medical Director
Lindsay Rudge **(LR)**	Deputy Chief Nurse
Maxine Travis **(MT)**	Senior Risk Manager
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Dr Peter Bamber **(PB)**	Staff Governor and Consultant Anaesthetist **(for Christine Mills)**
Denise Sterling **(DS)**	Non-Executive Director **(Observing)**
Elisabeth Street **(ES)**	Clinical Director of Pharmacy **(item 143/19)**

188/19 APOLOGIES

Christine Mills **(CM)**	Public Governor

189/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

190/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 30 September 2019 were approved as a correct record, with the exception that the date of the meeting is corrected from Tuesday, 3 September 2019 to Monday, 30 September 2019, and that the title of Dr Cornelle Parker is changed from Associate Medical Director and amended to Deputy Medical Director.

191/19 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

192/19 FRIENDS AND FAMILY TEST

Ellen Armistead (Chief Nurse) presented appendix C, briefing the Quality Committee on the changes to the Friends and Family Test by NHS England, due to be implemented from 1 April 2020.

The main changes are intended to improve the Friends and Family Test by:

- Making the wording of the mandatory question and standard response scale more effective in collecting good quality feedback.
- Making it easier for patients to give feedback by changing the timing requirements in the Emergency Department, general and acute inpatients and maternity settings, bringing them into line with other settings.
- Placing greater emphasis on use of the Friends and Family Test feedback to drive improvement

The changes will mean that it is no longer possible to report on the response rate because there is no limit on how often a patient or service user can give feedback. Data will continue to be published that gives an indication of how effectively the Friends and Family Test is being implemented, in line with all other settings.

The new arrangements will be implemented from 1 April 2020, which means the first data using the new question would be submitted in May 2020 for publication in June 2020.

A small task and finish group was commissioned by the Patient Experience and Caring Group to lead the changes. The group is made up of colleagues from Health Informatics, Inpatient and Outpatient Services and Quality Improvement, and an implementation plan has been designed to ensure a timely response.

The progress made so far was detailed in the report.

Discussion ensued on whether the change will be for all areas, and it was confirmed that implementation of the new Friends and Family Test cards will be for all areas. It was also asked whether any LGBTQ data collection questions will be available on the card and it was stated that enquiries have already been made in regard to this.

Progress on this will continue through the Patient Experience and Caring Group, who will provide further updates to the Quality Committee.

OUTCOME: The Quality Committee received and noted the content of the report.

193/19 CARE QUALITY COMMISSION (CQC) UPDATE

Dr Anne-Marie Henshaw (Assistant Director for Quality and Safety) presented appendix D summarising key actions undertaken in quarter 2 in relation to CQC work and priorities for quarter 3.

During quarter 2 there was 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 Provider Information Request (PIR) document.
- Identifying outstanding practice across the Trust and opportunities for sharing learning.
- Benchmarking core services against outstanding rated trusts

At the end of quarter 2, a further three 'must-do' and seven 'should-do' actions from the 2018-2019 post-CQC inspection action plan were completed and embedded. Two '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:

- **MD8 (CRH**): *The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.*
- **SD9 (HRI & CRH)**: *The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.*

Further detail was given into the embeddedness of SD 21 - *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.*
Following a presentation of the review of the Huddersfield Birth Centre (HBC) 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, it highlighted the overall positive outcome of women who commence labour at HBC, regardless of final place of birth and several areas of

excellent practice. 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 one 'must-do' and two 'should-do' actions still rated as green are yet to be tested.

Scheduled engagement meetings between the Trust and the CQC took place in March, May and October 2019. From 1 September 2019, our inspection manager Ruth Dixon was replaced by Ruth Sadler. There was no change to our relationship manager Catherine Robson.

During quarter 2, the CQC relationship manager spent a day visiting critical care at HRI and CRH, and visits are planned for the Emergency Departments on both sites in November 2019.

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.

At the end of quarter 2, the Trust has 13 open enquiries with the CQC. All enquiries are responded to in a timely manner and updates on open enquiries will start to take place on a quarterly basis.

Two CQC-style peer reviews took place in quarter 2: a ward-based medicine peer review and a nutrition and hydration peer review. Details of both were included in the report.

In July 2019, the CHFT CQC Intranet pages were updated and re-launched as a 'Resource Centre for Everything CQC'. The aim is to be able to provide colleagues with all information relating to CQC in one place. The pages are updated as a minimum on a monthly basis and can be found at: https://intranet.cht.nhs.uk/non-clinical-information/chft-cqc-homepage/

A new approach to managing the monthly CQC insight summary report was agreed, where position statements will be submitted from governance forums on 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. The report is a standing item at the CQC Response Group and is presented quarterly at the Risk and Compliance Group.

Priorities for quarter 3 are:

- Provider Information Request (PIR) preparation
- Go-see to 'outstanding' Trusts
- To create a CQC-focused 'Go-see planning guide'
- Learning portal to be live on the CHFT Intranet page
- Sharing learning guide to be available for all colleagues
- How to achieve 'outstanding'
- To raise awareness about CQC across the trust as part of the preparation for the next inspection
- CQC inspection preparation

The Quality Committee was requested to approve the updated terms of reference, which were agreed.

There are no indications as yet as to when the next inspection will be.

OUTCOME: The Quality Committee received and noted the content of the report.

194/19 SERIOUS INCIDENT REPORT

Maxine Travis (Senior Risk Manager) presented appendix E, summarising the new serious incidents declared and a summary of learning from serious incident reports for the reporting period of September 2019.

Seven new incidents were reported - one actual self-inflicted harm, one child safeguarding incident, two diagnostic incidents, one medication incident and two slips, trips and falls, all of which were detailed in the report.

One completed serious incident investigation report on treatment delay was submitted to commissioners, details of which were provided in the report.

Discussion ensued on learning and how we are assured that colleagues receive and learn from lessons. It was stated that a number of approaches are taken; a shared learning intranet page which includes learning is available, as well as a weekly bite-size learning screensaver and article in the CHFT weekly newsletter. Enquiries on how to share learning have been made to the West Yorkshire Association of Acute Trusts forums and a recent sharing learning improving care workshop held in at the Trust in October 2019 generated new ideas and mechanisms on how to share and spread learning.

A query was raised in regard to bank and agency staff and whether their brief stay at the Trust compromises how they absorb learning and how much of it is included in induction. It was stated that further work is to be done on how short-term placement staff are prepared as induction has been taken over by the use of the Electronic Patient Record. A suggestion was made as to whether guidelines could be laminated and made available as reference in order to adopt best practice, and whether certain diagnosis could be linked to into the Electronic Patient Record and directs colleagues to the appropriate guideline that is needed. It was also proposed that an application-based programme similar to the Ignaz handbook is implemented for guidelines/learning to be made more available to colleagues.

The Quality Committee agreed that assurance is needed on actions followed-up and audited once serious incidents have closed, and that appropriate guidance is used and appropriate practice followed.

OUTCOME: The Quality Committee received and noted the content of the report.

195/19 HIGH LEVEL RISK REGISTER

Andrea McCourt (Company Secretary) presented appendix F summarising risks as at 25 October 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*

- Two new risks:
  - **7430**: *Radiology request risks*
  - **7527**: *Maxillofacial follow-up appointment risk*

- Two reduced risks:
  - **7062**: *Funding for capital programme risk*
  - **7477**: *Tissue viability risk*

Details on the new risks and the rationale for the decrease of both risks was included in the report.

A new pie chart depicting the high level risks by type was provided, with 15 risks relating to quality and safety, three relating to estates, two relating to workforce and one relating to finance.

The high level risk register will also be submitted to the Board of Directors on Thursday, 7 November 2019.

OUTCOME: The Quality Committee received and noted the content of the report.

196/19 SAFEGUARDING REPORT

Lindsay Rudge (Deputy Chief Nurse) presented appendix G, which provided key highlights from the Safeguarding Committee for the last 6 months:

- *Prevent* – the safeguarding team has undertaken a review of its assurance arrangements in relation to Prevent following receipt of a letter from NHS England / NHS Improvement advising that collection of training data is a contractual matter and trusts missing quarterly data submissions may/will be subject to contractual levers. The Safeguarding Team identified a discrepancy when the training data was collated, which has now been rectified. Going forward NHS England envisage that Prevent training will sit in levels of safeguarding adults and children training, and not separately, and we await update at NHS regional forums.

- *Kirklees Local Authority reports related to Child Sexual Exploitation (CSE)* – Kirklees Council produced two documents relating to non-recent CSE cases in the district. The Trust responded to these reports and provided assurance that the trust works as a partner agency in safeguarding and supporting children and young people.

- *Kirklees Ofsted re-inspection (June 2019) report publication -* Ofsted re-inspected Kirklees in June 2019 and summarised its overall effectiveness as 'requires improvement to be good'. The safeguarding team continue to work with the Safeguarding Board in new partnership arrangements, and with local authority teams to ensure that partnership arrangements are in place and CHFT systems and processes interlink with multi-agency arrangements.

- *Kirklees Safeguarding Partnership Arrangements* - In June 2019 Kirklees Safeguarding Children's Board became Kirklees Safeguarding Partnership (KSCP). CHFT will continue to support the partnership in multi-agency working through attendance and involvement in the sub-groups.

- *Female Genital Mutilation (FGM) recording and reporting* – The Trust was asked to clarify and establish the legal position where re-infibulation and piercing cases have occurred, and that reporting and safeguarding risks are appropriately identified. Guidance has been included in the updated FGM policy updated in December 2018, and CHFT are compliant with the FGM Information Sharing System (FGM-IS) and also flag children and siblings at risk of FGM.

- *Mental Capacity (Amendment) Act 2019* - The Amendment Bill introducing the Liberty Protection Safeguards (LPS) was passed in April 2019, and it is anticipated that the Act will be implemented in October 2020, with the draft code of practice towards the end of 2019. It is expected that the code of practice will be laid before Parliament in April 2020 and regulations to support the details of the Act are awaited. Details outlining the key implications and changes for trusts were included in the report.

- *Safeguarding risk register* – Four new risks were added to the risk register, which were discussed and accepted at the August 2019 Committee meeting. Seven risks were closed.

Discussion ensued on the impact of the change to the Mental Capacity Act and whether the Trust is prepared. It was stated that a short note will need to be issued to the Committee in relation to this.

OUTCOME: The Quality Committee received and noted the content of the report.

197/19 MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

Elisabeth Street (Clinical Director of Pharmacy) presented appendix H summarising the September and October 2019 Medication Safety and Compliance Group meetings and also an update to their response regarding improving standards of safe and secure handling of medicines.

Whilst work is progressing to support Trust wide solutions to safe storage of medication wastage and temperature monitoring of medication storage areas, both internal and external audits indicate we still have further work and focus to improve the safe management of medicines on our wards. A summary of Medication Safety and Compliance Group recommendations to improve medicines standard 'must do's' was received at the last Quality Committee meeting. This opened debate as to the differences in management of medication incidents depending on professional groups and therefore the Medication Safety and Compliance Group were asked to review their recommendations paper in light of these differences.

A meeting was held with the Clinical Director of Pharmacy, Deputy Medical Director, Deputy Chief nurse and Allied Health Professional lead to review the Medication Safety and Compliance Group recommendations and discuss next steps. The original Medication Safety and Compliance Group recommendations were specific to the management of nurses and midwives failing to complete the must do's. It was agreed that as such, these recommendations and actions should still stand and be followed. The discussions did however highlight that there is a gap in our governance processes with regard to guidance on management of healthcare staff involved in medication incidents. Whilst medics (and Allied Health Professionals and pharmacists) have a clear process for management of staff where fitness to practice issues are raised, there was less of a consistent / standardised process where incidents involving failure to follow the Trust Medicines Code are reported.

