Table of Contents

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

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

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Rosemary Hedges, Publicly Elected MC Peter Middleton, Publicly Elected MC David Longstaff, Nominated Stakeholder MC	Chair	**VERBAL**	**Note**
2	**Apologies for absence:**	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Receive**
4	**Minutes of the previous meeting** held on 31 March 2016	Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log**	Chair	**APP B**	**Review**
6	**Staff Story – Improvement Ward Update** Presented by Sister Rachel Garside and Matron Catherine Briggs		**VERBAL**	**Receive**
7	**Chairman's Report** a. Membership Council Meeting – 7.4.16	Chair	**VERBAL**	**Receive**
8	**Chief Executive's Report:** a. Board Appointments Update	Chief Executive	**VERBAL**	**Receive**
Transforming and improving patient care				
9	Consultation Process - Update	Director of Transformation and Partnerships	**VERBAL**	**Receive**
Keeping the base safe				
10	Risk Register	Acting Director of Nursing	**APP C**	**Approve**
11	Care of the Acutely Ill Patient	Executive Medical Director	**APP D**	**Approve**
12	Safeguarding Update – Adults and Children – Annual Report	Acting Director of Nursing	**APP E**	**Approve**
13	Review of Progress Against	Company Secretary	**APP F**	**Approve**

	Strategy			
14	Membership Council Election – Proposed Timetable	Company Secretary	**APP G**	**Approve**
15	Modern Slavery and Human Trafficking Statement for Annual Report	Company Secretary	**APP H**	**Approve**
16	Integrated Performance Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Monitor Indicators - Finance	Chief Operating Officer " Acting Director of Nursing Acting Director of Nursing Executive Medical Director Interim Director of Workforce & OD Executive Director of Finance " "	**APP I (TO FOLLOW)**	**Approve**
Financial Sustainability				
17	Month 12 – March 2016 – Financial Narrative	Executive Director of Finance	**APP J**	**Approve**
A workforce for the future				
18	Medical Re-validation	Executive Medical Director	**APP K**	**Approve**
19	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 29.3.16 and verbal update from meeting 26.4.16 ▪ Finance and Performance Committee – minutes of 29.3.16 and verbal update from meeting 26.4.16 ▪ Audit and Risk Committee – verbal update from meeting 20.4.16 ▪ Workforce (Well Led) Committee – verbal update from meeting 21.4.16		**APP L**	**Receive**
Date and time of next meeting Thursday 26 May 2016 commencing at 1.30 pm **Venue:** Boardroom, Sub Basement, Huddersfield Royal Infirmary				

Resolution

The Board resolves that representatives of the press and public be excluded from the meeting at this point on the grounds that the confidential nature of the business to be transacted means that publicity of the matters being reviewed would be prejudicial to public interest. *(Section 1(2) Public Bodies (Admission to Meetings Act 1960).*

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 31.3.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 31 March 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 minutes of the last Public Board of Directors Meeting held on Thursday 31 March 2016.

Main Body

Purpose:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 31 March 2016.

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 31 March 2016.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 31 3 16.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on
Thursday 31 March 2016 in the Boardroom, Sub-basement, Huddersfield Royal Infirmary HD3 3EA

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing /Deputy Chief Executive
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Richard Hopkin	Non-Executive Director
Jeremy Pease	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director
Owen Williams	Chief Executive

IN ATTENDANCE/OBSERVERS

Anna Basford	Director of Transformation and Partnerships
Gary Boothby	Deputy Director of Finance
Kathy Bray	Board Secretary
Jackie Green	Interim Director of Workforce and OD
Caroline Wright	Communications Manager
David Himelfield	Huddersfield Examiner Reporter
Grenville Horsfall	Membership Councillor
Lynn Moore	Membership Councillor
George Richardson	Membership Councillor

Item

39/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting and in particular Karen Heaton and Richard Hopkin, newly appointment Non-Executive Directors.

40/16 APOLOGIES FOR ABSENCE

Apologies were received from:

Keith Griffiths	Executive Director of Finance
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Victoria Pickles	Company Secretary

41/16 DECLARATION OF INTERESTS

There were no declarations of interest to note.

42/16 MINUTES OF THE MEETING HELD ON THURSDAY 25 FEBRUARY 2016

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

43/16 MATTERS ARISING FROM THE MINUTES/ACTION LOG

CAIP – MORTALITY REVIEW – The Medical Director reported that he was awaiting further contact from Professor Mohammed with a view to him presenting his review again to the Board and also to the Membership Councillors.
STATUS: Open

177/15 – BOARD ASSURANCE FRAMEWORK (BAF) – MORTALITY - It was noted that the wording in the BAF and Risk Register had been amended.
STATUS: Closed

180/15 – PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT – It was noted that this item would be brought back to the Board again in July.
STATUS: **Open – July 2016**

202/15 – IBR – WELL-LED – SICKNESS POLICY – The Interim Director of Workforce and Organisational Development reported that the new policy had been in operation in the Trust since November and arrangements had been made to include sickness within the full Integrated Board Report.
STATUS: Closed

10/16 – CALDERDALE SUPPORT AND INDEPENDENCE TEAM – The Chief Operating Officer confirmed that the enablement staff were employed by the Local Authority and deployed under one of the Trust managers on appointment. Both deployment and line management responsibilities were being recommended to move back but it was not certain whether this had been progressed and further work was underway.
ACTION: Chief Operating Officer
STATUS: Open

12/16 – RISK REGISTER – HEATMAP CHANGES – The Executive Director of Nursing reported that due to a misunderstanding further work was required on the heatmap.
ACTION: Executive Director of Nursing/Risk Team
STATUS: Open

24/16 – CLINICAL RESEARCH – CLINICAL EXCELLENCE AWARDS – The Executive Medical Director reported that consideration would be given to increasing the weighting within the Clinical Excellence Awards the following year.
STATUS: Closed

22/16 – GO SEE – TYNE AND WEAR – END OF LIFE CARE – Professor Peter Roberts reported that Jan Potts and he had made a visit on the 29 March and information from the session would be circulated to the Board. Outside the meeting further discussions would take place with the Chief Operating Officer regarding the format of the Integrated Performance Report.
STATUS: Closed

44/16 CHAIRMAN'S REPORT

a. BOARD TO BOARD MEETING WITH MID YORKSHIRE TRUST – 21.3.16
The Chairman updated the Board on the discussions held which included:-

- Memorandum of Understanding – agreed.
- Winter Pressure – significantly affected both Trusts recently.
- Joint Initiatives:- Assisted conception – work ongoing
  - Radiology – shared work ongoing
  - Sharing of cost improvement ideas
  - Delays in joint working on Microbiology and Pathology – technical issues noted
  - Estates updates
  - Clinical strategies

b. NHS PROVIDERS CHAIR AND CE MEETING – 17.3.16
The Chairman updated the Board on the discussion held at the NHS Providers Chair/Chief Executive Meeting held on 17.3.16. He explained that Chris Hopkins, Chief Executive of NHS Providers, had shared his view on the state of the nation (slides were available) which included Sustainability and Transformation Plans, the NHS financial position, the Junior Doctors contract and regulation.

Jim McKay, Chief Executive of NHS Improvement had given a presentation at the meeting. The key messages included:-

- Trusts were encouraged to push back at regulators where they are unhappy and proposed actions were not in the interests of the Trust.
- A/E attendances had risen by 20% across the country with no clear reason for the increase.
- Plea for Trusts to work together and keep their nerve around agency spend.
- This was a people business and the key issue was looking after our people.
- A workforce race equality presentation was received.

b. CHAIRS INFORMATION EXCHANGE – Intermediate Care Facilities - The Chairman reported that at the Membership Councillors Chairs Information Exchange held on the 21 March the Membership Councillors present had discussed Intermediate Care Facilities and enquired whether the Trust would be looking at opportunities to develop this area.

The Chairman reported that this had been raised with the Chief Operating Officer and the PMO team had been asked to look into this further.

Prof Roberts advised that around 15 Trusts were enabled in similar models of care which provided equal standards of care with cost reductions being realised.

Jeremy Pease emphasised the need to consider the patient needs first and the services be wrapped around those needs.

ACTION: Chief Operating Officer/Director of Transformation and Partnerships

45/16 CHIEF EXECUTIVE'S REPORT

a. BOARD APPOINTMENTS UPDATE – The Chief Executive reported that the Trust had recently made an offer of employment for the post of Executive Director of Workforce and Organisation Development. This had been accepted and will be formally announced once a start date has been agreed.

The search for a successor for the post of Executive Director of Nursing was underway with formal interviews scheduled for 20 April 2016.

Further information would be provided to the Board in due course.
ACTION: Chief Executive

b. CQC INSPECTION UPDATE – The Chief Executive reported that the CQC Inspection Team had undertaken a visit within the Trust over the period 8-11 March 2016 and it was expected that the outcome of the process would be fedback to the Trust in approximately 8 weeks' time. It was noted that initial feedback received had indicated that they had identified some good examples of practice within the Trust, together with some areas which could be addressed. Staff had reported that this had been a good experience.

46/16 CONSULTATION PROCESS - UPDATE

The Director of Transformation and Partnerships advised that the Commissioners had now launched the Consultation Process with effect from 15 March 2016 and this had now negated the need for the Trust to express concern regarding the delay in the launch. Public consultation events had now been arranged and published and questionnaires were available on line or at public events.

Discussion took place regarding the varied response from the residents of Kirklees and Calderdale and Lynn Moore enquired whether the information had been circulated widely enough. It was noted that the Commissioners had undertaken significant communications and engagement work across all areas of both Calderdale and Huddersfield, including publicizing the consultation in the local media. This would continue throughout the consultation period.

Dr Anderson reported that he had been invited as a GP representative to two of the engagement events.

OUTCOME: The Board noted the progress with the Consultation.

47/16 RISK REGISTER

The Executive Director of Nursing reported that the top risks (scored 15+) within the organisation remained the same as the previous month. The **top risks** were:-

Progression of service reconfiguration impact on quality and safety
Over-reliance on middle grade doctors in A&E
Failure to meet cost improvement programmes
Outlier on mortality levels
Staffing risk, nursing and medical
Delivery of Electronic Patient Record Programme
Patient flow

Risks with increased score:-
The Board noted that the revised patient flow risk, risk 6658 (new reference) has increased from a previous score of 16 to 20.

Risks With Reduced Score
The risk related to capacity and capability of delivering service transformation had been reviewed at the Risk and Compliance Group on 15 March.
The score had been reduced to 12 in light of the CQC visit having taken place and confidence in deliverability of key transformation schemes following a mapping of milestones.

New Risks
New risks proposed for addition to the Corporate Risk Register in March 2016 were:

- 6658: replaces 2828 - Inefficient patient flow
- 6665: replaces 6507 – delays to patient communication due to voice recognition software functionality
- 6693: lack of compliance with Monitor cap rules
- 6694: Divisional governance arrangements

OUTCOME: The Board received and approved the Risk Register report.

Richard Hopkin requested clarification on the increased scoring for patient flow. It was recognised that due to the increased number of A/E attendances and admissions, along with increased lengths of stay, this had resulted in outliers within the Trust. It was expected that the risk may reduce next month as the number of 'open' beds was reduced.

48/16 GOVERNANCE REPORT

In the absence of the Company Secretary the Executive Director of Nursing delivered the Governance Report.

It was noted that this report brought together a number of items that evidenced or strengthened the corporate governance arrangements and systems of internal control within the Trust. The issues brought to the Board's attention were:-

1. Board of Directors attendance register

The Board were asked to identify any amendments required to the Attendance Register prior to publication of the Annual Report and Accounts.

OUTCOME: The Board noted the attendance register and no amendments were identified.

2. Board of Directors Declaration of Interest Register

Board members were asked to confirm that their entry on the Register was correct before publication on the Trust website. All present agreed their entries with the exception of Dr David Anderson who reported that his entry required amending and would submit this to the Company/Board Secretary.

ACTION: DA to resubmit entry to the Company/Board Secretary.

3. Q3 2015-16 submission feedback from Monitor

The Board received and noted the feedback from Monitor regarding the Q3 submission

4. Update on appointments to the Board.

The Board noted the contents of the update which included the recent appointments of two Non Executive Directors – Karen Heaton and Richard Hopkin with effect from 1 March 2016. In addition, recruitment had taken place for the executive posts. As reported by the Chief Executive the interviews for the Director of Workforce and Organisational Development had been held on Friday 18 March and an offer had been accepted. Interviews for the Director of Nursing were scheduled for Wednesday 20 April.

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

5. Board Work Plan

The Board work plan had been updated and presented to the Board for review and amendment. No amendments were requested.

6. Board Meeting Dates 2017

The suggested dates for the Board of Directors meetings for January to June 2017 had been circulated.

OUTCOME: The Board approved the Board of Directors meeting dates for January to June 2017.

7. Code of Conduct for Operational PFI-PP Contracts

The Director of Planning, Performance, Estates and Facilities advised the Board that the Department of Health had encouraged Trusts to sign up to a voluntary code of conduct which sets out the basis on which public and private sector partners agree to work together to make savings in operational Public Private Partnership (PPP) contracts. The Board noted and agreed the contents of the code and noted that the launch of the code formed part of the government's wider work on reducing the cost of PFI deals under the Operational Savings programme

OUTCOME: The Board approved to sign up to the code as it represented best practice.

49/16 WELL-LED GOVERANCE REVIEW – UPDATE ON ACTION PLAN

The Chairman presented the updated Action Plan and reported that this had been shared with Monitor at the last PRM Meeting. It was noted that work had now been undertaken to address the following areas:-

- **Risk management:** Additional capacity to work with divisions on the quality of risk registers and embedding the risk culture: Further work was done as part of our preparation for our Care Quality Commission inspection to thoroughly review all divisional and corporate risk registers. A need for more risk management training was identified and this is being delivered across the Trust and will be complete in May. In addition, a session on risk appetite will be included in the Board development programme for 2016/17

- **Clinical leadership:**. Finalising the structure and the development arrangements: This work remains outstanding although some progress had been made.

- **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. The current board development programme completed in March and the learning from this as well as items picked up through the Well Led Governance Review and the recent CQC inspection will be built into the plan for 2016/17. This will be further considered by the new Director of Workforce and Organisational Development once they are in post.

In addition to these areas there were a further two areas to focus on over the next two months:

- **Data quality**: As part of the Board development programme for 2016.17 there will be a session on understanding data quality. In addition the revised Integrated Board Report and Quality Reporting formats will include a data quality mark. These are both due to come to the Board in May / June.
- **Multiprofessional leadership**: The revised education and training arrangements are due to be implemented from April.

OUTCOME: The Board received and agreed the updates to the Well Led Governance Review Action

50/16 END OF LIFE STRATEGY

The Executive Director of Nursing presented the End of Life Strategy which had been prepared by the End of Life Group which pulled all the strands of end of life together and built on the work already undertaken in the Trust.

The Board received the strategy and noted the key aims of the strategy:
• Improve the quality of end of life care
• Improve access to end of life services
• Increase the number of people who are cared for and die in their preferred place

The Executive Director of Nursing advised that a National Audit had been undertaken and some areas had been identified which may require amendment within the strategy

Jan Wilson requested that the strategy be more specific in relation to communications with families.

OUTCOME: The Board approved the End of Life Strategy subject to any amendments recommended by the National Audit and the inclusion of communications with relatives.

Professor Peter Roberts advised the Board that Jan Potts, Head of Unplanned Services and he had visited Homegroup on Tyne and Wear. Homegroup had shared their best practice in developing End of Life Care and expressed a willingness to work with the Trust, particularly Calderdale Community Services, in moving this forward. Prof Roberts agreed to circulate the information obtained and offered his services to the Board to continue to work on this issue if a Non-Executive Director lead was required.

51/16 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief Operating Officer introduced the Integrated Board Report as at 29 February 2016 and explained that key areas would be presented in detail by the appropriate Executive leads. It was noted that this was a shortened version to that circulated to the Quality Committee and Finance and Performance Committee.

It was noted that the February IPR report shows a mixed picture with continued deterioration in patient flow related metrics. The areas of specific note were:

Responsiveness

• Emergency Care Standard failed for the month and Quarter 4. It was noted that this was a national position. Internal issues around flow and decision making were underway. Increased pressure on both hospital and GP services was noted.
• 6 week diagnostics recovered in February
• RTT and cancer achieved with the exception of D38 where revised actions plans are in development
• DTOC improved but green X numbers remain high
• There was one 28day breach relating to critical care access
• 100% of patients requiring thrombolysis for stroke received this within 1hr.

Caring

• Some patients are not able to die in their preferred place
• Complaints performance continues to require focus. The Executive Director of Nursing identified that the quality of complaints responses had improved and there had been an improved performance in the management of complaints with the lowest number of backlog complaints for two years.
• Some maternity patients continue to report feeling left alone during labour

Effectiveness

• C Difficile was worse than target in February
• Mortality remains a concern and is the focus of significant work
• #NoF performance in relation to Theatre within 36 hours remains slightly worse than the required standard
• Emergency readmissions have increased and will be reviewed as part of Patient flow action plan

Safety

• There had been an increase in falls with harm – further work was underway looking at the RCA to identify whether any could have been avoidable.
• The Executive Director reported that a further Never Event had been reported in February. Both Never Events related to retained swabs in maternity and these were being investigated. No detrimental harm had come to the patients involved.
• Duty of Candour has deteriorated in month

Well led

• 4 of 8 staff groups have a sickness level worse than Trust target.
• Only 2 out of 7 Divisional groups have achieved their appraisal plan. Focus continues within the Trust.

• Prevent training continues to be under trajectory. This was a classroom based training course.
• Hard Truths for qualified day shifts was amber for the month.

Karen Heaton enquired whether costs for sickness were monitored by the Trust and Director of Planning, Performance Estates and Facilities advised that this is available to Divisions at the Finance and Performance Divisional Meetings.

CQUINs
Sepsis and Acute Kidney Injury CQUINs remain a challenge to deliver.

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

53/16 MONTH 11 – FEBRUARY 2016 FINANCIAL NARRATIVE

The Deputy Director of Finance presented the finance month 11 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 29 March 2016:-

The key issues included:-

Summary Year to Date:

- The overall deficit (excluding restructuring costs) is £19.81m versus a planned
- deficit of £18.96m.
- The overall deficit is £20.91m against the planned £21.96m, due to restructuring costs not being incurred.
- A&E and Non Elective activity were above plan in month, planned activity further behind plan due to capacity driven cancellations.
- High pay expenditure continues including significant agency expenditure, some of which is above the Monitor price cap.
- Capital expenditure year to date is £15.81m against the planned £19.35m due to timing differences mainly on IT spend.
- Cash balance is £5.98m against a planned £1.90m, due predominantly to securing cash payments in advance for clinical activity.
- CIP schemes delivered £16.18m in the year to date against a planned target of £12.51m.
- 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 £20.61m, against an adverse variance of £0.60m. This position includes full release of remaining contingency reserves and delivery of £17.77m CIP against the original planned £14m
- This is an improvement compared with the M10 forecast due to clinical income generation being higher than anticipated through non elective volume and elective case mix. A year end settlement has been reached with the main commissioners which brings greater security to the forecast.
- The overall forecast deficit position shows a favourable variance of £2.00m from plan driven by a reduction in forecast restructuring costs and exceptional non cash income relating to the Joint Venture. Reliance on external cash support remains as per last month at £12.90m.
- Forecast Capital expenditure is below plan by £0.67m. The year end FSRR is forecast to be at level 2 as planned.

OUTCOME: The Board received and approved the financial narrative for February 2016.

54/16 CAPITAL PROGRAMME

The Deputy Director of Finance presented the Capital Programme. It was noted that this paper outlined the anticipated capital forecast for 2015/16 as well as the process undertaken to prioritise the capital plan for 2016/17. The Board noted the contents of the report and approved the proposed capital plan for 2016/17.

OUTCOME: The Board received and approved the proposed Capital Programme for 2016/17

55/16 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

a. Quality Committee – The Board received and noted the minutes from the meeting held on 23 February 2016 and verbal update from meeting held on 29 March 2016 was received from Jeremy Pease. Matters arising from the March meeting included:-

- Hospital Mortality
- Integrated Peformance Report
- Serious Untoward Incidents
- Safety – Never Events
- CQC Inspection Feedback
- Quality Accounts – being developed
- Report on safeguarding – Mandatory Training improving.

b. **Finance and Performance Committee** – minutes of the meeting held on 23 February 2016 were received and noted and a verbal update from the meeting held on the 29 March 2016 was received from Jan Wilson.
Matters arising in the February meeting included:-

- Carter Review and bed planning
- EPR update
- Bank and agency spend
- Sustainability and Transformation Fund monies.
- Monitor control challenge
- CIP

c. Workforce (Well Led) Committee – The minutes from the meeting held on 19 February 2016 were received and noted.

The Chairman thanked everyone for their attendance and contributions.

56/16 DATE AND TIME OF NEXT MEETING

Thursday 28 April 2016 commencing at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital

The Chairman closed the meeting at 15:15 hours.

