Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 28 January 2016 from 1:30 pm

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital, Halifax HX3 0PW

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
001/16	**Welcome and introductions:** Rev Wayne Clarke, Publicly Elected Membership Councillor Mrs Dawn Stephenson, Nominated Stakeholder Membership Councillor	Chair	**VERBAL**	**Note**
002/16	**Apologies for absence:** Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities Dr David Anderson, Non-Executive Director Dr Linda Patterson, Non-Executive Director	Chair	**VERBAL**	**Note**
003/16	Declaration of interests	All	**VERBAL**	**Receive**
004/16	**Minutes of the previous meeting** held on 17 December 2015	Chair	**APP A**	**Approve**
005/16	**Matters arising and review of the Action Log** **a. Well Led Governance Review – Updated Action Plan**	Chair Company Secretary	**APP B** ***APP C***	**Review** **Approve**
006/16	**Staff Story** presented by Tracy Fennell, Associate Director of Nursing – Experiences of a new employee	Executive Director of Nursing		**Receive**
007/16	**Chairman's Report:** a. Update from MC Meeting – 19.1.16 b. Update from Nomination/Remuneration (BOD) Cttee held on 28.1.16	Chair	**VERBAL**	**Receive**
008/16	**Chief Executive's Report:**	Chief Executive	**ITEM 8** **CIRCULATED**	**Receive**

	a. Sustainability and Transformation Plan (STP)			
Transforming and improving patient care				
009/16	CCG Pre Consultation Business Case and Decision	Director of Transformation and Partnerships	**APP D**	**Approve**
010/16	Calderdale Support and Independence Teams Update	Director of Transformation and Partnerships	**APP E**	**Update**
P11/16	EPR Update – Gateway Report	Director of THIS	**APP F**	**Receive**
Keeping the base safe				
012/16	Risk Register	Executive Director of Nursing	**APP G**	**Approve**
013/16	Review of Progress Against Strategy	Director of Transformation and Partnerships	**APP H**	**Approve**
014/16	Equality and Diversity Report and Public Sector Equality Duty Compliance Evidence	Executive Director of Nursing	**APP I**	**Approve**
015/16	CQC Readiness Update	Executive Director of Nursing	**ITEM 15 CIRCULATED**	**Information**
016/16	Integrated Board Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Monitor Indicators - Finance	Chief Operating Officer “ Executive Director of Nursing Executive Director of Nursing Executive Medical Director Executive Director of Nursing Chief Operating Officers Executive Director of Finance Executive Director of Finance	**APP J**	**Approve**
Financial Sustainability				
017/16	Month 9 – December 2015 – Financial Narrative	Executive Director of Finance	**APP K**	**Approve**
A workforce for the future – no items				
018/16	**Update from sub-committees and receipt of minutes** ▪ Quality Committee – minutes of 15.12.15 and verbal update from meeting 26.1.16 ▪ Finance and Performance Committee – minutes of		**APP L**	**Receive**

	15.12.15 and verbal update from meeting 26.1.16 ▪ Remuneration and Nomination Committee (Membership Councillors) Minutes from meeting held 7.12.15 ▪ Audit and Risk Committee – verbal update from meeting 20.1.16		**VERBAL**	

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 17.12.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 17 December 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 17 December 2015.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 17 December 2015.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 17 12 15(2).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 17 December 2015 in the Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations/Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non Executive Director
Prof Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive

IN ATTENDANCE/OBSERVERS

Kathryn Aldous	General Manager – Operating Services, Pain Service and Critical Care (for part of meeting
Helen Barker	Interim Associate Director of Operations
Anna Basford	Director of Transformation and Partnerships
Jacqui Booth	Communications Officer
Kathy Bray	Board Secretary
Nick Lavigueur	Huddersfield Examiner Reporter
Maggie Metcalfe	Matron, Operating Services (for part of meeting)
Jackie Murphy	Acting Director of Health Informatics Service
Victoria Pickles	Company Secretary
Brian Richardson	Publicly Elected Membership Councillor
Kate Wileman	Publicly Elected Membership Councillor

Item

189/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Mandy Griffin	Director of the Health Informatics Service
Jeremy Pease	Non-Executive Director
Jan Wilson	Non-Executive Director

The Chairman welcomed everyone to the meeting.

190/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

191/15 MINUTES OF THE MEETING HELD ON THURSDAY 26 NOVEMBER 2015

The minutes of the meeting were approved as a true record.

192/15 MATTERS ARISING FROM THE MINUTES/ACTION LOG

a. NICE GUIDELINES – CANCER DRUGS - The Board noted the response received from the Commissioners which had previously been circulated to the Board.

"No-one likes having to ration, but we all accept that resources are finite. The NHS needs a body like NICE taking responsibility and issuing national advice in order to maintain some

consistency. They also apply a necessarily objective formula to these decisions in terms of QALYs. [Quality Adjusted Life years] *Without such discipline we can end up spending huge amounts of NHS money for very marginal gains."*

b. **161/15 – CARE OF THE ACUTELY ILL PATIENT – GO AND SEE VISIT TO TYNE & WEAR** – It was noted that arrangements had yet to be made between Prof. Roberts and the Medical Director to visit Tyne and Wear to obtain information around End of Life care.

ACTION: Executive Medical Director
OUTCOME: BoD Action Log

c. 165/15 – INTEGRATED BOARD REPORT (IBR) CONTENT – The Interim Associate Director of Operations and the Executive Director of Planning, Performance, Estates and Facilities (DPPEF) reported that they had met to discuss the level of detail required in the IBR to ensure that the Board receives information at the correct level from the various committees. It was suggested that a summarised version of the Integrated Board Report would be developed in the future and a more formal reporting back system from the various Board sub-committee Chairs put in place. This would allow the Board to be more forward focussed.

d. 182/15 – FEMALE GENITAL MUTILATION – Following Jan Wilson's request the previous month, the Executive Director of Nursing reported that the Safeguarding team would review and raise the profile of this metric. To date only one incident had been reported. It was suspected that this may be an area of under reporting.

e. 195/15 – GREEN CROSS PATIENTS – The Interim Associate Director of Operations reported that a 'deep dive' would be undertaken in the January 2016 Board report.

ACTION: Interim Associate Director of Operations
OUTCOME: Agenda item – BoD – January 2015

f. 183/15 – HARD TRUTHS – It was noted that, as suggested at the Board of Directors in November, the paper presented had now been submitted to the Commercial Investment and Strategy Committee and further information had been requested from them. This would be taken to the Executive Board for discussion in January 2016 prior to discussion at the Board of Directors.

ACTION: Action Log

193/15 PATIENT/STAFF STORY

Kathryn Aldous, General Manager, Operating Services, Pain Service and Critical Care and Maggie Metcalfe, Matron, Operating Theatres attended the meeting and gave a short presentation to the Board outlining the improvements made in pre-operative assessment. The presentation detailed a patient who had been affected due to a backlog in the pre-assessment process. The patient was invited to attend for surgery earlier than anticipated but had not had a pre-assessment undertaken. An appointment was made at short notice but the patient was concerned that they had not been given sufficient time to digest the information given and the patient refused to have the surgery. A meeting took place with the patient and carer and apologies were made by the Trust. A further pre-assessment was made and the operation went ahead successfully.

It was noted that improvements in the pre-operative assessment had now been made following additional recruitment and pathway redesign which had enabled the back-log to be managed and currently patients are seen within 1-2 weeks of referral. This patient story has been shared with staff and every effort was being made to ensure

that patients are given time to ask questions and digest information at pre-assessment appointments.

The Board thanked Kathryn and Maggie for the information and felt confident that staff were doing as much as possible to improve the patient journey. It was noted that cancellations are monitored every week, together with text messaging patients two days before surgery which would also assist with improving theatre utilisation which currently stands at 90%.

The improvement in the fractured neck of femur target within the Trust was noted.

194/15 CHAIR'S REPORT

a. NHS Providers – Chair/Chief Executive Meeting – 8.12.15

The Chair shared the discussion at the meeting on the 8 December led by Chris Hopson and the key themes were noted:-

1. Spending Review 2016/17 – challenging position noted.
2. Concern was expressed regarding the robustness of the CQC inspection assessments with the variable criteria of assessors.
3. Importance of data sharing arrangements and system leadership to provide influence.
4. Lord Carter presentation received. Report expected in January regarding Acute Hospital work.

b. Board to Board with South West Yorkshire Partnership NHS Foundation Trust – 9.12.15

The Chair reported on the key themes discussed at the meeting on the 9 December:-

1. Shared strategic plans from both Trusts
2. Vanguard bids
3. CQC inspections
4. Psychiatric Liaison Services
5. High intensity users.
6. Improvements in communications around shared services
7. Sharing intelligence.

c. Right Care Joint Stakeholder Event – 10.12.15

The Chair reported that the event had been arranged to mark the end of the engagement phase. The event had been well attended with good debate and acceptance that change was required, together with an acknowledgement of the amount of engagement work which has been undertaken over the last few years by the CCGs and the Trust.

195/15 CHIEF EXECUTIVE'S REPORT

The Chief Executive wished to thank staff and volunteers for their hard work undertaken during the year and asked for continued support as we move into the winter period.

The Chair reported that he had attended the Volunteer/League of Friends Christmas celebrations on both sites and had thanked the Trust's 450 volunteers, emphasising that the hospital could not run as efficiently as it did without their continued help and support.

196/15 RISK REGISTER

The Executive Director of Nursing and Operations reported that the top risks (scored 15+) within the organisation remained the same as the previous month with the inclusion of a revised Electronic Patient Record risk. The **top risks** were:-

- Progression of service reconfiguration impact on quality and safety

- Over-reliance on middle grades in A&E
- Failure to meet cost improvement programmes
- Outlier on mortality levels
- Staffing risk, nursing and medical
- Ability to deliver service transformation
- Delivery of Electronic Patient Record Programme

Risks with increased score:-

- No risks had increased score over the previous month.

Risks with reduced score:-

- No risks had reduced in score over the previous month.

New risk added:-

The following new risks have been added to the Corporate Risk Register in December 2015.

- Delivery of Electronic Patient Record (EPR) Programme, risk score of 20
- Clinical administration workforce, risk score of 15

Prof. Roberts expressed concern regarding the number of risks which had remained static. The Executive Director of Nursing reported that a deep dive is undertaken every 6 months. It was suggested that a workshop might be arranged involving interested parties to review the Risk Register in the future.

The Chief Executive stressed the importance of supplying the Board with updates to the Register on a regular basis and where possible including real time reviews.

ACTION: Executive Director of Nursing.
OUTCOME: The Board received and approved the Risk Register report.

197/15 NURSING REVALIDATION

The Executive Director of Nursing thanked Jackie Murphy for preparing the update for the Board. Jackie outlined the work which had been undertaken to help staff prepare for the revalidation process and every effort was being made to get the message out to staff to encourage them to ask for assistance if needed. A number of nursing staff events had been held and a buddying system was being looked at. The risks to retention were noted, particularly from nurse bank and retirement age nurses.

It was noted that this process was dependent on appraisals being completed as this would help with the continuous development and on-going learning and improvement in performance of all staff.

OUTCOME: The Board supported the revalidation process to ensure there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training to be assured that nurses and midwives remain fit for practise.
The Board was reminded of the additional time commitment and noted the retention risk associated with revalidation.

198/15 GOVERNANCE REPORT

The Company Secretary presented the Governance Report which brought together a number of governance items for review and approval by the Board:

a. Attendance at Board of Director Meetings

The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors.' All present were asked to check the accuracy of the register which would be published in the Annual Report at year-end.

OUTCOME: The Board NOTED the attendance register.

b. Q2 2015-16 submission feedback from Monitor

The Trust had received feedback from Monitor in relation to the Q2 15/16 submission on 15 September 2015. Clarification was sought regarding the discrepancy between the Trust's agreed calculation of the FRR and that reported in their letter. The Company Secretary had confirmed with Monitor that an error had been made and the Trust's FRR was level 2 as submitted.

OUTCOME: The Board NOTED the clarified information.

c. Board Appointments Update

At the September Nominations and Remuneration (Board of Directors) Committee it was agreed to recruit to the position of Chief Operating Officer. Helen Barker had been the successful candidate and would take up post with effect from 1 January 2016.

It was noted that the Nominations and Remuneration (Membership Council) Committee had met on 7 December 2015 and agreed the recruitment of two Non-Executive Directors. They had supported the recommendation that candidates be sought with experience of the commercial sector or HR / workforce. The advertisement for these posts was placed on 8 December with a closing date of Wednesday 13 January 2016. Interviews were scheduled for week commencing 15 February 2016.

OUTCOME: The Board NOTED the progress in appointments to the Board of Directors.

d. Board Workplan

The Company Secretary advised that the Board work plan had been updated and was presented to the Board for review and inclusion.

OUTCOME: The Board CONSIDERED the items allocated for the January meeting were correct and agreed three additions:-

a. CQC Readiness Paper – to be added in January/February 2016.

ACTION: Executive Director of Nursing

b. Risk and Compliance Group Minutes – to be added to the workplan for the Board to receive on a regular basis.

ACTION: Company Secretary

c. Urgent Care Board Highlight Report – Arrangements to be made for SRG Minutes to be circulated in addition to UCB Highlight Reports.

ACTION: Interim Associate Director of Operations

e. Use of Trust Seal

It was noted that five documents have been sealed since the last report to the Board. These were in relation to:

- The refurbishment of the Child Development Unit at Calderdale Royal into the new Rainbow Unit (2 documents)
- Building works in relation to key fob changes at Calderdale
- The deed for St Luke's Hospital between Pennine Property Partnerships, Kirklees Council and the Trust
- A licence for Dental Care Direct to occupy rooms at Huddersfield Royal Infirmary.

OUTCOME: The Board RATIFIED the sealings.

f. Calderdale Artefacts

The Company Secretary reminded the Board that the Trust holds a number of artefacts that were kept following the closure of the Halifax Royal infirmary. The Trust had been approached a number of years ago by the Halifax Royal Infirmary Hospital Management Company and the Halifax Civic Trust to request that the artefacts be held and displayed within the old building (now apartments) given their historical significance to that property.

There had been significant work since this time to locate and itemise the artefacts which include paintings, plaques, and a number of small trophies. A full itemised list of the items was available for the Board to review. Following several discussions and legal advice, it was recommended that, subject to a final valuation report, the items be transferred to the management company under an exhibition agreement. A copy of this agreement was available for review by Board members if required.

While they remain the property of the Trust, this agreement will enable the management company to display and archive the artefacts. Further work will then be undertaken to look at the possibility of giving the artefacts to the management company. There were three items which reference existing organisations in Halifax:
- The Queens Club Cup
- The Halifax Infirmary Football Cup
- Lister Horsfall Cricket Trophy

It was proposed and agreed that these organisations be approached separately to see if they would like to receive these items under the same terms.

The items will be insured by the management company while in their possession. The Company Secretary had reviewed the proposed locations for display and storage of the items to ensure that these were secure.

OUTCOME: The Board APPROVED the proposal in relation to the Calderdale artefacts.

199/15 CARE OF THE ACUTELY ILL PATIENT REPORT

The Executive Medical Director highlighted the key issues from the report:-

- **HSMR** – The most recent published rolling 12 months data for HSMR, Sept 2014 to August 2015, indicates a score of 116.44, showing no significant change since the previous release.
- **SHMI** – The most recent published SHMI was released in October, and shows a slight decrease from 109.3 to 108.9
- **Crude Mortality** - Overall the latest current rolling 12 month mortality rate (Dec 2014 – Nov 2015) is higher than the same time period last year.

The Executive Medical Director updated the Board on the quality of care work and mortality reviews undertaken. Capacity issues had been acknowledged and appointments had now been made to clinical roles to help with the mortality review process. The Board's attention was drawn to the key issues from the report:-

- HSMR and SHMI remain higher than target, with no reduction expected in the near future.
- Actions following on from the work of Professor Mohammed in conjunction with the Improvement Academy were noted.
- The mortality review process is resulting in a consistent number of reviews being done each month but this is not at yet sustainable at the 100% level that the trust is aspiring to.

- Recruitment of consultant colleagues allocated time specifically for coding and mortality reviews.
- Clinical Coding support into the upper gastrointestinal team.
- A regular monthly report of findings is in place, scheduled for Clinical Effectiveness and Audit Mortality (CEAM) and Clinical Outcomes Group (COG).
- There will be a focus on learning from the review findings, and implementing targeted actions to make improvements
- New Bundle process to be tested in January 2016
- Clinical Leadership Fellow will commence her role in December to examine the e-handover and Hospital @ Night model locally
- DNACPR compliance continues to improve.

OUTCOME: The Board NOTED the contents of the Care of the Acutely Ill Patient Report.

200/15 MEDICAL REVALUATION

The Executive Medical Director presented the Medical Revalidation Report which updated the Board on the progress of the Trust towards the management of medical appraisal and revalidation in 2015/16 to comply with the GMC requirements regarding medical appraisal and revalidation of medical staff. The paper outlined the action plan to improve the current processes in place and the value of revalidation and appraisal.

Discussion took place regarding the medical staff appraisal compliance which currently stood at 43.5% and it was expected to achieve over 85% by year end. Work was ongoing to spread the appraisals throughout the year i.e. to coincide with the month of the member of staff's date of birth. The allocation of appraisers to appraisees for medical staff was being considered to make the process smoother.

OUTCOME: The Board received and noted the progress to date.

201/15 AGENCY CAP/SPEND

The Executive Medical Director reported that a new process had been put in place across nursing, admin and clinical but it was expected that medical and nursing agency staffing would exceed the cap specified by Monitor. It was noted that the new process put in place required Director on call sign off of arrangements before employing bank/agency staff.

OUTCOME: The Board noted the work being undertaken to reduce the Agency Spend.

202/15 INTEGRATED BOARD REPORT

The Interim Associate Director of Operations apologised that it had not been possible to circulate the report with the papers due to the cut-off date for the data. She introduced the Integrated Board Report as at 30 November 2015 and explained that key areas would be presented in detail by the appropriate Executive leads.

Key issues arising from the report were:

Responsive

- Emergency Care Standard failed the month but quarter still green and plans in place to manage the peak pressure points between Xmas and mid-January
- Day 38 cancer performance and 62day screening performance deteriorated
- Delayed transfer of care continues to deliver better than 5%
- Stroke performance failed in 2 of the 3 metrics
- RTT performance remains green

Caring

- Complaints responded to within target deteriorated in month

- Friends and Family inpatients who would recommend continues at above 96%
- Real Time Monitoring - previously undertaken by Membership Council Members had ceased due to Family & Friends Test. It was agreed that RTM would be revisited in the future by the Patient Experience Group.

ACTION: Executive Director of Nursing

Safety

- C-section rates improved slightly
- Pressure Ulcers remains a concern with numbers remaining high. It was noted that further work has been undertaken through a study group and RCAs. Dr Linda Patterson reported that further improvement guidance was being issued and the Executive Director of Nursing agreed that she would check out compliance and likely impact for the future.

ACTION: Executive Director of Nursing

Effectiveness

- C Difficile improvement noted
- HSMR remain high
- Fractured neck of femur, access to theatre within 36hours continues to improve
- Readmission rates are better than target

Well led

- Staff in post and FTE is static
- Over 91% of colleagues have now started their mandatory training programme.
- Appraisal activity plans are in place with divisions now RAG rated against these plans.
- Sickness has increased in 5 of the 7 service areas reported and 7 out of 8 staff categories with overall % sickness at its highest point in current service year.

  The Chief Executive asked whether revalidation of the Sickness Policy had been included in the Board of Directors Workplan. It was agreed that this should come back to the Board at the End of March 2016.

ACTION: EXECUTIVE DIRECTOR OF NURSING/ACTION LOG

It was noted that work had commenced on the Performance Management and Accountability Framework agreed at November Board meeting.

OUTCOME: The Board received and approved the contents of the Integrated Board Report.

203/15 MONTH 8 – NOVEMBER 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 8 report (including the contents of the Integrated Board Report). It was noted that this information had been discussed in detail at the Finance and Performance Committee held on the 15 December 2015:-

The key issues included:-

Summary Year to Date:

- The year-to-date deficit (excluding restructuring costs) is £14.24m versus a planned deficit of £12.89m
- The overall deficit is £14.89m against a planned £15.89m, due to restructuring costs not being incurred.
- Daycase activity continued to fall behind planned levels but this was offset in month by improved levels of outpatient activity.

- High pay expenditure including significant levels of agency expenditure, some of which is above the Monitor price cap.
- Capital expenditure year to date is £12.62m against the planned £15.60m due to timing differences mainly on IT spend
- Cash balance is £10.38m against a planned £1.94m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £10.90m in the year to date against a planned target of £8.24m
- The new Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

Summary forecast:

- The forecast year-end deficit (excluding restructuring costs) is £20.82m against a planned £20.01m, an adverse variance of £0.81m. This position includes full release of remaining contingency reserves and delivery of £17.76m CIP against the original planned £14m
- Whilst this is a slight improvement on the £20.93m deficit (excluding restructuring) reforecast plan submitted to Monitor in Month 7, risks remain against the settlement of commissioner contracts and winter expenditure pressures.
- The overall forecast deficit position shows a favourable variance of £1.09m from plan due to a reduction in forecast restructuring costs of £1.9m. This is not a reflection of the trading position but does bring the reliance on external cash support down from £14.90m to £13.90m.
- Year-end capital expenditure is forecast to be £20.92m. The year end FSRR is forecast to be at level 2.

OUTCOME: The Board received and approved the financial narrative for November 2015.

204/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received and noted the minutes from the meeting held on 24 November 2015 and in Jeremy Pease's absence received a verbal update from the Executive Director of Nursing from the meeting held on 15.12.15.

  Matters arising from the meeting not already discussed at the Board meeting included:-
  - NICE Guidance – non-compliance. It was noted that further work was required on the revised guidance. The would be reported back to the next meeting and if necessary an entry would be put on the Risk Register on any areas of noncompliance
  - CQC Monthly Assessment – risks were being reviewed and the key risks would be identified.
  - Serious Incidents – discussion about whether an investigation team should be set up was on going.
  - Quality Strategy Workshop – had taken place and feedback from this would be built into the development of the Quality Strategy.
  - Mixed Sex Accommodation breaches – two breaches had been reported but unfortunately these had not been included in the November 2015 Integrated Board Report.

- **Finance and Performance Committee** - The Board received the minutes of the 17.11.15 and a verbal update from Phil Oldfield on the meeting held 15.12.15.

The main issues discussed at the Committee included:-

- Performance was on track but conscious of winter period approaching
- 2016/17 budget – likely to be February before able to fully update the Board on the budget.
- F&P had agreed to triangulate information from performance, finance and workforce.
- Update received on Carter Report
- Update received on Agency Spend/Cap.
- CIP looking ahead to 2016/17 - £4m schemes – confidently been through gateway process.
- CNST premiums – review of scope for negotiation against peer groups. This would be fed into the Quality Committee.
- Theatre Productivity – more work being undertaken on restrictions and impact.
- F&P risks from BAF – more information to next meeting to help and justify moves in scores.

The Chairman thanked everyone for their attendance and contributions.

205/15 DATE AND TIME OF NEXT MEETING

Thursday 28 January 2016 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW

The Chairman closed the meeting at 3.30 pm.

APPENDIX B

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS ACTION LOG AS AT 1.1.16 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 January 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 January 2016

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 January 2016

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 1 JANUARY 2016.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
29.10.15	**CAIP/MORTALITY REVIEWS** The Executive Medical Director reported that Brian Fill and Professor Mohamed from Bradford University were working within the Trust to review the Trust's data and this would be brought back to the Board at a future date.	Executive Medical Director	**26.11.15** DB to contact Prof. Mohammed with a view to him presenting to the Board again on his return from leave in the New Year.	TBC ?Feb 2016		
29.9.15	**NURSING & MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT – WORKFORCE MODELS** Update received. Agreed a further paper be presented to the Board in November 2015 which will recommend any adjustment to Nursing and Midwifery workforce models.	Executive Director of Nursing	**26.11.15** Paper to be submitted to Commercial Investment and Strategy Committee and summary then provided to Board re. size of investment and how it is structured. **17.12.15** The paper presented had now been submitted to the Commercial Investment and Strategy Committee and further information had been requested from them. This would be taken to the Executive Board for discussion in January 2016 prior to discussion at the Board of Directors.	?Feb 2016		
29.10.15 (161/15)	**CARE OF THE ACUTELY ILL PATIENT** Consideration to be given to a 'go-see' in Tyne and Wear	Executive Medical Director / PR	Liaison through Prof. Roberts and DB to visit – update to December 2015 Board. **17.12.15** It was noted that arrangements had yet to be made between Prof. Roberts and the Medical Director to visit Tyne and Wear to obtain information around End of Life care.	?Feb 2016		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
29.10.15 (165/15)	**INTEGRATED BOARD REPORT** Review to take place on how information is presented and summarised	Chair / Interim Associate Director of Operations / Company Secretary	**17.12.15** The Associate Associate Director of Community Services and Operations and the Executive Director of Planning, Performance, Estates and Facilities (DPPEF) reported that they had met to discuss the level of detail required in the IBR to ensure that the Board receives information at the correct level from the various committees. It was suggested that a summarised version of the Integrated Board Report would be developed in the future and a more formal reporting back system from the various Board sub-committee Chairs put in place. This would allow the Board to be more forward focussed going forward.	26.5.16		
26.11.15 (177.15)	**BOARD ASSURANCE FRAMEWORK – WINTER RESILIENCE** Reference to Winter Resilience in Risk Register to be recorded to create an overarching statement in BAF,	VP		25.2.16		
26.11.15 (177.15)	**BOARD ASSURANCE FRAMEWORK – MORTALITY** Following changed position in the Trust, rewording of Mortality section of BAF to be undertaken before its next update.	DB		25.2.16		
26.11.15 (178/15)	**RISK REGISTER – TRANSFER OF SERVICES** Agreed that financial and service risks would be clarified on	HB		28.1.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	the Risk Register					
26.11.15 (179/15)	**WELL LED GOVERNANCE REVIEW** Milestones to be built in against each action	JD/VP		28.1.16		
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) – TROLLEY WAITS** Over 4 hour trolley waits to be included	HB		25.2.16		
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	HB		25.2.16		
26.11.15 (182/15)	**SAFEGUARDING REPORT** Agreed to investigate whether there were any concerns regarding Female Genital Mutilation.	JD	**17.12.15** Following Jan Wilson's request the previous month, the Executive Director of Nursing reported that the Safeguarding team would review and raise the profile of this metric. To date only one incident had been reported. It was suspected that this may be area of under reporting.			
26.11.15 (185/15)	**INTEGRATED BOARD REPORT – DAILY DISCHARGES** Below target – further work on going with 4 Eyes and a detailed report to be provided to December BOD Meeting	HB				
26.11.15 (185/15)	**INTEGRATED BOARD REPORT – GREEN CROSS PATIENTS** Further assurance about direction of discharges to be	HB	**17.12.15** The Associate Director of Community Services and	28.1.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	provided to December BOD Meeting		Operations reported that a 'deep dive' would be undertaken in the January 2016 Board report, taking up comments from Linda Patterson and Jeremy Pease.			
199/15d 17.12.15	**ITEMS FOR BOARD WORKPLAN** **CQC Readiness Update**		**17.12.15** Agreed to be added to Workplan for Jan 2016	Jan 2016		
202/15 17.12.15	**IBR – WELL LED – Sickness Policy** The Chief Executive asked whether revalidation of the Sickness Policy had been included in the BoD Workplan. It was agreed that this should come back to the Board at the End of March 2016.			31.3.16		

APPENDIX C

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

PAPER TITLE: MATTERS ARISING – WELL LED GOVERNANCE REVIEW ACTION PLAN	**REPORTING AUTHOR:** VICTORIA PICKLES, COMPANY SECRETARY
DATE OF MEETING: 28 JANUARY 2015	**SPONSORING DIRECTOR: JULIE DAWES, DIRECTOR OF NURSING**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note

PREVIOUS FORUMS: BOARD OF DIRECTORS – November 2015

EXECUTIVE SUMMARY:

The final version of the Well Led Governance Review action plan was approved by the Board at its meeting in August. It was agreed to receive quarterly updates on progress against the actions. This is the second of those progress reports which shows significant progress from the version presented to the Board in November.

There are three areas where additional work is required:

- Risk management. Additional capacity to work with divisions on the quality of risk registers and embedding the risk culture.
- Clinical leadership. Finalising the structure and the development arrangements.
- Board development. Following appointment of the new Non-Executive Director posts, the development plan will be reviewed to ensure it meets the needs of all board members.

Monitor are also providing oversight of the Trust's implementation of its action plan through the monthly Progress Review Meetings and a copy of this report will be sent to them following this Board meeting.

FINANCIAL IMPLICATIONS OF THIS REPORT:
There are no specific implications as the actions have been captured within the divisional work streams.

RECOMMENDATION:

The Board is asked to review and comment on the progress against the Well Led Governance Review actions.

APPENDIX ATTACHED: YES ~~/ NO~~

WELL LED GOVERNANCE REVIEW ACTION PLAN	
Date	**November 2015**
Lead Manager	**Victoria Pickles, Company Secretary**
Lead Director	**Julie Dawes, Deputy Chief Executive**
Monitoring Committee	**Board of Directors**
Date signed off as complete	

REF	ACTION	LEAD	DEADLINE	PROGRESS
1	**Audit Committee** The private session of the Audit Committee should not include members of management, including the Director of Finance.	Chair of the ARC / Company Secretary	Immediate	Private session built into work plan for the Committee First two meetings held.
2	**Accountability framework** The Trust should consider the introduction of a more formal accountability framework as an enabler to performance management and operational delivery. This internal contractual agreement between the Trust Board, divisions and directorates should be used as a basis to define an appropriate level of devolution across the Trust.	Chief Operating Officer	1-3 months	The Performance Management Framework has been approved. This will now be used to form the basis of key performance indicators which will be used through the performance meetings to ensure accountability is clear from ward to board.
3	**Capacity** The Trust must assess and reflect on the capacity of the Board and staff at all levels to deliver operational improvement and future strategic priorities, and therefore the resilience of the organisation and individuals.	Chief Executive	1-3 months	Posts agreed through Nomination and Remuneration Committees Recruitment process for Chief Operating Officer is complete. Longlisting for the NED posts complete. Shortlisting to take place w/c 8 Feb with interviews on 19 February 2016

4	**Turnaround Executive** The Trust should seek to adopt and adapt the lessons learnt from the Turnaround Executive structure within divisions and consider how this process, developed during turnaround, could be adapted to strengthen performance management more generally (that is, not just to facilitate CIP delivery), allowing the Trust to meet the ongoing challenges that it will face.	Chief Executive	1-3 months	Lessons from the Turnaround Executive process have been built into divisional performance reporting arrangements and linked to the Performance Accountability Framework
5	**Divisional risk management** The Trust should undertake an in depth review of risk management, incident reporting and escalation in the divisions to ensure that these processes are robust and aligned to the Trust's strategic priorities (see also actions 12 & 14).	Executive Director of Nursing	1-3 months	Revised Incident and Serious Incident reporting policy and revised Risk Management Policy clearly setting out the responsibilities within Divisions. Terms of reference for PSQBs revised to ensure clear review and assessment of risks and incidents. Investigation lead and team being appointed. Tighter serious incident panel process implemented. Divisional Risk Registers have been reviewed. Additionally work on completion of Risk Registers and Risk Management. Additional external resource being utilised to continue to strengthen the risk capability.
6	**Clinical Leadership** The Trust should evaluate the current clinical leadership models as a means of strengthening leadership roles. The Trust should build on the leadership training provided to clinicians by clearly defining the job description and responsibilities of Divisional and Clinical Directors, and ensuring that there is sufficient ring-fenced time in their roles for this to be completed. There are several well established models of medical leadership that may provide further insight, for example, the Clinical Leadership Model developed at University Hospital of South Manchester NHS Foundation Trust.	Medical Director / Chief Operating Officer	1-3 months	Workshop undertaken with Divisions to describe divisional structure and role description for Clinical Director in place including appropriate time for responsibilities set out in the role description. Options developed for structure of role to be discussed at WEB. Support programme to be put in place building on existing clinical leadership training and development.

7	**Board challenge** Board debate and challenge could be enhanced by ensuring that all aspects of issues are considered, and that the debate "closes the loop" by identifying the actions to be taken, their expected impact, how this will be measured and under what timeframe.	Chairman /Company Secretary	1-3 months	Externally facilitated workshop held with Non-Executives. Development programme for both Non Executives and Executives in place. Will be refreshed following the new appointments.
8	**Board reporting** The Board needs to be assured that the Trust is delivering its strategic priorities. Information presented to the Board should be integrated and triangulated to enable to the Board to make efficient judgements as to whether strategic and operational objectives are being achieved as expected. The Board should receive intelligence distilled from a more detailed review at the sub-committees.	Chairman / Chief Operating Officer	1-3 months	Quarterly report to Board on progress against strategic priorities. Integrated Board Report and key strategic risks reviewed at each of the sub-committees. Cycle of more detailed reporting on major programmes of work has been built into the Board work plan. Already looked at EPR and mortality.
9	**Data and data quality** Further development of the data quality kite mark will allow Board members to gain assurance over the reliability of each measure and could provide greater assurance that there are no unknown data quality issues. The Board should consider how the skills within the Trust (in particular, within the Health Informatics Service) could be leveraged to take a more transformation approach to data and data quality, and should consider the development of an information strategy to achieve this.	Chief Operating Officer	1-3 months	Data quality assessment included in the Integrated Board Report. Internal audits being undertaken around specific indicators. Data quality requirements being considered as part of implementation of the EPR
10	**Executive Portfolios** To address a perceived lack of clarity over responsibility for planning, and to more closely align structures and processes relating to planning, the Trust should ensure that the responsibility and oversight for planning is clearly defined in Executive portfolios.	Chief Executive	1-3 months	Chief Operating Officer recruited to. Planning agreed within portfolios. Annual planning – LH; Strategic planning - AB
11	**Development of the strategy** The Trust should formalise the process for refreshing the strategy annually, ensuring involvement with external stakeholders, staff, patients and the wider public.	Chief Executive	1-3 months	Completed as part of development of 5 Year Strategic Plan

12	**Risk and safety culture** The Trust should continue its focus on improving its risk management and safety culture. This could include applying the "go see" methodology by observing an organisation with a strong risk management and safety culture. For example, Mid Cheshire Hospitals NHS Foundation Trust was the highest acute trust nationally for "Fairness and effectiveness of incident reporting procedures" in the 2014 staff survey. Salford Royal NHS Foundation Trust achieved outstanding for the well-led domain in a recent CQC inspection; risk management culture and processes were praised in a number of divisions by the CQC (link to actions 5 & 14)	Director of Nursing	1-3 months	Support in place working with divisions to improve their risk registers with experience in other trusts. Newly recruited Assistant Director of Nursing for Medicine brings experience from one of the recommended Trusts to be shared.
13	**Lessons learnt** The Trust should review the processes in place for sharing issues, lessons learnt and good practice between teams and consider whether further mechanisms at ward and service level might be required.	Director of Nursing	1-3 months	Learning lessons process reviewed and an internal audit completed setting out further actions to be undertaken. Investigation lead and small team to support divisions in conducting investigation to improve learning from incidents. Learning lessons bulletins in place.
14	**Divisional risk management** The Trust must strengthen risk management capability within the divisions as they are a foundation to manage and mitigate risk. The Trust should could consider using external support to engage with divisions to improve risk management culture, in the same way that this has been done at a Board level. (link to actions 5 & 12).	Director of Nursing	4-6 months	Capacity brought in to support divisions in improving quality reporting including risk management. Risk management training delivered across divisions.
15	**Board sub-committees** The ongoing development of the Board sub-committees should be continued. This should focus on the strength of challenge from all members and the presentation and use of information, to ensure that appropriate scrutiny is applied and that assurance can be given to the Trust Board.	Company Secretary	4-6 months	Self-assessment and review process tested with Audit and Risk Committee and built into work programme for all sub-committees. This includes an assessment of the information they receive and how this can be improved. Formal induction agreed for each sub-committee and checked with Internal Audit good practice

				Annual meeting of sub-committee chairs, led by Chair of Audit and Risk Committee diarised.
16	**Board awareness of data quality** As the Board development programme is refreshed, the Trust should consider the inclusion of data quality and interpreting information to inform judgments as a subject for Board training, to ensure that the Board are equipped to identify potential indicators of poor data quality and challenge these. (link to action 9)	Chairman /Company Secretary	4-6 months	Data quality mark added to Integrated Board Report. Data quality session built into the development plan for 2016/17 so can include new Non-executive directors
17	**Cultural barometer** The Board should seek assurance that the programme of work generated from the PwC review of quality of care in October 2014 is having the planned impact on the culture of care. The Trust should could consider the use of a cultural barometer or similar tool as a way of assessing this.	Director of Workforce & OD	4-6 months	Agreement reached at WEB that the Trust's Investor in People assessment would support this. Received a Bronze award.
18	**Multi-professional leadership** The Trust should consider how to ensure that all professions are included and represented in leadership across the Trust. This will be of particular importance as the service model of the Trust continues to develop.	Medical Director / Director of Nursing	4-6 months	Due to be completed by April. Revised multi-professional education structure reviewed at WEB to commence April 2016. Will sit alongside workforce and organisational development. Continue to access leadership programmes available at national and local level for individual members of staff.
19	**Community engagement** The Trust should consider the use of wider community networks to ensure that the diversity of the local population is reflected in its membership, Membership Council and Board.	Chairman	4-6 months	The approach has been built into the recently revised Membership Strategy and the Patient and Public Involvement Plan to ensure that community networks are engaged in the Trust and encouraged to become part of its membership.
20	**Board development** In recognition of recent Board changes, and the changing context the Trust operates in, the Trust should consider the Board and organisational development needs to ensure that leadership, the desired behaviour and delivery capacity is optimised. This should reflect lessons learnt from previous development programmes, and	Chairman /Company Secretary	6 -12 months	The capacity of the Board was assessed and is being addressed through the recruitment of the Chief Operating Officer and the additional Non-Executive Director post. Director of Workforce and OD post reviewed to ensure sufficient focus on

	how leadership can be enhanced at all levels in the Trust.			organisational development. Board development programme in place.
21	**Development of the strategy** Strategic development must include alignment of structures, processes and KPIs to the Trust's strategic priorities. The more robust planning process from 2015/16 should be embedded to ensure plans reflect capacity and workforce constraints, as well as the financial position.	Chief Executive	Ongoing	Planning process agreed as part of development of 5 Year Strategic Plan
22	**Communication of the strategy** The Board and those in leadership and managerial positions must consistently communicate strategic priorities to ensure the development and delivery of the operational plan.	Chief Executive	Ongoing	Strategic priorities built in to all communications channels including CHFT weekly; Big Brief. Re-instating CE blog.

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National ‘must dos’ for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine ‘must dos’ for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    - how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
    - their planned contribution to the efficiency savings;
    - their plans to deliver the key must-dos;
    - how quality and safety will be maintained and improved for patients;
    - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
    - how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    - greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    - closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    - faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

APPENDIX D

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CLINICAL COMMISSIONING GROUP - PRE CONSULTATION BUSINESS CASE AND DECISION - The Board is asked to note the publication of the CCG Pre Consultation Business Case and support the decision to proceed to public consultation.	
Action required: Approve	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Transforming and Improving Patient Care	
Sustainability Implications: None	

Executive Summary

Summary:

On Wednesday 20th January, the Governing Bodies of NHS Greater Huddersfield and NHS Calderdale Clinical Commissioining Groups took a decision to undertake public consultation on the future of hospital services.
The Board is asked to note the pre-consultation business case which can be accessed by the attached link http://www.calderdaleccg.nhs.uk/news/calderdale-ccg-and-greater-huddersfield-ccg-governing-bodies-meeting-20-january-2016/ and to support the CCGs in undertaking their consultation..

Main Body

Purpose:

The two local Clinical Commissioning Groups took their pre-consultation business case to a joint meeting in public on 20 January 2016.
The pre-consultation business case (PCBC) describes:
- The case for transforming health services in Calderdale and Greater Huddersfield.
- The Future Model of Care for Hospital Services and how it has been developed
- Details of the pre consultation engagement that has been undertaken with the public, clinicians, staff and other stakeholders in developing the Future Model of Care; and
- The case to commence public consultation on proposals for changes in the way hospital services in Calderdale and Greater Huddersfield are delivered.

A copy of the pre-consultation business case is available by copyig the link: http://www.calderdaleccg.nhs.uk/news/calderdale-ccg-and-greater-huddersfield-ccg-governing-bodies-meeting-20-january-2016/

At the meeting, they agreed that they were ready to commence full public consultation. The CCGs will now undertake at least a 12-week period of formal consultation beginning in early February.

The Trust will be asked to support the deilvery of this public consultation including the detailed scrutiny process which will be undertaken.

It is important that the public, our staff and other stakkeholders are given every possible opportunity to understand fully the clinical drivers behind the need to change, the reasons why Calderdale has been selected as the preferred site for unplanned care and to provide their feedback through this consultation period.

Background/Overview:

As above

The Issue:

As above

Next Steps:

As above

Recommendations:

The Board is asked to note the publication of the CCG Pre Consultation Business Case and support the decision made by the CCG to proceed to formal public consultation.

Appendix

Attachment:

There is no PDF document attached to the paper.

APPENDIX E

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Anna Basford, Director of Commissioning & Partnerships
Date: Thursday, 28th January 2016	**Sponsoring Director:** Owen Williams, Chief Executive
Title and brief summary: Calderdale Support and Independence Teams - The attached report was presented to CMBC Cabinet in December. The report summarises developments during the past 12 months and recommends continuation of the partnership agreement between CMBC and CHFT for the delivery of these services.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: CMBC Cabinet Meeting 14 December 2015	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: Improve local conditions, especially in disadvantaged areas, eg encourage social inclusion, develop business and social enterprise or develop the workforce and labour market Reduce social and health inequalities	

Executive Summary

Summary:

CMBC and CHFT entered into a partnership agreement in October 2012 to deliver a range of intermediate care services through an integrated model of delivery working within a joint management structure with CHFT as the lead provider. In November 2013 and November 2014 progress reports were submitted to CMBC Cabinet and CHFT Board. This report summarises developments and performance over the past 12 months and makes recommendation for the future management of the reablement element within the Support and Independence Teams (SIT).

The report was presented to CMBC Cabinet in December 2015 and it was agreed that the Partnership Agreement between CMBC and CHFT should continue for a further 12 months, with revised line management arrangements for the Reablement staff to ensure that improvement is sustained and to allow time for Care Closer to Home and Vanguard to be progressed. This will influence future arrangements as part of a whole system approach.

The Board is requested to agree the recommendations in this report.

Main Body

Purpose:

The Board is requested to agree the recommendations in this report for continuation of the Partnership Agreement with CMBC for a further 12 months to jointly deliver the Support and Independence Teams service.

Background/Overview:

As described in the Executive Summary.

The Issue:

As described in the Executive Summary.

Next Steps:

The Partnership Agreement is approved for a further 12 months, with revised line management arrangements for the Reablement staff to ensure that improvement is sustained and to allow time for Care Closer to Home and Vanguard to be progressed.

Recommendations:

The Board is requested to receive the report and agree that the Partnership Agreement with CMBC is approved for a further 12 months.

Appendix

Attachment:

Support and Independence Team Report - Trust Board Jan 2016.pdf

Calderdale MBC

Wards Affected ALL

Cabinet

Date 14th December 2015

SUPPORT AND INDEPENDENCE TEAMS

Report of the Director, Adults, Health and Social Care

1. Issue

1.1 CMBC and CHFT entered into a partnership agreement in October 2012 to deliver a range of intermediate care services through an integrated model of delivery. At the time of establishing the Support and Independence Teams the council's Reablement staff remained as council employees, working within a joint management structure with CHFT as the lead provider.

1.2 In November 2013 and November 2014 Cabinet resolved that further reports be submitted to Cabinet to monitor progress of the partnership. [B61 CABINET, 11th November 2013, 88(c) and B63 CABINET, 16th November 2014, 76].

1.3 This report summarises the developments which have taken place over the past twelve months and makes recommendations for the future management of the reablement element within the Support and Independence Teams (SIT).

2. Need for a decision

2.1 The Partnership agreement between the council and CHFT includes a requirement to review performance of the range of services covered by it and to report jointly to their respective boards, and to decide at each review if the arrangements should cease, continue or further develop. The Partnership agreement includes a crucial qualification for the continuation of the arrangements:

The Partners enter into these Partnership Arrangements to provide integrated health and social care services to better meet the needs of the Service Users of the Area than if the Partners were operating independently.

2.2 This report builds on the findings of the 2014 review and the Cabinet decision to continue with the arrangements for a further year, without transferring staff employment to CHFT, while continuing to seek improvement in cost effectiveness and the outcomes for individuals.

2.3 The options for the council and Calderdale and Huddersfield NHS Foundation Trust are:

- To dissolve the current arrangements for the management of the Reablement service within the Support and Independence Teams – if outcomes could be improved by working separately

- To continue to work in partnership to improve the effectiveness of the intermediate care services, remaining in co-located multi agency teams without changing the management arrangements.

- To continue to work in partnership to improve the effectiveness of the intermediate care services while changing aspects of the management arrangements. The Reablement element of the teams would benefit from revised line management and a decision to target a smaller, more streamlined resource towards the people who will benefit most

- To move towards further integration

3. Recommendation

- To continue to work in partnership to improve the effectiveness of the intermediate care services while changing aspects of the management arrangements. The Reablement element of the teams would benefit from revised line management and a decision to target a smaller, more streamlined resource towards the people who will benefit most.

4. Background

4.1 In October 2012 CMBC and CHFT entered into a Partnership Agreement to deliver integrated intermediate care services. An overview of the arrangements was provided to Cabinet in November 2014 [B63 CABINET, 16th November 2014, 76]

4.2 The Reablement Performance Improvement Project was established as the core business of the Partnership Board in March 2014. The Partnership Board received regular highlight reports on the work-streams. In November 2014 CMBC Cabinet and CHFT Board approved a recommendation to continue with the partnership arrangements for a further year. This would allow time for the impact of commissioning initiatives such as the Better Care Fund and Care Closer to Home to become clearer.

4.3 Since the previous report, the development of the Vanguard programme has offered further opportunities for integration which will influence how our joint working evolves. The Calderdale approach to "whole system working" is still growing and developing, and therefore the context for this service will change over the coming months. The commitment to joining up services around the individual and their carers remains the focal point for Care Closer to Home and Vanguard.

4.4 A development of the pathway was proposed and initiated in April and May 2015 following the Partnership Board away-time. The proposal included an enhanced role for social workers in overseeing the individual's journey from referral and assessment, through Reablement and onwards to living as independently as possible, or where necessary receiving a lower level of ongoing care and support than might otherwise be the case.

4.5 The development of the Community Social Work Practice is beginning to shape this work more effectively in the cases where they are involved. Their work is also helping to reduce the volume of referrals into Reablement from the community.

4.6 The revised pathway was intended to improve the success rate of Reablement by more actively promoting full independence, and to ensure that access to ongoing packages of care for those people who need it were not subject to any bureaucratic delays by streamlining the decision making. There is some evidence that this is starting to build. Its' success was inter-dependent with the expected increase in home care capacity in the community, following the completion of the home care contracts transfer.

4.7 The home care market has begun to stabilise in recent months and we continue to closely monitor the capacity of providers to take on new cases.

5 Current Position

5.1 The improvement project has developed clearer management information about how the Reablement resources are currently deployed. This has built a shared understanding of how many people are receiving a service at any one time, how long they receive it for, and what outcomes are achieved. It has also enabled the partners to know how the whole system is working, for example once an individual

has been assessed by the social worker as requiring an ongoing package of care, how long they might wait for that to be transferred to an independent sector provider.

5.2 Considering this aspect of the service performance - that is to say whether it is being targeted towards the people for whom it is most appropriate - analysis of the caseload suggests that at least one third of the service at any given time has been directed towards people whose needs have been assessed as suitable to be met by independent sector home care.

5.3 This analysis further supports proposals to recalibrate the level of staffing resource we dedicate to different elements of serve:

- Active Reablement,
- Post Reablement home care for people waiting – being described as the "home care holding team",
- Rapid access home care for people who would not be appropriate referrals for Reablement,
- Rapid access home care for people who need some time to recover sufficiently from their episode of ill health in order to be ready for Reablement.

5.4 It should be noted that post-Reablement or rapid access home care provided in this context would be a chargeable service. The annual expenditure for Reablement in 2014-15 was £1.49m.

5.5 If people who have completed their Reablement programme were to transfer to an alternative service from an independent sector provider more quickly there would be a significant financial saving as a result.

5.6 As part of this recalibration, and in the context of changes in SIT management, the partnership has already made some pragmatic changes to operational management arrangements. The Social Services in house CQC registered Manager has taken on more direct responsibility of the social services staff and re-established the council line management arrangements.

5.7 The staff team continues to work from the Health Centre bases so still benefit from integrated working relationships with health colleagues, this works well and over the life of the partnership has improved communication, reduced duplication and built positive relationships. It is the intention to continue with this co-location arrangement.

5.8 The council Operations Manager continues to oversee the Social Services staff including the CQC Manager and maintains the focus on service improvement.

5.9 The Support and Independence teams, including Reablement, continue to face a number of challenges relating to resources, workforce and market capacity. These reflect national pressures, not unique to Calderdale:

- Availability of therapists - recent recruitment processes have not attracted sufficient interest

- Capacity of the home care market, including their ability to recruit and retain sufficient staff
- Capacity of the social work teams to undertake the volume of assessments and reviews

5.10 Both organisations are taking action to mitigate these risks. CHFT has explored deploying the therapy resource more flexibly across the teams and services. AHSC has implemented a revised operating model for social work which is now embedded, and recruited a Business Relationship Manager to work closely with the home care sector, with strong evidence that regular communication and collaboration is starting to improve the transfer of cases from Reablement.

5.11 An illustration of the revised pathway is attached at Appendix 2.

6 Performance

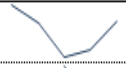
6.1 The service had been reporting poor performance in comparison to regional and national benchmarks in previous years.

6.2 This has been the focus for the improvement project which continues to address the range of factors affecting performance, such as the case mix and pathway, clarifying the dataset for the metrics and the market capacity for people needing an ongoing service.

6.3 Health partners joined council colleagues at a recent local government sector led improvement "masterclass" on Reablement. It was noted that comparisons between the Reablement services in different council areas are inconclusive due to their different arrangements, referral criteria and local health and social care economies. However, the "masterclass" afforded insight into the approaches that have been found effective across the Yorkshire and Humber region. The targeting of the Reablement resource to people who are more likely to benefit – that is to say applying clear referral criteria – is seen as highly beneficial to the outcomes achieved.

6.4 The outturn position for 2014-15 showed some improvement against benchmarks when compared to 2013-14, however progress has not been as significant as we had aimed it to be. The table below illustrates the trend. A large font version of the data is included at Appendix 1.

KEY Not Collected — Upper Quartile
Indicator definition has changed, data not comparable to previous years — Lower Quartile

ASCOF Indicator	Good Performance	10/11 Score	11/12 Score	12/13 Score	13/14 Score	14/15 Score	Calderdale Trend	14/15 Comparator Rankings: National (151)	Yorks and Humber (15)	Cipfa Group (16)
2B(1) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	High	84%	79%	70%	71.9%	79.7%		106	13	13
2B(2) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)	High			1.5%	1.10%	1.1%		143	14	16
2D - Proportion of those that received a short term service during the year where the sequel to service was either no ongoing support or support of a lower level	High					59.3%		123	12	15

6.5 The tables above show that Calderdale has improved its position against the comparator groups for ASCOF 2B1, however we are still in the bottom quartile. This is the indicator relating to older people remaining at home 91 days after discharge.

6.6 Performance against this indicator for 2015-16 Q2 appears to have improved significantly, however the figures require further validation to be assured of the level of confidence. This work is being undertaken in the current quarter.

7 Quality

7.1 The service uses a satisfaction questionnaire to obtain the views of people who have received support, and follow up telephone calls are made as part of the data validation process for the ASCOF measure relating to "91 days still at home", offering an opportunity for the manager to gather insights in to customer experience.

7.2 In the most recent satisfaction survey the service received 42 responses. In response to the NHS "Friends and Family" test, where patients are asked to say how likely they would be to recommend the service to friends and family, all respondents stated that they were likely or extremely likely to recommend it.

7.3 Respondents to the questionnaire are invited to offer a comment on their experience of the service; 32 of the 42 took this opportunity. Of these, 31 comments were positive, and 1 was negative, relating to a decision to leave the individual to see how they would manage over a weekend without support, and this had not been a good experience.

7.4 A sample of the positive comments is below:

- Helped me become independent
- All the team were friendly, caring and helpful
- Helped me remain at home
- Everyone has been so lovely - thank you
- The talking was often the only conversation I had with other people
- Excellent and professional - care with a lightness and understanding
- Always turn up on time - very good care
- All fulfilled their tasks with remarkable cheerfulness
- Wonderful

7.5 Although many of the individuals accessing Reablement require some ongoing care afterwards, this is to be expected where the service is targeted to people with significant needs. In many cases the number of calls from home care required is lower than at the outset of the Reablement programme. In the four week reporting period ending 13th October 2015, 29 people were discharged from the reablement service with an ongoing care package, while 33 were discharged fully independent.

8 Cost effectiveness

8.1 Section 5 of this report refers to analysis showing that people with ongoing support needs may experience a delay for a package of care following the conclusion of their active Reablement. At present they are not charged for this period of service, and the cost of delivery is higher than the contracted rate for personal home care. It would be

more cost effective for the council to identify those individuals who have fulfilled their Reablement potential yet have ongoing needs in order to transfer them as efficiently as possible to a contracted provider or to a designated home care element of the in-house service and where appropriate to commence a charge for this.

8.2 While some improvement has been made in the performance outcomes from the service over the past year we hope and expect this to improve further with the direct management oversight by the CQC registered manager and greater input from therapists in the care planning. This will improve the cost effectiveness of the service by reducing the ongoing demand for care following discharge from Reablement.

9 Considerations

9.1 In the context of the challenges faced by Calderdale, including rising demand, pressure on services and financial restraints the cost, value for money and performance outcomes of the Reablement service continues to come under intense scrutiny.

9.2 Reablement and the seamless intermediate care service are underpinning initiatives to support the CCG strategic objective of delivering care closer to home. Care Closer to Home is a key strategic objective of the CCG 5 year plan, now accelerated by the development of the Vanguard pilot site in Upper Valley. These programmes are predicated on the joining up of services around the individual.

9.4 The commissioning intentions of the CCG have been set out, and will not result in changes to the provider arrangements in Calderdale before 2017, if at all. This is a significant factor impacting on the timing of the current recommendation relating to the continued co-location staff and sharing of resources.

10 Options considered

- To dissolve the current partnership arrangements for the management of the Reablement service within the Support and Independence Teams – if it was judged that outcomes could be improved by working separately. This would mean withdrawing staff from SIT and return their management to the council and continue to address the factors impacting on performance

- To continue to work in partnership to improve the effectiveness of the intermediate care services, remaining in co-located multi agency teams without changing the management arrangements. This would not address the slow rate of improvement over the previous year, nor the changes in circumstances faced by CHFT in relation to management capacity.

- To continue to work in partnership to improve the effectiveness of the intermediate care services while changing aspects of the management arrangements. The Reablement element of the teams would benefit from revised line management and a decision to target a smaller, more streamlined resource towards the people who will benefit most. This would mean moving to the more widely recognised model of service in place across the region. This would mean that the overarching agreement stays the same – maintain the current partnership arrangements while adapting the

operational management to continue to address the factors impacting on performance. This will enable the council to await the outcome of other programmes such as Care Closer To Home and Vanguard.

- To move towards further integration with CHFT in relation to management of the service and transfer of council employees. This was ruled out as an option for the foreseeable future by Cabinet in 2014.

10 Consultation

The recommendation to Cabinet has been agreed with joint commissioners from the CCG and senior managers from CHFT. This report will be received by CHFT Board.

11 Financial implications

11.1 The local authority budget investment in the Reablement service has been increasing over the past three years:

Year	Local authority investment
2011 - 12	£ 1.312m
2012 – 13	£ 1.25m
2013 - 14	£ 1.40m
2014 – 15	£ 1.66m
2015 - 16	£ 1.65m (estimate)

12 Equality and Diversity

The Support and Independence team is subject to a full equalities impact assessment, carried out at the time of its establishment.

13 Contribution to Delivering Population Outcomes

The Adults Health and Social Care Directorate focuses on delivery against the Building Ambition for Calderdale theme of Resilience. The priority outcomes are as follows:

Priority Outcome: *Helping individuals and families to live free and independent lives*
Priority Outcome: *Providing support for vulnerable residents where it is most needed*
Priority Outcome *Older people live fulfilling and independent lives (JWS priority outcome)*

The Support and Independence Teams contribute to all three outcomes as described in the model set out in section 4 of this report.

14 Corporate Implications

The funding for reablement is subject to a Section 256 transfer from the CCG under the NHS England funding transfer from health for adult social care. It is included in the plans for the Better Care Fund under the Health and Wellbeing Board.

15 Conclusion

16.1 That Cabinet is asked to note the progress made over the past year.

- The aims and objectives of the partnership remain relevant to both organisations and to the whole system. The Care Act 2014, the Better Care Fund and Care Closer To Home and Vanguard are influencing the further development of services, and shaping the context in which they are commissioned and operate in Calderdale.

- Reablement and the seamless intermediate care service are underpinning initiatives to support the CCG strategic objective of delivering care closer to home.

- The revised line management arrangements, with clearer lines of accountability will be embedded in the current year, and will work to establish a smaller, more streamlined resource in Reablement, targeted to the people who will benefit the most.

- The resource freed up from Reablement will be targeted towards supporting the immediate requirements of people needing ongoing packages of care.

- Partners will continue to address the workforce challenges facing the system.

16.2 That Cabinet approve that the Partnership Agreement continues for a further 12 months but with revised line management arrangements for the Reablement staff to ensure that improvement is sustained and to allow time for Care Closer To Home and Vanguard to be progressed . This will influence future arrangements as part of a whole system approach.

For further information on this report, contact:

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The documents used in the preparation of this report are:

1. Support and Independence Team – Cabinet Report, November 2013
2. Care and Support Statutory Guidance
3. Closer to Home draft commissioning intentions

The documents are available for inspection at:

Adults, Health and Social Care,
1 Park Road,
Halifax,
HX1 2TU.

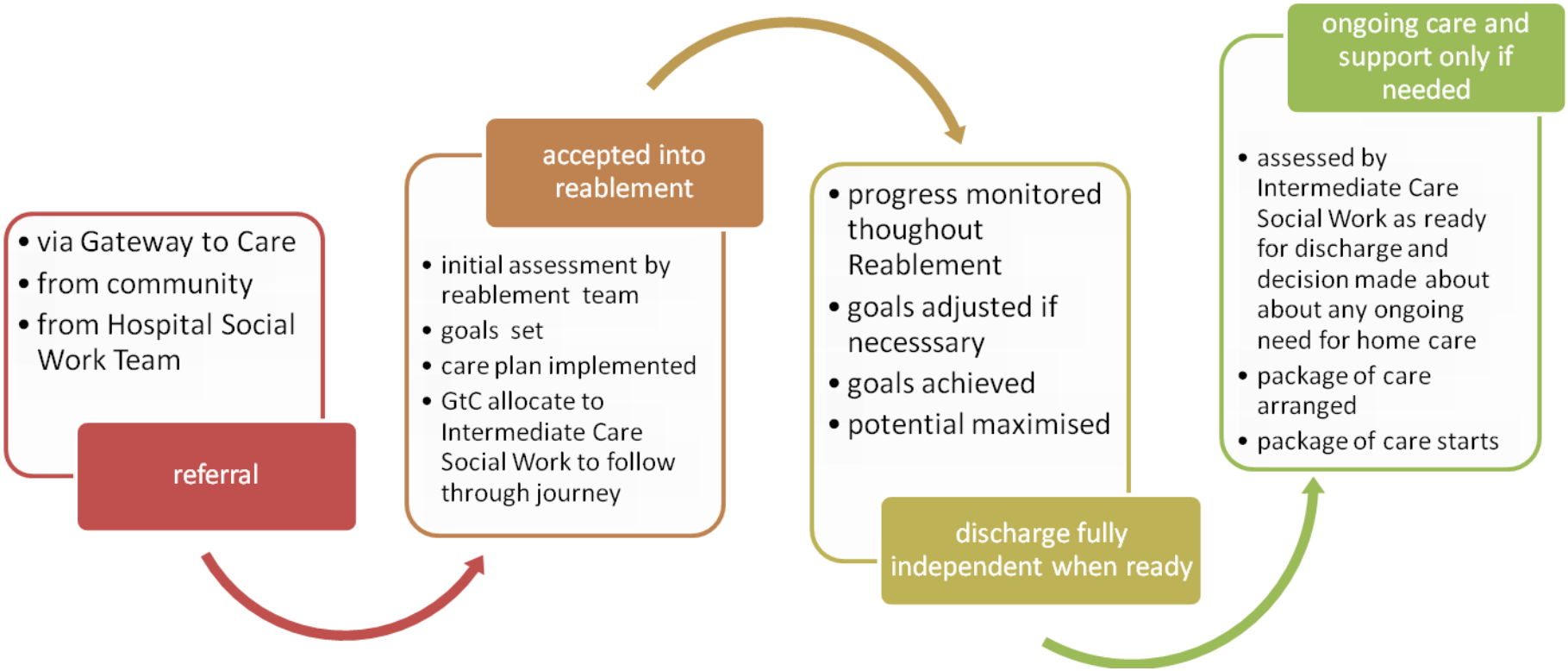
Appendix 1

Upper Quartile

Lower Quartile

						2014/15 Comparator Ranking		
ASCOF Indicator	10/11 Score	11/12 Score	12/13 Score	13/14 Score	14/15 Score	National (151)	Yorkshire & Humber (15)	CIPFA Group (16)
2B(1) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	84%	79%	70%	72%	80%	106	13	13
2B(2) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)			1.5%	1.1%	1.1%	143	14	16
2D - Proportion of those that received a short term service during the year where the sequel to service was either no ongoing support or support of a lower level					59%	123	12	15

APPENDIX 2 - ILLUSTRATION SHOWING REABLEMENT PATHWAY (November 2015)



APPENDIX F

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEETING TITLE: Board of Directors - Private session	**REPORT AUTHOR: Mandy Griffin**
DATE OF MEETING: 28/01/2016	**SPONSORING DIRECTOR: Mandy Griffin**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUM(S) WHERE PAPER HAS BEEN DISCUSSED: Paper and action plan approved by EPR Assurance programme Board	

EXECUTIVE SUMMARY:
The review team found that overall delivery confidence assessment is AMBER.