Next steps are for the original recommendations regarding the medicines management must do's to be accepted and actioned, and for the Clinical Director for Pharmacy to work with Deputy Medical Director and Medication Safety and Compliance Group to ascertain if there are any gaps in medicines management training for doctors and other Allied Health Professionals and if so, to identify if this is reflected in incidents resulting from poor prescribing practice. All actions will be monitored through the Medication Safety and Compliance Group and regular updates reported to Quality Committee.

- *Medication key security / storage of medication waste* - A business case for digilocks and key safes was submitted to Commercial Investment and Strategy Committee in October 2019 to request capital funding which was approved. A request has been made to Estates to purchase and install these digilocks and key safes to relevant areas, which will be completed by Christmas 2019.

- *Update on fridge temperature monitoring* - The annual fridge temperature monitoring audit was completed in July 2019, the results of which have now been collated and shared with teams. The audit was completed prior to the roll out of the new temperature monitoring tool. The annual ward manager's medicines management is due for completion by October 2019. This audit includes a section on fridge temperature monitoring; therefore results will be compared to note any improvement in compliance since the introduction of the new monitoring tool.

- *Wi-fi temperature monitoring trial* - Medical Engineering are currently trialling a Wi-Fi temperature monitoring solution, the aim of which is to establish if there would be any interference from scanners etc. in areas where these sensors are used. The trail is to

continue to the end of November 2019 and results will be shared with the Medication Safety and Compliance Group.

- *Calibration of fridge thermometers* – 30% of the total trust fridge thermometers have been recalibrated/replaced. A request has been made for this work to be prioritised and the latest update is that completion for the work will be at the end of November 2019.
- *Electronic Controlled Drugs audits* - The medication safety officer is working with the web development team to produce an electronic controlled drug audit tool, the advantages of which will be simpler reporting and monitoring, avoiding paper copies of audits and having immediate access to up-to-date reporting compliance. The tool is in the testing phase of development.
- *Medication shortages* – this continues to be an issue and the pharmacy procurement team are working with regional procurement teams to manage such shortages and source alternatives where appropriate. Uncertainties regarding the impact of the European Union exit deal / no deal on medication supply continue. Our medication shortage standard operating procedure has been reviewed and following current national guidance in terms of not increasing our stockholding of medicines. Trust prescribers have been requested not to increase the quantities of medications supplied on outpatient's prescriptions as this would compound supply issues.
- *Pharmacy staffing* – staffing levels continue to be a concern. The pharmacy team have been working at a reduced capacity and delays in recruitment for pharmacist's posts have resulted in reduced pharmacists to serve wards. This issue is recorded on the Pharmacy risk register; however, the situation is due to improve over the next eight weeks.

Discussion ensued on the calibration of fridge thermometers, and it was requested that this is escalated to ensure completion by the end of November 2019.
Update following meeting – 50% of thermometer calibration is now completed, with most of HRI finished and focus moving to CRH.

OUTCOME: The Quality Committee received and noted the content of the report, and conveyed thanks to the pharmacy team on the amount of work completed.

198/19 PATIENT EXPERIENCE AND CARING GROUP

Lindsay Rudge (Deputy Chief Nurse) presented appendix I summarising outputs from the Patient Experience and Caring Group during August and September 2019.

- *Governance* – the End of Life Care Group is now reporting to Patient Experience and Caring Group (previously to the Clinical Outcomes Group). The terms of reference for this group were received and ratified; the end of life care strategy has been refreshed and the work plan is being updated to reflect this.
- *National inpatient survey results* – CHFT were reported as scoring better than the majority of other Trusts for the question: *After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?* (Scoring 7.3 out of a possible 10) and about the same all other questions. Comments and results are being shared through divisions and considered as part of improvement plans.
- *Interpreting* - the task and finish group are working to the publication of a Policy and standard operating procedure to increase awareness about: Why interpreters are important in Healthcare; Working arrangements at CHFT; Accessing supporting information on the Trust intranet; Internal processes for logging interpreter information; Increasing knowledge re not using family members/staff members and When to use face to face versus telephone. This is a good piece of assurance. A risk has also been revealed where patients may not have a full and accurate interpretation of their care and treatment due to family, friends or other staff members being used to interpret.

- *Dementia update* - a breakthrough event is planned to address screening compliance; dementia champions are being requested for wards / departments; the Butterfly scheme is being re-launched with two training sessions delivered by the national lead at the end of September 2019.
- *Patient information boards* - a piece of work has been commissioned to review patient-facing boards across areas within the trust, to ensure focus of the information provided is on what helps people feel safe in our care.

OUTCOME: The Quality Committee received and noted the content of the report.

199/19 INTEGRATED PERFORMANCE REPORT

September's performance score is 74% with three green domains continuing the Trust's excellent performance for 2019/20. The safe and effective domains have both maintained their green performance with effective now at 91%, with the latest Summary Hospital-level Mortality Indicator score at < 100. 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 responsive domain remains amber with cancer 62-day screening missing target for the third month. Two of the four 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 essential safety training continuing their strong performance, which is a great achievement. Efficiency and finance remains amber.

- Caring
  - Complaints performance improved in September 2019 to 47% responded to within time. Work continues to improve responsiveness and a number of strategies are in place to improve the quality of complaint responses.
  - Friends and Family Test A&E survey continues to drop to the lowest rate of 9% in over 12 months. Work ongoing to improve response rate. A go-see visit to Newcastle is planned in November 2019 to see how they maintain a good response rate. The 'would recommend' rate is also at its lowest at 80% in over 12 months.
  - Dementia screening performance remains at 46%, a long way from the 90% target.
- Responsive
  - Emergency care standard 4 hours – this has deteriorated further to 87% in September 2019. The Committee are aware that there has been some renewed focus on supporting mechanisms that need to be in place in order to bring about positive change in this standard, which will be a huge piece of work.

OUTCOME: The Quality Committee received and noted the content of the report.

200/19 QUALITY COMMITTEE 2020 MEETING DATES

Proposed meeting dates for 2020 were circulated (appendix K) with possible amendments being made to meetings scheduled on a Wednesday. Consultation with the Chair and Vice-chair to take place and dates to be confirmed at the next meeting.

201/19 ANY OTHER BUSINESS

Quality Report

Dr Anne-Marie Henshaw (Assistant Director for Quality and Safety) presented a late paper summarising compliance against each of the five CQC indicator domains, an update on progress with the three Quality Account priorities and the five CQUINs (Commissioning for Quality Innovation) for 2019-2020.

In the safe domain, details on compliance was provided on pressure ulcers, falls, venous thromboembolism (VTE), sepsis, serious incidents and maternity investigations, as well as

learning from safety incidents in quarters 1 and 2; in the caring domain, details were provided on dementia screening, claims, inquests and complaints; the responsive domain gave details on outpatients and appointments; the effective domain details infection prevention control and acute kidney injury and the well led domain featured compliance with essential safety training, compliance with role-specific essential safety training, CQC and accreditation visits.

Progress made with the five CQUIN targets for 2019-2020 with CCG1a and 1b in antibiotic resistance, CCG 2 in staff flu vaccinations, CCG 3 alcohol and tobacco, CCG 7 high impact actions to prevent hospital falls and CCG 11 on same day emergency care were provided.

The Trust identified three quality priorities for 2019-2020, and progress made against all three (clinical outcomes linked to waiting times in the Emergency Department; ensuring that new national guidance on observations for deteriorating patients is implemented; and improving psychological and social support for mental health patients in the Emergency Department) during quarters 1 and 2 was given, with further improvement actions planned for quarters 3 and 4.

The report will also be submitted to the Board of Directors on Thursday, 7 November 2019.

OUTCOME: The Quality Committee received and noted the content of the report.

202/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- Continued emphasis with medication safety
- Priority with getting an 'outstanding' rating with CQC

203/19 EVALUATION OF MEETING

What went well……

- Challenges from staff governor were welcomed and appreciated.
- The level of assurance provided in the report

Even better if……..

- Individual reports were not submitted on the day of the meeting, as this makes it difficult to read beforehand.

204/19 THE INTERNAL AUDIT NETWORK INSIGHT REPORT

The monthly NHS insight report from the Internal Audit Network (TIAN) for September 2019 was circulated for information (appendix L).

205/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix M) was accepted.

NEXT MEETING

Monday, 2 December 2019
3:00 – 5:30 pm
Acre Mill Room 4, **HRI**

Patient Safety and Quality Board Q2 reporting

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE held on Tuesday 5 November 9.30am – 11.30am Acre Mill Outpatients

PRESENT:

Helen Barker	(HB)	Chief Operating Officer
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development (Chair)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Andrea McCourt	(AMC)	Board Secretary
Andy Nelson	(AN)	Non-Executive Director
Alison Schofield	(AS)	Governor
Sharon Senior	(SS)	Staff Side Representative

IN ATTENDANCE:

Azizen Khan	(AK	Assistant Director of Human Resources (for items 81/19 and 87/19)
Nikki Hosty	(NH)	FTSU/ED&I Manager (for items 81/19 and 83/19)
Ruth Mason	(RM)	Associate Director of Organisational Development (for item 85/19)
Adam Matthews	(AM)	Workforce BI Manager – Analytical Lead
Charlotte North	(CN)	Assistant Director of Human Resources (for item 81/19 and 84/19)
Lindsay Rudge	(LR)	Deputy Director of Nursing (for Ellen Armistead)
Denise Sterling	(DS)	Non-Executive Director

77/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

78/19 **APOLOGIES FOR ABSENCE:**

David Birkenhead, Medical Director
Gary Boothby, Director of Finance
Ellen Armistead, Director of Nursing/Deputy Chief Executive
Karen Heaton, Non-Executive Director

79/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

80/19 **MINUTES OF MEETING HELD ON 7 OCTOBER 2019:**

The minutes of the Workforce Committee meeting held on 7 October 2019 were approved as a correct record.

81/18 **MATTERS ARISING**

- 2018 Staff Survey Results – Bullying and Harassment of Staff

NH presented information that show since 2016 there has been an increase in BAME colleagues telling us in the survey they have experienced bullying/harassment by service users/patients. In response the Trust has signed up to the anti-bullying alliance, will work on supporting colleagues in accordance with 'one culture of care' and be clear with service users/patients about the consequences of bullying/harassment of our colleagues.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the response**.**

- Healthcare Scientist Turnover

AK explained that Healthcare Scientist roles are hosted by Families and Specialist Services, Medical and Surgery and Anaesthetics and total 122 employees. There have been 26 leavers from the group in the last 3 years. The top 3 reasons for leaving are resignation due to work/life balance, promotion and retirement. Three specific work areas were highlighted:-

Specific work has taken place within Pathology to ensure that career pathways are accessible and well managed. Most other Trusts in the region offer a clear development pathway from Band 5 to Band 6. It was noted that pathology reconfiguration work across the WYAAT footprint may create benefits and risks to turnover based on the recommended hub and spoke models which are likely to be Leeds, Airedale and Pinderfields.

Physiology posts are a national issue as non-NHS providers pay at higher rates.

The position in Audiology has settled over recent months as a direct consequence of more robust leadership team arrangements.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report**.**

- Time to Hire Targets

CN highlighted the current performance position on internal time to hire targets. It was reported significant delays exists in the initial authorisation process. (regional target is7 working days, the Trust's average is 14.1 days) and at shortlisting 8 days on average and 20 days from an advert closing to conducting an interview compared to regional targets of 3 days for shortlisting and 12 days from closing date to interview date.

The Committee supported the recommendation to retain current targets and to move to the more challenging regional time to hire targets in the future following improvements to the current process.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the recommendations**.**

- Consultant Appointments

CN took the Committee through the significant progress made in consultant appointments. Since 2017/2018 there has been an overall net gain of 12.6 wte Consultants in post up to 25 October 2019. The reputation of the organisation as a great place to work has meant that some established consultants have left other organisations to join the Trust.