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - 1 APRIL 2016 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 April 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 April 2016

Main Body

Purpose:

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

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 April 2016

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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. This would also include the MCs.	TBC		
29.10.15 (165/15)	**INTEGRATED BOARD REPORT** Review to take place on how information is presented and summarised	Chief Operating Officer	**17.12.15** The 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 (179/15)	**WELL LED GOVERNANCE REVIEW** Milestones to be built in against each action	DoN/Co Sec	**28.1.16** Agreed a report would be brought back to Board in March 2016.	31.3.16		31.3.16

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	COO	25.2.16 Report received. Likely implementation to be July 2016	? July 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.	DoN	31.3.16 New policy in operation since November 2015. Arrangements made to include sickness/absence within full Integrated Performance Report.	31.3.16		31.3.16
10/16 28.1.16	**CALDERDALE SUPPORT & INDEPENDENCE TEAM** Board was unclear on locality team management structure and it was agreed that this would be clarified.	COO	25.2.16 The COO was awaiting further information with regard to employment and line management of the teams delivery of service. 31.3.16 Progress with deployment and line management responsibilities was not clear and further work was underway	28.4.16		
12/16 28.1.16	**RISK REGISTER** Changes to be made to heat map on Risk Register	DoN	31.3.16 Due to a misunderstanding further work was required on the colour rating of the heatmap on the Risk Register	28.4.16		
24/16 25.2.16	**CLINICAL RESEARCH – CLINICAL EXCELLENCE AWARDS** The Chief Executive suggested that the Medical Director might wish to consider a greater weighting being put on the clinical research element of the Clinical Excellence Awards in the future and he agreed	CE/MD	31.3.16 Consideration to be given to increasing weighting within CEA in the following year.	31.3.16		31.3.16

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 April 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
	to discuss this with him on his return.					
25/16a 25.2.16	**IMPLEMENTING THE FORWARD VIEW** Following discussion it was agreed that a paper would be prepared for the Board once the footprint levels/Trust's role had been finalised	DoF/DTP		TBC		
26/16b 25.2.16	**MENTAL HEALTH – 5 YEAR FORWARD VIEW** Board to consider having Mental Health champions both in terms of Exec and Non Exec Directors. Detailed resources to be brought back to a future BOD Meeting for discussion.	Chair/CE		TBC		
28/16 25.2.16	**BOARD ASSURANCE FRAMEWORK – EPR** Concern was expressed by Membership Councillors that the meeting scheduled for 15.2.16 had been cancelled. The Chief Executive reported that a meeting was scheduled for 26.2.16 and agreed to circulate an update and latest position after that meeting.	CE	31.3.16 Update supplied to MC at MC Public Meeting held 7.4.16.			7.4.16
29/16 25.2.16	**RISK REGISTER** It was agreed that following the agreement to circulate a letter of concern to the CCG regarding the Consultation, the risk on both the Risk Register and Board Assurance Framework should revert to its original risk level.	DoN/Co Sec		31.3.16		31.3.16

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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
30/16 25.2.16	**RISK MANAGEMENT POLICY** The draft policy was agreed subject to further work to include non-clinical as well as clinical risks. The Chairman reported that it was some time since the Board had discussed appetite for risk and with the new Board Members now being appointed this was felt to be the right time. It was agreed that this topic would be scheduled into the Board Development programme session to be held on 13 July 2016.			13 July 2016 Board Dev Session		
32/16 25.2.16	**CARE OF THE ACUTELY ILL REPORT** The Chairman thanked the team for the report but suggested that consideration be given to the Board receiving a summary of the key themes in the future rather than the full report.	MD		28.4.16		
33/16 25.2.16	**QUARTERLY QUALITY REPORT** The Board agreed that the level of detail being reported to the Board should be reviewed by the Quality Committee. Juliette Cosgrove agreed to ascertain the level of information required for the various sub-committees and make recommendations accordingly.	DoN		29.9.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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
34/16 25.2.16	**END OF LIFE REPORT** The Board noted the progress made. Lindsay Rudge reported that the End of Life Strategy would be brought to the March Board of Directors Meeting for information.	DoN	31.3.16 Approved by BOD subject to inclusion of any recommendations by National Audit and the inclusion of communications with relatives.	31.3.16		31.3.16
38/16b 25.2.16	**FINANCE AND PERFORMANCE COMMITTEE - PRM FEEDBACK** Once further information was received from Monitor regarding the Trust's response to the Sustainability and Transformation Fund this would be shared with the Board.	CE/Chair		28.4.16		
44/16b 31.3.16	**CHAIRS INFORMATION EXCHANGE – INTERMEDIATE CARE FACILITIES** MCs enquired whether Trust would be looking at opportunities to develop in this area. Chairman reported that this had been raised with the COO and the PMO team had been asked to look into this further	HB/AB		28.4.16		
45/16 31.3.16	**BOARD APPOINTMENTS UPDATE** Update received. Further information would be provided to the Board following the DoN interviews on 20.4.16.	OW		28.4.16		

This page has been left blank

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 April 2016	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Corporate Risk Register - This paper presents to the Board the corporate risk register as at April 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Risk and Complianve Group reviewed the risk register at it's meeting on 13 April 2016.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

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 corporate risk register.

Background/Overview:

The CRR is presented 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 may potentially may be deemed a corporate risk,w i those with a risk score of 15 or more, prior to these being presented to the Board.

The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at April 2016 which identifies the highest scoring risks (between 15 and 25), risks with increased scores, reduced scores, new risks and closed risks.

ii. The Corporate Risk Register which identifies 18 risks and the associated controls and actions to manage these.

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 risk facing the organisation

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

COMBINED RISK REGISTER FOR BOD.pdf

CORPORATE RISK REGISTER REPORT

Risks as at 19th April 2016

TOP RISKS
6131 (20): 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 6503(20): Delivery of Electronic Patient Record Programme 6658 (20): Patient flow
RISKS WITH INCREASED SCORE
No risks have increased in score.
RISKS WITH REDUCED SCORE
6130: This risk relating to the potential loss of income to the Trust due to competitive procurement was reduced from a risk score of 20 to 12 following discussion at the Risk and Compliance Group on 13 April due to there being no active procurements underway. 6665: This risk relating to the clinical administration workforce has been reduced from 15 to 9 due to additional resources secured for this group of staff.
NEW RISKS
There is 1 new risk identified since the last report – this is risk 6709 relating to the failure to provide adequate care during the junior doctor's strike on 26 and 27 April 2016
CLOSED RISKS
The 2015/16 financial risks (4706, 6150, 6027) are included within this report for completeness. These will be removed at the end of April and new 2016/17 financial risks will be added to the risk register in May.
RISKS TO BE DISCUSSED AT NEXT MEETING
• Maternity Services • Gastroenterology Rota • Documentation

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

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	December 2015	January 2016	February 2016	March 2016	April 2016
		Strategic Risks						
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme	Chief Executive	20!	20=	20=	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 =	20 ↓	20	20=
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=
6709	Keeping the base safe	Impact on care - Junior Doctors strike	Chief Operating Officer					!16
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!	16=	16=	16=
6598	Keeping the base safe	Essential skills training data	Interim Director of Workforce and OD	-	16!	16=	16=	16=
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (JD)			!16	16	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=
6150	Keeping the base safe	Cash flow risk	Director of Finance (KG)	15	15 =	15 =	15 =	15=
6027	Keeping the base safe	Suspension of capital programme risk	Director of Finance (KG)	15	15 =	15 =	15 =	15=

		Performance and Regulation Risks						
6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (JD)	16	16 =	16 =	20↑	20=
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing	-	16!	16=	16=	16=
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Deputy Director of Workforce (JE)			15!	15	15=
		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=

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 19th April 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 Failure to comply with monitor staffing cap	= 4783 Outlier on morality levels = 6345 Staffing risk, nursing and medical = 6 6 5 8 Inefficient patient flow = 6131 service reconfiguration	
Likely (4)				= 5806 Urgent estate work not completed = 6300 Clinical, operational and estates risks outcome = 6594 Radiology risk/ diagnostic tests = 6596 Serious Incident investigations = 6598 Essential Skills Training Data =6694: Divisional governance arrangements ! 6709 Junior Doctor Strike 26/27 April	= 2827 Over reliance on middle grade doctors in A&E = 4706 Failure to meet CIP & adhere to financial governance = 6503 Non delivery of EPR programme
Possible (3)					= 6299 Medical Device failure levels = 6150 Cash flow risks = 6027 Suspension of capital risk programme
Unlikely (2)					
Rare (1)					

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

Corporate Risk Register
Extreme and Major Risks (15 or over)

18/04/2016 14:53:53

Apr-16

NHS
The Health Informatics Service
Informing Healthcare

	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. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***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	**March Update:** Calderdale and Greater Huddersfield CCGs started public consultation on the proposed reconfiguration of hospital services on the 15th March. The period of public consultation will extend over a 14 week period. Public meetings and information sessions have been scheduled - with CCG and Trust representation at all of these. Calderdale and Kirklees Joint Overview and Scrutiny Committee has scheduled and commenced a series of meetings to review the proposals and these are being attended by CCG and Trust representatives. **April Update** Programme of consultation meetings underway.	Apr-2016	Oct-2016	WEB	Anna Basford	Catherine Riley

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk Risk to delivery of safe and effective high quality care and experience for patients due to inability to recruit to vacant posts, nursing (50 wte), doctors and therapy staff. Lack of medical staffing (Consultant / middle grade doctor / junior doctor vacancies) across A&E, Ophthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service. Dual site working impacting on medical staffing rotas. lack of therapy staffing (Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians) in both the acute hospital and in the community across a number of different teams Lack of medical workforce planning resulting in not achieving recommended nurse staffing levels as per Hard Truths workforce model, - increase in clinical risk to patient safety in multiple areas - negative impact on staff morale, sickness and absence - inability of staff to attend mandatory training and participate in appraisal - cost pressures due to increased costs of interim staffing There is a risk that patients in the extra capacity wards cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate	**Nursing** - electronic duty roster for nurse staffing apporved by Matrons - risk assessement of nurse staffing elvels for each shift and escalation process To Director of nursing To secure additional staffing - staff redeploymenr where possible - staff skill mix (extended roles, Allied Health professionals) - nursing retention strategy - flexible labour used for shortfalls (bank, internal, agency) and weekly report on usage as part of HR workstream **Medical** - Medical Workforce Group chaired by Medical Director - active recruitment activity including international recruitment - revised approvals process for medical staffing to reduce the delay in commencing recruitment - interim resource in HR to manage medical workforce issues - exit interviews for Consultants - identification of staffing gaps within divisional risk registers, reviewied through divisional governance arrangements - daily ward based review of staff by medical staff and nursing staff **Therapy** **-** posts designed to be as flexible as possible - revise of skill mix and development Assistant Practitioners - Flexible working - increase availability fo staff through additional resource / bank staff All - contribute to Health Education England surveyr to inform future commissioning/ provision	**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 **Therapy staffing** Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - 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	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). February Update - finalising report on vacancy position with therapy staffing March Update A summary report produced for the medical workforce and therapy workforce setting out: current staffing position , gaps and risks, mitigating actions, approach to recruitment and retention. Wwill inform the development of the workforce strategy incorporating a workforce plan to support the 5-year strategic plan. **April Update:** Medical Staffing - during April proceeding to international recruitment via specialist recruitment agency for hard to fill Consultant level posts.	Jun-2016	Sep-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues 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. **April Update** Proceeding to international recuritment for hard to fill Consultant level posts.	May-2016	Aug-2016	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now within unexpected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result 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.	2 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. 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	Final reports from Royal College of Physicians awaited (expected June 2016) 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	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. January Update Depth of coding increasing, Palliative care coding actions being implemented, Reliability in sepsis care improving. February Update: Palliative care coding improving. Consultant coding leads developing improvement plans, mortality reviews continue at similar level of compliance. SHIMI position is now an outlier. **April update**: Two Invited Service Reviews have been completed by the Royal College of Physicians to look at the Elderly Care service and the Respiratory Service. We are awaiting the final reports for both the services but some recommendations have been made that are being progressed. Improvements in coding continue to be made. Mortality reviews not showing increased levels of avoidable death.	May-2016	Aug-2016	COB	David Birkenhead	Juliette Cosgrove

Major	6658	Medical	Emergency Network	Accident & Emergency	Mar-2016	Active	Keeping the base safe	There is a patient safety risk and a risk to patient experience from ineffective patient flow due to increase in demand, with peaks and troughs, slow internal pathway decision-making, bottlenecks in internal capacity and exit blocks resulting in an increased mortality risk, excessive movement of patients between wards, increase in outliers, impact on elective activity and failure of emergency care standard.	1 Patient flow team supported by on-call Management arrangements. 2 Employed an Unplanned Care Lead to focus across the Organisation. 3 Daily reporting. 4 4 Hourly SIP reports. 5 Surge and escalation plan. 6 Discharge Team. 7 Recently established roving MDT. 8 Active participation in systems forums relating to Urgent Care. 9 Phased capacity plan	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group	20 4 x 5	20 4 x 5	16 4 x 4	Update March 2016. 1 and 4. Unplanned care expert appointed on fixed term contract - from February 2016 - focused on coaching of patient flow team & empowerment of ward staff delivered through roving MDT. Emergency Care Improvement Programme to undertake a diagnostic of the local health social care system on 18 March 2016 Joined next ambulatory care cohort commencing April 2016 to enable a health and social care system increase ability to avoid admissions, Command and Control arrangements in place at times of pressure. 5. Some late non -recurrent funding provided by Calderdale CCG used for additional beds and associated staffing 6. Working directly with local social care providers to aim to increase out of hospital capacity. **April 2016 Update** Safer patient flow programme launched (including partners), ECIST draft report received and being incoporated. Ambulatory programme commenced. Short term recovery plan developed by Medicine Divisoin with key actions identified to support improved patient experience and delivery of 95% for quarter 1. Excess bed days remain very high with particular risks across the Calderdale health and social care system. Winter plans being formally evaluated and SRG holding a half day workshop to ensure common understanding of cause and agreement on effective actions to deliver sustainable improvement. Some risk of removal of winter pressures funding by CCGs from May, currently being assessed	May-2016	Sep-2016	BOD	COO Helen Barker	Bev Walker
Major	4706	Corporate	Finance	Corporate Finance	Apr-2015	Proposed for Closure	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	March 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. The Trust continues to aim to meet the £20.0m deficit (excluding restructuring costs), operational pressures in the final quarter bring further risk to achievement of this. **April Update:** The month 12 unaudited position shows a deficit of £21m which is £2m ahead of the original plan and £1m improvement on the revised plan. The 2015/16 risk of failing the plan has been managed and this risk will now be closed. A new risk will be identified regarding the 2016/17 financial plan on the risk register in May.	Apr-2016	Apr-2016	FPC	Keith Griffiths	Kirsty Archer

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 - Programme Risk log to be presented at April R&C group to understand the current position and how programme risks could relate to Trust risks. April Update - Risk and Compliance Group to review EPR risk register in May.	Jun-2016	Sep-2017	RC	Mandy Griffin	Mandy Griffin
Major	6594	Family & Specialist Services	Radiology	CT & MRI	Jan-2016	Active	Transforming and improving patient	Acting upon radiological results This risk relates to how radiology clinical results are received and acted on by the referring clinician. It is the responsibility of the referring clinician to act upon any findings reported in a diagnostic tests. On occasions there may have been examples where important clinical results were followed up, with instances such as these posing a potentially significant risk to patients. This risk has been identified by a recently 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. The current process does not however guarantee that a clinician has read and acted upon these results.	- No current 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 April Update Report of Task and Finish Group being shared with Serious Incident Review Group 20 April 2016	May-2016	May-2016	RC	David Birkenhead	Lindsay Rudge

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	6 3 x 2	B) ICU floor to be monitored until decant possible. H) CCU Flooring at CRH will be monitored until decant possible. I) A&E Resus area to be identified at HRI. J) Review condition of windows Trust wide Dec 15 Update Feasibility on A&E Resus Area taking place. Review state of windows across HRI wards. Jan 16 Update Review of windows completed at HRI and temporary fixes made on wards (based on risk). Curtains hung at windows on a number of wards. Feb 16 Update Curtains hung at windows on a number of wards and temporary fix to close windows carried out by estates March 16 Ward 5 improvements completed and ward returned (from ward 11) No April update	Jun-2016	Mar-2017	RC	Lesley Hill	Paul Gilling / Chris Davies
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	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 April Update Progress made with clearing outstanding serious incidents however need to embed within divisions process for managing red and orange incidents in a timely way.	May-2016	Jul-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 where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation.	There is an essential skills matrix which aims to identify all the essential skills training within the organisation. There is a 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. We have a 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	16	12	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, No April update	May-2016	May-2016	NA	Interim Director of Workforce and Organisational	Bev France
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. Key areas of concern identified for CQC self assessment: Medical Care - safe, responsive and well-led domain Urgent and Emergency Services - safe domain Community Services for Adults - safe domain	- 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 -Action plans in place for areas that have been identified s requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is to be held to monitor progress with the action plans chaired by the Chief Executive - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, is being commissioned	- Assessments show us to be be in the "requiring improvement" category -We have had feedback from the CQC relating to some areas which require improvement- these are maternity, CDU, patient flow, record keeping and the acute gastro-intestinal haemorrhage service	16	16	8	April update The CQC inspection is now completed and all additional data requests have been responded to. Initial feedback has shown areas for improvement some were responded to immediately and plans are in place to resolve the remaining concerns. There will be a fortnightly meeting chaired by the Chief Executive to monitor progress against the plans. The report is expected sometime during the summer.	May-2016	Jul-2016	WEB	Julie Dawes	Juliette Cosgrove
Major	6694	Trustwide	All Divisions	All Departments/Wards	Mar-2016	Proposed for Acceptance	Keeping the base safe	Risk that the divisional governance structures are not sufficiently standardised and mature to provide assurance on quality and safety due to inconsistent divisional governance systems and processes and lack of application of agreed terms of reference and divisional and directorate Patient Safety Quality Boards (PSQB) resulting in The Quality Committee having a lack of assurance on quality and safety at divisional and directorate governance level	Divisional PSQB terms of reference used for each divisional PSQB. Supplementary governance manager resource within divisions.Quarterly quality and safety report from divisional PSQB to quality committee and hoc reports to Quality committee on specific quality issues eg, Stroke, # Neck of Femur	Consistent application of PSQB terms of reference at Divisional and Directorate level.Variable quality quarterly PSQB reports to Quality Committee.Varied model of governance support into and within Divisions. Varying structures and processes for Quality governance at Directorate and Speciality level.	16	16	8	Review of governance support to divisions Application of standardised governance approach to PSQBs April Update Work continues with governance managers and divisional leads to embed new terms of reference for PSQBs.	Jul-2016	Dec-2016	QC	Director of Nursing Julie Dawes	Juliette Cosgrove
Major	6709	Trustwide	All Divisions	All Departments/Wards	Apr-2016	Active	Keeping the base safe	There is a risk of CHFT failing to provide adequate patient care, including emergency care, due to the planned junior doctors industrial action on 26th & 27th April. This risk could result in poor patient experience and delayed care during and after the strike period and also increase the pressure on other staff and departments prior to, during and after the strike period A on 26th & 27th April. This risk will also result in loss of income.	Strategic Planning Group in place preparing for the strike period to ensure sufficient controls are in place to mitigate the risks.	TBA - strategic team meeting w/c 11th April, w/c 18th April and w/c 25th April with key stakeholders internally and external partners.	16	16	12	TBA - attach minutes of meetings.	Apr-2016	Apr-2016	QC	Helen Barker	Em. Planning Officer

Major	6693	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Mar-2016	Proposed for Acceptance	Keeping the base safe	Risk Of: Failure to comply with the Monitor cap rules. Due to: Bed capacity – The Trust has opened a significant number of additional beds in response to service pressures requiring safe staffing levels. No. of vacancies in the workforce – The Trust has a high number of vacancies across its workforce resulting in the requirement to engage agency staff (including national shortages). Resulting in: High usage of externally sourced agency workers, utilising agency that breaches the cap rate and in circumstances uses off-framework agencies. Regulator sanction – The Trust receiving a regulatory sanction given the number of breaches the Trust currently reports against the Monitor agency cap. Safety risk – The Trust is unable to fill vacant posts (Medical, Nursing, AHP, A&C) resulting in the risk of patient safety, quality and care.	The Trust collects weekly information on the number of breaches of the Monitor cap and reports this through to Monitor. The Trust has performed a number of challenge sessions to review all existing long term breaches of the Monitor cap. Following this one-off exercise the Trust has sought to integrate this review/challenge into the existing Divisional Business Meetings. An exercise has been carried out to write a letter to all agencies (across all staff groups) requiring agencies to comply with the Monitor cap imposed. Nursing - The Trust has a centralised escalation process in place for the authorisation of requests to secure agency workers for Nursing staff (qualified and non-qualified), through to Nursing Director. The Trust has rich information on the Nursing workforce, covering bank, overtime and agency as a monitoring tool for spend/bookings. Medical – Divisional authorisation of requests to secure agency workers/locums AHP's – Divisional authorisation of requests to secure agency workers Admin & Clerical – Divisional authorisation of requests to secure agency workers	Reportable breaches are currently signed off at Director level though the Trust could further raise the awareness and action by including this information within a report to the Executive Board. Robust escalation and management information for all non-Nursing staff groups. Routine divisional review of agency spend.	15 3 x 5	15 3 x 5	9 3 x 3	A further paper to the Weekly Executive Board that requests gaps in controls are addressed and requests a directive from the Exec Board about absolute compliance with the agency cap and framework compliance guidance. Implementation of a Trust wide management system for all temporary workforce groups (rolled out from the existing system for locums). Manage a safe bed reduction plan from the Trust's current position. Recruit to all vacant posts across all workforce groups. Implement the EPR and reduce the Trust's reliance on agency staff. No April update	Jun-2016	Jun-2016	WLG	Coo Helen Barker	Jason Eddleston
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	January Update Work to improve the situation continues. January 2016 medical device backlog report confirms work in progress and will be presented to February Patient Safety Group. Feb Update PPM scheduling in progress using additional bank resource.BOC on HRI site to carry out inspection/maintenance activities of a number of devices. Overtime offered to give improved focus. Database audit continues using existing staff. Additional support brought in (Med Device Engineering & Admin for training database). Improvement shown in completed maintenance activities. Improvement shown on review of devices on database. No April update	May-2016	Mar-2017	DB	Lesley Hill	V Wotherspoon

Major	6150	Corporate	Finance	Trustwide	Apr-2015	Proposed for Closure	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	15	10	March update: Pro-active cash management actions continue, Revenue Support Loan approved and £12.9m to be drawn down from Independent Trust Financing Facility (ITFF) in March 2016. April update: 'In 2015/16 pro-active cash management has ensured that the closing cash balance is in line with plan. However, this has required delays in payments to suppliers. Cash will be a risk in 2016/17 and the register will be updated in May relating to the 2016/17 risk.	Apr-2016	Apr-2016	FPC	Keith Griffiths	Kirsty Archer
											5 x 3	5 x 3	5 x 2						
Major	6027	Corporate	Finance	Corporate Finance	Apr-2015	Proposed for Closure	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. This also risks knock on reputational damage to the Trust	• 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 Management 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		16	15	10	April Update The 2015/16 capital programme was not suspended and this risk has been managed. For 2016/17 /there will be a risk regarding the overall value of the capital programme which is not yet agreed and has not yet had agreement for cash support. This will be updated for 2016/17.	Mar-2016	Apr-2016	CISC	Keith Griffiths	Kirsty Archer
											4 x 4	5 x 3	5 x 2						

APPENDIX D

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 28th April 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient - This paper provides the Board with an update on the Care of the Acutely Ill Patient Programme.	
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 Care of the Acutely Ill Patient (CAIP) programme, last revised in August 2015, is divided into six themes:

1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

This is a working document and is reviewed with updates monthly to the Clinical Outcomes Group (COG).