Overall the review team found significant evidence of the two organisations that were committed to making the EPR implementations a success. There was clear governance, strong leadership, effective working between the two trusts, a strong EPR delivery team.

Progress to date was encouraging and the trusts had sought out significant lessons learned experience from previous trusts who had already implemented EPR.

The programme business cases have a small margin of ROI and on-going uncertainties on both benefits and costs. Work is underway in both trusts to review and revise the cost and benefit models. In addition the review team found a lack of clarity on the scope of the programme at a high level.

Recommendations were categorised into three areas,
Critical - For immediate action (4)
Essential - That are critical before the next review (12)
Recommend – Potential improvements (7)

The critical areas are as described below;

- Produce an overarching programme aim document.
- Develop scenarios to understand the cost and benefit (ROI) impact of go-live slippage.
- Articulate the cost contingency/optimism bias modelling.
- Review of the benefits, as the context has changed since business case approval,

with approval sought for any changes.

Response

An action plan from the review has been developed and shared with GE (attached)
Progress to date is that all recommendations are complete or on track to complete

An internal audit on the progress of the action plan for both trusts took place in December the results of which will be shared with the assurance Programme Board in February

2nd Gateway review including a review of progress on these actions starts 19th January 2016.

Next

Review action to ensure the desired change has occurred

RECOMMENDATION:

For the Board of Directors:
To accept and note final report from gateway 1
To accept and note action plan and responses

APPENDIX ATTACHED: Yes

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
Critical (Do Now)						
R1	The programme is in need of an overarching document to set out what the programme is aiming to achieve, why it is important, how it relates to the wider context, what is in and out of scope etc. Depending on the programme methodology being used this could be referred to as the Blueprint, Project Initiation Document, Programme Definition Document etc. This lack of clarity impacts end users clarity on what is or is not in scope, technical clarity on what will or will not be interfaced and the associated strategic ambiguity for related systems (TPP, ICU, Maternity, community etc...) It is therefore recommended that a PID (or similar) is created and approved for the programme.	Recommendation agreed. A programme would not normally have a PID. Most of the scope and interfaces were covered by the OBS however the team recognise this is not a useful document for end users and therefore accept the recommendation to develop a clearer document. Action plan • Develop matrix for scope • Develop matrix for integration • Present to Jan Programme Board for recommendation • Present to Jan Transformation board for approval	 23 Dec 2015 23 Dec 2015 18 Jan 2016 22 Jan 2016	D Lang	A risk concerning the potential impact on scope, schedule, and quality has been raised (risk id 191) Current risk rating 6	complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R2	Whilst it is recognised that the financial models for the FBCs included a number of scenarios, it is recommended that the programme develop a specific set of scenario models to better understand the cost and benefit impact of go-live date slippage and the subsequent impact on ROI.	Recommendation agreed. This recommendation has already been identified and actioned by the team. A model has already been developed which can be used to cost the change in go live dates. This model has been adapted so that costing of any go live date can be calculated.	23 Dec 2015	Accountable Keith Griffiths Responsible S Baron	The cost of financial slippage is in the Risk Register, rated (Risk ID 123) Current risk rating 8	Complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R8	There is ambiguity in the cost models being used to underpin the business cases going forward. In particular we recommend that the Trusts articulate much more clearly the approach being taken to handle emerging IT equipment costs and also to be clear how contingency / optimism bias is being modelled. There are standard optimism bias models available which should be evaluated as a possible approach.	Recommendation agreed. We provide a financial model by Trust and the overall programme on a monthly basis which includes a financial forecast. Action: • Future reports will separately identify the contingency / optimism bias for the programme. Plans are in place to separate out the contingency element within the financial plans/forecasts and this will form part of the monthly financial reports to the Programme & Transformation Board from January onwards. Furthermore, a scheme of delegated limits has been established and agreed by the	18 Jan 2016	Accountable Matthew Horner Responsible J Matthews	The financial risk is logged on the risk register (Risk ID 123) Current risk rating 8.	complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
		Programme Board as to authorisation levels for the virement of budgets between lines/contingency. This will be supplemented with a logging process of agreed virements (including contingency) within the shared financial model.				

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R13	Since the development of the business cases, the macro context and service emphasis in the NHS has potentially changed. In addition the understanding of the system and its potential benefits has increased. Accordingly, a number of the current forecast benefits look unlikely to materialise fully as cash releasing benefits. It is therefore recommended that the Trusts complete a full review and refresh of the benefits cases and gain formal approval	Recommendation agreed. The benefits strategy plan has already been developed and there is a benefits team is part of the EPR team. Action: • Benefit sponsors and owners identified in business case. • Review of benefits and identification of further benefits being undertaken. • Action plans to ensure realisation of benefits to be drafted by benefit owners. • In addition to EPR governance, benefits realisation will be monitored by the Trusts' existing transformation boards.	Completed 23 Jan 2016 TBD Ongoing monthly	Accountable Dave Lang Responsible J Motta	The risk of not realising benefits is logged on the risk register as a number of risks. (Risk ID 31 & 177) Current risk rating 9. This risk rating is being reassessed.	On track to complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
Essential (Must Do)						
R3	It is recommended that all MSP strategies (e.g. quality, monitoring and control, information management, resource management, benefits management etc…) are completed and formally signed off.	Recommendation agreed. All of the MSP strategies have been produced and are now signed off by the Programme Board.	18 Jan 2016	Accountable M Szekely	A risk will be added if there are any outstanding strategies post target date	Complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R4	The Programme should develop a service management framework which will provide clarity on how the IT services will be managed leading up to and beyond the EPR system go live. This should be based on ITIL concepts. The programme governance also needs clarifying to account for the post go-live governance regime needed for service management, contract management and development of the commercial relationship.	Recommendation agreed. Some of the principles have been described in the Full Business Case regarding a shared service solution. Action Plan: • Ask Risk Review Board to consider risk. • To develop detailed plan for the delivery of the IT service specification for on-going support • To design and agree on the how shared service model will operate post go live • To bring the service model live in advance of go-live	16 Dec 2015 1 Feb 2016 31 Mar 2016 TBD	Accountable D Lang Responsible R Gamble	This work is currently logged as an issue. Will consider logging as a risk.	On track to complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R5	It is recommended that the Terms of Reference for all groups in the governance structure are clearly defined and agreed and the links between the groups, especially clinical groups, are clearly articulated	Recommendation agreed. There are current draft Terms of Reference for the clinical groups which are awaiting agreement from the appropriate board. Action • Overall finalised governance document to go to Programme Board for recommendation for Transformation Board approval. • Assurance that this is working correctly will be monitored through the Senior Leadership of the Programme	23 Dec 2015 Ongoing	Accountable D Lang	No logged risk as updates to the Governance structure is already in draft, agreed, and ready for final approval.	Complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R6	Many of the benefits in the business cases imply changes to staff working patterns and processes. It is recommended that the Trusts are clear about how their respective HR teams will be included in the formal programme governance to ensure that impacts to staffing and processes are optimally managed	Recommendation agreed. HR resource was identified within the original governance structure. Both Trusts do not have full clarity around the staff working changes associated with an implementation of an EPR Action • Formalise relationship between the two Trusts' HR Departments and the EPR Team.	23 Dec 2015	Accountable D Lang	This appears as several significant risk on the risk register in terms of change management (Risk ID 20, 41 & 44) Current risk rating 9, 12 & 12.	Complete – Discussions taken place between HR & EPR Teams. Joint EPR / HR Meeting arranged. Spec for additional HR resource developed and will be put out to tender

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R9	There is significant challenge in training the numbers of staff in the required time. These staff will also need a safe environment to test out their new skills. It is therefore recommended that 'live-like' systems are provided to allow staff who have received their training to experiment / play with the new system in order that they can gain confidence and identify implementation issues early	Recommendation agreed. It is important that as many staff as possible are familiar and confident with the new system pre go-live. Action • An instance of the EPR will be available shortly after Future State Validation in February 2015. • Workflow-based sessions will be available for staff to try out the new system. • Simulations will be conducted. • This will be publicised and made available to all staff both pre and post staff training.	28 Feb 2016 Mid to late Feb 2016 onwards	Accountable M Szekely Responsible R Pyrah	There are several significant risks associated with staff not having the appropriate training to use the system properly (Risk ID 5, 17 & 40) Current risk rating 6, 16 & 9	On track to complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R10	Establish the EPR Divisional Boards in BTHT and EPR representation on existing Boards at CHFT to ensure appropriate two way clinical engagement in designing future state systems	Recommendation agreed. It is important that the design and operation of the new system supports the clinical and operational delivery of services. Action • Ensure EPR Divisional Boards are set up and meeting objectives of engagement. • Ongoing monitoring to ensure efficiency.	 1 Dec 2015 Monthly monitoring	Accountable M Griffin	The risk of not having effective senior leadership and engagement is logged as a risk (Risk ID 21) Current risk rating 4	Complete Both organisations now have Divisional Boards in place as either part of their Divisional Board Meeting or as a separate sub-board

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ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R11	There appeared to be a lack of clarity whether all relevant staff was aware of the purpose for the programme risk register. In particular we saw numerous questions of how risks and issues differ, how risks should be coded and categorised, what constitutes a risk (as opposed to a question), how often a risk should be updated and lack of completeness of all relevant fields in the risk register. There is therefore a recommendation to more clearly implement the agreed risk strategy across the programme	Recommendation agreed. It is important that all EPR staff understand the process of logging and managing risks Action • Ensure EPR staff have been familiarised with the risk & issue management strategy and made aware of their roles responsibilities regarding the logging, monitoring and management of risks and issues.	8 Dec 2015	Accountable D Lang Responsible R Gamble	N/A	Complete - Training session held. Being monitored ongoing by Risk Review Board.

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R16	Building on its previous steps using survey monkey, the programme should establish an ongoing regime of communications effectiveness reviews which will allow the impact of communications activities to be monitored, evaluated and refined.	Recommendation agreed. It important that the programme understands the effectiveness of its communications Action • Regular communication surveys will be undertaken. Next survey to be done in Dec 2015. • Further surveys to be done bi-monthly.	30 Dec 2015 Ongoing	Accountable K Pagan Responsible R Pyrah	There are several risk logged that relate to the consequence of lack of engagement, (Risk ID 20. 21 & 44) Current risk rating 9, 4 & 4	Complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R17	Much of the communications to date has been focussed on information sharing and encouraging engagement. We recommend the communication team develops mechanisms for obtaining feedback and taking on board staff opinions	Recommendation agreed. Addressing concerns raised by staff will be key to a successful outcome for the programme Action • Answer to queries are regularly fed back as FAQ's • Comments from staff will be reviewed by the communications team and escalated to Programme Board as appropriate. • Process to be agreed by the Jan 2015 Programme Board	18 Jan 2016 18 Jan 2016 18 Jan 2016	Accountable K Pagan Responsible R Pyrah	There are several risk logged that relate to the consequence of lack of engagement, (Risk ID 20. 21 & 44) Current risk rating 9, 4 & 4	Complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
Recommended (Should Do)						

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R7	There are signs that there will be increased pressure on estates and facilities in the run up to go-live. It is recommended that training facilities at or close to hospital locations is confirmed.	Recommendation agreed. The Training Board met for the first time in January. A detailed training plan is being developed with regular meetings to manage the strategy. Enhanced engagement and demos (pre-training) are taking place at Bradford the last week of January and at CHFT the first week of February, these sessions will be delivered in the Simulation Suite and teams will visit the wards. Helen Whitaker will escalate any issues re lack of accommodation for training to Jackie Murphy or Kay Pagan in order to ensure alternatives can be sought. Action • Fully develop training plan	28 Feb 2016	Accountable J Murphy Responsible H Whitaker	The risk of not having sufficient resource to provide all the required training is identified (Risk ID 5) Current risk rating 6	On track to complete

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
		• Identify and secure additional training facilities based on the requirement that is identified in the training plan				
R12	As the programme approaches go-live and enters the high demand post go-live period, the reporting needs of the SRO and governance structures may change. It is recommended that the programme teams review best practice from other implementations and agree the revised approach in advance with their SROs and governance chairs	Recommendation agreed. There will to be transitional and BAU governance and reporting arrangements in place. Action • Collect lessons learned and best practice from other EPR implementations ensuring use of Cerner expertise. • Develop a Go-live plan that includes various forms of communication, adjusting format and timing in recognition of programme intensity changes.	30 Jan 2016 Draft 30 Jan 2016	A Taylor	The risk of not continuing to engage with the SRO's is recognised (Risk ID 21) Current risk rating 4	On track to complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R14	The Trusts should ensure that they have a clearly documented approach to linking the EPR programme with the other transformation programmes running in each organisation. This approach should make clear the governance group which has oversight of the integrated transformation plan in each Trust.	Recommendation agreed. Further ahead with identifying the benefit sponsors and owners at CHFT, there is further work to do at BTHFT in regards to agreement of sponsors and owners. The Executive Directors meeting at BTHFT agreed that the Benefits Tracker will be tracked through the Trust Transformation Programme and progress will be reported at the fortnightly Trust Improvement Board (TIB) meetings. Meeting taking place on Tuesday 12th January with Julie Motta and the Transformation Team. Action • Ensure that benefits delivery is aligned to other transformation schemes.	 23 Dec 2015	Accountable D Lang Responsible J Motta	The risk of competing priorities affecting the project is recognised (Risk ID 22) Current risk rating 9	On-going, further work been undertaken to map interdependencies

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
		• Map interdependencies between each Trust's transformation programmes and the EPR Programme. • Ensure EPR Transformation Board executes mandate to communicate and manage interdependencies.	18 Jan 2016 18 Jan 2016			
R15	There is ambiguity about where and how benefits realisation progress will be reported at each Trust. It is therefore recommended that the benefits management governance approach is formally agreed.	Recommendation agreed. A clear process for reporting benefits need to be in place. Action • Benefits reporting process to be agreed within the Programme and within each Trust and formally documented. • Governance Document to be updated to show benefits reporting structure.	21 Dec 2015 21 Dec 2015	Responsible D Lang	Benefits realisation risk is logged on the risk register (Risk ID 177) Needs scoring	Complete Processes in place and Governance Document updated

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R18	There is ambiguity over the physical devices which will be used to access the new system functionality. As this will impact training, roll-out and confidence it is recommended that a plan is developed to provide clarity to end users on this matter and communicate out to staff on this matter	Recommendation agreed. Staff will need to confident in the use of new systems and technology pre go-live Action • Update device strategy to be produced. • Users will be part of the device acceptance testing. • Finalise plan in advance of workflow training	 18 Jan 2016 28 Feb 2016 28 Feb 2016	Accountable D Lang Responsible N Staniforth	There is a risk that recognise that staff need the appropriate devices to access the EPR (Risk ID 42) Current risk rating 9	On track to complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R19	There has rightly been much focus on clinical and nursing engagement as key parts of the change programme. However, based on feedback from a number of interviewees, it is recommended that the programme considers how it can engage with other key Trust staff groups who are critical to successful implementation of the programme (such as ward clerks, porters etc.).	Recommendation agreed. The intention is to engage with all staff working in the Trust as the EPR Programme is likely to impact on everyone to some degree. • Action Review engagement strategy to ensure it is comprehensive and complete. • Vet engagement strategy with clinical and corporate divisions. • Complete work to segregate individual stakeholders and track progress. • Ensure adequate plans to include all staff groups through the Nursing Leads.	23 Dec 2015 18 Jan 2016 18 Jan 2016 31 Jan 2016	Accountable K Pagan	The risk of engagement is logged on the risk register (Risk ID 20. 21 & 44) Current risk rating 9, 4 & 4	On track to complete on time

GE Healthcare - First Review Action Plan

ID	Recommendation	Management Response and Action	Target Completion Date	Lead	Associated Risk	Status on Actions
R20	Formalise lessons learnt from previous Trust clinical systems implementations (e.g. Maternity solutions, NerveCentre etc.) and ensure these are appropriately recognised in the planning and implementation of the EPR programme	Recommendation agreed. It is important to learn from previous projects as this will help to ensure successful outcomes. Action • Share collated list of Critical Success Factors from other implementations inside and outside the Trusts and develop plans to manage against these CSFs. Ongoing update of this document. • Collate lessons learned from recent Informatics projects in both Trusts and hold workshop with team to ensure knowledge transfer and inclusion in plans. Four projects to be included and also Cambridge's EPR deployment.	23 Dec 2015 18 Jan 2016 & 26 Feb 2016	Accountable R Gamble Responsible S Coady	Learning lessons is not explicitly documented as a risk on the Risk Register, however is the foundation of several risks that are rated as 15.	Complete Critical success Factors circulated Cambridge Lessons Learned action plan agreed Workshop planned with Workstreams leads to understand Lessons Learned from previous Trust projects

Bradford Teaching Hospitals NHS Foundation Trust and Calderdale and Huddersfield NHS Foundation Trust

External Assurance of the Programme to Implement Cerner Millennium

Review 1 - Programme Governance

finnamore

Report Status:	Issued Version 1.0
Date/s of Review:	29/10/2015 to 03/11/2015
Draft Report Issued to SROs:	09/11/2015
Final Report Issued to SROs:	12/11/2015
Delivery Confidence Assessment:	AMBER
Senior Responsible Owners:	Owen Williams, Chief Executive, Calderdale and Huddersfield NHS FT Clive Kay, Chief Executive, Bradford Teaching Hospitals NHS FT

Contents

1 Background

1.1 Aims of the Programme

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and Calderdale and Huddersfield NHS Foundation Trust (CHFT) are working in partnership to implement an Electronic Patient Record (EPR) and have jointly procured the Cerner Millennium solution to deliver this. Both Trusts are seeking to create a patient centric comprehensive clinical record and share common aims for the programme, centring around:

- Improving care quality, clinical safety and outcomes
- Improving the patient experience
- Improving clinical services, facilitating new models of care
- Supporting an improvement in the efficiency and productivity
- Improving the experience for users by providing staff with a single point of access to all relevant information about a patient.

1.2 Driving Force for the Programme

All NHS organisations face a challenging environment and the need to transform services in order to remain clinically and financially viable. The Five Year Forward View identified harnessing the information revolution as a key enabler to securing a sustainable NHS and made a commitment that, by 2020, all electronic health records would be fully interoperable so that patient records are paperless. This vision was supported by the establishment of the National Information Board and its ambition to transform the health and care digital landscape outlined in Personalised Health and Care 2020 – A Framework for Action.

Locally, there is a considerable gap between the vision to create an EPR that supports this long term viability and the current position. This gap and the following issues in particular are driving the need for this EPR Programme:

- It is difficult (and sometimes impossible) to get a single view of the patient from current systems
- Systems are predominantly administrative focused rather than clinically focused
- Some applications and processes are unnecessarily complex having evolved in a piecemeal way
- Information about the patient often doesn't follow the patient as they move through their care settings
- Reengineered care pathways cannot be fully implemented without modernisation of IM&T

- There is no current provision for clinical decision support in clinical systems, including access to knowledge bases in the context of the clinical process, decision support rules enforced for order communications
- Trust management and clinicians do not have a 'real-time' view on activity and performance across the Trust
- Users of Information Systems in the Trust often have to use more than one 'log in' process to access information about the same patient.

1.3 Procurement/Delivery Status

In early 2015, the Trusts completed the procurement, and following approval of Full Business Cases (FBC) by the respective Trust Boards, CHFT signed the commercial agreement with Cerner and a back to back agreement with BTHFT. The joint Programme governance structure is established and the majority of posts in the joint programme team filled, with Cerner representatives working alongside the Trust team. The status of the main programme activities is as follows:

- The development of Programme documentation and management strategies is nearing completion
- Programme work streams are established, with planning for each workstream on track in accordance with the programme plan
- A risk strategy is in place and a detailed risk review has recently taken place
- Current state documentation is complete
- Future state workflows are under development
- A joint benefits register with supporting benefits maps and profiles are nearing completion
- A communications plan is in place with a range of communications activities having taken place.

The final scope of the Programme is yet to be confirmed and the first view of the solution configured to the Trusts requirements is scheduled for November 2015. The exact go live date is yet to be confirmed, with the schedule indicating autumn 2016.

1.4 Current Position Regarding External Assurance Reviews

The Programme Governance structure includes an EPR Assurance Board, with the membership including the Chair of CHFT and the Vice-Chair of BTHFT. These two people rotate the position of Assurance Board Chair. The Directors of Informatics for both Trusts attend and an external Chief Information Officer has agreed to join the group. The remit of the EPR Assurance Board includes the commissioning of both external assurance reviews and internal audits performed by the West Yorkshire Audit Commission which provides audit services in a range of areas to both Trusts.

2 Purpose and Conduct of the Review

2.1 Purpose of the Review

Please reference Appendix 1

This report is an evidence-based snapshot of the programme's status at the time of the review. It reflects the views of the independent review team from GE Healthcare Finnamore, based on information evaluated over a four day period, and is delivered to the SROs. It is intended to supplement the Trusts' own existing internal and external assurance frameworks.

The review has been documented to bring out both what seems to be working well, what may not be quite so good, and a set of specific recommendations which the review team felt were important to be addressed. Within the timescales available for this review it has not been possible dig deeply into every area where practices could be improved, and accordingly, it is expected that the Trusts will want to review the comments listed as 'not so good' to see if further action would be helpful in the light of their detailed local knowledge.

2.2 Conduct of the Review

The External Assurance Review was carried out on 29/10/2015 to 03/11/2015 at Bradford, Huddersfield and Halifax sites. It should be noted that on this occasion the review team were scheduled to see more BTHT staff than CHFT staff. For future reviews we will press to see a more evenly distributed interviewee list.

The Review Team members and the people interviewed are listed in Appendix 3.

The Review Team would like to thank the SROs, the Directors of Informatics and the EPR Programme Teams and all interviewees for their support and openness, which contributed to the Review Team's understanding of the programme and the outcome of this review.

3 Gateway Review Conclusion

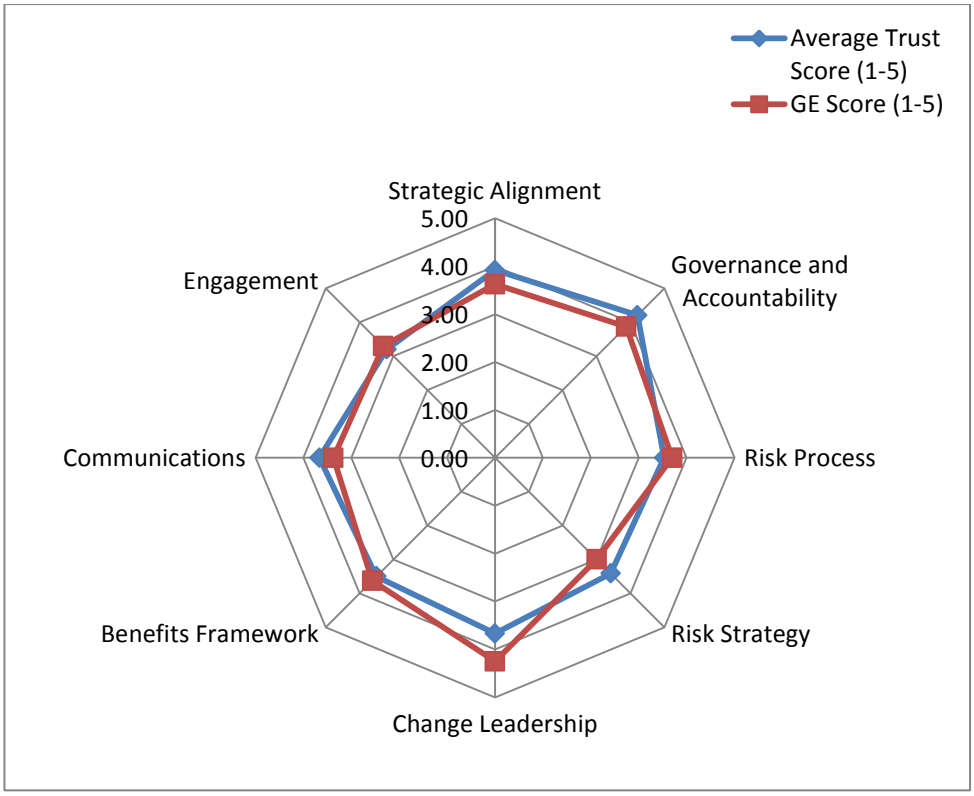
Delivery Confidence Assessment. The Review Team finds that overall delivery confidence assessment is AMBER.

Overall the Review Team found significant evidence of two organisations that were committed to making their EPR implementations a success. There was clear governance, strong leadership, effective working between the two Trusts, a strong EPR delivery team, and a healthy recognition that the EPR implementation was both a huge opportunity and a major undertaking with significant risks. Progress to date was encouraging and the Trusts had sought out significant lessons learned experience from previous Trusts who had implemented an EPR to avoid common delivery and implementation issues. Senior Trust staff also seemed to be bought into the vision and benefits of the EPR programme.

However, the programme business cases have a small margin of ROI and ongoing uncertainties on both benefits and costs cause the review team concerns. Work is underway in the Trusts to review and revise these cost and benefit models but at this stage we could not be certain how this exercise would conclude. We could therefore not be sure that a positive ROI would result. In addition we found a lack of clarity on the scope of the programme at a high level.

A summary of the Report Recommendations is available at Appendix 2.

In addition to the report recommendations, we asked the Trusts to complete a self-assessment against the eight criteria specified for this assurance review. We then compared it to the Review Team Assessment. The scoring criteria are listed in Appendix 4, and range from "1-not met" to "5-fully met". Average Trust scores align reasonably well with the Review Team Assessment, but it should be noted that within the average Trust score presented here, BHFT scored themselves more cautiously than CHFT.



The following eight sections of this report deal separately with each of the key assurance areas identified in the assurance scope in Appendix 1.

The Delivery Confidence assessment RAG status uses the definitions below.

RAG	Criteria Description
Green	Successful delivery of the project/programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
Amber/Green	Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into major issues threatening delivery
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/schedule overrun
Amber/Red	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and whether resolution is feasible
Red	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The Project/Programme may need re-base lining and/or overall viability re-assessed

4 Alignment of programme with business development objectives and priorities

4.1 What's good?

- There is good evidence of the required funding (capital and revenue) being available to support the programme from the outset, with appropriate financial governance in place
- There is good evidence of the programme being joined up across both organisations at senior management, clinical and programme level
- There is widespread recognition that EPR was critical to the sustainability of both organisations and supported on-going transformation activity in both Trusts
- There are good lines of communication and open discussion with Monitor regarding the EPR Programme at CEO level, aided by both Trusts having the same Monitor relationship manager. Monitor have been invited to visit for a more focussed discussion on the EPR programme and its delivery
- There is recognition of the need to connect EPR with TPP SystmOne to support the development of a care record across a range health and social care providers. This is to act as a key enabler of an accountable care system across both health economies that support integrated models of care.

4.2 What's not so good?

- There is currently no single document which bridges between the FBC and the Cerner commercial agreement setting out the scope of work to be undertaken. This would normally be in a Project Initiation Document (PID) or a Programme Definition Document created prior to starting work on the programme, and then updated as the future state is agreed to confirm the functionality to be deployed into each clinical area. Such a document would also inform the scope of the individual programme work streams and aid the achievement of a cohesive programme. It would also serve to clarify any changes from the original business case
- The financial risk associated with the potential loss of income around the implementation period has not been fully modelled. This loss of income may arise for a number of reasons including reduced productivity and reduced data quality. It is not clear what the potential impact of this may be to the organisation

- Although it is acknowledged that linkages with clinical systems used on community and primary care services (TPP SystmOne and EMIS in particular) are important, it is not completely clear how interfaces and subsequent data sharing will work in practice. This also applies to data sharing within each organisation with other departmental systems, for example the Galaxy Theatres system, Medway and K2 Maternity systems, BadgerNet neonatal, ICU systems and other key IT systems such as NerveCentre. This should be clarified in a PID / Programme Definition Document and illustrate how this supports new models of care
- It is unclear how the business case will be kept up to date to ensure that the costs and benefits associated with the project are monitored, managed and adjusted as necessary to reflect changes since the baseline business case was signed off
- There is currently a lack of clarity about how the EPR will support operational reporting and strategic decision making as a result of the intelligence that the system will provide, and how this will improve both internal and external reporting
- There is a clear need for rationalisation of clinical forms as part of the programme of work, however this work is likely to take a significant amount of time and involve time consuming sign-off from both Trusts which could impact go-live dates if not dealt with in the near term
- There is currently no clear mechanism to brief the Care Quality Commission (CQC) on the programme and keep it appraised of progress and risks management and mitigation activities. This is particularly important for CHFT given the with planned CQC visit in early 2016.

4.3 Recommendations

Number	Recommendation	Status
R1	The programme is in need of an overarching document to set out what the programme is aiming to achieve, why it is important, how it relates to the wider context, what is in and out of scope etc... Depending on the programme methodology being used this could be referred to as the Blueprint, Project Initiation Document, Programme Definition Document etc. This lack of clarity impacts end users clarity on what is or is not in scope, technical clarity on what will or will not be interfaced and the associated strategic ambiguity for related systems (TPP, ICU, Maternity, community etc...) It is therefore recommended that a PID (or similar) is created and approved for the programme.	Critical
R2	Whilst it is recognised that the financial models for the FBCs included a number of scenarios, it is recommended that the programme develop a specific set of scenario models to better understand the cost and benefit impact of go-live date slippage and the subsequent impact on ROI.	Critical

5 Programme governance and accountabilities clearly defined and implemented

5.1 What's good?

- There is a comprehensive governance structure in place, with a range of meetings that are generally well attended, with documented decisions and actions which are followed up and reported. The governance structure was developed from the start of the Programme in conjunction with Trust Executives and has evolved in line with input from Cerner as they became the third party in the partnership
- There is good evidence at both Trusts that the EPR Programme is a regular discussion item at Trust Board and Trust Executive team level
- There is evidence that the Transformation Board is providing an appropriate level of challenge to the programme, demonstrating that at a senior level, the two organisations were working well together and that the three way partnership agreement (including Cerner) is currently proving effective
- Given the pace and scale of the programme, the Trusts have recognised the need for the Transformation Board to continue to meet monthly going forward to support the management of risks associated with benefits delivery and provide regular senior decision making and guidance to the programme
- The Trusts are maximising the opportunity to utilise knowledge and experience from other Cerner deployments and are using their relationship with Cerner to good effect in respect of this. This has been enabled by good Account Executive and Project Manager input from Cerner to the project to date
- Accountabilities and responsibilities for key aspects of the programme, in particular risk, benefits and clinical engagement, were clearly understood by the relevant senior members of the Trusts
- The Trusts have responded well to the need to ensure that the programme has engagement and is owned at a divisional / specialty level through the setting up of specific EPR boards at divisional level in BTHT and EPR representation at existing divisional boards in CHFT
- Alignment of the EPR programme with wider transformation activity in both Trusts is well recognised, with EPR reporting into the Trust Improvement Board at BTHT and the transformation PMO at CHFT. This needs to be continued and built upon to ensure that major projects (such as patient flow and re-organisation projects) are enabled by EPR
- There is a good awareness of the key risks associated with deploying such a solution on the scale of the two Trusts. The risks associated with lack of major EPR deployment experience in the EPR team have been managed well to date through the appointment of knowledgeable and experienced external contractors working alongside existing in-house informatics staff and staff with significant organisational knowledge and experience

- The current programme management and reporting structure featuring a Programme Director, Informatics Director, Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO) in each Trust who works with and supports the programme manager and senior business change manager (and their various workstreams) is considered to support effective working at both programme and organisational level
- The programme workstreams are well resourced and clear in their mandate. The organisation and governance structure provides for significant clinical input to the programme workstreams via the clinical design authority and the divisional boards. This will assist in ensuring buy-in an sign off to the future system design
- The establishment of a Programme Assurance Board, chaired by a Non-Executive Director with experience in IT assurance projects, is a welcome development for the programme. This governance group is starting to have a positive impact through activities such as challenging programme risk register. The inclusion of an external representative from a Trust that has already deployed the Cerner solution is also a very positive development
- Involvement of patients in the governance structure through governors / membership council representation is a welcome development and should be continuously reviewed to ensure that there is patient engagement at all appropriate levels of the programme governance structure
- There has been good alignment of the programme's use of MSP and PRINCE2 processes with Cerner's contractual use of gateways to manage deliverables by phase
- There is good recognition of the significant issues associated with go-live planning and the planned use of a command centre to support the go live phase is a positive development.

5.2 What's not so good?

- There has been a perception that more programme meetings have been held in Huddersfield rather than Bradford, however it was well recognised that this was being addressed. There is an opportunity to use technology (e.g. videoconferencing) to reduce the travel requirements related to this project
- At least one Transformation Board meeting was recorded as not quorate due to limited attendance.
- There is some concern that on occasion the Programme Board discusses some items in too much detail, resulting in little time for other agenda items. It may be helpful to ensure that the Programme Board agenda and discussion focusses on insight into the wider development of the programme and not just assurance and reporting

- There is recognition that programme progress reporting requires further development. For example with feedback included that there are too many papers for Transformation Board (which were subsequently not read prior to the meeting) and that the reporting is not at the correct level of detail (varying between too much and too little) to provide the SROs with all the information they need to respond to queries from the their Trust Board and other key stakeholders. Other issues associated with the current reporting approach included:
  - Progress report brings together Delivery into one but doesn't differentiate between Scope, Schedule and Quality issues. These should be separated out
  - The need for a single programme action log with clear assignment of actions to individuals that can be easily accessed by all
- Whilst the feedback on Cerner's contribution was generally very positive, there was concern raised about some Cerner staff and their approach to engaging clinical teams in workshops. It was felt that there were occasionally too many 'can't do that' statements from the Cerner consultants and a number of their staff were unable to answer questions on the system, with a variability of responses depending on who was asked.
- As the programme is being managed through MSP, not all the relevant MSP strategies are in place which would be expected at this point in the programme. Although noted that they are in development, there was no evidence provided of:
  - Information Management strategy
  - Monitoring and Control strategy
  - Quality Management strategy
  - Resource Management strategy.
- The terms of reference for a number of the governance boards have not been fully completed and signed off (e.g. Clinical Advisory Board) and it is currently unclear as to how the Clinical Design Authority links with the Technical Design group.
- There is currently no formal HR or staff side representation in the programme governance structure, which given the significant change in staff roles and the potential for reduction in staff numbers (as outlined in the benefits case) is a potentially significant omission
- Although recognised, there is currently no service management group in the overall programme governance structure, which will be essential to establish at an early stage due to the implementation of a shared system and processes across two Trusts. This would also help address concerns about the capacity of the technical infrastructure in the hospitals and whether it is fit for purpose for the new solution coming on stream
- There are some concerns over service change readiness, experience and skills in both organisations, which is evidenced by the current interim technology projects proving difficult to adopt

- Having the programme team predominantly based at Huddersfield has led to a perception of lack of presence of the programme team at the Bradford site
- Decision making can be slow and cumbersome when trying to get sign off from both Trusts (e.g. common communications materials). This will become particularly pertinent for development and sign off of future clinical design of the system and will need strong leadership at clinical level to manage
- There is a need for a further focus on Change Control and how this will be handled across the two Trusts. Currently there is too much responsibility for change control at Transformation Board level and further delegation to Programme Board is needed to make this process effective
- The governance structures should be reviewed to ensure that there is appropriate representation at an operational level outside the two Trusts to support wider health system working (e.g. GPs, non-Trust managed community services, social services etc.)
- Plans for a number of key aspects of preparation for go-live need to be clearly defined in the very near future, and appropriately resourced. This includes:
  - Needing to get the location of the command centre for go-live support finalised and the appropriate resources secured for the go-live period
- Finalising the training plan - there is a need to have the physical facilities for classroom training in place and clear and realistic plan in place to release staff for training in the 8 week period prior to go-live with minimal impact to care
- There is a need to confirm the go-live dates for each Trust and ensure there is joint agreement across both organisations for each other's' go-live commitments.

5.3 Recommendations

Number	Recommendation	Status
R3	It is recommended that all MSP strategies (e.g. quality, monitoring and control, information management, resource management, benefits management etc...) are completed and formally signed off.	Essential
R4	The programme should develop a service management framework which will provide clarity on how the IT services will be managed leading up to and beyond the EPR system go live. This should be based on ITIL concepts. The programme governance also needs clarifying to account for the post go-live governance regime needed for service management, contract management and development of the commercial relationship.	Essential
R5	It is recommended that the Terms of Reference for all groups in the governance structure are clearly defined and agreed and the links between the groups, especially clinical groups, are clearly articulated	Essential

Number	Recommendation	Status
R6	Many of the benefits in the business cases imply changes to staff working patterns and processes. It is recommended that the Trusts are clear about how their respective HR teams will be included in the formal programme governance to ensure that impacts to staffing and processes are optimally managed	Essential
R7	There are signs that there will be increased pressure on estates and facilities in the run up to go-live. It is recommended that training facilities at or close to hospital locations is confirmed.	Recommended

6 Risk management processes in place

6.1 What's good?

- There is good evidence that risks are being activity managed across the various Programme governance groups, especially relating to potential financial risks such as VAT recovery
- The key programme risk of having one system (and one set of core processes) across two Trusts is well recognised and understood by a wide range of stakeholders
- There is also a good recognition that EPR has the potential to improve patient safety through reducing 'cutting corners' on forms and resulting in improved clinical practice
- There is good mitigation in place for the risk presented by the level of process change and the need for behavioural change by clinicians if new ways of working and the associated benefits are to be achieved. This mitigation includes the appointment of CCIO and CNIOs at both Trusts and the recruitment of clinical champions or 'EPR friends' at specialty level
- The programme team have implemented an additional risk review process to filter and prioritise the significant number of risks that had been captured; this will assist in enabling the programme to focus on the most important risks
- There is good mitigation for data migration risks in place through the appointment of an ex-Cerner staff member as the Data Migration workstream lead and the appointment of Stalis as a supporting technical partner who bring previous experience of iPM to Cerner migrations
- The data migration testing strategy provides further mitigation of data migration quality risks, the proposed 'trial loads' and 'mini-loads' approach allows for multiple pre-migration data quality checks and corrections.

6.2 What's not so good?

- The requirement for IT infrastructure replacement including replacement and additional access devices is not fully defined. This creates a significant cost risk to the programme
- The risks associated with a 'big bang' implementation do not appear to be adequately mitigated currently - this will need more detailed documentation of the risk and management in accordance with the risk process
- There is a real concern from a number of staff regarding the risks associated with the go-live period, in particular the potential impact on patient care and reduced productivity. This includes significant concern regarding the difficulty and impact of releasing staff from clinical areas for training, particularly the ability to ensure adequate training whilst maintaining safe nursing staffing levels
- The two Trust business cases for EPR seem to inconsistently, and without full transparency, deal with contingency and optimism bias. Whilst we understand that both Trusts are holding a contingency for this programme, the optimism bias in particular appears very low in comparison to other large, risky IT project (typically the range would be 15 - 30% rather than 2% in the current business cases)
- The risks associated with the following do not have adequate mitigation in:
  - An aging workforce with limited IT skills that may impact on the speed of uptake and familiarisation with the EPR system,
  - The potential impact on retention of staff and sickness levels in and around go-live
  - Access to and connectivity of IT equipment, especially in community services
  - Provision of appropriate 'back office' support to ensure that the EPR, which will become mission critical for both organisations, has the appropriate level of 24/7 support
  - Clear understanding of business continuity plans (BCP) at Ward and community level to support downtime and intermittently connected services (e.g. for community midwives)
  - The use of Bank Staff and Agency staff across the two sites and its potential impact on EPR awareness, cost, training and delivery
- The risk register extract that was reviewed was incomplete:
  - Not all risks that were documented were risks - some were questions
  - Not all risks had an owner
  - Not all risks have an action owner
  - Not all risks or issues have a mitigation or action plan
  - Target dates need to be included and updated

  - Risks should be reviewed and updated frequently, and re-scored (even if the score remains the same)

  The risk register should be reviewed on a regular basis to ensure it contains appropriate risks and with actions taken for each risk in accordance with the risk strategy. Actions to address this are already in place as set out in the section below

- The Risk description in the Progress Reports is limited and the level of detail is insufficient for the risk to be fully understood by the reader. The appropriate level of detail should be tailored to the relevant governance group. This also applies to issue reports which require a clearer description, actions to be taken and an action owner place, with any issues that are stopping delivery clearly articulated.

6.3 Recommendations

Number	Recommendation	Status
R8	There is ambiguity in the cost models being used to underpin the business cases going forward. In particular we recommend that the Trusts articulate much more clearly the approach being taken to handle emerging IT equipment costs and also to be clear how contingency / optimism bias is being modelled. There are standard optimism bias models available which should be evaluated as a possible approach.	Critical
R9	There is significant challenge in training the numbers of staff in the required time. These staff will also need a safe environment to test out their new skills. It is therefore recommended that 'live-like' systems are provided to allow staff who have received their training to experiment / play with the new system in order that they can gain confidence and identify implementation issues early.	Essential
R10	Establish the EPR Divisional Boards in BTHT and EPR representation on existing Boards at CHFT to ensure appropriate two way clinical engagement in designing future state systems	Essential

7 Risk and issue management strategy in place

7.1 What's good?

- There is a Risk and Issue Management Strategy in place, signed off by the Transformation Board
- The strategy is of high quality and uses good practice principles from other MSP managed programmes
- The strategy is consistent and in line with both Trust's risk management frameworks

- The strategy has been modified following initial sign off to reflect the need to adjust Trust definitions of proximity which led to too many frequent reviews of some of the longer term risks
- A Risk Review Board has been put in place to proactively manage the risk register, and this is a welcome development
- On-going education for the programme team in risk management is in place to ensure that not too many risks are logged and that key risks are not lost in the volume of other risks that have been identified.

7.2 What's not so good?

- The Risk Review Board does not appear on any governance documentation (although it does appear in the revised Risk Management Strategy) and therefore should be included in documentation related to the overall programme structure
- The Issue resolution section of the strategy should be reviewed to confirm the use of 'Likelihood' as a measure for issues (as the risk has already materialised). Our previous experience would indicate that issues be managed by a single measure only (e.g. Severity / Impact)
- The strategy should ensure that risk action owners act on risks quicker and update the risk register in a timelier manner. The audit trail for changes to risks should also be maintained.

7.3 Recommendations

Number	Recommendation	Status
R11	There appeared to be a lack of clarity whether all relevant staff were aware of the purpose for the programme risk register. In particular we saw numerous questions of how risks and issues differ, how risks should be coded and categorised, what constitutes a risk (as opposed to a question), how often a risk should be updated and lack of completeness of all relevant fields in the risk register. There is therefore a recommendation to more clearly implement the agreed risk strategy across the programme	Essential

8 Sponsorship and ownership of change led by Board and senior management team

8.1 What's good?

- Constructive criticism of the programme is openly supported across both organisations and this is welcomed and facilitated by the SROs
- There is a very good understanding at a senior clinical and managerial level that this is an enormous challenge for the organisations and that there is significant risk to successful delivery
- For Bradford there is good evidence that the senior team are positioning the EPR programme as being very different to their previous attempts to implement electronic patient records
- There have been real benefits and positive comments from both Trusts of having clinical teams working together in design workshops and sharing problems and solutions (not just in EPR), particularly for staff in operational and frontline care roles
- There is evidence of open and honest communication between the two Directors of Informatics and the two SROs regarding the programme
- There is evidence of attention to detail and seeing the macro picture at senior level both in business and IT roles across both organisations, with a Board level IT Director at Bradford with clear delegation of responsibility from SRO, and a Director level post at CHFT with clear lines of accountability into the executive team
- EPR is a standing item on the Trust Board and Executive team meetings for both organisations, as well as the relevant Finance and Performance Sub-committee meetings
- In CHFT, each executive has responsibility for briefing a number of consultants on the programme in order that all consultants have a named executive with which they can discuss the programme.

8.2 What's not so good?

- With the SROs being the CEOs of the respective organisations, there is a risk that other major issues will take priority (e.g. Monitor intervention, CQC visits, 5 year financial plans, hospital configuration etc.). The Directors of Informatics will need to ensure that appropriate reporting to the senior leadership is in place to recognise this and the need for more frequent reporting as go-live approaches

8.3 Recommendations

Number	Recommendation	Status
R12	As the programme approaches go-live and enters the high demand post go-live period, the reporting needs of the SRO and governance structures may change. It is	Recommended

Number	Recommendation	Status
	recommended that the programme teams review best practice from other implementations and agree the revised approach in advance with their SROs and governance chairs.	

9 Benefits management framework in place

9.1 What's good?

- There is a Benefit Management Strategy and framework drafted
- There is good evidence that operational leads were aware of the benefits EPR will bring to their areas and their responsibility for delivery of these benefits
- Benefits profiles for all 138 benefits identified in the business case have been drafted and measurement of the benefits baseline is in progress
- There is recognition that not all the benefits in the business case were clearly evidenced and are therefore unlikely to be delivered as planned. There is work underway to identify other benefits to replace the financial savings associated with these unrealistic benefits
- Benefits maps are under development, setting out the dependencies between solution functionality, outcomes and benefits.

9.2 What's not so good?

- Some of the cash releasing benefits outlined in the business case will be very difficult to deliver, particularly those related to a reduction in clinical staff numbers and reduced length of stay
- There is potential for double counting of benefits from the EPR Programme with other transformation or CIP projects in each Trust
- It is not clear where benefits realisation progress will be reported in each organisation - this should be made clearer in the governance documentation
- Review team comments on the Benefits Management Strategy include:
  - It is still in draft form and needs signing off
  - The document doesn't fully reflect that benefits management carries on beyond the end of the project to monitor delivery as use of EPR becomes Business as Usual (BAU)
  - None of the benefit categories relate to Better Clinical Outcomes which may indicate a preference for seeing cash releasing benefits

- Benefits tracking should be clarified to ensure that a cash releasing benefit is only recorded as delivered when money is taken out of the relevant budgets (in agreement with the appropriate divisions)
- It is not clear how often benefits reviews will be undertaken, this requires clarification
- The benefits profile template should include fields to outline target metrics and a description of how the benefit will be measured

9.3 Recommendations

Number	Recommendation	Status
R13	Since the development of the business cases, the macro context and service emphasis in the NHS has potentially changed. In addition the understanding of the system and its potential benefits has increased. Accordingly, a number of the current forecast benefits look unlikely to materialise fully as cash releasing benefits. It is therefore recommended that the Trusts complete a full review and refresh of the benefits cases and gain formal approval.	Critical
R14	The Trusts should ensure that they have a clearly documented approach to linking the EPR programme with the other transformation programmes running in each organisation. This approach should make clear the governance group which has oversight of the integrated transformation plan in each Trust.	Essential
R15	There is ambiguity about where and how benefits realisation progress will be reported at each Trust. It is therefore recommended that the benefits management governance approach is formally agreed.	Recommended

10 Communications strategy agreed

10.1 What's good?

- There is a lot of evidence of programme communications activities of the programme in terms of materials, meetings, workshops, staff restaurant displays etc.
- There is good recognition from the stakeholders that the EPR system will not be perfect from day 1 of go-live and thus appropriate expectation management is in place
- There is a recognition that ambiguity related to the scope of the final system build and new operating processes is acceptable at this point in the programme
- A Customer Relationship Management (CRM) system is being used to record communications activity by the programme team

- There has been good progress on branding, agreeing key messages and engagement with key stakeholders
- There is very good evidence of a high level of visibility of senior staff at both Trusts regarding the programme
- A baseline measure of staff understanding of EPR awareness has been undertaken using SurveyMonkey, with plans to repeat this on a regular basis to assess how awareness improves over time
- There are good links at both Trusts between the respective corporate communications teams and the communications lead for the EPR programme.

10.2 What's not so good?

- The Communications Strategy could be improved through:
  - Ensuring the document places an equal focus on the communications strategy as well as the communication plan - the document is currently more focused on outlining a plan
  - Improving the section on Feedback– this should be a major section and focussed on eliciting as much feedback as possible, with processes in place for the programme team to deal with that feedback
  - Establishing a series of metrics / Key Performance Indicators (KPIs) to assess the outcome and impact of the communication and not just communication activity.
- Forthcoming communications need to include focus on:
  - Benefits and disbenefits for staff, and in particular address the underlying concerns that have surfaced in some interviews that EPR may lead to job cuts
  - Managing expectations - EPR is not a 'magic box' that solves all the Trust's problems
  - Role based communications - i.e. what it will mean specifically for a ward nurse, a porter, a junior doctor, a ward clerk, a community matron etc.
  - Directing people to the website for more information
  - Ensuring that cascade briefing takes place reliably and quickly from the various governance groups and meetings associated with the programme, particularly at specialty level.

10.3 Recommendations

Number	Recommendation	Status
R16	Building on its previous steps using survey monkey, the programme should establish an ongoing regime of communications effectiveness reviews which will allow the impact of communications activities to be monitored, evaluated and refined	Essential

Number	Recommendation	Status
R17	Much of the communications to date has been focussed on information sharing and encouraging engagement. We recommend the communication team develops mechanisms for obtaining feedback and taking on board staff opinions	Essential
R18	There is ambiguity over the physical devices which will be used to access the new system functionality. As this will impact training, roll-out and confidence it is recommended that a plan is developed to provide clarity to end users on this matter and communicate out to staff on this matter.	Recommended

11 Initial engagement status is appropriate

11.1 What's good?

- There is good evidence of significant clinical and operational engagement in the procurement and selection of Cerner as the EPR system
- There has been a significant amount of clinical engagement to date with more planned across both organisations, this will support the need to agree largely common future working processes
- Some engagement has begun with external bodies (e.g. GPs, CCGs, patient groups etc.)
- The use of tactical IT projects (e.g. iPAMS, Medway / K2 for Maternity, NerveCentre etc.) to build confidence and skills in IT across the workforce is positive
- There is a lot of experience in both Women's and Children's divisions from their own EPR implementations of Medway (BTHFT) and K2 (CHFT) and this should be built upon.

11.2 What's not so good?

- The EPR Engagement Strategy:
  - Is in draft form and so needs signing off
  - Refers to an external stakeholder strategy, but no document exists
  - Contains key messages which would be better placed in the Communications Strategy document
  - Refers to a Stakeholder Map being developed, but there is no evidence that this is completed or is only partially complete
  - Needs to provide more focus on building the 'EPR friends' network to ensure that there is local ownership and support for EPR

  - Lacks detail on how the engagement tracker will work – this may be the same as the CRM system noted previously but should be clarified
- There is a need to fully implement plans for divisional representation in the project - to address concerns regarding adequate representation and engagement of the diverse workforce in both Trusts. The use of clinical champions / EPR friends will help address this
- There is a need to engage whole ward teams (not just doctors and nurses) in ensuring the EPR solutions works for all roles involved in the patient care process (e.g. ward clerks, junior doctors, porters, HCAs etc.)
- It is not clear how the Trust is using the relevant skills and experiences from recent Maternity EPR projects to support the wider EPR programme
- Engagement is being hindered by the lack of clarity on scope and not being able to see the final product, leading to the engagement team not being in a position to answer all the questions being asked by frontline staff
- Some clinical meetings have not taken into account the need for 6 week notice for clinicians to attend meetings. This has now been recognised more fully.

11.3 Recommendations

Number	Recommendation	Status
R19	There has rightly been much focus on clinical and nursing engagement as key parts of the change programme. However, based on feedback from a number of interviewees, it is recommended that the programme considers how it can engage with other key Trust staff groups who are critical to successful implementation of the programme (such as ward clerks, porters etc.).	Essential
R20	Formalise lessons learnt from previous Trust clinical systems implementations (e.g. Maternity solutions, NerveCentre etc.) and ensure these are appropriately recognised in the planning and implementation of the EPR programme	Essential

12 Readiness for next phase – delivery of outcomes

The next phase of the programme will, amongst other things, develop the future state models for the EPR and associated processes. We found that the Trusts were well placed for this stage having strong clinical engagement and high levels of participation. Our next assurance review has been timed to coincide with the delivery of these future state models as we anticipate that the process of developing these models will highlight any

key areas of functional, system, engagement or transformation workstreams which may need further attention to secure a successful EPR implementation.

13 Previous External Assurance Review Recommendations

Not Appropriate

14 Next Gateway Review

The next External Assurance Review (Programme Management) is expected to take place 19-22 January 2016.

15 Distribution of the Gateway Review Report

The contents of this report are confidential to the SROs and their representative/s. It is for the SROs to consider when and to whom they wish to make the report (or part thereof) available, and whether they would wish to be consulted before recipients of the report share its contents (or part thereof) with others.

The Review Team Members will not discuss its content or conclusions with others.

Any other request for copies of the Gateway Report will be directed to the SROs.

Appendix 1 Purpose of the External Assurance Review

The Trusts identified the following as the initial scope and priorities for the three assurance gateway reviews:

Gateway Review 1 - Governance

- Alignment of programme with business development objectives and priorities.
- Programme governance and accountabilities clearly defined and implemented.
- Risk management processes in place for identification, analysis, control, monitoring and review.
- Risk and issue management strategy in place
- Sponsorship and ownership of change led by Board and senior management team.
- Benefits management framework in place.
- Communications strategy agreed
- Initial engagement status is appropriate

Gateway Review 2 – Programme Management

- Risks and patient safety aspects being addressed
- Robust programme plan developed and effective reporting and escalation processes in place
- Project impact assessments are being done.
- Role based training plan in place.
- Data migration and integration assessment plans completed and risk assessed.
- Benefits are being managed to deliver.
- Programme management resources, controls and reporting defined and implemented.
- Engagement status is appropriate for this stage of the programme
- Future state processes complete

Gateway Review 3 – Prior to Go-live

- Preparation for implementation in place (data, infrastructure, suppliers).
- Process design complete, vetted and clinically risk assessed where required.
- Role security design complete.
- Process, systems and data migration testing complete
- Requirements and accountabilities for end to end support and service management in place.
- Go live and cutover planning complete approach and scope and clinically risk assessed
- Risks and patient safety continue to be addressed.
- Organisational readiness and capacity and engagement appropriate for this stage of the programme

Appendix 2 Summary of Recommendations

Each recommendation has been given Critical, Essential or Recommended status. The definition of each status is as follows:

- **CRITICAL** - Critical for immediate action, i.e. to achieve success the project should take action immediately to address the following recommendations:
- **ESSENTIAL** - Critical before next Review, i.e. the project should go forward with actions on the following recommendations to be carried out before the next Gateway Review of the project:
- **RECOMMENDED** - Potential Improvements, i.e. the project is on target to succeed but may benefit from uptake of the following recommendations.

Number	Recommendation	Report Section	Status
R1	The programme is in need of an overarching document to set out what the programme is aiming to achieve, why it is important, how it relates to the wider context, what is in and out of scope etc... Depending on the programme methodology being used this could be referred to as the Blueprint, Project Initiation Document, Programme Definition Document etc. This lack of clarity impacts end users clarity on what is or is not in scope, technical clarity on what will or will not be interfaced and the associated strategic ambiguity for related systems (TPP, ICU, Maternity, community etc...) It is therefore recommended that a PID (or similar) is created and approved for the programme.	4	Critical
R2	Whilst it is recognised that the financial models for the FBCs included a number of scenarios, it is recommended that the programme develop a specific set of scenario models to better understand the cost and benefit impact of go-live date slippage and the subsequent impact on ROI.	4	Critical
R3	It is recommended that all MSP strategies (e.g. quality, monitoring and control, information management, resource management, benefits management etc...) are completed and formally signed off.	5	Essential
R4	The programme should develop a service management framework which will provide clarity on how the IT services will be managed leading up to and beyond the EPR system go live. This should be based on ITIL	5	Essential

Number	Recommendation	Report Section	Status
	concepts. The programme governance also needs clarifying to account for the post go-live governance regime needed for service management, contract management and development of the commercial relationship.		
R5	It is recommended that the Terms of Reference for all groups in the governance structure are clearly defined and agreed and the links between the groups, especially clinical groups, are clearly articulated	5	Essential
R6	Many of the benefits in the business cases imply changes to staff working patterns and processes. It is recommended that the Trusts are clear about how their respective HR teams will be included in the formal programme governance to ensure that impacts to staffing and processes are optimally managed	5	Essential
R7	There are signs that there will be increased pressure on estates and facilities in the run up to go-live. It is recommended that training facilities at or close to hospital locations is confirmed.	5	Recommended
R8	There is ambiguity in the cost models being used to underpin the business cases going forward. In particular we recommend that the Trusts articulate much more clearly the approach being taken to handle emerging IT equipment costs and also to be clear how contingency / optimism bias is being modelled. There are standard optimism bias models available which should be evaluated as a possible approach.	6	Critical
R9	There is significant challenge in training the numbers of staff in the required time. These staff will also need a safe environment to test out their new skills. It is therefore recommended that 'live-like' systems are provided to allow staff who have received their training to experiment / play with the new system in order that they can gain confidence and identify implementation issues early.	6	Essential
R10	Establish the EPR Divisional Boards in BTHT and EPR representation on existing Boards at CHFT to ensure appropriate two way clinical engagement in designing future state systems	6	Essential
R11	There appeared to be a lack of clarity whether all relevant staff were aware of the purpose for the programme risk register. In particular we saw numerous questions of how risks and issues differ, how risks should	7	Essential

Number	Recommendation	Report Section	Status
	be coded and categorised, what constitutes a risk (as opposed to a question), how often a risk should be updated and lack of completeness of all relevant fields in the risk register. There is therefore a recommendation to more clearly implement the agreed risk strategy across the programme		
R12	As the programme approaches go-live and enters the high demand post go-live period, the reporting needs of the SRO and governance structures may change. It is recommended that the programme teams review best practice from other implementations and agree the revised approach in advance with their SROs and governance chairs.	8	Recommended
R13	Since the development of the business cases, the macro context and service emphasis in the NHS has potentially changed. In addition the understanding of the system and its potential benefits has increased. Accordingly, a number of the current forecast benefits look unlikely to materialise fully as cash releasing benefits. It is therefore recommended that the Trusts complete a full review and refresh of the benefits cases and gain formal approval.	9	Critical
R14	The Trusts should ensure that they have a clearly documented approach to linking the EPR programme with the other transformation programmes running in each organisation. This approach should make clear the governance group which has oversight of the integrated transformation plan in each Trust.	9	Essential
R15	There is ambiguity about where and how benefits realisation progress will be reported at each Trust. It is therefore recommended that the benefits management governance approach is formally agreed.	9	Recommended
R16	Building on its previous steps using survey monkey, the programme should establish an ongoing regime of communications effectiveness reviews which will allow the impact of communications activities to be monitored, evaluated and refined.	10	Essential
R17	Much of the communications to date has been focussed on information sharing and encouraging engagement. We recommend the communication team develops mechanisms for obtaining feedback and taking on board staff opinions	11	Essential
R18	There is ambiguity over the physical devices which will be used to access the new system functionality. As this	11	Recommended

Number	Recommendation	Report Section	Status
	will impact training, roll-out and confidence it is recommended that a plan is developed to provide clarity to end users on this matter and communicate out to staff on this matter.		
R19	There has rightly been much focus on clinical and nursing engagement as key parts of the change programme. However, based on feedback from a number of interviewees, it is recommended that the programme considers how it can engage with other key Trust staff groups who are critical to successful implementation of the programme (such as ward clerks, porters etc.).	12	Essential
R20	Formalise lessons learnt from previous Trust clinical systems implementations (e.g. Maternity solutions, NerveCentre etc.) and ensure these are appropriately recognised in the planning and implementation of the EPR programme	12	Essential

Appendix 3 Review Team and Interviewees

Review Team:

Review Team Leader:	Max Jones Director GE Healthcare Finnamore
Review Team Members:	Adam Drury Director GE Healthcare Finnamore
	Kate Salsbury Associate Consultant GE Healthcare Finnamore

List of Interviewees:

Name	Role (Organisation)
Jason Matthews	Assistant Finance Director (BTHFT)
Sarah Freeman	Head of Nursing - Medicine (BTHFT)
Paul Southern	Associate Medical Director - Informatics (BTHFT)
Cindy Fedell	Director of Informatics (BTHFT)
Terri Sanderson More Derrick	DGM, Surgery and Anaesthesia (BTHFT) Matron, Surgery and Anaesthesia (BTHFT)
Julie Walker Des Gibney Janette Reynolds	Head of Midwifery, Women's and Children's (BTHFT) Clinical Director, Women's and Children's (BTHFT) DGM, Women's and Children's (BTHFT)
Clive Kay	Chief Executive (BTHFT)
Rachel Pyrah Helen Webster-Mair Sophia Khan Katherine Nuttall	Senior Change Manager (Programme Team) Business Change Manager (CHFT) Business Change Manger (BTHFT) Cutover Project Manager (Programme Team)

Dave Lang Maddie Szeleky Kay Pagan	Programme Director (CHFT) Programme Director (BTHFT) CNIO (BTHFT)
Ginette Baker	Senior Consultant (HSCIC)
Andrew Haigh	Chairman (CHFT)
Bob Black	Account Executive (Cerner)
Mandy Griffin	Director of Health Informatics (CHFT)
Anne Marie Henshaw	Head of Midwifery, Maternity services (CHFT)
Owen Williams	Chief Executive (CHFT)
Keith Griffiths Stuart Baron	Director of Finance (CHFT) Assistant Director of Finance (CHFT)
Rod Gamble	Programme Manager (Programme Team)

Appendix 4 Self-Assessment Criteria

		Scoring against stated criteria:	Risk based assessment (impact of not taking action to meet the stated criteria)
1	Not Met	Statement/criteria not met	Catastrophic impact on either programme timescales, cost or quality if the required action is not taken to meet the criteria. Very difficult and costly to recover if at all
2	Poorly Met	Statement/criteria partially met but considerable work required to achieve a score of 4	Major impact on either programme timescales, cost or quality if the required action is not taken to meet the criteria. Medium to long term effect (including after go live) and/or expensive to recover.
3	Partially Met	Statement/criteria partially met and applies to the majority of the requirement with only a relatively small amount of effort required to achieve a score of 4.	Moderate impact on either programme timescales, cost or quality if the required action is not taken to meet the criteria. Medium term effect (including after go live) and/or moderately expensive to recover.
4	Mostly Met	Statement/criteria met with only minor action required to achieve a score of 5	Minor disruption to either programme cost, time or quality if the required action is not taken to meet the criteria. Short to medium term effect with little or no associated cost.
5	Fully met	Statement/criteria fully met with no additional work or adjustment required.	Insignificant impact on either programme cost, time or quality if no further action is taken. With no associated cost.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 28th January 2016	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - Corporate Risk Register - This paper presents to the Board the Corporate Risk Register as at January 2016 for review	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The January Corporate Risk Register has been review at the Risk and Compliance Group on 12 January 2016.	
Governance Requirements: Keeping The Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper presents to the Board the Corporate Risk Register (CRR), which identifies the current significant risks facing the organisation as at January 2016, for the Board's consideration and oversight.