ACTION: Ensure that the recruitment internet micro site includes stories from recently recruited employees (CN).

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

82/19 **ACTION LOG (items due this month)**

JE advised the Committee that the Trust is not progressing with a CQC peer inspection approach. It was agreed to delete the action.

The action log was reviewed and updated accordingly.

83/19 **EQUALITY, DIVERSITY & INCLUSION (ED&I) 5 YEAR PLAN**

NH presented a comprehensive year by year 5 year plan to embed ED&I within the Trust. The presentation illustrated the approach and scope of activity channelled to deliver an inclusive culture.

AN asked how progress would be monitored. The Committee noted a RAG wheel will measure progress.

Next steps include collaborative work to promote the plan within the Trust. The plan will be incorporated into the Trust's people strategy 'The Cupboard'.

ACTION: Provide bi-annual update to the Committee (NH).

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Plan.

84/19 **RECRUITMENT STRATEGY**

CN took the Committee through the proposed Strategy describing a 3 year plan to establish the Trust as a Centre of Excellence for recruitment and contribute to achieving 'Outstanding' status by the CQC. The strategy actions focus on marketing, including the development of an external website, new starter experience and retention, talent management, training and development and policies, processes and reporting. The Strategy links to 'The Cupboard' and the Trust 5 and 1 year plan.

ACTION: Provide current national recruitment benchmark data for turnover and vacancy rates through the quarterly vacancy report (CN/AK/JE).

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Strategy.

85/19 **LEADERSHIP DEVELOPMENT PROPOSAL**

RM provided a detailed presentation of the proposed leadership offer. RM explained how the proposal builds on current offerings, WTGR and Compassionate Leadership in Practice (CLIP), with a bespoke 'CLIP +' which provides add-on modules comprising Nursing and Midwifery Leadership, Consultant Leadership, Need to Lead and Technical Masterclass. All learning would be open to all grades of staff in a management role.

AN noted the points for consideration outlined in the presentation and the challenges to delivering the proposal and there was acknowledgment there were detailed practicalities which needed to be considered and worked through to successfully deliver the programmes.

The Committee was supportive of the proposal and requested an update at a future meeting.

ACTION: Provide a six month update to the Committee (RM).

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Proposal.

86/19 **CLINICAL EDUCATION COMMITTEE PROPOSAL**

LR introduced a paper which outlined the proposal to establish a Clinical Education Committee. The strengths of this proposal include leadership and oversight of all clinical education delivery within the Trust, rationalisation of budgets, effective use of resources and consistent, accurate and real-time capture of key education and training metrics. Currently there are well developed training and education teams across the medical and

nursing professions but are often working in isolation and are not aligned or include other professional groups across the organisation. There is no one governing process or group that brings this together in a cohesive and effective way.

DS asked about links with external providers. LR advised there are established learning and development agreements and the Trust is further branching out as roles evolve for example the Nursing Associate role is now included in the Huddersfield University curriculum.

The Committee approved the proposal and it also requested to see terms of reference for the Education Committee. The proposal will be taken to Executive Board to note in the near future.

ACTION: Draft Terms of Reference ensuring that the focus extends beyond the clinical workforce and provide an update to the Committee (LR/SD).

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Proposal.

87/19 **WORKFORCE DATA DEEP DIVE: EMPLOYEE RELATIONS**

The Committee had requested to see a deep dive into the Trust's Employee relations cases.

AK advised the Committee that when dealing with difficult employment matters through formal process all people are treated with dignity and respect. Work is currently underway to ensure our policies reflect our one culture of care.

AK took the group through the data for each of the headings.

Disciplinary cases - 28 cases opened in the reference period of November 2018 to October 2019. 21% of these were BAME colleagues which is disproportionate given the Trust employs 15.2% BAME colleagues. 50% were due to inappropriate behaviour. The HCA group is also high at over 35%. There are currently 6 cases open at present. The average case takes 105 days from start to finish. One particular case took 365 days and it was noted this was a police investigation.

Grievance cases – 7 cases were opened during the period November 2018 to October 2019 with a further case starting prior to November 2018. 42.9% of the grievances related to a policy or procedure. 7 of the 8 cases have closed. 3 of the 8 cases were related policy application. 3 out of the 8 cases were upheld.

Bullying/Harassment cases – 4 cases were opened during the period November 2018 to October 2019. 3 cases were due to allegations of bullying and 1 classified as 'other harassment'. All cases are now closed. 2 of the cases led to disciplinary hearings and 2 found no evidence of bullying/harassment.

Capability – Attendance Management – 803 attendance management cases were added to ESR in the period November 2018 – October 2019. 439 remain open at the end of October 2019. 25.7% of open cases are healthcare assistants. There is some work being undertaken with HCA colleagues as they told us in the last NHS Staff Survey they weren't feeling valued. 18.8% of phlebotomists are currently in an attendance management process.

AK stated there is a focus on the HCA group and BAME colleagues which will be done by way of case reviews. There is a focus on time to complete grievance and bullying/harassment cases. There is ongoing work with HCAs and phlebotomists with regard to attendance management.

OUTCOME: The Committee **RECEIVED** and **NOTED** the information.

88/19 **IMPROVING PEOPLE PRACTICES**

JE presented a paper which provided an assessment of the Trust's current practice against NHS Improvement (NHSI) recommendations and guidance to improve people practices based primarily on learning from a critical incident involving a London NHS Trust. Following the death of an NHS employee who was subject to formal action within conduct procedures in 2016, the employing Trust commissioned an independent inquiry. The report concluded that in addition to serious procedural errors throughout the investigation and disciplinary process the employee was treated poorly. The NHSI recommendations have been tested against our existing practice and actions identified to incorporate the learning from the review into our processes. The actions are consistent with our commitment to one culture of care.

ACTION: Report progress to future Committee meeting (JE).

OUTCOME: The Committee **RECEIVED** and **NOTED** the actions.

89/19 **2018/2019 MODEL HOSPITAL WORKFORCE DATA**

AM advised that since the removal of iView by NHS Digital in May 2019 benchmarking of up to date workforce metrics has proved difficult. However within the Model Hospital there is a 'HR Function' section that allows comparisons with other NHS Trusts, albeit using 2018/2019 data.

The complete set of data had been shared with the Committee. AM highlighted that:-

Staff retention is above the median for 2018/2019.

Appraisal rate for 2018/2019 was 96.74%. CHFT ranked 11th out of 222 Trusts.

Essential Safety Training compliance rate for 2018/2019 was 94.5%. CHFT ranked 22nd out of 224 Trusts. CHFT had the highest compliance rate across WYAAT.

OUTCOME: The Committee **RECEIVED** and **NOTED** the Data.

The following items were dealt with outside of the meeting:-

90/19 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – SEPTEMBER 2019**

The report had been circulated prior to the meeting. The highlights are recorded as follows:-

Performance on workforce metrics continues to be high but the Workforce domain remained at to 86.2% in September 2019. This is now 6 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 - September 2019
The Staff in Post increased by 31.97 FTE, which, due, in part, to 88.15 FTE new starters in September 2019. This led to a reduction of 29.09 FTE vacancies.

Turnover improved again to 7.97% for the rolling 12 month period October 2018 to September 2019. This is the lowest turnover on record beating the previous lowest achieved in August 2019.

Sickness absence – August 2019
The in-month sickness absence increased to 3.72% in August 2019. The rolling 12 month rate increased for the first time in 18 months, to 3.63%.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 27.39% of sickness absence in August 2019, dropping from 29.21% in July 2019.

The RTW completion rate improved slightly to 74.48% in August 2019.

Essential Safety Training – September 2019
Performance has improved in all 9 core suite of essential safety training. 8 of the 9 remain above the 90% target with 5 achieving the 95% 'stretch' target.

Overall compliance improved to 95.22, above the stretch target for the first time.

Workforce Spend – September 2019
Agency spend dropped by £0.2M, whilst bank spend increased by £0.1M.

Recruitment – September 2019
4 of the 5 recruitment metrics reported deteriorated in September 2019. The time to hire for colleagues starting in September 2019 was just over 16 weeks.

91/19 **NHS STAFF SURVEY**

This CHFT Overall response rate (as at 4 November 2019) is 30.8%. A breakdown of response rates was circulated to members following the meeting. Activities continue to encourage and support colleagues to complete the survey.

92/19 **CQC UPDATE**

Work is progressing on specific actions following an analysis by the Director group within the well led domain.

93/19 **RISK REGISTER WORKFORCE RISKS**

Medical Staffing Risk
Nursing Staffing Risk
Essential Skills Training

During the discussions regarding both consultant and general recruitment the Committee agreed the Medical and Nurse staffing risk score should be reviewed.

ACTION: To systematically review the Medical Staffing risk and Nurse Staffing risk respectively to confirm or amend the risk score in the context of the success story in relation to recruitment and retention (DB/EA).

94/19 **QUARTERLY ESCALATION FROM PRMs**

HB provided a comprehensive briefing note which was shared with Committee members after the meeting.

95/19 **ANY OTHER BUSINESS**

There was no other business.

96/19 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

SD to provide a comprehensive 'Cupboard' update to the January 2020 Board.

97/19 **EVALUATION OF MEETING**

This item was not discussed.

98/19 **DATE AND TIME OF NEXT MEETING:**

10 December 2019, Hot House, 2.00pm–4.00pm, Discussion Rooms 1 & 3, Learning Centre, HRI
10 December 2019, Review Quality & Performance Report, 4.00pm–5.00pm, Discussion Room 2

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE REVIEW OF QUALITY AND PERFORMANCE REPORT (WORKFORCE)
Held on Tuesday 10 December 4.00pm – 5.00pm
Discussion Room 2, Learning Centre, HRI

PRESENT:

Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Adam Matthews	(AM)	Workforce Business Intelligence Manager
Andrea McCourt	(AMc)	Board Secretary
Andy Nelson	(AN)	Non-Executive Director

99/19 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

100/19 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
David Birkenhead, Medical Director
Gary Boothby, Director of Finance
Ellen Armistead, Director of Nursing/Deputy Chief Executive

101/19 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

102/19 **MINUTES OF MEETING HELD ON 5 NOVEMBER 2019:**

During the discussion of the Leadership Development Proposal item AN had made two points which had not been noted.

- The proposal should address the requirements of leaders to play an active role in the Digital Health agenda, as advocates and adopters and driving best practice in the use of new technology.

- More emphasis required on performance management as a key skill in successful leaders from setting SMART objectives through continuous feedback, good appraisals and handling poor performance (difficult conversations).

Subject to this additional record, the minutes of the Workforce Committee meeting held on 5 November 2019 were approved as a correct record.

103/19 **ACTION LOG**

The action log was reviewed and updated accordingly.

104/19 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – OCTOBER 2019**

The report had been circulated prior to the meeting. The highlights are recorded as follows:-

Performance on workforce metrics continues to be high and the Workforce domain improved to 87.9% in October 2019. This is now 7 consecutive months of a 'Green' domain.

Only 2 of the 17 metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Medical Appraisals'.

Workforce - October 2019

The Staff in Post increased by 22.8 FTE, which, due, in part, to 40.02 FTE new starters in October 2019. This led to a reduction of 16.21 FTE vacancies.

Turnover improved again to 7.87% for the rolling 12 month period November 2018 to October 2019. This is the lowest turnover on record beating the previous lowest achieved in September 2019.

Sickness absence – September 2019

The in-month sickness absence increased to 3.86% in September 2019. The rolling 12 month rate increased for the second consecutive time in 18 months, to 3.66%.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 29.86% of sickness absence in September 2019, increasing from 27.39% in August 2019.

The RTW completion rate fell slightly to 72.4% in September 2019.