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

Please see attached

Appendix

Attachment:

COMBINED CAIP - APRIL BOD.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors; April 2016

The Care of the Acutely Ill Patient (CAIP) programme, last revised in August 2015, is divided into six themes:

1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

This is a working document and is reviewed with updates monthly to the Clinical Outcomes Group (COG).

Performance is attached in the CAIP dashboard and a brief progress against themes notes below.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	The trust continues to have high mortality Ratios (HSMR = 116.9, SHMI = 113) **Learning from Mortality (LfM)** The mortality review process has lost momentum as pressures in the system mount impacting on the time available to the clinical reviewers to complete the allicated set of cases. Learning from the 50% of cases which have been reviewed in the last 6 months is confirming some known themes around escaltion (although this has imporved post Nerve Centre implementation), availability of senior review and documentation. All themes are feed back through a monthly LfM report and action points fed into the appropriate workstream either within the CAIP programme or in other key pieces of work.	The trust will be establishing a Mortality Surveillance Group which will report directly to the Board. This will bring together oversight on the any improvements required and enable a focus on gaining futher clairty on the drivers behind the mortality ratio and the quality of clincal care being develivered.

	Alerting Conditions: The Trust is showing as an outlier for two diagnostic groups, Acute Cerebrovascular Diease (ACD) and Pnuemonia. **External Reviews:** There have been two external review, with the potential to commision a third. One for Complex Care and one for Respiratory.	A meeting took place with the stroke team and a weekly improvement group has set up. The metrics from this will be monitored. Recommendations to be evaluated. Some could require systematic change.
2) Reliability in clinical care	Bundle compliance remains variable across the five that are being measured.	The bundles have been fully integrated in the Clerking in Document which has enabled retrospective audit to take place. From April 16 onwards the audit of these figures will become more robust and from there an improvement trajectory put in place.
3) Early recognition and treatment of deteriorating patients.	Nerve centre has been adjusted to take account of the different early warning score that applies in paediatrics.	The next steps are to implement the Hospital and Night modules, which includes processes for OOH escalation and handover, in the evenings and also over the weekend. Staff are currently being appointed.
4) End of life care	The % of patients being managed on the ICODD remains around 45%. The specialities benefitting from palliative care support is widening, as the teams support move to support more of the non-malignant conditions. An annual audit of End of life care set out recommendations regarding best practice and areas the trust could improve in the provision of end of life care. DNACPR compliance continues to improve, with over 90% of review dates being filled in for the first time this year.	Moving into 16/17 the recommendations of the national audit will be reviewed and will likely form the basis of the next reiteration of the End of Life action plan in the CAIP.

5) Caring for frail patients	The Frailty work stream is yet to be formally established, a number of systematic factors, such as patient flow and clinical resources play a part in this area	
6) Clinical coding	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 of specialty pro-formas including the Stroke Pathway and Day Surgery templates. To improve clinical coding and the link to clinical colleagues 5 doctors are to have 1 PA – 2 are now in post (Simon Sturdee and Venkat Thiyagesh) and additional clinicians have been approached for the remaining 3 vacancies . 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.	Futher work has been commissioned with our Benchmarking information supplier, to provide regular insight how we are performing with peers for comorbidity capture and palliative care capture. Wider clinical engagement needed, either through additional PA time or with clinicians involved in specific clinical pathways.

March 2016 - Dashboard

compassionate care

Theme 1: Investigating Mortlaity and Learning from findings

Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Performance T	Comments
Rolling 12 month SHMI (from HED Monthly - latest HSCIC publication date) October 2014- September 2015	100	109.03			109.3			108.9			111.0		**113.9**	111.00	↑	SHMI has increased from the 111.0 released in January. The figures in the bold text are the latest release figures. Local data in the HED system predicts a slight rise for the next release.
HSMR - comparing to same time period as latest SHMI	100	104.81			105.85			110.01			114.32		116.97	114.32	↑	Conversely HSMR for the same period rose.
HSMR - January 15- December 15	100							116.15	116.44	116.62	116.51	116.34	117.36	116.51	↑	The latest HSMR figures show that there is no significant movement in HSMR.
HSMR - Number of New Alerts								1	0	0	1	0	0			There was 0 new alerts in the latest HSMR Release. 4 old ones.
SHMI - Number of New Alerts								1	n/a	n/a	3	n/a	1			The new alert for SHMI was 217 - Other congenital anomalies 565.35 with 4 deaths against 0.71 expected
Number of ongoing Alerts								8	4	4	6	2	2			2 Alerts, ACD and Pneumonia
Number of completed Alert investigations								1	1	0	0	1	1			The contusion alert and colon cancer complete, PID are currently underway,
COPD - SHMI October 2014- September 15	100	111.5			121.06			132.8			122.76		117.86	122.76	↓	The most recent release indicates that COPD SHMI fell considerably.
COPD - HSMR- comparing to same time period as latest SHMI	100	114.52			141.33			142.96			127.3		129.07	127.3	↑	HSMR for the same time period also shows a rise.
COPD HSMR- January 15- December 15	100							139.2	125.68	125.47	132.3	132.87	133.39	132.3	↑	The latest HSMR figures indicate a rise in COPD scores since the SHMI release period
Heart Failure - SHMI October 14- September 15	100	112			108.53			109.5			108.61		113.89	108.61	↑	Heart Failure SHMI scores have gone up, and now exceed the April release
Heart Failure - HSMR comparing to same time period as latest SHMI	100	103.72			98.08			103.77			105.24		107.33	105.24	↑	HSMR for the same time period also rose slightly
Heart Failure HSMR - January 15 - December 15	100							106.56	105.86	107.06	105.88	111.07	113.74	105.88	↑	The rise in HSMR figures show a fall in scores. Heart Failure HSMR and SHMI tend to follow a similar pattern, as such HF may rise in the next release.
ACD (inc Stoke) - SHMI October 14 - September 15	100	107.2			109.55			113.7			134.82		144.62	134.82	↑	The latest SHMI release shows that ACD figures are rising considerably.
ACD (inc Stoke) - HSMR- comparing to same time period as latest SHMI	100	103.04			103.94			107.46			125.77		127.99	125.77	↑	HSMR for the same time period show a continuing upward trend
ACD (inc Stoke) HSMR - January 15 - December 15	100							119.78	127.67	128.27	127.55	129.71	130.41	127.55	↑	The latest HSMR figures indicate that a rise in ACD HSMR scores since the SHMI release period
Number of In Hospital Deaths	NA	159	140	120	118	120	120	122	131	140	148	142	148	1608	↑	November, December, January, February and March have all seen less deaths than the same period last year.
Deaths within 30 days of Discharge	NA	75	45	74	76	68	53	75	36	28	32	45	37	644	↑	There is a noticeable amount of variation in the raw numbers
% of Deaths Occurring in Hospital	NA	68%	76%	62%	61%	64%	69%	62%	78%	83%	82%	76%	80%	71%	↑	Just examining the total number of deaths either in hospital or within 30 days of discharge, Between 61-83% of deaths occur in hospital.
% Crude Mortality - All Admissions	NA	1.62%	1.41%	1.19%	1.08%	1.17%	1.20%	1.22%	1.33%	1.41%	1.53%	1.46%	1.49%	1.34%	↑	There were 148 Deaths in March which resulted in a crude rate of 1.49%.This is a rise on March 15 = 1.45%.
% Crude Mortality - Weekend Discharges	NA	2.86%	2.44%	2.63%	2.70%	2.62%	2.76%	2.72%	2.65%	2.65%	2.56%	3.47%	3.36%	2.8%	●	Off the 148 Deaths, 42 occurred over the weekend. This is less than the same time period last year, when 56 of the 161 deaths occurred at the weekend (34.8%)
% Mortality Reviews (Month behind)	100%	59.5%	33.1%	25.2%	29.5%	76.1%	55.8%	54.7%	58.5%	63.4%	55.9%	41.4%	34.5%	43.4%	↓	The new mortality review process has resulted in 30.9% of February's deaths being reviewed, a reduction from the previous month
% Mortality Reviews Preventability *(Hogan of 4 or above)*	1%	1.06%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	4.4%	3.8%	1.6%	4.0%	0.0%	1.17%	↓	0 of the February's deaths reported a Hogan score of 4 or above.

March 2016 - Dashboard

compassionate care

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Performance T	Comments
Theme 2: Reliability	Asthma - Bundle Started	95%	50%	86%	0%	75%	0%	57%	0%	n/a	n/a	75%	38%	67%	53%		The March bundle had **8** identified patients who required a bundle - **2** started the bundle
	Asthma - Bundle Completed	95%	100%	100%	n/a	0%	n/a	25%	n/a	n/a	n/a	100%	100%	100%	74%		Of these **2** started, **2** were completed
	AKI - Bundle Started	95%	47%	47%	65%	62%	64%	76%	53%	n/a	n/a	33%	71%	91%	61%		The March bundle had **11** identified patients who required a bundle - **10** started the bundle
	AKI - Bundle Completed	95%	67%	38%	45%	33%	29%	32%	70%	n/a	n/a	0%	67%	40%	44%		Of those **10** started, **4** were completed
	Sepsis - Bundle Started	95%	59%	54%	59%	66%	65%	70%	58%	n/a	n/a	89%	70%	63%	63%		The March bundle had **8** identified patients who required a bundle - **5** started the bundle
	Sepsis - Bundle Completed	95%	60%	62%	58%	51%	55%	38%	58%	n/a	n/a	50%	71%	60%	54%		Of these **5** started, **3** were completed
	COPD - Bundle Started	95%	62%	43%	80%	85%	44%	63%	47%	n/a	n/a	47%	48%	78%	59%		The March bundle had **9** identified patients who required a bundle - **7** started the bundle
	COPD - Bundle Completed	95%	38%	56%	25%	73%	57%	53%	60%	n/a	n/a	60%	62%	57%	56%		Of these **7** started, **4** were completed
	Pneumonia - Bundle Started	95%	62%	67%	100%	86%	0%	100%	50%	n/a	n/a	0%	38%	50%	57%		The March bundle had **6** identified patients who required a bundle - **3** started the bundle
	Pneumonia - Bundle Completed	95%	88%	83%	100%	100%	n/a	100%	100%	n/a	n/a	0%	100%	33%	92%		Of these **3** started, **2** were completed
	Heart Failure	In Development															
Theme 3: Early recognition and treatment of deteriorating patients	Number of Cardiac Arrests	NA	16	15	20	11	10	9	15	14	17	18	10	18	155		Numbers have been reducing however this month has seen a rise (note- pre hospitals not removed)
	Number of Cardiac Arrests per 1000 bed days (Rate)	0.68	0.77	0.60	0.97	0.54	0.50	0.45	0.66	0.66	0.66	0.67	0.65	0.79	0.64		The target for 2015-2016 is to be -10% on 2014-2015 figures. Beginning to reach target month on month
	Unplanned Admission to ICU	43	37	55	51	45	40	49	49	39	48	57	41	33	544		Target of no more than 43 per month. Not achieving this regularly.
Theme 4: End of Life Care	DNACPR % Discussion completion	95%	90.5%	83.1%	85.7%	88.4%	86.0%	82.8%	92.3%	93.7%	89.7%	90.3%	96.2%	96.0%	89.1%		Compliance rising over the last 3 months. Is inclusive of a discussion talking place with either the patient, or if not applicable i.e. cognitive impairment, unconscious ect, then a relevant other. Now at its higest point for the year, and above target.
	DNACPR Review date completion %	95%	76.2%	68.2%	71.1%	74.4%	73.0%	68.1%	84.6%	77.2%	78.2%	68.8%	76.9%	90.7%	74.9%		Data now reported monthly, improvements were seen, and has risen considerably this month
	% of patients on the ICODD	N/A	38.0%	32.7%	37.2%	44.4%	41.7%	45.3%	46.6%	40.0%	35.3%	45.5%	42.5%	42.1%	40.8%		Number of patient on the ICODD is increasing as training is rolled out.
Theme 5: Frailty	% frailty Deaths (as a proportion of all deaths)	N/A	10.8%	12.8%	14.7%	6.8%	14.3%	9.2%	8.2%	4.6%	11.4%	4.7%	14.8%	6.8%	10.7%		These are deaths where the criteria is patients aged 80+, with 3+ Comorbidities and 3+ previous admissions. A seasonal variation can be seen
Theme 6: Coding	Average Diagnosis	5	4.0	3.9	4.0	4.0	4.1	4.4	4.4	4.5	4.7	4.7	4.8	4.9	4.4		Has been adversely affected by new coding rules from April 2015 which no longer require some administrative procedures to be coded
	Average Charlson Score	4	3.6	3.5	3.7	3.5	3.6	3.7	3.9	3.9	4.2	4.0	4.3	4.3	3.9		The Charlson Score has remained the same in March and stays above target.
	Co-morbidity capture	90%	28%	35%	12%	11%	26%	24%	30%	47%	41%	44%	44%	41%	32%		Co-morbidity capture has remained the same as last month's point
	% Sign and Symptom	9.5%	9.5%	9.7%	9.6%	10.0%	9.4%	10.9%	10.1%	9.9%	9.6%	9.1%	9.1%	9.4%	9.6%		Same as last month. Now at target level.
	% Coded with Specialist Pall Care	NA	0.7%	0.6%	0.6%	0.6%	0.6%	0.7%	0.7%	0.7%	0.6%	1.0%	1.0%	0.9%	0.7%		Recently we have seen a steady rate of 0.7% for speciallist palliative care, but has risen to 1.0% this month

This page has been left blank

APPENDIX E

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 2016	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: SAFEGUARDING REPORT - ADULTS AND CHILDREN - ANNUAL REPORT - The Board is asked to note and approve the contents of the Annual Safeguarding Report 2015-16	
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 note and approve the contents of the Annual Safeguarding Report 2015-16

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 note and approve the contents of the Annual Safeguarding Report 2015-16

Appendix

Attachment:

CHFT SAFEGUARDING ANNUAL REPORT 2015-16 Final.pdf

Calderdale and Huddersfield NHS

NHS Foundation Trust

Annual Safeguarding Report 2015 – 2016

1. Foreword

This is Calderdale and Huddersfield Foundation Trusts (CHFT) Annual Safeguarding Report. This reporting period covers April 2015 to March 2016; this is in line with other Trust reports and reporting periods. The report will describe and inform CHFT Board of Directors and Non-Executive Directors of its commitment and pledge to ensure Safeguarding Adults and Children remains a key priority. The report has been written by the Head of Safeguarding in conjunction with the Named Nurses for Safeguarding Children and Adults and the Named Midwife.

2. Introduction

The report provides an overview of activity within the organisation outlining key achievements and challenges, and highlights on-going work and developments across the Trust, as well as work across the health and social care footprint in both Calderdale and Kirklees. The purpose of this report is to ensure that CHFT is informed of progress and developments both locally and nationally on issues relating to the children's and adults safeguarding agendas.

The report provides further plans and continued development for the forthcoming year, following the introduction of the Care Act 2014 in April 2015, and further case law in relation to Deprivation of Liberty Safeguards. The Care Act 2014 now legislates Adult Safeguarding and imposes a legal duty on NHS organisations.

CHFT has continued to work hard over the past year both as an organisation, and with partners, to ensure a clear focus remains on those who are at risk of harm and are in need of support and protection.

Safeguarding Children and Adults is an integral aspect of patient care within CHFT, and this requires services to work effectively together to prevent harm and intervene when harm, neglect, or abuse is suspected; and ensure systems and processes effectively support patients and staff. The key element to safeguarding is partnership working and as such the Safeguarding Team have continued to progress CHFT's contribution to multi-agency working.

3. Background

3.1 Adults

The Care Act 2014 has now replaced the 'No secrets' guidance (2000) from April 2015; it not only addresses and recognises stopping abuse or neglect and preventing harm and reducing risk but also promotes an approach that improves the life for the adult concerned.

The Care Act aims to provide a clearer legal framework for adult safeguarding by putting Safeguarding Adult's Boards on a statutory footing, making safeguarding enquiries a corporate duty for councils, and making serious adult reviews mandatory when certain triggering situations have occurred and partners believe that safeguarding failures have been implicated. In addition duties will be placed on relevant agencies to co-operate over the supply of information and a duty of candour will be placed on providers about failings in hospital and care settings, with the creation of a new offence of supplying false or misleading information in the case of information they are legally obliged to provide. Further case law has contributed to changes in practice in relation to Deprivation of Liberty Safeguards (DOLS) such as Deprivation of Liberty in intensive care is not seen as a deprivation of liberty in some cases. The safeguarding team work closely with the Supervisory Bodies (Local Authorities) for Kirklees and Calderdale to ensure appropriate and suitable applications and authorisations are made.

3.2 Children

Whilst historically safeguarding children policy and practice has been more established within all organisations following the introduction of the Children's Act in 1989/2004. Child protection continues to have a high profile on a national basis and CHFT safeguarding team work closely with Children's services and the Commissioners (CCG) to ensure that new processes are clearly implemented ensuring that staff are made aware of changes at the earliest opportunity. Our safeguarding team has supported both Kirklees and Calderdale Safeguarding Children Boards and their subgroups in their attendance and have been involved particularly in the neglect strategy.

CHFT is one of the five West Yorkshire partner organisations which work within the North and West Yorkshire Safeguarding Adults Policy and Procedures, and the West Yorkshire Safeguarding Children Policy and Procedures. This encompasses Bradford, Leeds,

Calderdale, Kirklees and Wakefield. Its procedures are reflected within the Trust Safeguarding Policies.

4. Key Achievements and Update from last Year's Report

Considerable progress has been made since the last annual report to continue embedding safeguarding collectively across the partnership, and it is crucial that safeguarding becomes embedded in practice and in everything we do, as opposed to there being a culture where 'safeguarding' is seen as being someone else's responsibility. If we are to learn lessons and ensure quality and safe services, staff across all organisations have to be skilled, competent and supported in taking ownership and responsibility for dealing with issues that arise.

4.1 Policy and Guidelines

a) Continued improvements and additions are made to the Safeguarding Webpage as new developments and information arises. The Safeguarding padlock icon / branding portrays a clear message to staff when accessing safeguarding information. Mouse mats, posters, post-it pads and pens have been widely distributed to all staff areas with information relating to Learning Disability and Safeguarding. The safeguarding webpage has separate web pages for adult and children safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, Domestic Violence and Abuse, Child Sexual Exploitation, PREVENT, Female Genital Mutilation and information regarding Local Safeguarding Boards.

b) MCA/DoLS prompt cards have been widely circulated along with additional information notes relating to the Mental Capacity Act.