Main Body

Purpose:

The role of the Board is to assure itself that all risks are accurately identified and mitigated adequately by reviewing the risks identified on the CRR.

Background/Overview:

The CRR is presented to the Board on a monthly basis to ensure that the Board is aware of all current key risks facing the Trust and is a key part of the Trust's risk management system.

On a monthly basis the Risk and Compliance Group considers all the risks that potentially may be deemed a corporate risk, ie those with a risk score of 15 or more, prior to presenting these to the Board.

The Issue:

The attached paper includes:

- A summary of the Trust risk profile as at January 2016 which identifies the highest scoring risks (with scores of 25, 20, 16 and 15), risks with increased scores, risks with reduced scores, any new risks and any closed risks.

- The Corporate Risk Register which identifies 19 risks and the associated controls and actions to manage these.

To note the Risk and Compliance Group on 12 January 2016 agreed that three new risks should be added to the CRR and these are included within the attached report and summarised below:

6594 – Radiology risk re: not acting on findings from diagnostic tests, risk score of 16
6596 – Essential skills data training risk, risk score 16
6598 - Timeliness of serious incident investigations, risk score of 16

Next Steps:

The CRR is a dynamic document and will continue to be reviewed on a monthly basis and presented to the Board to ensure it is aware of all significant risks facing the organisation.

Recommendations:

Board members are requested to:

- consider, challenge and confirm that potential significant risks within the Corporate Risk Register are under control
- consider and approve the current risks on the risk register
- advise on any further risk treatment required.

Appendix

Attachment:

COMBINED RISK REGISTER - JAN 2016.pdf

CORPORATE RISK REGISTER REPORT

Risks as at 19 January 2016

TOP RISKS

6131 (25): Progression of service reconfiguration impact on quality and safety
2827 (20): Over-reliance on middle grade doctors in A&E
4706 (20): Failure to meet cost improvement programmes
4783 (20): Outlier on mortality levels
6345 (20): Staffing risk, nursing and medical
6346 (20): Ability to deliver service transformation risk
6503(20): Delivery of Electronic Patient Record Programme

RISKS WITH INCREASED SCORE

No risks have increased in score.

RISKS WITH REDUCED SCORE

Risk 6499 regarding CQC standards in the community division has been revised and has a lower score on the community division risk register.

Risk 6094 regarding potential loss of training grade posts, scored at 12, has been removed from the corporate risk register and will be managed within the divisional risk register.

NEW RISKS

The following new risks have been added to the Corporate Risk Register in January 2016:

6594 – Radiology risk re: not acting on findings from diagnostic tests, score of 16
6596 – Essential skills data training risk, score 16
6598 - Timeliness of serious incident investigations, risk score of 16

CLOSED RISKS

No risks have been closed.

CORPORATE RISK REGISTER –JANUARY 2016 Summary of Risks by Risk Type

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Sept. 2015	Oct. 2015	November 2015	December 2015	January 2016
		Strategic Risks						
6346	Transforming & Improving Patient Care	Capacity and capability to deliver service reconfiguration	Director of Nursing (JD)	20	20	20	20	**20 =**
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme	Chief Executive	-	-	-	20!	20=
		Safety and Quality Risks						
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	25	25	25	25	25 =
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20	20	20	20	20 =
2827	Developing Our workforce	Poor clinical decision-making in A&E	Medical Director (DB)	20	20	20	20	20 =
6299	Keeping the base safe	Failure of high risk medical devices	Director of Estates and Performance (LH)	15	15	15	15	15 =
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	16	16	16	16	16 =
6300	Keeping the base safe	Clinical, operational and estates risks	Director of Nursing	16	16	16	16	16=
6594	Keeping the base safe	Radiology risk acting on diagnostic test findings	Medical Director (DB)	-	-	-	-	16!
6598	Keeping the base safe	Essential skills training data	Interim Director of Workforce and OD	-	-	-	-	16!
		Financial Risks						
4706	Financial sustainability	Failure to meet cost improvement plans and not adhere to financial governance	Director of Finance (KG)	20	20	20	20	20 =
6130	Financial sustainability	Loss of income / service due to commissioner procurement decisions	Director of Commissioning and Partnerships (AB)	16	16	16	16	16=
6150	Keeping the base safe	Cash flow risk	Director of Finance (KG)	-	15	15	15	15 =
6027	Keeping the base safe	Suspension of capital programme risk	Director of Finance (KG)	-	15!	15	15	15 =

		Performance and Regulation Risks						
6078	Keeping the base safe	Insufficient Appointment Slots	Director of Nursing (JD)	16	16	16	16	16 =
2828	Keeping the base safe	Slow patient flow and breach of A&E targets	Director of Nursing (JD)	16	16	16	16	16 =
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing	-	-	-	-	16!
		People Risks						
6345	Keeping the base safe	Ability to deliver service transformation	Medical Director (DB) , Director of Nursing (JD), HR Director	20	20	20	20	20 =
6057	Keeping the base safe	Clinical Administration workforce	Chief Operating Officer	-	-	-	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

Trust Risk Profile as at 19 January 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					= 6299 – Medical Device failure levels = 6150 Cash flow risks = 6027 Suspension of capital risk programme = 6057 Clinical administration workforce
Likely (4)				= 2828 – Slow patient flow & breach of A&E targets due to bed blockages / transport = 5806 – Urgent estate work not completed = 6078 – Iinsufficient appointment slots = 6130 = Loss of income/services due to commissioner procurement decisions = 6300 – Clinical, operational and estates risks outcome = 6503 – Non delivery of EPR programm ! 6594 – Radiology risk/ diagnostic tests ! 6596 – Serious Incident investigations ! 6598 – Essential Skills Training Data	= 2827 –Over reliance on middle grade doctors in A&E = 4706 – Failure to meet CIP & adhere to financial governance
Highly Likely (5)				= 4783 – Outlier on morality levels = 6345 – Staffing risk, nursing and medical = 6346 – Ability to deliver service transformation	= 6131 – Progression of service reconfiguration impact on quality and safety

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

Corporate Risk Register (15 or over)

The Health Informatics Service
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	Risk No	Div	Dir	Dep	Opened	Status	Goal	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Major	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	15 5 x 3	Joint working is in place with Commissioners (through the joint Hospital Board) to revisit the clinical model, activity, workforce and financial modelling of options for hospital reconfiguration. The Trust is required by Monitor to develop a 5 year strategic plan that will improve the Trust's financial and clinical sustainability. This plan will be completed by December 2015 and will include plans for reconfiguration of services across hospital sites. The Trust's five year plan will inform and enable CCG's to make a decision in early January to commence public consultation. The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks (cardiology and respiratory service configuration, Emergency Pregnancy Assessment configuration). **January update** - Public engagement commenced on Cardiology and Respiratory inpatient change. Change in consultant recruitment will reduce time to appointment. Commenced January 2016.	Jan-2016	Apr-16	WEB	Anna Basford	Catherine Riley
Major	6346	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Transforming and improving patient care	Capacity and Capability of Delivering Service Transformation Risk of not achieving service transformation due to insufficient capacity and capability across the organisation to deliver the many transformation schemes underway (Electronic Patient Record (EPR), clinical administration review, financial turnaround and cost improvement schemes, CQC preparation, service reconfiguration, i.e. consultation and planning for Outline Business Case, Care Closer to Home Proposal) resulting in impact on delivery of safe clinical care for patients in the right setting and financial imbalance.	Programme Management Office established to managing schemes Strategic and Financial Turnaround Plan, 2015/166 financial plans and cost improvements Integrated Board report details Trust financial position monthly Well Led Governance Review identifies areas to strengthen governance across the Trust CQC Steering Group reviews progress with CQC action plan preparation to identify areas of risk of non-delivery EPR implementation programme	Assurance that the totality of transformation schemes can be delivered	16 4 x 4	20 4 x 5	9 3 x 3	To consider adding the risk to the Board Assurance Framework. July update: Workshop held with Executive team to consider this conflicting priorities. A number of proposals developed to be discussed at next Directors meeting. **January Update**: PMO office mapping key deadlines and impact of transformation schemes to inform discussion of risk mitigation	Jan-16	Mar-2016	WEB	Julie Dawes	Assistant Director of Quality, Juliette Csogrove

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe and effective high quality care and 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 workforce model) - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Opthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams cont. below	Nurse Staffing: To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing: staff redeployment, staff skill mix, eg extend roles of nursing / Allied Health professionals, use of flexible labour where identified staffing shortfalls - bank/ additional hour payments (nursing), internal / agency locum cover - weekly report on usage of agency / bank staff and review of interim resource costs as part of control workstream by Director of HR Active recruitment activity, including international recruitment Retention strategy for nursing Integrated Board Report /Hard Truths report identifies nursing staffing levels below requirements Divisional management:specific staffing gaps identified on Risk Register and reviewed through governance structures, divisional business meetings identify staffing risks and plan to mitigate risk Ward based medical staff reviewing patients daily-escalation to responsible Consultant Consultant allocated to review daily as outliers Escalation of patients who become acutely unwell to return as priority to speciality bed base. Band 7 and matron reviewing ward daily Band 6 appointed. Staff released from other wards for 6 months. Gaps in controls - Inability to recruit qualified nurses to cover gaps.	Medical Staffing Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients	16 4 x 4	20 4 x 5	9 3 x 3	Nursing recruitment - investigate the possibility of outsourcing flexible workforce department Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Secure resource to develop medical staffing workforce planning (Medical Director) Improved operational management of medical staffing workforce (Medical Director) Set up a Task and Finish Group led by Assistant Director of Operations to agree the response to manage the medical workforce risk (September 2015). November update Medical Staffing: Progress International recruitment through the procurement process. Trust Board paper to approve improvements to the Consultant Recruitment process written by senior clinical and HR colleagues. Senior nursing colleagues on Medical Workforce Group . 1-1 discussions will take place with Consultants planning to leave to aid understanding of the reasons why, to commence January 2016 **January Update - see below**	Jan-16	Mar-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk 6345 cont. resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) There is a risk that patients in the extra capacity wards (6A, 5B, 4D and HRI11) cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate - there is no established workforce for these areas and the directorate has on average 50WTE Band 5 vacancies at any one time ongoing, resulting in possible harm to patients, poor management of deteriorating patients, poor patient experience and negative feedback.	6345 cont Medical Staffing Establishment of the Medical Workforce Group chaired by the Medical Director, dealing with recruitment and selection, international recruitment, non-contract spend, speed up the Consultant recruitment process and controlling the deployment of staff by improved rota management. Exit interviews for Consultants are being conducted. Therapy Staffing Try to make posts as flexible as possible, review of skill mix across the workforce with development of Assistant Practitioner posts where appropriate. Aim to increase availability of flexible work force by actively recruiting bank staff and staff to work additional hours. All staff Contribute to Health Education England survey to inform future commissioning / provision of education / training	6345 cont. Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	6345 cont. **January Update** Additional support is being arranged through HR to build a better understanding of the gaps in the medical and therapy workforce.	Jan-16	Mar-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson

Major	6503	Corporate	THIS	THIS Modernisation	Dec-2015	Active	Transforming and improving patient care	RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable. The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception. This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised.	A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT. Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register Executive sponsorship of the programme with CEO's chairing the Transformation Board Separate assurance process in place Clinical engagement from divisions Clearly identified and protected funding as identified in the Full Business Case. All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.	- Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success. - Completed future state review by all parties including Cerner - This is essential to understand what the fundamentals will look like post go live. - Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live.	20 5 x 4	20 5 x 4	5 5 x 1	- Continual monitoring of actual programme risk and issues log - Any risks escalated to the Transformation Board brought to this committee - Access to the full EPR Risk Log will be made available to R&C group via the Cerner Portal if required, any escalations from transformation group will be brought to R&C by the programme leads.	Mar-2016	Sep-2017	RC	Mandy Griffin	Jackie Murphy/Alistair Morris
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	There is a risk of poor clinical decision making in A/E due to a dependence on locum Middle Grade Doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff.	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time October 2015 4 Consultant posts advertised in June 15 still vacant as no applications and under consideration for international recruitment December 2015- Recruited to 1 consultant post. To advertise posts again.Locum consultant now in post.	Mar-2016	Aug-2016	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

Major	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Financial sustainability	The Trust is planning to deliver a £20m deficit (excluding restructuring costs) in 2015/16. There is a risk that the Trust fails to achieve it's financial plans for 2015/16 due to failure to deliver cost improvement plans or not adhering to good financial governance, resulting in compromised patient safety and increased external scrutiny.	Standing Financial Instructions set spending limits Turnaround structure in place which has created a more robust Project Management Office and the rigorous administration of cost improvement schemes Implementation of Turnaround Governance procedures (i.e. accurately reporting and projecting financial performance) Divisions can respond to activity targets on a specialty basis (e.g. additional theatre sessions/outsourcing if necessary) Formal Finance Our Future training Board to Budget Holders in place Budget reviews hold budget holders to account Accurate Income and Expenditure forecasting CIP target greater than actual savings required and contingency reserve established by the Director of Finance	The unpredictability of Commissioners tendering process and possible decommissioning of services. Impact of decisions in wider local health and social care system on capacity driven expenditure requirements in Trust.	15 5 x 3	20 4 x 5	10 5 x 2	Plans to be agreed to manage gains or losses following tendering process. **January update:** Re-forecast year end position submitted to Monitor in late November is to deliver a year end deficit of £20.94 against the originally planned £20.0m deficit (excluding restructuring costs). Inclusion of restructuring costs at £1.10m brings the overall re-forecast deficit to £22.04m. Latest forecast position is to meet the re-forecast plan.	Feb-2016	Mar-2016	FPC	Keith Griffiths	Kirsty Archer
Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Transforming and improving patient care	There is a risk that the Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients/frail elderly patients and possible incorrect clinical coding resulting in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15 Care bundles not reliably commenced and completed	20 4 x 5	20 4 x 5	16 4 x 4	To complete the work in progress - CQUINS To be monitored by the Trust - External review of data and plan To take place - assistance from Prof Mohammed (Bradford) August update: Further information received with increased risks To mortality. Action plan reviewed and presented To WEB. PMO approach To be adopted for reliable implementation of care bundles Sept update: Compliance with mortality reviews for last month significantly increased. October update: Improvements in coding noticed. Professor Mohammed, mortality expert, has made recommendations which are being progressed. plan To commission Royal College review into some key services.R13 January update Depth of coding increasing, Palliative care coding actions being implemented, Reliability in sepsis care improving.	Jan-2016	Aug-2016	COB	David Birkenhead	Juliette Cosgrove

Major	6594	Family & Specialist Services	Radiology	CT & MRI	Jan-2016	Active	Transforming and improving patient	It is recognised that the responsibility for acting upon the findings reported in any diagnostic test (specifically radiology) rests with the referring clinician, on occasions there have been examples where important clinical results may not been followed up and these pose a significant risk to patients. Indeed this risk has been identified via a reported incident. Without appropriate action been taken there is a potential risk to patient safety	Radiology reports are flagged to referring clinicians when important findings are recorded, a manual system utilising the **Alert Process is in place where Radiology seek to inform clinicians of these findings. This process does not however guarantee that a clinician has acted upon these results.	No electronic system to record that Radiology reports have been received. No failsafe system in place to ensure that referring clinicians have acted upon the results of a finding.	16 4 x 4	16 4 x 4	4 1 x 4	Initial paper submitted by Radiology describing a set of future actions that will required to minimise risks, copy of paper attached. Deputy Director of Nursing to lead an urgent, Trust-wide task and finish group to respond to this risk which will report in March 2016	Apr-2016	Apr-2016	SC	David Birkenhead	Lindsay Rudge
Major	6596	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Jan-2016	Active	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs). due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Interim resource in place in Risk Management to oversee management of Serious Incident Investigations	1. Lack of capacity to undertake investigations in a timely way and 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group	Apr-2016	Apr-2016	QC	Director of Nursing, Julie Dawes	Juliette Cosgrove
Major	6598	Corporate	Workforce, OD & Training	Training	Jan-2016	Proposed for Acceptance	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and by target audience, due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process, resulting in lack of assurance to the organisation that all staff have the relevant essential skills to practice safely and a failure to understand essential skills training compliance against set targets across the whole of the organisation.	Essential skills matrix which aims to identify all the essential skills training within the organisation. Training strategy proforma to capture the target audience for essential skills subjects. Clinical supervision/preceptorship structures are in place to monitor staff compliance with essential skills training. Learning management system, Oracle Learning Management (OLM) which can centrally record training attendance and compliance against a target where one is set within it's functionality limitations.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be required.	16 4 x 4	16 4 x 4	2x 2	1/ A data gathering exercise is currently ongoing to draw in all existing essential skills training data and will be completed by end January 2016 2/ Target audience setting for all essential skills subjects will be completed by end Feb 2016 3/ A manual system to accommodate recording and reporting to the level required must be designed and implemented to facilitate full reporting/monitoring by end March 2016. There are resource implications in completing this action.	Apr-2016	Apr-2016	NA	Interim Director of Workforce and	Bev France

Major	2828	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Keeping the base safe	There is a risk of slow patient flow and breaches against the ED national standards due to bed blockages across the Trust, resulting in harm to patients through delayed treatment, increased external scrutiny for the Trust and financial penalties against the contract. There is a risk that patients in the extra capacity wards (6A, 5B, 4D and HRI11) cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate - there is no established workforce for these areas and the directorate has on average 50WTE Band 5 vacancies at any one time ongoing, resulting in possible harm to patients, poor management of deteriorating patients, poor patient experience and negative feedback.	Escalation protocol in place which requires ED Co-ordinator to link with Patient Flow/Clinical Site Commander to ensure patients are moved from ED to a bed within national guidelines. Site Commander can authorize additional beds by using flexible capacity. Level discharges (required discharges at certain points of the day) plan in place. Site Commander to work with Ward Managers at 2 hourly meetings to ensure these happen. All patients have a personal plan established by their Ward which includes discharge arrangements. Medically stable patients are reviewed daily by the Discharge Team and Local Authority. Surge and escalation plan in place to escalate to higher levels of authority (e.g. cancel next day surgery). Ward based medical staff reviewing patients daily-escalation to responsible Consultant. Consultant allocated to review daily as outliers. Escalation of patients who become acutely unwell to return as priority to speciality bed base. Band 7 and matron reviewing ward daily. Band 6 appointed. Staff released from other wards for 6 months. Gaps in controls - Inability to recruit qualified nurses to cover gaps.	Despite the controls, the bed base in still insufficient at certain times. Occupancy levels remain high. The night period is particularly vulnerable. The number of patients who are a delayed transfer of care have increased and social care have limited capacity to transfer patients into the community with support.	20	4 x 5	16	4 x 4	8	4 x 2	Bed modeling review underway as part of the ED Action Plan. Completion by mid-June 15. Capacity and demand modeling being undertaken (matching resources to peak activity periods). To be complete by June 15. Urgent Care Board is accessible to consider new initiatives and act as an escalation decision making body in the case of very urgent situations. The Board has reserve resources October update: Daily review of staffing, patients, staff re-deployment. Reallocation of Trust staff from within the medical division to support the ward. Monthly job fairs to address vacancies plus overseas recruitment - some nurses already commenced and further due to commence in due course. Weekly "hotspots" escalation to flexible workforce priority for agency for this ward. **December/January update:** Further Winter capacity beds established to ensure timely patient flow on 8B and 4D at CRH and Ward 4 at HRI. Approval to high cost agency via flexible workforce. Each extra capacity area given dedicated Matron support System wide Silver command meetings ongoing. Detailed bed modelling 2016/17 with Foureyes.Clear plans to provide Senior nurse leadership in all areas. However these areas are high risk and current bed rduction plan being implemented to close additional flex beds above plan.	Mar-16	Mar-2016	Capacity Group	Julie Dawes	Sajid Azeb

Major	5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	Active	Keeping the base safe	There is a risk that the following urgent Estates schemes cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls A) Failure to maintain privacy and dignity on the Chemotherapy Unit at HRI B) Poor/unsafe flooring in ICU at HRI C) Environmental/safety standards on Ward 18 at HRI D) Temperature control in winter on Ward 4 at HRI E) Poor environmental conditions on Ward 5 at HRI F) Uneven floor surface on Ward 19 G) Poor fitting windows on Ward 6 at HRI H) Damaged floor on CCU at CRH I) A&E Resus requires more space. J) Poor fitting windows on MAU at HRI	B) ICU- temporary repairs carried out as & when required but decant necessary for full floor replacement. C) Ward 18- Discharge lounge re-located onto Ward 18 which has been decorated & patient entertainment fitted. Ongoing concerns with Ward 18 (Childrens Area). Estates working with AM Henshaw to provide action plan for intermediate repairs (ward upgrade necessary) - ACTION COMPLETE D) Ward 4- heaters were available for cold rooms. Ward 4 has now been connected to existing vent plant The heating system has been set up to enable the BMS system to control BMS valves within the ward to give better heating control within the area. ACTION COMPLETE E) Ward 5- now moved to ward 11 whilst the ward has works done and a minor upgrade. F) Staff aware of issue; decant to be planned to enable re-skimming of floor G) Windows repaired (temporary) & heaters provided H) Cofley aware of CCU Flooring which is being monitored prior to decanting ward to refurb under lifecycle. I) Project to move switchboard to another location to enable expansion of Resus J) Windows are of an age and difficult to open / close without significant force.	B) ICU Floor - monitored by Estates until opportunity to decant ward and fully replace,. G) Superficial repair of Ward 6 windows (carried out Site Wide); windows will be monitored by Estates. H) Cofley aware of CCU Flooring at CRH, on life-cycle replacement however monitored prior to decant. I) A&E resus area requires expansion at HRI J) Understand size of problem with windows on Wards at HRI.	16 4 x 4	16 4 x 4	8 4 x 2	B) ICU floor to be monitored until decant possible. H) CCU Flooring at CRH will be monitored until decant possible. I) ED resus area at HRI. J) Review condition of windows on MAU Sept Update:- Repairs carried out to Ward 4 Heating; action complete. October Update: Chemo Unit transferred onto new facilities. Action complete November Update:- a) Discussions taking place with Estates, Clinicians / A&E to agree suitable location for Resus. b) Monthly meetings organised with Ward Staff / Nursing & Estates to agree a prioritised programme of maintenance work. Dec 15 Update Feasibility on A&E Resus Area taking place. Review state of windows across HRI wards.	Mar-2016	Apr-16	RC	Lesley Hill	Paul Gilling
Major	6078	Family & Specialist Services	Appointments & Records	Appointment Services	Aug-2014	Active	Keeping the base safe	Appointment Slot Issues – A failure to provide sufficient appointment slots to manage demand. Caused by an increase in referrals to services/reduced available capacity to manage demand. Resulting in: - poor patient experience - inability to access referral letter as e-referrals cannot be accessed until an appointment is allocated - increased administration (reliance on spreadsheets to track capacity requirements) - impact on Trust ability to attract income	Process: Daily spreadsheet to Clinical Divisions highlighting capacity requirements. Regular communications with Specialty capacity leads. Reallocation of cancelled slots to maximise capacity.	- Variations in capacity and demand plans. - Consultant vacancy factor. - Manual process in place to record ASIs extracting information from ERS and PAS. - THIS are working on a live document that clinical and administrative leads can access to eliminate the emailing and filtering of spreadsheets on a daily basis.	16 4 x 4	16 4 x 4	4 4 x 1	ASI action plan developed which includes trajectories at specialty level November 2015 update The volume of ASIs has decreased from 2136 to 1387 representing a decrease of 32% in ASIs. Further actions planned to improve the position including weekly cross-divisional access meetings to monitor performance, development of a capacity management team within appointment centre, development of the Knowledge portal as a capacity planning tool to assist directorates. **January 2016 update** As of 13th January there are 1390 patients on the Trusts ASI list. Weekly variation in this number but no further sustained improvement made following November update. Further action to confirm full divisional recovery plans to reduce ASI list further. Review at weekly ADD performance meeting and monitor at Planned Care Board. Formal review of progress in March 2016 with target date of June for sustained improvement	Mar-16	Jun-16	PCB	Helen Barker	Rob Aitchison / Katharine Fletch

Major	6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the base safe	Clinical, operational and estates risks in:Children and young people, maternity and family planning, out patients and diagnostic imaging, A&E, Medical care, end of life care, surgery causing increased risks to patients and possible non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance), which could cause the Trust to have breach of licence.	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports - Weekly strategic CQC meetings	- Full Divisional and Corporate self-assessment still to be completed - Some out of date policies and procedures - Assessments show us to be be in the "requiring improvement" category	16 4 x 4	16 4 x 4	8 4 x 2	CQC compliance Steering Group Implementation CQC Compliance action plan CQC Operational Group Embed CQC assurance into Divisions and Corporate Governance structure October Update: External support for assurance on key areas, confirmed date of inspection, CCG handbook to staff and focus groups held. Noember Update: Assurance inspections commenced with actions for divisions identified. Additional capcity at corproate level to assiss planning for the inspection. Identify risks in month to inform overall position. **January Update** CQC data submitted. Self assessmentsubmitted identifying 5 areas requiring improvement.	Feb-2016	Feb-2016	WEB	Julie Dawes	Juliette Cosgrove
Major	6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Financial sustainability	There is a risk of loss of income to the Trust due to Greater Huddersfield CCG and Kirklees and Calderdale Councils undertaking competitive procurements. This could have negative impact by increasing the Trust's underlying deficit and on the clinical resilience and stability of retained services.	There is a robust system of horizon scanning in place to identify when services are to be tendered both within and beyond the catchment area to ensure the Trust is able to respond and make decision of whether to submit tenders. New models of care have been developed in response to the requirements of tenders.	Need to anticipate weaknesses and gaps in services through risk assessments prior to tender processes to make service model changes rather than wait for pressure of a tender to force changes Use of Service Line Reporting needs to be strengthened to identify profitability of services and whether to bid against tenders or disinvest. Need to develop appropriate market exit strategies (disinvestment) to eliminate costs where income is lost.	16 4 x 4	16 4 x 4	12 4 x 3	Develop new models of care in advance of Commissioner tendering processes with advance notice of services likely to be tendered in the future. November 2015 Update: The Trust is awaiting update from Kirklees Council regarding their review of the procurement of sexual health services. **January Update:** Decision made by Kirklees local authority to reverse decision to award sexual health contract to CHFT. Service contract awarded to Locala resulting in TUPE of CHFT staff and loss of contract and assoicated income from 1st April 2016	Apr-16	Apr-16	CISC	Anna Basford	Rob Aitchison & Lisa Williams

Major	6150	Corporate	Finance	Trustwide	Nov-2014	Active	Financial sustainability	There is a risk that the Trust will not be able to pay suppliers, staff and PDC loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as a going concern	• Agreed capital loan from Independent Trust Financing Facility received in April 15 • Agreement with main Commissioners to maintain their matching cash flow payments prior to agreement of contracts for 2015/16 • Capital Programme restricted by risk assessing and prioritising schemes • Cash forecasting processes enhanced through 13 week rolling forecasts • Discussed and planned for Distress Funding cash support from Monitor • Trust's Standards Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers • Agreed re-profiling of cash payments of clinical contract income with commissioners to support treasury management in the short term. • Cash management committee being initiated to review and implement actions to aid treasury management.	Distressed cash support through 'Revenue Support Loan' not yet formally approved by Monitor.	15	5 x 3	15	5 x 3	10	5 x 2	Working Capital Facility from the Independent Trust Financing Facility (ITFF) approved in September to secure cash in advance of approval for Revenue Support Loan being sponsored by Monitor to ITFF. **January update:** Pro-active cash management actions continue	Jan-2016	Mar-2016	FPC	Keith Griffiths	Kirsty Archer

Major	6507	Trustwide	All Divisions	All Departments/Wards	Dec-2015	Active	Keeping the base safe	There is a risk of patients coming to harm due to the current capacity and capability gap within the clerical and admin workforce. This arises from: Voice Recognition - releasing workforce through the voluntary redundancy and MARS schemes without the implementation of Voice Recognition. V.R solution is being tested in December 2015, full scale implementation date of July 2016. Issues with Clinical Administration infrastructure (variation and ambiguity in the roles and responsibilities of 'Clinical Admin' staff, reliance upon temporary staff, decline in the provision of training, staff working in isolation, teams too small to provide support 52 weeks of the year, variation within in the processes and procedures of the administrative pathways which enable the clinical pathways, numerous handoffs, inconsistent ratio of case holding clinicians to the number of clinical admin team members supporting them. This is resulting in time delays and failure demand within the current workflow from CHFT SLAs (e.g.): Clinical letter turnaround, outpatient, booking of follow-up pre-treatment outpatient appointments, response to inbound telephone call answering, booking of diagnostic & therapeutic appointments), result receipt, review & action, scheduling of inpatient treatment, consultant to consultant and provider to provider referral, turnaround of discharge letters, booking of FU appointments, response to inbound telephone call answering. This may resulting in a negative impact upon the patient pathway macro process measures, outcome measures associated with the workflow activities, e.g. increased cancellations	· Divisional performance framework (in part) · Transforming our clinical Admin programme board (Clinical Admin Team (CAT) & Voice Recognition projects) Voice Recognition – meeting capacity & capability gap through the use A&C temporary resource (agency).	Interim operational capacity deficit reduction plan & multi divisional clinical admin.performance framework – mitigated following a review & options exploration by the ADD's and Programme Lead. Implementation of the Voice Recognition software (Project) - to be mitigated once VR software has proved successful in the testing phase (18.12.2015 milestone) & implementation (July 2016 milestone).Comprehensive (multi divisional) & standardised clinical admin. operating model & performance framework (Process and outcome measures). Mitigate by implementation of the C.A.T model (Project) (October/November 2016). Voice recognition – temporary staff - transition period 3 months for an experienced medical typist Implementation of EPR - Digitalisation of aspect of the manual process Sept 2016.	15	15	9	Voice recognition: December 18th 2015 end of the testing phase and future review C.A.T: Turnaround Executive to make investment decision E.P.R: System implementation August 2016 January Update: Risk to be re-presented at February 2015 Risk and Compliance Group, split risk into two separate risks	Mar-2016	Mar-2017	NA	Chief Operating Officer	Rob Aitchison, FSS
										5 x 3	5 x 3	3 x 3								

Major	6299	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the base safe	Patient Safety Risk Risk of failure of high risk medical devices (patient monitoring infusion devices, incubators, phototherapy equipment) due to lack of routine maintenance, staffing capacity and systems in Medical Engineering, resulting in potential patient harm and inability to meet CQC requirements for medical devices.	Maintenance prioritised based on categorisation / risk analysis of medical devices Tight control of management of service contracts to ensure planned preventative maintenance (PPM) activity performed. PPM programme being developed. Progress monitored by Health & Safety Committee ensuring recruitment issues, database, risk analysis of devices is progressing. Recruitment of administrator and 1 Medical Engineer	1. PPM Programme development ongoing. 2. Complete review Medical Device database to ensure accuracy on medical devices needing maintenance. 3. Lack of information on what proportion of equipment has accurate recording of location on medical devices database 4. Medical Devices Assessor final report and action plan not yet received, meaning further actions required not yet known 5. Newly recruited Medical Engineer not yet in post.	15 5 x 3	15 5 x 3	5 5 x 1	1. PPM Programme to be competed by end October 2015 by V. Wotherspoon 2/3. Medical devices database audit by V. Wotherspoon, completion August 2016 to ensure accurate picture of devices needing maintenance and location of devices.. 4. Review final report and actions of independent assessor (due September 2015) and amend plans accordingly. 5. Newly recruited Medical Engineer to start September 2015 6. Medical Engineering team to move to Estates from end of September 2016 to ensure systems and processes for medical devices are closely monitored. **January Update** Work to improve the situation continues.January 2016 medical device maintenance backlog report confirms work in progress and will be presented at February Patient Safety Group.	Feb-2016	Aug-2016	DB	Lesley Hill	V Wotherspoon
Major	6027	Corporate	Finance	Corporate Finance	May-2014	Active	Financial sustainability	There is an operational risk that the Trust will have to suspend its capital programme for 2015/16 due to having insufficient cash to meet on-going commitments resulting in a failure to develop infrastructure in support of a sustainable future for the organisation.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Capital programme has been risk assessed and reduced based on this risk assessed process. • Capital programme managed by Capital Planning Group and overseen by the Commercial, Investment and Strategy Group, including forecasting and cash payment profiling. • Discussed and planned for distressed funding cash support from Monitor. • Agreed re-profiling of cash payments of clinical contract income with commissioners to support treasury management in the short term. • Cash Committee established	Distressed cash support through 'Revenue Support Loan' not yet approved by Monitor.	16 4 x 4	15 5 x 3	10 5 x 2	Working Capital Facility from the Independent Trust Financing Facility (ITFF) approved in September 2015 to secure cash in advance of approval for Revenue Support Loan being sponsored by Monitor to ITFF. **January update:** The Trust has reviewed its planned capital programme for 2015/16 and considers that there is scope to reduce the programme up to the value of £1.0m without having an adverse impact on patient safety. Discussions with Monitor are ongoing to determine whether the Trust option is available to transact a capital to revenue transfer of £1.0m to reduce the dependency upon external cash support and bring equivalent benefit to I&E. Pending conclusion of these discussions, the full capital expenditure is currently forecast	Feb-2016	Mar-2016	WEB	Keith Griffiths	Kirsty Archer

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: REVIEW OF PROGRESS AGAINST THE STRATEGY - The Board is asked to receive and approve the review of progress against the strategy.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors Meeting - October 2015	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to comment on and approve the review of progress against the 1 year plan.

Main Body

Purpose:

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2015/16.

Background/Overview:

In May 2015, the Board of Directors agreed the 1 year plan and quality priorities for 2015/16. The plan describes the four goals of the Trust:
- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

The Issue:

Significant progress has been made against all of the priorities in the plan. Of the 22 deliverables:
• None are rated red i.e. off track with no plan in place.
• Two are rated amber / red i.e. off track with a plan in place.
• 17 are rated amber / green i.e. on track but not yet delivered.
• Three have been fully delivered or rated green

Next Steps:

The Plan will be refreshed over the next few weeks in line with the Annual Planning process to prepare the 1 year plan for 2016/17.

Recommendations:

The Board is asked to comment on and approve the review of progress against the strategy.

Appendix

Attachment:

Progress against strategy Board report January 2016.pdf

Calderdale and Huddersfield NHS Foundation Trust
1 Year Plan - Progress Report January 2016

Introduction

The Trust's vision is:
Together we will deliver outstanding compassionate care to the communities we serve.

In May 2015, the Board of Directors agreed the 1 year plan and quality priorities for 2015/16. The plan describes the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

These goals are underpinned by the four behaviours:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The plan sets out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering our goals have been assessed and are included in the Board Assurance Framework. The risks associated with each area of delivery have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Design and implement the community division while continuing to work on CC2H	Implement the local quality priorities (see separate page)	Plan and implement workforce change to ensure that our people and resources actively support the reconfiguration of integrated hospital and community services..	Deliver a robust financial plan including CIP for 2015/16 and 2016/17
	Develop and roll out the first wave of 7 day working standards	Ensure readiness to achieve CQC rating of good	Design an innovative Trust-wide internal communications strategy and implementation plan.	Refresh the Commercial Strategy
	Roll out of the first year of programmes to support implementation of EPR	Strengthen our performance framework at corporate and divisional level	Secure safe staffing levels and have clear mitigation plans ready to be deployed if required.	Strengthen our financial control procedures
	Continue the implementation of the Care of the Acutely Ill Patient action plan	Ensure robust plans are in place to monitor and deliver A&E and C Diff	Launch a campaign to actively support improvements in health and well-being and reduce absence	Develop the 5 year turnaround plan with agreement across the local and regional health economy
	Work with commissioners and providers locally and across WY to develop plans for the future configuration of integrated services	Respond to Monitor in relation to breach of licence and undertake Well Led Governance Review	Design a strategic framework to articulate and govern a value driven people focussed approach using work together to get results	
	Develop and implement a Public and Patient Involvement Plan	Implement the health and safety action plan	Create a Trust-wide, multi-disciplinary approach to Learning delivered via a fully integrated education and training function	

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2015/16.

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables responses and this is rated using the following categories:

1. On track – delivered (green)
2. On track - not yet delivered (amber / green)
3. Off track – with plan (amber / red)
4. Off track – no plan in place (red)

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 22 deliverables (figures in brackets are the October position):

- None (none) are rated red i.e. off track with no plan in place.
- Two (six) are rated amber / red i.e. off track with a plan in place.
- 17 (16) are rated amber / green i.e. on track but not yet delivered.
- Three (none) have been fully delivered or rated green.

Recommendation

Trust Board Members are requested to:

- Note the assessment of progress against the 2015/16 goals.
- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care			
Deliverable	Progress rating	Progress summary	Assurance route
Design and implement the community division while continuing to work on CC2H	**Delivered (green)** The Vanguard work will continue and will be taken forward into the 16/17 plan	ADD for Community Directorate appointed and will take up post on 1 March 2016. Interim structure agreed and in place from 1st January 2016	Design and implement the community division while continuing to work on CC2H
Develop and roll out the first wave of 7 day working standards	**Off track with plan in place (amber/red)**	Follow up report presented to WEB detailing how the Trust benchmarks against other organisations in progress against plans. Set out the priority areas. Medicine action plan produced. The trust has been successful in being awarded a Leadership Fellow (50% funded by the Deanery) who will work with the Trust for a period of 12 months.	Reported to Weekly Executive Board (Nov) and Quality Committee.
Roll out of the first year of programmes to support implementation of EPR	**On track but not yet delivered (amber/green)**	Agreement reached on go-live dates with Bradford to go live ahead of CHFT. Engagement work being increased. Benefits work ongoing. Design and Build is progressing with an aim to complete for future state validation in February. Gateway 1 assurance report received (to be considered at the Board on this agenda). Gateway 2 taken place.	Reported monthly to Board and Finance and Performance Committee.
Continue the implementation of the Care of the Acutely Ill Patient action plan	**On track but not yet delivered (amber/green)**	Plan has been refreshed. Independent external analysis of the data completed and showed no specific concerns. Learning has been built into the refreshed plan. Ongoing work to improve the care of frail patients. Mortality reviews are ongoing and improving compliance to 60%. Clinical review leads have been appointed. Compliance with care bundles remains an issue	Bi-monthly report to Board. Board workshop held on results of independent review of mortality.
Work with commissioners and providers locally and across WY to develop plans for the future configuration of integrated services	**On track but not yet delivered (amber/green)**	The West Yorkshire Association of Acute Trusts (WYAAT) is an alliance of the 6 Acute Providers (including Harrogate). The ambition is to draw on West Yorkshire's track record on technology innovation and use this as a platform to deliver a radical change in the way clinical resource and expertise is delivered to patients in acute services across the West Yorkshire population. Opportunities for joint working being explored particularly around human resources and estates and facilities.	Chief Executive report to Board on WYAAT. Board to boards with SWYPFT and MYHT
Develop and implement a Public and Patient Involvement Plan	**On track but not yet delivered (amber/green)**	Patient and public engagement plan developed and awaiting approval. Engagement work around Emergency Gynaecology and Early Pregnancy Assessment services completed and approval by the OSC to progress the service change. Patient and public pre-consultation work	PPI section included in quarterly Quality Report.

		on the right care, right time, right place programme completed and final event held in December. Agreed reporting and sign-off processes for engagement and involvement agreed with CCG .	

Goal: Keeping the base safe			
Deliverable	Progress rating	Progress summary	Assurance route
Implement the local quality priorities	**On track but not yet delivered (amber/green)**	Making good progress against local quality priorities. Detailed quarterly report demonstrating progress and any areas of concern presented to Quality Committee and Board.	Integrated Board Report Quarterly Quality Report Quality Committee minutes.
Ensure readiness to achieve CQC rating of good	**On track but not yet delivered (amber/green)**	Significant work taking place to prepare for the CQC visit. First two data returns completed including self-assessment of ratings and assessment of Trust strengths and weaknesses. Trust self-assessed as requires improvement. Divisions completing 90 day plans. Weekly CQC Executive meeting. Regular reporting to Quality Committee and Board. Intensive communications and engagement plan in place.	Monitored through WEB and Quality Committee. Report on self-assessment to Quality Committee (26/1). Item included on agenda for this Board meeting.
Strengthen our performance framework at corporate and divisional level	**On track but not yet delivered (amber/green)**	Performance Management Framework has been approved and improvements made to the current Integrated Board Report to provide greater detail for assurance. Role of F&P committee within structure agreed and briefing for new reporting suite completed. Key performance indicators at Divisional and Directorate level out to consultation with associated documentation and elements tested through Q4 for full implementation on performance from 1st April.	Integrated Board Report Report to Nov Board on Performance Management Framework Update on progress scheduled for February Board
Ensure robust plans are in place to monitor and deliver A&E and C Diff	**On track but not yet delivered (amber/green)**	Delivered the A&E 4 hour wait target in quarter 3, only trust in West Yorkshire to do so. This continues to be closely managed with significant pressures since 1st January. Robust processes for managing cases of C. diff with each case undergoing a detailed root cause analysis, followed by discussion at a multi-professional/multi-agency group.	Integrated Board Report to Board and Quality Committee Quarterly quality account
Respond to Monitor in relation to breach of licence and undertake Well Led Governance Review	**On track but not yet delivered (amber/green)**	A full update on progress against the recommendations presented to the Board at this meeting. Significant progress made against all requirements.	Report to November Board Monthly review at Monitor performance review meeting.

Implement the health and safety action plan	**On track but not yet delivered (amber/green)**	Health and Safety Manager / Local Security Management Specialist appointed. Health and Safety training planned up to the end of December and compliance continues to be closely monitored. Testing use of risk assessment methodology and DATIX in relation to health and safety incidents and risks to see if this has led to an increase in reporting. Work being done to increase staffside representation on health and safety group.	Quality Committee from Health and Safety Group including half year review of progress against the annual report priorities.

Goal: A workforce fit for the future			
Deliverable	Progress rating	Progress summary	Assurance route
Plan and implement workforce change to ensure that our people and resources actively support the reconfiguration of integrated hospital and community services.	**On track but not yet delivered (amber/green)**	Steps have been taken to ensure accurate workforce information as the basis for informed decision making by improving the interface between the financial ledger and the Electronic Staff Record (ESR). Engaging interim support to implement this work alongside finance colleagues.	To be monitored through Workforce Committee
Design an innovative Trust-wide internal communications strategy and implementation plan.	**On track but not yet delivered (amber/green)**	Divisional colleague engagement plans complete and being rolled out. Website update almost complete and ready for launch which will release capacity to focus on intranet improvements. New 'four pillars' based posters campaign to be up by the end of January. Colleague engagement plan almost delivered. Specific work being undertaken around CQC and right care, right time, right place.	Monitored through Colleague engagement, health and wellbeing group reporting to Well Led Workforce Committee
Secure safe staffing levels and have clear mitigation plans ready to be deployed if required.	**On track but not yet delivered (amber/green)**	Nurse recruitment and retention being delivered as per plan. Significant number of newly qualified nurses joined the Trust in September however additional bed capacity is having an impact on staffing levels. Keep in touch scheme in place. Work done to strengthen staff bank arrangements to extend coverage both week day and weekends. Nursing Workforce Group set up and reporting to Well Led Workforce Committee	Hard Truths report to Board. Well Led Workforce Committee / Quality Committee
Launch a campaign to actively support improvements in health and well-being and reduce absence	**On track but not yet delivered (amber/green)**	Colleague engagement, health and wellbeing has reviewed the draft Colleague Health and Wellbeing Strategy. Attendance management team in place and operational.	To be monitored through Well Led Workforce Committee
Design a strategic framework to articulate and govern a value driven people focussed approach using	**Off track with plan in place (amber/red)**	Interim support secured to develop the workforce plan to support the 5 Year Strategic Plan and set the strategic direction for workforce. Draft leadership and management	To be monitored through Well Led Workforce Committee

work together to get results		development programme awaiting approval.	
Create a Trust-wide, multi-disciplinary approach to Learning delivered via a fully integrated education and training function	**On track but not yet delivered (amber/green)**	Further work done to progress discussions to identify and agree the operational steps to reorganise activities and seek approval for establishing the organisational structure through which education and training activity will be delivered.	Reported to WEB (21/1)

Goal: Financial sustainability			
Deliverable	Progress rating	Progress summary	Assurance route
Deliver a robust financial plan including CIP for 2015/16 and 2016/17	**On track but not yet delivered (amber/green)**	Detailed CIP report monitored weekly at Turnaround Executive. Currently forecasting delivery of £ £17.93m of CIP for 2015/16. £13. m CIP identified for 2016/17 against a target of £14m.	Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Refresh the Commercial Strategy	**On track but not yet delivered (amber/green)**	During FY14/15, Monitor determined the Trust was in breach of its licence and the Trust agreed a number of undertakings with Monitor. One of the undertakings agreed with Monitor was that the Trust would commission external support to enable development of a longer term strategic turnaround and sustainability plan. The 5 Year strategic turnaround plan provides the new refreshed commercial strategy for the Trust. Following approval of the 5 Year Strategic Plan, the commercial elements will be brought together and identified within the detailed implementation plans.	Reviewed by the Board as part of the 5 Year Strategic Plan
Strengthen our financial control procedures	**Delivered (green)**	All identified actions have now been completed.	Finance & Performance Committee
Develop the 5 year turnaround plan with agreement across the local and regional health economy	**Delivered (green)**	The 5 Year Strategic Plan was approved by the Board on 29th December before being sent to both the Commissioners and Monitor. Detailed implementation plans will now be developed and agreed. An update of the plan to reflect the 2016/17 funding allocations will be shared with the Board.	Board meeting December.

APPENDIX I

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Ruth Mason, Associate Director of Engagement & Inclusion
Date: Thursday, 28th January 2016	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Equality & Diversity Report and Public Sector Equality Duty Compliance Evidence - To meet the statutory duty to publish progress against, and achievement of, agreed equality and diversity objectives.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Transform care, improve the patient experience, deliver the regulations, develop the organisation for the future.	
Sustainability Implications: Improve local conditions, especially in disadvantaged areas, eg encourage social inclusion, develop business and social enterprise or develop the workforce and labour market Reduce social and health inequalities	

Executive Summary

Summary:

As a public sector body, the Trust has a statutory duty to comply with the Equality Act 2010. In line with the specific duties of the Act, the Trust is required to publish an annual report, detailing the ways in which the Trust meets the general duties of the Act to:
• Eliminate unfair discrimination, harassment and victimisation
• Advance equality of opportunity between different groups
• Foster good relationships between different groups

This annual report, known as the Public Sector Equality Duty (PSED) report, must be approved by the Board for publication by the end of January each year.

Main Body

Purpose:

The purpose of this paper is to present the latest PSED report to the Board for consideration. A copy is attached as Appendix 1.

Appendix 1 contains information and evidence of activities throughout 2015 which have improved the patient experience and helped the Trust comply with equalities legislation.

Background/Overview:

Consultation with communities of special interest in 2011 indicated that they wanted the Trust to focus on areas of improvement that fall broadly into three categories and in March 2012 the Board of Directors agreed the following high level corporate objectives:
1. Access
2. Information and communication
3. Staff attitude, behaviour and training

These objectives cover the period 2012 to 2016. Every year the Trust is required to publish (by January 31st) a Public Sector Equality Duty (PSED) report highlighting progress against these agreed objectives.

During 2015, consideration was also given to two new mandatory NHS initiatives: the Equality Delivery System (2); and the Workforce Race Equality Standard. In light of these, the Trust has refreshed its approach under a wider strategy encompassing both equality and diversity, and patient and public involvement (PPI) in readiness for 2016 onwards.

The Issue:

Equitable, fair and diverse services across the Trust for all patients and staff.

Next Steps:

Following Board approval the Trust is required to publish equality compliance evidence by January 31st 2016.

Recommendations:

The Board is asked to note the achievement of statutory timescales in relation to production of the PSED report and agree its publication before the end of January 2016.

Appendix

Attachment:

APPENDIX 1 - CHFT PSED Report 2015.pdf

Calderdale and Huddersfield NHS

NHS Foundation Trust

CHFT Public Sector Equality Duty Annual Report 2015

Equality Act Compliance Evidence
Published January 2016

CONTENTS

1 Executive Summary

This Equality Report is to show the progress the Trust has made during 2015 in meeting its equality duties under:

- Section 149 of the Equality Act 2010 (the public sector equality duty) and
- The Equality Act 2010 (Specific Duties) Regulations 2011

This report provides assurance to the Board of how the Trust is meeting the requirements of the Public Sector Equality Duty. This report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the General Equality Duty. The report also contains the Equality in our Workforce Report for the Trust.

In 2012, following Board approval, the Trust adopted three priority equality objectives which became the focus for its work on equality for the period 2012-16. Whilst significant progress has been made against those objectives, covered in the "Our Equality Objectives" section of this report, it is important to note that these equality objectives do not cover all the work that is being carried out by the Trust with the aim of improving equality.

The Trust strives to provide the highest quality of service to all of its patients. Equality and diversity considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care. This report highlights our approach and work to address any additional needs of those patients who identify with a range of protected characteristics.

2 The Legal and Compliance Framework

2.1 Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like Calderdale and Huddersfield NHS Foundation Trust (CHFT) to publish relevant information to demonstrate their compliance with the duty.

The Act applies to service users and Trust employees who identify with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The duty has two parts – the general duty and the specific duties. The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the Equality Duty published on our website by 31 January each year;

- Equality Objectives (which are specific and measurable) published for the first time by April 5th 2012, reviewed annually and re-published at least every four years.

2.2 Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Equality and diversity considerations are specifically addressed as part of its key line of enquiry around a Trust's responsiveness to patient needs. The CQC asks "Are services planned and delivered to meet the needs of people?" and "Do services take account of needs of different people, including those in vulnerable circumstances?"

2.3 New Mandatory Requirements – EDS2 and WRES

The Equality Delivery System 2 (EDS2) is a generic framework designed for both NHS commissioners and NHS providers. The framework helps NHS organisations to review and improve their performance for people with protected characteristics, and through it, to deliver on the Public Sector Equality Duty. It emphasises engagement with stakeholders and users; and encourages local adaptation to focus on local issues.

EDS2 comprises 18 outcomes focused on the achievement of four goals (see Appendix 1).

A gap analysis of our current state of readiness and what we need to do to implement EDS2 has been completed. This includes an analysis of the sources or type of evidence that will be required to demonstrate progress and prove compliance.

Under the EDS2 framework, we are required, in conjunction with local stakeholders, to analyse our E&D performance, taking account of each relevant protected group. In order to achieve this, the Trust took park in 2 CCG-led stakeholder events in December 2015. Local stakeholders and community groups attended the events and following a presentation outlining progress against the actions under the three high level E&D objectives, the Trust was assessed as "developing".

The Workforce Race Equality Standard (WRES) is now part of standard NHS contracting arrangements for 2015-16 and requires providers to start to address the low levels of Black and Minority Ethnic (BME) employees within their workforce and specifically at board level.

WRES comprises 9 indicators:

Workforce indicators

Nos 1 – 4	For each of these four workforce indicators, the Standard compares the metrics for white and BME staff

National NHS Staff Survey findings

Nos 5 – 8	For each of these four staff survey indicators, the Standard compares the metrics for the responses for white and BME staff for four specific survey questions

Boards

No 9	Requires organisations to ensure that their board is broadly representative of the population they serve

Evidence has been compiled to establish a baseline position for compliance with WRES. This baseline position was published before July 2015. This position is based on data as available at April 2015, to enable comparison with April 2016. Further information on progress against the WRES can be found in Appendix 2, the Equality in Our Workforce Report.

3 Our equality objectives

3.1 Our existing objectives for 2012-2016

Consultation with communities of special interest in 2011 indicated that they wanted the Trust to focus on areas of improvement that fall broadly into three categories and in March 2012 the Board of Directors agreed the following high level corporate objectives:

1 **Access:** The Trust will demonstrate improvements in access to services for people with protected characteristics.

2 **Information and communication:** The Trust will demonstrate improvements in data collection, utilisation and analysis to inform service improvement for people with protected characteristics.

3 **Staff attitude, behaviour and training:** The Trust will deliver training programmes that reflect the need for employees to respect equality, diversity and human rights.

Underneath these three high level objectives, plans for action, with measurable dates and outcomes, were developed. This initially resulted in 102 individual actions for completion during the 2012-2016 period. Following annual reviews of the objectives in December 2012, December 2013 and December 2014, the overall number of actions scheduled for completion before March 2016 rose to 162. The high-level objectives were retained for 2015-16 and as at December 2015, 94% of the total actions had been completed or partially completed. Work is continuing on the outstanding actions, many of which have become "business as usual" across the organisation.

3.2 Our Achievements

Some examples of actions that have been taken to help to achieve the 3 high-level objectives are shown below. Note – this is only a sample of the work going on across the Trust around equality and diversity issues.

Age – Younger People
Child/Young Person FFT (Friends and Family Test) cards have been developed and feedback is evaluated via the Paediatric Forum and Staff Council meetings. Results are displayed on public facing boards in ward areas using a "You said-We did" approach.

The Trust's Children's inpatients and daycase services took part in a CQC National Survey for Children and Young People. The results were published in July 2015, action planning against the feedback is in progress and this is being monitored through the Paediatric Forum and the Patient Experience and Caring Board.

The Child Development Service consulted with children and families as part of the reconfiguration and redevelopment of the newly opened Rainbow Child Development Service in December 2015.

In recognition of the fact that more play activities are needed for older children, additional play and family support assistants have been recruited and their roles across inpatients and outpatients have been reviewed. Additional play equipment has also been purchased and the Directorate is exploring the possibility of recruiting play volunteers.

Religion and Belief
The Chaplaincy team now contributes on a routine basis to the ongoing programme of end of life care training sessions for CHFT staff, thereby ensuring that the spiritual/religious needs of different faiths are addressed.

A multi-faith team of chaplains delivered a session on Spirituality at Huddersfield University in May. It is hoped that the team will be able to host a regular slot on the nurse training course at the University.

Disability – Learning
On two separate occasions in the year, inpatients with a Learning Disability have been sent an easy read patient experience questionnaire.

An easy read FFT (Friends and Family Test) has been given to all patients with a Learning Disability on discharge and the results collated for analysis.

Learning disability awareness training has been included on the Trust's e-learning training portal. Although the training is not mandatory, it is highly recommended.

Age – Older People
Intensive pieces of work have been undertaken with 2 families of patients in this group, to develop a journal of the families' experiences. This will help to ensure that patient feedback is acted upon, The aim is to have completed this piece of work with 3 or 4 families by the end of the financial year.

Disability – Physical
In order to further improve access to the Trust's services, an external company (Wayfinder UK Ltd) has been commissioned to undertake a full review of wayfinding on the Huddersfield Royal Infirmary site. This review will encompass all aspects of wayfinding, from information provided in appointment letters through to physical signage and seeks to:

"…provide a solution allowing all patients/visitors to orientate themselves easily and effectively at any point within the public space and to always be in sight of the information they need to reach their destination or complete their journey…" and "…deliver a solution that considers all the cognitive processes and behavioural responses associated with navigation..."

Equality and diversity issues will be given high priority as part of this review.

Disability – Visual Impairment
A review of our Acre Mills Outpatient facility reception area was carried out by the Guide Dogs for the Blind Association, and various actions were identified and taken, including:

- Training for reception staff and volunteers on how to guide a blind patient
- One check-in screen adapted and now has yellow background with black text for visually impaired patients

Pregnancy/Maternity
A new service to help women with complex needs during their pregnancies has been set up by specialist midwives. This takes the form of a group information session aimed at women who are currently in treatment recovering from substance misuse or need help and support reducing alcohol and drug use during their pregnancy.

Facilities are provided to support breast feeding mums within community settings and the Community Division has achieved the World Health Organisation's breast feeding initiative accreditation.

All protected characteristics
The Trust has introduced "Behind the Bed Boards" which are used to display key information relating to patients' individual nutrition, hydration and nursing needs and conditions, whilst maintaining privacy and dignity. Magnetic cards are attached to the boards as patients are admitted to a ward. Some examples of cards used at the Trust are:

Patient is deaf/blind or both	 Db2g1c	**Patient has communication difficulties**	 CI2g
Patient requires an interpreter	 CI4g	**Patient holds a VIP passport**	 VIP_CH2
Patient has been diagnosed with dementia	 C29gt	**Defines mobility aids needed by the patient**	 ME4_CHg

Race
A poster to help non-English speaking visitors to find their way around the Trust has been created and distributed to all reception areas (see Appendix 3)

Race, Disability, Age
A communications 'crib sheet' of prompts to help colleagues when caring for patients and visitors who have additional communications needs has been created and distributed (see Appendix 4)

As a Foundation Trust, CHFT has a council of governors, named its "Membership Council". The Membership Council is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change. Other examples of involvement include regular 'walkabouts' into clinical areas where Trust members can observe services first hand and talk directly to staff and patients; and the involvement of members in recruitment panels for the appointment of hospital consultants and senior nursing staff.

Other examples of proactive involvement and engagement with our patients/users with protected characteristics are shown below.

Disability – Hearing Impairment
In line with its objective of improving communication with groups with protected characteristics, whilst reviewing its provision of high quality, professional BSL interpreting services for its patients with a hearing impairment, the Trust held an engagement event with over 40 members of the deaf communities of Calderdale and Kirklees. The audience comprised patients, carers, parents and local BSL interpreters. The event had BSL interpretation and was an opportunity for the audience to learn about the services that one provider could supply. Each member of the audience was given the opportunity to introduce themselves and give feedback.