Essential Safety Training – October 2019

Performance has improved in 5 of the core suite of essential safety training. With all 9 remaining above the 90% target with 5 achieving the 95% 'stretch' target.

Overall compliance improved to 95.30, above the stretch target for the second consecutive month.

Workforce Spend – October 2019

Agency spend rose by £0.08M, whilst bank spend fell by £0.1M.

Recruitment – October 2019

2 of the 5 recruitment metrics reported deteriorated in October 2019. The time to hire for colleagues starting in October 2019 increased and was just over 16 weeks.

KH noted that overall appraisal compliance rates had increased but there was some concern with regard to medical appraisal compliance rates. It was noted there are a limited number of appraisers and also medical appraisal dates are based around a 12 week period of the birthday of the individual, this is in line with the national approach.

The Committee discussed the increase in short-term sicknes absence. It was noted the figure may worsen over the winter months but it is hoped to stay on trend at under 4%. AN noted in particular the position in the Pharmacy Manufactoring Unit (PMU). JE advised the Divisional HRBPs continually monitor data, work with managers, teams and each other to gain best solutions and benefits across all areas.

KH asked about the recruitment of the Philippine nurses. JE advised that the Trust anticipates 50 nurses in total will start with the Trust. SD shared that pastoral care is an integral aspect to the Trust's recruitment journey to help support colleagues to settle in at the Trust.

AN enquired about the recruitment weekly cycle. JE confirmed that it had been agreed to retain the existing targets and work to the recommendations and then take the final step to move to the regional target measures. Weekly authorisation had been implemented and Trac is reviewed on a daily basis and any hot spots identified.

KH concluded that the workforce data presents a good overall picture. AN agreed there is much to be proud of and is a real good news story.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

105/19 **ANY OTHER BUSINESS**

AMc reported on recent feedback from staff governors. The governors want to be more engaged with workforce topics. SD agreed to be involved in discussions and the next meeting date would be shared.

106/19 **DATE AND TIME OF NEXT MEETING:**

18 February 2020, Deep Dive, 3.00pm–5.00pm, Discussion Rooms 1, Learning Centre, HRI

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Wednesday 6 November 2019

Present: Philip Lewer, Kirsty Archer David Birkenhead, Ellen Armistead, Linda Patterson, Sheila Taylor

In attendance: Emma Kovaleski, Carol Harrison, Rashpal Khangura (KPMG) Lyn Walsh (minutes)
Apologies: None.

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Audit Highlights Memorandum & Management Letter
R Khangura presented the paper which summarised any audit differences; recommendations follow ups from prior year and confirmation of auditor independence. KPMG are satisfied that there were no issues found during the audit such as override of controls or adjusting items being made. The accounts were signed off by P Lewer, K Archer and R Khangura. Action approved.

3. Draft Letter of Representation
R Khangura presented the letter and this was signed off by P Lewer and K Archer. Action approved.

4. Draft Annual Report & Accounts 2018/19.
The report was tabled for information with the updated auditors report added. Action noted.

5. Minutes of the last meeting
The minutes of the last meeting held on 23 August2019 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

6. Action Log
Brand Launch & promotion of charitable funds - Jan-20.
Risk register & strategy update - Coincides with policies being produced action on going.

Review of consolidating smaller funds - on going.
CCLA Investment performance review. No requirement to tender after reviewing the data. After charges they still out perform and therefore it is recommended that we should continue to hold the investments with CCLA. Action closed.
Calderdale Community foundation healthy minds to provide outcome data prior to funds being released. No data has been received P Lewer to chase up and circulate anything received outside the meeting. Action: on-going.
Calderdale Community foundation healthy minds feedback from GP's. P Lewer has been in contact with Andrew O'Conner who had a positive view but he wants further information from the CCG. Action on going.
L Patterson mentioned news of possible GP surgery closures in Todmorden.
Name of the Charity. The name of the Charity has been agreed as Calderdale and Huddersfield NHS Charity. Action Closed.
Business case for fundraising CRM. Delayed to next year. Action: on-going.

7. Investment Mangers review. This was reported in action log item 6 above.

8. Quarter 2 SOFA & Balance Sheet 2019/20
C Harrison reported on the Quarter 2 position. The Q2 investment gain was £240k.
Action Noted.

9. Quarter 2 2019/20 Expenditure Summary
C Harrison reported on the major items of expenditure incurred in Q2.
Action Noted.
There was a discussion about making this paper more detailed to paint a bigger picture and report on impact. It was decided that a forecast of income would also be produced. Action: E Kovaleski to update this paper going forward.

10. Items reviewed under item 6.

11. Allowable / non allowable Expenditure – for review.
E Kovaleski produced a power point presentation for information about gratitude and promotion of a charity.
This was well received by the committee.
The current expenditure guidelines were shared along with two examples from other Trusts.
P Lewer stated that the expenditure policy needs to be in place before the re-launch. It was agreed that a hybrid of all the information was the aim. Action P Lewer to arrange a meeting with E Kovaleski and A McCourt to produce a draft to be circulated for view and further comment prior to Board approval.

12. Minutes from Staff lottery for information. Action noted.

13. Staff Lottery Committee Membership change for ratification.
Action ratified.

14. Any other business.
K Archer asked that a freedom to speak up concern be noted. The concern was that expenditure had been made from a fund that was not allowable. The use was for

team building meals and a spa pamper. A review was carried out against the current guidance, it was concluded that the expenditure policy was too vague and subjective to different peoples judgement. Due to policy clarity it was decided it was not a clear breach and a challenge to recoup the expenditure would be hard to pursue. The counter fraud department had been involved with the investigation and it has been recognised that lessons can be learned, that policy can be strengthened. The approved form is being redesigned to include more information requirements and questions to support challenge. P Lewer ''said that this had been handled well and was pleased that freedom to speak up was being used''.
L Patterson reported that this was her final meeting. The Committee gave their thanks for her contribution.

15. Date and time of next meeting

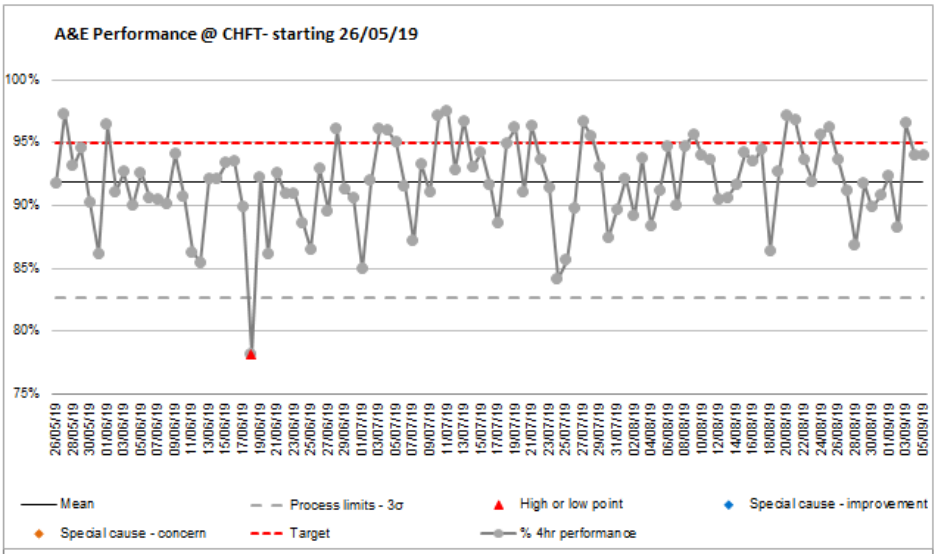
26th February 2020 at 8.30am – 10.00am Room 3 Acre Mills

CHARITABLE FUNDS COMMITTEE MEETING
6 November 2019
Action Log - 2019/20

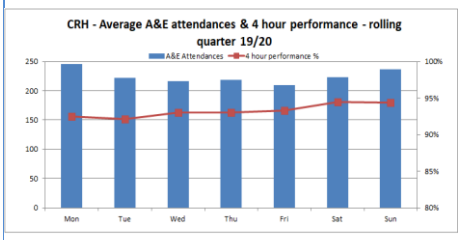
CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Brand launch and promotion of Charitable Funds.	**PL/GB**	Jan-20	ongoing
Risk Register & Strategy update	28.08.18	Papers are being written and audit will support governance. Update Coincides with policies being produced.	**GB/ EK**	Nov-19	ongoing
AOB	27.02.19	EK to bring review of options to consolidate smaller accounts alongside merits of both options. Update ongoing.	**EK**	Nov-19	ongoing
Calderdale Community foundation (Healthy Minds) Presentation	23.08.19	Healthy Minds to provide outcome data prior to approved £37.5k funding being released. Update no data received P Lewer to chase Healthy Minds and circulate outside of the meeting.	**PL**	Nov-19	ongoing
Calderdale Community foundation (Healthy Minds) Presentation	23.08.19	Email Lead GP in Todmorden area for feed back on Healthy Minds. Update contact made with A O'Conner seaking further information from the CCG.	**DB / PL**	Nov-19	ongoing
Budget Proposal	23.08.19	Business case for fundraising CRM. Update delayed till next year.	**EK**	Jan-20	ongoing
Expenditure Summary	6.11.19	This paper will be updated to present the bigger picture and report on impact. A forecast of income with also be provided.	**EK**	Feb-20	

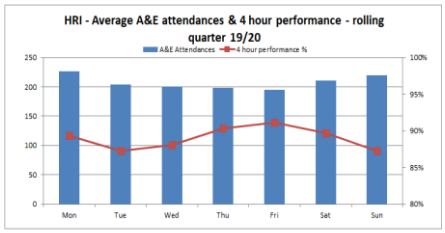
Calderdale and Greater Huddersfield A&E Delivery Board (A&EDB) Highlight Report		
10th September 2019	**12:30 – 14.00**	**Shibden Room Dean Clough**

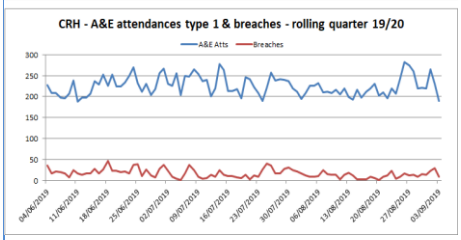
Chair	Helen Barker (HB) – CHFT
Attendees	Amanda Evans (AE) – KMC John McSorley (JM) – YAS Andrew Simpson (AS) – YAS Debbie Graham (DG) – CCCG Farrukh Javid (FJ) – CCCG Bev Walker (BW) – CHFT Iain Baines (IB) – CMBC Jane Close (JC) – Locala John Keaveny (JK) – SWYPFT Mark Davies (MD) – CHFT Matthew Bleach (MB) – CCCG Vicky Dutchburn (VD) – GHCCG Jon Parnaby (JP) – GHCCG Carol McKenna (CM) – GHCCG Helen Carr (HC) – LCD
Note Taker	Emily Addison – Calderdale CCG
1. Welcome and Apologies	
Lead	**HB**
Apologies	Members were welcomed to the meeting and a round of introductions made. The following apologies were noted; Matt Walsh, Catherine Bange, Louise Metcalf, Keith Wilson
2. Sign off Highlight Report and Action log	
Lead	**DG**
	The board reviewed the notes from 13th August 2019 and agreed they were an accurate record of the meeting. DG reviewed the action log along with the board: Actions Closed; 364 (No obvious impact seen as of yet from increase in weekend discharges), 367 Closed (VD working through), 369 (On agenda) An email to be sent to find communication leads group in order to link them with YAS
3. Performance	
Lead	**MB**
	A&E is still showing a stable and strong performance throughout June (in spite of one challenging day in June with 120 breaches), July and August. August performance was at 92% in spite of the 3.6% increase in attendance this year. CHFT is not hitting the 95% target but is benchmarking well nationally and is ranked 10th in the country.