4.2 Events held

a) A masterclass on the Mental Capacity Act and Deprivation of Liberty Safeguards. This was extremely well attended by staff from both sites (approximately 350 staff).

b) An external barrister attended in July 2015 to present a masterclass aimed at clinicians and clinical staff on the MCA and DoLS, and went into great depth regarding assessing capacity and when a deprivation of liberty needs to be authorised.

c) In March 2015 CHFT contributed to Safeguarding Week. Safeguarding week is a collaborative event where partners raise awareness of the role of 'everyone' in safeguarding vulnerable children and adults at risk to highlight support available and intervention in Calderdale. As part of this week:

    - CHFT hosted Hempson's Solicitors to present a Consent Update. This event was open to all professionals across Calderdale

- CHFT in collaboration with the Police hosted an event surrounding Domestic Abuse and Claire's Law on two occasions
- CHFT also held a stall in the canteen and main entrance of CRH.

4.3 Supervision

a) Adult Safeguarding supervision is not statutory however it is promoted as best practice and where staff request supervision this is provided on either a one to one or group basis. One to one supervision can be ad-hoc, for example over the telephone or planned face to face. Group supervision can be a regular planned occurrence or can be more od a one-off debriefing session following the conclusion of a particular case. Colleagues are encouraged to contact the safeguarding team to discuss their requirements, and also members of the safeguarding team offer supervision support directly to colleagues and teams in known cases.

b) Staff who work with children require mandatory safeguarding supervision in line with the recommendations from the Intercollegiate Document 2014 and Working Together to Safeguard Children 2015. The team have recently recruited to ensure mandatory compliance with safeguarding supervision is maintained and outstanding cases are addressed to meet full compliance by end of April 2016.

c) Children Supervision; both individual and group supervision has been developed further and uptake is closely monitored. Target groups have been established identifying the type and frequency of supervision and are outlined in the safeguarding supervision policy. Safeguarding supervision levels will be monitored closely by the Safeguarding Committee.

4.4 Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009)

a) The MCA/DOLS came into effect on 1st April 2009. The safeguards apply to vulnerable people aged 18 or over who have a mental health disorder including dementia, who are in hospital or a care home and who do not have the mental capacity to make decisions about their care or treatment. Those providing the care should consider all options, which may involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and the hospital believes it is necessary to deprive a person of their liberty in order to care for them safely, they must get permission to do this by following processes known as the Deprivation of Liberty Safeguards; and they have been designed to ensure that a person's loss of their liberty is lawful and that they are protected. A ruling from the UK Supreme Court in March 2014 has given a new 'acid test' for deprivation of liberty:

- being under continuous supervision and control; and
- not being free to leave; and
- lacking the mental capacity to consent to these arrangements.

The legislation includes a statutory requirement to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person's representative and the documentation related to termination of authorisation.

b) CHFT Safeguarding Team ensures that there is a comprehensive database of all DoLS urgent and standard authorisations; this includes capturing the outcomes after assessments have taken place. CQC are notified of all DoLS authorisations and outcomes.

c) Data

In 2014 - Number of DoLS Applications 11/ Number of DoLS authorisations 5 (Reasons for non-authorisations 2 discharged, 1 regained capacity, 2 under MHA, 1 best interest decision)

In 2015 - Number of DoLS Applications 113 / Number of DoLS authorisations 38 (Reasons for non-authorisations 46 discharged, 7 regained capacity, 9 under MHA

In 2016 (up to 31.3.16) - Number of DoLS applications 94

There have been two MCA/DoLS audits last year and improvement plans were developed to address issues identified and we continue to raise awareness in this area.

4.5 Training

Safeguarding training is mandatory for all staff depending on their role and responsibility within the Trust and contact with adults and children. A significant piece of work has taken place this year that has reviewed the different levels of training in line with the Intercollegiate Document (2014) for safeguarding children and the draft intercollegiate document for safeguarding adults.

a) Work is near completion in relation to re-assigning children and adult safeguarding training target groups. Safeguarding children training also needs to be recorded in hours to ensure compliance; the preferred method is capturing this is through appraisal where the appraiser verifies the number of hours before final approval. The appraisal documentation has been amended to reflect this.

b) Work has also been completed in line with the draft intercollegiate document for Safeguarding Adults. Staff who require of training are identified on the Electronic Staff Register (ESR)

c) Named and Designated Nurses and Doctors are also identified regarding level 4 and 5 which includes additional training for the specialist role and responsibility.

d) Level 2 e-learning package for safeguarding children and adults training is now complete and this will be the preferred method of training for level 2 from the 17th March 2016. Level 3 safeguarding children sessions are currently delivered on a monthly basis. The change to eLearning for level 2 staff will allow extra capacity within the team to increase the number of level 3 training sessions.
Comparative figures prior to the review of the staff groups training up to Mid-March 2016; compliance is:
    - Level 1 training figures have gone up from 66% at the end of quarter 3 to 72.6%
    - Level 2 was at 53.2% and is now 47.3% (adults) and 50.49 % (children). This training is now delivered via eLearning
    - Level 3 adults – has never been captured before and now at 11.54%. This target group is under review and reconsideration. Updated figures will be provided once completed.
    - Level 3 Children was 64% and is now 41.55%. This target group is also under review and updated figures will be provided once completed.

e) PREVENT is a one off training session that can be delivered in any organisation as long as it was the WRAP training advised by NHS England. New staff do not need to complete this if they can produce evidence of previous attendance. Prevent figures are increasing each month, previously at 51.4% and is now 55.35% the target is 85% before December 2016. Additional sessions have been planned for the year.

4.6 **Further governance work** is ongoing in attending and sharing safeguarding data and information at Patient Quality and Safety Divisional Meetings ensuring safeguarding continues to be a priority.

4.7 **A new spreadsheet** that collates all the Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHRs) and Serious Adult Reviews (SARs).

4.8 A new Female Genital Mutilation (FGM) Guideline has been produced and awaiting ratification. This reflects the District wide FGM Strategy. Information was shared at the Nursing and Midwifery Committee to raise awareness.

4.9 The safeguarding team have worked with the risk department to contribute to the incident and inquest policies and have been involved with ensuring that safeguarding cases are highlighted with the risk department

4.10 The Safeguarding team has collaborated with Bradford Teaching Hospitals to complete the work for the new Electronic Patient Record (Cerner Millennium)

4.11 Developing training sessions for Volunteers for safeguarding and PREVENT and working with Volunteers Department to ensure that safeguarding training is updated every 3 years.

5. Management Arrangements/ Governance

a) The Head of Safeguarding commenced in post in June 2015, during the period of 2015-2016.

b) The Safeguarding Committee previously reported to the Patient Safety Group and was held quarterly. The Safeguarding Committee is now held monthly and reports directly to the Quality Committee; which emphasises CHFT's commitment and assurance to the Board that Safeguarding remains and is a key Trust priority. The new terms of reference reflect a more direct 'ward to board' line of accountability and escalation process to allow concerns to be raised quickly and efficiently so the Trust Board is aware of any risks and good practice at an earlier stage. The Committee is chaired by the Executive Lead for Safeguarding. For CHFT this means the Board has a distinct sight of how safeguarding and risks are managed within CHFT.

c) The Children's and Adults Operational Groups have now collaborated to form the Joint Operational Group and terms of reference reflect this new reporting structure. The frequency of the meetings has now increased to monthly to ensure that the Safeguarding Committee are kept up to date with changes and risks can be escalated quickly. The Safeguarding Operational Group has new terms of reference

and task and finish groups for Child Sexual Exploitation, Domestic Violence and Abuse and Mental Health have commenced.

d) Working Together to Safeguard Children 2015 states that all health organisations providing services for children should identify a Named Doctor and a Named Nurse (and a Named Midwife if maternity services are provided) for Safeguarding. It also outlines the need for a person with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation to be a member of the LSCB. All statutory posts within CHFT are filled.

In addition the Trust employs three Designated Doctors for Safeguarding Children and Looked After Children and a Designated and Named Nurse for Looked After Children. There is a Named Nurse and a Specialist Advisor for Safeguarding Adults. Both the Safeguarding and the Looked After Children Team are supported by administrative roles. The Head of Safeguarding is accountable to the Director of Nursing.

Although new roles and reporting structures are embedding a safeguarding culture has continued; the safeguarding team playing in pivotal part of supporting staff in carrying out their safeguarding responsibilities. Work has continued with other partner agencies across Kirklees and Calderdale to ensure CHFT is discharging its statutory responsibilities.

One of the main functions of the committee is to review practice and ensure robust arrangements are in place, to share good practice and learn lessons, as well as monitor compliance issues around training.

There has been further work in relation to capturing divisional safeguarding activity. This is ongoing and the committee will have an overview of divisional reporting in relation to safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, Serious incidents with a safeguarding concern, orange incidents. The safeguarding committee's reporting schedule also ensures it receives regular updates from key named professionals for example child sexual exploitation.

6. Attendance at External Meetings

The Head of Safeguarding represents CHFT at the Local Safeguarding Adults and Children's Board for Calderdale and Kirklees Councils. The Named and Designated Professionals for CHFT attend and pro-actively contribute to the work of the sub-groups of the Boards. Our Safeguarding staff meets with the Designated

Professionals for Safeguarding Adults and Children (CCG) regularly, and the Designated Professionals also attend our Safeguarding Committee meeting.

7. Activity and Performance Data

a) Further work continues to ensure that internal systems are capturing the data required to report safeguarding activity consistently and effectively. Data has been captured quarterly reflecting the frequency of the safeguarding committee meeting. A new safeguarding dashboard within the Datix system and Dataset for the Safeguarding Committee has been developed and will be

b) The Safeguarding Children team receive reports of suspected safeguarding incidents in relation to children via the DATIX reporting system, and respond to individual incidents on a case by case basis. The safeguarding team have developed a database to capture concerns and incidents and log all referrals received.

c) To improve data collection a new children's safeguarding referral form has been developed by the team to improve communication and data collection. There have been developments in new databases within the team to record all activity and contacts made into the office.

d) The Safeguarding Adults team also receive notifications of any suspected safeguarding incidents involving adults via the DATIX reporting system. The team respond to each incident on a case by case basis; it may trigger further investigation or it may inform the team that it does not require referral through the safeguarding procedures. All safeguarding incidents that meet the threshold for referral are reported to the relevant Local Authority who leads any safeguarding investigation unless the incident requires criminal intervention and the Police would be the lead investigator.

e) The Child Protection Information Sharing System (CPIS) went live last year (2015). CPIS is an NHS England sponsored programme that has a national roll out, dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings nationally. CP-IS will share information for those children who are subject to a Child Protection Plan (CCP), Looked after Children (LAC) and any pregnant woman whose unborn child has a pre-birth protection plan. There is an expectation that 80% of NHS Trusts will

be on board by 2018, the Local Authority have an earlier completion date. The Safeguarding Team receive alerts via this system.

8. PREVENT

CONTEST, is the UK national counter-terrorism strategy, and one of the elements of it is PREVENT, which aims to stop people becoming terrorists or supporting terrorism. The NHS is a key strategic partner in the PREVENT work stream, as it is recognised that healthcare professionals may meet and treat people who are vulnerable to radicalisation. This duty is incorporated into the NHS contract. CHFT's PREVENT Policy describes how the PREVENT Strategy is implemented in CHFT. PREVENT has 3 national objectives:

- Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
- Objective 3: work with sectors and institutions where there are risks of radicalisation which we need to address.

Representation is provided by the Trust at appropriate external meetings including the regional PREVENT leads meeting and district level CHANNEL meetings, by the Resilience Manager. CHANNEL is a multi-agency group, which meets on an as required basis, with the purpose of undertaking risk assessments of PREVENT referrals and then developing support programs to divert those identified away from potential radicalisation where appropriate.

PREVENT is part of the NHS contract. CHFT has made significant progress in working towards its responsibilities towards the PREVENT agenda. CHFT is considered an exemplar site in relation to the number of staff trained. All staff are required to attend a one off face to face Health Wrap training session. Additional training sessions and larger target audiences aimed at will ensure numbers of staff trained in PREVENT continue to increase. The Trust has trained 3868 members of staff and has 8 trainers currently delivering this in addition to their roles within the organisation. PREVENT figures are monitored monthly at the safeguarding committee meeting.

9. Savile Legacy

In December 2014 CHFT completed its 'Investigation into the role Jimmy Savile is alleged to have played at the RHI,' which found no evidence to connect him with RHI in the 1970's or at any other time. In February 2015 an independent report for the Secretary of State for health was published (Themes and lessons learnt from NHS Investigations into matters relating to Jimmy Savile). CHFT has further updated this in March 2016. CHFT VIP and Media Policy has been recognised as an area of good practice by Calderdale Safeguarding Children's Board, and adopted by them to be shared with other agencies.

10. Audit

A number of audits have taken place over the past year in order to monitor policy and practice and inform us of how we can further improve our safeguarding practices including:

Children

- Section 11 Audits in 2015 for both Calderdale and Kirklees Safeguarding Children Boards and participated in challenge events. Section 11 of the Children Act 2004 places a statutory duty on organisations, and individuals, to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children and all agencies are required to submit an annual self-assessment to the Safeguarding Children Board.
- The referrals audit.
- Paediatric Liaison form audit.
- The EDIS audit for flagging LAC and Child Protection plans.

Adults

Mental Capacity and Deprivation of Liberty safeguards Audit in June 2015 and October 2015. Comparatively this has shown MCA/DoLS awareness has improved. This correlates in line with the significant increase in the number of DoLS applications to the Local Authorities. Actions were put in place after the initial audit to provide further training to ward areas where a DoL was more likely to occur based on the analysis of the audit.

11. Serious Case Reviews (SCR), Serious Adult Reviews (SAR), and Domestic Homicide Reviews (DHR)

The Safeguarding Team contribute and are authors of SCRs, SARs, and DHRs. There are currently:

- DHRs –
  Calderdale x1 ongoing
  Kirklees x3 completed and x1 ongoing/ Out of area – x2 ongoing
- SCRs-
  Calderdale x4 completed, x2 ongoing, x2 pending
  Kirklees – x2 completed, x2 pending, x1 single agency review pending/ out of area – x2 pending
- SAR- none

12. New Domestic Violence Hub In Calderdale

National estimates suggest that 30% of women and 16% of men have experienced domestic abuse since the age of 16, with 7.1% of women and 4.4% of men having experienced domestic abuse in the past year. The estimated number of women and girls aged between 16 and 59 who have in the past 12 months been a victim of domestic abuse in Calderdale is 5,179.

The police recorded 3,753 domestic violence incidents in 13/14, although the true number is more likely to be 9,154, based on an assumption of a third of cases being reported (West Yorkshire Police, 2014). It was recorded that Calderdale has the highest proportion of repeat victims in West Yorkshire at 37.7% (West Yorkshire Police, 2014). The data collected showed that there was a child present at 39.5% of incidents that the police attended.

With these figures at the forefront a new Domestic violence Hub in the police station went live in January. CHFT has seconded a member of staff in this Hub. Two new posts will be created in a band 6 and 7 from April who will target training for GPs and in the accident and emergency department. CHFT will host these members of staff.

A task and finish group in the Trust is focusing on the new NICE guidance for Domestic Abuse along with updating the Policy and looking at how we capture the children of victims is ongoing.

13. Joint work on Safeguarding and Risk

The following areas of work are taking place to ensure a more integrated approach to risk management and safeguarding, with weekly meetings between the Head of Safeguarding and Head of Governance and Risk taking place.

- Review of new and ongoing safeguarding incidents and linkage with any coroner activity
- Identification of incident and complaints data for safeguarding dashboard and identification of cases to review improvements in practice
- Attendance by safeguarding team at pressure ulcer meeting (weekly) to identify and pressure ulcers arising due to abuse or neglect
- Sharing of outcomes of serious case reviews re; Trust with senior Serious Incident Review Group
- Supporting the development of the risk register for safeguarding

14. Further plans for 2016-2017

a) The Safeguarding Children Policy requires updating in line with Working Together to Safeguard Children 2015 due to the review of the target groups

b) The Domestic Abuse Policy also requires updating this year

c) The Managing Allegations of Abuse Against Staff is currently under review to strengthen the systems and structures and reporting within the Divisions and departments

d) Work with the Risk Department to ensure that datix is capturing all reported concerns correctly for reporting purposes, and on the presentation of themes and trends

e) Further embedding of the Care Act and ensuring that outcomes are feedback to staff who report concerns in close liaison with other partner agencies.

f) Further plans once the Safeguarding Adult Policy is reviewed to have a separate the MCA/DoLS policy

g) Safeguarding training compliance will be monitored closely at each safeguarding committee meeting and actions taken where training figures do not continue to rise

h) Further work is planned within Calderdale CCG and a new Domestic Violence Lead (Band 7) will be in post this year and a band 6 to support this work hosted and employed by CHFT. This is part of Calderdale's strategic response to Domestic Violence and Abuse and its commitment to ensuring its support. The main priorities for this post are providing training for GP's, in accident and emergency departments, and being the single health representative in the Domestic Violence Hub based in Calderdale Police Station.

i) The Safeguarding newsletter continues to be a source of updates for staff. CHFT weekly has also ensured key messages such as FGM have been publicised.

j) Further work is being undertaken with South West Yorkshire Mental Health Trust. CHFT is registered to provide the regulated activity of assessment or medical treatment for people detained under the Mental Health Act 1983.

k) Following notification of the statutory Goddard Inquiry the Safeguarding Team are formulating a 'Goddard Action Plan' to assure the Trust Board that systems and process are in place and where there are potential gaps action plans are formulated.

l) The Safeguarding Team is working closely with the Risk department to capture learning from incidents and complaints from a safeguarding perspective. This will involve the development of a template for capturing key lessons and learning.

m) The Allegations Management Policy is being reviewed and updated at present by both Human Resources and the Safeguarding Team. A database is now kept of any allegations that are made against members of staff.

n) Further work should be completed this summer in relation to Child Sexual Exploitation with CSE being added to the Trust safeguarding Children Policy, relevant information on CSE throughout the Trust for young people to access; targeting of staff in Accident and Emergency to identify young people at risk and continuing to collect information in relation to young people at risk of CSE who may access our services.

o) The Safeguarding Team are planning on Integrating within the same offices in the true spirit of the Care Act 2014.

p) There is development of a safeguarding strategy and plan which has commenced and is ongoing. With further planned collaborative working with Discharge Matron and continued attendance at the length of stay meeting.

q) Securing honorary contracts to enable Mental Health Liaison Psychiatrists to act as Responsible Clinicians for CHFT detained patients, writing a Mental Health Act policy for CHFT to include roles and responsibilities processes and training strategies, finalising a service level agreement for the Mental Health Liaison Team service and servicing of Mental Health Act papers by SWYPT, training for Duty Matrons and Site Commanders on the receipt and scrutiny of mental health act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the act.

r) Work is planned within the Domestic Violence and Abuse task and finish group to update the Domestic Violence Policy and development of a pathway for low and medium risk cases; within this pathway will be identifying children of victims of domestic violence and abuse.

Conclusion

This annual report provides an insight into CHFT developments and plans for 2016-2017. It aims to provide assurance to the Trust Board that safeguarding remains a key trust priority and continued work is ongoing to embed a culture of safeguarding children and adults in all aspects of patient care.

The board is asked to note the contents of this report.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 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: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

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:

-

Next Steps:

The plan will be refreshed for 2016/17 and discussed as part of the Board / Membership Council workshop in May

Recommendations:

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

Appendix

Attachment:

Progress against strategy Board report April 2016.pdf

Calderdale and Huddersfield NHS Foundation Trust
1 Year Plan - Progress Report April 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. The 1 year plan for 2016/17 is currently being developed and will be discussed at the Board workshop in May prior to sign-off by the Board.

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.
- One (two) is rated amber / red i.e. off track with a plan in place.
- 14 (17) are rated amber / green i.e. on track but not yet delivered.
- Five (three) have been fully delivered or rated green.
- Two are closed i.e. the deliverable has been superceded.

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 in post. New structure to be approved at Divisional Business Meeting in April.	Divisional Business meeting
Develop and roll out the first wave of 7 day working standards	**On track but not yet delivered (amber/green)**	Included in West Yorkshire early implementer programme; Detailed audit currently underway for completion mid-April (on track) with result expected May. High level action plan completed and submitted as per national requirements and programme aligning to wider Patient flow programme to maximise benefits Plan agreed for roll-out of hospital@night	Reported to Weekly Executive Board (Apr) and Quality Committee. To be included in Safer Flow programme report to Programme Board.
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 2 assurance review has 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. All care bundles have been reviewed. 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 Trust is a member of the West Yorkshire Association of Acute Trusts (WYAAT). This is an alliance of the 6 Acute Providers (including Harrogate). The aim is to work together (and with commissioners) to deliver change in the way clinical resource and expertise is delivered to patients in acute services across the West Yorkshire population and as a result generate clinical and financial sustainability benefits. Examples of key areas of work in progress includes: • Input to development of the West Yorkshire Sustainability and Transformation Plan (key areas of focus are mental health, specialist commissioning, stroke and cancer services). • New models of access to imaging services and the increased use of technology to support this.	Chief Executive report to Board on WYAAT. Board to boards with SWYPFT and MYHT

		• Collaboration on estates and facilities management. • Cost improvement planning and implementation of the recommendations of the Carter Review. Review of Pharmacy supply models.	
Develop and implement a Public and Patient Involvement Plan	**On track but not yet delivered (amber/green)**	Approved PPI Plan in place and being delivered. .	PPI section included in quarterly Quality Report.