Key messages from the audience were noted and used to help draw up a list of requirements that the Trust will want to see from its BSL provider. The Trust has made a commitment to continue to work with its deaf communities during this process to help it make the best decision about BSL interpretation services.

Religion/Belief
One of the Trust's Chaplaincy Muslim Spiritual Advisers has been funded by the Chaplaincy to undertake outreach work within the South Asian community in Halifax to ascertain the issues around low uptake of services for end of life care within the community. She has undertaken listening events within the community as well as appraising herself of the services on offer. She is now producing an action plan as to how to promote uptake of services and it is likely that an outreach event will take place during the spring of 2016.

Age – Younger People
Following the decision to close the Princess Royal Hospital, which housed the Child Development Service in Huddersfield, public engagement and consultation on the centralising of the Child Development Service at the Calderdale Royal Hospital site was undertaken during 2014. Engagement with service users and their families on the development of the new facilities, as well as the community based service that will be delivered alongside it, was ongoing throughout the building work on the centre at Calderdale. This has included sharing the plans for the new development and a

Saturday open day and drop in to discuss the service.

Pregnancy/Maternity
The views and experiences of services users, members of the public, NHS staff and stakeholders were invited on proposals to centralise Emergency Gynaecology and Early Pregnancy Assessment services, currently provided from the Cedarwood Unit, Huddersfield Royal Infirmary, with services provided at Calderdale Royal Hospital.

There was engagement with women's groups across Kirklees in line with the engagement plan, through on-line and paper questionnaires as well as facilitated groups.

The Calderdale community midwives held an engagement event in November 2015 called 'Meet the Midwives' to make people more aware of the permanent clinic they run at Halifax's Asda store. The event aimed to promote community midwifery services & other support services that are available within local children's centres, as well as focusing on some health services including stopping smoking, immunisation & healthy eating.

Race
The Trust has a large membership which is assessed against our local population to ensure that we are engaging with the diverse communities that we serve. Analysis of the latest census information (see Appendix 5) shows that we continue to have under representation in two different sectors of our communities, namely males and those with an ethnic group of Asian/Asian British. During the year a number of measures were taken to address this issue, including forging a link with the Muslim Youth Association with whom a tree planting exercise took place to recruit new members.

Links have also been made with the President of the Indian Workers' Association in Huddersfield and there are plans in place to engage regularly with this group.

4 Strengthening Equality & Diversity

4.1 Equality & Diversity Training

The Trust is committed to ensuring that it provides a high quality service for all of its patients and is an employer of choice in the local area. It also has a legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between protected groups.

With this in mind, the Trust has taken steps to improve awareness of equality and diversity issues for all staff, with the introduction of **mandatory** equality and diversity training, through an e-learning package, in June 2015. Previously, equality and diversity training was recommended but optional, and was classroom based.

As the training is now on line, it is possible to obtain accurate compliance figures, and these show that as at 1 December 2015, 63.3% of staff have undertaken equality and diversity training. This is good progress in a relatively short period of time. The aim is for 100% of staff to have completed the training by the end of March 2016.

To complement the on-line course, the classroom-based awareness session will continue to be offered during 2016, aimed at line managers and supervisors who may need additional guidance. This is also made available to the Trust's Membership Councillors.

All staff must complete equality and diversity training every three years.

4.2 Learning from Experience

The Trust has prioritised learning from patient experience as an important way of improving care, quality and experience.

Managers dealing with complaints are required to complete a "Capturing the Learning" report at the conclusion of a complaint, which ensures that valuable lessons are recorded and shared appropriately.

Senior staff produce "patient stories" where lessons have been learned, and these are used to educate staff and improve services as necessary.

Patient stories are presented to the Trust's Membership Councillors at Divisional Reference Group meetings. This provides our governors with an assurance that lessons are learned and action is taken where shortcomings in our systems or processes have been uncovered.

Since March 2015, any complaint relating to a patient with a protected characteristic is routinely escalated to the the Trust lead for the protected characteristic, and also to the Equality and Diversity function at the Trust. All such complaints are reviewed by the E&D function to establish the nature of the complaint and whether there is any

suggestion that the patient feels they were discriminated against due to their protected characteristic.

Since the introduction of this system, 36 complaints have been referred to the E&D function. Of these, 3 (8%) complaints alleged discrimination but none of these allegations were upheld by the Trust following a full investigation.

4.3 Embedding Practice

Members of the Patient Experience and Caring Group (PECG) have been mobilised in order to help imbed good equalities and inclusion practice into the patient experience. Managers now routinely report quarterly on:

- responses to protected characteristic related complaints;
- work to address E&I issues at divisional and/or ward and patient care level;
- liaison with related support groups, charities or community organisations; patient engagement

5 Our refreshed approach and our vision for 2016 onwards

The current governance and support structure for equality and inclusion has been successful in ensuring that the majority of the actions initially identified under our three equality objectives have been completed during the past three years.

However, a refreshed approach is needed to accelerate the rate of improved patient experience in the future. In addition, from April 2015, 2 NHS equality and diversity initiatives became mandatory (see section 2.3). The Trust is developing a corporate approach towards comprehensive and authentic patient and public engagement which in turn will help to identify, prioritise and support E&D objectives, and to meet the Trust's mandatory requirements.

With this in mind a "Putting the Patient First" strategy has been introduced, which sets out our vision of how Patient and Public Involvement (PPI) and Equality & Diversity (E&D) will be advanced in order to support the delivery of compassionate, individualised care.

Under the strategy, mechanisms will be created so that there are conversations with patient groups, representatives and 'communities of interest' on wider Trust issues and service developments. These mechanisms will be replicated in our divisions so that operational colleagues and clinicians have conversations with specific groups, organisations and charities about their services and specialties.

In addition, the Trust will link in with a range of external organisations such as local authority Voluntary Action organisations, local Healthwatch organisations, CCGs and their Community Assets in order to enhance engagement, support and collaboration.

6 Conclusions

The Trust has completed 153 out of 162 (94%) actions under its original objectives for 2012-2016. Significant improvements to the patient experience were achieved during this time.

The Trust has now refreshed its approach under a wider strategy “Putting Patients First – a strategy for involvement and equality”. This strategy identifies actions to enhance the patient experience, and to address specific needs of those with a protected characteristic. These in turn will also address the mandatory requirements of the EDS2 and the WRES.

Ultimately the Trust is striving to help colleagues feel confident and competent when caring for or dealing with people with any of the 9 protected characteristics, and to ensure that equality and diversity considerations are an everyday, intrinsic part of being a valued Trust colleague and of delivering excellent, compassionate care.

7 Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats, eg large print, braille, languages other than English, please contact Vanessa Henderson, Business Manager for Membership and Inclusion, on 01484 347342 or e-mail our dedicated inbox at equalityanddiversity@cht.nhs.uk

APPENDIX 1 – EDS2: THE 4 GOALS AND 18 OUTCOMES

GOAL 1: Better health outcomes
1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities
1.2 Individual people's health needs are assessed and met in appropriate and effective ways
1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
1.5 Screening, vaccination and other health promotion services reach and benefit all local communities

GOAL 2: Improved patient access and experience
2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
2.2 People are informed and supported to be as involved as they wish to be in decisions about their care
2.3 People report positive experiences of the NHS
2.4 People's complaints about services are handled respectfully and efficiently

GOAL 3: A representative and supported workforce
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
3.3 Training and development opportunities are taken up and positively evaluated by all staff
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
3.6 Staff report positive experiences of their membership of the workforce

GOAL 4: Inclusive leadership
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

APPENDIX 2 – EQUALITY IN OUR WORKFORCE REPORT

CONTENTS

1. Introduction

Equality and diversity related to the workforce is led by the Director of Workforce and Organisational Development. This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 30 November 2015. In accordance with the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

The Trust published its Workforce Race Equality Standard (WRES) on 1 July 2015. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES became operational from 1 April 2015. The standard has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black and Minority Ethnic (BME) staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients. The Trust is in the process of developing its action plan to remedy issues arising from the WRES.

2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 30 November 2015 against the previous four financial years.

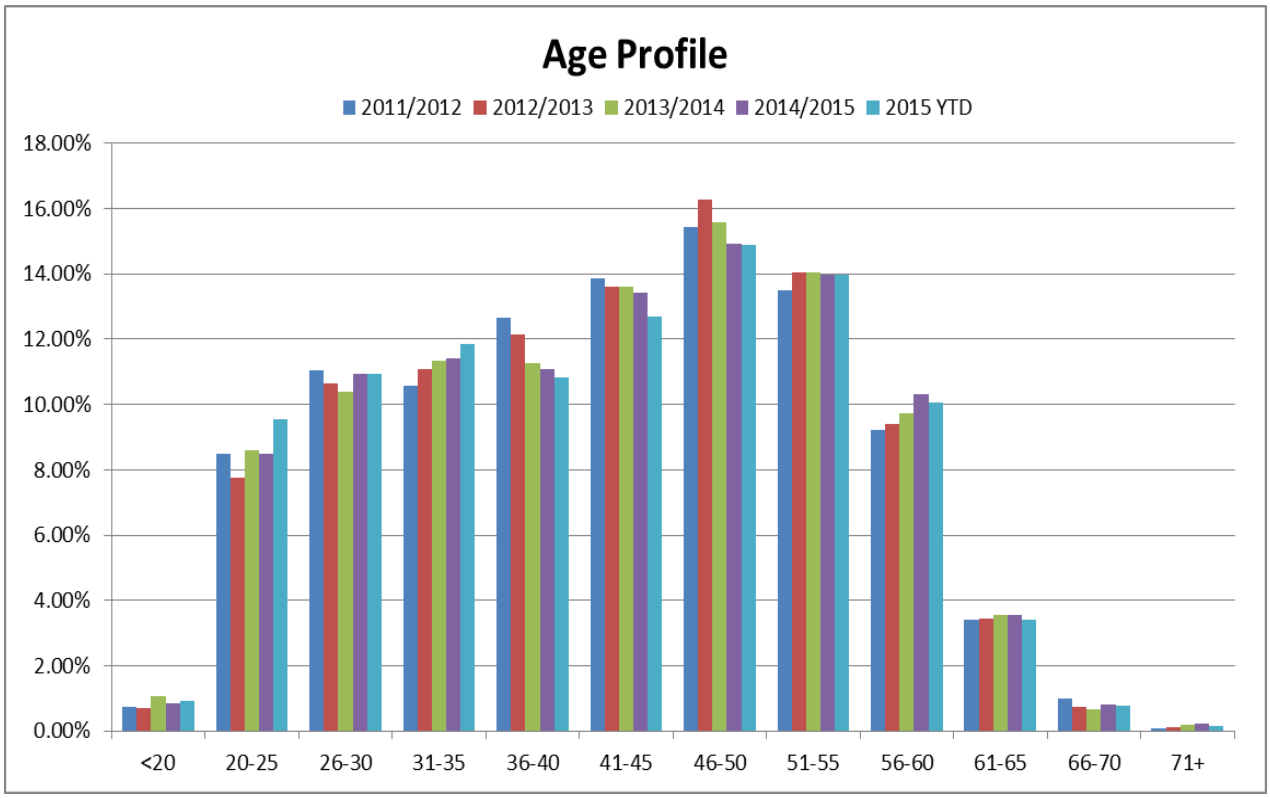
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

We have analysed the Trust's workforce information from the last four years using key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

- Age
- Disability
- Ethnicity
- Gender
- Religious Belief
- Sexual Orientation

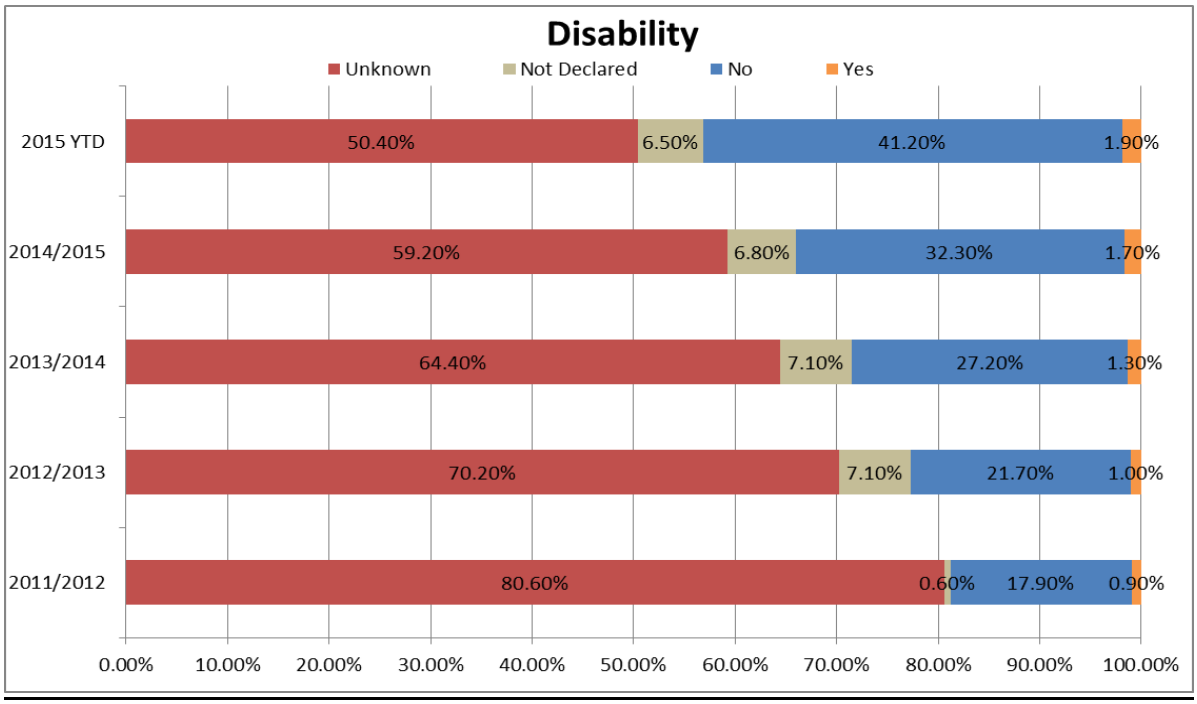
Age Profile

The highest proportion of Trust employees are in the age bracket 46-50. The age bracket showing the most growth during this financial year was 20-25, with an increase of 1.54% from the previous year.



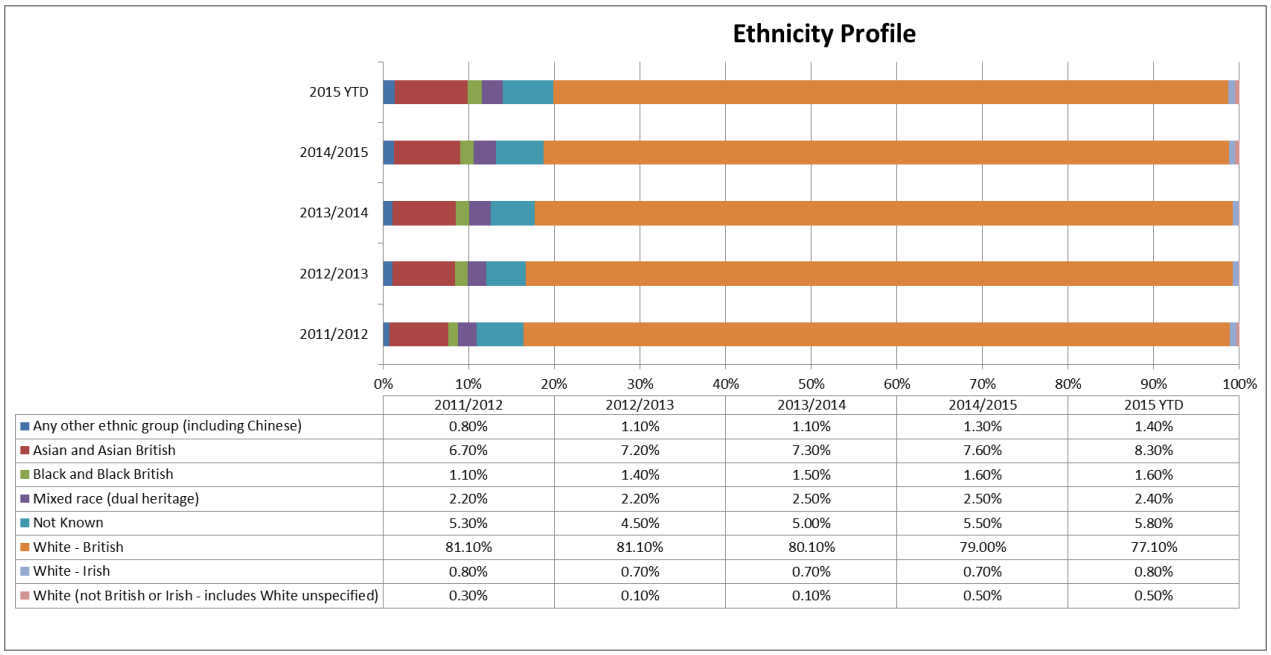
Disability

Information on the profile of the Trust's workforce in terms of disability is inadequate when analysing the data. Data quality has improved over the last 2 years; however there is still 50.4% of the workforce where information around disability is unknown. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



Ethnicity Profile

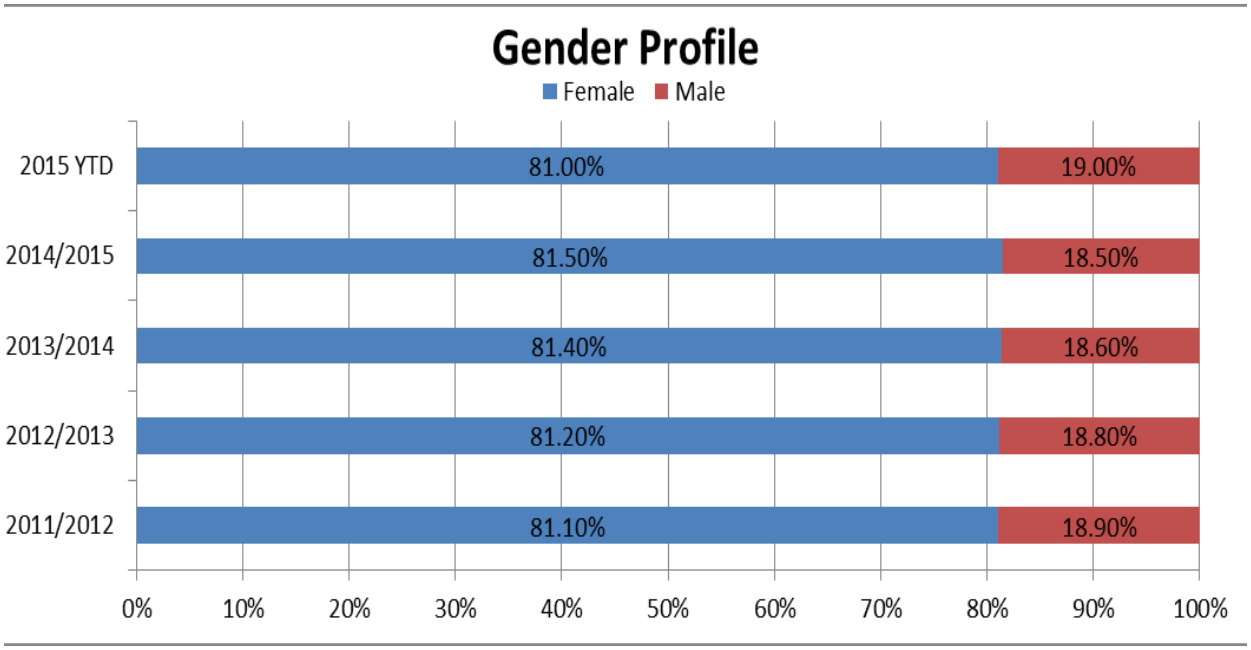
The ethnicity profile of the Trust has not shown much change over the last 4 years, the biggest proportion remains white British (77.10%)



	2011/2012	2012/2013	2013/2014	2014/2015	2015 YTD
Any other ethnic group (including Chinese)	0.80%	1.10%	1.10%	1.30%	1.40%
Asian and Asian British	6.70%	7.20%	7.30%	7.60%	8.30%
Black and Black British	1.10%	1.40%	1.50%	1.60%	1.60%
Mixed race (dual heritage)	2.20%	2.20%	2.50%	2.50%	2.40%
Not Known	5.30%	4.50%	5.00%	5.50%	5.80%
White - British	81.10%	81.10%	80.10%	79.00%	77.10%
White - Irish	0.80%	0.70%	0.70%	0.70%	0.80%
White (not British or Irish - includes White unspecified)	0.30%	0.10%	0.10%	0.50%	0.50%

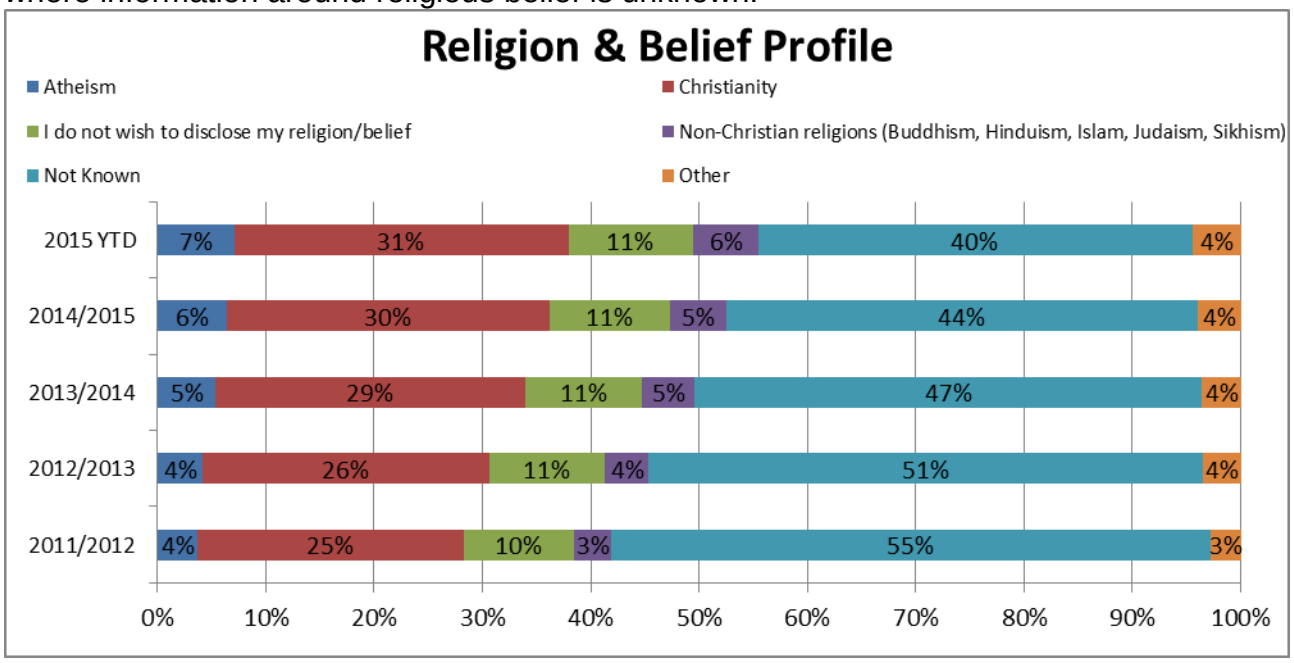
Gender Profile

The proportion of men working for the Trust is significantly lower than the national workforce. However, the health and social care sector traditionally employs more women than men.



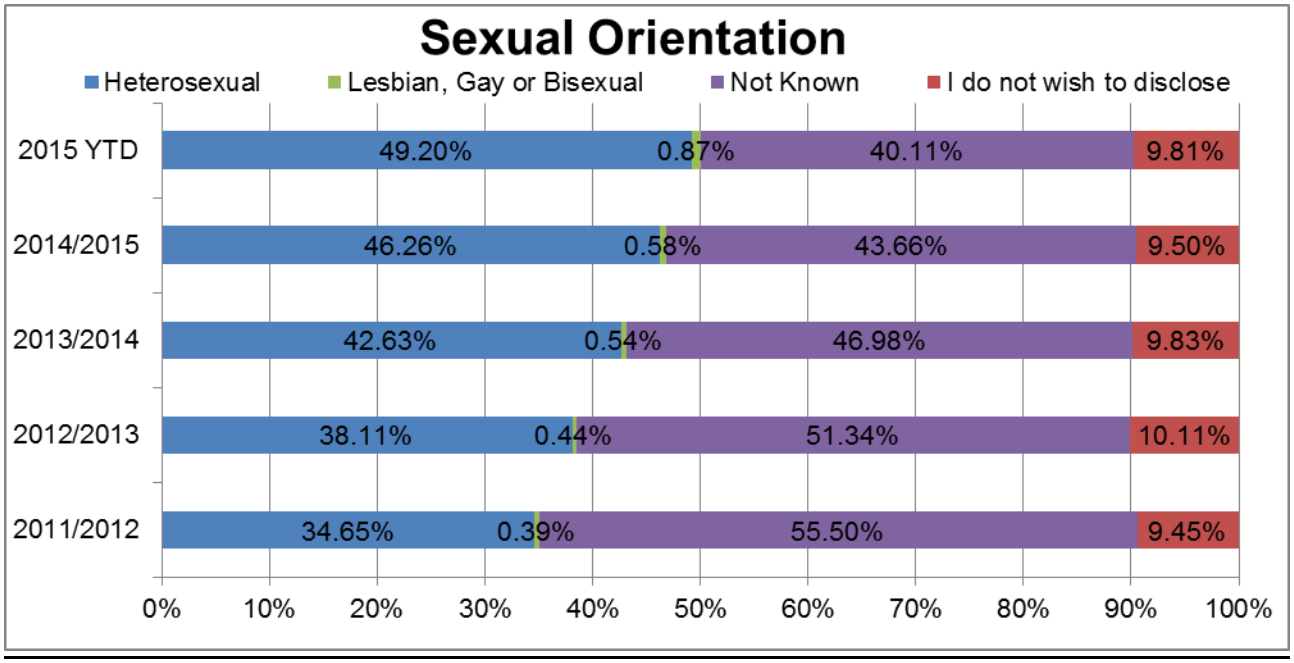
Religion & Belief

Data quality has continued to improve; however there is still 40% of the workforce where information around religious belief is unknown.



Sexual orientation

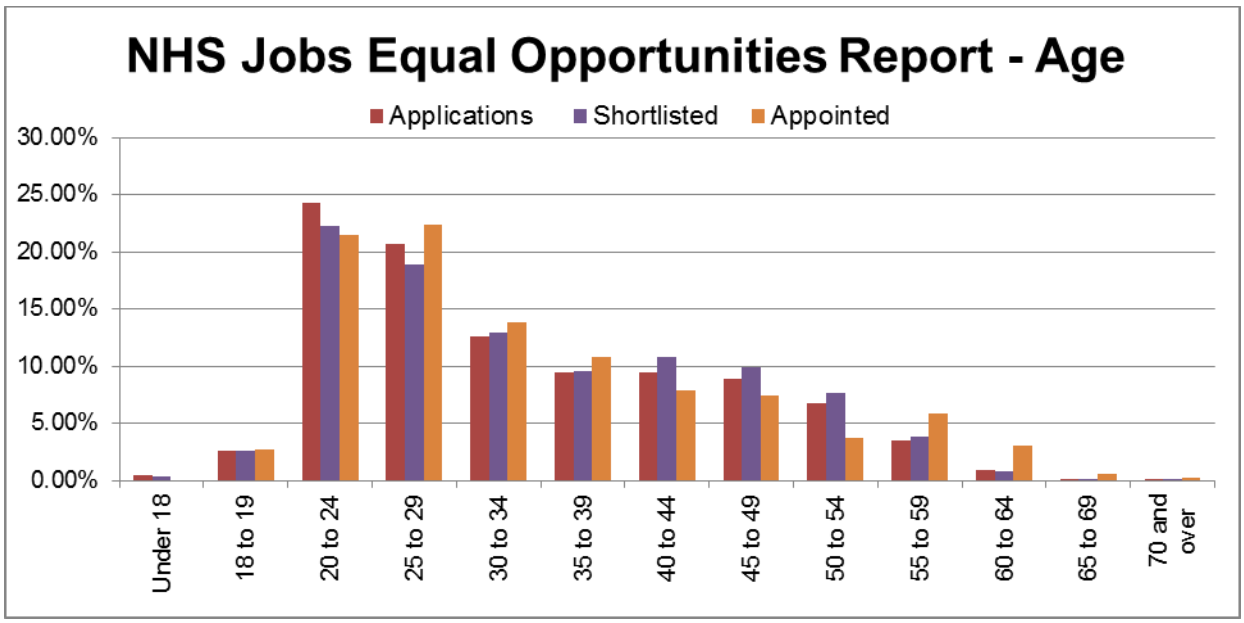
Data quality has continued to improve; however there is still 40.11% of the workforce where information around sexual orientation is unknown.

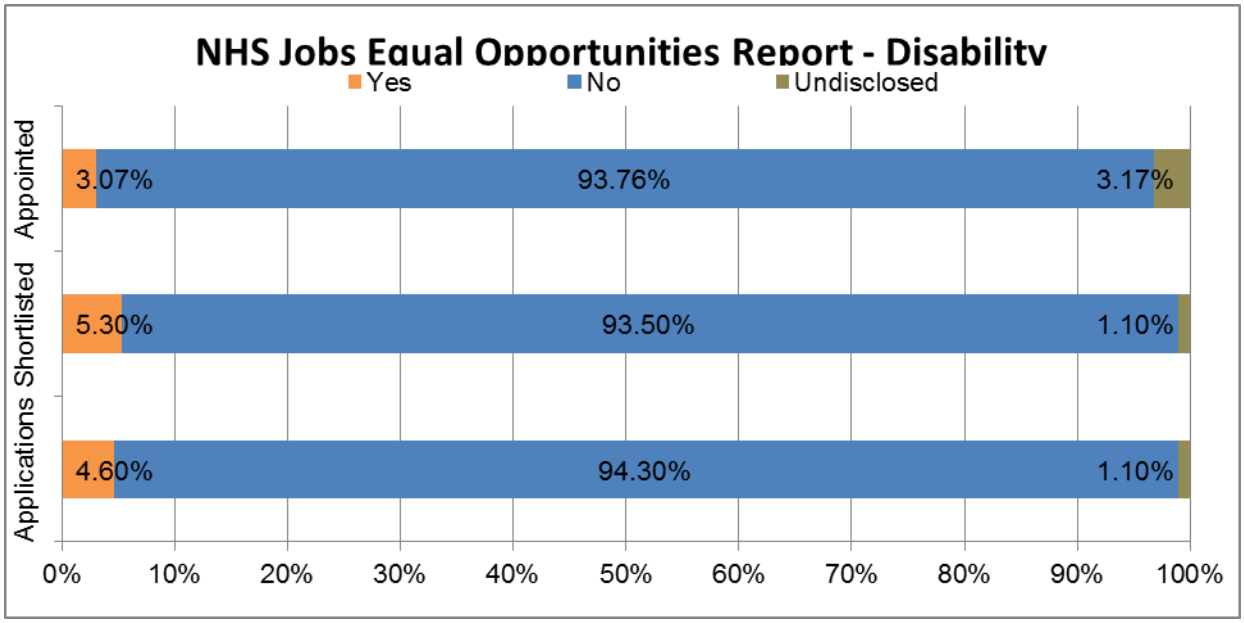


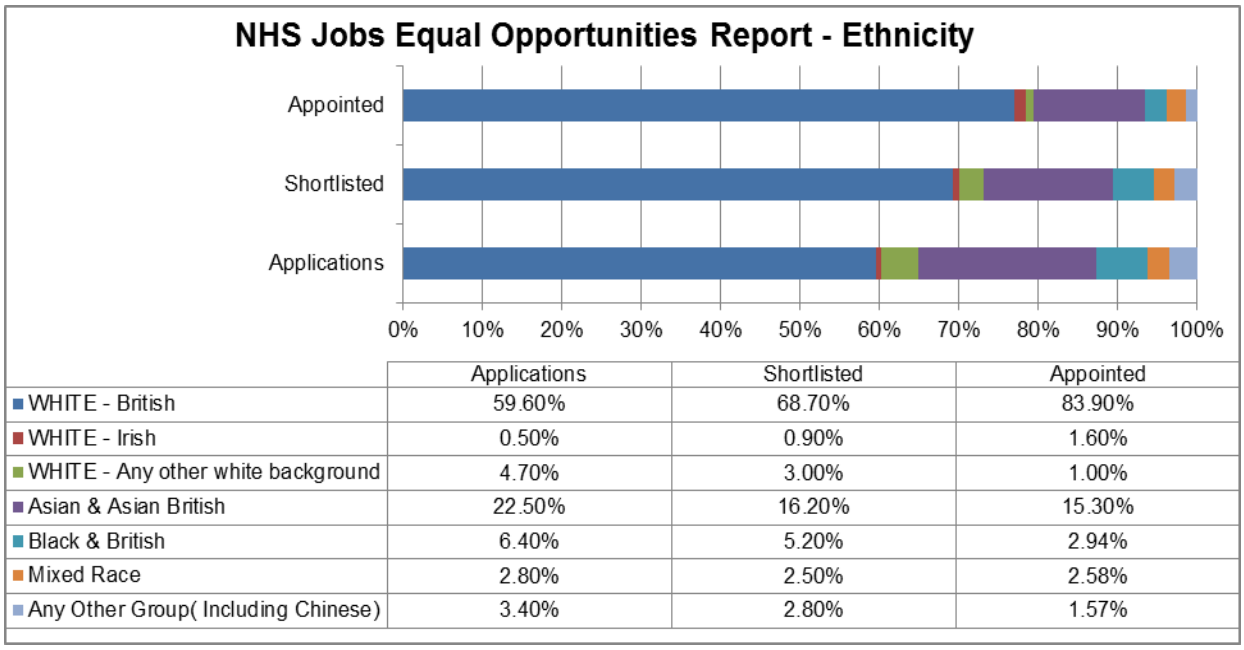
3. Staff joining the Trust

This section shows demographic data for the recruitment of staff and has been broken down using equality and diversity indicators. All information in this section comes from NHS Jobs, an online recruitment tool used by all NHS organisations.

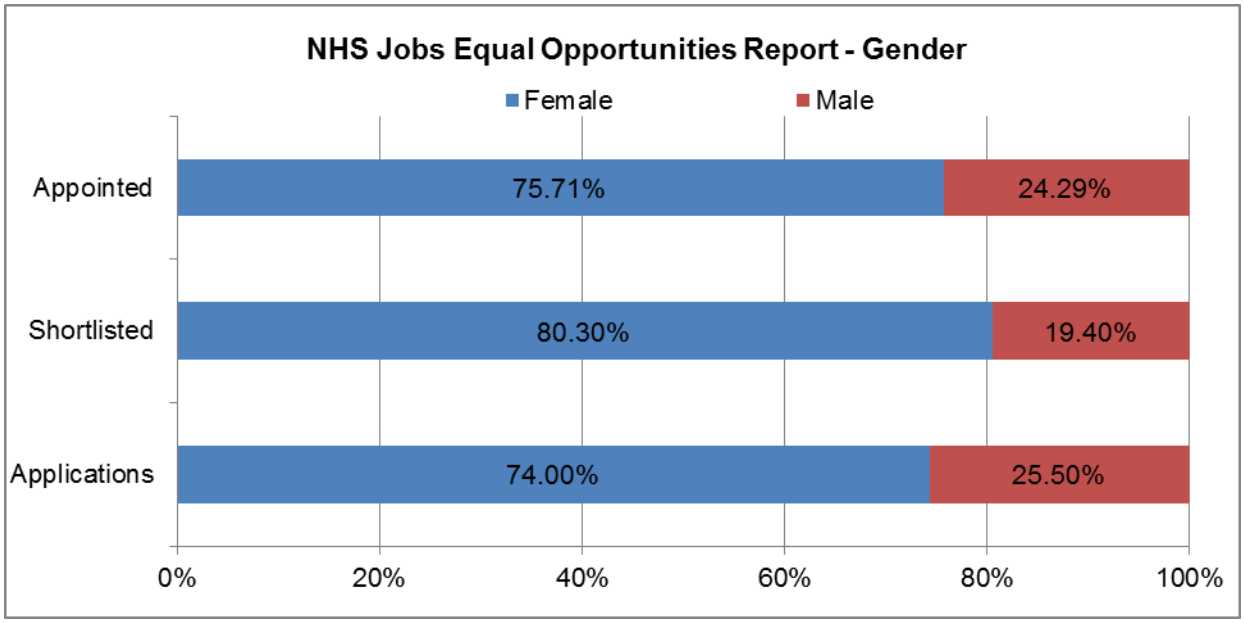
The data shown reflects all recruitment activity for the period 1 December 2014 to 30 November 2015, and provides a breakdown of number of applicants, number of applicants shortlisted and number of applicants appointed.

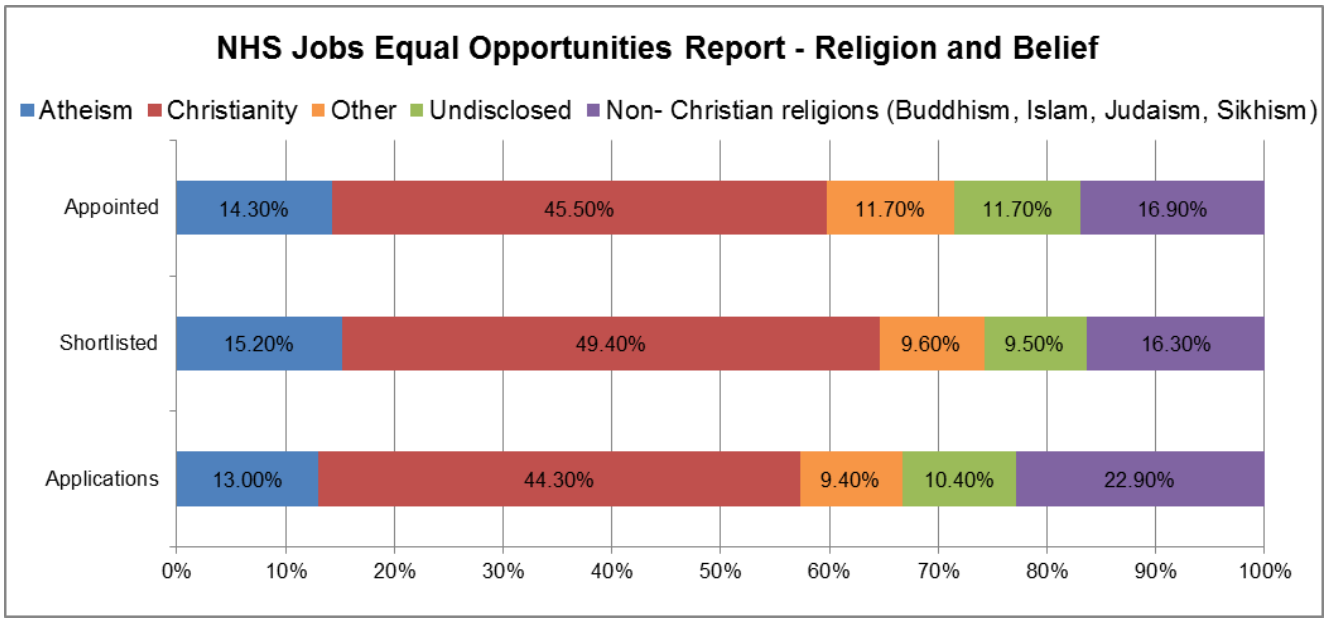


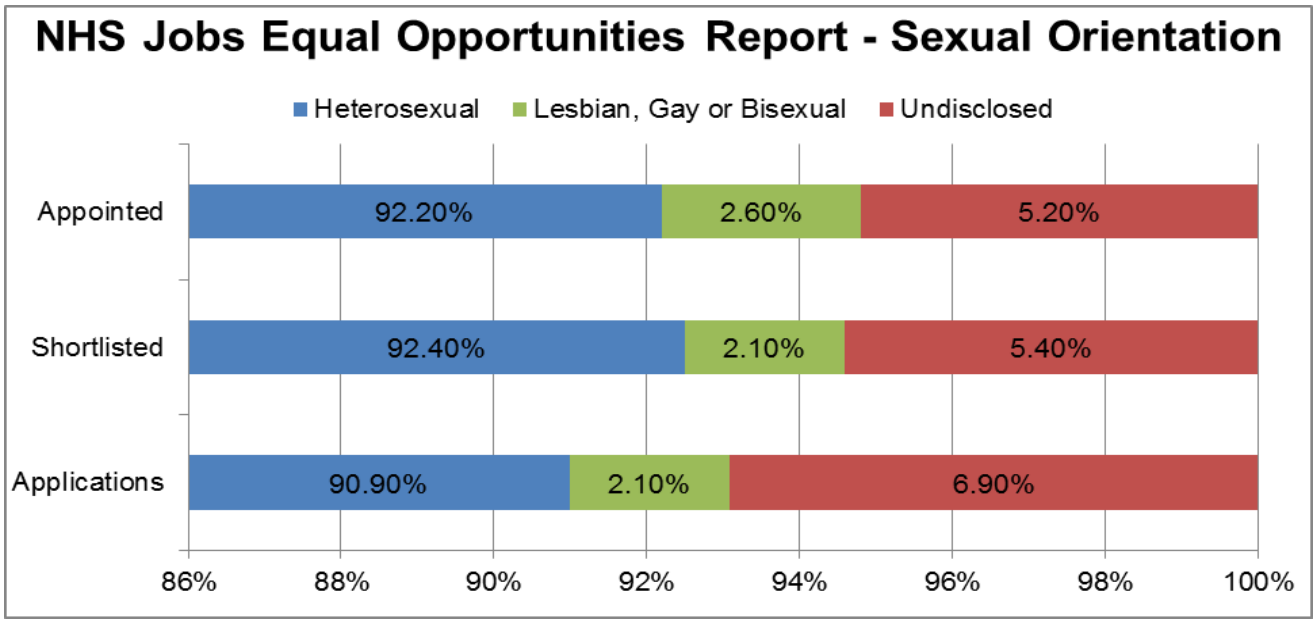




	Applications	Shortlisted	Appointed
WHITE - British	59.60%	68.70%	83.90%
WHITE - Irish	0.50%	0.90%	1.60%
WHITE - Any other white background	4.70%	3.00%	1.00%
Asian & Asian British	22.50%	16.20%	15.30%
Black & British	6.40%	5.20%	2.94%
Mixed Race	2.80%	2.50%	2.58%
Any Other Group(Including Chinese)	3.40%	2.80%	1.57%




NHS Jobs Equal Opportunities Report - Religion and Belief
Atheism
Christianity
Other
Undisclosed
Non- Christian religions (Buddhism, Islam, Judaism, Sikhism)
Appointed
14.30%
45.50%
11.70%
11.70%
16.90%
Shortlisted
15.20%
49.40%
9.60%
9.50%
16.30%
Applications
13.00%
44.30%
9.40%
10.40%
22.90%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

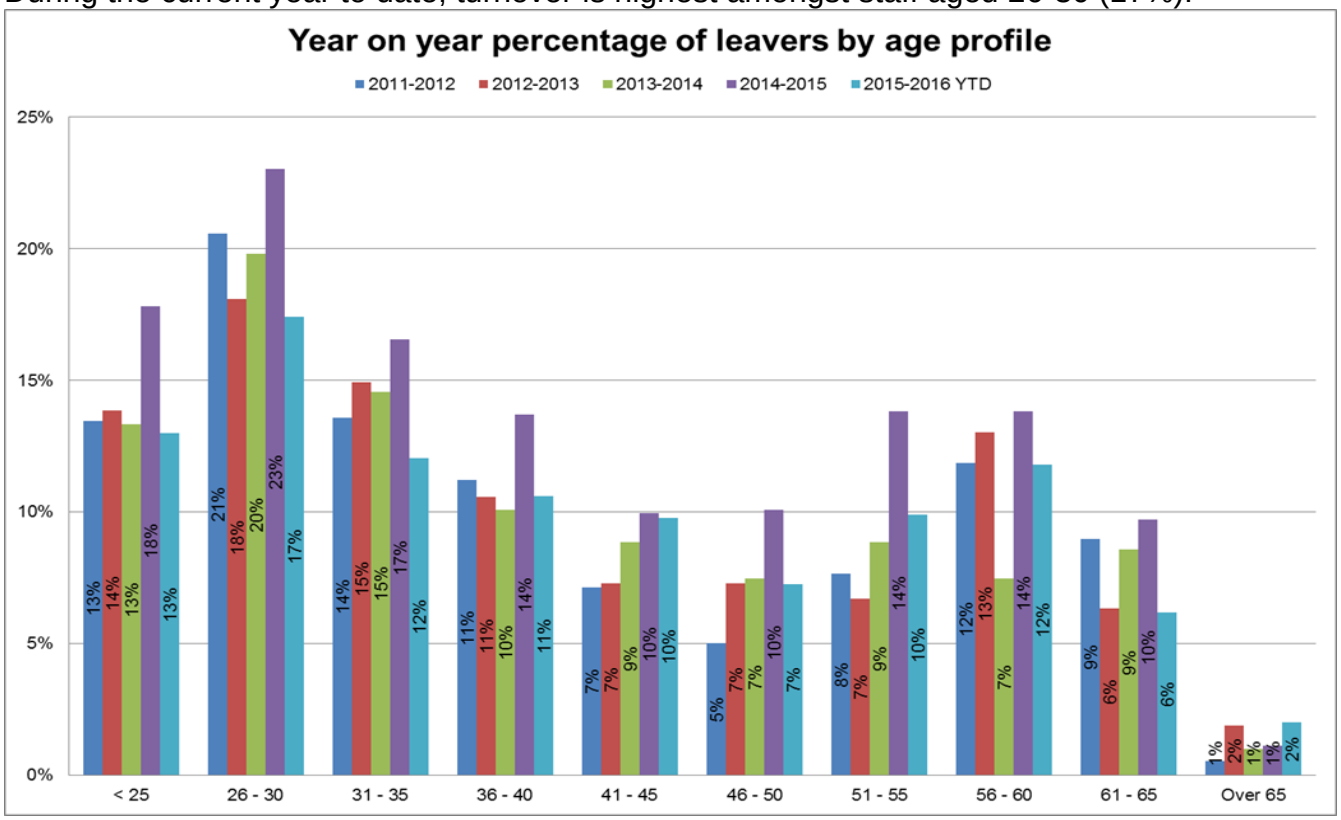

NHS Jobs Equal Opportunities Report - Sexual Orientation
Heterosexual
Lesbian, Gay or Bisexual
Undisclosed
Appointed
92.20%
2.60%
5.20%
Shortlisted
92.40%
2.10%
5.40%
Applications
90.90%
2.10%
6.90%
86%
88%
90%
92%
94%
96%
98%
100%

4. Staff leaving the Trust

This section shows data regarding staff that left the Trust between 1 April 2011 and 30 November 2015 broken down using the equality and diversity indicators.

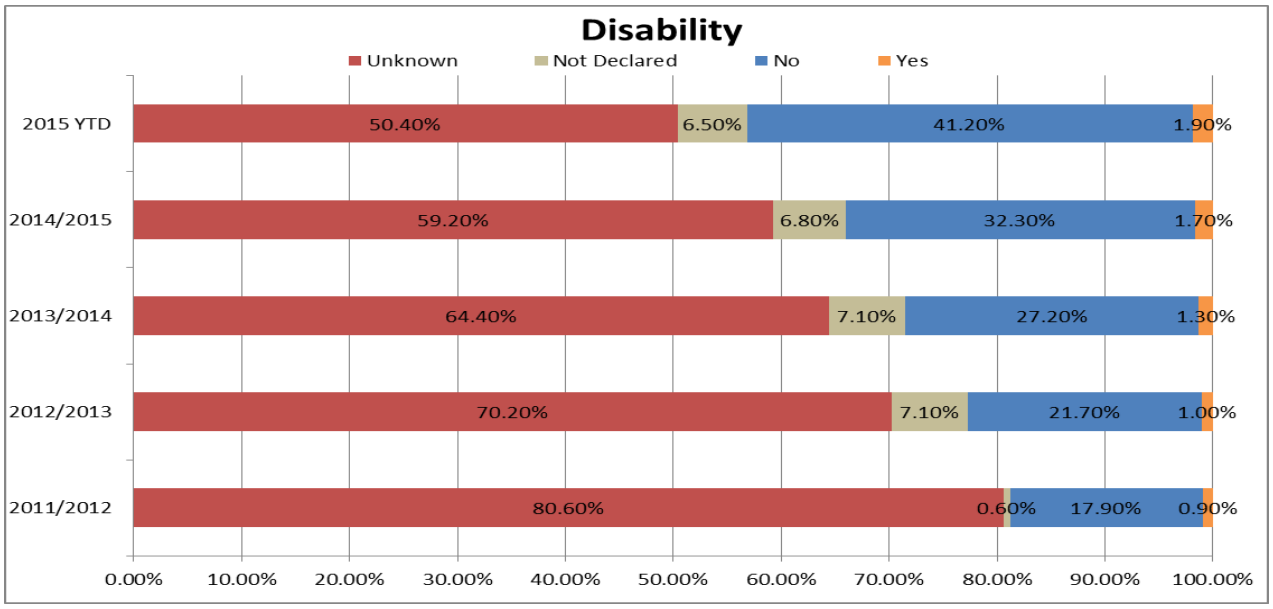
Age

During the current year to date, turnover is highest amongst staff aged 26-30 (17%).



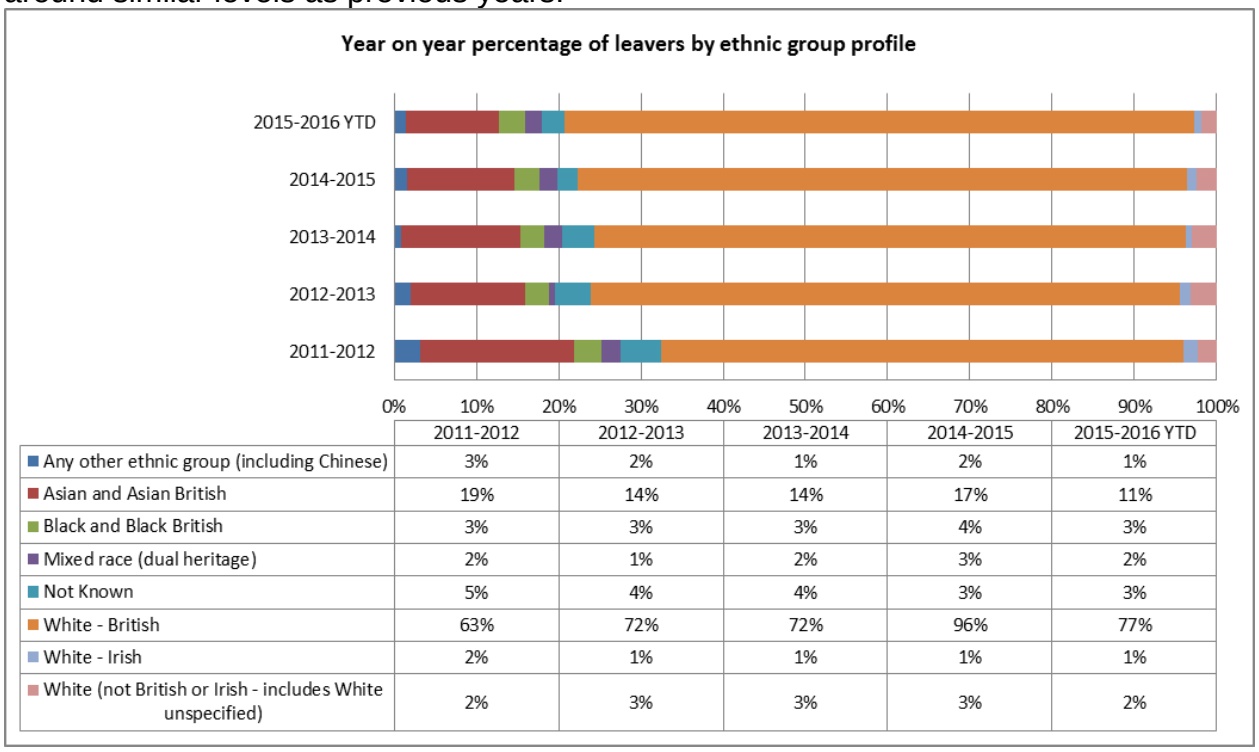
Disability

Data quality has improved in this area with a reduction of 8% in the in the 'not known' category.



Ethnicity Profile

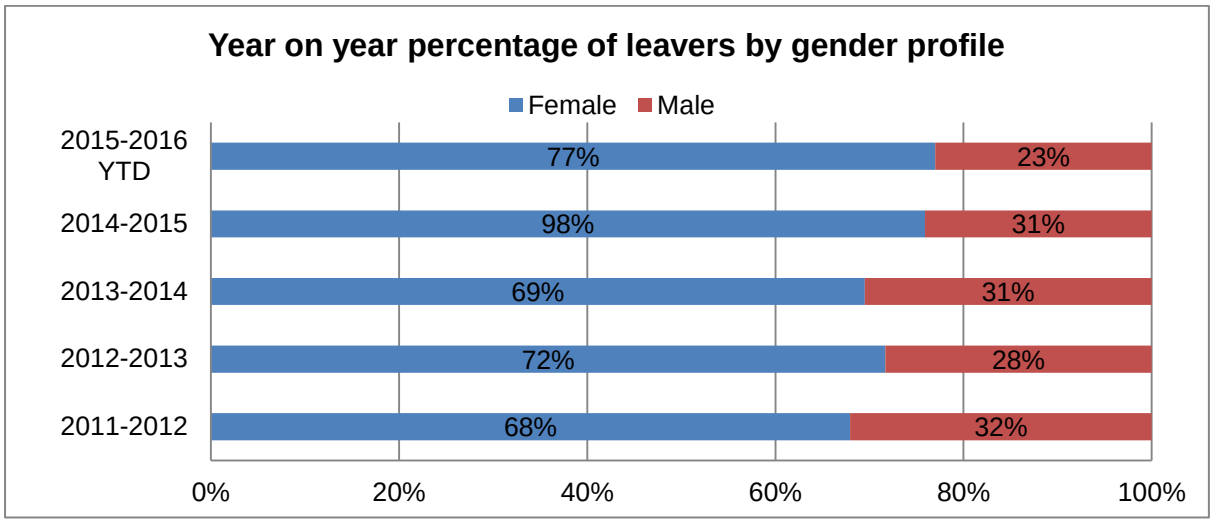
In the current financial year there has been a decrease of 19% of 'White British' leavers in the Trust, the other ethnic category that showed a significant change was 'Asian & Asian British' this has a decrease of 6%. All other categories remained around similar levels as previous years.



	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016 YTD
Any other ethnic group (including Chinese)	3%	2%	1%	2%	1%
Asian and Asian British	19%	14%	14%	17%	11%
Black and Black British	3%	3%	3%	4%	3%
Mixed race (dual heritage)	2%	1%	2%	3%	2%
Not Known	5%	4%	4%	3%	3%
White - British	63%	72%	72%	96%	77%
White - Irish	2%	1%	1%	1%	1%
White (not British or Irish - includes White unspecified)	2%	3%	3%	3%	2%

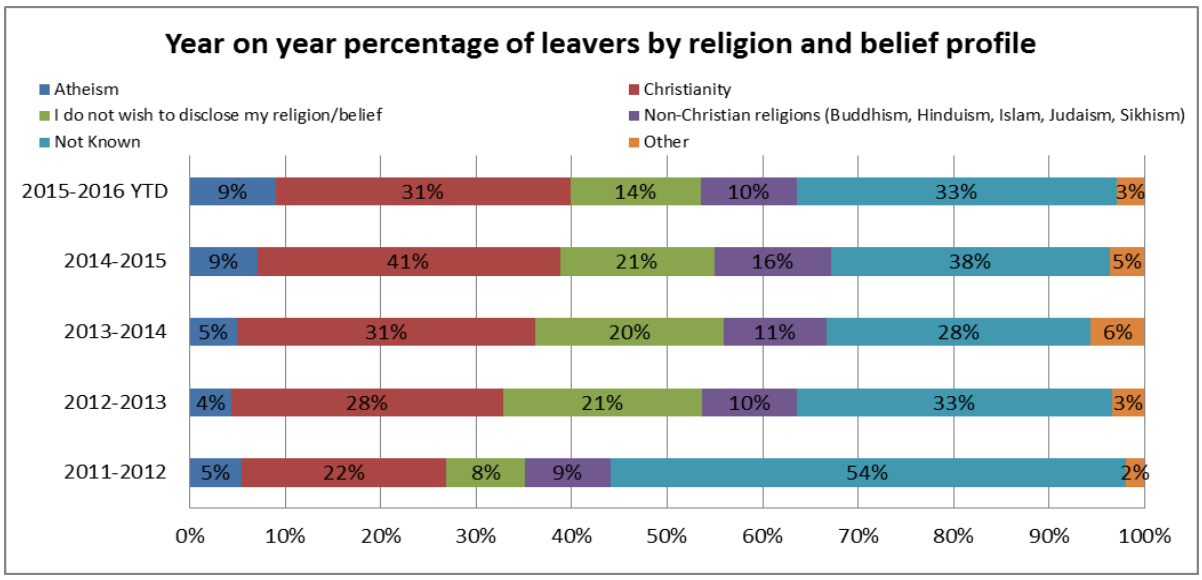
Gender

Again turnover is higher amongst female employees (77%): with the Trust employing a significantly higher ratio of female employees to male this is expected.



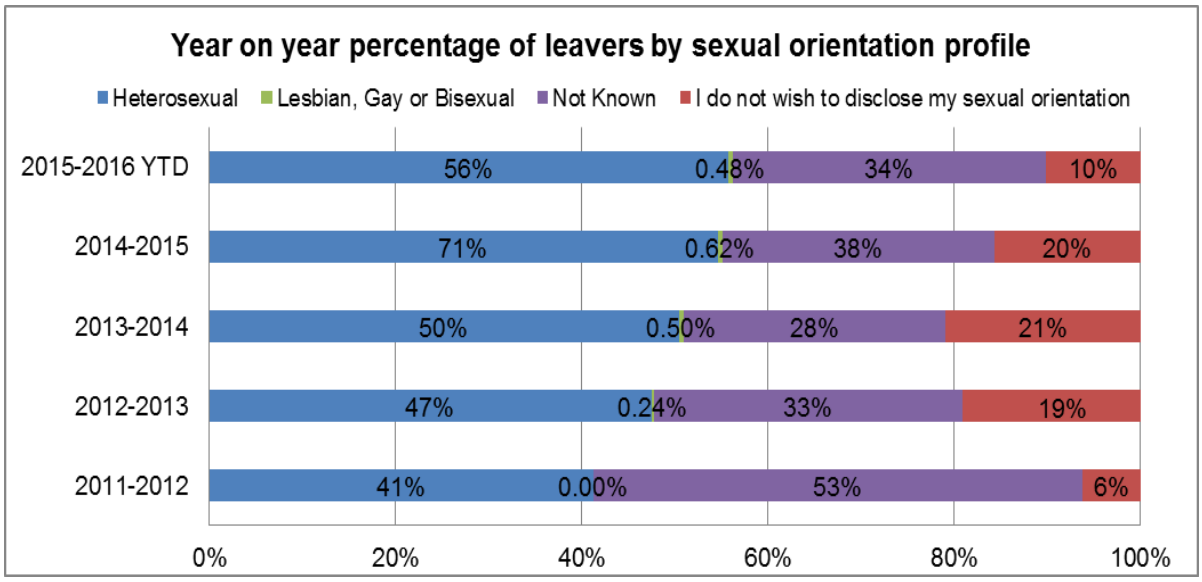
Religion & Belief

In the current year there has been a 5% decrease in the 'not known' category: this is something the Trust will try to continue to improve over the next 12 months.



Sexual Orientation

In the current year there has been a 4% decrease in the 'not known' category: this is something the Trust will try to continue improve over the next 12 months.



5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust staff as at 30 November 2015. This section looks at the organisation's pay and measures this against the key equality and workforce indicators.