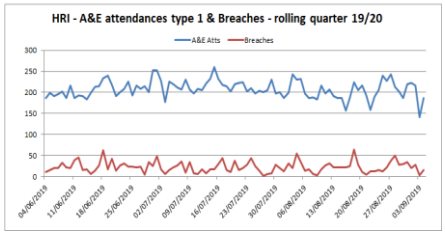


Attendances on a Monday and a Sunday are highest. There is still a significant variation at sight level with CRH performing at 95% and HRI performing at 92.5%. No significant variation in terms of admission and discharges.

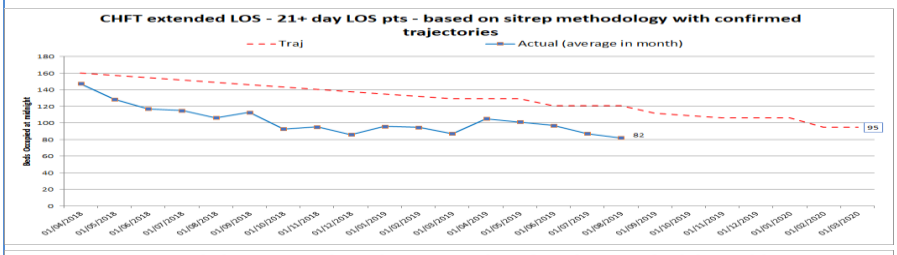


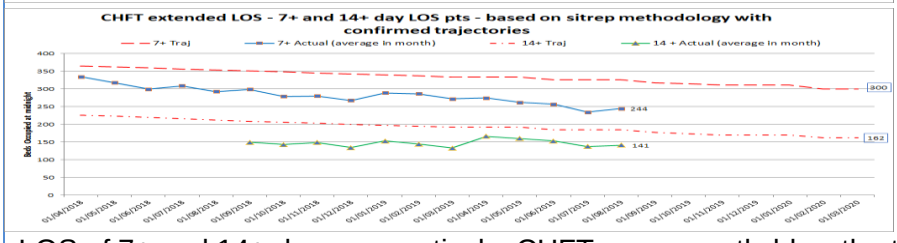






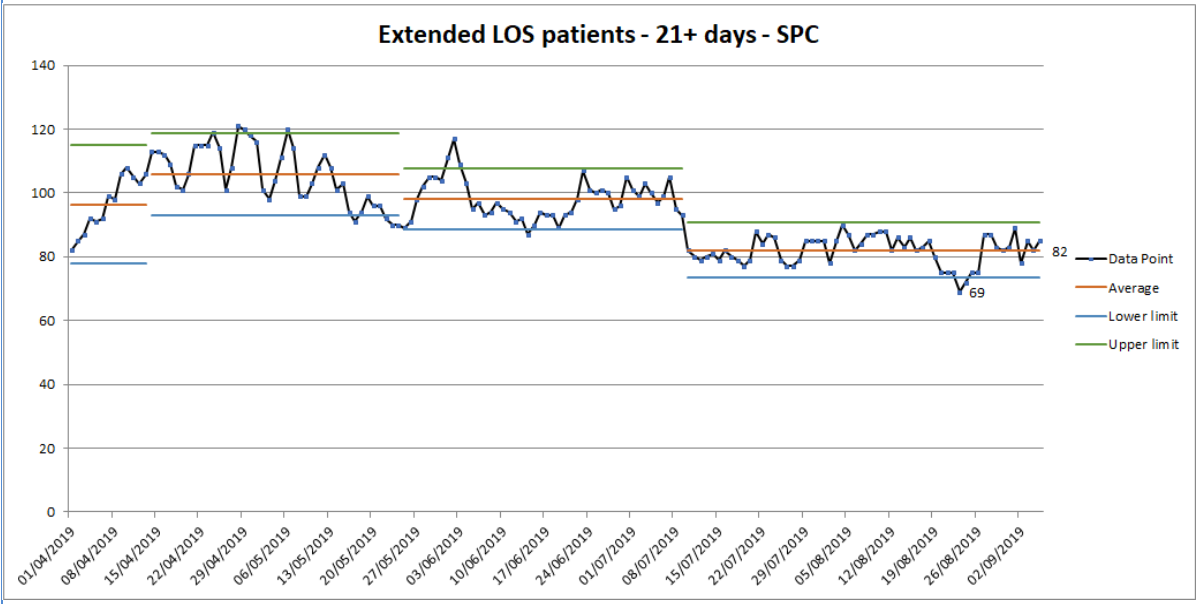
LOS of 21+ days, CHFT are currently below the trajectory position and on track to achieve the required 42% reduction by March 2020.





LOS of 7+ and 14+ days respectively. CHFT are currently blow the trajectory position and on track to achieve by March 2020. This is a case of maintaining the performance especially coming up to winter.

In the daily position the sustained reduction can be seen. The challenge here is how this can be maintained.



The same day emergency care standard which was set out in the five year plan was raised. The standard was to have the same day emergency care data reported by September 2019. It was reported that his timeline has been delayed nationally.

There was another ambition set out in the long term plan that each system sets a trajectory for reducing ambulance conveyances. It was reported that no expectations had been confirmed relating to this.

Action: To take ambulance conveyance query back to NHSE and ask for a view on expectations or whether there is a date set – DG to speak to LM.

HB raised the issue that the performance slides were still focused mainly on the hospital and that out of hospital slides would be helpful for visibility.

It was also said to be helpful to work out how we can overlay correlate emergency care standard performance with that for super stranded patients.

Action: MB to include in the next performance update

Discussion took place on the 4 hr standard. It was agreed that this was a system standard rather than one attributed to CHFT. This raised the issue about whether performance was visible in other partner Board performance systems.

Action: All members to discuss the inclusion of the 4 hour performance in their Board performance reports.

As part of their work, PCN will be nationally mandated to support a reduction in A&E attendance. As more detail emerges detail will be shared with the Board.

Action: DG to agenda a PCN item from both CCGs once more clarity on expectations related to urgent care are confirmed.

Primary care winter arrangements are seen as critical to system resilience over winter.

	Action; Both CCGs are asked to confirm what is being commissioned through winter verbally at the next meeting, and in detail as part of winter planning in November
4. Forward Planning; Winter	
Lead	**DG**
	(a) <u>Winter Plan and Surge and Escalation Process</u> Annually the Board refreshes its winter plan and the surge and escalation plans. This is based on the monthly be-briefs at A&EDB throughout the winter period. A refresh to come back to the October meeting led by JP. This would include how might align the work with expectations related to Brexit **ACTION: All partners to aim to send through a copy of their draft winter plans in advance of the next meeting to JP** **ACTION: A conversation with public health – Australia winter pattern and anything else which may be causing concern - VD/DG/PB/EPH** **ACTION: Consideration of the strength of our mutual aid arrangements to be included when the plans are discussed.** **ACTION: To think about setting up a standard bronze call (or digital conversation) on a Wednesday to make sure the system is prepared for a weekend – to be agreed as part of winter discussions at the October meeting - JP** **(b) <u>BCF Winter Funding</u>** **<u>Calderdale</u>** The Board discussed a paper setting our intentions for use of the winter pressures money. IB confirm that nationally there is still a question as to where the 1.2 billion is coming from in reality is it actually new money. However, in terms of winter funding Calderdale set out its plans, based on learning on what has provided the greatest system gain in previous year. He provided an opportunity for members to comment. Members were happy with the proposals for Calderdale. IB confirmed the retender of home care has just started and there appears to be good appetite from providers. Winter assumptions are built on the current provision, with the new approach in place from Spring 2020 The successes in LOS in Calderdale were seen as very positive in terms of efficiency and patient care, but had resulted in a large overspend/pressure on homecare budgets. **<u>Kirklees</u>** AR confirmed discussion had been ongoing between KMC and Locala around admission avoidance and discharge to assess and this was a feature of their spending plan. This included; trialling a triage model, strengthening joint intermediate care/re-enablement. In regards to home care, Kirklees have also been made aware of new providers but are currently in the middle of a contract and other providers cannot be added during the contract period. However, KMC were looking at the potential to strengthen the market. Kirklees also indicated that they were looking to uplift the funding for home care providers and recognised that this might have an impact on the system overall.

	Action: AE to confirm plans for potential uplifts in fees to care home providers in Kirklees
5. A&E DB Priorities;	
Lead	
	(a) <u>Transformation Funding Plans on a Page</u> Members were sighted on the plans on a page for the transformation money from five organisations; • C&GH System Proposal proof of concept over winter for an urgent care hub, moving things further to the front door of A&E. • Mid-Yorkshire System Proposal, • YAS Proposal • LCD Proposal • Community Pharmacy WY Proposal Mid-Yorkshire documents had been included to show what was happening across the Kirklees footprint. It was recognised that a gap existed in terms of spend of mental health transformation funding. **ACTION: Mental health plans on a page to come back to the board VD** At a regional level, recruitment issues were highlighted in all of these plans. The approach regional seeks conversations across the system to stop the potential of moving staff and simply creating gaps in other parts of the system. The aim is to share JDs so that bandings for the same jobs are consistent and secondly looking as to whether this can be done as expressions of interest with individuals been released on secondment. In terms of the C&GH proposal, DG will be taking this forward though SRG work stream A&E Avoidances/UTC once this group is formed, all nominations for this work stream to be in by the 15th September 2019. MB will be helping to create a dashboard for KPIs in the SRG Work Streams **<u>YAS Inter-facilitiesTransfer and Health Care Professionals Frameworks</u>** MS presented the new YAS IFT/HCP approach with the Board. The new framework will be implemented by the 9th October 2019. Board members raised issues around the need for good communications and for an update in 3 months so that the Board could support mitigation of any emerging risk **ACTION: New IFT/HCP Framework to be brought back in three months for an update. With feedback from GPs and A&Es – EA to put on workplan** **ACTION: Communications in regards to this for GPs will be circulated to partners and GP practices directly by YAS. Any issues to be raised with the A&EDB at the next meeting CB/MS**
6. Brexit Planning	
Lead	**DG**
	<u>EU Exit Table Top Exercise</u>

	Following regional meetings and desktop scenario planning. We agreed we need to do some work on operational expectations on systems regarding reporting etc. It was agreed that we should devote a good part of the next meeting to: • Understanding the expectations. • Thinking about how we bring together expectations around Brexit, winter and emergency planning in the context of our Surge & Escalation Plan • Agree practically how we can meet the expectations, without overload staff and duplicating activities. • Invite our Brexit Leads to attend as necessary **ACTION: JC to circulate EU Exit slides when they become available**
7. WY & H UEC Programme	
Lead	**DG**
	There has been a conversation at WY about the role of the UEC and whether it is achieving its goals. There is a clear view about the need to change ways of working and strengthen leadership. There is a view that the UEC Network needs to be more reflective of all the partners who are involved in UEC across West Yorkshire, and that the emerging strategy needs some work. **ACTION: To bring back an update in October – around looking at the relationship between A& E DBs and the programme if know - DG**
10. For information and AOB	
Lead	**DG**
	There were no items for information or AOB
Next Meetings	8th October 2019, Shibden Room, Dean Clough, 12.30-14.00 (one hour on Brexit Plans) 12th November 2019, Shibden Room, Dean Clough, 12.30-14.00 10th December 2019, Shibden Room, Dean Clough, 12.30-14.00 14th January 2020, Shibden Room, Dean Clough, 12.30-14.00 11th February 2020, Shibden Room, Dean Clough, 12.30-14.00 11th March 2020, Shibden Room Dean Clough, 12.30-14.00

Calderdale & Greater Huddersfield Health Economy
A&E Delivery Board (A&EDB) Action log