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	**CLOSED**	The CQC visit and unannounced visit were undertaken in March. The 2016/17 plan will capture the work being undertaken to deliver the actions resulting from the visit.	Monitored through WEB and Quality Committee. Report on self-assessment to Quality Committee. 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 implementation on track for M1 16/17 data. Incorporating requirements of Carter review into reporting suite	IPR to May Board with M1 data Terms of Reference for Directorate and Divisional Reviews Internal audit (requested by COO in 16/17 plan)
Ensure robust plans are in place to monitor and deliver A&E and C Diff	**On track but not yet delivered (amber/green)**	Q4 Emergency care Standard delivered at 90% reflecting significant internal and external pressures. Safer flow programme developed and launched on 11th April involving system partners. SEB dedicated to improvement planning in May 16. Emergency Care Standard monitoring suite in place with greater focus on quality metrics but further work on information flows across the system required to secure sustainable improvement. System currently being reviewed CDiff monitoring continues with positive outcomes	Integrated Board Report to Board and Quality Committee Quarterly quality account Safer flow Programme
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	**Delivered (green)**	Interim Health and Safety Manager is working closely with Divisions to raise the profile of health and safety and promote learning from incidents.	Quality Committee from Health and Safety Group including half year review of progress

		Regular reporting of incidents shared at Health and Safety committee which is well attended by all Divisions, key health and safety specialists and staff side. Risk Assessment methodology is aligned with risk register matrix encouraging a consistent approach to managing and controlling risk	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). A process for the sign-off of budgets and establishments agreed by workforce and finance is in place. Work in progress to refine process for authorising changes in-year to budgets and establishment.	To be monitored through Workforce (Well Led) 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 complete and launched releasing capacity to focus on intranet improvements. New 'four pillars' based posters campaign launched. Specific work being undertaken in relation to Right Care, Right Time, Right Place.	Monitored through Colleague engagement, health and wellbeing group reporting to Workforce (Well Led) 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. 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 Workforce (Well Led) Committee. Medical Workforce Group established with agenda to review staffing levels, progress international recruitment and refresh job planning framework. Allied Health Professional Workforce Group being established.	Hard Truths report to Board. Workforce (Well Led) 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. Year of Health and Wellbeing launched with further work established to support the introduction of the NHS staff health and wellbeing CQUIN from April 2016. Attendance management team operational with agreed KPIs reported to Workforce (Well Led) Committee and	To be monitored through Workforce (Well Led) Committee

		Executive Board.	
Design a strategic framework to articulate and govern a value driven people focussed approach using work together to get results	**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 development programme to be incorporated into this work.	To be monitored through Workforce (Well Led) Committee
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 completed 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. An Education and Learning Group workshop to inform the education and training strategy with an associated work plan scheduled for 10 May 2016.	Reported to WEB (21/1) To be monitored by the Workforce (Well Led) Committee

Goal: Financial sustainability			
Deliverable	Progress rating	Progress summary	Assurance route
Deliver a robust financial plan including CIP for 2015/16 and 2016/17	**Delivered (green)**	The 2015/16 reforecast financial plan has been delivered (subject to Audit). The actual deficit of £20.98m is an improvement on the original plan of £23.01m by £2.03m and an improvement on the reforecast plan of £22.03m by £1.05m. This includes an over achievement of CIP. £18.01m has been delivered against a plan of £14.05m. The 2016/17 plan has been agreed by the Board and submitted to Monitor for agreement. The ongoing CIP work will be included on the 2016/17 1 year plan.	Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Refresh the Commercial Strategy	**CLOSED**	The commercial opportunities have been captured in the 5 Year Plan and will be identified within the detailed implementation plans which form part of the 16/17 1 Year Plan.	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 Trust's 5 Year Strategic Plan was completed at the end of December 2015. Ernst & Young updated the plan in January 2016 to incorporate changes in national planning and tariff guidance and the updated plan was approved by the Trust Board. The plan has now been made publically available.	Board meeting December.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: MEMBERSHIP COUNCIL ELECTION - TIMETABLE - The Board is asked to receive and approve the Membership Council Election Timetable.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Membership Council Meeting - 7.4.16	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Each year, elections are held for a range of seats on the Membership Council. This year there are 11 seats spread across both public and staff constituencies which are eligible for election. Membership Councillors in some of these constituencies are eligible to stand for re-election.

In accordance with the Trust's constitution, and for the purposes of fairness and transparency, an independent specialist organisation conducts these elections on behalf of the Trust. Our provider of this service is currently Electoral Reform Services (ERS).

The process involves briefing prospective candidates; verification of membership; creating and distributing ballot papers; counting and notifying the Trust. In order for this to process to be conducted in an efficient and democratic manner, ERS issues a timetable for these activities on the attached.

Main Body

Purpose:

Please see attached timetable

Background/Overview:

Please see above

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to receive and approve the Membership Council Election Timetable.

Appendix

Attachment:

ELECTION TIMETABLE - 2016 - FINAL.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

PROPOSED ANNUAL ELECTION TIMETABLE – 2016

DAY	DATE	ACTION
Thursday	15 September 2016	Trust & Members Annual General Meeting – Formal Election Announcement
Monday	22 August 2016	Issue of Results to Trust
Friday	19 August 2016	Close of Ballot
Wednesday	27 July 2016	Voting packs despatched by ERS to members
Tuesday	26 July 2016	Notice of Poll Published by ERS provided to Trust
Wednesday	13 July 2016	Electoral data to be provided by Trust. Uncontested report provided to Trust
Friday	8 July 2016	Final date for Candidate withdrawal
Wednesday	6 July 2016	ERS & CHFT publish summary of nominated candidates upon validation
Tuesday	5 July 2016	Deadline for receipt of nominations
Tuesday	7 June 2016	ERS/CHFT issue the Notice of Election. Nomination forms to be made available to CHFT
Wednesday	25 May 2016	Briefing Sessions for prospective Council Members – Boardroom, Sub Basement, Huddersfield Royal Infirmary
Monday	23 May 2016	Briefing Sessions for prospective Council Members – Large Training Room, Learning Centre, Calderdale Royal Hospital

BRIEFING SESSIONS FOR PROSPECTIVE CANDIDATES		
Monday	**23 May 2016 at 6.00 pm**	**Large Training Room, Learning Centre, Calderdale Royal Hospital**
Wednesday	**25 May 2016 at 6.00 pm**	**Boardroom, Sub Basement, Huddersfield Royal Infirmary**

VACANT POSITIONS AND CANDIDATES ELIGIBLE FOR RE-ELECTION*	
NAME	**CONSTITUTENCY**
PUBLIC	
Rev. Wayne Clarke*	2 - Birkby, Crosland Moor, Deighton, Newsome, Paddock
Ken Batten (resigned 4.4.16)	2 - Birkby, Crosland Moor, Deighton, Newsome, Paddock
Dianne Hughes*	3 - Almondbury, Dalton, Denby Dale, Kirkburton
Vacant Posts x 2	4 - Batley East, Batley West, Birstall & Birkenshaw, Cleckheaton, Dewsbury East, Dewsbury West, Heckmondwike, Mirfield, Spenborough, Thornhill
Grenville Horsfall*	5 - Brighouse, Elland, Greetland, Stainland, Rastrick, Skircoat
Jennifer Beaumont*	8 - Colne Valley West, Golcar, Holme Valley North, South and Lindley
STAFF	
Vacant Post	10 - Allied Healthcare Professionals/HCS/Pharmacists
Vacant Post	12 - Ancilliary
Chris Bentley	13 - Nurses/Midwives
Julie Hoole (resigned 4.4.16)	13 – Nurses/Midwives
NOMINATED STAKEHOLDERS – 3 year tenure review	
Dawn Stephenson	South West Yorkshire Partnership NHS FT

* = Eligible for Re-election

/KB/MC-ELECTION2016

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: MODERN SLAVERY AND HUMAN TRAFFICKING ACT STATEMENT - The Board is a asked to receive and approve the statement for the Annual Report regarding the Modern Slavery and Human Trafficking Act	
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 a asked to receive and approve the statement for the Annual Report regarding the Modern Slavery and Human Trafficking Act

Main Body

Purpose:

In line with the Modern Slavery Act 2015, the Trust is required to make a statement of compliance within its Annual Report.

Background/Overview:

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act.

The Issue:

Please see attached

Next Steps:

Once approved, the statement will be included in the narrative of the 2015/16 Annual Report, due to come to the Board at the end of May.

Recommendations:

The Board is a asked to receive and approve the statement for the Annual Report regarding the Modern Slavery and Human Trafficking Act

Appendix

Attachment:

MODERN SLAVERY ACT 2015.pdf

MODERN SLAVERY ACT 2015

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act.

Summary

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36 million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the board of directors.

The aim of the statement is to encourage transparency within organisations, although it is possible to comply with the provision by simply stating that no steps have been taken during the financial year to ensure that the business and supply chain is modern slavery free. It is worth noting that although this may be an acceptable approach for this year's statement, there is an expectation that further work will be undertaken to provide these assurances in years to come. There are potential consequences for those organisations that do not appear to make progress in this area; especially for those that are funded wholly, or in part, by public money.

Assurance

The Trust will be required to review and /or prepare a similar statement on an annual basis. To support the production of the statement assurance mechanisms will be put in place, including the use of Internal Audit. Internal Audit's work would include a review of the systems in use by the Trust that seek appropriate assurance from other organisations. These assurances will be included in Internal Audit reports that will be discussed at the Audit and Risk Committee.

Modern Slavery and Human Trafficking Act 2015 Annual Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

Calderdale and Huddersfield NHS Foundation Trust provides acute hospital and specialist healthcare services from its two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary. The Trust also provides a range of community services in Calderdale. Our annual turnover is over £330 million.

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. The top 80% of suppliers nationally, affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain. During 2016 the Trust will be writing to all suppliers requesting them to affirm their compliance with the legislation.

Internal audit undertake an annual audit on financial control as part of their audit plan. The audit includes a statutory compliance element. In future this will include the modern slavery and human trafficking act requirements.

The procurement department's senior team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPs code of professional conduct. Over the next year, specific training will be provided for the Trusts internal supply chain management related to modern slavery and human trafficking.

Information on modern slavery and human trafficking has been shared through the Trust's internal communications methods. Human Trafficking training is delivered as part of the Level 2 eLearning package and Level 3 Safeguarding Training. Some staff have also attended 'Hope for Justice's' bespoke training regarding Human Trafficking.

The Trust has evaluated the principle risks related to slavery and human trafficking as:

- Lack of assurances from suppliers
- Lack of appropriate clauses in contracts
- Reputational.

Performance indicators will be developed during the year to provide the reader with an ability to assess the effectiveness of the statement.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

……	……
Andrew Haigh	Owen Williams
Chair	Chief Executive

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: March 2016

Board of Directors Report

Integrated Performance Report

Executive Summary Commentary

Responsiveness:

Variance against plan - Non elective and % day case variance against plan are both improving this month. But Elective and outpatient variance have both continued to decline. The overall picture as with most acute trusts is an increasing volume of admissions to A&E leading to increasing pressures on staff and beds. Targets related to this such as A&E admission and waiting times have been negatively impacted.

Patient Pathway metrics – The majority of patient pathway metrics, such RTT waits, diagnostic waits and % of incomplete pathways have been improving this quarter and are rated green. The exception being mostly measures relating to the increased patient pressure such as % of last minute cancellations to elective surgery which is red and continues to deteriorate this quarter.

Caring:

Patient experience-the trust maintains a high level of patients reporting through the Friends and Family test. Low scores were probably an impact of the access issues with Outpatient and A&E satisfaction falling in the past quarter and in Amber this month. The % that would recommend A&E is now in red as is the % that would recommend the community service, which has been falling throughout the quarter.

Complaints – the total numbers of Complaints are up again this month in line with the trend throughout this final quarter. This might be a consequence of the increased pressure that the trust has experienced throughout the quarter.

Safety:

Serious incidents and Never events – There were 3 serious incidents in month 1 in each division apart from community and 1 never event in month, related to the same issue as the event reported last month. This incident although reported this month took place in December so any action taken last month to address this would not impact this.

Ulcers – All categories of pressure ulcers increased in the quarter and Categories 2 and 3 pressure ulcers are reported red.

Effectiveness:

Mortality rates – all mortality indicators are now showing red and all have risen over the past quarter. This is the focus of significant work to understand and address this worrying trend.

Clostridium Difficile – There has been 2 cases of CDiff reported this month, 1 in Medical and 1 in Surgical. There were no cases of MRSA reported

#NoF performance – continues to fall and is now at less than 62% against a national target of 85%

Workforce:

Sickness – Absence rates for sickness are higher than target in 4 out of 7 divisional groups. Overall the majority of the trusts sickness is due to long term sickness rather than short term sickness.

Staff Friends and Family test – Whilst the figure for those that would recommend the trust as a place to receive treatment is increasing, those that would recommend the trust as a place to work is declining. This would suggest morale is falling, which if true might relate to increasing sickness levels. It is also possible that this relates to the increasing pressures on the hospital due to increased patient numbers through A&E.

Finance:

Finance: Month 12 elective income was below plan as was Day case, however overall total income was above plan and the Trust embedded the year with an overall £2.03million surplus above plan

CQUINS- all CQUINs apart from Acute Kidney injury and Sepsis were achieved, although it should be noted that results for pneumonia deteriorated in the final quarter and this might be an area to watch in the coming year.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Table Of Risk

compassionate care

	Improving						No Change						Deteriorating					
Monitor	Ccr 31 Dy Diag to Trt	Cdiff Tst Assgnd	Ccr 38 Dy Ref to Trtry				Ccr 62 Dy Scrn 2 Trt	Ccr 31 Dy Sub Sur Trt	Ccr 31 Dy 2nd or sub Trt drg	Ccr 2 Wk Wt Brst	Cmmnty - RTT info comp	Cmmnty - rfrrl info comp	A and E 4 hr	Ccr 62 Dy Gp	Ccr 2 Wk Wt			
							Cmmnt - actvty info comp											
Contract	% Strk 90% stay on unit	DQ NHS no comp A&E	DTOC	Percentage of Non-Compliant Duty of Candour	Total Duty of Candour shared within 10 days	RTT Admitted	VTE Rsk Ass	DQ NHS no comp IP	MRSA Trst Assgnd	Cncl Urgnt Ops 2nd time	Mixed Sex Breach	Never Events	% Strk scan < 1 hr arrival	% Strk Thrmblysd < 1 hr	A&E Amb H/O 30-60 mn	RTT Non-admitted	RTT Incomplete	Cncl Elctv Surg
	RTT Community	Breach Reg Cncl 28 Dy Std	Med Sfty – Recncltn	18 wks >=26 wks	A&E Amb Trans 60+ mins	Breach Reg Cncl 28 Dy Std	A&E Trlly Wts	RTT Waits > 52 wks					% Harm Free Care	Ccr 62 Dy Agg Trt & Scrn	Sls inv rep sub < tmscl	Med Sfty – Dschge Acc	Diagn 6 Wks	18 wks >=40 wks
													Home Births					
NHSE	FFT Mat recmmnd	Stg 1 RCAs HAT	Antenatal < 13 wk	Maternal smoking	IPMR - Breastfeeding	FFT Cmmty Response	Sepsis Screen						FFT IP recmmnd	FFT A&E recmmnd	FFT Cmmty recmmnd	FFT IP Response	FFT A&E Response	75+ dementia screen
	FFT OP Recmmnd	FFT Mat Response	Central Line Infections										FFT OP Response					
Quality	Local SHMI Relative Risk (1yr Rolling Data October 14	Mortality Reviews	Avg Diag / FCE	Falls - Serious Harm	All Falls	Stillbirths Rate	Nntl Dths (8-28 days)	Comp < 3 wking dys	Sls < 2 dys	Pat Incidents	Sls		Hospital Standardised Mortality Rate (1 yr Rolling Data	Crude Mort Rate	Percentage Non-elective NoF Patients With	A&E Left not seen	A&E Intl Ass	A&E Time to Treat
	Lbr concern over safety	Lbt alone & worried	Emer Rdmssns <= 30 Dys	Emer Rdmssns <= 30 Dys CCG	Emer Rdmssns <= 30 Dys GHCG	Sign & Sym coding							A&E Unplnnd Re-Attend	Diabetic pats self-care	SG Alerts by Trust	SG Alerts agnst Trust	Prntl Dths (0-7 days)	Ccr 104 Ref to Trt
	Cdiff Unavoidable	MRSA Screen	EColi	MSSA - Post 48 Hrs	Complaints < time	Women Physical Harm Free							Avg co-morbidity	Hand Hygiene	Cdiff Avoidable	Comp received	Concerns	Harm Incidents
	Women - Perception of safety	Women cmbnd Harm Free											PU CHFT acqrd	PU CHFT acqrd Cat 2	PU CHFT acqrd Cat 3	PU CHFT acqrd Cat 4	PU CHFT acqrd Cat 3&4	
Other Internal	% Out Var	T Util (TT) - CRH	T Util (TT) - HRI SPU	WHO	Outliers	Research Recruit	Elec C-Section	% DN with care plan					% Elective Var	% Day Case Var	% Non-elec Var	T Util (TT) - HRI Main	T Util (TT) - HRI DSU	Pre 12pm disc
	% Spells > 5 Moves	Full Trm to SCBU (NNU)	Major PPH	A and E 6 hr	A and E 8 hr	A and E 10 hr							Green Cross	1st DNA Rate	Hosp Out Cncl	Spells	Spells > 2 Moves	% Spells > 2 Moves
	Died in chosen place	Antenatal HV < 32 wk	HV Post Birth < 14 days	Home Equip < 7 days	Cmm Readmitted < 30 days								Spells > 5 Moves	Total C-Section Rate	Over 37 wks APGAR5<7	3rd / 4th Degree tear	% Non_Elec NoF Adm < 36 hrs	Ccr 7 Dy Ref 1st Frst Sn
													LTC with care plan	% leg ulcers < 12 wks	% Comm Ulcers docum			

Improving Green	Improving Amber	Improving Red	No Change Green	No Change Amber	No Change Red	Deteriorating Green	Deteriorating Amber	Deteriorating Red
33	5	16	19	0	1	23	4	29

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

Governance Rating : Red relating to enforcement action on finance

		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%	92.21%	91.86%	91.96%	91.92%
	% 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%	98.32%	98.39%	98.17%	98.48%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%	95.95%	95.80%	95.70%	95.70%
	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%	91.49%	89.44%	89.30%	93.88%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3	3	4	2	1	3	3	2	25
	Total Number of Clostridium Difficile Cases - Lapses in Care	10.5	1	0	1	0	0	1	1	1	0	0	0	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%	91.04%	94.53%	89.40%	91.19%
	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%	94.44%	100.00%	100.00%	95.74%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	100.00%	100.00%	100.00%	99.15%
	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%	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%	100.00%	99.09%	100.00%	99.81%
	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%	98.86%	99.27%	98.95%	97.34%
	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%	96.85%	96.55%	96.55%	95.82%
	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%	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%	97.82%	97.74%	97.68%	98.06%
	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%	100.00%	100.00%	100.00%

Third Party Reports	No new third party reports noted
Quality Governance Indicators	

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	4
	Use of Capital	£20.72m	£20.15m
	Income and Expenditure (excluding Restructuring)	(£20.01m)	(£19.88m)
	Cost Improvement Programme (CIP)	£14.05m	£18.01m