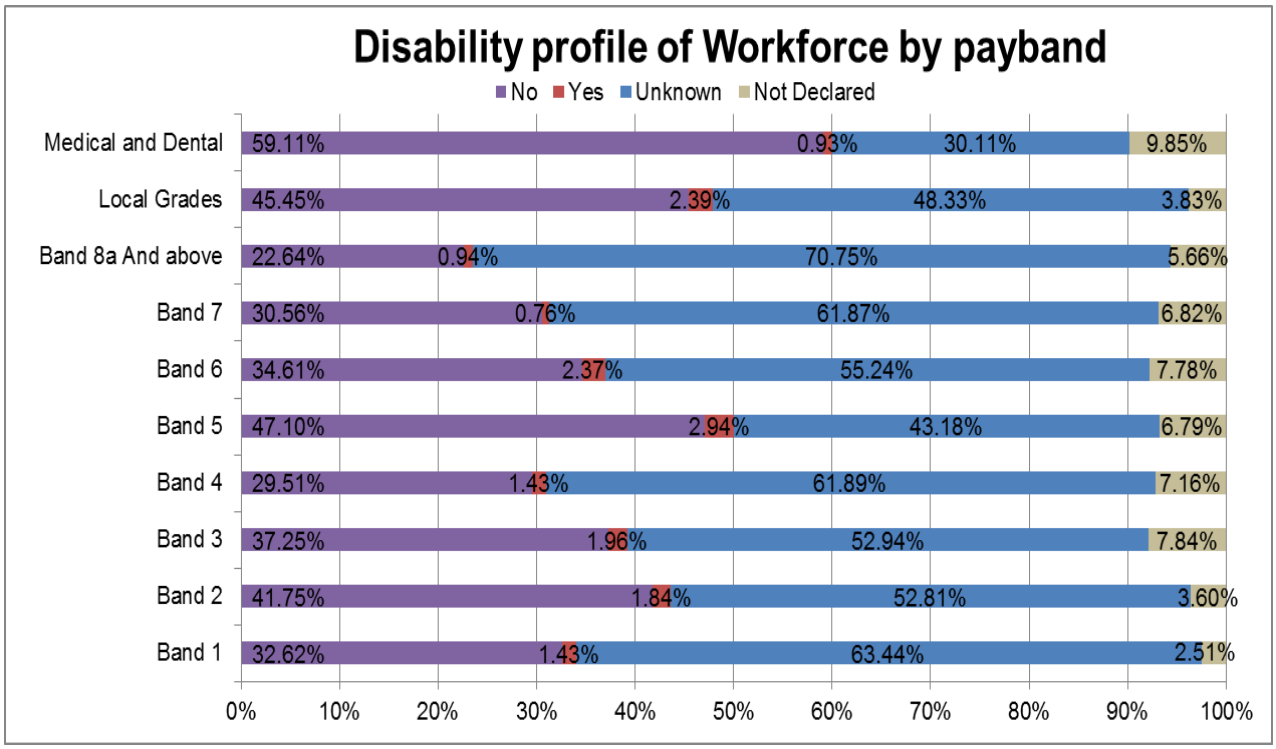
Age

The most common pay band in the Trust is band 5. 14.40% of people on this band are 26-30.

Age Band	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
<25	8.24%	11.75%	3.68%	5.16%	14.35%	3.38%	0.25%	0.00%	22.97%	12.08%
26 - 30	5.02%	10.18%	9.80%	7.45%	15.40%	9.92%	3.03%	0.94%	4.31%	17.29%
31 - 35	4.66%	9.12%	12.75%	8.31%	12.60%	16.57%	10.10%	4.72%	10.53%	14.87%
36 - 40	5.02%	7.02%	9.56%	11.46%	11.62%	12.40%	14.90%	9.43%	8.13%	13.57%
41 - 45	10.75%	12.63%	13.48%	14.90%	11.13%	15.33%	17.93%	16.98%	11.48%	13.75%
46 - 50	16.85%	13.95%	16.18%	20.92%	11.83%	17.02%	26.77%	31.13%	16.75%	11.15%
51 - 55	19.35%	15.18%	17.40%	18.91%	13.02%	14.32%	17.68%	22.64%	14.83%	8.55%
56 - 60	18.28%	14.91%	11.76%	10.03%	8.47%	8.46%	7.58%	9.43%	6.70%	4.83%
61 - 65	9.68%	4.56%	4.66%	2.87%	1.26%	1.92%	1.26%	4.72%	3.35%	2.79%
Over 65	2.15%	0.70%	0.74%	0.00%	0.35%	0.68%	0.51%	0.00%	0.96%	1.12%

Disability

Information on the profile of the Trust's workforce in terms of disability is inadequate. The chart below is based on responses from 60% of the Trust's workforce.



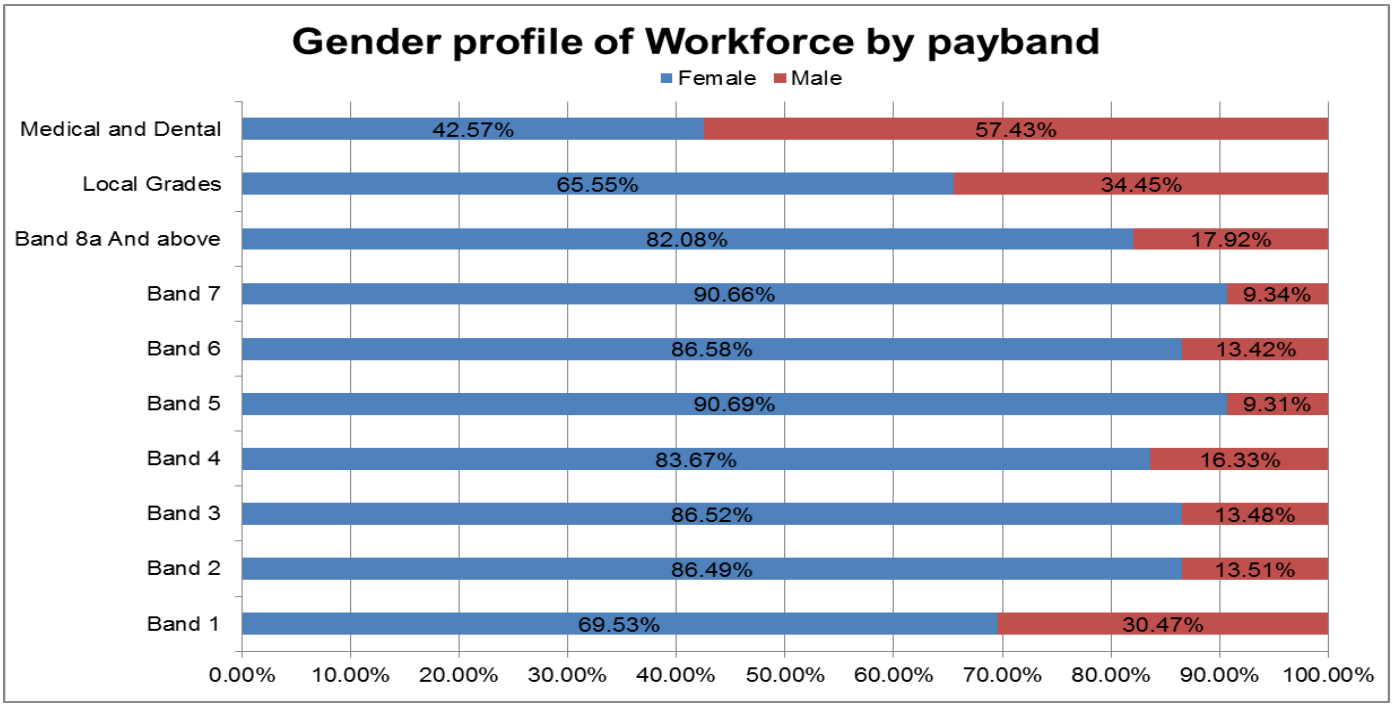
Ethnicity

Over all the Agenda for Change pay scales, the majority of staff are White British. Medical and Dental staff have a more even split between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

Ethnicity	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Any other ethnic group (including Chinese)	0.00%	0.88%	0.00%	0.29%	1.89%	1.01%	0.25%	1.89%	0.00%	7.81%
Asian and Asian British	11.47%	8.25%	4.66%	5.73%	7.70%	4.28%	2.27%	0.00%	11.96%	36.25%
Black and Black British	1.43%	0.88%	0.00%	0.29%	1.19%	0.56%	0.25%	0.00%	0.48%	3.16%
Mixed race (dual heritage)	3.58%	2.19%	0.98%	1.43%	1.33%	0.90%	2.02%	0.00%	0.96%	2.97%
Not Known	1.08%	2.89%	2.45%	1.72%	2.45%	2.82%	2.53%	0.94%	6.70%	5.95%
White - British	79.57%	83.07%	89.46%	89.11%	81.46%	87.60%	92.17%	97.17%	79.43%	36.43%
White - Irish	1.08%	0.79%	0.49%	0.00%	0.84%	1.47%	0.51%	0.00%	0.48%	0.56%
White (not British or Irish - includes White unspecified)	1.79%	1.05%	1.96%	1.43%	3.15%	1.35%	0.00%	0.00%	0.00%	6.88%

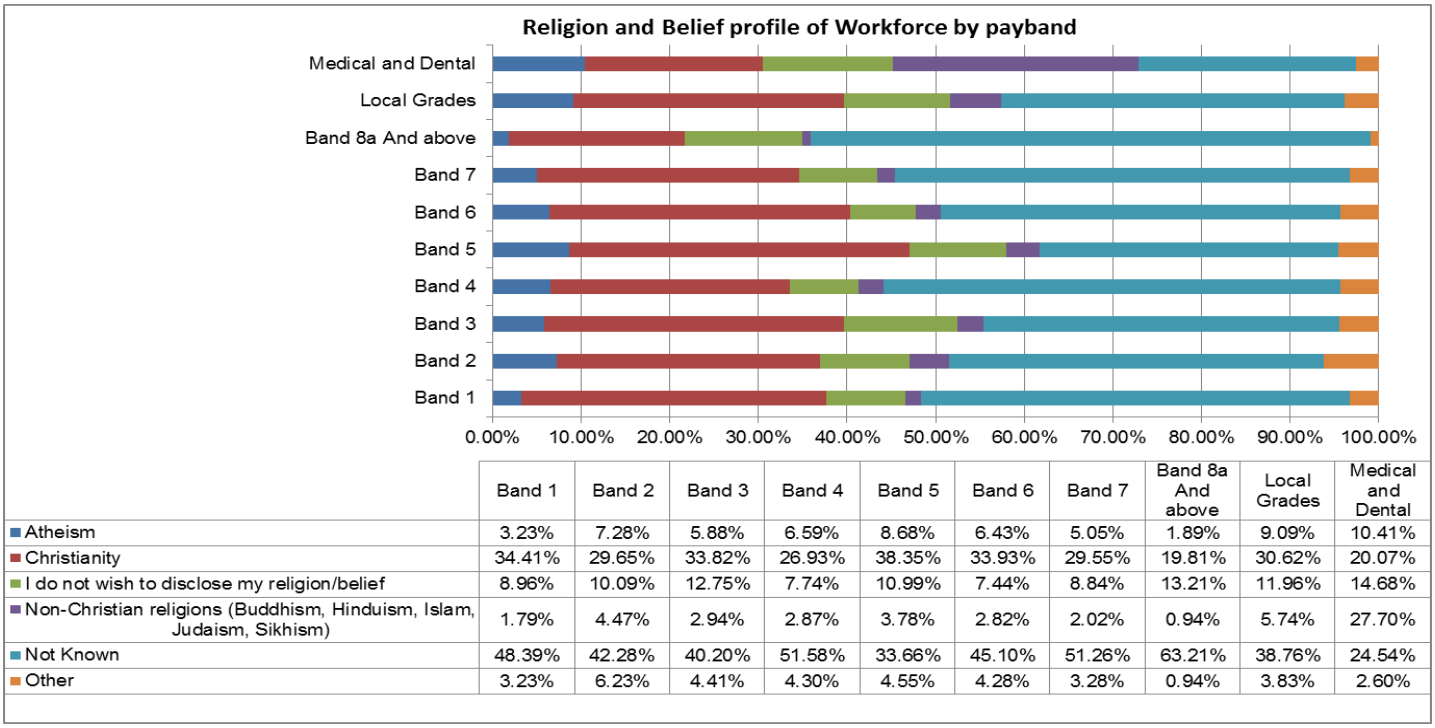
Gender

Men are over-represented in the Medical and Dental pay band (57.43%) compared with the workforce profile as a whole.



Religion and belief

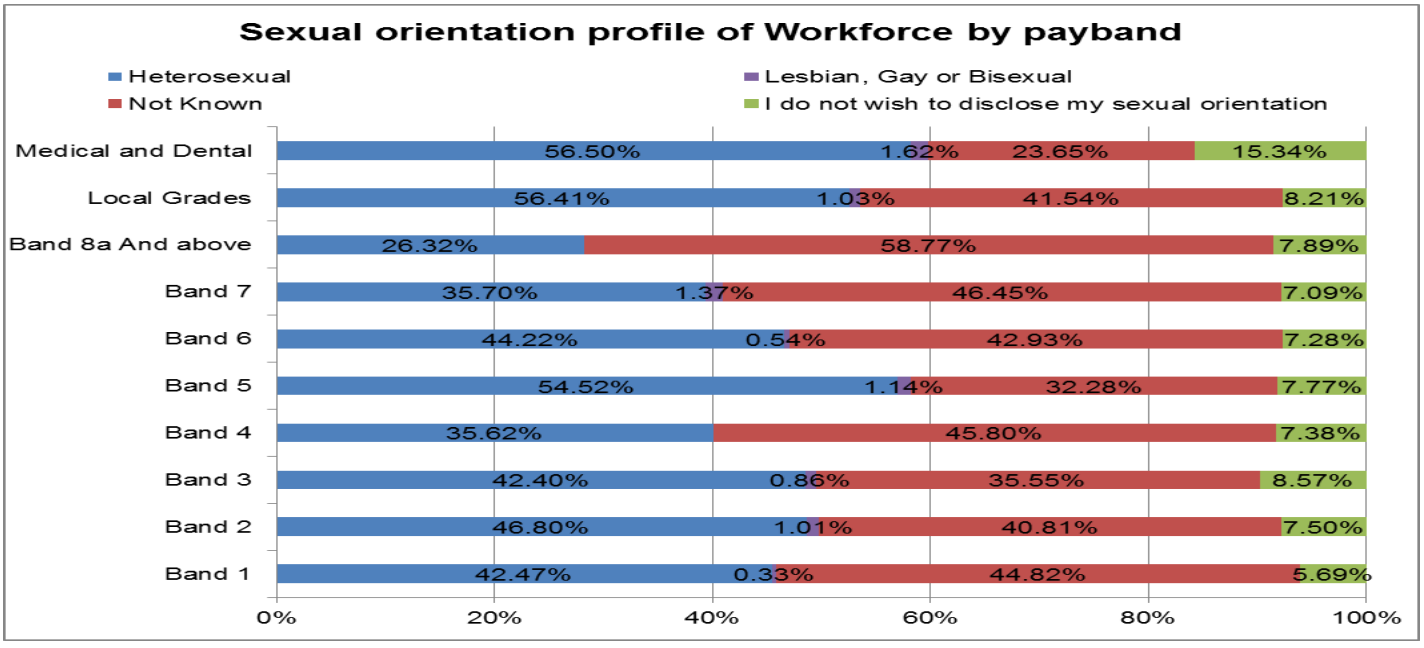
'Not known' information is predominant in all pay bands with the most significant being in Band 8a and above (63.21%). Progress is being made with regard to data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	3.23%	7.28%	5.88%	6.59%	8.68%	6.43%	5.05%	1.89%	9.09%	10.41%
Christianity	34.41%	29.65%	33.82%	26.93%	38.35%	33.93%	29.55%	19.81%	30.62%	20.07%
I do not wish to disclose my religion/belief	8.96%	10.09%	12.75%	7.74%	10.99%	7.44%	8.84%	13.21%	11.96%	14.68%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	1.79%	4.47%	2.94%	2.87%	3.78%	2.82%	2.02%	0.94%	5.74%	27.70%
Not Known	48.39%	42.28%	40.20%	51.58%	33.66%	45.10%	51.26%	63.21%	38.76%	24.54%
Other	3.23%	6.23%	4.41%	4.30%	4.55%	4.28%	3.28%	0.94%	3.83%	2.60%

Sexual orientation

'Not known' information is predominant in all pay bands with the most significant being in Band 8 and above.



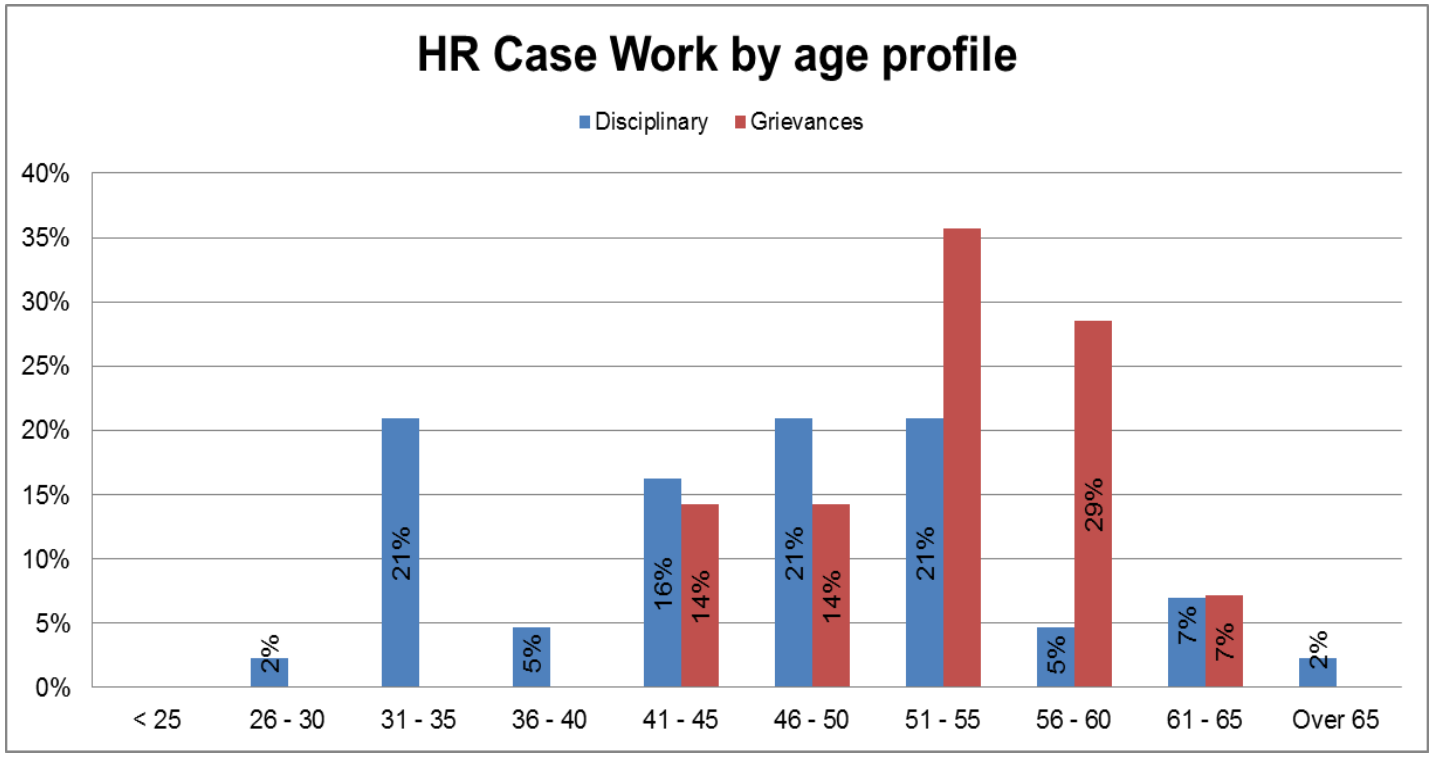
6. Disciplinary, grievance and bullying and harassment

Overall, between December 2014 and November 2015 there were:

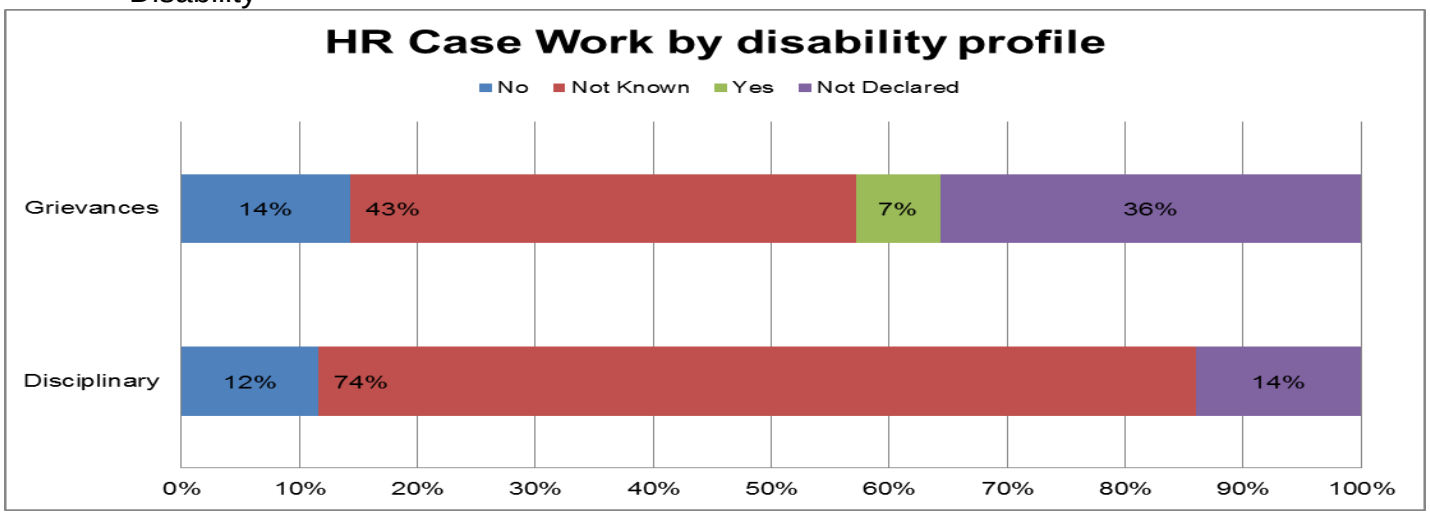
- 25 disciplinary investigations
- 9 grievance investigations
- 3 bullying and harassment investigations

To protect the anonymity of the data we have merged the bullying and grievance cases together. This section looks at the number of employee relation cases and measures this against the key equality and workforce indicators.

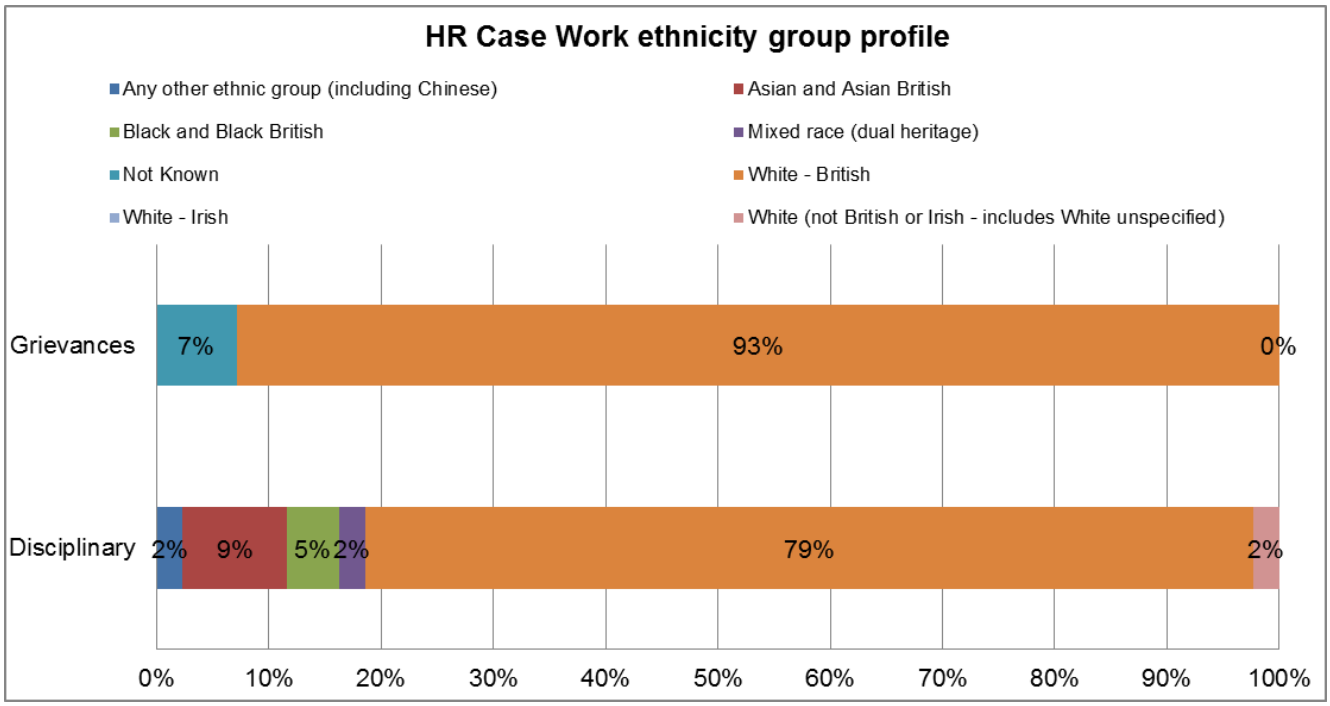
Age Profile



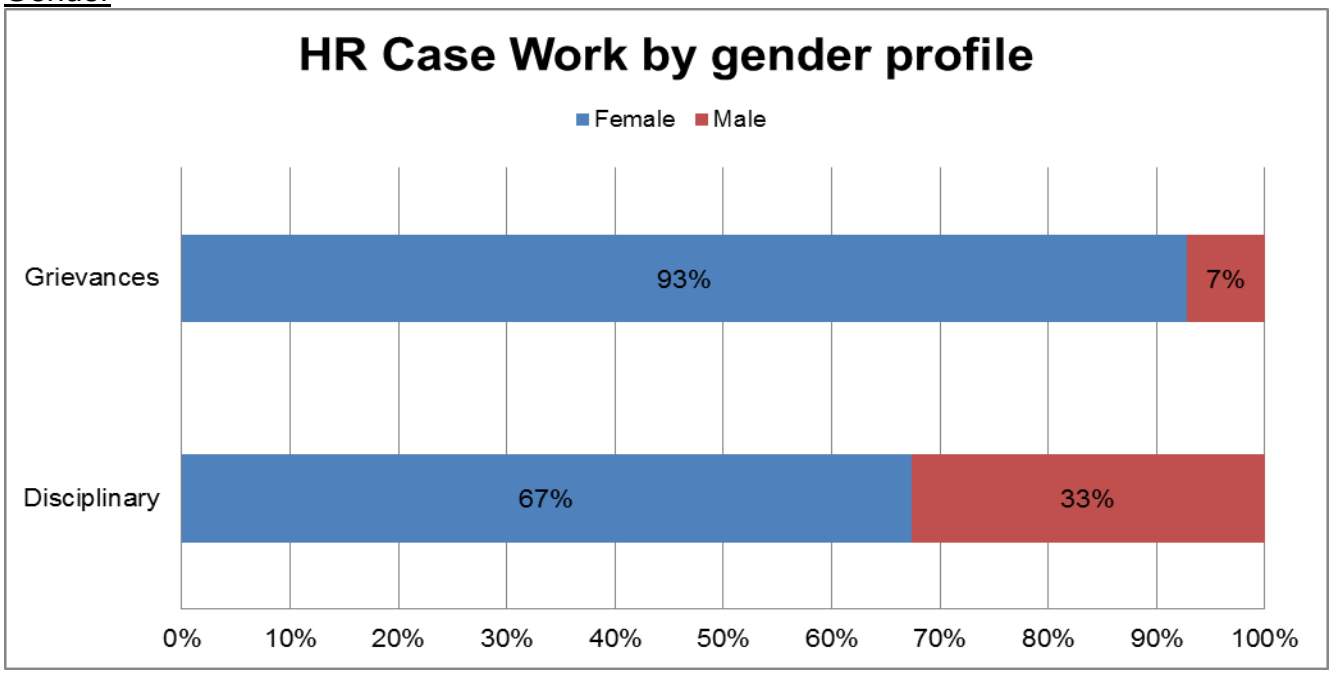
Disability



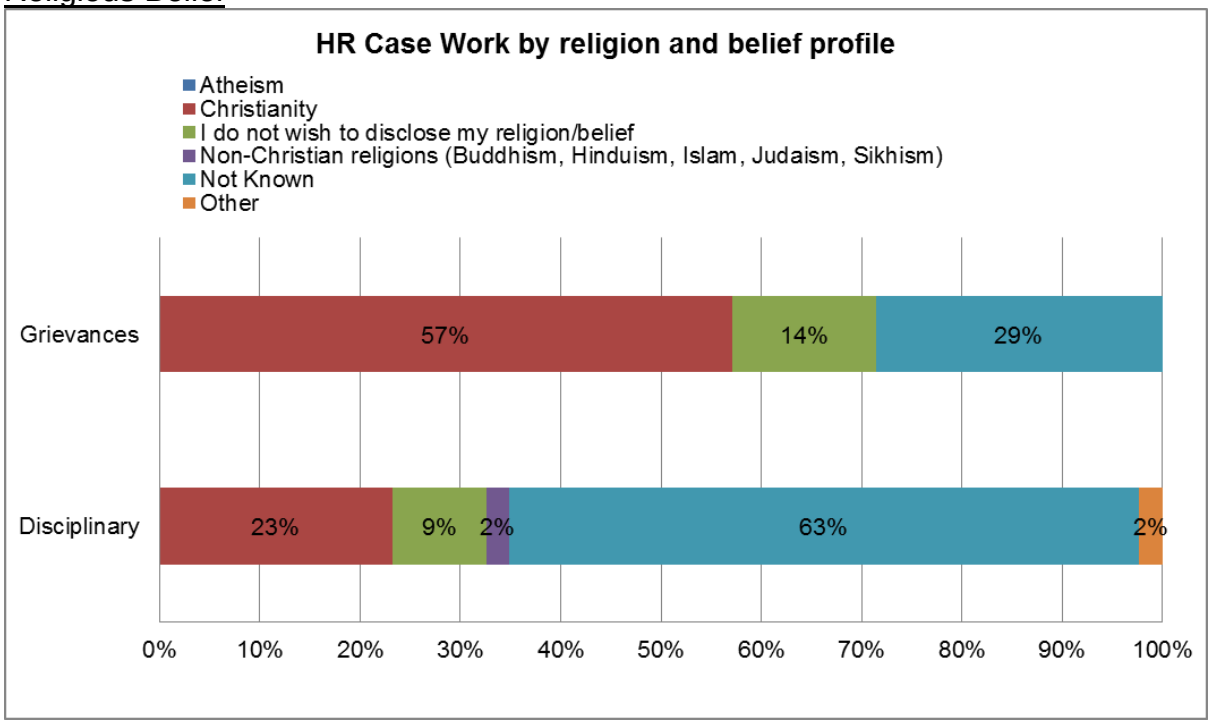
Ethnicity



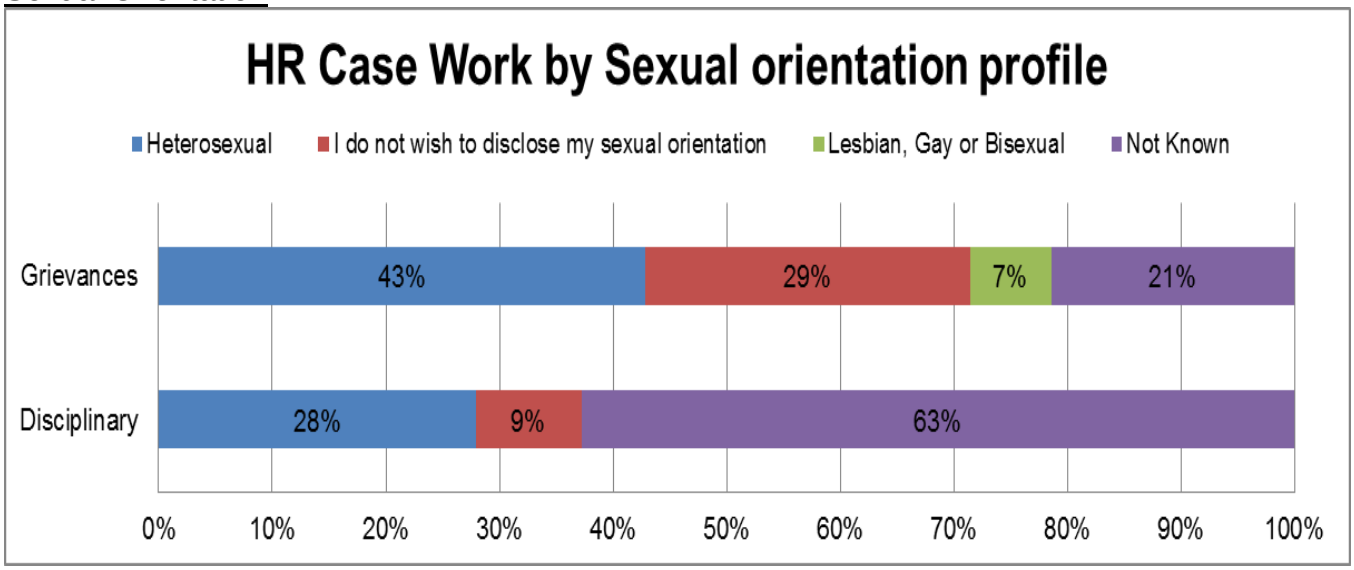
Gender



Religious Belief



Sexual Orientation



7. Policies and programmes in place to address equality issues

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees. The Trust's policies apply to all staff.

The Trust continues to undertake equality impact assessments which were initially introduced as part of the Equality Act 2010. These are no longer a legal requirement but the Trust recognises the importance of them and views them as good practice. The Trust will continue to review the usage of equality impact assessments in 2016.

The Trust has retained the disability `two tick' symbol which the Trust is assessed against by the Employment Service on an annual basis. The Trust has to demonstrate that it can meet the five commitments which include: to interview all applicants with a disability who meet the minimum criteria for a job vacancy, and consider them on their abilities; to ensure there is a mechanism in place to discuss the developed of disabled employees; to make every effort when employees become disabled to make sure they stay in employment; to take action to ensure that all employees develop the appropriate level of disability awareness needed.

The Trust successfully introduced the apprenticeship scheme for all posts at Agenda for Change pay bands 1 and 2, and continues to recruit to posts through the scheme. The Trust has recruited to healthcare assistant, administrative and clerical and gardening roles using the scheme. Whilst the Trust recruits to all roles a key success has been through the cohort recruitment approach for healthcare assistants. The first cohort of 14 employees commenced in July 2013 with four further cohorts recruited to date. The first two cohorts have successfully been recruited into substantive posts.

The Care Certificate has been incorporated into the apprenticeship programme for all new healthcare assistant roles ensuring we deliver to the standards. The Trust is looking to widen participation by ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation, into the employment market. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting on health and wellbeing.

The Trust's colleague engagement strategy adopts a consistent approach to change management with colleague engagement at its core. The strategy focuses on four behaviours that set out the Trust's values for employees, which the Trust expects to be demonstrated by all employees.

The Trust's Occupational Health Department is fully accredited to Safe Effective Quality Occupational Health Standards (SEQOHS). The standards measure that the Occupational Health Department meets minimum requirements, reflecting existing ethical and professional guidance and consensus and helps the department achieve uniform good practice. The Occupational Health Department has a strong focus on the health and well-being of staff and will focus on initiatives such as becoming a smoke free Trust, supporting staff and managers on mental health pathways and reducing the impact of musculoskeletal conditions. The service took a lead role in developing and engaging colleagues in the Year of Wellbeing 2015.

The Trust published its Workforce Race Equality Standard (WRES) in July 2015 following its introduction in April 2015. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust's WRES has identified a number of areas where improvement is required and these relate to recruitment, career progression and bullying and harassment. In order to develop an action plan the Trust has arranged a number of focus groups with Black and Minority Ethnic (BME) staff during February and March 2016 so the Trust can hear directly from the affected staff about the improvements that are required across these areas. The Trust is also working towards creating a BME network which would help to support the action plan for the WRES during 2016.

The Trust conducts a leaver's survey where staff leaving the organisation are given an opportunity the complete the survey. The response rate is 27%. The top three reasons for leaving the Trust are retirement, improved work/life balance and better career opportunity.

All new starters to the Trust are invited to complete a 'New Starter Feedback Form' when they have been with the Trust for 3 months. The response rate is 34%, with the majority of new starters reporting a positive start to working at the Trust and 99% agree that they are aware of and recognise the four pillars of behaviour the Trust expects of new colleagues.

8. Summary

In 2015, we have:

- Improved the quality of data stored within the Electronic Staff Record (ESR) around ethnicity, sexual and religious beliefs for all new starters since April 2010. This is in line with the ESR central team and the Health and Social Care Information Centre validation and data quality reporting system, and the Workforce Validation Engine (WOVEN). Reports are received on a monthly basis and highlight improvements within ESR.
- Improved processes with the recruitment of applicants through NHS Jobs to make sure demographic information is captured in a timely manner.
- Established a Well Led Organisation Group. This group monitors and provides assurance on staff engagement and experience and the factors that contribute to this.
- Continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in July 2015.
- Introduced the new starter feedback form.

APPENDIX 3 – POSTER FOR NON-ENGLISH SPEAKING VISITORS

Calderdale and Huddersfield NHS
NHS Foundation Trust

If you would like some help to find your way, please contact one of our hospital volunteers.

They are wearing light blue polo shirts.

اگر آپ کو کہیں معلوم کرنے کے لئے مدد کی ضرورت ہو تو ہمارے ہسپتال کے رضاکاروں میں سے کسی سے بات کریں ؟
وُہ ہلکے نیلے رنگ کی پولو شرٹ پہنے ہوئے ہیں؟

Pokud potřebujete pomoci najít cestu, kontaktujte prosím jednoho z našich nemocničních dobrovolníků. Mají na sobě světle modré tričko s límečkem.

Ha szeretne a tájékozódáshoz segítséget kapni, kérem, forduljon az egyik kórházi önkéntesünkhöz.
Világoskék pólót viselnek.

Jeżeli potrzebują Państwo pomocy w znalezieniu drogi, prosimy skontaktować się z naszym i szpitalnymi wolontariuszami.
Są ubrani w jasnoniebieskie koszulki polo.

ਜੇ ਤੁਸੀਂ ਆਪਣਾ ਰਸਤਾ ਲੱਭਣ ਵਿੱਚ ਕੁੱਝ ਮਦਦ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਹਸਪਤਾਲ ਦੇ ਸੇਵਕਾਂ ਵਿੱਚੋਂ ਕਿਸੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।
ਇਨ੍ਹਾਂ ਦੇ ਫ਼ਿੱਕੀਆਂ ਨੀਲੀਆਂ ਪੋਲੋ ਸ਼ੱਰਟਸ ਪਹਿਨੀਆਂ ਹੋਈਆਂ ਹਨ।

Interpreting Services are available to patients in several languages and in British Sign Language
The Big Word: Translation Service Telephone (0)870 748 8000

APPENDIX 4 – COMMUNICATION CRIBSHEET

10 WAYS TO HAVE GREAT COMMUNICATION WITH YOUR PATIENTS

Every patient needs and expects great care from you and your colleagues. Some patients may have additional communication needs, eg those with a hearing or visual impairment - here's 10 questions you can use to evaluate how well you communicate with all of your patients…..

No	Do you……..	✓
1	....provide information to your patients about the hospital, ward and procedure before their admission/appointment, in a format that is appropriate to their needs?	
2	….provide information to your patients about follow-up care, medication and contact numbers on discharge in a format that is appropriate to their needs?	
3	(if your patient has a carer)….use the carer sheet developed within Older People's Services to request information about the patient's preferences, likes, dislikes, support needs and behaviour?	
4	….know how to access patient information in alternative formats, eg large print, braille and how to access "The Big Word" language service?	
5	….know whether patient complaints relating to the attitude of colleagues and communication are regularly reviewed and acted upon?	
6	….ask patients/groups with additional needs, eg visual or hearing impairment, to share their views and suggestions at departmental meetings, in order to directly improve patient experience?	
7	….make use of material in Easy Read format, eg the Easy Read leaflet available at: xxxxxxxxx	
8	….have access to a communication toolkit for use with patients with learning disabilities?	
9	….make patients aware of the services offered by the chaplaincy, for people of faith or no faith?	
10	….have resources/processes in place to give patients information about domestic arrangements such as meals, toilets, how to use the call button etc?	

APPENDIX 5 – MEMBERSHIP ENGAGEMENT DATA

Membership Representation as at December 2015 by Age, Ethnicity & Gender

	Members	% of total members	Eligible membership*	% of eligible membership
Age (years)				
0-16	8	0.1%	10398	1.6%
17-21	545	5.7%	52215	8.2%
22+	8404	87.4%	573203	90.2%
Ethnicity				
White	7623	79.3%	529668	83.3%
Mixed	167	1.7%	9659	1.5%
Asian or Asian British	726	7.5%	79829	12.6%
Black or Black British	229	2.4%	10162	1.6%
Other	37	0.4%	3935	0.6%
Gender				
Male	3401	35.4%	309248	48.6%
Female	6214	64.6%	326568	51.4%
Transgender	1	0.0%	Not available	-

* 2011 Census Data

Please note these totals are approximate as not all Trust members declare their age or ethnicity.

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting: Board of Directors	**Report Author:** Alison Lodge/Juliette Cosgrove
Date of meeting: 28 January 2016	**Sponsoring Director:** Julie Dawes
Title and Brief Summary: Action plan in preparation for the CHFT Care Quality Commission (CQC) inspection	
Action required by the Board of Directors: To note the work to date and plans for moving forward	
Strategic Direction area supported by this paper: Keeping the base safe	
Forums were this paper has been previously considered: Quality Committee	
Governance requirements: None noted	
Sustainability implications: None noted	

EXECUTIVE SUMMARY

Summary: This report provides a further update of the progress being made in advance of the forthcoming CQC inspection. The date for this has been confirmed as Tuesday 8th March 2016 and the Trust is now moving into the final phase of preparation ahead of the inspection.

MAIN BODY

Core service and domain presentations: Two rounds of presentations have now been completed by each core service and domain. Presentations from Round 1 were based on self-assessments and development of 90 day plans. The second rounds focused on what has improved, what actions are outstanding and a forecast of when each domain will become green. The group is now focused on any remaining risks to gain assurance on mitigation.

Provider information request (PIR): A significant amount of the steering group meeting has been dedicated to the PIR which was received mid December 2015 with a 4 week deadline – Monday 11th January 2016.
The request covered 3 main areas:

- **Trust wide and core service information:** A significant amount of information was requested and required cooperation from all core service teams as well as corporate functions in order to ensure it was submitted within the deadline. This was particularly challenging given the Christmas and New Year period, however the submission was made on time and the few areas where the information was not available a narrative was provided.
- **Self-assessment:** A self-assessment against each core service by domain was required for both hospital sites – see appendix 1 for the submitted ratings.
- **Strengths and weaknesses:** The Trust was required to submit a view on the strengths and weaknesses of the organisation; this was linked to the concerns raised in the self-assessment – see appendix 2 for the submitted commentary.

Communication plan

- **Presentations and roadshow**: Three sessions were delivered on Monday, 14th December 2015 by a senior CQC inspector, all were well received. A key message was for people to recognise their own personal responsibility for providing a safe and good quality service for patients. A write up from the sessions has been shared with each department and also featured in CHFT weekly and the Trust News
- **Briefings:** regular CQC related articles continue to feature in the Big brief, Trust news and CHFT weekly
- **Go see:** an increased number of assurance visits have taken place across wards and departments, where an issue is identified they are being tested out across the Trust via the ADNs
- **Intranet page:** has been updated – it provides access to key CQC documents, examples of CQC reports and some of the presentations shared at the steering group.
- **Capsticks** have carried out some work with the Trust Board and senior management team during December and early January, these have taken the form of mock inspections to help teams appreciate the level of challenge they can expect to receive.

Actions for next month

- Continued focus on evidence gathering and preparing for the next Provider information request (PIR)
- Increase in the staff briefings via corporate and divisional sessions
- Re-focus the steering group meetings to receive risk profiling for each core service and domain
- Commence a programme of mock inspections
- Logistical preparations for the visit

Attachments:

Appendix 1: self-assessment

	Safe	Effective	Caring	Responsive	Well-led	Comments
Urgent and emergency services	Requires Improvement	Good	Good	Good	Good	SAFE - Due to dual site working and difficulties in recruiting medical staff we are unable to provide the senior medical cover we would like. Whilst we mitigate this on a day to day basis by the use of locums and other non medical staff there are times when there are delays to see patients
Medical care (including older people's care)	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	SAFE - The service has a range of staffing pressures: medical- there are times when there are delays to access senior decision makers, particularly out of hours; nursing- pressures related to fully staffing surge beds; AHP's-delays for reviewing patients and fully meeting rehab plans. These pressures are exacerbated by dual site working across a range of medical specialities. RESPONSIVE - The service does not always promptly investigate incidents and has sometimes built up a backlog, whilst this is not unique to the service, all services have at times had a concern with this area, the size of this service means that it has an impact on the overall position of the organisation. Reduced patient flow, including delayed discharge, has an impact on the services ability to ensure that patients are in the correct bed base and have their needs fully met. WELL-LED - Training Records for this service are not comprehensive leading
Surgery	Good	Good	Good	Good	Good	
Critical care	Good	Good	Good	Good	Good	
Maternity and gynaecology	Good	Good	Good	Good	Good	
Services for children and young people	Good	Good	Good	Good	Good	
End of life care	Good	Good	Good	Good	Good	
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	

	Safe	Effective	Caring	Responsive	Well-led	Comments
Community						
Services for Children & Young	Good	Good	Good	Good	Good	
End of Life Care	Good	Good	Good	Good	Good	
Community services for adults	Good	Good	Good	Good	Requires Improvement	WELL-LED – This is a newly formed division and therefore has not got an established management and governance structure including setting up the Divisional Management Board. This had affected the senior management teams ability to comprehensively manage the performance of the division. Extra staff are being recruited to support the divisional management team.

Appendix 2: strengths and weaknesses

Which services or areas of the trust do you consider to be good or outstanding?

Please explain in 250 words

Calderdale and Huddersfield is a good Trust performing well across the majority of indicators with no major concerns identified.

A dedicated and loyal workforce, committed to providing compassionate care to our patients.

The Trust's vision of providing compassionate care and the four pillars of behaviour which underpin it are well recognised and understood. 'Working together to get results' programme is being embedded and equips colleagues to address difficult issues, poor performance and deliver better patient care.

The Trust is aspirational and this is evidenced through:

- The implementation of an electronic patient record and new technologies as a way of harnessing information so patients get top quality care. These include NerveCentre' observation technology across all our wards, provision of new mobile technologies for all community staff with and a new maternity electronic patient record.
- The Clinical Strategy which addresses the two-site working and movement of care from a hospital to a community setting.
- Safety initiatives such as a pilot site for always events and membership of the safety collaborative
- Strong partnership working including a successful community vanguard in Calderdale often leading innovations such as Quest for Quality improving the level of support provided to Calderdale care homes and their residents to improve health outcomes. The Quest team has helped to reduce admissions by more than 20% and hospital bed days by 15%.
- Consistently positive feedback from the GMC and Deanery about the education and training provided to junior doctors.
- Implementation of shift working in acute surgery which has reduced mortality by 50%.

Which services or areas of the trust do you feel are your weaker areas?

Please explain in 250 words

Like many other Trusts the Trust is facing a number of significant challenges including its financial position.

One of the key factors is that the Trust operates across two hospital sites with some services being split across both locations. This has an impact on a number of areas including:

- The emergency pathway. While the Trust has been successful in recruitment of nursing staff, the additional capacity is having an impact on safe staffing levels and the use of bank and agency staff.
- Recruitment and retention of medical and therapy staff. As a result we have agreed a contingency plan should there be an urgent need to temporarily close one of the ED sites. This has been shared with local CCGs, OSCs and Monitor.
- Meeting the 7-day core standards is significantly challenging.
- Meeting the standards for Children and Young People in Emergency Care settings. This is mitigated through a number of measures in place on both sites.

HSMR is higher than expected. Mortality reviews are being undertaken and an independent clinical view has been sought to identify and address any identified causes.

The Trust is also looking to review and strengthen education and training including essentials skills.

While there has been significant work to strengthen quality governance, there is further work being undertaken to respond to the recommendations of the Well Led Governance Review and address areas for development such as risk, incident reporting and complaints.

Please describe what actions you are taking to address these weaker areas, Please include any support that you feel the trust may need (or has already sought) to address the challenges it is facing in ensuring the quality of care and patient safety.

Please explain in 250 words

The Trust has developed a 5 Year Strategic Plan which sets out how services can be reconfigured onto a planned and unplanned site to address many of the weaknesses described. This Plan is currently with the Clinical Commissioning Groups to form the basis of their pre-consultation business case with the intention to go to consultation in February. This would address the concerns around the emergency pathway, medical staff for the emergency department and some medical specialties and compliance with the standards for Children and Young People in Emergency Care settings, and some of the 7-day core standards.

The independent review of the Trust's mortality ratio has identified that the Trust has a well-developed plan for reducing mortality but highlighted some additional areas to focus improvement. These are being progressed through the Care of the Acutely Ill Patient programme.

We have developed and are implementing a recruitment and retention strategy to address the gaps across all professional groups in key specialties.

The Trust has agreed a plan to create a multi-professional education and training department, which will address both essential skills training and professional training and education.

The Well Led Governance Review has a clear action plan for delivery which is being monitored through the monthly Progress Review Meeting with Monitor.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Helen Barker, Associate Director of Community Services and Operations
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and approve the Integrated Board Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board - 21.1.16	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The December IPR report shows improved performance across a number of the national and local standards. The areas of specific note are as follows:
Responsiveness
• In month there have been several areas of overtrade against plan with a postive impact on financial forecasts despite periods of reduced activity for the Christmas
period. In particular there continues to be a significant overtrade against the non-elective activity in Medicine which is 4% above planned levels.
• Emergency Care Standard delivered in December and the quarter
• Pressures continue in key elements of patient flow meaning performance secured through additional capacity rather than pathway improvement.
• Elective access - All 18 week RTT targets and 6 week diagnostic targets have been achieved in month.
• ASI reporting remains problematic but issues know to continue; current focus required on clincial and non clinical validation
• Stroke standards have been revised to better reflect national stroke audit standard 'A' rating with improvement required to acheive these; both the TIA and
Thrombolysis targets were delivered.
• All regulatory cancer targets were achieved, D38 standard improved and no patients had a pathway in excess of 104days
Caring
• Complaints response times remain a challenge with focussed activity in January to close high volumes.
• FFT would recommend in Community and AED has reduced
• There have been increased concerns rasied by women in labour
Effectiveness
• Hand Hygience compliance has improved in December
• Mortality remains a concern and is the focus of significant work
• # NoF performance in relatio to Theatre within 36hours has improved again and reached the 85% target
Safety
• There remains a high proportion of Serious Incident reports out of time
• Duty of Candour is 100% across both metrics
• The predicted improvement has not been acheived for 'falls with harm'
Well led
• Sickness has increased in 5 of the 7 service areas reported and 5 out of 8 staff categories with overall % sickness at its highest point in current service year.
• Staff in post and FTE is static
• Over 96% of colleagues have now started their mandatory training programme.
• Appraisal activity plans are in place with divisions now RAG rated against these plans
CQUINs
• Sepsis and Acute Kidney Injury CQUINs remain a challenge to deliver, threshold set nationally and the Trust is in a similar position to peers on delivery

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Integrated Board Report

Appendix

Attachment:

IPR Report Dec 15.pdf

Board of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: December 2015

Board of Directors

Integrated Performance Report

Executive Summary Commentary

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Table Of Risk

compassionate care

	Improving						No Change						Deteriorating					
Monitor	A and E 4 hr	Ccr 62 Dy Scrn 2 Trt	Ccr 31 Dy Sub Sur Trt	Ccr 31 Dy Diag to Trt	Ccr 2 Wk Wt	Cdiff Tst Assgnd	Ccr 31 Dy 2nd or sub Trt drg	Cmmnty - RTT info comp	Cmmnty - rfrrl info comp	Cmmnt - actvty info comp			Ccr 62 Dy Gp	Ccr 2 Wk Wt Brst				
	Ccr 38 Dy Ref to Trtry																	
Contract	VTE Rsk Ass	A&E Amb H/O 30-60 mn	RTT Admitted	RTT Community	Ccr 62 Dy Agg Trt & Scrn	Med Sfty – Recncltn	DQ NHS no comp IP	MRSA Trst Assgnd	DTOC	Percentage of Non-Compliant Duty of	Total Duty of Candour shared within 10	Cncl Elctv Surg 28 Dy Std	% Strk 90% stay on unit	% Strk scan < 1 hr arrival	% Strk Thrmblysd < 1 hr	DQ NHS no comp A&E	RTT Non-admitted	RTT Incomplete
	18 wks >=26 wks	Home Births	A&E Amb Trans 60+ mins				Cncl Urgnt Ops 2nd time	Mixed Sex Breach	Never Events	A&E Trlly Wts	Diagn 6 Wks	RTT Waits > 52 wks	Cncl Elctv Surg	% Harm Free Care	SIs inv rep sub < tmscl	Med Sfty – Dschge Acc	18 wks >=40 wks	
NHSE	FFT A&E recmmnd	FFT Cmmty recmmnd	FFT IP Response	Maternal smoking	FFT OP Recmmnd	Central Line Infections	Stg 1 RCAs HAT						FFT IP recmmnd	FFT Mat recmmnd	FFT A&E Response	Sepsis Screen	Antenatal < 13 wk	IPMR - Breastfeeding
													FFT Cmmty Response	FFT OP Response	FFT Mat Response			
Quality	Mortality Reviews	Avg Diag / FCE	Percentage Non-elective NoF Patients	A&E Time to Treat	Falls - Serious Harm	Diabetic pats self-care	Local SHMI - RR	HSMR	A&E Unplnnd Re-Attend	Prntl Dths (0-7 days)	Nntl Dths (8-28 days)	SIs < 2 dys	Crude Mort Rate	A&E Left not seen	A&E Intl Ass	All Falls	SG Alerts by Trust	SG Alerts agnst Trust
	Lbr concern over safety	Lbt alone & worried	Emer Rdmssns <= 30 Dys	Emer Rdmssns <= 30 Dys CCG	Ccr 104 Ref to Trt	Avg co-morbidity	Pat Incidents	Harm Incidents	PU CHFT acqrd Cat 3	PU CHFT acqrd Cat 4	PU CHFT acqrd Cat 3&4		Stillbirths Rate	Emer Rdmssns <= 30 Dys GHCG	Sign & Sym coding	MRSA Screen	Cdiff Avoidable	MSSA - Post 48 Hrs
	Cdiff Unavoidable	EColi	Hand Hygiene	Complaints < time	Comp received	Comp < 3 wking dys							Concerns					
	SIs	PU CHFT acqrd	PU CHFT acqrd Cat 2	Women Physical Harm Free	Women - Perception of safety	Women cmbnd Harm Free												
Other Internal	% Day Case Var	% Out Var	T Util (TT) - CRH	Pre 12pm disc	Research Recruit	Major PPH	% Spells > 5 Moves	Elec C-Section					% Elective Var	% Non-elec Var	T Util (TT) - HRI Main	T Util (TT) - HRI DSU	T Util (TT) - HRI SPU	WHO
	3rd / 4th Degree tear	% Non_Elec NoF Adm < 36 hrs	Ccr 7 Dy Ref 1st Frst Sn	District Nursing Performance Urgent	District Nursing Performance Non	A and E 6 hr							Green Cross	Outliers	1st DNA Rate	Hosp Out Cncl	Spells	Spells > 2 Moves
	A and E 8 hr	A and E 10 hr											% Spells > 2 Moves	Spells > 5 Moves	Total C-Section Rate	Over 37 wks APGAR5<7	Full Trm to SCBU (NNU)	

Improving Green	Improving Amber	Improving Red	No Change Green	No Change Amber	No Change Red	Deteriorating Green	Deteriorating Amber	Deteriorating Red
28	4	20	24	1	2	26	4	13

Green	Currently Achieving Target

Amber	Under target but close to threshold

RED	Not currently achieving target

White	No target or performance cannot be determined as yet

Monitor Risk Assessment Framework

Overall Rating: Red reflecting enforcement action in place.