No	Minute Ref	Action	Who	Date	Update	Status
354	YAS 999	Urgent Care and Communications leads meeting to discuss joint response to members at scrutiny and H&WBB	CB	September 2019	Communications leads from partner organizations to be identified	Open
356	Board Governance	Update on next steps from the May workshop and governance arrangements to the October A&EDB to review our position and decide future actions	DG	November 2019	After groups have a chance to embed this will be brought back for discussion	Open
363	UEC	Workforce planning piece to come back to the A&E DB	MD	November 2019		Open
364	Performance	Community providers to test whether there has been an impact on their services due to the increase in weekend discharges	JC/HB	September 2019	Closed no obvious impact seen from weekend discharges	Closed
365	Performance	Louise Metcalf to look into national data in regards to A&D Attendance increases over the summer as to whether that is a pattern of increased attendances everywhere.	LM	September 2019		Closed
367	YAS MH programme	VD to ensure that MH work is a fed into the new work-stream, and ensure links are made with YAS in terms of progress.	VD	September 2019	Closed CB emailed for YAS MH presentation an email to go round requesting communication leads from each organization	Closed
369	Transformation and BCF Funding	DG to bring back an update to the September meeting on transformational allocations which impact on our system DG to ensure that BCF winter funding from both local authorities is available at the next meeting. MW to write to Tim Swift to confirm the position regarding transformation funding into Calderdale.	DG/ MW	September 2019		Closed on agenda
370	EU Exit	Louise Metcalf to invite Screening team, NHS Commissioning team, Paul Butcher & Emily Parry-Harris invited into conversation around flu chain supply with NHSE.	LM	September 2019		Open

Enclosure A

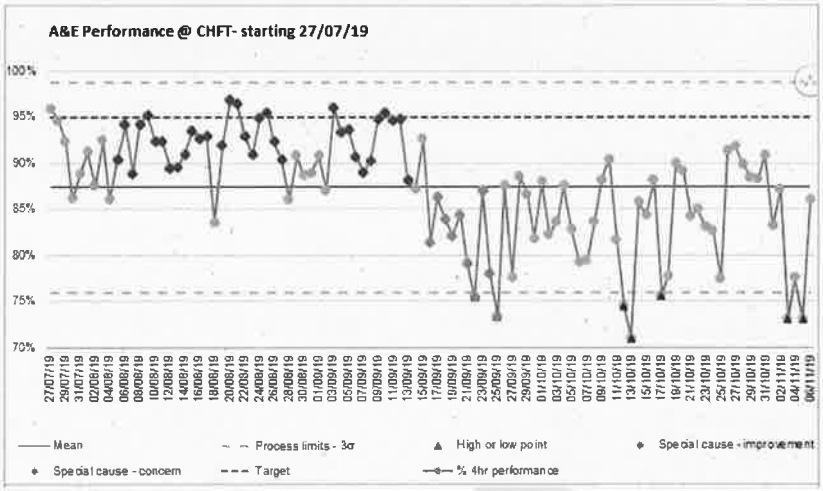
No	Minute Ref	Action	Who	Date	Update	Status
371	EU Exit	Matt to ensure the H&CP are considering the full impact on health the EU exit might have.	MW	September 2019	To be confirmed at October meeting `	Open
372	EU Exit	Brexit to be a standing order on the agenda until October		October 2019		Closed
373	WY&H UEC programme	DG to update the Board once next steps were know regarding the UEC strategy and ways of working	DG	October 2019		Closed
374	Performance	To take ambulance conveyance query back to NHSE and ask for a view on expectations or whether there is a date set.	DG/LM	October 2019		Closed
375	Performance	MB to include out of hospital slides from other partner organisations in performance update. MB to look at how we can overlay correlate emergency care standard performance with super stranded patients.	MB	November 2019		Open
376	Performance	All members to discuss the inclusion of the 4 hour performance in their Board performance reports.	ALL	October 2019		Open
377	Performance	DG to agenda a PCN item from both CCGs once more clarity on expectations related to urgent care are confirmed.	DG	November 2019		Open
378	Winter Planning	Both CCGs are asked to confirm what is being commissioned through winter verbally at the next meeting, and in detail as part of winter planning in November	DG/VD/ JP	November 2019	Verbal Update October 2019	Open
379	Winter Planning	All partners to aim to send through a copy of their draft winter plans in advance of the next meeting to JP	JP	October 2019		Open
380	Winter Planning	A conversation with public health – Australia winter pattern and anything else which may be causing concern	VD/DG/ Public Health	October 2019		Open
381	Winter Planning	Consideration of the strength of our mutual aid arrangements to be included when the plans are discussed.	DG	October 2019		Open

Enclosure A

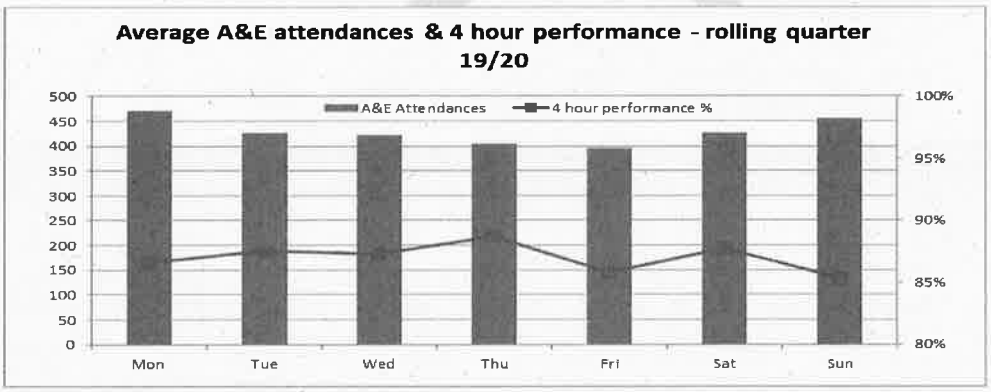
No	Minute Ref	Action	Who	Date	Update	Status
382	Winter Planning	To think about setting up a standard bronze call (or digital conversation) on a Wednesday to make sure the system is prepared for a weekend – to be agreed as part of winter discussions at the October meeting	JP	October 2019		Open
383	Winter Planning	AE to confirm plans for potential uplifts in fees to care home providers in Kirklees	VD/JP	October 2019		Open
384	MH – SRG Work stream	Mental health plans on a page to come back to the board	VD	November 2019		Open
385	YAS IFT/HCP Framework	New IFT/HCP Framework to be brought back in three months for an update. With feedback from GPs and A&Es- EA Work plan	CB/JM EA	December 2019		Open
386	YAS IFT/HCP Framework	Communications in regards to this for GPs will be circulated to partners and GP practices directly by YAS. Any issues to be raised with the A&EDB at the next meeting	CB/MS	September 2019		Closed
387	EU Exit	EU Exit regional meeting slides to be circulated when they become available	JC	October 2019		Open
388	EU Exit	To request all organisations EU Exit Plans	EA	October 2019		Closed
389	WY&E UEC Prog.	To bring back an update in October – around looking at the relationship between A& E DBs and the programme	DG	October 2019	On agenda	Closed

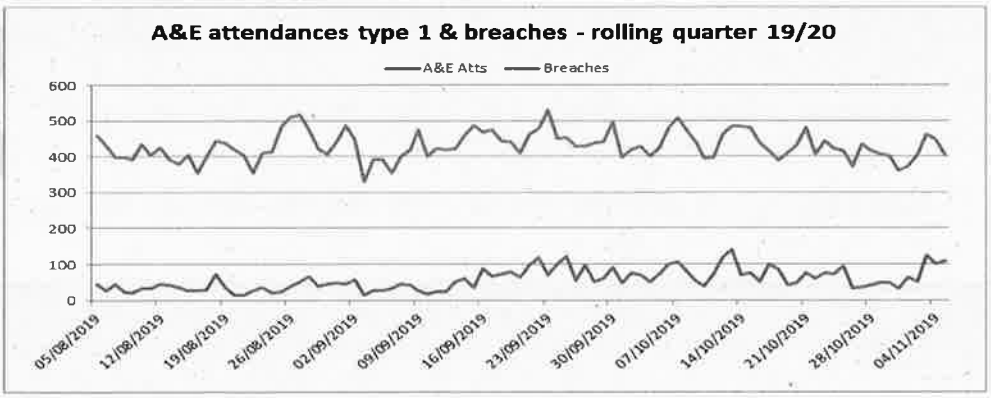
Calderdale and Greater Huddersfield A&E Delivery Board (A&EDB) Highlight Report		
12th November 2019	**12:30 – 14.00**	**Shibden Room Dean Clough**

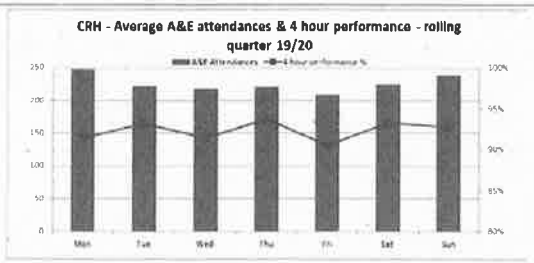
Chair	Matt Walsh (MW) – CCCG
Attendees	Amanda Evans (AE) – KMC Debbie Graham (DG) – CCCG Farrukh Javid (FJ)- CCCG Ged Taylor (GT) – CMBC Helen Barker (HB) – CHFT Jane Close (JC) – Locala John Keaveny (JK) – SWYPFT Jon Parnaby (JP) – GHCCG Jordan Wall (JW)- YAS Louise Metcalfe (LM)– NHSE Matthew Bleach (MB) – CCCG Michelle Day (MD) – Locala Vicky Dutchburn (VD) – GH CCG
Note Taker	Emily Kennedy – Calderdale CCG
1. Welcome and Apologies	
Lead	**MW**
Apologies and Focus of Meeting	Members were welcomed to the meeting and a round of introductions made. The following apologies were noted; Carol McKenna, Catherine Bange, Keith Wilson, Ruth Buchan, Mark Davies, Caroline Smith, Helen Carr, Andrew Simpson, Bev Walker, Kate Gatherer
2. Sign off Highlight Report and Action log	
Lead	**DG**
	The board reviewed the notes from 8th October 2019 and agreed they were an accurate record of the meeting. DG reviewed the action log: Actions closed; 370, 371, 372, 375, 377, 378, 379, 380, 381, 382, 383, 387, 388, 390, 391, 395
3. Performance	
Lead	**MB**
	(a) MB shared an overview of performance; A&E performance at the end of July was relatively strong but not hitting the constitutional target. There was a deterioration seen in mid-September and this performance has been maintained to date (November). There has been some challenging weeks within the system with performance close to 70%. This has been exaggerated by a 5% increase in A&E attendances compared to last year and pressures in hospital flow at the back end. MB compared CHFT to the regional and national position and despite the variation CHFT still ranks highly.

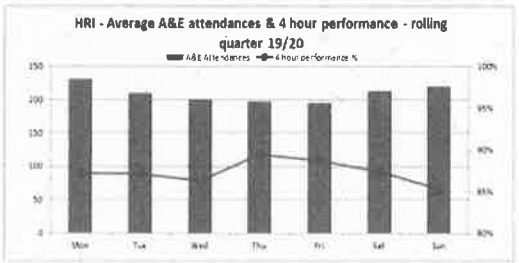


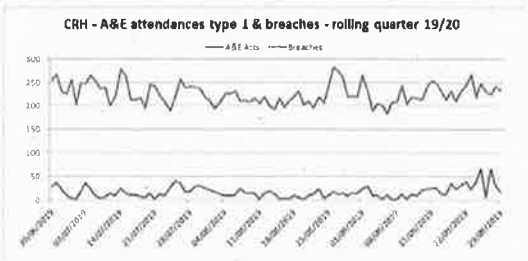
A&E attendances for CHFT in October was at 85% and there is a 10% disparity between both sites.