Responsive

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker, Chief Operating Officer

compassionate care

Report For: March 2016		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date 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%	-26.16%	-30.91%	-20.16%	-7.32%	-	0.00%	-6.36%	-8.50%	-5.40%	3.53%	-		↓		
	% Day Case Variance against Plan	Local	0.00%	-15.35%	-22.95%	2.16%	-1.83%	-	0.00%	-13.02%	-18.33%	-1.73%	1.07%	-		↑		
	% Non-elective Variance against Plan	Local	0.00%	5.09%	3.48%	9.37%	-1.28%	-	0.00%	3.65%	-0.72%	4.73%	4.46%	-		↑		
	% Outpatient Variance against Plan	Local	0.00%	-3.22%	-1.58%	-0.68%	-13.51%	-	0.00%	-0.37%	0.11%	0.24%	-3.12%	-		↓		
RESPONSIVE - Planned Activity	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	83.99%	81.45%	-	102.86%	-	92.50%	86.05%	84.40%	-	98.25%	-		↓		
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	88.36%	88.36%	-	-	-	92.50%	94.42%	94.42%	-	-	-		↓		
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	78.00%	76.90%	-	89.05%	-	92.50%	78.04%	76.94%	-	88.01%	-		↑		
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	84.68%	84.68%	-	-	-	92.50%	82.73%	82.73%	-	-	-		↑		
Exception Report - Patient Flow	% Daily Discharges - Pre 12pm	Local	40.00%	16.84%	29.46%	13.21%	12.97%	-	40.00%	19.47%	28.12%	16.00%	17.50%	-		↓		
	Delayed Transfers of Care	Local	5.00%	3.30%	-	-	-	-	5.00%	5.13%	-	-	-	-		↓		
	Green Cross Patients (Snapshot at month end)	Local	40	98	10	88	-	-	40	98	10	88	-	-		↑		
	Number of Outliers (Bed Days)	Local	495	883	41	842	0	-	5868	8878	596	8524	0	-		↑		
	No of Spells with > 2 Ward Movements	Local	M	143	26	96	21	-	-	1634	288	1041	305	-		↑		
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.72%	1.83%	4.97%	1.11%	-	2.00%	2.42%	1.58%	4.85%	1.10%	-		↑		
	No of Spells with > 5 Ward Movements	Local	M	2	0	2	0	-	-	42	4	38	0	-		↓		
	% of spells with > 5 ward movements (No Target)	Local	M	0.04%	0.00%	0.10%	0.00%	-	-	0.06%	0.02%	0.18%	0.00%	-		↓		
	Total Number of Spells	Local	M	5250	1420	1933	1897	-	-	67474	18243	21482	27839	-		↓		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker, Chief Operating Officer

compassionate care

	Report For: March 2016	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	Data Quality
									Year To Date									
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	89.30%	-	89.30%	-	-	95.00%	93.88%	-	93.88%	-	-		↓		
	A and E 4 hour target - No patients waiting over 6 hours	Local	-	706	-	706	-	-	-	3884	0	3884	0	0		↑		
	A and E 4 hour target - No patients waiting over 8 hours	Local	-	269	-	269	-	-	-	1347	0	1347	0	0		↑		
	A and E 4 hour target - No patients waiting over 10 hours	Local	-	111	-	111	-	-	-	434	0	434	0	0		↑		
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:31:00	-	00:31:00	-	-	00:15:00	00:22:00	-	00:22:00	-	-		↑		
	Time to Treatment (Median)	National	01:00:00	01:06:00	-	01:06:00	-	-	01:00:00	00:57:00	-	00:57:00	-	-		↑		
	Unplanned Re-Attendance	National	5.00%	6.03%	-	6.03%	-	-	5.00%	5.17%	-	5.17%	-	-		↑		
	Left without being seen	National	5.00%	4.39%	-	4.39%	-	-	5.00%	3.21%	-	3.21%	-	-		↑		
	A&E Ambulance Handovers 30-60 mins (Validated)	National	0	101	-	101	-	-	0	184	-	184	-	-		↑		
	A&E Ambulance 60+ mins	National	0	25	-	25	-	-	0	41	-	41	-	-		↑		
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→		
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.61%	6.84%	6.65%	5.95%	3.49%	7.00%	6.64%	6.67%	6.86%	6.27%	3.48%		↓		
	% Hospital Initiated Outpatient Cancellations	Local	12.0%	16.00%	15.30%	20.00%	11.90%	-	12.0%	14.10%	13.90%	16.30%	11.20%	-		↑		
	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%	98.17%	98.49%	97.27%	98.98%	-	95.00%	98.48%	98.52%	98.29%	98.75%	-		↓		
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	91.96%	91.45%	98.57%	93.78%	-	90.00%	91.92%	91.23%	99.89%	94.80%	-		↓		
	% Incomplete Pathways <18 Weeks	National	92.00%	95.70%	94.35%	98.52%	98.46%	-	92.00%	95.70%	94.35%	98.52%	98.46%	-		↑		
	18 weeks Pathways >=26 weeks open	Local	0	139	124	11	4	-	0	139	124	11	4	-		↑		
	18 weeks Pathways >=40 weeks open	National	0	1	0	1	0	-	0	1	0	1	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%	99.52%	99.90%	100.00%	99.38%	-	99.00%	99.54%	99.91%	100.00%	99.40%	-		↓		
	Community - 18 Week RTT Activity	National	90.00%	98.70%	-	-	-	97.40%	95.00%	94.50%	-	-	-	94.50%		↑		
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.96%	1.48%	0.12%	0.74%	-	0.60%	0.67%	0.95%	0.08%	1.03%	-		↑		
	Breach of Patient Charter (Sitreps booked with 28 days of cancellation)	National & Contract	0	0	0	0	0	-	0	2	2	0	0	-		→		
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker, Chief Operating Officer

compassionate care

	Report For: March 2016	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities/ Non Financial Impact	Data Quality
Exception Report - Access Stroke	% Stroke patients spending 90% of their stay on a stroke unit	National	90.00%	83.70%	-	83.70%	-	-	90.00%	90.70%	-	90.70%	-	-		↑		
	% Stroke patients Thrombolysed within 1 hour	National & Contract	55.00%	80.00%	-	80.00%	-	-	55.00%	80.00%	-	80.00%	-	-				
	% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	National & Contract	90.00%	47.80%	-	47.80%	Data Source from SNAP. 2 months in arrears		90.00%	68.42%	-	68.42%	-	-				
Exception Report - Elective Access 3	62 Day Gp Referral to Treatment	National & Contract	85.00%	89.40%	91.30%	91.84%	85.00%	-	85.00%	91.19%	91.71%	91.30%	92.47%	-		↓		
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	100.00%	89.47%	-	100.00%	-	90.00%	95.74%	93.88%	-	100.00%	-		↑		
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	99.15%	100.00%	96.92%	-	-		→		
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	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%	90.64%	91.97%	87.76%	85.71%	-	86.00%	91.71%	91.97%	90.98%	94.07%	-		↓		
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	98.72%	100.00%	100.00%	-	96.00%	99.81%	99.80%	100.00%	97.18%	-		↑		
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	98.95%	99.05%	98.14%	100.00%	-	93.00%	97.34%	98.44%	94.41%	96.96%	-		↑		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	96.55%	96.55%	-	-	-	93.00%	95.82%	95.82%	-	-	-		↑		
	7 Day Referral to First Seen	National & Contract	50.00%	61.72%	64.83%	42.79%	81.31%	-	50.00%	44.47%	46.39%	36.03%	51.57%	-		↓		
	38 Day Referral to Tertiary	National & Contract	85.00%	52.94%	28.57%	60.00%	80.00%	-	85.00%	49.54%	48.44%	56.45%	44.00%	-		↑		
	104 Referral to Treatment	National & Contract	-	97.81%	100.00%	95.45%	88.89%	-	-	98.22%	94.91%	-	98.97%	-		↓		
Exception Report - Maternity	Antenatal Assessments < 13 weeks	National & Contract	90.00%	93.80%	-	-	93.80%	-	90.00%	91.60%	-	-	91.60%	-		↑		
	Maternal smoking at delivery	National & Contract	11.90%	9.70%	-	-	9.70%	-	11.90%	9.90%	-	-	9.90%	-		↑		

Caring

Calderdale and Huddersfield NHS Foundation Trust

Caring Executive Summary - Julie Dawes Director of Nursing

compassionate care

	Report For: March 2016	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									
Caring	% Patient died in preferred place of death	Local	95.00%	91.60%	-	-	-	91.60%	95.00%	98.38%	-	-	-	98.38%				
	% District Nursing Patients with a care plan	Local	90.00%	98.00%	-	-	-	98.00%	90.00%	98.17%	-	-	-	98.17%				
	% of patients with a LTC with a Calderdale Care Plan	Local	90.00%	61.00%	-	-	-	61.00%	90.00%	82.50%	-	-	-	82.50%				
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	n/a	0	14	5	9	0	n/a		→		
	% Complaints closed within target timeframe	Local	100.00%	45.45%	36.36%	36.36%	57.89%	50.00%	100.00%	48.45%	45.45%	45.76%	60.93%	29.63%		↑		
	Total Complaints received in the month	Monitor	M	65	13	36	15	1	-	641	189	252	151	27		↑		
	Complaints acknowledged within 3 working days	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.31%	92.53%	95.05%	92.97%	81.94%		↑		
	Total Concerns in the month	Monitor	M	94	29	26	23	1	-	716	239	254	150	25		↑		
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	28.00%	30.70%	37.36%	23.10%	29.00%	-	28.00%	28.60%	32.60%	25.20%	27.33%	-		↑		
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	96.00%	96.94%	97.58%	95.18%	98.15%	-	96.00%	96.85%	97.41%	95.41%	96.85%	-		↑		
	Friends and Family Test Outpatient - Response Rate	Contract	5.00%	13.20%	-	-	-	-	5.00%	13.50%	-	-	-	-		↑		
	Friends and Family Test Outpatients Survey - % would recommend the Service	Contract	95.00%	90.70%	-	-	-	-	95.00%	89.60%	-	-	-	-		↓		
	Friends and Family Test A & E Survey - Response Rate	Contract	14.00%	8.37%	-	8.37%	-	-	14.00%	8.49%	-	8.49%	-	-		↓		
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	96.90%	84.59%	-	84.59%	-	-	90.00%	86.93%	-	86.93%	-	-		↓		
	Friends & Family Test (Maternity Survey) - Response Rate	Contract	22.00%	34.47%	-	-	34.47%	-	22.00%	30.76%	-	-	30.76%	-		↑		
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	96.90%	97.82%	-	-	97.82%	-	96.90%	96.34%	-	-	96.34%	-		↑		
	Friends and Family Test Community - Response Rate	Local	3.40%	13.00%	-	-	-	10.00%	3.40%	11.60%	-	-	-	11.60%		↑		
	Friends and Family Test Community Survey - % would recommend the Service	Local	96.20%	85.80%	-	-	-	86.00%	96.20%	88.80%	-	-	-	88.81%		↓		
Caring Maternity	Proportion of Women with a concern about safety during labour and birth not taken seriously	Local	6.50%	1.75%	-	-	1.75%	-	6.50%	2.84%	-	-	2.84%	-		↓		
	Proportion of women who were left alone at a time that worried them during labour	Local	4.50%	1.75%	-	-	1.75%	-	4.50%	4.16%	-	-	4.16%	-		↓		
	Proportion of Women who received Physical 'Harm Free' Care	Local	70.00%	80.70%	-	-	80.70%	-	70.00%	75.93%	-	-	75.93%	-		↑		
	Proportion of Women with a perception of safety	Local	90.40%	96.49%	-	-	96.49%	-	90.40%	93.87%	-	-	93.87%	-		↑		
	Proportion of Women who received Combined 'Harm Free' Care	Local	70.90%	78.95%	-	-	78.95%	-	70.90%	72.43%	-	-	72.43%	-		↑		

Safety

Safety Executive Summary - Julie Dawes Director of Nursing

Report For: March 2016

		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 Impact	Data Quality
									Year To Date									
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	2	0	2	0	0	12	29	5	23	1	0		→		
	All Falls	Local	M	156	30	124	2	0	-	2033	356	1626	45	36		↓		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	43	7	25	0	11	300	484	79	180	2	223		↑		
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	34	7	20	0	7	204	399	62	150	2	185		↑		
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	8	0	5	0	3	84	77	15	29	0	33		↑		
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	1	0	0	0	1	12	8	2	1	0	6		↑		
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	9	0	5	0	4	96	85	17	30	0	38		↑		
	% of leg ulcers healed within 12 weeks from diagnosis	Local	75.00%	93.30%	-	-	-	93.30%	75.00%	92.15%	-	-	-	92.15%				
	% of patients within community nursing services that have had a pressure ulcer screening documented in their care plan	Local	90.00%	88.20%	-	-	-	88.20%	90.00%	86.97%	-	-	-	86.97%				
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.10%	95.90%	95.70%	89.20%	-	95.00%	95.30%	95.40%	95.60%	94.60%	-		↓		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	n/a	n/a	100.00%	97.70%	97.70%	100.00%	n/a	n/a		→		
	% Harm Free Care	CQUIN	95.00%	93.04%	91.98%	90.00%	100.00%	95.34%	95.00%	93.63%	93.90%	91.01%	99.84%	94.70%		↑		
	Alert Safeguarding Referrals made by the Trust	Local	M	11	-	-	-	-	-	157	-	-	-	-		↑		
	Alert Safeguarding Referrals made against the Trust	Local	M	13	-	-	-	-	-	99	-	-	-	-		↑		
	World Health Organisation Check List	National	100.00%	99.16%	-	-	-	-	100.00%	98.44%	-	-	-	-		↑		
	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%	-				

Safety Executive Summary - Julie Dawes Director of Nursing

Report For: March 2016

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date 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	737	163	331	213	29	-	8539	1770	3963	2260	522		↑		
	Number of SI's	Monitor	M	3	1	1	1	0	-	78	10	32	10	20		↑		
	Number of Incidents with Harm	Monitor	M	156	27	77	38	13	-	2035	319	983	459	270		↑		
	Never Events	National	0	1	0	0	1	0	0	2	0	0	2	0		↑		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.50%	99.50%	99.50%	99.50%	99.50%	99.50%		→		
	Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		↑		
	Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident	National & Contract	100.00%	80.00%	100.00%	57.00%	100.00%	100.00%	-	-	-	-	-	-		↓		
	Total Duty of Candour shared within 10 days	National & Contract	100.00%	91.00%		87.00%	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%	23.60%	-	-	23.60%	-	22.50%	23.90%	-	-	23.90%	-		↑		
	No. of Babies over 37 weeks with APGAR5<7	National	8.00%	0.70%	-	-	0.70%	-	8.00%	0.80%	-	-	0.80%	-		↑		
	Full Term to SCBU (NNU)	National	4.00%	3.80%	-	-	3.80%	-	4.00%	3.00%	-	-	3.00%	-		↓		
	Major PPH - Greater than 1000mls	National	8.00%	10.60%	-	-	10.60%	-	8.00%	10.40%	-	-	10.40%	-		↓		
	3rd or 4th Degree tear from ANY delivery	National	3.00%	4.50%	-	-	4.50%	-	3.00%	3.00%	-	-	3.00%	-		↑		
	Planned Home Births	National	2.30%	0.40%	-	-	0.40%	-	2.30%	1.30%	-	-	1.30%	-		↓		
	Antenatal Health Visiting Contact by 32 Weeks	Local	95.00%	100.00%	-	-	-	105.00%	95.00%	91.80%	-	-	-	105.00%				
	Health Visiting - Post Birth Visits within 14 days	Local	95.00%	100.00%	-	-	-	113.00%	95.00%	96.60%	-	-	-	113.00%				

Effectiveness

Effectiveness Executive Summary

	Report For: March 2016	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									
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	2	1	1	0	-	21	25	5	20	0	0		↑		
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	0	-	-	-	-	0	5	1	4	0	0		→		
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	-	2	-	-	-	-	-	20	2	16	0	0		↑		
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	0	0	0	0	-	12	9	2	7	0	0		↓		
	% Hand Hygiene Compliance	Local	95.00%	99.31%	98.13%	99.89%	99.87%	97.00%	95.00%	99.52%	98.66%	99.81%	99.85%	100.00%		↓		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.11%	95.59%	93.50%	97.44%	n/a	95.00%	99.52%	-	-	-	-		↓		
	Number of E.Coli - Post 48 Hours	Local	-	0	0	0	0	-	23	26	7	18	1	0		↓		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.00	0.00	-	-	-	-	1.00	0.62	-	-	-	-				
Effectiveness 2	Stillbirths Rate (including intrapartum & Other)	National	0.50%	0.22%	-	-	0.22%	-	0.50%	0.41%	-	-	0.41%	-		↑		
	Perinatal Deaths (0-7 days)	Local	0.10%	0.22%	-	-	0.22%	-	0.10%	0.16%	-	-	0.16%	-		↑		
	Neonatal Deaths (8-28 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.04%	-	-	0.04%	-		↑		
	Local SHMI - Relative Risk (1yr Rolling Data October 14 - September 15)	National	100	113.88					100	109.1						↑		
	Hospital Standardised Mortality Rate (1 yr Rolling Data Jan 15 - December 15)	National	100.00	117.18					100.00	113.00						↑		
	Mortality Reviews (one month in arrears)	local	100.00%	38.10%	60.00%	36.00%	n/a	n/a	100.00%	48.80%	58.00%	47.70%	n/a	n/a		↓		
	Crude Mortality Rate	National	1.46%	1.49%	0.50%	3.04%	0.14%	-	1.26%	1.34%	0.40%	3.06%	0.10%	n/a		↑		
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.86%	99.94%	99.96%	n/a	99.00%	99.94%	99.92%	99.95%	99.94%	n/a		→		
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	98.89%	-	98.89%	-	n/a	95.00%	99.04%	-	99.04%	-	n/a		↓		
	% Sign and Symptom as a Primary Diagnosis	National	9.50%	9.4%	-	-	-	n/a	9.50%	9.67%	-	-	-	n/a				
	Average co-morbidity score	National	4.0	4.25	2.2	7.3	-	n/a	4.0	4.09	2.86	6.37	1.73	-				
	Average Diagnosis per Coded Episode	National	4.90	4.89	3.99	6.39	2.76	n/a	4.90	4.34	3.65	5.98	2.46	n/a		↑		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness Executive Summary

compassionate care

Report For: March 2016

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date 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%	61.29%	-	-	-	-	85.00%	69.40%	69.90%	-	-	-		↓		
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - based on admission	National	85.00%	60.47%	-	-	-	-	85.00%	73.36%	74.67%	-	-	-				
	IPMR - Breastfeeding Initiated rates	National	70.00%	78.30%	-	-	78.30%	-	70.00%	79.80%	-	-	79.80%	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.00%	7.37%	4.38%	10.98%	5.46%	-	7.37%	7.72%	4.23%	12.25%	6.05%	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	National	7.63%	7.08%	-	-	-	-	7.97%	7.85%	-	-	-	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	National	6.73%	8.06%	-	-	-	-	7.05%	7.95%	-	-	-	-		↑		
	% 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	100.00%	2.75%	-	-	-	2.75%	10.00%	4.20%	-	-	-	4.20%				
	CHFT Research Recruitment Target	National	92	96	-	-	-	-	1008	933	-	-	-	-		↓		
	Home equipment delivery < 7 days	Local	95.00%	99.80%	-	-	-	99.80%	95.00%	99.47%	-	-	-	99.47%				

Workforce

Well Led March 2016

compassionate care

	Workforce Metric	Trust Target	Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS	Trust Trend
Sickness YTD	Sickness Absence rate (%) ***Target date*** *- 31 Dec 2016*	4.00%	4.61%	4.97%	5.65%	3.89%	4.21%	5.25%	2.38%	3.00%	
	Long Term Sickness Absence rate (%) ***Target date*** *- 31 Dec 2016*	2.70%	3.13%	3.37%	3.99%	2.55%	2.65%	3.96%	1.61%	2.15%	
	Short Term Sickness Absence rate (%) ***Target date*** *- 31 Dec 2016*	1.30%	1.48%	1.60%	1.66%	1.34%	1.57%	1.30%	0.77%	0.85%	
Sickness in month	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.65%	5.60%	5.26%	4.33%	4.27%	4.31%	2.67%	2.09%	
	Long Term Sickness Absence rate (%) (1 Month Behind)	2.70%	3.13%	3.75%	3.58%	2.92%	2.71%	3.54%	1.81%	1.49%	
	Short Term Sickness Absence rate (%) (1 Month Behind)	1.30%	1.52%	1.85%	1.69%	1.40%	1.56%	0.78%	0.86%	0.61%	
Attendance Management KPIs	Sickness returns submitted per month (%) ***Target date*** *- 30 April 2016*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
	Return to work Interviews (%) ***Target date*** *- 31 Dec 2016*	100.00%	33.10%	33.40%	13.90%	48.10%	39.70%	52.70%	47.50%	66.60%	
	Number of cases progressing/not progressing from short term absence to long term absence		***Indicator in development - Data to be validated 30 April 16***								
	Long Term Sickness cases with a defined action plan ***Target date*** *- 30 April 2016*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
	Number of short term absence cases managed at each stage in the formal procedure		***Indicator in development - Data to be validated 30 April 16***								
	Number of visits to dedicated intranet web pages.		1514	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Staff in post	Staff in Post Headcount		5820	1252	1447	654	1567	344	358	198	
	Staff in Post (FTE)		5090.64	1121.40	1308.99	543.63	1342.50	269.10	314.89	190.13	
Turnover	Turnover rate (%)		0.82%	0.71%	0.81%	0.46%	1.01%	1.01%	1.34%	-	
	Turnover rate (%) (Rolling 12m)		14.88%	12.01%	15.46%	23.69%	13.55%	12.24%	16.22%	10.83%	
Vacancies	Vacancies (FTE)*		484.70	66.64	233.11	27.19	76.69	59.74	13.27	8.06	

	Workforce Metric	Trust Target	Add Sci & Tech	ACS	Admin & Clerical	AHP	Estates & Ancil.	Healthcare Scientists	Medical and Dental	Nursing & Midwifery	Staff Group Comparison
Sickness YTD	Sickness Absence rate (%)	4.00%	3.53%	6.98%	3.71%	2.54%	5.93%	2.24%	1.10%	5.34%	
	Long Term Sickness Absence rate (%)	2.70%	2.21%	4.84%	2.53%	1.58%	4.36%	1.03%	0.70%	3.60%	
	Short Term Sickness Absence rate (%)	1.30%	1.31%	2.14%	1.17%	0.96%	1.57%	1.22%	0.40%	1.73%	
Sickness in month	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.25%	7.14%	3.51%	3.01%	5.62%	1.49%	1.76%	5.13%	
	Long Term Sickness Absence rate (%) (1 Month Behind)	2.70%	3.09%	4.99%	2.40%	1.36%	4.66%	0.92%	0.93%	3.43%	
	Short Term Sickness Absence rate (%) (1 Month Behind)	1.30%	1.16%	2.16%	1.11%	1.66%	0.97%	0.57%	0.83%	1.70%	
Staff in post	Staff in Post Headcount		189	1334	1142	400	177	124	534	1920	
	Staff in Post (FTE)		168.97	1096.88	1015.30	337.63	160.91	114.01	514.16	1682.78	
Turnover	Turnover rate (%)		-	0.81%	0.49%	1.00%	-	-	0.70%	1.21%	
	Turnover rate (%) (Rolling 12m)		11.45%	12.94%	14.33%	26.52%	10.98%	14.15%	16.92%	14.26%	
Vacancies	Vacancies (FTE)*		5.91	110.64	78.36	25.93	-0.02	15.11	86.68	159.09	

*Vacancy information is updated monthly and is based on the funded establishment in ESR, this is fed by the establishment information stored in the Trust's financial systems.