CQC status – Formal announced inspection date confirmed as commencing on the 8th March 2016. Planning continues with updates presented to Quality Committee

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Access and Outcome Metrics	% Admitted Closed Pathways Under 18 Weeks	>=90%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	91.63%	92.04%				91.89%
	% Non-admitted closed Pathways under 18 weeks	>=95%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%	98.44%				98.54%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%				95.45%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%	94.87%	95.26%				95.17%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3	3	4	2	1				17
	Total Number of Clostridium Difficile Cases - Lapses in Care	10.5	1	0	1	0	0	1	1	1	0				5
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%	93.94%	88.24%	91.77%	95.00%	93.98%				91.31%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%	95.65%	88.24%	96.67%				94.56%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%				98.90%
	31 day wait for second or subsequent treatment drug treatments	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
	31 Days From Diagnosis to First Treatment	>=93%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%	100.00%	99.12%	99.30%				99.74%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%	98.73%	96.84%	97.06%				96.79%
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	>=93%	93.33%	93.75%	94.92%	94.87%	98.60%	98.47%	94.85%	95.89%	94.05%				95.58%
	Community care - referral to treatment information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
	Community care - referral information completeness	>=50%	98.10%	98.12%	97.99%	97.58%	98.14%	97.70%	97.52%	97.44%	97.07%				97.84%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%

Third Party Reports	The Quality Assurance report for the Bowel Cancer Screening service CHFT/MYNHST has been received with several areas of good practice and no immediate concerns; 5 high priorities have been identified and the Surgical Divisoin is developing the corrective actions
Quality Governance Indicators	**Patient Metrics -Narrative on Friends and Family included within Exception reports.**
	Staff Metrics : Reported quarterly – no further update from previous report

Finance	Financial Sustainability Risk Rating	2	2
	Operational Performance (Capital Service Cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	1	1
	Income & Expenditure Margin	1	1
	Income & Expenditure Margin - Variance from Plan	3	3
	Use of Capital	£16.54m	£13.64m
	Income and Expenditure (excluding Restructuring)	(£15.34m)	(£16.42m)

Responsive

Year To Date

Report For: December 2015		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Directon of travel (past 4 months)	Financial Penalities/Non Financial Impact	Data Quality
Activity	% Elective Variance against Plan	Local	0.00%	2.38%	-0.99%	20.14%	4.85%	-	0.00%	-2.03%	-3.00%	-5.36%	5.48%	-		↑		
	% Day Case Variance against Plan	Local	0.00%	1.34%	-6.88%	20.61%	14.54%	-	0.00%	-13.49%	-18.52%	-3.27%	1.98%	-		↓		
	% Non-elective Variance against Plan	Local	0.00%	2.21%	1.63%	1.36%	3.99%	-	0.00%	3.09%	-1.19%	3.95%	4.27%	-		↓		
	% Outpatient Variance against Plan	Local	0.00%	7.25%	8.74%	0.52%	9.33%	-	0.00%	-0.35%	0.40%	0.57%	1.26%	-		↑		
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	85:93%	84:61%	-	95.26%	-	92.50%	87.39%	85.90%	-	98.27%	-		↑		
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	95.01%	95.01%	-	-	-	92.50%	94.60%	94.60%	-	-	-		↑		
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	76.33%	76.03%	-	78.57%	-	92.50%	77.99%	76.75%	-	98.61%	-		↓		
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	80.94%	80.94%	-	-	-	92.50%	82.41%	82.41%	-	-	-		↓		
Exception Report - Patient Flow	% Daily Discharges - Pre 12pm	Local	40.00%	19.74%	26.55%	18.49%	16.35%	-	40.00%	20.02%	28.09%	16.23%	18.49%	-		↓		
	Delayed Transfers of Care	Local	5.00%	4.50%	-	-	-	-	5.00%	6.10%	-	-	-	-		↓		
	Green Cross Patients (Snapshot at month end)	Local	40	79	-	79	-	-	40	71	-	71	-	-		↑		
	Number of Outliers (Bed Days)	Local	848	781	36	793	0	-	3616	5971	492	5721	0	-		↑		
	District Nursing Performance Urgent referrals seen within 4 hours	Local	80.00%	63.00%	-	-	-	63.00%	80.00%	85.00%	-	-	-	85.00%		↑		
	District Nursing Performance Non urgent referrals seen within 2 days	Local	80.00%	49.00%	-	-	-	49.00%	80.00%	49.00%	-	-	-	49.00%		↑		
	No of Spells with > 2 Ward Movements	Local	M	135	34	83	18	-	-	1223	209	771	243	-		↑		
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.51%	2.25%	4.50%	0.89%	-	2.00%	2.34%	1.49%	4.84%	1.10%	-		↑		
	No of Spells with > 5 Ward Movements	Local	M	3	1	2	0	-	-	31	1	29	0	-		↓		
	% of spells with > 5 ward movements (No Target)	Local	M	0.06%	0.07%	0.11%	0.00%	-	-	0.06%	0.01%	0.18%	0.00%	-		→		
	Total Number of Spells	Local	M	5376	1512	1844	2020	-	-	52164	14060	15942	22162	-		↓		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker, Chief Operating Officer

compassionate care

Report For: December 2015

Year To Date

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities /Non Financial	Data Quality
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	95.26%	-	95.26%	-	-	95.00%	95.17%	-	95.17%	-	-		↓		
	A and E 4 hour target - No patients waiting over 6 hours	Local	-	145	-	145	-	-	-	1159	0	1159	0	0		↑		
	A and E 4 hour target - No patients waiting over 8 hours	Local	-	40	-	40	-	-	-	339	0	339	0	0		↑		
	A and E 4 hour target - No patients waiting over 10 hours	Local	-	9	-	9	-	-	-	67	0	67	0	0		↑		
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:20:00	-	00:20:00	-	-	00:15:00	00:19:00	-	00:19:00	-	-		↑		
	Time to Treatment (Median)	National	01:00:00	00:55:00	-	00:55:00	-	-	01:00:00	00:57:00	-	00:57:00	-	-		↓		
	Unplanned Re-Attendance	National	5.00%	5.27%	-	5.27%	-	-	5.00%	5.08%	-	5.08%	-	-		↑		
	Left without being seen	National	5.00%	2.85%	-	2.85%	-	-	5.00%	3.13%	-	3.13%	-	-		↓		
	A&E Ambulance Handovers 30-60 mins (Validated)	National	0	1	-	1	-	-	0	58	-	58	-	-		↓		
	A&E Ambulance 60+ mins	National	0	2	-	2	-	-	0	6	-	6	-	-		→		
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→		
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.94%	6.74%	8.22%	6.88%	3.47%	7.00%	6.71%	6.77%	6.84%	6.35%	3.50%		↑		
	% Hospital Initiated Outpatient Cancellations	Local	12.0%	12.90%	11.60%	17.90%	9.40%	-	12.0%	13.80%	13.80%	15.60%	10.90%	-		↓		
	Appointment Slot Issues on Choose & Book	Local	-	-	-	-	-	-	5.00%	15.00%	12.25%	8.33%	7.38%	-				
Exception Report - Elective Access 2	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.44%	98.54%	98.33%	98.23%	-	95.00%	98.54%	98.54%	98.47%	98.69%	-		↓		
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	92.04%	91.46%	100.00%	94.30%	-	90.00%	91.89%	91.15%	100.00%	95.04%	-		↑		
	% Incomplete Pathways <18 Weeks	National	92.00%	95.45%	94.47%	97.99%	96.97%	-	92.00%	95.45%	94.47%	97.99%	96.97%	-		↓		
	18 weeks Pathways >=26 weeks open	Local	0	126	106	13	7	-	0	126	106	13	7	-		↓		
	18 weeks Pathways >=40 weeks open	National	0	0	0	0	0	-	0	0	0	0	0	-		↓		
	RTT Waits over 52 weeks Threshold > zero	National & Contract	0	0	0	0	0	0	0	0	0	0	0	0		→		
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	99.65%	100.00%	100.00%	99.55%	-	99.00%	99.66%	99.93%	100.00%	99.55%	-		↑		
	Community - 18 Week RTT Activity	National	95.00%	83.90%	-	-	-	80.30%	95.00%	95.20%	-	-	-	95.20%		↓		
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.75%	1.09%	0.00%	1.50%	-	0.60%	0.63%	0.92%	0.02%	1.07%	-		↓		
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	1	1	0	0	-		→		
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		

Report For: December 2015

Year To Date

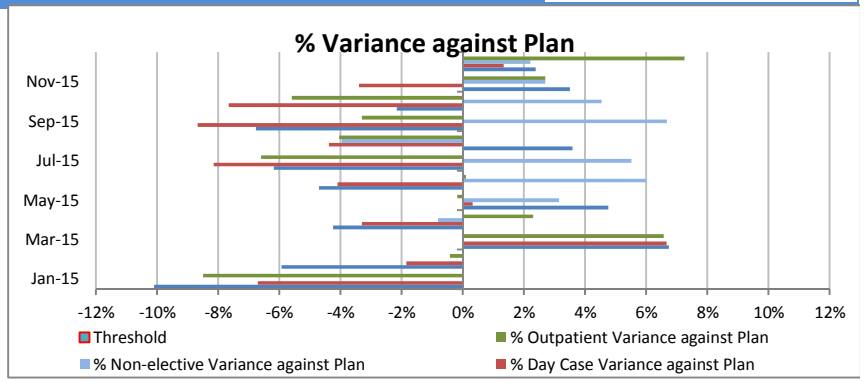
		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/ Non Financial Impact	Data Quality
Exception Report - Access Stroke	% Stroke patients spending 90% of their stay on a stroke unit	National	90.00%	80.00%	-	80.00%	-	-	90.00%	81.80%	-	81.80%	-	-		↑		
	% Stroke patients Thrombolysed within 1 hour	National & Contract	55.00%	50.00%	-	50.00%	-	-	55.00%	50.00%	-	50.00%	-	-				
	% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	National & Contract	90.00%	66.70%	-	66.70%	Data Source from SNAP. 2 months in arrears		90.00%	71.89%	-	71.89%	-	-				
Exception Report - Elective Access 3	62 Day Gp Referral to Treatment	National & Contract	85.00%	93.98%	95.96%	91.67%	91.30%	-	85.00%	91.31%	91.65%	90.78%	94.81%	-		↑		
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	96.67%	96.30%	-	100.00%	-	90.00%	94.56%	93.04%	-	100.00%	-		↓		
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	98.90%	100.00%	96.00%	-	-		→		
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	100.00%	100.00%	100.00%	-	-	98.00%	100.00%	100.00%	100.00%	100.00%	-		→		
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National & Contract	86.00%	94.39%	96.03%	91.67%	92.31%	-	86.00%	91.62%	91.73%	90.78%	96.07%	-		↑		
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	99.30%	100.00%	100.00%	87.50%	-	96.00%	99.74%	99.87%	100.00%	96.15%	-		↓		
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	97.06%	98.88%	93.92%	91.82%	-	93.00%	96.79%	98.23%	93.05%	96.18%	-		↓		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	94.05%	94.05%	-	-	-	93.00%	95.58%	95.58%	-	-	-		↓		
	7 Day Referral to First Seen	National & Contract	50.00%	54.85%	58.47%	38.67%	60.91%	-	50.00%	37.59%	39.69%	30.95%	39.69%	-		↑		
	38 Day Referral to Tertiary	National & Contract	85.00%	73.68%	90.00%	83.33%	0.00%	-	85.00%	54.14%	57.69%	54.39%	41.18%	-		↑		
	104 Referral to Treatment	National & Contract	-	100.00%	100.00%	100.00%	100.00%	-	-	98.47%	98.27%	98.56%	100.00%	-		↑		
Exception Report - Maternity	Antenatal Assessments < 13 weeks	National & Contract	90.00%	91.60%	-	-	91.60%	-	90.00%	92.00%	-	-	92.00%	-		↑		
	Maternal smoking at delivery	National & Contract	11.90%	8.20%	-	-	8.20%	-	11.90%	10.10%	-	-	10.10%	-		↓		

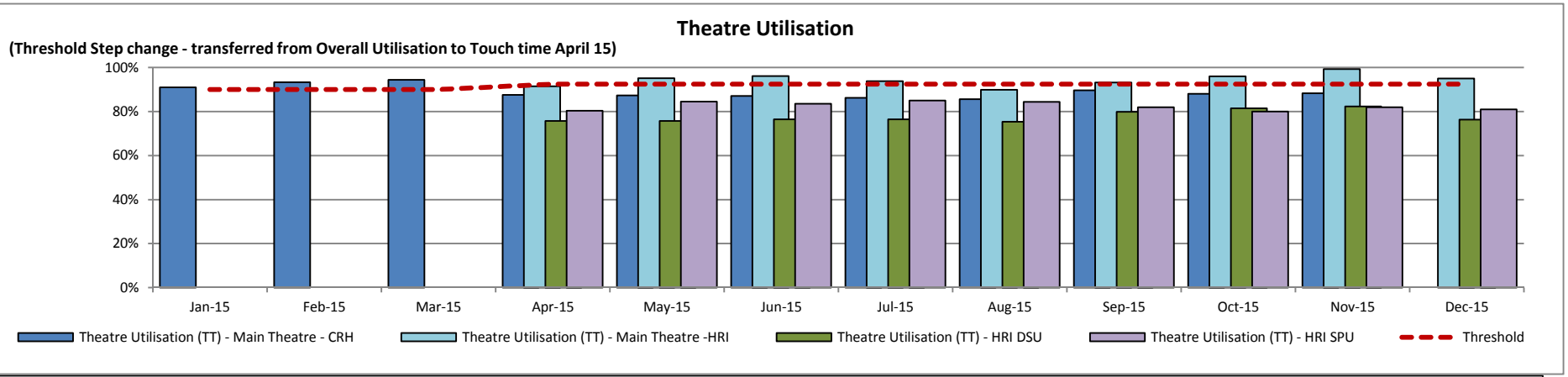
Calderdale and Huddersfield NHS Foundation Trust

Exception Report - Planned Activity - Helen Barker, Chief Operating Officer

compassionate care

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	85:93%	84:61%	-	95.26%	-
Theatre Utilisation (TT) - HRI DSU	92.50%	76.33%	76.03%	-	78.57%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	80.94%	80.94%	-	-	-





Details of position on activity presented to Finance and Performance Committee

Theatre Utilisation:

Why off track?
A planned switch to more day case a reduction in planned elective activity and some cancellations.

Actions?
Continued focus on theatre productivity through the theatre productivity workstream. Wider weekly engagement sessions are now in place. The focus is on starting on time and the group are conducting PDSA cycles to test how we can improve this. Focus on fallow lists and target numbers on lists continues to be reviewed weekly.

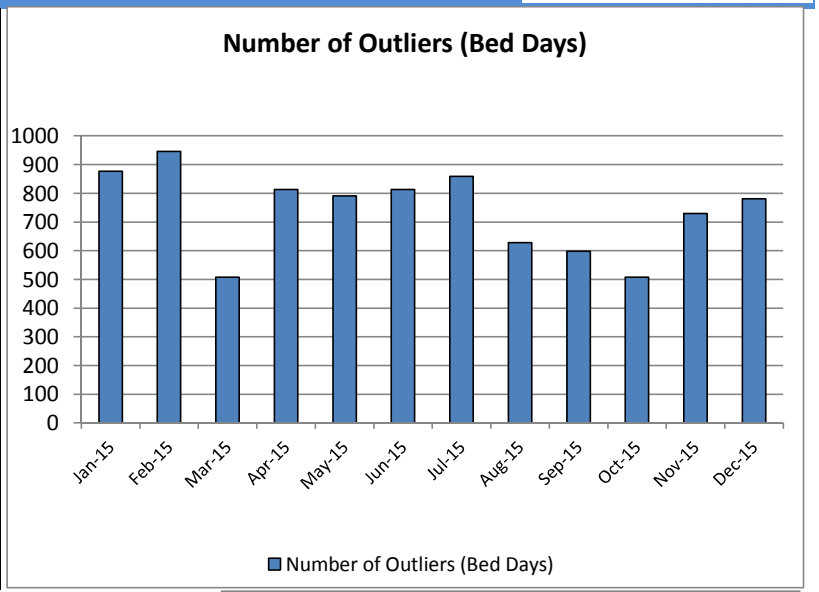
When will we be back on track?
Expected improvement in February. January performance has been impacted upon in the first week and there is a risk due to winter pressures that performance will not improve until winter pressures improve.

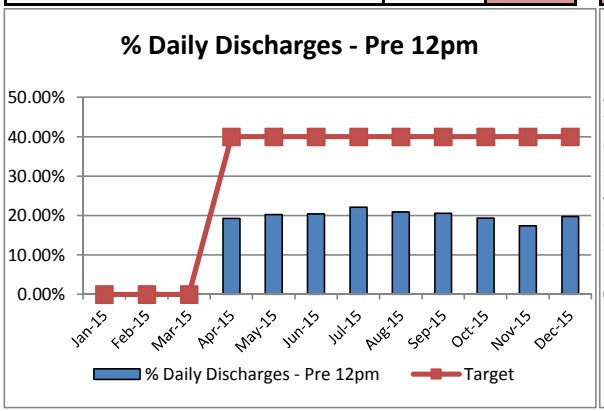
Calderdale and Huddersfield NHS Foundation Trust

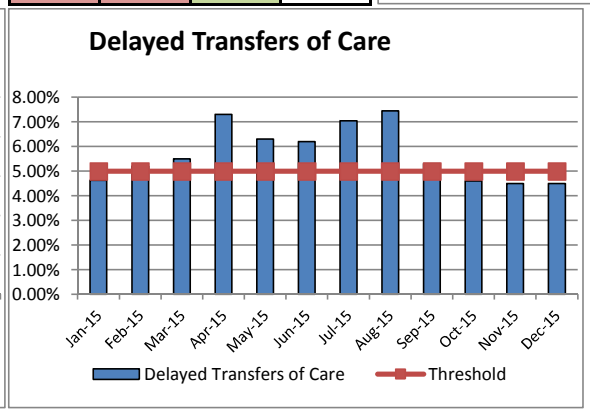
Exception Report - Patient Flow Helen Barker, Chief Operating Officer

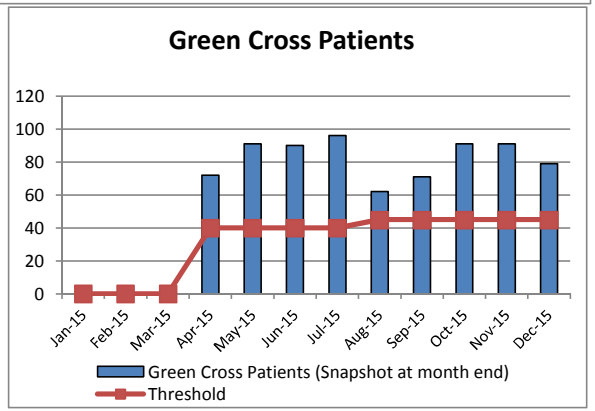
compassionate care

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 12pm	40.00%	19.74%	26.55%	18.49%	16.35%	-
Delayed Transfers of Care	5.00%	4.50%	-	-	-	-
Green Cross Patients (Snapshot at month end)	45	79	-	79	-	-
District Nursing Performance Urgent referrals seen within 4 hours	80.00%	63.00%	-	-	-	63.00%
District Nursing Performance Non urgent referrals seen within 2 days	80.00%	49.00%	-	-	-	49.00%
% of Spells with > 2 ward movements (2% Target)	2.00%	2.51%	2.25%	4.50%	0.89%	-





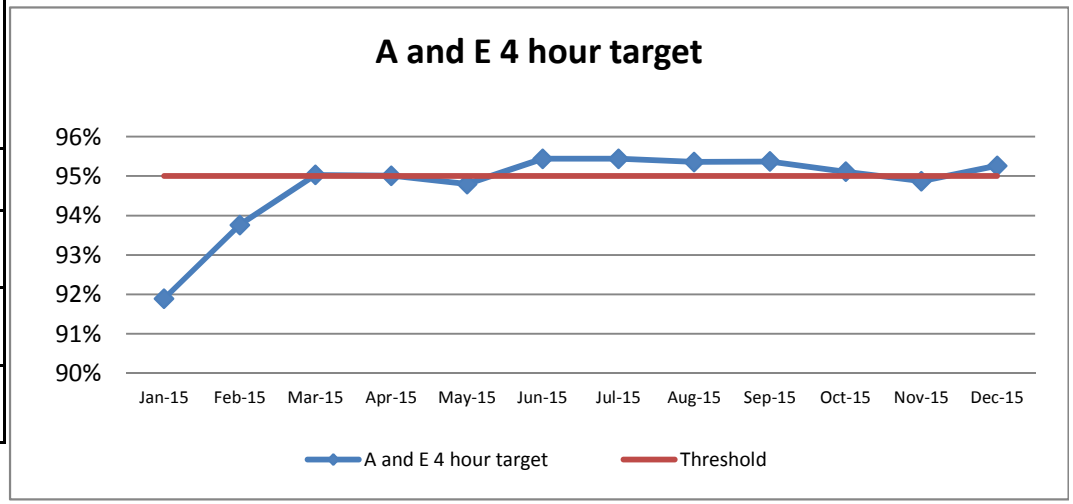




Patient Flow

A number of the patient flow metrics remain below required levels during December 2015. These include the pre 12 o'clock discharges, the number of patients on green cross pathways and the number of patients with greater than 2 ward moves. Non-elective activity continues above plan which places pressure upon the bed base leading to patients being moved to accommodate the more acutely ill patients. System wide pressures with placement of patients into Nursing Homes or those awaiting for a package of care has meant the number of patients awaiting transfer out of hospital has increased.
Details of the position on urgent care flow and associated metrics included in the Q3 Quallity report discussed in the December Quality Committee

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Time to Initial Assessment (95th Percentile)	00:15:00	00:20:00	-	00:20:00	-	-
Unplanned Re-Attendance	5.00%	5.27%	-	5.27%	-	-
A&E Ambulance Handovers 30-60 mins (Validated)	0	1	-	1	-	-
A&E Ambulance 60+ mins	0	2	-	2	-	-



Patient Flow – Ambulance Handover

Why off plan

During the months of December we had 2 patients who waited longer than 60 minutes to be handed over from the ambulance crew. This is against a target of 0. The YTD position is 6 patients. Both cases have been the subject of a Root Cause Analysis which highlighted that both breaches occurred on the same day; both patients were deemed low risk with a low triage category neither patient has been subjected to harm as a result of this delay in handover. The reasons for the delay were associated with Exit Block which meant there were no cubicles free to allow these patients to be accepted.

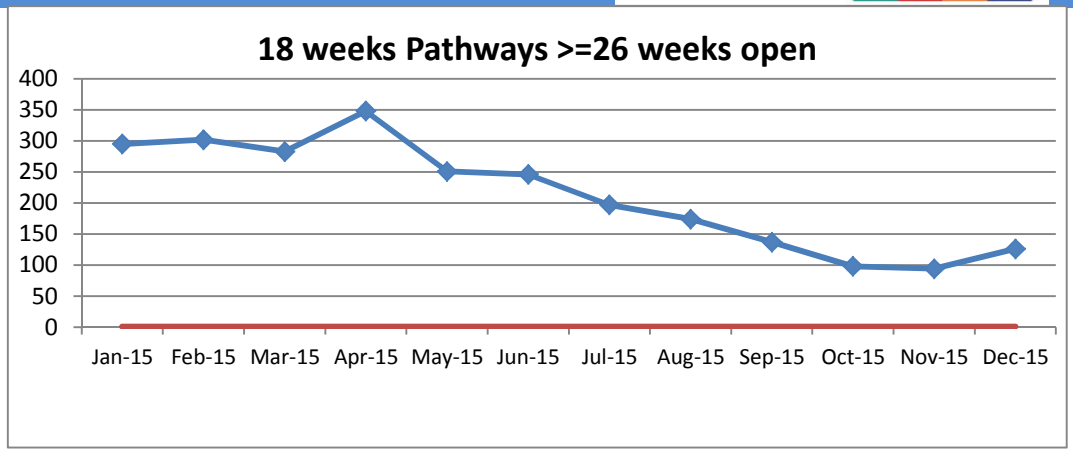
Actions to get back on plan

These breaches are extremely rare with a total of 6 since April 2015. Our overall handover performance is significantly better than the same period last year. Early escalation for beds and alert to the clinical commanders is in place to try and ensure timely flow of patients through the department. Silver command is currently in place and external system support is initiated as and when needed.

Accountable : ADD Medicine

Report For: December 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
18 weeks Pathways >=26 weeks open	0	126	106	13	7	-
Community - 18 Week RTT Activity	95.00%	83.90%	-	-	-	80.30%
% Last Minute Cancellations to Elective Surgery	0.60%	0.75%	1.09%	0.00%	1.50%	-



18week pathways

Meeting held between Informatics and Operational teams to review administrative pathways and reporting of RTT where concerns have been highlighted on the need for repeated validation and the one off appearance of very lengthy pathways. Actual position on over 18week admitted pathways lower than 126 which will have a further positive impact on 92% incomplete performance.

Agreed Informatics validation to complete in 4 weeks.

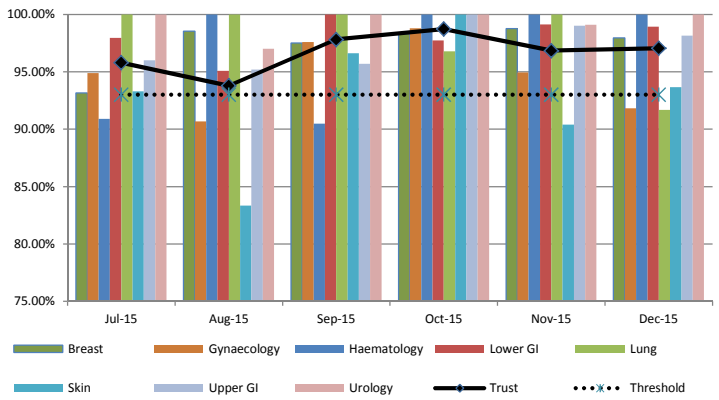
Community RTT

Pathways have been included that have been retrospectively closed or are not CHFT activity. This is being reviewed by Informatics team however as SystmOne is still being used by staff transferred to new provider there is a concern that this will not be able to be accurately separated.

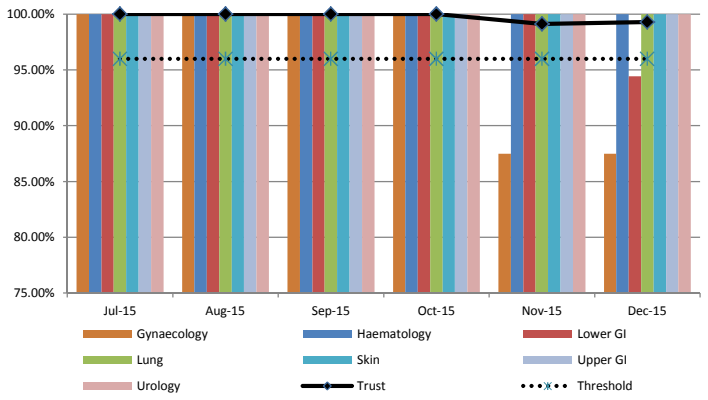
Exception Report - Cancer by Tumour Site

compassionate care

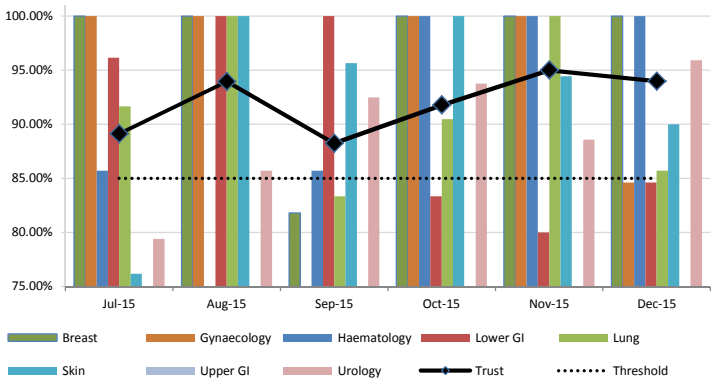
14 Day Referral to Date First Seen



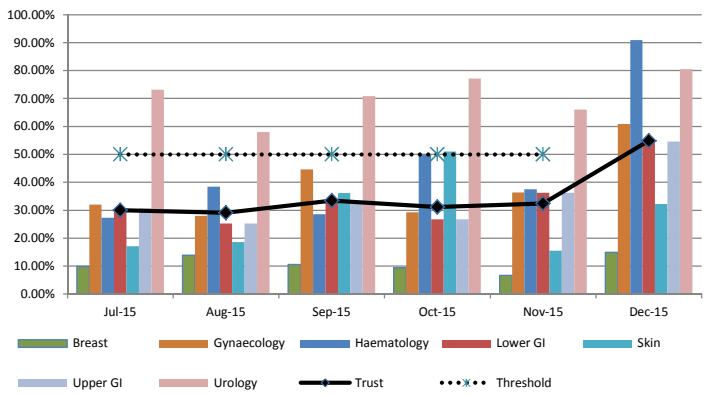
31 Day Diagnosis to First Treatment



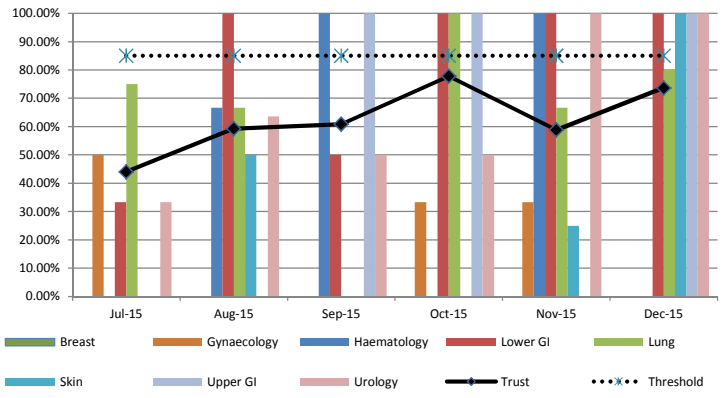
62 Day Referral to Treatment



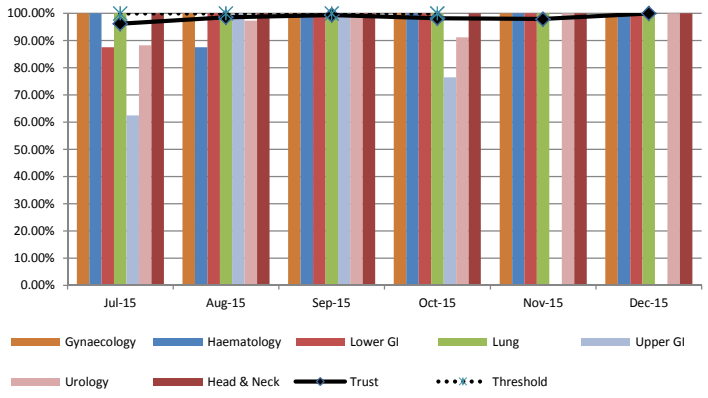
7 Day Referral to First Seen



38 Day Gp Referral to Referral to Tertiary



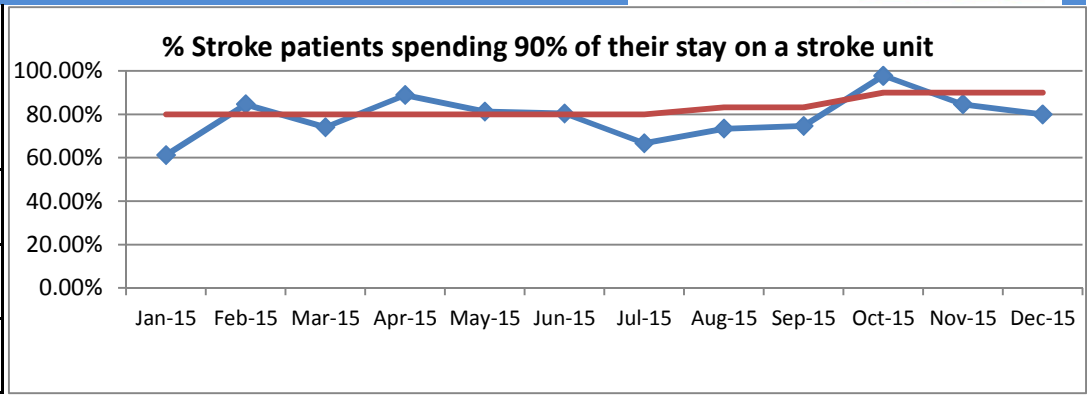
104 Day Referral to Treatment



Exception Report - Stroke - Helen Barker, Chief Operating Officer

Report For: December 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Stroke patients spending 90% of their stay on a stroke unit	90.00%	80.00%	-	80.00%	-	-
% Stroke patients Thrombolysed within 1 hour	55.00%	50.00%	-	50.00%	-	-
% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	90.00%	66.70%	-	66.70%	-	-



Scanning within 1hr of arrival:
Members of the stroke team have recently visited the Stroke Unit at North Lincolnshire and Goole NHS Foundation Trust. This Trust scored an "A" in the SSNAP score. The aim of the visit was to learn how to best minimise time delays in the management of stroke patients, in particular those patients needing thrombolysis. Since the team has undertaken mock dummy runs and developed a new DTN (Door to Needle) process (see Below). We are working with YAS, ED and radiology to implement this.

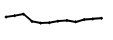
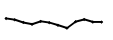
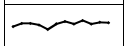
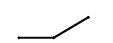
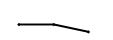
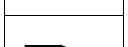
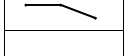
% Stroke patients spending 90% of their stay on a stroke unit
Previously a number of breeches were due to availability of beds on the ASU where a number of measures have been introduced. There is a weekly ASU sitrep report indicating the number of empty beds, beds occupied by stroke patients and beds occupied by non-stroke patients (see appendix). Using this we have been able to actively intervene and reduce the number of non-stroke patients on the ASU and increased the availability of ASU beds. We have also increased the bed base for the stroke team with an additional 6 stroke rehab beds.
The outstanding and most significant factor now affecting performance is the early recognition of stroke as the diagnosis. Patients presenting with atypical symptoms for example dizziness or a collapse may be admitted to the acute medical units and only after further investigation is a stroke identified. The stroke team is working with YAS, ED and acute medical teams to ensure a higher degree of suspicion for stroke in patients presenting with atypical features.
Data from previous years shows a reduced performance in December and January reflecting the wider bed pressures associated with Winter

The Medical division has recalibrated the stroke standards as we aspire to reach SSNAP standard 'A' rating. This means we have increased the targets (%of stroke patients who stay on the stroke ward for 90% of their time) from 80% to 90%. Had we remained at the previous % compliance rates the metric would have remained compliant both for the month of December and YTD. The target will be red whilst further improvement work is undertaken.
Actions to get back to plan
Standard Operating Procedure for stroke patients requiring admission has been developed. Any stroke patients requiring admission to the stroke unit are discussed and managed through the 2 hourly patient flow meeting. All breaches against the standard are reviewed at the stroke clinical governance group.

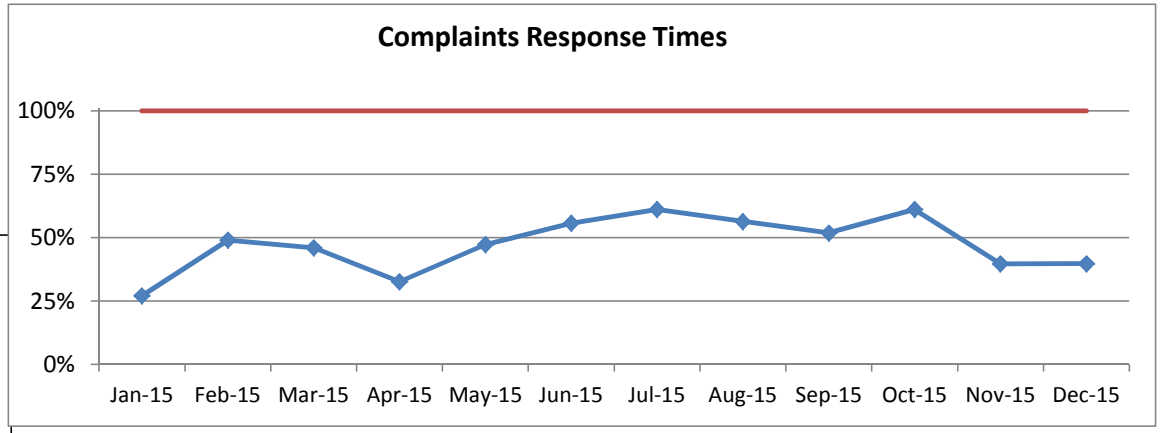
Caring

Caring Executive Summary - Julie Dawes Director of Nursing

Year To Date

	Report For: December 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Monthly)	Direction of travel (past 4 months)	Financial Penalities/Non Financial Impact	Data Quality
Caring	% Patient died in preferred place of death	Local	95.00%	100.00%	-	-	-	100.00%	95.00%	100.00%	-	-	-	100.00%				
	% District Nursing Patients with a care plan	Local	90.00%	98.00%	-	-	-	98.00%	90.00%	98.00%	-	-	-	98.00%				
	% of patients with a LTC with a Calderdale Care Plan	Local	90.00%	92.00%	-	-	-	92.00%	90.00%	87.00%	-	-	-	87.00%				
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	n/a	0	9	0	9	0	n/a		→		
	% Complaints closed within target timeframe	Local	100.00%	39.73%	50.00%	36.11%	33.33%	0.00%	-	49.36%	46.24%	46.00%	66.36%	25.00%		↓		
	Total Complaints received in the month	Monitor	M	49	19	20	9	1	-	470	153	168	103	24		↑		
	Complaints acknowledged within 3 working days	Local	100.00%	97.96%	100.00%	95.00%	100.00%	100.00%	-	91.55%	89.47%	94.09%	96.58%	89.47%		↓		
	Total Concerns in the month	Monitor	M	60	29	14	15	2	-	495	167	178	99	20		→		
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	28.00%	34.30%	42.20%	27.00%	26.00%	-	28.00%	27.40%	30.96%	25.02%	26.39%	-		↑		
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	96.00%	96.40%	97.00%	94.50%	98.40%	-	96.00%	96.80%	97.27%	95.53%	97.64%	-		↓		
	Friends and Family Test Outpatient - Response Rate	Contract	5.00%	12.90%	-	-	12.90%	-	-	13.50%	-	-	13.60%	-		↓		
	Friends and Family Test Outpatients Survey - % would recommend the Service	Contract	95.00%	91.60%	-	-	-	-	95.00%	89.40%	-	-	-	-		↑		
	Friends and Family Test A & E Survey - Response Rate	Contract	14.00%	9.10%	-	9.10%	-	-	14.00%	8.20%	-	8.20%	-	-		↓		
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	90.00%	85.40%	-	85.40%	-	-	90.00%	87.50%	-	87.50%	-	-		↓		
	Friends & Family Test (Maternity Survey) - Response Rate	Contract	22.00%	33.60%	-	-	33.60%	-	22.00%	30.40%	-	-	30.40%	-		↓		
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	96.90%	96.50%	-	-	96.50%	-	96.90%	95.90%	-	-	95.90%	-		↓		
	Friends and Family Test Community - Response Rate	Local	3.40%	10.00%	-	-	-	10.00%	3.40%	12.00%	-	-	-	14.00%		↑		
	Friends and Family Test Community Survey - % would recommend the Service	Local	96.20%	86.00%	-	-	-	86.00%	96.20%	89.64%	-	-	-	89.64%		↓		
Caring Maternity	Proportion of Women with a concern about safety during labour and birth not taken seriously	Local	6.50%	7.32%	-	-	7.32%	-	6.50%	3.32%	-	-	3.32%	-		↑		
	Proportion of women who were left alone at a time that worried them during labour	Local	4.50%	9.76%	-	-	9.76%	-	4.50%	4.98%	-	-	4.98%	-		↑		
	Proportion of Women who received Physical 'Harm Free' Care	Local	70.00%	80.49%	-	-	80.49%	-	70.00%	73.75%	-	-	72.69%	-		↑		
	Proportion of Women with a perception of safety	Local	90.40%	85.37%	-	-	85.37%	-	90.40%	92.36%	-	-	92.36%	-		↓		
	Proportion of Women who received Combined 'Harm Free' Care	Local	70.90%	70.73%	-	-	70.73%	-	70.90%	68.77%	-	-	68.77%	-		↓		

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	39.73%	50.00%	36.11%	33.33%	0.00%
Complaints acknowledged within 3 working days	100.00%	97.96%	100.00%	95.00%	100.00%	100.00%



% Complaints closed within target timeframe

Why off Plan: 73 complaints were closed in December. This is an increase from November, however only 29 of these were within timescale (40%). Closing a large number of overdue complaints (44 cases) will adversely affect the % of complaints closed within time in a reported month. By catching up with the backlog, the number of overdue complaints is reducing month on month (38 this month, compared to 49 the previous month and 55 the month previous). There has been a 17% increase in Surgery complaints and a 27% decrease in FFS complaints closed within timescale.

Actions to get back on plan: Utilising the weekly report, weekly meeting with Divisions and Complaints Team continue to improve responsiveness of complaints. The complaints teams are now actively seeking updates on individual overdue responses and providing additional support in helping getting closed.

When back on track: There are still a number of overdue complaints to close, as such performance is not expected to be at 100% until the new performance year.

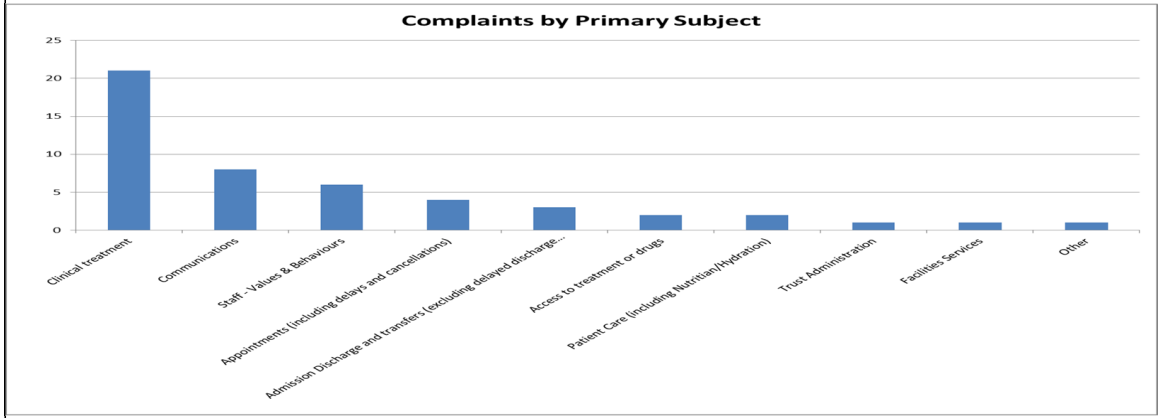
Complaints acknowledged within 3 working days

Why off Plan: There was one out 49 complaints which was not acknowledged within time. The deadline was missed by one day to an administrative error.

Actions to get back on plan: The process of acknowledging complaints has been reviewed and importance of keeping timescales has been discussed with the team.

When back on track: Improvement expected next month.

Accountable: Head of Risk and Governance



Complaints Overview:

There were 49 new complaints received in December which is a reduction of 16% from November.

Of the 38 responses overdue from Divisions at the end of December the split by divisions was: M**edical 17, SAS 14, FSS 4, Community 2, Corporate 1**

The top 3 Complaints subjects were:

Clinical Treatment

Communication

Staff Attitudes

There has been a increased in the complaints regarding staff attitudes compared to the previous month.

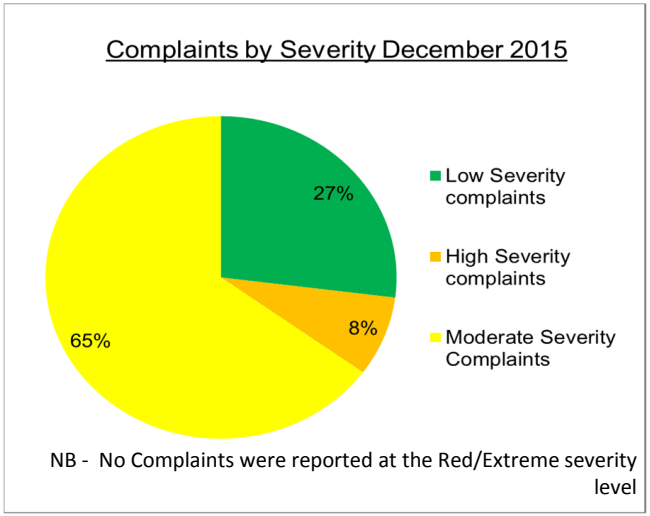
Severity: 65% of complaints received in December were of moderate severity an increase of 11% compared to November; however, there has been a 6% decrease in the number of high severity complaints. There were no red complaints received in December.

PHSO Cases:

There were no new cases received from the Ombudsman / PHSO in December 2015.

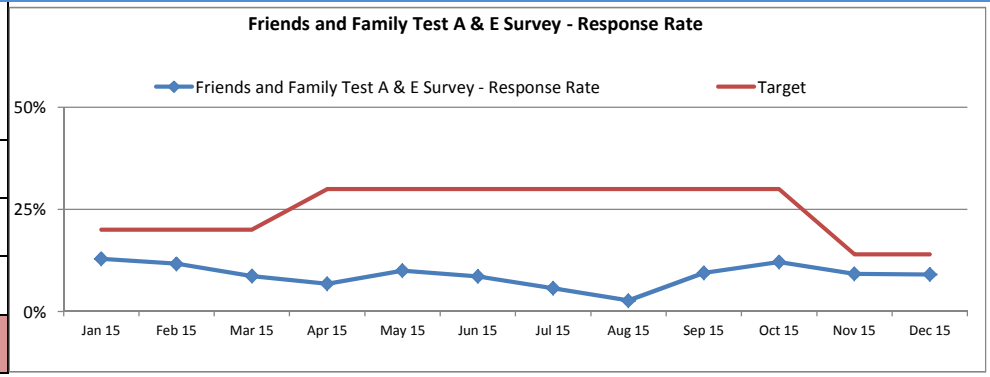
Two cases were closed in December; both were NOT UPHELD.

There were 9 active cases under investigation by the Ombudsman as at the end of December 2015.



NB - No Complaints were reported at the Red/Extreme severity level

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends and Family Test Outpatients Survey - % would recommend the Service	95.00%	91.60%	-	-	-	-
Friends and Family Test A & E Survey - Response Rate	14.00%	9.10%	-	9.10%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	90.00%	85.40%	-	85.40%	-	-
Friends and Family Test Community Survey - % would recommend the Service	96.20%	86.00%	-	-	-	86.00%



Indicator Update: *the Target threshold for all FFT indicators have undergone a review against national performance levels. Targets have now been aligned with achieving a performance level which will see the trust in the top 50% of trusts for each element.*

A&E FFT – Response Rate:
1.Why off plan: A steady Improvement has been seen since the introduction of the text system in September 2015, from a low of 2.7% in Aug, to 9.1% this month, which gives an amber rating. A position of 15% would place the department above the England average (based on Jun – Aug).

2. Actions to get back on plan: Reception staff continue to collect mobile phone numbers to enable use of the texting system. There are daily reminders for staff during the morning safety briefings to promote the test with patients, this includes all staff, inclusive of the medical team. The teams improvement plan will be further updated this month, involving some newly appointed senior staff members. Action to improve the response rate will be included in this.
3. When will we be on track: The aim to be above the England average of 14.9% by the end of December 2015, was not achieved, the team will continue to have this as their goal for the end of the financial year.

A&E FFT - Would recommend:
1. Why off plan: An improved position has been achieved in month from 81.6% (red) to 85.4% (amber). A review of the comments show fewer references being made to waiting times and none about **not** being kept up to date, this follows the improved use of the electronic board advising patients of current waits.
There are very few negative comments provided by patients, but many positive that acknowledge the professionalism of staff and their efficiency. *"Good experience. Quick, well looked after and very efficient"*

2. Actions to get back on plan: The team's improvement plan is to be updated during this month, this will be informed by the recent FFT comments along with other sources of feedback. Increased engagement with the A&E workforce will be a priority and will include further opportunities of inviting complainants to attend meetings to share their story.

3. When will we be on track: Whilst the target is to achieve a position of being above the England average (85.0%). For the remainder of quarter 4 the aim will be to achieve an improved amber rating (threshold range: 85.0% - 89.9%).

Community FFT - Would Recommend:
1. Why off plan? Analysis of negative comments from SMS text messages and voice messaging shows that there were 35 negative comments in Dec. The main themes were around care, privacy and dignity, waiting and communication. The 3 teams with the highest comments were: Out-patient Physio 12 – communication, waiting, pain /care, Podiatry 7 – competence, care and waiting and District Nursing 6 – pain, care, waiting and communication. Of note, negative comments only account for 4% of the response rate.

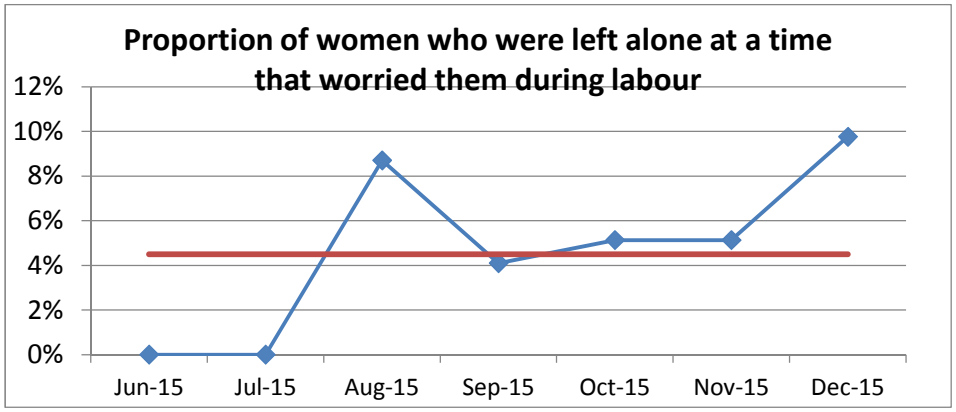
2. Actions to get back on plan: In podiatry one of the remaining issues relates to not having the correct patient contact information, as such staff are being made aware of the importance to double checking this information at each contact they may have with the patient. For the out-patient Physio team, to address the communication comments, staff are to reflect on how information communicated regarding the importance of self-management, as it is often this area that attracts some negative feedback.

3. Achieved by date: Whilst a number of the improvements identified are already in progress (i.e.in Podiatry), the impact on improving the overall community score will take some time, therefore the aim is to work towards an amber rating by the end

Outpatient FFT Would Recommend:
1. Why off plan:
Outpatients remains below the revised target of 95%required to be in the top 50% of trusts, however there has been an improved score this month of 91.6% (90.5%) in Nov 15, which gives an amber rating (no longer ranked in the bottom 20%).
2. Actions to get back on plan: An OPD improvement plan is in place based on core themes picked up from the patient comments across all specialties; this is being led by Matron Rachel Roberts.
Individual specialty results indicate variation in practice with some achieving a 100% rating. A greater focus is being directed to the underperforming areas in order to understand and address the reasons for variation across the outpatient services
3. Achieved by date
It is anticipated that a continued increase will take place over the next few months, achieving an improved amber rating by the end of quarter 4 (threshold range: 91.0 – 94.9%).

Accountable: Deputy Director of Nursing

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Proportion of Women with a concern about safety during labour and birth not taken seriously	6.50%	7.32%	-	-	7.32%	-
Proportion of women who were left alone at a time that worried them during labour	4.50%	9.76%	-	-	9.76%	-
Proportion of Women with a perception of safety	90.40%	85.37%	-	-	85.37%	-
Proportion of Women who received Combined 'Harm Free' Care	70.90%	70.73%	-	-	70.73%	-



The indicators above are all taken from the Maternity Safety Thermometer. The audit is carried out over 1 day at the same point in time every month.

The indicators that are off track this month all relate to measures which are known as psychological harm events.

Proportion of Women with a concern about safety during labour and birth not taken seriously: There were 2 women who reported that they had been left alone in labour at a point which concerned them
Proportion of women who were left alone at a time that worried them during labour: There were 4 women who were left alone at the time that worried them.
Proportion of Women with a perception of safety: The number of women who reported concerns was slightly reduced from the preceding month, however was still above the national average
Proportion of Women who received Combined 'Harm Free' Care: Performance against the psychological measure of harms discussed above contributed to the lowering of the Combined Harm Free Score. This combined score looks at both physical harm and any psychological harm which many have occurred

The actions to get back on plan: All of the psychological harm indicators will be address through the recruitment of new midwives (20+) which were recruited in October with the intention of being able to achieving 100% 1:1 care in labour (maternity dashboard shows we are currently at 98%) and improve the patient experience. The benefit of having new midwives has not yet not been fully recognised as their supernumery status, and involvement in induction programmes has resulted in them being out of the clinical area or not able to act independently. This is no longer the case and improvement as expected in the coming months.

When will we be back to target: End of Q4.

Accountable: ADN - Anne- Marie Henshaw

Safety

Report For: December 2015

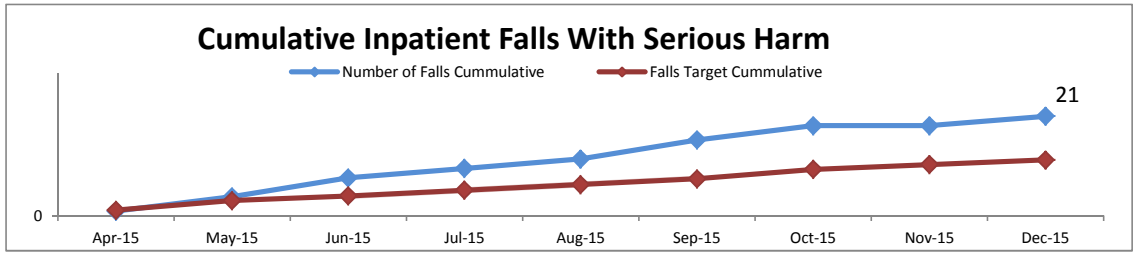
		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Data Quality
									Year To Date									
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	2	0	2	0	0	9	21	3	17	1	0		→		
	All Falls	Local	M	194	52	140	2	1	-	1523	277	1215	31	30		↑		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	13	3	10	0	0	225	418	55	138	2	223		↓		
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	13	3	10	0	0	153	329	43	110	2	174		↓		
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	0	0	0	0	0	63	81	11	26	0	44		↓		
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	0	0	0	0	0	9	8	12	28	0	5		↓		
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	0	0	0	0	0	72	89	12	28	0	49		↓		
	% of leg ulcers healed within 12 weeks from diagnosis	Local	75.00%	94.30%	-	-	-	94.30%	75.00%	93.50%	-	-	-	93.50%				
	% of patients within community nursing services that have had a pressure ulcer screening documented in their care plan	Local	90.00%	84.00%	-	-	-	84.00%	90.00%	84.61%	-	-	-	84.61%				
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.40%	95.90%	96.10%	90.80%	-	95.00%	95.40%	95.30%	95.40%	95.70%	-		↑		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	n/a	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		→		
	% Harm Free Care	CQUIN	95.00%	92.27%	95.79%	85.82%	98.70%	96.76%	95.00%	93.63%	93.90%	91.01%	99.84%	94.70%		↓		
	Safeguarding Alerts made by the Trust	Local	M	7	-	-	-	-	-	126	-	-	-	-		↓		
	Safeguarding Alerts made against the Trust	Local	M	8	-	-	-	-	-	67	-	-	-	-		↑		
	World Health Organisation Check List	National	100.00%	98.84%	-	-	-	-	100.00%	98.23%	-	-	-	-		↑		
	Missed Doses (Reported quarterly)	National	10.00%	8.68%	7.30%	8.49%	18.36%	-	10.00%	8.24%	8.47%	7.80%	12.46%	-				

Report For: December 2015

		Indicator Source	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Data Quality
Safety 3	Number of Patient Incidents	Monitor	M	2	140	303	169	11	-	70	1253	2882	1645	438		↓		
	Number of SI's	Monitor	M	97	0	1	1	0	-	1556	9	31	8	20		↑		
	Number of Incidents with Harm	Monitor	M	0	15	55	26	1	-	0	216	734	353	251		↓		
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	-	100.00%	100.00%	-	-	-	-	-	-	-		→		
	Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	Local	100.00%	21.00%	25.00%	50.00%	0.00%	0.00%	-	-	-	-	-	-		↓		
	Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident	National & Contract	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-	-		→		
	Total Duty of Candour shared within 10 days	National & Contract	100.00%	100.00%		100.00%	100.00%		-	-	-	-	-	-		→		
Safety - Maternity	Elective C-Section Rate	National	10.00%	9.60%	-	-	9.60%	-	10.00%	8.70%	-	-	8.70%	-		→		
	Total C-Section Rate	National	22.50%	25.70%	-	-	25.70%	-	22.50%	24.10%	-	-	24.10%	-		↑		
	No. of Babies over 37 weeks with APGAR5<7	National	8.00%	1.00%	-	-	1.00%	-	8.00%	0.80%	-	-	0.80%	-		↑		
	Full Term to SCBU (NNU)	National	4.00%	4.20%	-	-	4.20%	-	4.00%	2.80%	-	-	2.80%	-		↑		
	Major PPH - Greater than 1000mls	National	8.00%	9.60%	-	-	9.60%	-	8.00%	10.10%	-	-	10.10%	-		↓		
	3rd or 4th Degree tear from ANY delivery	National	3.00%	3.00%	-	-	3.00%	-	3.00%	2.80%	-	-	2.80%	-		↓		
	Planned Home Births	National	2.30%	1.90%	-	-	1.90%	-	2.30%	1.50%	-	-	1.50%	-		↑		
	Antenatal Health Visiting Contact by 32 Weeks	Local	95.00%	100.00%	-	-	-	100.00%	95.00%	90.00%	-	-	-	100.00%				
	Health Visiting - Post Birth Visits within 14 days	Local	95.00%	94.00%	-	-	-	94.00%	95.00%	94.00%	-	-	-	94.00%				

Exception Report Safety - Director of Nursing

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	2	0	2	0	0



Falls with Serious Harm

Why off Plan: The Trust has now had 21 falls with harm. The recurring outcome of the RCA's is that falls prevention bundles have not been completed. The safety huddles will ensure compliance is improved by delegating the completion of the bundle to a specific individual. The poor bundle completion compliance will be discussed at the Falls Collaborative Group within Medicine.

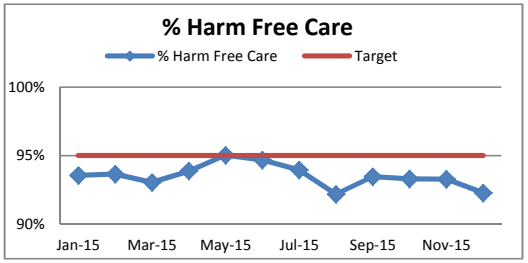
Actions to get back on plan: Actions from the internal harm summit in November are being implemented. This included introducing safety huddles in their clinical areas. Other areas of focus were around footwear and ensuring availability of non-slip slipper socks. Mapping work on the Stroke and elderly care wards is to be reviewed to determine any key theme which will be discussed as part of an overall Fall stagey review which is due to take place in this quarter. Wards on CRH site are progressing with the implementation of drop down tables in the individual bays to ensure nursing colleagues can provide close observations to our patients whilst completing nursing care plans

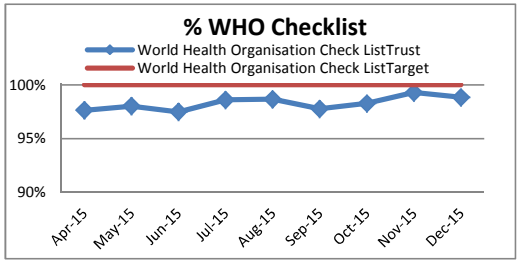
When will we be back on track: As the 10% reduction target has already been passed future work focuses on reversing the current trends. This reversal will be expected as a result of outcomes of the safety summit. A realistic timescale of 3 months was given but Ward Sisters will continue to update on progress. As such the impact of this is not likely to be seen until Q4.

Accountable: Deputy Director of Nursing

Exception Report - Safety - Director of Nursing

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Harm Free Care	95.00%	92.27%	95.79%	85.82%	98.70%	96.76%
World Health Organisation Check List	100.00%	98.84%	-	-	-	-





World Health Organisation Check List

1.Why off plan. Due to a system upgrade, the Bluespier system was offline for a short amount of time, this resulted in some information being manually recorded and retrospectively entered onto the system. There are still some barriers relating to the time out section not always being completed.

2. Actions to get it back on plan: Targeted work with those specialties which are experiencing problem with full completion of the sign out process. Clinical Directors have been made aware and messages are going out to all relevant staff.

3. Achieved by date: February 2016

4. Accountable: GM for Theatres

Harm Free Care:

1. Why off plan? Harm free care for the trust is at 92.27%, which is a slight reduction from the previous month. The harm events contributing to this are primarily old pressure ulcers, of which there were 30, this is a decrease from the 51 in November however. These are ulcers which are present on admission or developed within the first 72 hours of admission. Alongside this there were also 8 new pressure ulcers, 13 harm falls, 18 UTI's in patients with a catheter and 10 VTEs. Harm falls, UTIs and VTEs have all increased from November.

2. Actions to get back to plan: Work is ongoing to improve the trust position in relation to the number of ulcers and Falls occurring in the trust

3. Achieved by date: See individual subject areas for Ulcers and Falls

4. Accountable: Deputy Director of Nursing

Wards in special measures

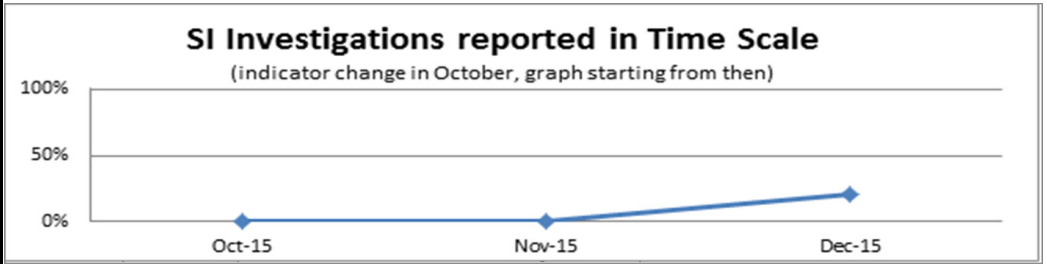
At present there are 2 wards in special measures.
These wards have be identified as requiring additional support to enable them to achieve the required standards.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Exception Report - Safety - Director of Nursing

compassionate care

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	100.00%	21.00%	25.00%	50.00%	0.00%	0.00%



Incidents summary
There were 623 incidents reported in December 2015 compared with 715 in November 2015.
The number of harm incidents reported has reduced from 167 in November 2015 compared with 97 in December 2015. The implementation of improved processes for reviewing and checking initial grading of incidents has led to this reduction in the number of reported harm incidents.

Percentage of SIs investigations where reports submitted within timescale (60 days unless extension agreed)

Why off Plan: There were 24 SI reports sent to the CCG in December 2015, 5 of these were within timescale. The implementation of the revised SI process has started to impact on the number of Sis being submitted on time.

Actions to get back on plan:
There continues to be close monitoring with SI report writers and divisions to ensure completion and sign off of reports in a timely way., which is being monitored via Patient Safety Group.
We have now full y implemented the revised system for collecting SI information and anticipate a significant increase in the number of SI reports submitted within timescale once the revised SI process is embedded across the Trust. Of note, the process for identifying and reviewing pressure ulcer incidents will change from January 2016 with focus on cluster investigations of pressure ulcers.

When will we be back on track: There are still some overdue SIs in the system, which will not be completed until January 2016., as such not expected to be back on track until the end of Q4.