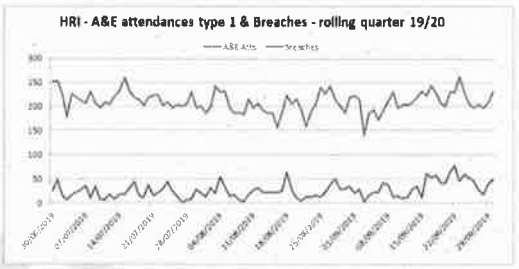




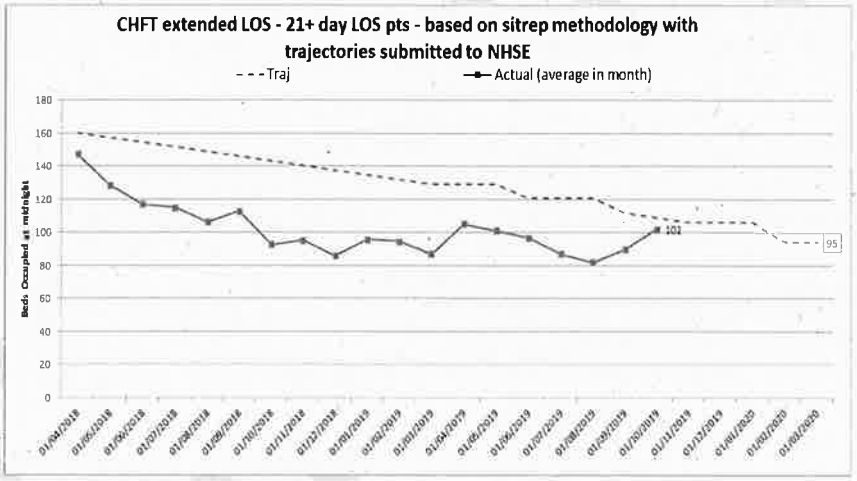




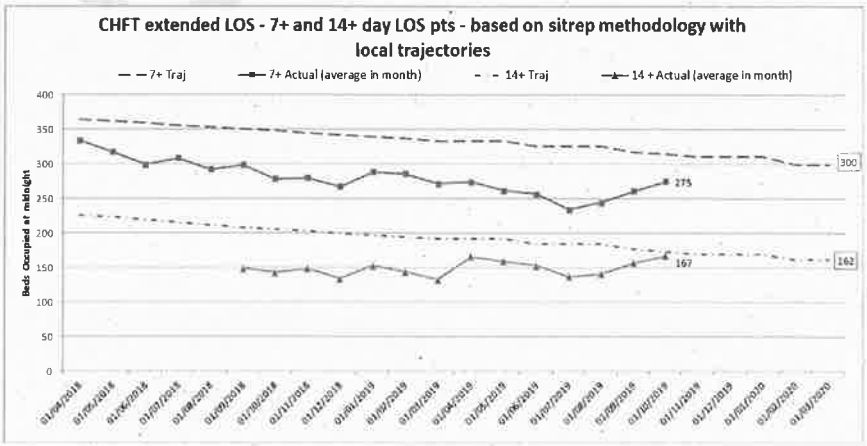




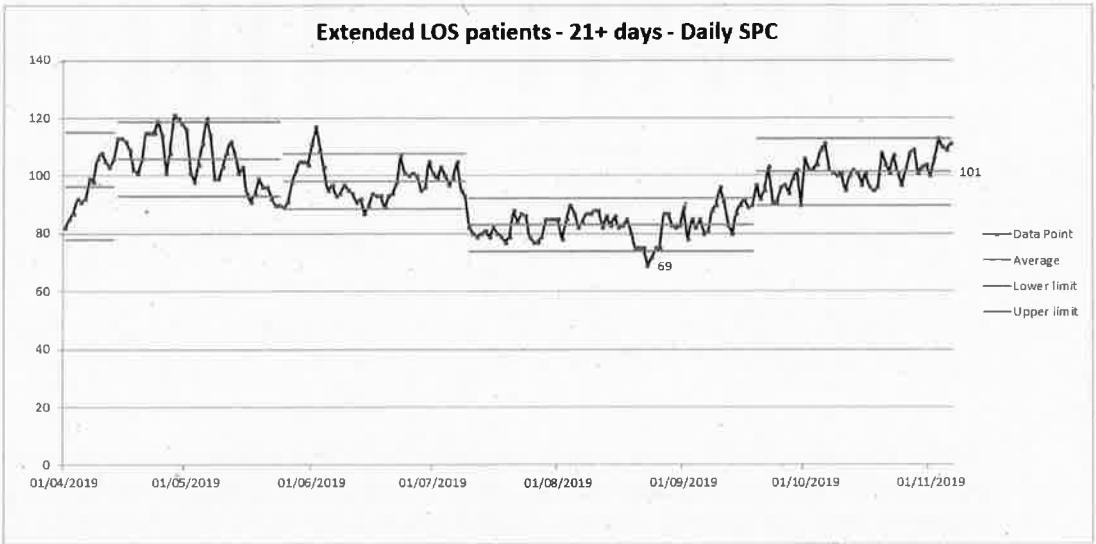
LOS of 21+ days, CHFT are currently below the trajectory and on track to achieve the required 42% reduction by March 2020 which equates to 95 patients. The latest monthly report showed 102 patients. There has been a rise in the last 3 months and if this continues next month CHFT will be above the trajectory.



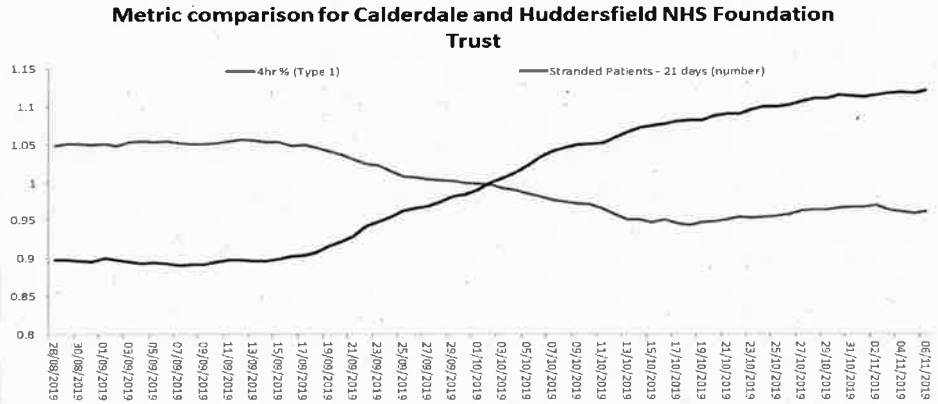
LOS of 7+ and 14+ are local targets but may become national next year. The 14+ day is very close to the target. There has been on overall increase seen recently in the long length of stay patients.



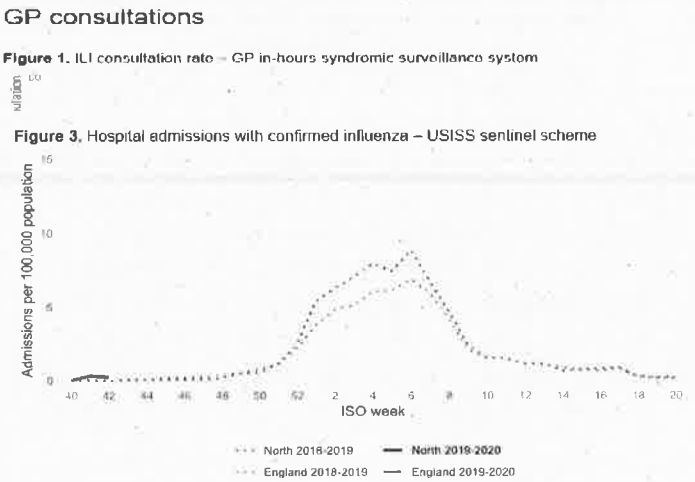
This was further broken down to daily variation of long length of stay patients. In mid-September as A&E performance has decreased, the extended length of stay patients has increased. Latest figures show there are 109 patients who have been in for 21 days or more. At the end of August there was a record low of 69 patients recorded.



The below table illustrates the direct correlation between decrease in A&E performance and increase in super stranded patients;



MB then provided an update on flu across Y&H. We are currently in week 42 and there are low GP consultation rates and hospital admissions. This is expected to increase.

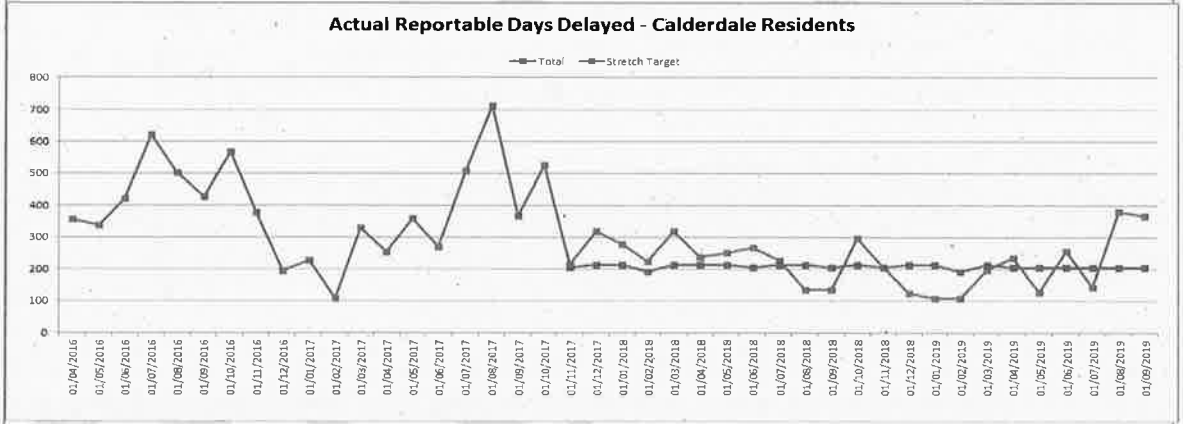


The Board discussed the importance of ensuring the staff in our system are immunised for flu as part of our preparations for winter. The collection of staff flu immunisation uptake. Organisations were happy to share data, however it was recognised that for social care there is not systematic process, and they would need to find different ways to collect the information. Social care does not currently have data for care providers and nursing homes and it was agreed that they would explore opportunities to collect this.

Actions:
IB and AE to explore the collection of uptake data for their organisations
IB and AE to consider how it might be possible to collect staff flu uptake data from care homes and home care providers.
All members to share flu uptake figures for the Board's performance update – EK to action.

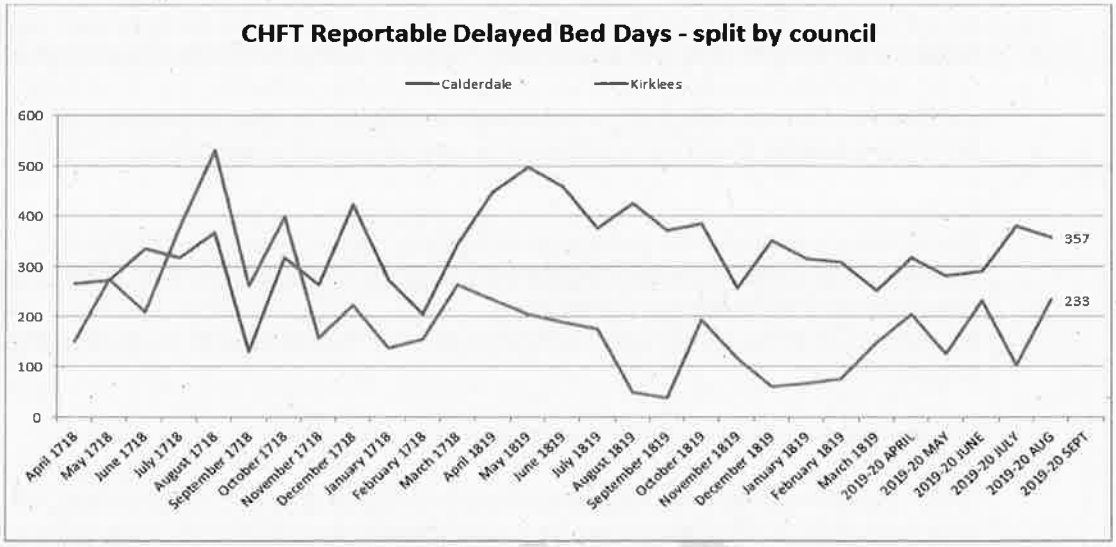
MB shared an overview of TOC performance;

CHFT reportable bed days have been split into Calderdale and Huddersfield; this is published data from Sept 2019. Calderdale, for a considerable length of time, have been under the BCF stretch target but in the last 2 months have become significantly over the target. The October position is looking similarly over target but this is invalidated data at present.