Sickness Absence/Attendance Management

Why are we away from plan?

1. Long term absence is above target at 3.13%.
2. Short term absence is above target at 1.48%.
3. Return to work interviews are not consistently undertaken.

Action to get on plan with timescales:

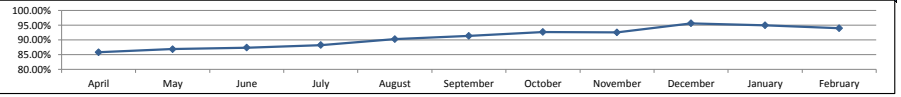
1. 100% of long term sickness absence cases have a 'wrap around' management plan. This is monitored on a routine basis and reported to the Board monthly.
2. Cases moving from short term to long term are monitored and reviewed by the end of the 2nd week each month.
3. Return to work interview 'hot spots' identified and barriers to consistent application examined with relevant line managers – 30 April 2016/31 May 2016.
4. Guidance for line managers on return to work interviews to be produced – 29 April 2016.
5. 'How to' conduct a return to work interview video – 31 May 2016.
6. Staff survey results colleague focus groups/1 to 1 interviews conducted in April 2016 with action plan developed for Board – 31 May 2016
7. NHS staff health and wellbeing CQUIN plan for health and wellbeing initiatives – June 2016

Well Led March 2016

Workforce Metric		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS	Trust Trend
Mandatory Training	Prevent	61.59%	54.58%	45.52%	83.20%	68.82%	50.45%	78.00%	84.10%	
	Equality & Diversity	85.89%	83.47%	79.44%	88.74%	91.85%	79.88%	87.71%	99.49%	
	Information Governance	84.24%	82.37%	78.27%	87.93%	89.88%	77.78%	83.14%	96.92%	
	Infection Control	85.07%	82.29%	79.96%	87.44%	91.58%	76.88%	83.43%	98.97%	
	Health & Safety	84.60%	82.12%	78.63%	86.79%	90.96%	76.88%	85.14%	99.49%	
	Manual Handling	86.73%	84.66%	82.45%	90.54%	92.19%	76.88%	83.71%	98.97%	
	Safeguarding	78.34%	77.46%	70.19%	84.34%	84.58%	72.67%	74.86%	91.28%	
	Fire Safety	73.38%	59.32%	64.61%	82.06%	79.82%	98.80%	80.00%	89.23%	
	Dementia	81.88%	80.00%	75.11%	86.46%	87.64%	76.58%	80.00%	95.90%	
	Conflict Resolution	77.63%	74.07%	69.38%	82.06%	84.44%	74.17%	79.14%	95.38%	

Number of Mandatory Training Elements Completed		0	1	2	3	4	5	6	7	8	9	10
	Trust	5.03%	3.72%	2.47%	1.83%	1.07%	1.40%	2.23%	4.65%	11.69%	24.57%	41.33%

Percentage of Employees Started Mandatory Training



		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Appraisal	Percentage of Appraisal completed Since April	78.57%	67.80%	67.59%	87.30%	88.59%	97.60%	72.67%	90.36%
Medical Devices	Percentage of Medical Devices Training Completed (Target 100%)	80.00%	75.00%	68.00%	86.00%	86.00%	84.00%	80.00%	-

Mandatory Training

Why are we away from plan?

1. The functionality of the Oracle Learning Management (OLM) system in the national Electronic Staff Record (ESR) is limited and is not user friendly which has deterred some colleagues from using the tool enabling them to be fully compliant.
2. There is an absence of a sanction for non-compliance.
3. The PREVENT element of mandatory training is delivered on a classroom basis through the Safeguarding team and capacity to deliver sufficient sessions to facilitate full compliance is limited. The requirement to deliver this training in a classroom environment is a DH requirement placed on all public sector bodies.

Action to get on plan with timescales:

1. Undertake an assessment of alternative Learning Management Systems to the OLM system in ESR for the capture, recording and reporting of training compliance with a view to option appraise the procurement of a new system – 30 June 2016.
2. Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 May 2016.
3. Establish what alternative delivery methods are available within the DH requirement to provide PREVENT training – 30 April 2016.

Appraisal

Why are we away from plan?

1. There is an absence of a sanction for non-compliance.
2. The appraisal scheduler tool which captures planned activity is not fully or consistently utilised.
3. Limited opportunity for appraiser training.

Action to get on plan with timescales:

1. Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 May 2016.
2. Produce clearer rules for the use of the appraisal scheduler in each division – 15 May 2016.
3. Review the current appraiser training offer and increase the opportunities to participate – 15 June 2016.

compassionate care

	Workforce Metric	Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Staffing Levels	Hard Truths Summary Day - Nurses/Midwives	89.58%	94.79%	86.89%	-	89.56%	-	-	-
	Hard Truths Summary - Day Care Staff	102.83%	101.39%	107.56%	-	83.62%	-	-	-
	Hard Truths Summary - Night Nurses/Midwives	95.40%	100.58%	94.18%	-	91.95%	-	-	-
	Hard Truths Summary - Night Care Staff	119.06%	116.95%	131.10%	-	75.35%	-	-	-
Staff Friendsand 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%

Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Trust Financial Overview as at 31st March 2016 - Month 12

compassionate care

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

YEAR TO DATE POSITION: M12

CLINICAL ACTIVITY

	M12 Plan	M12 Actual	Var
Elective	9,185	8,029	(1,156)
Non Elective	49,263	51,056	1,793
Daycase	43,731	36,238	(7,493)
Outpatients	327,200	327,492	292
A & E	146,774	147,620	846

TRUST: INCOME AND EXPENDITURE

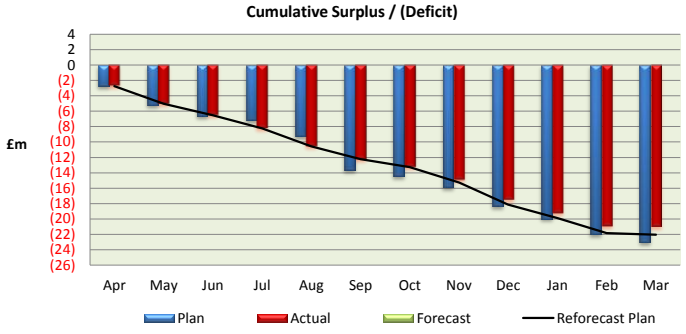
	M12 Plan	M12 Actual	Var
	£m	£m	£m
Elective	£23.39	£20.62	(£2.78)
Non Elective	£79.89	£84.48	£4.59
Daycase	£30.25	£24.86	(£5.40)
Outpatients	£39.45	£40.81	£1.35
A & E	£15.49	£16.08	£0.59
Other-NHS Clinical	£117.49	£119.74	£2.25
CQUIN	£6.69	£6.79	£0.10
Other Income	£38.90	£36.83	(£2.07)
Total Income	**£351.56**	**£350.18**	**(£1.37)**
Pay	(£224.98)	(£227.39)	(£2.41)
Drug Costs	(£32.05)	(£32.27)	(£0.22)
Clinical Support	(£31.15)	(£30.44)	£0.72
Other Costs	(£45.94)	(£44.47)	£1.47
PFI Costs	(£11.92)	(£11.81)	£0.11
Total Expenditure	**(£346.04)**	**(£346.38)**	**(£0.34)**
EBITDA	**£5.51**	**£3.80**	**(£1.71)**
Non Operating Expenditure	(£25.52)	(£24.79)	£0.73
Deficit excl. Restructuring	**(£20.01)**	**(£20.99)**	**(£0.98)**
Restructuring Costs	(£3.00)	(£1.10)	£1.90
Joint Venture Profit / Investment	£0.00	£1.11	£1.11
Surplus / (Deficit)*	**(£23.01)**	**(£20.98)**	**£2.03**

* Excluding (Impairments)/ Revaluations

DIVISIONS: INCOME AND EXPENDITURE

	M12 Plan	M12 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£20.01	£17.64	(£2.37)
Medical	£27.33	£24.08	(£3.25)
Families & Specialist Services	(£1.36)	(£1.29)	£0.06
Community	£5.77	£5.84	£0.07
Estates & Facilities	(£28.51)	(£25.83)	£2.68
Corporate	(£20.45)	(£22.08)	(£1.64)
THIS	£0.53	£0.47	(£0.06)
PMU	£3.15	£2.22	(£0.94)
Central Inc/Technical Accounts	(£25.10)	(£22.00)	£3.11
Reserves	(£4.38)	(£0.02)	£4.36
Surplus / (Deficit)	**(£23.01)**	**(£20.98)**	**£2.03**

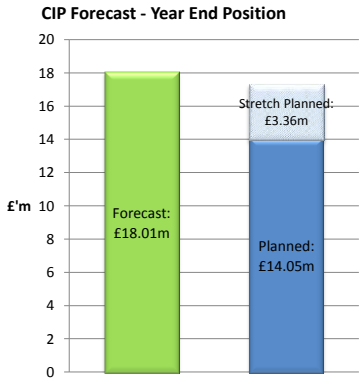
TRUST SURPLUS / (DEFICIT)

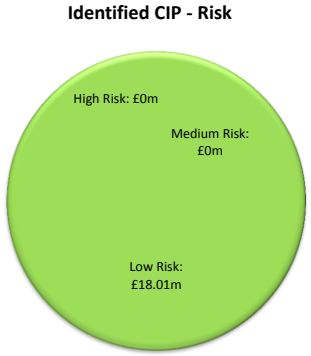


KEY METRICS

	Year To Date			Year End: Forecast		
	M12 Plan	M12 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£23.01)	(£20.98)	£2.03	(£23.01)	(£20.98)	£2.03
Capital	£20.72	£20.15	£0.57	£20.72	£20.15	£0.57
Cash	£1.92	£1.94	£0.02	£1.92	£1.94	£0.02
CIP	£14.05	£18.01	£3.96	£14.05	£18.01	£3.96
	Plan	**Actual**		**Plan**	**Forecast**	
Financial Sustainability Risk Rating	2	2		2	2	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£14.05m** **Total Forecast** **£18.01m**

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,029	(1,156)
Non Elective	49,263	51,056	1,793
Daycase	43,731	36,238	(7,493)
Outpatients	327,200	327,492	292
A & E	146,774	147,620	846

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£20.62	(£2.77)
Non Elective	£79.89	£84.48	£4.59
Daycase	£30.25	£24.86	(£5.39)
Outpatients	£39.45	£40.81	£1.36
A & E	£15.49	£16.08	£0.59
Other-NHS Clinical	£117.49	£119.74	£2.25
CQUIN	£6.69	£6.79	£0.10
Other Income	£38.90	£36.83	(£2.07)
Total Income	**£351.55**	**£350.18**	**(£1.37)**
Pay	(£224.98)	(£227.39)	(£2.41)
Drug Costs	(£32.05)	(£32.27)	(£0.23)
Clinical Support	(£31.15)	(£30.44)	£0.71
Other Costs	(£45.94)	(£44.47)	£1.47
PFI Costs	(£11.92)	(£11.81)	£0.11
Total Expenditure	**(£346.04)**	**(£346.38)**	**(£0.34)**
EBITDA	**£5.51**	**£3.80**	**(£1.71)**
Non Operating Expenditure	(£25.52)	(£24.79)	£0.73
Deficit excl. Restructuring	**(£20.01)**	**(£20.99)**	**(£0.98)**
Restructuring Costs	(£3.00)	(£1.10)	£1.90
Joint Venture Profit / Investment		£1.11	£1.11
Surplus / (Deficit)*	**(£23.01)**	**(£20.98)**	**£2.03**

* Excluding (Impairments)/ Revaluations

DIVISIONS: INCOME AND EXPENDITURE

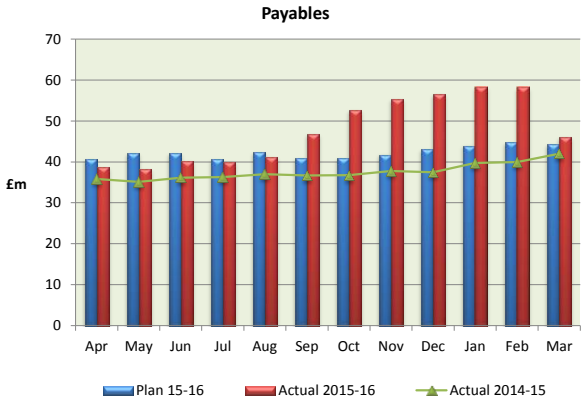
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£20.01	£17.64	(£2.37)
Medical	£27.33	£24.08	(£3.25)
Families & Specialist Services	(£1.36)	(£1.29)	£0.06
Community	£5.77	£5.84	£0.07
Estates & Facilities	(£28.51)	(£25.83)	£2.68
Corporate	(£20.45)	(£22.08)	(£1.64)
THIS	£0.53	£0.47	(£0.06)
PMU	£3.15	£2.22	(£0.94)
Central Inc/Technical Accounts	(£25.10)	(£22.00)	£3.11
Reserves	(£4.38)	(£0.02)	£4.36
Surplus / (Deficit)	**(£23.01)**	**(£20.98)**	**£2.03**

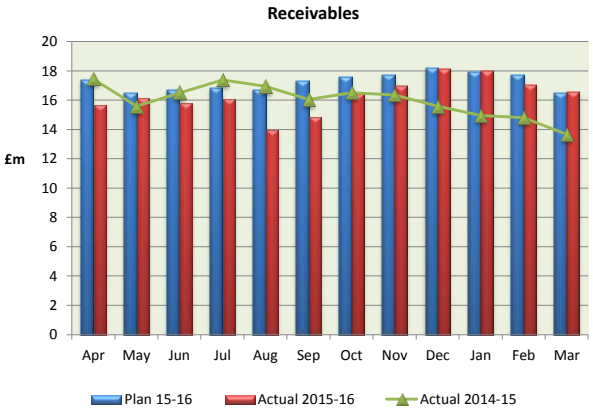
Trust Financial Overview as at 31st March 2016 - Month 12

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

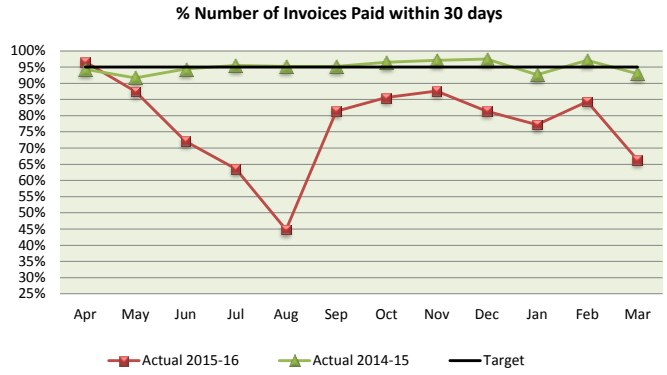
WORKING CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Payables * See note below	(£44.46)	(£46.22)	£1.76	
Receivables	£16.52	£16.56	(£0.04)	



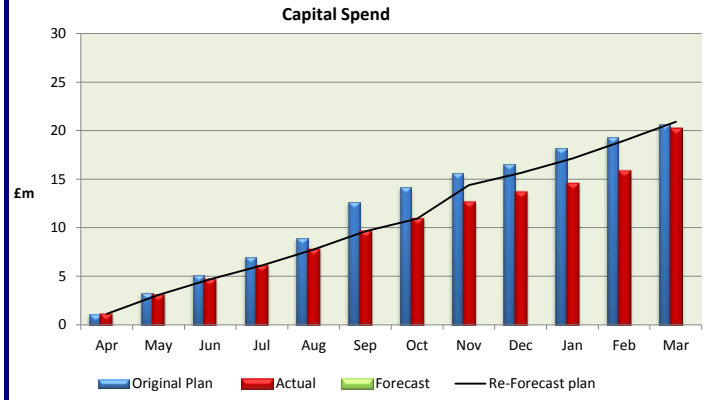


BETTER PAYMENT PRACTICE CODE



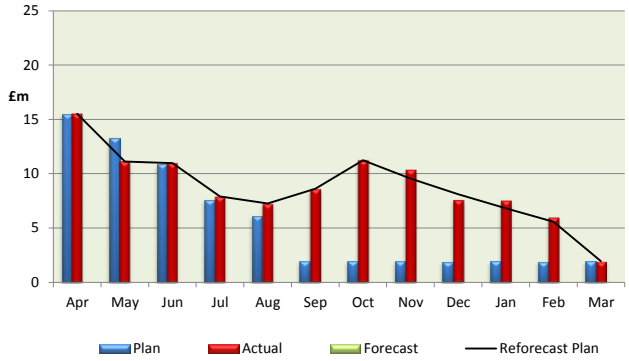
CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Capital	£20.72	£20.15	£0.57	

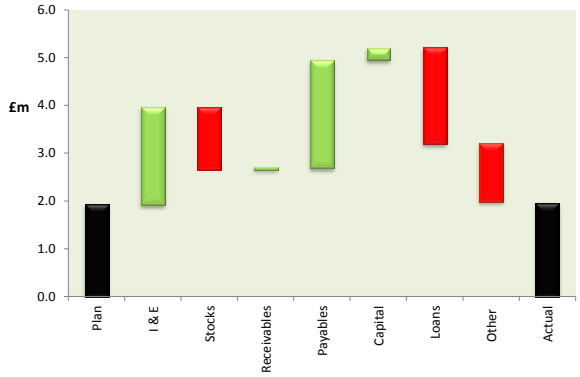


CASH

	M12 Plan £m	M12 Actual £m	Var £m	M12
Cash	£1.92	£1.94	£0.02	



CASH FLOW VARIANCE



SUMMARY 2015/16

- Overall deficit (incl. restructuring costs & Joint Venture investment gains) is £20.98m which is in line with Monitor's expectations.
- At EBITDA level which represents the operational trading position there is an adverse variance from plan of £1.71m.
- A&E and Non Elective activity above plan in month, planned activity further behind plan due to capacity driven cancellations.
- Pay expenditure exceeded plan and included £19.93m agency costs, much of which was above the Monitor price cap.
- Capital expenditure for the year is £20.15m against the planned £20.72m.
- Cash balance is £1.94m against a planned £1.92m.
- CIP schemes delivered £18.01m in the year against a planned target of £14.05m.
- The new Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

POINTS TO NOTE

- **The financial position presented here is in advance of the finalisation and audit review of the year end accounts. The position excludes fixed asset impairments and revaluations which are exceptional in nature and have no bearing on cash, FSRR or the underlying trading position.**
- The year end financial position is £20.98m (including restructuring costs and joint venture profits and revaluation gains). This means that the Trust has delivered a bottom line deficit equivalent to the original planned £20m trading deficit plus £1m restructuring costs which were recognised by Monitor as an exceptional item. The financial position was delivered in spite of considerable operational pressure driving unplanned costs.
- As anticipated, the Trust is now reliant upon external cash funding support via a loan of £12.90m from the Department of Health.
- Overall therefore, the Trust has delivered to Monitor's expectations against its original 2015/16 financial plan in both I&E and cash terms.

(* Payables note: The trade payables figure was inflated from Sept-Feb 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)

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 2016	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 12 - FINANCIAL NARRATIVE - MARCH 2016 - The Board is asked to approve the Month 12 Financial Narrative - March 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee 26.4.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 12 Financial Narrative - March 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 Month 12 Financial Narrative - March 2016.

Appendix

Attachment:

Month 12 15_16 financial commentary for BOD.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 12 MARCH 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 2015/16 financial out turn and is presented in three sections as follows:

- Key messages;
- Detailed commentary for the period with variance analysis against the original plan submitted to Monitor in May 2015;
- Financial Sustainability Risk Rating (FSRR) and conclusion.

This report and the contents of the financial dashboard are still subject to the year-end external audit process.