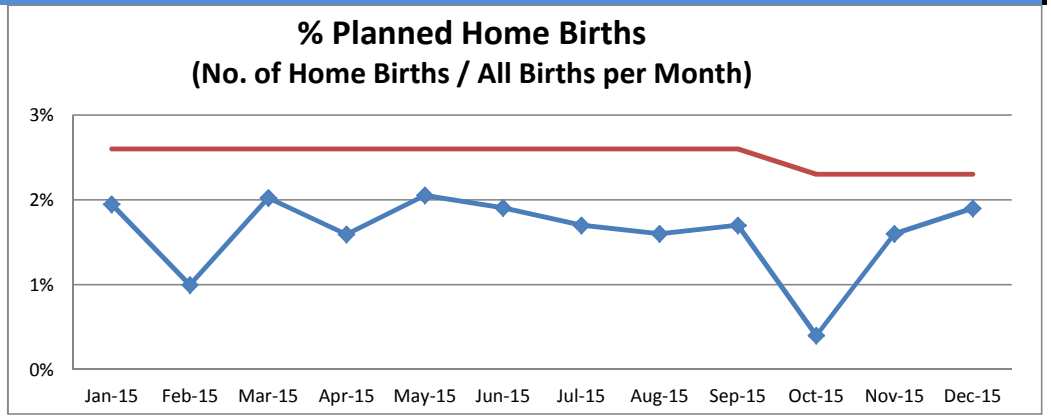
Accountable : Head of Risk and Governance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Exception Report - Safety - Director of Nursing

compassionate care

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Total C-Section Rate	22.50%	25.70%	-	-	25.70%	-
Full Term to SCBU (NNU)	4.00%	4.20%	-	-	4.20%	-
Major PPH - Greater than 1000mls	8.00%	9.60%	-	-	9.60%	-
Planned Home Births	2.30%	1.90%	-	-	1.90%	-



Total C-Section Rate
Why off plan: The emergency c-section rate has increased slightly in the last month, overall increasing the c-section rate in month.
Actions to get back on plan: All plans for emergency c-section are discussed with the Consultant on LDRP/ on call, to ensure that this is best plan of care. A divisional programme has been in place for a number of months looking at the variation seen month in month. The programme looks specifically at clinical decision making in relation to caesarean section. The program looks to increase standardisation in terms of decision making, and as such reduce the rate of emergency C-sections.
When will we be back to target: End Q4 2015-2016

Full Term to SCBU (NNU)
Why off plan: The Number of Full term babies admitted to SCBU (NNU) has seen a s substantial increase this year, however we saw 20 babies admitted >37 weeks in December 2015
Actions to get back on plan: To review and understand the reasons for the increase in admissions, then address any identified issues. A review of our current position shows just 2 babies have been admitted to NICU to date in Jan 2016, which would translate to < 2% in month.
When will we be back to target: End Q4 2015-2016

Major PPH
Why off plan: PPH rates remain broadly in line with last month's performance and this month relates to a high number of operative births compared to previous month. s
Actions to get back on plan: Division have changed management plan for all operative births to administer prophylactic oxytocic agents. As part of the work to address quality in the division, there is a specific piece of work to review PPHs and what proportion relate to instrumental or operative births as opposed to normal vaginal birth. The C- Section work above will also impact here.
When will we be back to target: End of Q4 of 2015/16
Planned Home Births
Why off plan: Performance remains below target, but has substantially increased on the previous month and is back in line with the previous average.
Actions to get back on plan: The home Birth Team continue to work to activity promote homebirth amongst women and colleagues, alongside the directorate work which should lead to increased homebirth rates
When will we be back to target: April 2016
Accountable: Midwifery Senior Clinical Manager - Community

Effectiveness

Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness Executive Summary

compassionate care

Report For: December 2015

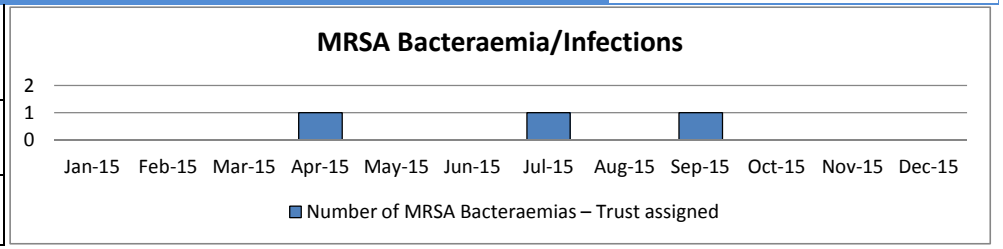
								Year To Date										
		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	0	0	0	0	0	0	3	0	2	0	1		↓		
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	1	1	0	1	0	-	18	17	3	14	0	0		↓		
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	-	-	-	-	-	0	5	1	4	0	0		↓		
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	1	-	-	-	-	-	18	11	1	10	0	0		↓		
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	1	1	0	0	-	9	7	2	5	0	-		↑		
	% Hand Hygiene Compliance	Local	95.00%	99.50%	98.50%	99.94%	99.87%	100.00%	95.00%	99.66%	99.08%	99.82%	99.94%	100.00%		↓		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	96.08%	94.70%	99.45%	92.45%	n/a	95.00%	95.06%	92.00%	99.00%	95.00%	-		↑		
	Number of E.Coli - Post 48 Hours	Local	2	1	0	1	0	-	29	25	7	17	1	-		↑		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.00	0.66	-	-	-	-	1.00	0.67	-	-	-	-				
Effectiveness 2	Stillbirths Rate (including intrapartum & Other)	National	0.50%	0.42%	-	-	0.42%	-	0.50%	0.40%	-	-	0.40%	-		↑		
	Perinatal Deaths (0-7 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.10%	-	-	0.10%	-		↓		
	Neonatal Deaths (8-28 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.00%	-	-	0.00%	-		↑		
	Local SHMI - Relative Risk (1yr Rolling Data April 14 - March 15)	National	100	108.9	-	-	-	-	100	109.1	-	-	-	-		↓		
	Hospital Standardised Mortality Rate (1 yr Rolling Data Sept 14 - Aug 15)	National	100.00	116.00	-	-	-	-	100.00	113.00	-	-	-	-		↑		
	Mortality Reviews – November Deaths	local	100.00%	60.30%	71.40%	59.00%	n/a	n/a	100.00%	49.40%	53.72%	48.84%	n/a	n/a		↑		
	Crude Mortality Rate	National	1.68%	1.41%	0.40%	3.07%	0.18%	n/a	1.17%	1.30%	0.39%	3.02%	0.09%	n/a		↑		
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.90%	99.90%	n/a	99.00%	99.90%	99.90%	99.90%	99.90%	-		→		
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	99.10%	-	99.10%	-	n/a	95.00%	99.10%	-	99.10%	-	-		→		
	% Sign and Symptom as a Primary Diagnosis	National	9.50%	9.5%	-	-	-	n/a	9.50%	9.84%	-	-	-	n/a				
	Average co-morbidity score	National	4.0	4.20	2.0	7.7	0.3	n/a	4.0	4.06	3.11	6.04	1.88	-				
	Average Diagnosis per Coded Episode	National	4.90	4.74	3.86	6.36	2.66	n/a	4.90	4.23	3.59	5.81	2.40	n/a		↑		

Effectiveness Executive Summary

	Report For: December 2015	Indicator Source	Target	Trust	Year To Date Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Monthly)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Data Quality
Effectiveness3	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	National	85.00%	86.00%	86.00%	-	-	-	85.00%	69.74%	69.74%	-	-	-		↑		
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - based on admission	National	85.00%	86.96%	86.96%	-	-	-	85.00%	74.19%	74.19%	-	-	-				
	IPMR - Breastfeeding Initiated rates	National	70.00%	77.60%	-	-	77.60%	-	0.00%	79.80%	-	-	79.80%	-		↓		
	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.82%	6.73%	3.87%	10.09%	6.32%	-	7.43%	7.61%	4.18%	12.07%	6.01%	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	National	8.23%	6.60%	-	-	-	-	8.00%	7.87%	-	-	-	-		↓		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	National	7.62%	7.06%	-	-	-	-	7.08%	7.85%	-	-	-	-		↑		
	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	Local	10.00%	3.40%	-	-	-	3.40%	10.00%	3.90%	-	-	-	3.90%				
	CHFT Research Recruitment Target	National	92	114	-	-	-	-	736	602	-	-	-	-		↑		
	Home equipment delivery < 7 days	Local	95.00%	100.00%	-	-	-	100.00%	95.00%	99.50%	-	-	-	99.50%				

Exception Report - Effectiveness

Report For: December 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Avoidable number of Clostridium Difficile Cases	0	-	-	-	-	-
Unavoidable Number of Clostridium Difficile Cases	1	-	-	-	-	-

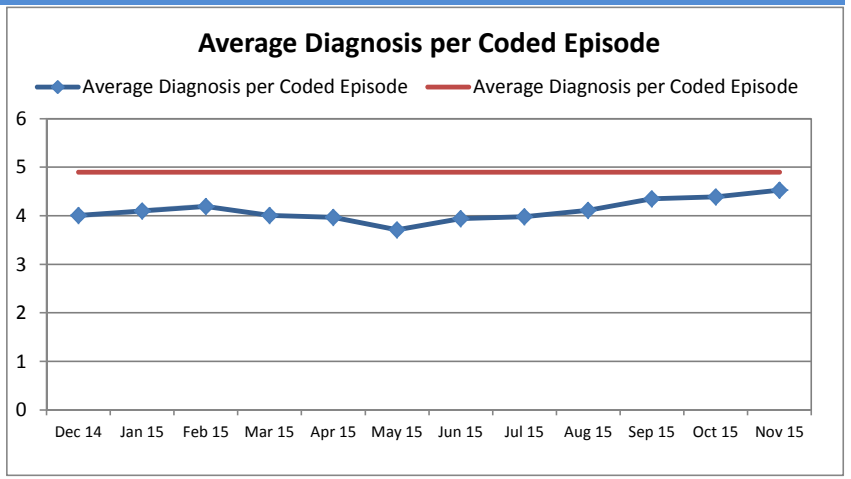


Total Number of Clostridium Difficile Cases - Trust assigned

There was one case of Clostridium difficile in December on ward 6C at CRH. Due to staff sickness there has been a delay in processing the RCA, as such it is not yet know if the case is avoidable.
The RCA investigation will take place on the 20th January.

Exception Report - Effectiveness

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Local SHMI - Relative Risk (1yr Rolling Data April 14 - March 15)	100	108.90	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Sept 14 - Aug 15)	100.00	116.00	-	-	-	-
Crude Mortality Rate	1.38%	1.41%	0.40%	3.07%	0.18%	n/a
Mortality Reviews – November Deaths		60.30%	71.40%	59.00%	n/a	n/a
Average Diagnosis per Coded Episode	4.90	4.74	3.86	6.36	2.66	n/a



% Sign and Symptom as a Primary Diagnosis/Average co-morbidity score/Average Diagnosis per Coded Episode

1. Why off plan? CHFT depth of coding and average co-morbidity score are less than plan due to missed or undocumented relevant secondary diagnoses/complexities/comorbidities within the coding source documentation. This may also be due to incomplete coding documentation at the time of coding or as a result of the terminology, content and quality of what is written within the case notes. Since May coding depth has gradually improved although not to national average levels. Since July average co-morbidity score has continued to improve each month. CHFT Sign and Symptom coding compares favourably with the National average and has the local target in Dec. There is variable improvement across specialties for each KPI.
2. Action to get it back on plan: Clinical engagement continues around importance of complete and accurate documentation and developing existing documentation to assist coding process e.g. inclusion of co-morbidities and improved structure. A pilot commenced at the start of December of 3 coders attending the ward round with 3 Upper GI clinicians in order to gain better mutual understanding. This will be reviewed in January. Work continues with Graham Walsh on developing theatre templates which will improve documentation and assist the coding process. The recruitment process is ongoing with 3 coders being interviewed at the end of January. Recruitment process has also commenced for 4 additional trainees this will start to address the vacancy issue within the team. Procurement has started for replacing the Encoder the clinical coders use for coding it is anticipated that the 3M software will assist the coding process and improve quality of coding particularly for less experienced coders. There is a meeting at end of January to assess responses to the procurement. To improve clinical coding and the link to clinical colleagues 5 doctors are to have 1 PA – meeting took place mid Jan with Simon Sturdee. This work is anticipated to increase the speed of future coding improvement initiatives with known direct links always available to the coding team from a capacity perspective.
3.Achieved By: Expect to see continued improvement month on month across each coding KPI, with a trajectory to hit target by March 2016
4.Accountable: Head of Clinical Coding

SHMI/HSMR
1. Why it is off plan? The most recent release indicated a SHMI which had a slight reduction to 108.9 for the 12 months of Apr 14 to Mar 15. It remains in the "as expected" category, indicating that there are not significantly more deaths than would be expected for the trust's patient population. The most recent 12 months data for HSMR indicates a score of 116, which is a maintained position from previous release but continues to be an outlying position. The November2015 crude mortality is lower that the same point in the previous year,.
2. Action to get it back on plan: The Care of the Acutely Ill Patient (CAIP) plan continues with a focuses on six areas: mortality reviews and leaning; reliability; deteriorating patients; end of life care; frailty; and coding. The latest figure of the number of the mortality reviews carried out in December (Novembers death's) is 60.3%. A slight improvement since last month but performance is still short of the target. more reviewers have been recruited and performance is expected to continue to improve. Intelligence is being received in the form of thematic learning reports received at the CEAM group. these themes are now being feed back into the CAIP work streams. The work around the reliability of care, is planning to roll out a new integrated care bundle document in January 2016 to increase reliability. The Nerve Centre rollout is progressing well. The Frailty work stream is currently in the process of compiling a business case to address how best to support frail patients following an emergency admission.
3.Achieved By: Progressive improvement in morality review completion is expected month on month. As HSMR and SHMI are delayed indicators then the impact of changes as a result of learning from mortality will not be seen in these figures for a number of months.
4. Accountability: Medical Director

Workforce

Well Led December 2015

Workforce Metric		Trust Threshold	Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS	Trust Trend	Division Comparison
Sickness YTD	Sickness Absence rate (%) (Year to date)	4.00%	4.54%	4.79%	5.68%	3.77%	4.21%	4.93%	2.16%	3.20%		
	Long Term Sickness Absence rate (%) (Year to date)		3.14%	3.33%	4.07%	2.50%	2.72%	3.69%	1.50%	2.29%		
	Short Term Sickness Absence rate (%) (Year to date)		1.40%	1.46%	1.61%	1.27%	1.49%	1.24%	0.66%	0.91%		
Sickness in month	Sickness Absence rate (%) (1 Month Behind)	4.00%	5.10%	6.32%	6.24%	3.85%	4.19%	5.91%	2.45%	3.28%		
	Long Term Sickness Absence rate (%) (1 Month Behind)		3.50%	4.55%	4.19%	2.77%	2.68%	4.44%	1.98%	1.66%		
	Short Term Sickness Absence rate (%) (1 Month Behind)		1.60%	1.77%	2.05%	1.08%	1.51%	1.47%	0.47%	1.62%		
Staff in post	Staff in Post Headcount		5730	1221	1434	648	1533	346	348	200		
	Staff in Post (FTE)		4998.98	1093.91	1295.99	535.76	1312.19	263.07	306.33	191.73		
Turnover	Turnover rate (%)		0.94%	0.76%	1.77%	0.68%	0.77%	0.56%	0.36%	-		
	Turnover rate (%) (Rolling 12m)		16.33%	12.78%	16.49%	28.72%	14.39%	12.29%	18.59%	11.40%		

Workforce Metric		Trust Threshold	Add Sci & Tech	ACS	Admin & Clerical	AHP	Estates & Ancil.	Healthcare Scientists	Medical and Dental	Nursing & Midwifery	Staff Group Comparison
Sickness YTD	Sickness Absence rate (%) (Year to date)	4.00%	3.20%	6.82%	3.59%	2.49%	6.15%	2.44%	1.02%	5.34%	
	Long Term Sickness Absence rate (%) (Year to date)		1.84%	4.82%	2.47%	1.64%	4.56%	1.21%	0.74%	3.67%	
	Short Term Sickness Absence rate (%) (Year to date)		1.36%	2.00%	1.12%	0.85%	1.59%	1.23%	0.28%	1.68%	
Sickness in month	Sickness Absence rate (%) (1 Month Behind)	4.00%	6.34%	7.74%	3.96%	2.64%	7.30%	2.17%	1.08%	5.76%	
	Long Term Sickness Absence rate (%) (1 Month Behind)		4.70%	5.28%	2.71%	1.61%	5.14%	0.55%	0.84%	3.96%	
	Short Term Sickness Absence rate (%) (1 Month Behind)		1.63%	2.46%	1.25%	1.03%	2.16%	1.62%	0.25%	1.80%	
Staff in post	Staff in Post Headcount		181	1296	1102	400	175	125	537	1908	
	Staff in Post (FTE)		161.82	1053.54	975.34	338.12	155.80	113.87	516.93	1677.55	
Turnover	Turnover rate (%)		0.62%	0.81%	0.39%	0.79%	0.64%	0.45%	2.20%	1.27%	
	Turnover rate (%) (Rolling 12m)		13.67%	14.24%	15.79%	26.46%	11.64%	18.04%	18.14%	15.90%	

Sickness Absence/Attendance Management at work

Why are we away from plan -

The 2015-16 year to date sickness rate of 4.54% compares to a outturn of 4.26%. The year to date figure compares to the 2014-15 sickness rate of 4.01% at the same point last year. Short term YTD sickness absence for the Trust is at 1.40%, long term YTD absence at 3.14%. The November YTD 2015 figures compare to November YTD 2014 figures of 1.23% short term absence and long term absence of 2.78%. Community ,THIS and Corporate have a YTD % below the 4% threshold identified.

In month short term sickness absence for the Trust is 1.60%, long term absence is at 3.50%. The November 2015 figures compare to November 2014 figures of 1.16% short term absence and long term absence of 3.08%. Community, THIS and Corporate have an in month % below the 4% threshold identified for November 2015.

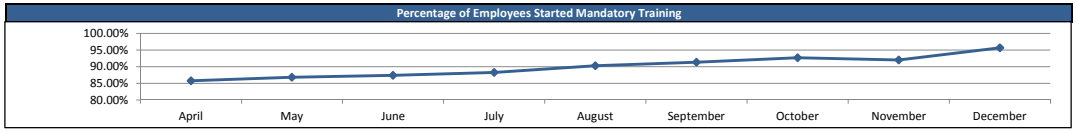
Action to get on plan?

There are a number of key interventions planned to address the current rate of sickness absence:-
Members of the Attendance Management team are meeting with managers to conclude long term absence cases.
Awareness of the new policy and organisations expectations.
Briefing sessions taking place and Individual support provided for managers with high levels of absence.
Implementation of the BI tool in the Medical Division.
Information tools for managers, F & Q,s , case studies
Clear procedure for the reporting of absence.
Clear and simple KPIs to monitor progress

NHS Foundation Trust

Workforce Metric		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS	Trust Trend	Division Comparison
Mandatory Training	Prevent	51.42%	46.05%	41.90%	74.92%	53.88%	38.84%	59.75%	65.63%		
	Equality & Diversity	70.37%	68.37%	63.97%	71.57%	80.96%	43.12%	72.45%	86.98%		
	Information Governance	76.48%	72.06%	71.69%	80.60%	85.66%	54.74%	77.71%	89.58%		
	Infection Control	66.73%	64.76%	61.44%	68.06%	78.12%	37.92%	63.16%	81.25%		
	Health & Safety	66.47%	64.85%	60.25%	67.56%	78.60%	36.09%	65.94%	78.13%		
	Manual Handling	71.99%	72.06%	68.72%	79.60%	80.12%	36.39%	63.47%	84.90%		
	Safeguarding	66.05%	68.28%	58.10%	81.10%	77.08%	31.50%	55.42%	55.73%		
	Fire Safety	63.49%	63.09%	61.89%	65.38%	63.85%	66.97%	62.85%	64.06%		
	Dementia	54.05%	57.12%	46.29%	58.70%	62.33%	35.78%	53.87%	45.31%		
	Conflict Resolution	47.68%	47.72%	39.67%	50.17%	58.52%	30.28%	49.85%	40.63%		

Number of Mandatory Training Elements Completed		0	1	2	3	4	5	6	7	8	9	10
	Trust	4.36%	7.77%	8.21%	6.00%	3.86%	3.67%	5.38%	10.06%	15.53%	19.84%	15.33%



		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Appraisal	Planned activity as at 31.12.2015	70.00%	47.90%	47.90%	81.20%	80.00%	87.00%	76.96%	67.40%
	Percentage of Appraisal completed since April	56.5%	30.0%	43.3%	68.6%	83.2%	75.5%	45.8%	53.6%
Medical Devices	Percentage of Medical Devices Training	77.00%	65.00%	65.00%	80.00%	77.00%	100.00%	78.00%	

Mandatory Training

Why are we away from plan?

The mandatory training approach (The Core Skills Training Framework or CSTF) has been in operation since 1 June 2015. Colleagues are becoming more familiar with the approach and this is factoring positively into the compliance figures. 95.6% of colleagues have commenced completion of the new programme of mandatory training since 1 June 2015, this is an increase of 4.6% from last month. However, full completion across all of the 10 available programme elements is still below desired levels. The final two subjects to complete the 10 mandatory subjects , Conflict Resolution and Dementia Awareness, were made live on 1 November 2015 and as they have just been launched they will clearly affect the overall compliance rate. Uptake of the final two subjects has however been good at 47% and 54% respectively.

Action to get on plan including timescales:-

An intranet portal has been established giving access into the Electronic Staff Record (ESR) to complete the mandatory training elements. The web pages contain comprehensive support materials including videos and scripts which are to be used by colleagues enabling them to access the training and complete it satisfactory. A help facility has been established as well as an FAQ which sets out issues colleagues have raised in using the system and the solutions to them. Extra PREVENT classroom sessions have now been scheduled to increase availability for colleagues however capacity of the existing internal facilitators remains an issue as to deliver for all the remaining outstanding colleagues would require a further 150 classroom sessions. DH is currently considering the creation of a Prevent e-learning package to be available alongside the classroom structure. This is anticipated in spring 2016. Information about home access for colleagues who wish to complete training outside of the workplace has been strengthened on the mandatory training web page and a small bank of loanable Trust devices is now available to increase Smartcard enabled users access the mandatory training. Work to ascertain which of the mandatory subjects might have alternate, higher level qualifications which satisfy the learning outcomes for the mandatory subjects and therefore avoid the need for colleagues to complete the awareness level mandatory packages has now been completed and is a contributing factor in the in-month increase in compliance in these subjects

Appraisal

Why are we away from Plan?

Significant progress has been made in planning appraisals for the period 1 April 2015 to 31 March 2016. All divisions report a comprehensive plan for ensuring 100% compliance by 31 March 2016.

FSS compliance is beyond planned activity as at 31 December 2015.

Compliance in Medical is 4% below panned levels of activity , Community 12% behind planned activity, THIS is 14% below planned activity. Corporate is 31% behind planned levels of appraisal activity, Estates and Facilities is 12% behind plan and Surgery and Anaesthetics 18% behind plan.

Action to get on plan:-

Continued focus within divisions to deliver planned activity and to ensure that completed appraisals are confirmed in ESR. Where appraisals have not been undertaken up to change date as planned appraisal profilers will be refreshed to identify new appraisal dates. A review of appraisal and mandatory training compliance on the agenda for WEB on 28 January 2016. It is anticipated that enhanced reporting and subsequent divisional action planning to attain compliance by 31st March 2015 will result from the review.

Medical Devices

Medical Devices Training is currently at 77% compliance across the Trust.

Action to get on Plan - (1) Regular reminders to all staff re Medical Devices training requirements via newsletter, intranet notices, link nurse, matrons and department managers group emails (2)Discuss and remind Medical Devices training group and link nurse meeting members to cascade Medical Devices Training requirements throughout divisions. (3) Organise and promote medical devices training events (4) Contact all areas below 75% compliance (in the red) to develop an action plan to improve training compliance

By Who- (1) Director of Planning, Performance, Estates & Facilities, ADN's, Matrons, General Managers, Department Heads, Line Managers and link nurses (2) Medical Devices Training Coordinator and Medical Devices Training support on-going throughout the year

Workforce Metric		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Staffing Levels	Hard Truths Summary Day - Nurses/Midwives	90.18%	92.03%	84.74%	-	102.59%	-	-	-
	Hard Truths Summary - Day Care Staff	99.51%	95.17%	104.42%	-	83.96%	-	-	-
	Hard Truths Summary - Night Nurses/Midwives	94.18%	94.13%	94.12%	-	94.36%	-	-	-
	Hard Truths Summary - Night Care Staff	111.86%	112.05%	120.63%	-	71.85%	-	-	-
Staff Friends and Family Test	FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	77.00%	79.00%	76.00%	77.00%	76.00%	83.00%	82.00%	72.00%
	FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	78.70%	-	79.40%	-	78.40%	-	-	-
	FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q1	51.00%	55.00%	49.00%	49.10%	51.50%	45.00%	52.00%	72.00%
	FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q2	49.10%	-	55.30%	-	46.00%	-	-	-

Average Fill Rate Qualified Nurses (Day and Night)	CRH	HRI
Oct-15	85.99%	90.22%
Nov-15	90.20%	91.90%
Dec-15	93.73%	90.31%

Average Fill Rate Un Qualified Nurses (Day and Night)	CRH	HRI
Oct-15	100.20%	107.00%
Nov-15	100.10%	107.80%
Dec-15	102.40%	109.20%

Average fill rate for non registered nurses (day and night) has increased on both sites in October to 102% at CRH and 107% at HRI.

			Day		Night		
			Qualified	Unqualified	Qualified	Unqualified	Combined
Red (less than 75% fill rate)			4	4	2	2	12
Amber (75 – 89% fill rate)			14	11	4	1	30
Green (90-100% fill rate)			14	9	27	8	58
Blue (greater than 100%)			6	12	4	21	43

Hard Truths Staffing Levels

Why we are away from plan

Average fill rates for qualified nurses and non-registered nurses have increased in comparison to November 2015 with the exception of qualified nurse average fill rates at HRI (See table 1 and table 2 for detail). Increased additional capacity has been required in December with the highest number of beds reported open (via standard activity model knowledge portal) was 850 this month.

To achieve the average fill rates the nursing workforce have introduced a "Winter Incentive Scheme" for substantive qualified nurses and utilised a level of temporary workforce.

The proThe total proportion of areas rag rated Green and Blue and have increased this month in comparison to the last quarter. This is in part due to successful recruitment; the nursing workforce incentive scheme and temporary workforce use.portion of areas rag rated Green and Blue have increased this month in comparison to September and October. This is in part due to the successful recruitment of newly qualified nurses and midwives.

Table 4: Analysis of Areas with Qualified Nurse Average fill rates less than 75%

Area	Day	Night	Reason
5AD	66.7%		Vacancies; Increased number of long shifts worked against planned resulting in decreased fill rates. Supported by additional HCA fill rate (131%)
21	69.9%		Sickness; Supporting additional capacity areas and vacancies. Supported by additional HCA fill rate (115%)
CCU		69.0%	Vacancies; Sickness; Supporting additional capacity.
4C	70.2%		Vacancies
8D		72.6%	Vacancies; Supporting additional capacity.
5B	74.6%		Vacancies

There has been increased demand for non registered nurses this month due to the amount of additional capacity areas open.
Vacancies within FSS division have impacted on fill rates for non registered nurses this month.
Increased fill rates for non registered nurses from substantive staff are expected to be evident within the next two months due to : further recruitment to Healthcare Assistant posts completed in December 2015; Apprentice Healthcare recruitment planned for February 2016 and Apprentice Healthcare assistants due to complete their apprenticeship March 2016.
In December 2015 a number of inpatient areas had average fill rates above 100% for non registered nurses, predominantly to support reduced fill rate for qualified nurses and to support 1-1 care requirements.

Area	Day	Night	Key Indicators for Fill Rate
MAU CRH		116%	18 additional 1-1 support shifts required Supporting reduced fill rate for qualified nurses of 81.8%
MAU HRI		135.6%	Supporting reduced fill rate qualified nurses 0f 89% 9 additional 1-1 support shifts required
11	110%	206%	Ward trialling changed workforce model with 1 non registered nurse additional on night shift transferred from late shift. Planned hours not changed until trial reviewed. Matron monitoring. Supporting reduced fill rate qualified nurses on days of 80%
2AB		143.3%	Supporting reduced fill rate qualified nurses 93% 14 additional 1-1 support shifts required
5	114%		2 additional 1-1 support shifts required
5AD	131.4%	120%	Supporting Reduced fill rate qualified nurses of 66% days 68 additional 1-1 support shifts required
6	118.3%	112.5%	12 additional 1-1 support shifts required Supporting reduced fill rate qualified nurses (86% days)
7AD		133.9%	69 additional 1-1 support shifts required
8	129.8%	109.7%	51 additional 1-1 support shifts required
12		135.5%	Supporting reduced fill rate qualified nurses of 88%
17		132.8%	Supporting reduced fill rate qualified nurses of 90% 8 additional 1-1 support shifts required
21	115.7%		Supporting reduced fill rate qualified nurses 69%
3	144.95	193.1%	71 additional 1-1 support shifts required
10			3 additional 1-1 support shifts required Supporting reduced fill rate qualified nurses of 86%
22		106.4%	16 additional 1-1 support shifts required
SAU		118.8%	Supporting reduced fill rate qualified nurses of 94%
NICU	112%		Supporting acuity within unit
Paeds CRH		110%	Additional staff due to acuity and number of under 2's within the ward.
Paeds HRI	140.25		Supporting reduced fill rate qualified nurses of 84%
5B	129%	111%	Supporting reduced fill rate qualified nurses 4 additional 1-1 support shifts required
6A	241%	229%	Additional capacity area with workforce model under review. 44 additional 1-1 support shifts required

Action Plan and Achieved by Date

Focused recruitment of both qualified and non registered nurses (ongoing)
International recruitment of nurses from both EEA and Non EEA recommended for approval (January 2016)
Roster efficiency tool trialled in 5 areas in January 2016. Following feedback process for roll out to be agreed by Nursing Workforce Group for February 2016
Site Staffing reports to be signed off 3 times per 24 hours by senior nurse to identify and record daily staffing situation; risks identified and mitigating action taken; split of substantive staff and temporary workforce for both qualified and non registered by site to be active January 2016.
Increased number of Tier 1 agencies to be recruited January 2016.
Report to identify number of beds open on a daily basis each month to be developed (January 2016)
Extend Winter Incentive Scheme for qualified nurses (January 2016)

Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Trust Financial Overview as at 31st Dec 2015 - Month 9

compassionate care

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

YEAR TO DATE POSITION: M09

CLINICAL ACTIVITY

	M09 Plan	M09 Actual	Var	
Elective	6,639	6,305	(334)	
Non Elective	36,935	38,098	1,163	
Daycase	31,972	27,083	(4,889)	
Outpatients	245,222	246,065	843	
A & E	112,144	110,138	(2,006)	

TRUST: INCOME AND EXPENDITURE

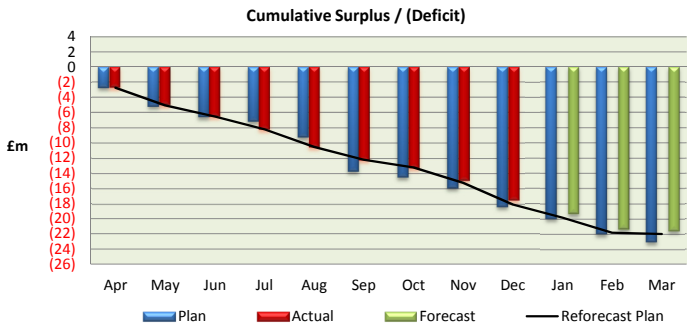
	M09 Plan	M09 Actual	Var	
	£m	£m	£m	
Elective	£17.33	£16.18	(£1.16)	
Non Elective	£59.95	£62.44	£2.49	
Daycase	£22.46	£18.50	(£3.97)	
Outpatients	£29.54	£30.42	£0.87	
A & E	£11.82	£11.97	£0.15	
Other-NHS Clinical	£87.62	£88.40	£0.78	
CQUIN	£5.02	£5.07	£0.05	
Other Income	£28.47	£27.51	(£0.96)	
Total Income	**£262.21**	**£260.48**	**(£1.73)**	
Pay	(£167.94)	(£168.40)	(£0.46)	
Drug Costs	(£23.86)	(£23.77)	£0.09	
Clinical Support	(£23.28)	(£23.00)	£0.28	
Other Costs	(£34.41)	(£34.03)	£0.38	
PFI Costs	(£8.94)	(£8.86)	£0.08	
Total Expenditure	**(£258.43)**	**(£258.05)**	**£0.37**	
EBITDA	**£3.78**	**£2.42**	**(£1.36)**	
Non Operating Expenditure	(£19.12)	(£18.84)	£0.28	
Deficit excl. Restructuring	**(£15.34)**	**(£16.42)**	**(£1.08)**	
Restructuring Costs	(£3.00)	(£1.08)	£1.92	
Surplus / (Deficit)	**(£18.34)**	**(£17.50)**	**£0.84**	*

* M9 Reporting - pre-finalisation and audit of M9 Accounts.

DIVISIONS: INCOME AND EXPENDITURE

	M09 Plan	M09 Actual	Var	
	£m	£m	£m	
Surgery & Anaesthetics	£14.84	£13.61	(£1.23)	
Medical	£21.07	£18.65	(£2.42)	
Families & Specialist Services	(£1.38)	(£1.47)	(£0.09)	
Community	£4.36	£4.63	£0.27	
Estates & Facilities	(£21.30)	(£19.40)	£1.90	
Corporate	(£15.31)	(£16.96)	(£1.65)	
THIS	£0.32	£0.25	(£0.07)	
PMU	£2.23	£1.54	(£0.69)	
Central Inc/Technical Accounts	(£20.06)	(£18.07)	£1.99	
Reserves	(£3.13)	(£0.28)	£2.84	
Surplus / (Deficit)	**(£18.34)**	**(£17.50)**	**£0.84**	

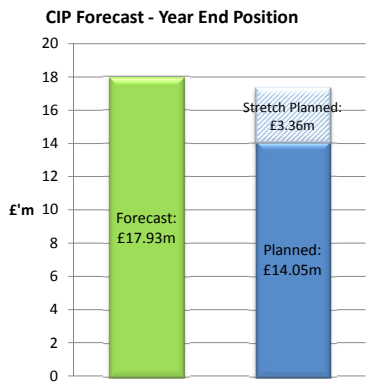
TRUST SURPLUS / (DEFICIT)



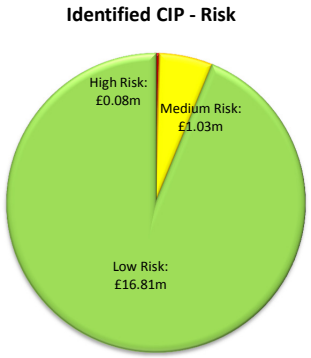
KEY METRICS

	Year To Date M09 Plan	Year To Date M09 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£18.34)	(£17.50)	£0.84	(£23.01)	(£21.64)	£1.37	
Capital	£16.54	£13.64	£2.90	£20.72	£19.73	£0.99	
Cash	£1.91	£7.60	£5.69	£1.92	£2.02	£0.10	
CIP	£9.57	£12.65	£3.08	£14.05	£17.93	£3.88	
	Plan	**Actual**		**Plan**	**Forecast**		
Financial Sustainability Risk Rating	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.05m



Total Forecast £17.93m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var	
Elective	9,185	8,405	(780)	
Non Elective	49,263	50,745	1,482	
Daycase	43,731	36,284	(7,447)	
Outpatients	327,200	328,389	1,189	
A & E	146,774	144,149	(2,625)	

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var	
	£m	£m	£m	
Elective	£23.39	£21.62	(£1.77)	
Non Elective	£79.89	£83.40	£3.51	
Daycase	£30.25	£24.91	(£5.34)	
Outpatients	£39.45	£40.84	£1.39	
A & E	£15.49	£15.67	£0.18	
Other-NHS Clinical	£117.49	£118.93	£1.44	
CQUIN	£6.69	£6.76	£0.07	
Other Income	£38.90	£37.68	(£1.22)	
Total Income	**£351.55**	**£349.81**	**(£1.74)**	
Pay	(£224.98)	(£226.46)	(£1.48)	
Drug Costs	(£32.05)	(£32.01)	£0.03	
Clinical Support	(£31.15)	(£30.38)	£0.77	
Other Costs	(£45.94)	(£44.58)	£1.36	
PFI Costs	(£11.92)	(£11.81)	£0.11	
Total Expenditure	**(£346.04)**	**(£345.24)**	**£0.80**	
EBITDA	**£5.51**	**£4.57**	**(£0.94)**	
Non Operating Expenditure	(£25.52)	(£25.11)	£0.41	
Deficit excl. Restructuring	**(£20.01)**	**(£20.54)**	**(£0.53)**	
Restructuring Costs	(£3.00)	(£1.10)	£1.90	
Surplus / (Deficit)	**(£23.01)**	**(£21.64)**	**£1.37**	

DIVISIONS: INCOME AND EXPENDITURE

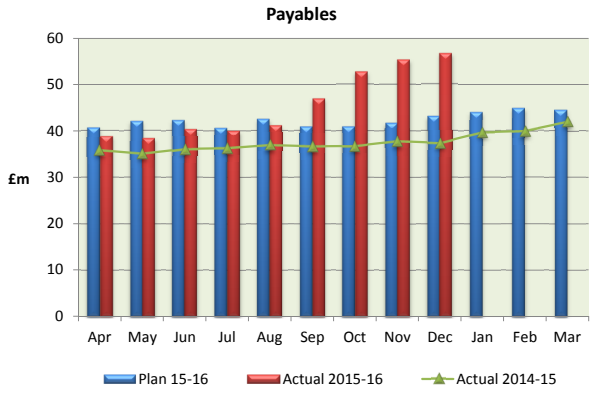
	Plan	Forecast	Var	
	£m	£m	£m	
Surgery & Anaesthetics	£20.01	£17.86	(£2.15)	
Medical	£27.33	£23.42	(£3.91)	
Families & Specialist Services	(£1.36)	(£1.40)	(£0.04)	
Community	£5.77	£5.69	(£0.08)	
Estates & Facilities	(£28.51)	(£26.77)	£1.74	
Corporate	(£20.35)	(£22.27)	(£1.91)	
THIS	£0.53	£0.42	(£0.11)	
PMU	£3.15	£2.95	(£0.20)	
Central Inc/Technical Accounts	(£25.20)	(£21.54)	£3.66	
Reserves	(£4.38)	£0.00	£4.38	
Surplus / (Deficit)	**(£23.01)**	**(£21.64)**	**£1.37**	

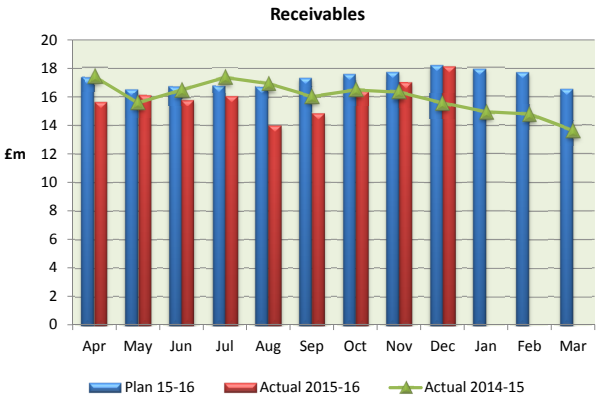
Trust Financial Overview as at 31st Dec 2015 - Month 9

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

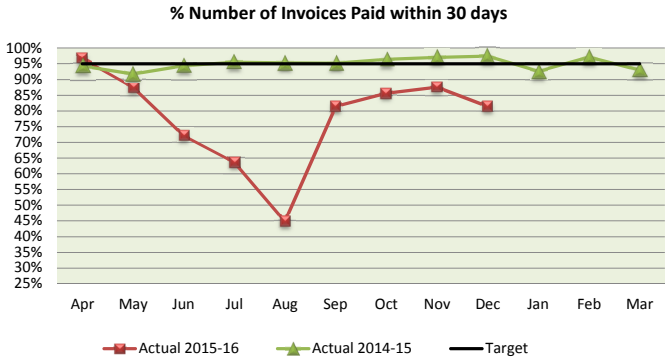
WORKING CAPITAL

	M09 Plan £m	M09 Actual £m	Var £m	M09
Payables * See note below	(£43.15)	(£56.65)	£13.50	
Receivables	£18.22	£18.15	£0.07	



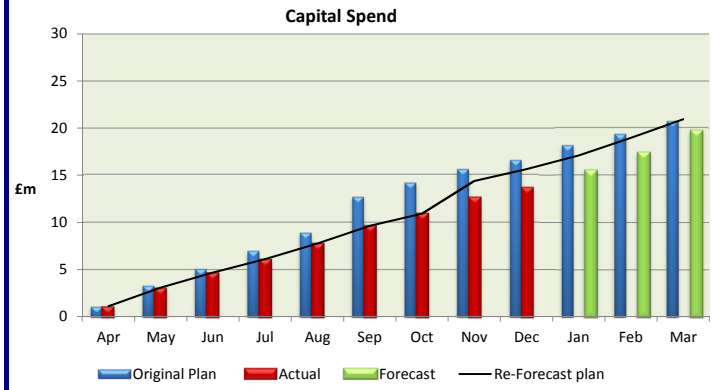


BETTER PAYMENT PRACTICE CODE



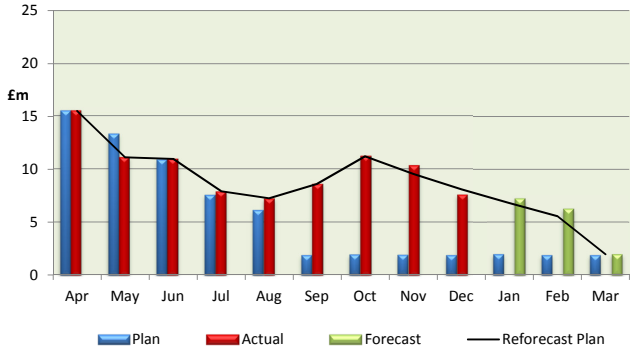
CAPITAL

	M09 Plan £m	M09 Actual £m	Var £m	M09
Capital	£16.54	£13.64	£2.90	

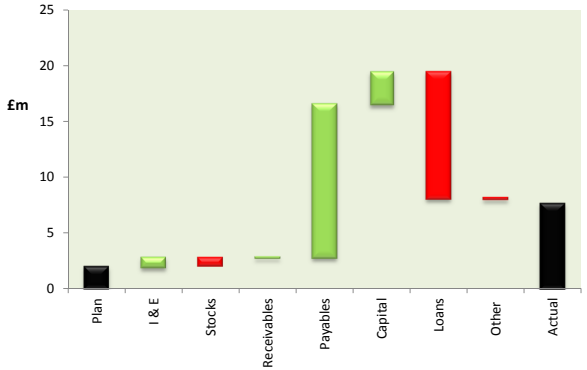


CASH

	M09 Plan £m	M09 Actual £m	Var £m	M09
Cash	£1.91	£7.60	£5.69	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit (excluding restructuring costs) is £16.42m versus a planned deficit of £15.34m.
- The overall deficit is £17.50m against the planned £18.34m, due to restructuring costs not being incurred.
- Outpatient activity was above plan in month and there was an improvement in levels of day case and elective activity.
- High pay expenditure including significant levels of agency expenditure, some of which is above the Monitor price cap.
- Capital expenditure year to date is £13.64m against the planned £16.54m due to timing differences mainly on IT spend.
- Cash balance is £7.60m against a planed £1.91m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £12.65m in the year to date against a planned target of £9.57m.
- The new Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

SUMMARY FORECAST

- The forecast year end deficit (excluding restructuring costs) is £20.54m against a planned £20.01m, an adverse variance of £0.53m.

This position includes full release of remaining contingency reserves and delivery of £17.93m CIP against the original planned £14m.

- Whilst this is a slight improvement on the £20.93m deficit (excluding restructuring) reforecast plan submitted to Monitor in Month 7,

risks remain against the settlement of commissioner contracts, winter expenditure pressures and junior doctor strike action.

- The overall forecast deficit position shows an favourable variance of £1.37m from plan due to a reduction in forecast restructing costs of £1.9m.

Reliance on external cash support has come down from a planned £14.90m to £12.90m due to reduced Capital expenditure and restructuring costs

- It has been decided to reduce capital expenditure by £1m, to reduce reliance on external cash support. The year end FSRR is forecast to be at

level 2. (* Payables note: The trade payables figure is inflated by £15.75m due to the receipt of cash payments in advance for clinical activity)

RAG KEY: (Excl: Cash)

- 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 Monitor risk indicator).

RAG KEY - Cash:

- At or above planned level or > £18.6m (20 working days cash)
- < £18.6m (unless planned) but > £9.3m (10 working days cash)
- < £9.3m (less than 10 working days cash)

Calderdale and Huddersfield NHS
NHS Foundation Trust

CQUINS Performance Report 2015-16

compassionate care

Goal Number	Goal Name	Current Target	Q1	Q2	Q3 to Date	Q4	Q4 Target	Commentary
1	Acute Kidney Injury	45%	22%	32%	57%		90%	Improvement Work Required
2a	Sepsis	Baseline	88%	40%	61%		90%	Improvement Work Required
2b	Sepsis	Baseline	41%	63%	TBC		90%	Improvement Work Required
3	Urgent care	85%	86%	88%	88%		85%	On Plan
4.1	Dementia	90%/90%/90%	91%/99%/100%	91%/100%/100%	92%/100%/100%		90%/90%/90%	On Plan
4.2	Dementia	Written Report	n/a	Y	n/a		Report	On Plan
4.3	Dementia	Written Report	n/a	Y	n/a		Report	On Plan
5.1	Respiratory - Asthma	Q3 = 72%	66%	80%	76%		75%	On Plan
5.2	Respiratory - Pneumonia	Q3 = 70%	70%	78%	70%		75%	Improvement Work Required
6	Diabetes	50%	74%	64%	80%		50%	On Plan
7.1	Improving Medicines Safety	80%/70%	84%/80%	83%/85%	89%/83%		80%/70%	On Plan
7.2	Improving Medicines Safety	Development	Y	Y	Y		Report	Target to be set after Q2
8	End of Life Care	Monitoring	36%	44%	47%		Monitoring	On Plan
9.1	Hospital Food	70%	78%	76%	73%		70%	On Plan
9.2	Hospital Food	Baselining	5.70%	5.48%	4.84%		4.70%	On Plan
9.3	Hospital Food	Written Report	Y	Y	Y		Report	On Plan
Total								

Goals - CCG CQUINs

Value of CQUIN (£)	Q1	Q2	Q3	Q4
627,071	62,707	125,414	125,414	313,536
313,536	78,384	78,384	78,384	78,384
313,536		62,707	125,414	125,414
1,254,142	125,414	376,243	376,243	376,243
250,828	62,707	62,707	62,707	62,707
125,414		62,707		62,707
250,828		125,414		125,414
250,828	62,707	62,707	62,707	62,707
376,243	94,061	94,061	94,061	94,061
627,071	156,768	156,768	156,768	156,768
125,414	31,354	31,354	31,354	31,354
501,657	125,414	125,414	125,414	125,414
627,071		313,536		313,536
250,828		125,414		125,414
250,828		50,166	100,331	100,331
125,414				125,414
6,270,712	**799,516**	**1,852,995**	**1,338,797**	**2,279,404**

Acute Kidney Injury - Q4 Achievement Plan

the expected step change in performance occurred once the roll out of the EDS changes were complete. However there is still some way to go to reach the 90% Q4 target.

Divisional directors have been contacted regarding the CQUIN elements and importance of delivery via e-mail in August 2015, and this will be reiterated in January 2016. A procedure for informing non-complying clinical teams is now embedded and appears to be increasing compliance levels.

Weekly monitoring of the CQUIN continues.

Sepsis - Q4 Achievement Plan

Intensive improvement work is needed throughout the trust to ensure robust processes for screening applicable patients on admission, and ensuring that when indicated those patient get antibiotics within an 1hour.

There is some way to go to achieve the Q4 position, as such a safety and improvement nurse has been deployed to work with the ward and Sepsis Nurse Consultant to implement sustainable and high quality processes.

Whilst further improvement is expected in Q4, the 90% target remains a challenge. An engagement event is being run in January to work with the clinical teams on how to break down the barriers which make full compliance problematic.

Respiratory - Pneumonia - Q4 Achievement Plan

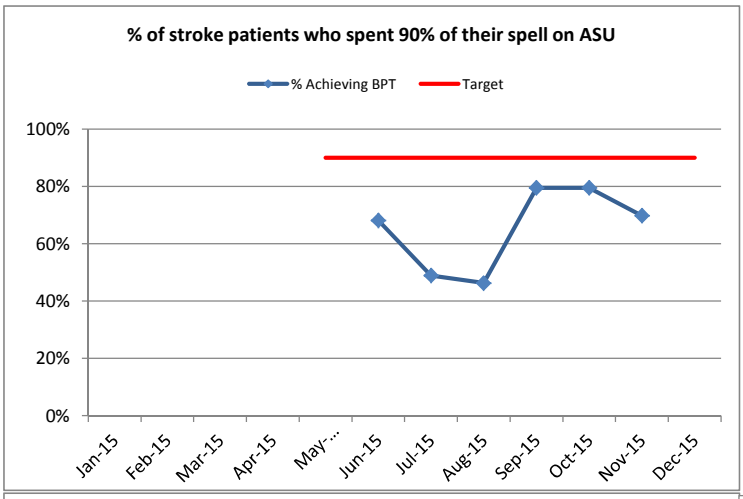
Performance was lower than anticipated in Q3 as such the Q4 position is at risk.

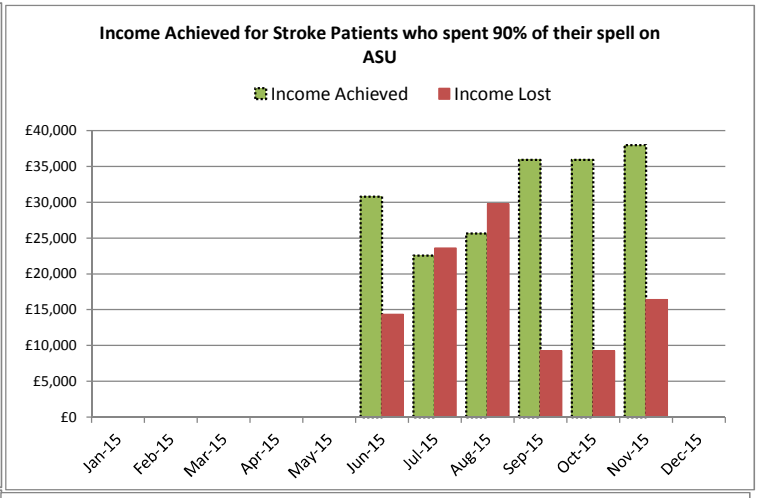
Element of non compliance centers around Requested X-ray within 4 hours and capturing the patient CURB score. Communication has been had with colleagues working the relevant areas.

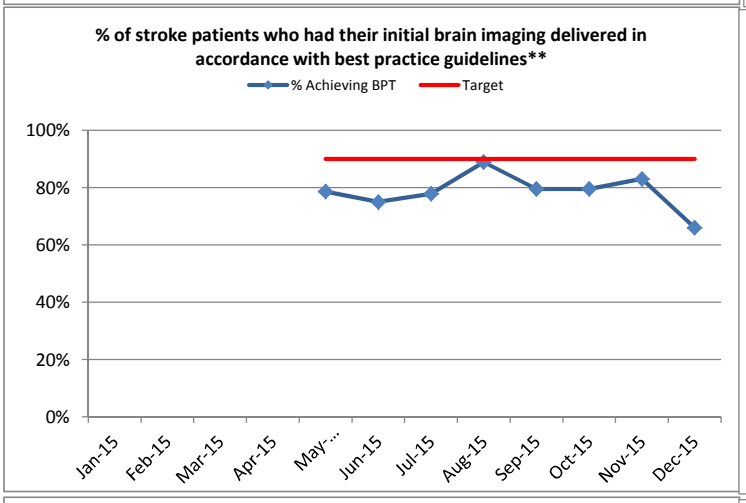
Closer monitoring of this target will commence in Q4.

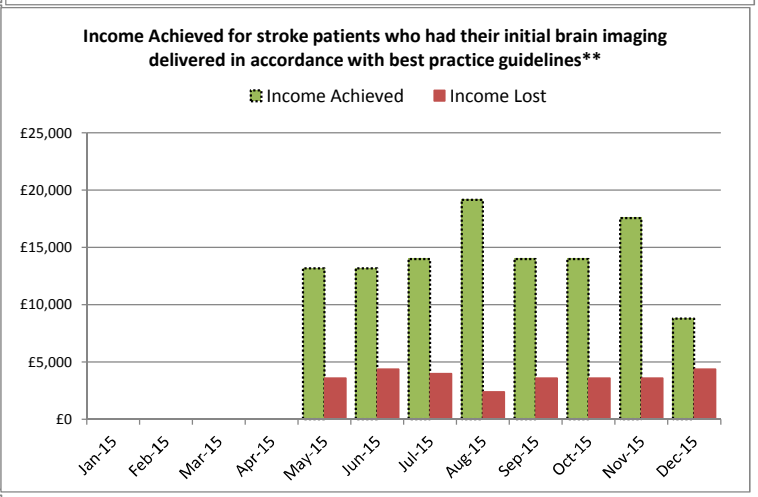
NHS England

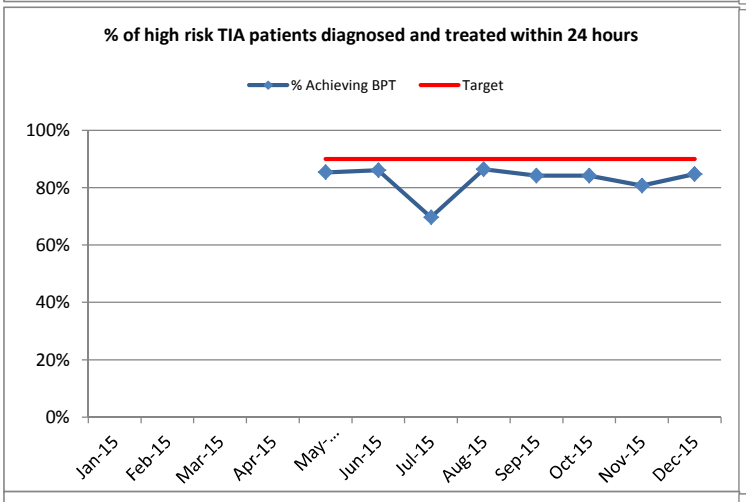
Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
NICU	38,051	9,513	9,513	9,513	9,513
Oncotype DX	38,051	9,513	9,513	9,513	9,513
QIPP	126,836	31,709	31,709	31,709	31,709
Vac and Immunisations	90,860	22,715	22,715	22,715	22,715
National CQUIN	22,715	5,679	5,679	5,679	5,679
HV Building Community Capacity	104,680	26,170	26,170	26,170	26,170
TOTAL NHS England	**421,193**	**105,298**	**105,298**	**105,298**	**105,298**
GRAND TOTAL	**6,691,905**	**904,814**	**1,958,294**	**1,444,095**	**2,384,702**

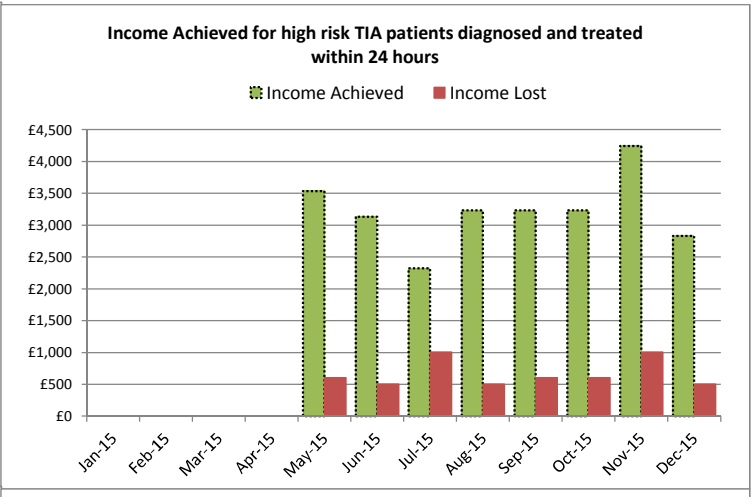

% of stroke patients who spent 90% of their spell on ASU
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

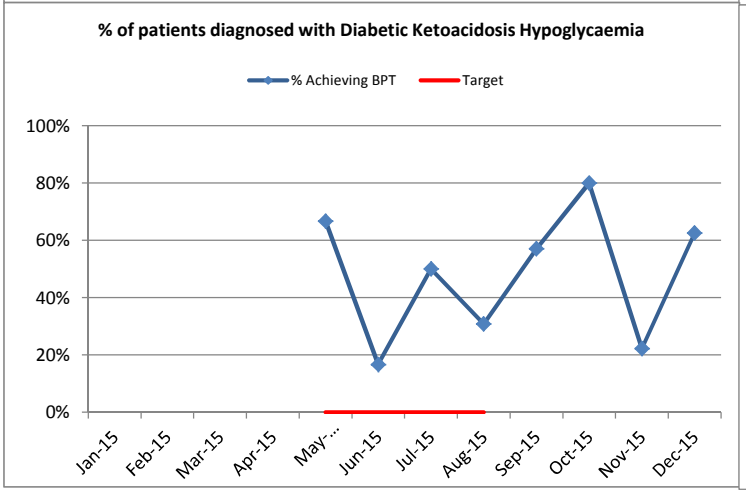

Income Achieved for Stroke Patients who spent 90% of their spell on ASU
Income Achieved
Income Lost
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

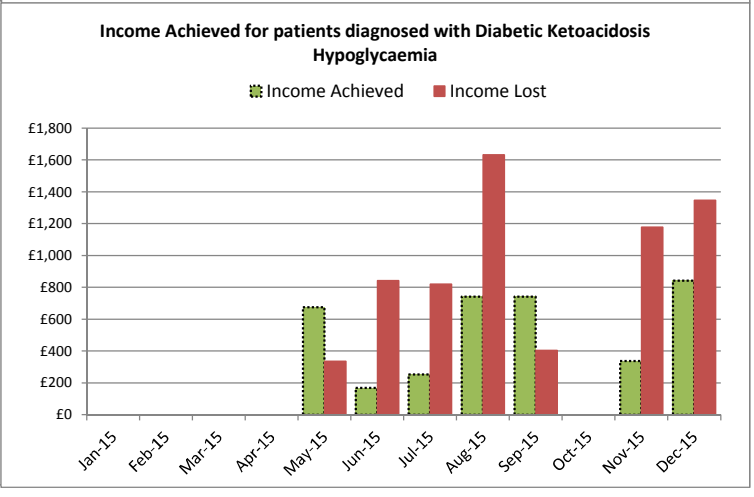

% of stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

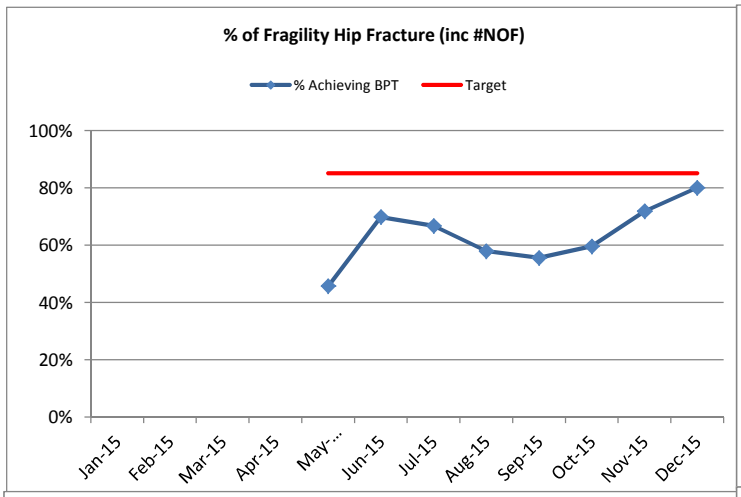

Income Achieved for stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**
Income Achieved
Income Lost
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

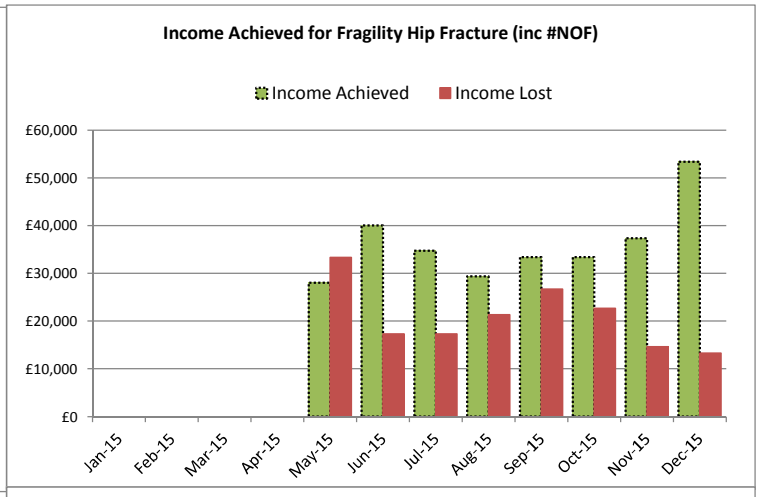

% of high risk TIA patients diagnosed and treated within 24 hours
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

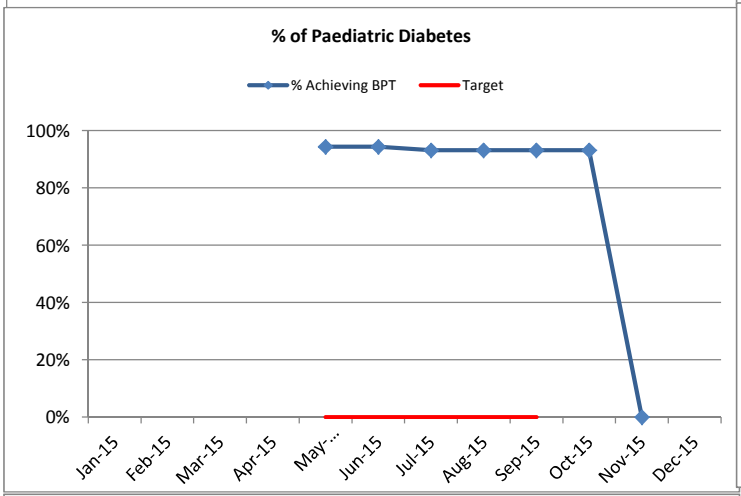

Income Achieved for high risk TIA patients diagnosed and treated within 24 hours
Income Achieved
Income Lost
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

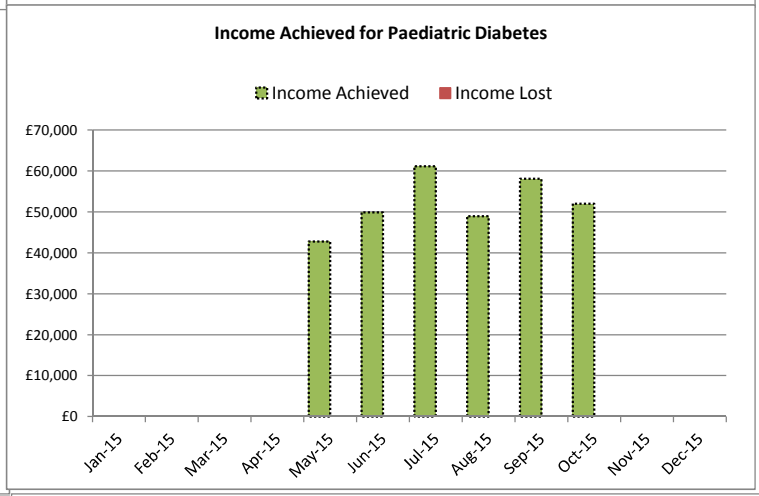

% of patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

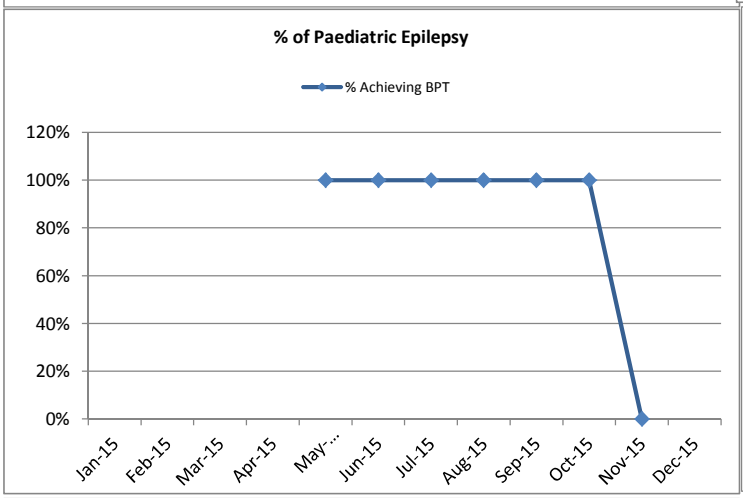

Income Achieved for patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia
Income Achieved
Income Lost
£1,800
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

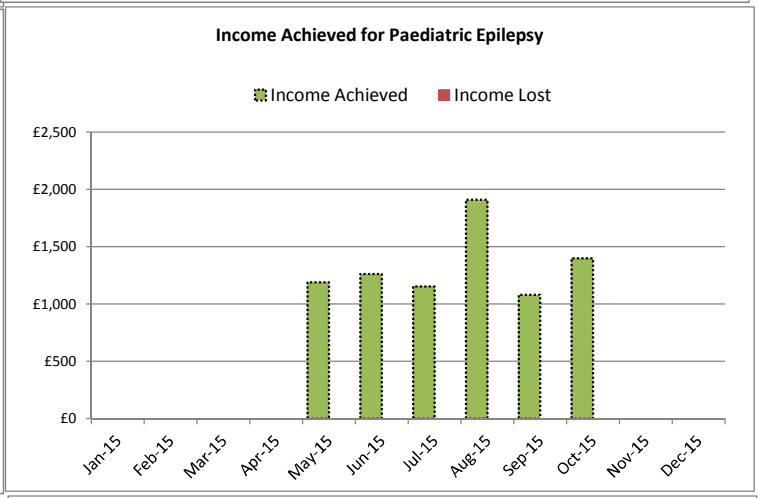

% of Fragility Hip Fracture (inc #NOF)
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

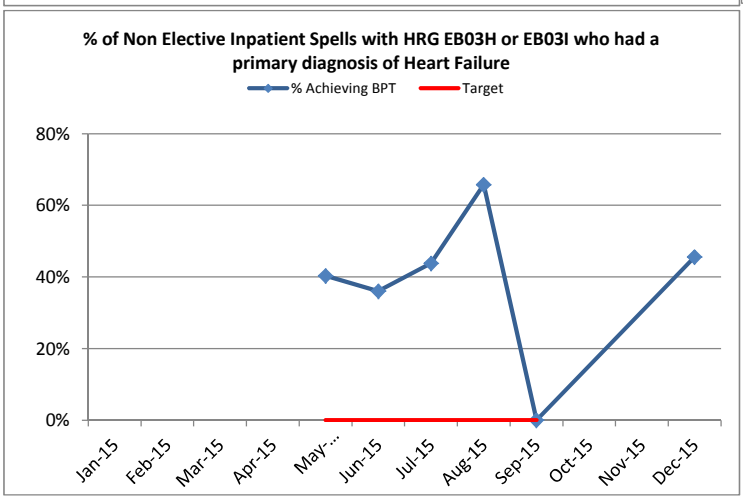

Income Achieved for Fragility Hip Fracture (inc #NOF)
Income Achieved
Income Lost
£60,000
£50,000
£40,000
£30,000
£20,000
£10,000
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

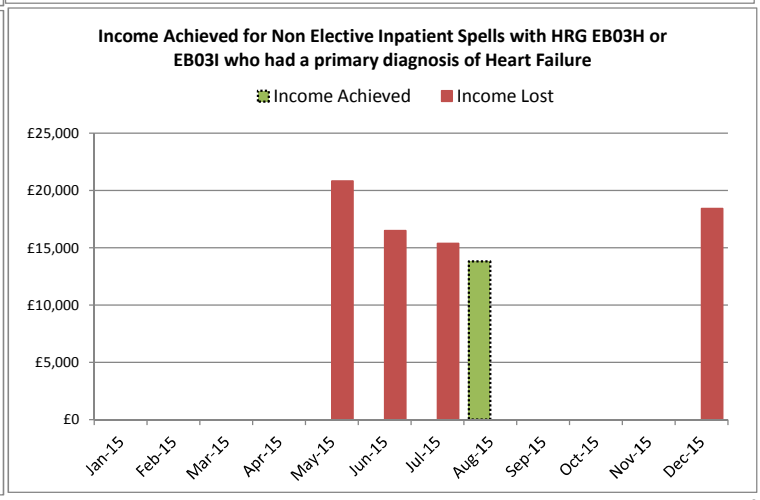

% of Paediatric Diabetes
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15


Income Achieved for Paediatric Diabetes
Income Achieved
Income Lost
£70,000
£60,000
£50,000
£40,000
£30,000
£20,000
£10,000
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15


% of Paediatric Epilepsy
% Achieving BPT
120%
100%
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15


Income Achieved for Paediatric Epilepsy
Income Achieved
Income Lost
£2,500
£2,000
£1,500
£1,000
£500
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15


% of Non Elective Inpatient Spells with HRG EB03H or EB03I who had a primary diagnosis of Heart Failure
% Achieving BPT
Target
80%
60%
40%
20%
0%
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15


Income Achieved for Non Elective Inpatient Spells with HRG EB03H or EB03I who had a primary diagnosis of Heart Failure
Income Achieved
Income Lost
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15

Board of Directors Integrated Performance Report

A "Data Quality Assessment" is now being made for each indicator. These assessments are being provided by those responsible for the indicator's information provision each month, and then signed off by the indicator's lead manager.