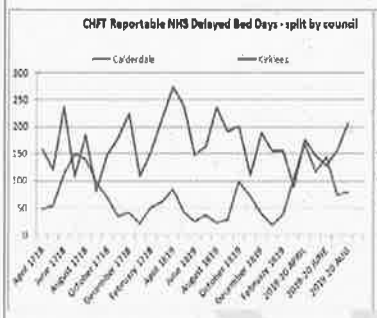


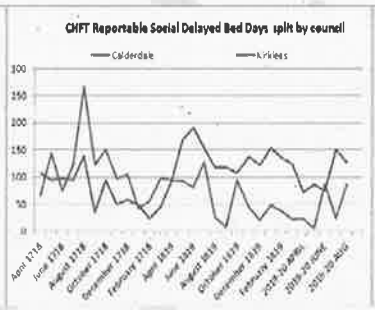
Kirklees position has seen a definite improvement from this time last year but has also been over target for the past 2 months (Kirklees data includes Mid Yorks).

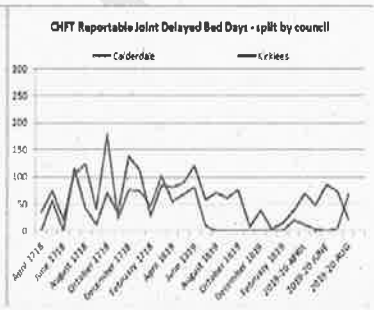
CHFT reportable delayed bed days have been split by local authority.



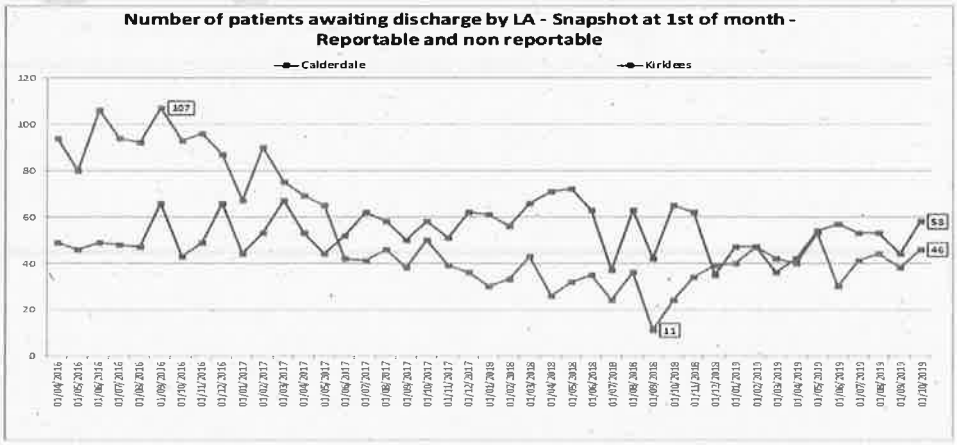
It was noted that Calderdale historically has been significantly below Kirklees for NHS attributed delays but in recent months they now have similar levels of delay.







CHFT reportable and non-reportable bed days split by local authority compiled of snap shots of patients on the DTOC list at the beginning of each month. Calderdale position in 2016 was high and then reached a record low in 2018. Recently the Calderdale position has increased. Kirklees DTOC positon has been the same over the last 3 years. Both local authorities are now at a similar overall DTOC positon.



MB is currently in talks with THIS who originally created the TOC dashboard. The dashboard at the moment is limited due to the recording the number of patients delayed and not the

days they have been delayed for. This would mean that an extra field would need to be filled out by clinical staff. HB agreed that CHFT support this.

Action
MB to liaise with BW (not present at meeting) regarding clinical staff completing an extra field o for DTOC dashboard (days patient delayed).
MB to then confirm the addition of the new data field in the new system and agree a timeline for implementation

MW summarised the degree of pressure within the system, and reflected that from the conversation today, it is clear that there is a very clear understanding what the pressures are and why they have occurred. The main change in performance relates to the deterioration of Calderdale position, however it was reflected that the Calderdale performance is now more on a par with Kirklees

b) JP and DG provided a system update and de-brief from this month's escalation process;

JP provided a system update for October. This included the system escalation to OPEL 3 on October 8th and the 7 subsequent Silver calls. Other organisations have also been in internal escalation measures and there are multiple system calls happening each week across Calderdale and Kirklees.

JP provided a further update on activities that have taken place regarding winter since the previous board. JP also gave an update on the activities planned for the coming month.

DG informed the board on the key themes and actions that have arisen from the reinstated Calderdale MADE twice weekly MADE calls;

- HAT assessment capacity reduced due to non-recurrent funding to posts from IBCF
- A move to exclusion criteria and discharge to assess for Intermediate Care Beds rather than current inclusion criteria
- Review being undertaken of home based reablement through Independent Living Model. This has shown that pathways are currently quite confused and complex
- Stroke pathway patients are some of the longest LOS. There is an opportunity for this to be part of the ILM
- CHFT staff value the role of the Home Care Liaison service at HRI as it creates a link with care providers and stimulates the trusted assessor role. There is work ongoing to mirror this in Calderdale within the skills existing in QUEST team
- There are issues that need amending in the non-weight bearing pathway.
- There is a recommendation during winter to reinstate the DTOC meeting

HB confirmed that due to internal pressures, CHFT held an extra-ordinary Executive Board to confirm a clear set of internal activities to recover performance. This plan has been deliberately created so the whole CHFT organisation takes responsibility. This includes refreshing the approach to triggers and tolerances. There has also been a high turnover of nursing staff in ED which has created an more inexperienced workforce, and CHFT are creating coaching opportunities for newer staff. HB highlighted the good work ongoing within frailty which turns around 40% patients each month.

Actions –
Calderdale to use twice weekly MADE meetings to take forward the actions identified and agree a view on an improvement trajectory which will be shared at December meeting – IB
To arrange the Calderdale DTOC meeting; DG/HW
AE/JP to consider how to feed into the Calderdale DTOC meeting Greater

	Huddersfield actions from the Kirklees DTOC meeting **Review learning from this winter and horizon scan and plan for next winter in May/June/July 2020 – EA for workplan** The group discussed the 5% increase in attendances. The UEC SRG work streams will be addressing this as part of their work. **Actions:** **UC SRG update at next meeting; HB/DG** **EK to invite communications colleagues to board meetings for the rest of winter** **AE to present Home First proposal and admission avoidance once it has gone through local governance processes, date to be confirmed**
4. Winter Planning	
Lead	
	(a) Adoption of System Winter Plan and Surge and Escalation Plan 2019/20 The Board discussed that through the review of partner surge and escalation plans the trigger numbers for OPEL. DG and JP are completing this work. **Action: DG and JP to review all organisations surge and escalation plans to ensure consistency. To also consider trigger numbers on the TOC list as part of this.** The chair asked members to ensure their system winter plan is being translated successfully in each organisation, and ensure clarity about response at different OPEL levels through surge and escalation plans. **Action: JP to ensure have received Kirklees surge and escalation plan** The board agreed that ED standards need to be included in the surge and escalation plans to ensure that all pressures are recognised, rather than just TOC data. The Board adopted the current Surge and Escalation Plan – acknowledging that this would be subject to change as the review of individual S&E plans progressed. Any refreshes will be brought back to A&E Delivery Board for agreement. The system is currently in OPEL 3 and plans show that there should be daily silver calls. This had been happening, but because of their regularity they have lost their impact, and are not currently happening. The Board agreed to have a weekly system call on Wednesday instead of daily silver calls to discuss the position of the system and discuss robust plans for the week ahead. on Wednesday 20th November. **Action: DG/JP to decide membership, agenda and information by COP Monday 18th for the first system call on 20th November** **a) Description on winter schemes in General practice and links to PCN development** FJ confirmed the 2 schemes currently being run in Calderdale practices. The first is a continuation of a scheme form last year to increase minimum capacity and ask for a minimum benchmark of 70,000 consultations which translates to 70% per 1000 patients. During winter there is a 5% increase. The second scheme is not live yet but is for networks to run an overflow hub for appointments to be held near the end of the day. 111 will be able to book into these appointments. It was not known for certain if LCD could book into this service **Action: FJ to confirm if LCD can book into the overflow hub appointments** **Action: HC to confirm within LCD if they can book into overflow hubs and if not help facilitate this**

	VD provided an update for Greater Huddersfield. All practices are being funded to achieve the requirement for extended core hours which are spread across the day. Extended hours are being provided by LCD for 1,000 registered patients have access to this. Hub and spoke model so that 100% of the registered population has access to everything even if only in limited practices. Extra sessions are on to make sure all bank holidays and weekends are covered. **b) Behaviour change campaign** DG confirmed that conversations have begun with Magpie for two potential CHFT footprint campaigns which will build on the 'week in the life of A&E' engagement work that took place in July. DG and HB will share the formal proposal with members at the next meeting. **Action: DG/HB share with board formal proposal from Magpie** **c) Letter from NHS Improvement and NHS England** The board discussed the winter letter circulated from Richard Barker, NHSE and NHSI, and a further letter from Rob Webster, WY HCP. The letter from Rob Webster requests 7 assurances from A&E Delivery Board chairs and a representative of each A&E Delivery Boards to attend the next SOAC meeting (22nd November). The return is requested for the 20th November. It was agreed the response can be signed off collectively at the system call on the 20th November. **Action: VD to speak to CMc about attending the SOAC meeting on behalf of C&GH A&E Delivery Board** **Action: DG to send out an email requesting information back to populate the stocktake and provide a briefing for CMc**
5. WY&H UEC Programme	
Lead	**DG**
	The Board discussed the WY&H UEC Programme, and the fact that the meeting is currently going through a review. An update will be provided of what this new format looks like at the next meeting. It will remain a standing item at the Board.
10. For information and AOB	
Lead	**MW**
	It was proposed to have a patient story or good news story at the beginning of each meeting. **Action: VD to share the template used for good news stories at the TCP board** Kirklees have a 7 night's crisis café over the Christmas period. The procurement has nearly finished for crisis helpline across Kirklees, Calderdale and Wakefield.
Next Meetings	10th December 2019, Shibden Room, Dean Clough, 12.30-14.00 14th January 2020, Shibden Room, Dean Clough, 12.30-14.00 11th February 2020, Shibden Room, Dean Clough, 12.30-14.00 11th March 2020, Shibden Room Dean Clough, 12.30-14.00

18. Date and time of next meeting

Thursday 5 March 2020, 9:00 am

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

To Note

Presented by Philip Lewer

Resolution

The Board resolves that representatives of the press and public be excluded from the meeting at this point on the grounds that the confidential nature of the business to be transacted means that publicity of the matters being reviewed would be prejudicial to public interest. (Section 1(2) Public Bodies (Admission to Meetings Act 1960).