It is a Red, Amber, Green (RAG) rating based on the evaluation of the following three questions -

1.What is the overall view for the robustness of the indicator documentation regards construction and completeness (RAG)?
2.What is the overall view regards the timeliness of the information for this indicator (RAG)?
3.What is the overall view regards the robustness of the collection for this indicator (RAG)?

The final rating for an indicator of Red Amber Green is assessed as follows -

Answers to the 3 Questions :	3 Green or 2 Green, 1 Amber	Final rating Green
	1 Green, 2 Amber or 3 Amber or 2 Green 1 Amber or 1 Green 1 Amber 1 Red	Final rating Amber
	Any other combination	Final rating Red

Any indicator that has its data quality assessment currently white has yet to be assessed or have its assessment signed off by the lead manager for the indicator.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 9 - FINANCIAL NARRATIVE - DECEMBER 2015 - The Board is asked to approve the Month 9 Financial Narrative - December 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 26.1.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 9 Financial Narrative - December 2015.

Main Body

Purpose:

The Board is asked to approve the Month 9 Financial Narrative - December 2015.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Month 9 Financial Narrative - December 2015.

Appendix

Attachment:

Financial Narrative Month 9 15_16 for BOD.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 9 DECEMBER 2015/16 FINANCIAL NARRATIVE

Purpose
This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the month and year-end forecast and is presented in three sections as follows:

- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to Monitor in May;
- Financial Sustainability Risk Rating (FSRR) and forecast.

This paper has previously been discussed at the Finance & Performance Committee held on 26 January 2015.

1. Key Messages

The year to date deficit (excluding restructuring costs) is £16.42m against an original plan of £15.34m. Whilst this is an adverse variance it does represent an improvement on the trajectory submitted to Monitor as a reforecast plan in November.

The improved in-month position has positive impact on the year end forecast position, although to a slighter degree, whilst the Trust seeks to mitigate against the uncertainties of further winter pressures, junior doctors strike action and contract settlement risks. The forecast year end deficit (excluding restructuring costs) now stands at £20.54m against a planned £20m.

Month 9, December Position (Year to Date)

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Actual £m	Var (vs. Original) £m
EBITDA	**3.78**	**1.62**	**2.42**	**(1.36)**
Deficit excluding restructuring	**(15.34)**	**(17.17)**	**(16.42)**	**(1.08)**
Restructuring costs	(3.00)	(0.98)	(1.08)	1.92
Deficit including restructuring	**(18.34)**	**(18.15)**	**(17.50)**	**0.84**

- An EBITDA of £2.42m, an adverse variance from plan of £1.36m.
- A deficit of £17.50m, a favourable variance of £0.84m from the planned position.
- Delivery of CIP of £12.65m against the planned level of £9.57m.
- Contingency reserves released of £1.97m to offset pressures.
- Capital expenditure of £13.64m, this is below the planned level of £16.54m.
- A cash balance of £7.60m, this is above the planned level of £1.91m.
- A Financial Sustainability Risk Rating (FSRR) of level 2 in line with plan (restated from a Continuity of Service Risk Rating of level 1).

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The month 9 position whilst an adverse variance from plan, again shows an improvement from the trajectory forecast last month. In late December the Calderdale region particularly experienced flooding which brought some operational pressures to patient flow as out of hospital services were diverted to cope with the associated logistical challenges. In spite of this, the number of extra beds open has continued to be contained at a slightly lower level than anticipated benefitting staffing costs. Planned daycase and elective activity improved from the previous trend as did outpatient activity, bringing additional income benefit.

In summary the main variances behind the year to date position, against the original plan are:

Operating income	(£1.73m) adverse variance
Operating expenditure	£0.37m favourable variance
EBITDA	**(£1.36m) adverse variance**
Non-Operating items	£0.28m favourable variance
Deficit excluding restructuring	(£1.08m) adverse variance
Restructuring costs	£1.92m favourable variance
Total	**£0.84m favourable variance**

Operating Income

There is a cumulative £1.73m adverse variance from the plan within operating income.

NHS Clinical Income

Of the £1.73m adverse income variance, £0.77m is driven by NHS clinical income. In summary daycase and elective activity remain below plan in the year to date but performance has improved in month and outpatient activity has also seen a strong month.

The activity position driving the reported PbR income is as follows:

- Planned day case and elective activity has seen an improved performance in month 9. The month 9 performance is 108 spells better than plan, mainly within day case activity but with a small improvement within elective. The improvement within day case can particularly be seen within Gastroenterology and Ophthalmology with other smaller improvements across a range of specialties.

- Non-elective admissions overall are above plan in month by 2.7% (118 spells). Activity is 3.9% (168 spells) higher than that admission levels in December 2014-15 and 3.9% (1,431 spells) higher cumulatively than last year.

- A&E attendances are below the planned level (595 attendances in month, 2,006 attendances year to date). Activity remains cumulatively 1% (1,101 attendances) higher than that delivered in 2014-15.

- Outpatient attendances are again above plan in-month (1,669 attendances). This follows an over performance last month. The increase in activity levels is across both first and follow-up attendances across a wide range of specialties.

- Pass through high cost drugs costs are under planned levels whilst conversely devices are above planned levels.

In recognition of the outstanding income risks, allowance to the value of £1.94m has been made in the year to date in the anticipation of contract sanctions; any shortfall on CQUIN performance; and contract challenges under a full PbR contract. Whilst the Trust has assurance from commissioners that they will endeavour to take a pragmatic view of the contractual position as a whole the response is likely to differ across the two main commissioners on the basis of affordability. With this in mind the provision against contract challenges has been increased by £0.4m above the previously allowed level as the activity overperformance in November and December may bring a harder line from commissioners.

Other income

Overall other income is £0.96m below the planned level. The Trust's Pharmacy Manufacturing Unit which generates commercial income had planned to exceed their prior year surplus delivery. As previously reported, there is a shortfall against this plan which is the main driver of the adverse variance.

Operating expenditure

There was a cumulative £0.37m favourable variance from plan within operating expenditure across the following areas:

Pay costs	(£0.46m) adverse variance
Drugs costs	£0.09m favourable variance
Clinical supply and other costs	£0.74m favourable variance

Employee benefits expenses (Pay costs)

Pay costs are £0.46m higher than the original planned level.

The largest single driver of the additional costs which have been incurred in the year to date is the need for additional bed capacity, this was projected to increase further over the winter period. A range of specific actions were put in place as required to ensure that the Trust had sufficient bed capacity as we entered the Christmas period with an aim to achieve a 20% unoccupied general and acute bed capacity on Christmas Eve. Elective lists and consultant availability was also reviewed to allow sufficient bed capacity and clinical time released to ensure review of acute patients. Against this backdrop, the level of additional nursing and medical staffing costs associated with capacity pressures have been held beneath the forecast level due to a lower level of beds being open than anticipated. In January, however the Trust has seen bed capacity requirements increase considerably and an array of operational actions have been put in place to deal with this.

Recruitment difficulties continue to be an issue in certain specialties for medical staff. This is driving additional costs through the requirement to engage agency locum staff in key specialties. Focussed activity is underway to manage attendance of clinical staff; ensure escalation of authorisation for agency cover for junior medical posts; drive down agency rates using the Monitor price cap as a lever where possible with success particularly with nursing agencies; and efficiently record and monitor these bookings.

Drug costs

Year to date expenditure on drugs was £0.09m below plan. The spend on 'pass through' high cost drugs is below plan matched by a corresponding income decrease.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.74m below plan.

This overspend includes £0.59m in excess of plan on pass through ICD costs which are offset by income as well as costs associated with the in-month in increase in elective and day case activity.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £2.20m below the plan.

Restructuring costs in the year to date are £1.08m. Of the costs incurred £0.10m relates to redundancy payments to enable CIP, whilst the balance is the E&Y consultancy support to strategic turnaround which is materially complete. £3.0m of restructuring costs in respect of redundancy had been allowed for in the plan, the lower level actually incurred explains the favourable variance from plan.

Cost Improvement Programme (CIP) delivery

The CIP and revenue generation schemes continue to perform in excess of plan in the year to date with £12.65m achieved against a planned £9.57m. The over performance is seen in the same areas as in previous months; achieving additional revenue from pricing through greater depth of clinical coding and delivery of additional non pay savings. The former is partially offset in the overall financial position by the provision made against contract challenges by commissioners.

The latest risk assessment against all of the work streams indicates that the vast majority are now low risk which is congruent with the fact that these schemes are already well underway.

Statement of Financial Position and Cash Flow

At the end of December 2015 the Trust had a cash balance of £7.60m against a planned position of £1.91m, a favourable variance of £5.69m, the key movements are summarised below.

		Variance £m
Operating activities	Deficit excluding restructuring	(1.08)
	Restructuring costs	1.92
	Deficit including restructuring	**0.84**
	Non cash flows in operating deficit	(0.14)
	Re-profiling of commissioner contract income	15.75
	Other working capital movements	(1.43)
	Sub Total	**15.01**
Investing activities	Capital expenditure	2.90
	Movement in capital creditors	(1.19)
	Sub Total	**1.71**
Financing activities	Drawdown of external DoH cash support	(11.30)
	Other financing activities	0.27
	Sub Total	**(11.03)**
	Grand Total	**5.69**

Operating activities

Operating activities show a favourable £15.01m variance against plan. This is driven by the favourable cash impact of the I&E position of £0.70m (£0.84m favourable I&E variance less £0.14m non-cash flows in operating deficit) offset by an adverse working capital variances from plan. As described in previous reports, agreement has been reached with our main commissioners to re-phase the contract income payments over eleven months rather than the standard twelve. This has enhanced the cash position by £15.75m in the year to date.

The adverse variance on working capital movements is predominantly due to timing differences on receivables. Settlement of invoices is due from other NHS organisations totalling £1.10m for services provided. The most material of these are due from Greater Huddersfield CCH and Calderdale CCG for services that sit outside of the main clinical contract; NHS England in relation to Cancer Drugs Fund charges for November; and Bradford NHS FT's contribution to EPR costs due in November. The latter two of these are to be settled in January and the remainder are being actively pursued by the Trust.

As this shortfall in receivables is considered a short term timing issue, payments to suppliers were not withheld in December. In month 81% of invoices have been paid within 30 days and the Trust remains mindful of the need to maintain healthy creditor terms, particularly given that external cash support will not be available to restore the balance sheet position on payables.

Investing activities (Capital)

Capital expenditure in the year to date is £13.64m, £2.90m below the planned level of £16.54m.

The decision has been taken by the Trust to re-prioritise capital expenditure where this can be done without detriment to safety in order to reduce reliance on external cash support. The year to date underspend is in part due to this re-prioritisation as well as issues of timing.

Against the Estates element of the capital expenditure the year to date expenditure is £5.43m against a planned £6.24m. The main area of spend in month was the continuation of the Theatre refurbishment at £0.23m at the Huddersfield Royal Infirmary site and £0.18m on CDU at the Calderdale Royal site. A material contributor to the underspend is £0.42m against the decommissioning of oil tanks which has been able to be delivered in a more cost effective way.

IM&T investments total £6.70m against a year to date plan of £8.36m. The main individual area of spend in month is again on the continuation of the Electronic Patient Record (EPR). This is also the key area of underspend against the plan although this is purely a timing difference which will rectify over forthcoming months.

Expenditure on replacement equipment is also lower than plan and contingencies have not been required to be spent.

The favourable cash impact of this £2.90m under spend is offset by a £1.19m adverse variance against capital creditors as invoices have been forthcoming in a timely way, explaining the overall £1.71m positive cash variance against investing activities.

Financing activities

Financing activities show a £11.03m adverse variance from plan but, as in previous months, in this instance this is positive news. The key driver for this variance is the fact that the Trust has not needed to draw upon external DoH loans, the reliance on which was originally expected to have reached £11.30m by December. This is further evidence that the actions being taken by the Trust to pro-actively manage cash are having a real impact.

As reported in previous months, the Trust has an approved working capital loan facility in place with the Independent Trust Financing Facility which is available to draw against up to a total value of £13.1m at an interest rate of 3.5%. This is a 'safety net' to the Trust as the requirement for external cash funding is not projected to arise until March 2016. The application process has commenced with the support of Monitor to progress to having a revenue support loan secured by March at the lower interest rate of 1.5%.

The separate £10m loan to support the EPR deployment was drawn down from the Independent Trusts Financing Facility (ITFF) in April as planned.

3. Financial Sustainability Risk Rating (FSRR) and forecast

FSRR

Against the new FSRR the Trust stands at level 2 in both the year to date and forecast position. This is in line with planned position (restated from the original CoSRR of 1).

Forecast – Income and Expenditure

The latest forecast is a £21.64m deficit, whilst this is an adverse variance from the original plan in trading terms (£20.54m against a plan of £20m excluding restructuring), this is an improvement of £0.40m against the reforecast plan submitted to Monitor in November.

The reforecast plan was to deliver a year end deficit of £22.04 (including restructuring costs of £1.10m). This incorporates £1.2m additional resource to compensate the Trust for its winter resilience plans which Calderdale CCG have confirmed and invoices have now been raised against. The associated costs had already predominantly been included within the forecast.

As previously reported and discussed with Monitor as a specific addition to the planned spend; the forecast includes £1m restructuring costs in respect of the appointment of Ernst & Young (to provide capacity and specialist capability to the development of the transformational five year strategic plan). It has now been confirmed with Monitor that this is an allowable extension to the deficit and consequent cash requirement.

At the time the reforecast plan was submitted, the option of a capital to revenue transfer could have brought a further benefit of £1.0m to I&E was unconfirmed. The Trust now understands that this route will not be available.

Even without this capital to revenue option being open to the Trust, an improved bottom line is forecast due to the strong performance in Month 8 and Month 9. The full benefit of the year to date position is diluted slightly in the forecast as financial risk remains in the quarter against the operational management of winter pressures and the junior doctors strike action. These issues bring the risk of additional costs which will need to be mitigated alongside the ongoing contract settlement risks where provision has been made and open dialogue continues but the outcome is still uncertain.

The forecast year end position is summarised at headline level below:

Year-end Forecast Position

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Month 9 Forecast £m	Var (vs. Original) £m
EBITDA	**5.51**	**4.14**	**4.57**	**(0.94)**
Deficit excluding restructuring	**(20.01)**	**(20.94)**	**(20.54)**	**(0.53)**
Restructuring costs - redundancy	(3.00)	(0.10)	(0.10)	2.90
Restructuring costs – consultancy support	0.00	(1.00)	(1.00)	(1.00)
Deficit including restructuring	**(23.01)**	**(22.04)**	**(21.64)**	**1.37**

Forecast – Capital

The Trust has reviewed its planned capital programme for 2015/16 and considers that there is scope to reduce the programme up to the value of £1.0m without having an adverse impact on patient safety. This remains under review with due consideration being given to CQC requirements and avoiding bringing unnecessary pressure to the 2016/17 capital plans. Whilst the Trust now understands that the option will not be available to transact a capital to revenue transfer to bring equivalent benefit to I&E, the forecast has been revised to reflect a £1.0m capital underspend and reduce reliance on external cash support.

Forecast – Cash

The total cash support requirement currently stands at £12.9m, taking into account the cash benefit of reduced capital spend. This level includes the additional cash requirement to support the restructuring costs relation to consultancy support £1.0m which, as referenced above, has now been agreed with Monitor to stand as an agreed discretionary extension to the cash support requirements.

The pro-active measures that have been put in place to secure and preserve cash mean that the timing of this need is pushed back from the original plan to March 2016.

Conclusion

The Trust continues to make every effort to improve upon the year end forecast I&E position and minimise the cash support required. All avenues to achieve this continue to be pursued to minimise the cash support required, through internal challenge to contain expenditure required to deliver the operational pressures which have heightened in January; the decision to reprioritise capital expenditure; and open dialogue with commissioners.

There continue to be a range of risks and opportunities to achievement of the year end forecast.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th January 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive and note the updates from Sub Committees and Receipt of Minutes.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive, note and approve the following:-
a. Quality Committtee - verbal update from meeting 26.1.16 and minutes from 15.12.15
b. Finance and Performance Committee - verbal update from meeting 26.1.16 and minutes of 15.12.15
c. Nomination and Remuneration Committee (Membership Council) - minutes from meeting held 7.12.15
d. Audit and Risk Committee - verbal update from meeting 20.1.16

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive, note and approve the following:-
a. Quality Committee - verbal update from meeting 26.1.16 and minutes from 15.12.15
b. Finance and Performance Committee - verbal update from meeting 26.1.16 and minutes of 15.12.15
c. Nomination and Remuneration Committee (Membership Council) - minutes from meeting held 7.12.15
d. Audit and Risk Committee - verbal update from meeting 20.1.16

Appendix

Attachment:

COMBINED UPDATED SUB CTTEE MINS.pdf

Minutes of the QUALITY COMMITTEE held on Tuesday 15 December 2015, 2pm – 5pm in Boardroom, HRI

PRESENT:
Anne-Marie Henshaw, Associate Director of Nursing: FSS Division
David Birkenhead, Medical Director
Diane Catlow, Interim Associate Director of Nursing, Community Services
Jackie Murphy, Deputy Director of Nursing – Modernisation
Jason Eddleston, Deputy Director of Workforce and OD
Jeremy Pease, Non-Executive Director
Joanne Middleton, Associate Director of Nursing – Surgery & Anaesthetic Services
Julie Dawes, Executive Director of Nursing
Julie O'Riordan, Divisional Director – Surgery & Anaesthetic Services
Juliette Cosgrove, Assistant Director of Quality
Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities
Lindsay Rudge, Deputy Director of Nursing
Lynn Moore, Membership Council

IN ATTENDANCE:
Kathryn Kershaw, Clinical Governance Midwife (representing FSS Division)
Stephanie Jones, Committee Secretary/ PA to Director of Nursing

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01/12/15 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting. The meeting was confirmed as quorate. There were no declarations of interest.

02/12/15 **APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER**

Apologies for absence were received from:
Andrea McCourt, Head of Risk & Governance
Keith Griffiths, Executive Director of Finance
Helen Barker, Chief Operating Officer
Linda Patterson, Non-Executive Director
Victoria Pickles, Company Secretary

03/12/15 **MINUTES OF THE MEETING HELD ON 24 NOVEMBER 2015**

The minutes of the meeting held on 24 November 2015 were approved as a true record, subject to the following amendment: Jan Wilson was in attendance.

04/12/15 **ACTION LOG** (Items due this month)

Review of Compliance with NICE Guidelines: discussed under agenda item 5.1.

Wards in Special Measures: A and B, CRH: discussed under agenda item 5.3

Mixed Sex Accommodation: It was reported the two breaches not detailed on the Integrated Performance Report had not been reported on Unify. Both had been reported to the Clinical Commissioning Group (CCG) and Root Cause Analysis (RCA) had been carried

out. The error appears to be in relation to validation.

05/12/15 **MAIN AGENDA ITEMS**

5.1 Compliance with NICE Guidelines – quarterly update

It was reported that Martin DeBono had taken the lead in reviewing NICE compliance. All areas of non-compliance and partial compliance are being reviewed and leads challenged regarding the timeframe for them to become fully compliant.

It is anticipated by the end of Q4 2015/16 all areas non or partially compliant will have a plan of their current position and reasons for non or partial compliance. Audits are being undertaken on those areas that are compliant.

The Director of Nursing questioned the risks for the Trust for non-compliance. The Assistant Director to the Nursing and Medical Director, Juliette Cosgrove, confirmed that none had been identified as a risk.

The Divisional Director for Surgery & Anaesthetics Services said the GI bleeds service will not be fully compliant whilst the service is being run on two sites. The Director of Nursing asked this be added to their Divisional Risk Register in order for the risk to be managed.

ACTION:
The Chair requested a further report to be brought to the Committee in January 2016 with consideration given to:

1) Review of current position/glossary of areas non-compliant
2) Challenge leads on those non or partial compliant to include what action is being taken and timeline of when they will be compliant by
3) Those non-compliant due to clinical reconfiguration need to be identified and added to risk register

The Medical Director acknowledged a lot of work had gone into NICE compliance to date, but there is still further work to be done.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

5.2 Visible Leadership: process and outcome of first visits

The item was deferred to the January 2016 meeting.

5.3 Special Measures Report: Wards A and B, CRH

The Deputy Director of Nursing verbally informed the Committee of the two wards that had been placed under special measures.

Ward A

Ward A at Calderdale Royal Hospital is a 30 bedded ward. The ward has experienced issues in relation to performance and recruitment. Alongside these issues a serious incident investigation, which highlighted multi-factorial issues, initiated the ward being placed in special measures.

Over the past few years the ward has had 3 ward sisters and struggled with recruitment. In addition, a change in the medical infrastructure has compounded issues further. Deborah Turner, Interim Associate Nurse Director, has undertaken an assurance review and an intervention have been put in place to manage performance, alongside a second intervention to review HR policies. Skill mix will be reviewed in order to strengthen the

nursing workforce and a revised operational policy for the medical staff will be issued.

Weekly meetings are being held with the Director of Nursing, Deputy Director of Nursing, General Manager, Matron and Ward Sister. An action plan will be developed and shared with the Committee.

Ward B

Ward B at Calderdale Royal Hospital was placed in special measures as a number of areas gave rise to concern, particularly in relation to a period of instability around therapy support, an increase in complaints and infection control issues (2 c.diffs).

The action plan developed is progressing well and a concise plan around infection control is in place. A recent infection control walk-round was positive. A second Band 6 post has been recruited to and the ward has recently appointed a new Band 7. An increase in mandatory training performance was noted. Special measure meetings have now been moved to monthly.

ACTION: Deputy Director of Nursing to prepare a written report regarding Ward A to include ward metrics.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

06/12/15 **CQC PREPARATION AND ACTIONPLAN**

6.1 Action Plan in Preparation for the CHFT CQC Inspection

The Assistant Director of Quality presented a report to further update on the progress being made in advance of the forthcoming CQC inspection.

The CQC group continues to meet weekly with a programme of presentations scheduled based on the 90 day plan for core services, divisions and domains. The second round is now being completed which has focussed on what has improved, what actions are outstanding and a forecast of when each domain will become green. Specific issues of concern will also be addressed at the weekly meetings.

Teleconferences have taken place with other Trusts that have undergone inspection; Southampton General Hospital, Frimley Park and Isle of Wight.

£182K from the Clinical Commissioning Group (CCG) has been granted to recruit support staff and help with improvement work.

Equality and Diversity: some good areas of practice evidenced, but further work to be done to increase awareness in relation to the 9 protected characteristics and promoting the importance of personalised care.

Caring domain: Area doing well and the domain is considered to be good and outstanding in some areas. Evidence improvement work is having an impact.

Effective domain: A lot of progress has been made with priorities covered. Extra attention is being paid to record keeping and 7 day working and nutrition.

Communication: Presentations and road shows have been delivered to staff and regular briefings have been issued via Big brief, Trust News and CHFT weekly. An increased amount of assurance visits across wards and departments have taken place.

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End of life: An end of life strategy is being developed jointly with the hospices. This will be launched via the Communications Department.

The CQC rating dashboard was received by the Committee. It is anticipated come January that more areas will be green.

A heat map highlighting the key risks will be brought to the Committee in January 2016.

The self-assessment will need to be submitted to the CQC by 4 January 2016. This will be brought to the Committee in January 2016.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

07/12/15 **RESPONSIVE**

7.1 Integrated Quality and Performance Report
Due to the Quality Committee meeting being held earlier in the month the data for the Integrated Performance Report was not available for a report to be produced.

08/12/15 **SAFETY**

8.1 Serious Incident Register
The Governance and Risk Department have undertaken a comprehensive review of how they manage the process of investigating serious incidents. Work is ongoing with investigators to improve the quality of reports. A new policy and procedure has been completed and training is being rolled out to help embed the policy.

48 hour panel meetings continue to be held chaired by the Director of Nursing or Medical Director.

The Governance and Risk Team are in the process of producing a document which identifies all the serious incident investigations completed in the last few years along with reports and action plans embedded within the document. This document is still work in progress, but once complete Divisions will be able to review the incidents they have investigated in the past, review the actions taken and also evidence the sharing of lessons learnt.

Pressure ulcers: community acquired pressure ulcers being reported as incidents from nursing homes and in the community are currently attributed to CHFT where there is district nursing input. In October there were 26 cases which were category 3 and 4. Going forward these will be investigated as a cluster involving all agencies that provide care for that particular patient.

It was noted that further improvement work is still required in relation to pressure ulcers and falls. This is being led by the Deputy Director of Nursing.

A Serious Incident Review Group has been established which will have senior membership and will be chair by the Chief Executive.

A Task and Finish group is to be established to review the process for mis-diagnosis. This will be chaired by the Deputy Director of Nursing and will involve a number of key clinical staff at consultant level.

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Nine Serious incidents have been reported in November;
- seven were pressure ulcers (four were category three and three were category three)
- one maternity incident (still birth)
- one medical equipment/devices/disposables incident meeting Serious incident criteria. This was initially reported as a Never Event involving a mis-placed naso-gastric tube, however further investigation proved this was not the case. There was no harm to the baby who has since been discharged.

The lessons learnt from serious incidents were briefly discussed.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

8.2 Patient Safety Group Report
The Patient Safety Group held its last meeting on 3 December 2015. The following highlights were noted from the meeting:
- The *What Happened Next…* Newsletter continues to be produced monthly and gives staff the opportunity to share learning with the rest of the organisation.
- A recent report in to Orange incidents flagged up an issue regarding Datix. A Datix User Group will be put in place to discuss the identified issues and support the recommended changes. A training need on the use of Datix has been recognised and the scope of the training is being assessed by the Risk Department.
- Safeguarding Training figures: a decrease in compliance for Level 2 and 3 Safeguarding training was noted. Training session have consistently been offered to staff but take-up has been poor due to capacity. Staff unsure of which level of training they are required to undertake is being addressed by the Safeguarding Team.
- Infection Control (hand hygiene): a decline in performance was noted. Assurance was received by the Infection Control Lead that a lot of training is ongoing between clinical areas and Link Practitioners. A letter will also go out to staff from Gavin Boyd, Consultant Microbiologist.
- Serious Incident Report: Arrangements for the signing off of reports was discussed to ensure they are done in a timely manner.
- Outliers: Audit completed across the Trust following concern outliers on the HRI site was high.
- CQC Preparation: Weekly Safety briefings are being delivered following a snap shot audit across wards. To date briefings have covered; medicines management and fluid balance charts.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

8.3 Board Assurance Framework
At the Board of Directors meeting in November it was agreed that each Committee should regularly review the risks it is responsible for on the Board Assurance Framework.
The Committee were presented with the risks (highlighted in purple) that they will be required to scrutinise and monitor.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

8.4 Serious Incident Review Group: Terms of Reference
The Assistant Director of Quality presented the draft Terms of Reference for the Serious Incident Review Group for approval. The newly established group will meet quarterly with senior divisional representation and will be chaired by the Chief Executive.

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The Committee agreed that the membership of the group should be extended to include the Chief Operating Officer and the Interim Associate Nurse Director for Community Services. With these amendments, the Terms of Reference were approved by the Committee.

OUTCOME: The Terms of Reference were approved by the Committee subject to the amendments to the membership as noted.

09/12/15 **COMPLIANCE**

9.1 Risk Register (Corporate)
The Director of Nursing presented the Corporate Risk Register to the Committee. The Corporate Risk Register highlights the significant risks that the organisation faces as at December 2015 and includes all risks with a score of 15+.

Two new risks had been added to the register since the last report;
- Electronic Patient Record (EPR) – risk 6503 – risk of score of 20
- Clinical administration – risk 6507 – risk score of 15

The Chair queried the difference between the two risks 2827; Poor clinical decision making in A&E and 6345; Ability to deliver service transformation. The Director of Nursing confirmed the two risks had been debated widely at the Risk and Assurance Committee and agreed that they should remain two separate risks.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

10/12/15 **EFFECTIVENESS**

10.1 Report from the Clinical Outcomes Group
The Medical Director presented a report from the Clinical Outcomes Group. The following was noted:
- HSMR remains broadly unchanged (116 and 109 respectively) and continues to be a challenge. Mortality data is under constant scrutiny and mortality reviews are being completed in approximately 60% of cases for October and November. However there are still some capacity issues around undertaking the reviews. EDMS is making the mortality review process quicker
- Care bundles work is being managed by the Project Management Office (PMO), all of which are being reviewed. Progress is staring to be seen in this area.
- Nerve Centre: is now in place within the Trust with the exception of Paediatrics. A Clinical Leadership Fellow has commenced work in the Trust working with Dr Sal Uka (Divisional Director for Seven Day Services/Hospital at Night) to examine the e-handover and Hospital at Night model locally. She will also work with the Nerve Centre team on the implementation of the Hospital at Night Task Management module.
- DNACPR: sustained improvement in DNACPR compliance has been noted.
- National Frailty Network: will commence in January 2016
- Coding: Progress is being made in a number of areas. Staffing levels remain an issue with recruitment of qualified coders a problem despite rolling adverts.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

11/12/15 **WELL LED ORGANISATION**

11.1 Report from the Well Led Organisation Group

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The Deputy Director of Workforce and Organisation Development informed the Committee that the first meeting of the Colleague Engagement, Health and Wellbeing Group will be held in January 2016. The group will receive feedback data from the Staff Survey and formal feedback on Investors in People (IIP). The minutes from the group will be received regularly by the Quality Committee going forward.

OUTCOME: The Committee **NOTED** the verbal update.

12/12/15 **CARING**

12.1 Report from the Patient Experience and Caring Group
The Assistant Director of Quality presented the report from the Patient Experience and Caring Group. The following highlights were noted from the report;
- PPI/Engagement framework: Development work is ongoing and being led by Ruth Mason, Associate Director for Engagement & Inclusion. The work will act as a good platform upon which a PPI Strategy will be developed.
- FFT: The group supported the proposed changes to the target as the target is consistently being missed.
Patient Information: Further assurance from the Patient Information task and finish group has been requested regarding the turnaround time for translated information.
Divisional reports: the group has received reports from the FSS Division and Community Division. Innovative work being undertaken by FSS Division. The Divisional reports will be emailed to Committee members for information.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

13/12/15 **HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE**

13.1 Update from the Health and Safety Group
The Director for Planning, Performance Estates and Facilities reported the last meeting of the Health and Safety Group was cancelled as there was no Union, Surgical or Medical Division representatives in attendance. The importance of the group was highlighted and attendance should be made priority.

- A second Environment Agency Inspection was carried out in October 2015 to review progress following their visit earlier in the year. Actions from this visit are being addressed.
- Bags to bed initiative in place and it is hoped it will help segregate waste from more toxic waste that can otherwise be costly for the Trust.
- Sharps injuries: being reviewed by the Needle-stick group.
- Moving and Handling: lack of resource in moving and handling training was noted. All staff need to undertake the training via e-learning.
- Medical Devices training: uptake of training is low for both the Medical and Surgical Divisions
- Fire Safety Awareness: figures improving, but still need to remind staff to read the booklet.

OUTCOME: The Committee **NOTED** the verbal update.

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14/12/15 **MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS BY THE COMMITTEE CHAIR:**

- NICE Compliance
- Update on CQC preparation
- Serious Incident Review Group: The Committee approved the Terms of Reference
- Well Led: Link between Well Led and Health Being Group.

15/12/15 **ITEMS TO NOTE**

15.1 QUALITY COMMITTEE WORK PLAN
The Committee **RECEIVED** the Quality Committee Work Plan for 2015/16 for information.

16/12/15 **ANY OTHER BUSINESS**

Finance Director Representation at the Committee: It was noted that the Finance Director had not attended a number of meetings and the Committee were asked to consider whether his attendance was necessary or whether a Deputy could be invited to attend on his behalf.
OUTCOME: The Committee agreed a Deputy could be invited to attend and the Committee secretary would send out an invite.

Quality Account: will be received in Q4 (2015/16) as part of the Quality Report. Clinical Effectiveness will also be included in one end of year document.

17/12/15 **DATE AND TIME OF NEXT MEETING**

Tuesday 26 January 2016
2pm – 5pm
Discussion Room 2, L&D Centre, HRI

DATE MINUTES APPROVED:

DRAFT

Minutes of the Finance & Performance Committee held on Tuesday 15 December 2015 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships (In part)
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance and Esates & Facilities
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Stuart Baron	Assistant Director of Finance
Brian Moore	Membership Councillor
Betty Sewell	PA (Minutes)

ITEM

259/15 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed attendees.

It was noted that as only one Non-Executive Director was present, the meeting was not quorate and business would be conducted on that basis.

260/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead, Executive Medical Director
Mandy Griffin, Acting Director of Health Informatics Services
Andrew Haigh, Chair
Linda Patterson, Non-Executive Director
Jeremy Pease, Non-Executive Director
Victoria Pickles, Company Secretary
Peter Roberts, Non-Executive Director
Jan Wilson, Non-Executive Director

261/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

262/15 MINUTES OF THE MEETINGS HELD 17 NOVEMBER 2015

The minutes were approved as a correct record.

263/15 ACTION LOG AND MATTERS ARISING

Action Log

193/08/15 – Treasury/National Audit paper to be recirculated.

72/02/15 – CNST/NHS LA – The Director of Finance reported that we have written to NHS LA but have not received a formal response. Discussions took place with regard to the position of other trusts and the fact that the impact of CNST is having an effect on their financial position. The question with regard to the number of

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complaints to help reduce payments was discussed it was acknowledged that there was an overlap but the complaints received are not in the main the reason for claims. It was noted that one high risk area is in A&E when fractures are missed and this is an area where more work is required. Further information was requested and it was agreed that the issue of complaints and claims would be discussed at Quality Committee.

ACTION: To provide information with regard to the action we are taking to minimise claims going forward, how we are benchmarked against other NHS organisations and what are the key themes and learnings. - **JD**

193/08/15 – Theatre Productivity - A further update – The Executive Director of PP&EF informed the forum that activity and income is rising and there are a reduced number of lists running due to vacancies. Theatre Action Week went well involving staff from across the Trust and as a result there is an action plan being rolled out. The project team are still meeting but there will be a change to the structure of the meeting in the new year.

In terms of theatre upgrades, Theatre 3 is now complete and is due to re-open which will mean we will have 3 laminar flow theatres, however, they will not all be used as laminar flow theatres at the moment. Over Christmas all 6 theatres will be available, however, over the holiday period there will be reduced activity due to patients not wishing to undergo treatment before Christmas and the New Year.

Discussions took place with regard to the introduction of 4 hour theatre sessions and it was acknowledged that staff do work 4 hours at the moment due to the time spent with patients prior to the start of operations. Work is starting to change the working time from 8am – 12.30pm to 9am – 1pm and job plans will be required to be re-worked to accommodate this change. The Four Eyes work is showing that we need to do more outpatient work in certain specialties to balance work out, therefore, some specialties need a review of job plans.

Lesley Hill went on to describe a situation on the Choose & Book system with regard to Orthopaedics which had come to light. It seems that this is only available to local GPs and we need to 'switch on' the option for anyone to be able to refer in. Discussions took place as to how this came about and Lesley was asked to investigate the issue.

ACTION: To update the next meeting with regard to the Choose & Book system for Orthopaedics and to review the implications with regard to capacity if this is 'switched on' - **LH**

All other items were included on the agenda.

FINANCE AND PERFORMANCE

264 to 267/15 **MONTH 8 PERFORMANCE SUMMARY REPORT**

In the absence of the Director of Transformation and Partnerships the Director of Finance reported on the financials with reference to the activity.

It was noted that November had been a good month particularly in terms of

outpatient activity and ended the month slightly ahead of plan. Spend on capacity issues were reduced in month and a question around medical agency spend is being investigated but at the end of November we are reporting a £300k improvement against forecast, due to winter risks only £100k has been moved into the year-end positon which will allow some movement to deal with the unexpected.

The Director of Transformation & Partnerships joined the meeting.

In terms of the year-end position the Director of Finance highlighted a conversation which took place with CCGs where they confirmed that they would contribute £1.2m to help with the financial implications required to deal with resilience. We have agreed to spend £200k out of the £1.2m on further initiatives to help with resilience over winter, which means that £1m has gone to the bottom line, this is included in the re-forecast. To re-cap the year-end position, the Director of Finance confirmed that the trading deficit was £22m, with the £1m from the CCG and the £100k we are still £900k, in trading terms, away from the planned deficit of £20m. We are still in discussions with Monitor with regard to the capital revenue transfer and if this was approved it would bring us back to plan. It was noted that conversations are still taking place with Monitor with regard to the EY restructuring costs and formal ratification is still required.

It was also confirmed that we are still holding a in reserve for income challenges, the Commissioners have picked up with regard to several areas and this is still a live issue. It was noted that challenges from the Commissioners are retrospective for the whole year and the challenge process was discussed.

In terms of Cash, we are ahead by approx. £800k but behind with Capital which is contributing to this position. With regard to the year-end outturn we still require £12.9m in cash.

Discussions turned to the January PRM which is due to take place on 6 January and the planning of the narrative for that meeting with regard to outpatient and elective activity noting that Christmas will be difficult and will have implications. Following discussions it was noted that admissions were up in Calderdale and down in Huddersfield and it was agreed that the Executive Director of Nursing would arrange an internal check to look at drivers.

ACTION : To have a 'soft' look at the admission criteria at both sites – **JD**

The Chair of the Committee asked if we were on track to deliver CIP for 15/16 and the Chief Executive reported that the £17m had been discussed at the last Turnaround Executive, this had been RAG rated and TE are confident that this will be the position. With regard to 16/17 it was acknowledged that this will be a challenge and not to be too reliant on income will make CIP reduction much harder going forward.

The Chair also asked about the Month 8 sensitivity analysis and the best/worst case scenario, the Director of Finance explained that at month end, everything that is uncertain is reviewed and a value is allocated and it would be inappropriate not to do this. In terms of liabilities, they are a best judgment and we need to be mindful of

these issues when having conversations with Commissioners. These issues are discussed with ADFs as part of the Finance Senior Team regular meeting with in depth discussions taking place at month end. We are still on track to hit close to the £20m and by Month 9, we could have a feel for how the year may turn out. It was noted that Vanguard is still an area where things may change in a positive way.

The Chair of the Committee requested that in terms of workforce, it may be useful to incorporate headcount into financials with a separate report to this Committee. The biggest uncertainty for the organisation is workforce and this should be scrutinised specifically for recruitment retention, sickness etc. It was acknowledged that lots of organisations attempt good workforce planning without success but if anyone new of any systems that work they should be called out.

ACTION : Next month see the first draft and review over the next 3 months - **JD**

268/15 AGENCY SPEND – PERFORMANCE AGAINST CAP

The Director of Finance circulated a paper to give the Committee a position statement with regard to the Monitor agency pricing cap in advance of the next PRM with Monitor. The Assistant Director of Finance, Kirsty Archer, explained the background with regard to the paper stating that Monitor have introduced caps on the total amount trusts can pay per hour for agency workers across all staff groups. In addition to the price caps, nursing agency usage is subject to further scrutiny and the Trust is required to report to Monitor on the following measures:

- Value of spend on qualified nursing agency staff as a percentage of overall qualified nursing spend. This is measured against a threshold for CHFT at 5%
- Number of nursing shifts booked through non-framework agencies
- Number of shifts in breach of the price cap

The current position for the Trust has been 383 shift breaches w/c 23 November and 371 shift breaches w/c 30 November, this was a cost over and above the cap of over £57k for the first week. The Committee were asked to note that the Medical staffing cap is still allowing us to spend 150% more than a substantive and that we are breaching the cap but the cap is very high. We are working pro-actively with agencies to try to bring fees down, and more work is taking place with regard to the extra controls and procedures that are being rolled out especially across medical staffing.

The weekly reporting process to Monitor has highlighted that our processors around nursing are working well but the processors around other groups are disparate and there is learning from this, it is also important that we do not take it purely as an exercise for Monitor but to use it for our own purposes and improvements.

It was agreed that this information should continue to be presented to this Committee over the next few months and would be incorporated into the Financial report.

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STRATEGIC ITEMS

269/27015 - TURNAROUND PROGRAMME UPDATE & CIP SCHEME POSITION

The Chief Executive reported that we are where we need to be at year-ending 15/16 and are reasonably confident we can deliver. In terms of cost improvement planning we are still between £13m to £14m of which £11m is identified as Red rated in terms of Gateway levels. EY held a joint session with the Trust looking at the divisional approach and testing the divisional position and then looked at the Executive process, all Executives have each been given a task to look at a set of schemes which EY have benchmarked and these will be reviewed with each Division.

With regard to 16/17 there is still work to do to find an additional £10m to £12m over the next few months to hopefully achieve £16m.

In terms of the Strategic Plan it was noted that we are on track and discussions followed with regard to the content and presentation of information for Monitor's meeting with the Treasury and the DoH.

The Director of Transformation & Partnerships highlighted that the additional costs for the Urgent Care Centre medical staffing was still an area for potential negotiation with Commissions regarding where this sits within the modelling.

It was confirmed that a Draft copy of the Strategic Plan will be available this evening.

271/15 LORD CARTER EFFICIENCY SAVINGS

The Director of Finance explained that since the previous meeting correspondence has been received from Lord Carter regarding potential savings, which is based upon data which came from our own reference costs submission. This exercise is being carried out nationally. Lord Carter and his team have analysed the data and compared against piers, they have provided savings targets which they believe organisations can achieve based the benchmark comparative.

The Director of Finance described for the Committee the differences between the reference costs and patient level costing (PLICS) costing mechanisms, and as we use PLICS which is more granular, data can be distorted.

The headline from Lord Carter's findings is suggesting that this Trust has a potential savings opportunity of £30m compared to the average trust. We were asked to analyse the data and complete a complex questionnaire to give our feedback.

The next steps will be to look at this information with PMO, looking at variation of care and PFI. In our response we will highlight where we feel there are differences between ourselves and other trusts and indicate that we are prepared to take this to the next stage internally to look at opportunities and possible CIP.

As regards national funding to restate trusts into financial balance, it was noted that there is £1.8bn which could potentially be allocated to trusts, and it is likely this money could be shared on a population basis, but additional caveats will be linked to Lord Carter's work to access this money.

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In addition, it was acknowledged that Lord Carter had reviewed procurement, and for CHFT non-pay spend going through electronic catalogue against the number of requisitions showed a disparate set of people who can place orders. It was noted that there has been focus since Inverto where with us and we have a better view of spend that doesn't go through iProc, we still have further work to go with conversations taking place at Cash Committee.

ACTION : To review with PMO to triangulate opportunities.

272/15 2016/17 TARIFF/EFFICIENCY EXPECTATIONS

The Director of Finance referenced the paper for information and update.

The 2016/17 Annual Planning Guidance is due to be issued prior to Christmas, with a draft national tariff prices due to be issued in early January 2016. These will then be subject to a period of consultation which is expected to be approximately 1 month with final tariff prices published in February 2016.

273/15 5 YEAR STRATEGIC PLAN (CONFIDENTIAL)

The Committee noted the Draft 5 Year Strategic Plan.

274/15 EPR UPDATE

The Assistant Director of Finance, Stuart Baron, reported that the key milestones have been achieved within November, highlighting the Assurance Gateway Review. The report is still to be finalised, however, there are 4 key recommendations which came out of the governance review:

- Scoping document sign off
- Build a financial model to reflect the change of the 'go-live' date
- Recognition of contingency costs
- Review of benefits position

It was also noted that we are still currently forecasting an underspend on the capital perspective of the project.

It was acknowledged that the 4 recommendations were discussed at Board and when this re-surfaces on the joint governance agreement at the gateway review, there will be an action plan that sits along-side it and it will go back to the January Board.

It was also noted that discussions will take place at WEB regarding the EPR deployment to go live, in relation to workforce, estates and financials.

Monitor made reference to EPR when they last visited with regard to the potential impact on our income. It was suggested that we should include a general provision for loss of income for next year and to label it accurately as "loss of clinical income due to EPR implementation".

It was acknowledged that we should not presume this will be a potential dip, because we will be asking staff to do things differently and not everyone will be comfortable with the transition.

As an aside, discussions took place regarding 16/17 Planning and it was agreed that the Budget timetable would be presented for the next meeting. The Director of Finance stated that the 16/17 Plan needed to be signed off at the February F&P.

TREASURY MANAGEMENT

275/15 CASH FLOW 13 WEEK FORECAST

The Director of Finance sighted the Committee to the report to provide assurance that the Trust has a tight regime but uncertainty and variance still remains within Capital and IM&T.

At the last Monitor visit Cash was reviewed and their feedback was positive and they left reassured. iProc was an area where tighter processes could be deployed and authorisation thresholds will be reviewed.

GOVERNANCE

276/15 BOARD ASSURANCE FRAMEWORK

The Director of Nursing presented a paper highlighting Risks for consideration by the Committee, Julie also requested that the Risk Register comes to future F&P Committee meetings in addition to the Board Assurance Framework.

The 3 main Financial risks for the Committee to consider are as follows:-

- CIP delivery for 15/16
- 2016/17 Financial Plans
- Inability to grow activity

Following discussions it was agreed that only the risks relevant to the F&P Committee should be tabled, also it was agreed that going forward, back up data needs to be provided to support any change to risk levels.

ACTION: Additional information requested along with clarification **– JD/VP**

Discussions then took place with regard to the OBC and it was agreed that during the consultation period we will develop for the Board an understanding of what an alternative plan will be assuming consultation takes place but does not get to a satisfactory conclusion and Owen Williams and Anna Basford will meet outside this forum.

ACTION: To identify alternative plans for the OBC – **OW/AB**

It was agreed that the F&P Chair will feedback to the Private Session to the Board.

277/15 WORKPLAN

The Board Assurance Framework and Risk Register were added to the Workplan to be tabled monthly.

278/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- OBC alternative plans
- Budget – February Board for sign off

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279/15 ANY OTHER BUSINESS

As the meeting was not quorate, the meeting was left open.

DATE AND TIME OF NEXT MEETING

Tuesday 26 January 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

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APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

HELD ON MONDAY 7 DECEMBER 2015 AT 11.00 AM IN SYNDICATE ROOM 3, LEARNING CENTRE, CALDERDALE ROYAL HOSPITAL

PRESENT: **Mr Andrew Haigh (Chairman)**
Mrs Eileen Hamer, Staff Elected Member
Mr Peter Middleton, Publicly Elected Member
Mr Brian Moore, Publicly Elected Member
Mr Brian Richardson, Publicly Elected Member
Mrs Dawn Stephenson, Nominated Stakeholder
Mrs Di Wharmby, Publicly Elected Member

IN ATTENDANCE:
Miss Kathy Bray, Board Secretary

1. APOLOGIES

Apologies were received from:-
Rev. Wayne Clarke, Publicly Elected Member
Mr Owen Williams, Chief Executive

The Chairman reported that this was the first combined Nomination and Remuneration Committee (Membership Council) and the main business of the meeting was to agree the recruitment of two Non-Executive Directors and Non-Executive remuneration.

2. MINUTES OF THE LAST MEETING

The minutes of the last Remuneration Committee (Non Executive Directors) meeting held on the 27 January 2015 were accepted as a correct record.

3. MATTERS ARISING

Proposal for Finance & Performance Committee Chair – item 7
It was noted that no further action had been taken regarding the Sub Committee Chairs producing a Summary on a Page, feeding back on their performance, activity and difference they had made throughout the year. It was noted that as part of the Well Led/Good Governance work the Company Secretary was aiming to generally review the feedback to the Board from the Sub-Committees in the future.

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Dawn Stephenson reported that a similar report is produced for the Board of Directors in SWYPFT and this would be shared for information with Victoria Pickles, Company Secretary. The Chairman reported that once this is in place, the summaries could be used as part of the Non-Executive Directors appraisal process, although he already took performance of Chairs on Board Sub Committees into account.

ACTION: Dawn Stephenson

4. TERMS OF REFERENCE

The Chairman reported that the Terms of Reference for the Nominations and Remuneration Committee had been approved by the Board of Directors and the Membership Council, following amendments to the Chairing arrangements for the Committee.

Eileen Hamer reported that on the previous Remuneration Committee the composition of the Committee was '6 members – at least 1 to be staff elected'. Discussion took place regarding whether it could limit the options of the Committee by amending the Terms of Reference to reflect this. It was felt that this was particularly relevant at the current time with a number of staff vacancies on the Membership Council and the Terms of Reference should remain unchanged.

It was noted that the quorum for this Committee was 3 members.

The Chairman suggested that, if possible, both public and staff members be included on the interview panels for the Non Executive Director appointments.

RESOLVED: The Committee approved the revised Terms of Reference

5. DECLARATIONS OF INTEREST/ELIGIBILITY TO SERVE

There were no declarations of interest to note.

All present completed their declaration of eligibility to serve on the Committee and these were duly handed to the Board Secretary. It was agreed that the Board Secretary would remind Rev Wayne Clarke to return his completed declaration before the next meeting.

ACTION: KB

6. DISCUSSION SESSION

The Chairman reported that two Non Executive Director appointments would be sought – one to support the decision of the Nominations and Remuneration Committee (Board of Directors) to appoint an Executive Chief Operation Officer and one in place of Jeremy Pease, Non-Executive Director who had tendered his resignation due to time commitments. It

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had been agreed he would continue in post until a successor had been appointed.

The Chairman also advised the Committee that Dr Linda Patterson had advised him that she been asked to undertake a 6 month contract in Australia and would be unavailable from January to August 2016. The Committee acknowledged the benefits of having Dr Patterson on the Board with the medical background she was able to offer. Arrangements would therefore be made for the advertisement to include the fact that the Trust would welcome interest from any candidates with a solid understanding of acute care provision and the new collaborative context we are facing. The Committee agreed that the position would therefore be reviewed once the appointments process had been completed.

Peter Middleton and other members of the committee expressed concern that under the current economic climate the Trust should not be looking to increase the number of top level managers and asked whether there was any benchmarking information available. The Chairman advised that recent reviews undertaken by PWC, Ernest & Young and Monitor had identified that the Trust has a capacity issue at senior level to deliver the forthcoming initiatives and agendas. The Board had therefore agreed the appointment of a Chief Operating Officer as an Executive Director. As a result, in order to meet the Trust's Constitution requirement of having a majority of Non-Executive posts on the Board this had necessitated the request for the Membership Council to appoint an additional Non-Executive Director.

6.1.1 Non-Executive Tenures

The Committee received the details of the current Non-Executive Directors, their tenures and remuneration and these were noted.

6.1.2 Skills and Competencies Assessment

The Chairman advised that the Skills and Competencies Assessment had been completed by each Board member and a composite, anonymous version had been collated for the Board and Membership Council, in order that the information could be used to identify the skills sets required to replace future vacancies on the Board.

Brian Richardson asked whether this document was interrogated and it was agreed that the Board Secretary would share individual Non Executive-Directors assessments with the Chairman in order that it could form part of the appraisal process and interrogated if required.

ACTION: BOARD SECRETARY/CHAIRMAN

6.1.3 Suggested Timetable

The Chairman advised that an external third party had been engaged to help the Committee with the appointments process. Market testing of this

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role was to be undertaken in the future but currently this service had been commissioned from Odgers Berndtson.

The proposed timetable was noted and Members were asked to schedule the longlisting and shortlisting dates in their diaries. (Tuesday 19.1.16 at 11.00 am and Tuesday 9.2.16 at 11.00 am – both meetings to be held in the Chairman's Office, Trust Offices, HRI).
It was agreed that the interview panel would be decided at a later date, dependent on Committee members availability.

ACTION: ALL (Apologies from Peter Middleton)

6.1.4 Draft Candidate Pack

The contents of the draft Candidate Pack were received and noted. It was agreed that the skills set required for the two posts would include Commercial Focus and Workforce and Organisational Development. As discussed earlier in the meeting it was noted that interest from candidates with a solid understanding of acute care provision would be welcomed. The Chairman also commented that interest from applicants with a legal position would not be ruled out.

RESOLVED: The Committee agreed that although it would be challenging for the Membership Council to defend the additional appointments in the current financial climate, it was agreed that the recommendations made by the Board were reasonable and the process should progress.

7. REMUNERATION

At this point in the meeting the Chairman declared an interest and left the meeting.

Peter Middleton agreed to take on the role of Acting Chairman.

The paper prepared by the Company Secretary was received and noted. This included benchmarking information against other Foundation Trusts. The paper proposed that in line with the pay of the broader workforce, the Non-Executive Director basic remuneration be maintained at current levels with no pay uplift.

The Committee agreed with this proposal and noted that the previous Remuneration Committee had agreed the allowances for the Sub Committee Chair allowances and these were not subject to inflation.

RESOLVED: The Committee unanimously agreed the proposal to maintain Non-Executive basic remuneration at current levels with no pay uplift.

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The Chairman returned to the meeting.

8. ANY OTHER BUSINESS

There was no other business to note.

9. DATE AND TIME OF NEXT MEETING

Longlisting Meeting - Tuesday 19.1.16 at 11.00 am to be held in the Chairman's Office, Trust Offices, HRI.

Shortlisting Meeting - Tuesday 9.2.16 at 11.00 am to be held in the Chairman's Office, Trust Offices, HRI.

Interviews – to be confirmed ? w/c 15.2.16
(**Apologies both meetings**:- Mr Peter Middleton)

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