This paper has previously been discussed at the Finance & Performance Committee held on 26 April 2016.

1. Key Messages

The year end financial position stands at a deficit of £20.98m (including restructuring costs and joint venture profits and revaluation gains). This means that the Trust has delivered a bottom line deficit equivalent to the original planned £20m trading deficit plus £1m restructuring costs which were recognised by Monitor as an exceptional item.

Considerable operational pressure has been across the year and particularly in the final quarter with elective surgical beds having been given over to accommodate non-elective demand. In spite of this, the financial position has been sustained through: maximising elective activity through the constrained available capacity and driving out improvements from non-operating financial elements.

Overall therefore, the Trust has delivered to Monitor's expectations against its original 2015/16 financial plan in both I&E and cash terms.

Month 12, March Position (Year to Date)

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Month 12 Actual YTD £m	Var (vs. Original) £m
EBITDA	**5.51**	**4.13**	**3.80**	**(1.71)**
Deficit excluding restructuring and JV profit / valuations	**(20.01)**	**(20.93)**	**(20.99)**	**(0.98)**
Restructuring costs - redundancy	(3.00)	(0.10)	(0.10)	2.90
Restructuring costs – consultancy support	0.00	(1.00)	(1.00)	(1.00)
JV profit / valuations	0.00	0.00	1.11	1.11
Deficit including restructuring and JV profit / valuations	**(23.01)**	**(22.03)**	**(20.98)**	**2.03**
Impairment losses / reversals (net)	0.00	0.00	(8.81)	(8.81)
Deficit	**(23.01)**	**(22.03)**	**(29.79)**	**(6.78)**

- An EBITDA of £3.80m, an adverse variance from the original plan of £1.71m (when compared with the reforecast plan this variance reduces to £0.33m).
- A deficit (including restructuring costs) of £20.98m, a favourable variance of £2.03m from the original planned position.
- Delivery of CIP of £18.01m against the planned level of £14.05m.
- Contingency reserves released of £3.00m in line with the forecast profile.
- Capital expenditure of £20.15m, this is below the original planned level of £20.72m.
- A cash balance of £1.94m in line with the planned level of £1.92m.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

In addition, the Trust has borne a net loss of £8.81m due to fixed asset impairments. These technical adjustments for impairments and revaluations are exceptional in nature and have no bearing on cash, FSRR or the underlying trading position.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

As described in previous reports, the operational situation seen in January with a peak in A&E attendances coupled with increased non elective length of stay meant that extra capacity was stretched to maximum levels and some elective procedures were cancelled to accommodate non elective patients. This had a small financial impact in January but was anticipated to have a considerably greater impact in February and March as a surgical elective ward was to be given over to non elective medical patients.

Whilst the operational plans implemented by the Trust have mitigated some of the predicted financial risks and as such the adverse impact to income generation was lessened, operational costs across the final quarter and particularly in March have increased above planned levels.

In summary the main variances behind the year to date position, against the plan are:

Operating income	(£1.37m) adverse variance
Operating expenditure	(£0.34m) adverse variance
EBITDA	**(£1.71m) adverse variance**
Non-Operating items	£0.73m favourable variance
Joint Venture profit / investment valuations	£1.11m favourable variance
Restructuring costs	£1.90m favourable variance
Total	**£2.03m favourable variance**

<u>Operating Income</u>

There is a cumulative £1.37m adverse variance from the plan within operating income.

NHS Clinical Income

Within the £1.37m adverse income variance, NHS clinical income shows a favourable variance of £0.70m (offset by other income). In summary this comprises an underperformance versus plan particularly in day case and elective activity, offset in part by an over performance in non-elective.

The activity position driving the reported PbR income is as follows:

- Planned day case and elective activity has seen a worsening in performance and is 14.1% below original plan in month 12 (-643 spells). This is compared to performance of 9.1% below plan in month 11. This worsening is across both elective and day case but more materially in the latter.

- Non-elective admissions overall are above the month 12 original plan by 5.2% (222 spells) which is a slight reduction on the over-performance seen in month 11. The slight reduction is within emergency long stay admissions, with emergency short stay admissions maintaining the level seen at month 11. Cumulatively activity is now 3.6% above plan (1,793 spells).

- A&E attendances are 8.4% (1,040 attendances) above the month 12 original plan which is a continuation of the over-performance seen in month 11. In the full year activity is above plan by 846 attendances. Penalties against the 4 hour wait target have again been triggered in the face of these high volumes.

- Outpatient attendances are below the month 12 original plan by 2.5% (-694 attendances) which is a continuation of the performance seen in month 11. Cumulatively outpatient activity is now 1.3% below plan (-4,120 attendances).

- Pass-through drugs and devices are below the original plan in aggregate.

As anticipated, the action described above in cancelling elective procedures to accommodate non elective patients has had continued adverse financial impact in March as a surgical elective ward has been given over to non elective medical patients. In addition the junior doctors strike action has had some negative impact upon planned activity.

As highlighted in last month's report, a year end contract settlement was reached with the Trust's two main commissioners in February. This year end agreement is fully inclusive and therefore removed the residual, outstanding financial risk against contract sanctions; any shortfall on CQUIN performance; contract challenges and commissioner affordability in the round.

Other income

Overall other income is £2.07m below the planned level. A slight shortfall against income generated from private patients and research and development is offset by additional education and training income. Lower than planned income within the Trust's Health Informatics Service does not adversely affect the bottom line as it is offset by reduced costs. The Trust's Pharmacy Manufacturing Unit continued to generate a profit but this was at a lower level than the plan.

Operating expenditure

There was a cumulative £0.34m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£2.41m) adverse variance
Drugs costs	(£0.22m) adverse variance
Clinical supply and other costs	£2.29m favourable variance

Employee benefits expenses (Pay costs)

Pay costs are £2.41m higher than the planned level. It should also be noted that the pay run rate has increased for the third month in succession, with the month of March representing a peak in expenditure for the year. £2.0m of contingency reserves have been released against the pay position, meaning that the underlying divisional pay overspend for the year was actually £4.41m.

As reported in previous months, the largest single driver of the additional costs which have been incurred in the year to date is the need for additional bed capacity. Whilst the total number of open beds has reduced from the exceptionally high level seen in January, additional capacity remains in use. As was the case last month surgical capacity has also been given over to medical patients. The level of additional nursing and medical staffing costs have consequently remained high to deal with the non elective demand and deliver required staffing ratios.

This pressure continues to be is exacerbated by recruitment difficulties which remain 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 management activity is underway to manage the need to meet staffing requirements through non-substantive means, balancing clinical safety and standards with achieving best value. Face to face executive challenge sessions with divisions are ongoing; the profile of when temporary cover arrangements can be safely released is under review; the administration arrangements for booking flexible staff are being centralised for all staff groups to ensure control and use of best practice; and new IT systems are being implemented to streamline processes.

For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by Monitor. This stands against actual expenditure incurred in 2015/16 in excess of £19m. The Trust must do all that it can to aim to achieve this target which will be challenging. This sits alongside capped hourly rates for agency staff introduced by Monitor in 2015/16 which are tightened to lower rates from April 2016 and the requirement for all agency staff to be booked through approved procurement frameworks. This sits alongside an increased number of medical staffing vacancies.

Drug costs

Year to date expenditure on drugs was £0.22m above the original planned level. Whilst the spend on 'pass through' high cost drugs against the main clinical contracts is £1.18m below plan, this is offset and slightly exceeded by additional costs which are charged as pass through costs against the Cancer Drugs Fund and a new Hepatitis C drug which is now in use and for which the Trust receives funding outside of the main clinical contracts directly from NHS England.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £2.29m below the original plan.

This underspend reflects the reduced level of costs associated with the lower than planned elective and day case activity as well as reduced utilities spend linked to the relatively mild weather and a benefit on PFI charges due to RPI being at a lower rate than plan. In addition, £1.0m of contingency reserves which were planned across the year as non pay costs have been released unused to mitigate against pressures which have predominantly been driven through pay expenditure.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.73m below the planned level.

This includes £0.38m reduction in PDC dividend payments versus the planned level, materially due to the adoption of a different valuation method for the PFI site which has reduced the asset value upon which PDC is chargeable.

The year end position at bottom line has been improved upon by the recognition of £1.11m share of profits and revaluation gain on investment property from the Trust's Joint Venture (JV) Pennine Property Partnerships. Final confirmation of this non cash gain has been received from our JV partners, this being higher than the £0.70m anticipated last month due to the level of the revaluation gain.

Both of the above are examples of where the Trust is pursuing innovative models to support financial improvement.

Restructuring costs for the year are £1.10m. 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 now complete with outputs handed over to the Trust. This compares with £3.0m originally planned restructuring costs for redundancy, thus driving a technical benefit to the bottom line.

Cost Improvement Programme (CIP) delivery

The CIP and revenue generation schemes have performed in excess of plan across the year, with £18.01m achieved against a planned £14.05m. 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. A slowing in performance against the Theatres Productivity scheme has been seen in the latter part of the year as a result of surgical bed capacity having been released to host medical non elective patients. In overall terms this has been compensated by the over performing work streams.

Statement of Financial Position and Cash Flow

At the end of March 2016 the Trust had a cash balance of £1.94m against a planned position of £1.92m, a favourable variance of £0.02m, the key movements are summarised below.

		Variance £m
Operating activities	Deficit including restructuring and JV profit / valuations	**2.03**
	Non cash flows in operating deficit	(1.60)
	Re-profiling of commissioner contract income	0.00
	Other working capital movements	1.67
	Sub Total	**2.10**
Investing activities	Capital expenditure	0.57
	Movement in capital creditors	(1.09)
	Sub Total	**(0.52)**
Financing activities	Drawdown of external DoH cash support	(2.00)
	Other financing activities	0.43
	Sub Total	**(1.57)**
	Grand Total	**0.02**

Operating activities

Operating activities show a favourable £2.10m variance against the plan. This is driven by the favourable cash impact of the I&E position of £0.43m (£2.03m favourable I&E variance less £1.60m non-cash flows in operating deficit) coupled with favourable working capital variances from plan. In previous months the Trust saw a cash benefit as a result of an agreement with our main commissioners to re-phase the contract income payments over eleven months rather than the standard twelve. This agreement has unwound in month 12, as the full year payments have now been received as planned.

Behind the favourable variance on working capital movement, the level of material invoices overdue from other NHS and local care organisations has decreased from last month as a number of invoices have been settled following active pursuit by the Trust. This includes invoices for year end over performance against clinical contracts which were raised up front and notified to commissioners in order to secure cash in March rather than April.

In spite of this level of catch up against receivables, payments to suppliers continue to need to be categorised and prioritised for payment. The Trust continues to seek to balance the need to

manage payments with performance against the Better Payment Practice Code. In month 66% of invoices have been paid within 30 days, an decrease on the 84% seen last month.

Investing activities (Capital)

Capital expenditure in the year to date is £20.15m, £0.57m below the planned level of £20.72m.

During the course of the year, the decision was taken by the Trust to re-prioritise capital expenditure where this could be done without detriment to safety. Whilst the option was not be available to transact a capital to revenue transfer to bring equivalent benefit to I&E, the investment has continued to be contained, as far as possible, to reduce reliance on external cash support.

Against the Estates element of the total, expenditure is £6.89m against a planned £7.78m. The main area of spend in month was on backlog maintenance including fire compartmentalisation and work to improve privacy and dignity within the radiology department. As previously reported an element of the underspend is £0.42m against the decommissioning of oil tanks which has been able to be delivered in a more cost effective way. The balance of the underspend is due to the restraint applied to reduce reliance on cash support.

IM&T investments total £10.31m against full year plan of £10.06m. 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 overspend due to the project reaching the next staged gateway in advance of planned timescales. This is offset in part by underspends in other areas of IM&T as a result of re-prioritisation, including switchboard investment which had been planned at £0.4m.

Expenditure on replacement equipment is also lower than plan and contingencies have not been required to be spent in full the year to date although have been called upon in part to support additional CQC requirements.

The favourable cash impact of this £0.57m under spend is offset by a £1.09m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way, explaining the overall £0.52m adverse cash variance against investing activities.

Financing activities

Financing activities show a £1.57m adverse variance from the original plan. This is predominantly due to the fact that the plan had anticipated the need to call upon external cash support of £14.9m. This amount was reduced in year by the containment of capital expenditure at a level lower than plan and the reduced level of restructuring costs incurred versus plan. In addition, the pro-active measures that have been put in place to secure and preserve cash meant that the timing of this need was pushed back from September 2015 as originally planned to March 2016.

As such, the external cash support requirement was reduced from £14.9m in the original plan to £12.9m, explaining the £2m adverse variance within financing activities. This has been received in March via an Interim Revenue Loan from the Department of Health. This loan is interest bearing at the rate of 1.5%.

The separate £10m capital loan to support the EPR deployment was drawn down from the Independent Trust Financing Facility (ITFF) in April as planned. This attracts interest at the rate of 2.35%.

3. Financial Sustainability Risk Rating (FSRR) and forecast

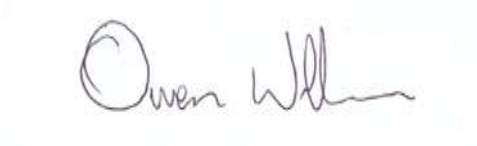
FSRR

Against the new FSRR the Trust stands at level 2 for 2015/16. This is in line with planned position (restated from the original CoSRR of 1).

Conclusion

The Trust has delivered a £21m year end I&E deficit, in line with the original plan, adjusted for one-off consultancy support costs. This represents an improvement of £1m against the reforecast planned position submitted to Monitor in November 2015. Whilst this remains a deficit position, adhering to plan is a considerable achievement in the face of a range of factors including; system wide resilience pressures experienced throughout the year with the closure of nursing home beds in the community and heightened through the winter period; the impact of flooding in the local area in December impacting patient flow; recruitment pressures for clinical staffing; and junior doctors strike action.

The organisation has pursued all avenues to secure this year end position in order to live within the means of the approved level of cash support and to play our part in improving the overall national financial performance.



Owen Williams
Chief Executive

Keith Griffiths
Executive Director of Finance

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Burton, Medical Education Manager
Date: Thursday, 28th April 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Medical Re-validation - Update on Appraisal Completion for Non Training Grade Medical Staff - To provide a summary of the status of appraisal completion for non training grade medical staff.	
Action required: Approve	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: None	
Governance Requirements: Workforce for the future	
Sustainability Implications: None	

Executive Summary

Summary:

The appraisal completion rates for non training medical grade staff for the 2015/2016 appraisal year.

Main Body

Purpose:

To update the Board on the appraisal completion rate for non training grade medical staff for the 2015/2016 appraisal year

Background/Overview:

Appraisal forms the cornerstone of the GMC revalidation process for non training grade medical staff. As a GMC designated body the Trust required to provide the necessary support and resources to ensure appraisals can be completed

The Issue:

All designated bodies are expected to achieve an appraisal rate of 90%

Next Steps:

To maintain the completion rate for the 2016/2017 year and at the same time to ensure that appraisals are more evenly spread over the appraisal year

Recommendations:

The Board is asked to approve the report

Appendix

Attachment:

BOD _ Appraisal Update - April 2016.pdf

BOARD OF DIRECTORS – THURSDAY 28th APRIL 2016

UPDATE ON THE APPRAISAL OF NON-TRAINING GRADE MEDICAL STAFF

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal for the appraisal year 1st April 2015 – 31st March 2016

Summary of key points:

- As at 31st March 2016, 309 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust. As part of the revalidation process the GMC require that all non-training grade medical staff complete an annual appraisal.
- Based on headcount 92.56% of non-training grade appraisals were completed in the appraisal year. 6.15% of non-training grade medical staff were not required to complete an appraisal.

2. Appraisal Completion Rate

The table below provides a breakdown for the completion of non-training grade appraisals for the period 1st April 2015 – 31st March 2016

		Number	Percentage
CHFT Non Training Grade Doctors who had a prescribed connection with the Trust as at 31st March 2016		309	
i)	Appraisals completed and submitted to the Revalidation Office by 31st March 2016	281	90.94%
ii)	Appraisals completed but not submitted to Revalidation Office by 31st March 2016	5	1.62%
iii)	Approved missed appraisals	19	6.15%
iv)	Unapproved, incomplete or missed appraisals	4	1.29%
Total			**100%**
Appraisal Completion Rate (i) + (ii)			**92.56%**

a) Completed appraisals: appraisal meeting between 1st April 2015 and 31st March 2016 for which the appraisal outputs have been agreed between appraiser and appraisee.
b) Approved or incomplete or missed appraisals: accepted reason for appraisal not taking place (eg joined the Trust within the last 6 months, prolonged leave, maternity leave, sabbatical etc).
c) Unapproved incomplete or missed appraisal: appraisal expected to be submitted with. No agreement for appraisal to be postponed/delayed.

The appraisal completion rate for the previous year (1st April 2014 – 31st March 2015) was 86.8%

3. Action Plan

a) NHS England expect an appraisal completion rate in excess of 90%. Whilst this has been achieved there was still the end of year flurry for appraisals to be completed with over 50% of appraisals being completed between December 2015 and March 2016.

b) The annual final push to ensure appraisals are completed is not ideal for either the appraisee or the appraisers. Since the introduction of revalidation in December 2012 non-training grade medical staff have been asked to move their appraisal dates to their month of birth. Whilst there has been some progress a significant number of doctors are still postponing their appraisal until the final moment.

c) A letter has been sent to all non-training grade medical staff stressing that from 1st April 2016 the appraisal must be completed during the month of birth. This will result in a more equal distribution of appraisals throughout the year.

d) The annual report for Medical Revalidation and Appraisal will be submitted to the June 2016 Executive Board

8 Action Required of the Board

The Board of Directors is asked to:

(i) receive this report.

Dr David Birkenhead
Medical Director/Responsible Officer
April 2016

This page has been left blank

APPENDIX L

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th April 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: Note	
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 and note the updates from Sub Committees and Receipt of Minutes.
- Quality Committee - minutes of 29.3.16 and verbal update from meeting 26.4.16
- Finance and Performance Committee - minutes of 29.3.16 and verbal update from meeting 26.3.16
- Audit and Risk Committee - verbal update from meeting 20.4.16
- Workforce (Well Led) Committee - verbal update from meeting 21.4.16

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 and note the updates from Sub Committees and Receipt of Minutes.
- Quality Committee - minutes of 29.3.16 and verbal update from meeting 26.4.16
- Finance and Performance Committee - minutes of 29.3.16 and verbal update from meeting 26.3.16
- Audit and Risk Committee - verbal update from meeting 20.4.16
- Workforce (Well Led) Committee - verbal update from meeting 21.4.16

Appendix

Attachment:

COMBINED UPDATE FORM SUB CTTEES.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Quality Committee held on
Tuesday 29 March 2016 in Discussion Room 2, Learning and Development Centre, Huddersfield Royal Infirmary

PRESENT

David Anderson	Non-Executive Director
David Birkenhead	Medical Director
Diane Catlow	Interim Associate Director of Nursing, Community Services
Helen Barker	Chief Operating Officer
Jan Wilson	Non-Executive Director
Jeremy Pease	Non-Executive Director / Committee Chair
Julie Dawes	Executive Director of Nursing
Julie O'Riordan	Divisional Director, Surgery and Anaesthetic Services
Karen Barnett	Assistant Divisional Director, Community Services
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Lynn Moore	Membership Council Representative

IN ATTENDANCE/OBSERVERS

Stephanie Jones	Committee Secretary/PA to Director of Nursing
Elaine Brotherton	Patient Safety and Quality Lead, FSS Division
Andrea McCourt	Head of Governance and Risk
Lisa Fox	Clinical Information Manager
Vicky Thersby	Head of Safeguarding, Adult and Children
Cath Briggs	Matron (Item 051/16)

ITEM	
045/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting. It was noted that there was no representative from the Medical Division at the start of the meeting until Cath Briggs attended to speak to Item 051/16.
046/16	**APOLOGIES** Anne-Marie Henshaw — Associate Nurse Director/Head of Midwifery, FSS Division Jackie Murphy — Deputy Director of Nursing, Modernisation Jason Eddleston — Deputy Director of Workforce and Organisational Development Joanne Middleton — Associate Nurse Director, Surgery and Anaesthetic Services Juliette Cosgrove — Assistant Director of Quality Keith Griffiths — Executive Director of Finance Kirsty Archer — Deputy Director of Finance Lindsay Rudge — Deputy Director of Nursing Martin DeBono — Divisional Director, FSS Division Sal Uka — Divisional Director, 7 Day Service/Hospital at Night Stuart Baron — Deputy Director of Finance Tracy Fennell — Associate Nurse Director, Medical Division Victoria Pickles — Company Secretary
047/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note.

048/16	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on 23 February 2016 were approved as a correct record subject to the following amendment; 034/16 Reduce stroke **morbidity** to a SHMI of less than 100 should read **mortality.**
049/16	**ACTION LOG** All the items on the action log due this month were agenda items under Matters Arising/Main Agenda.
MATTERS ARISING / MAIN AGENDA ITEMS	
050/16	**SAFEGUARDING ADULT AND CHILDREN REPORT – Q3** Vicky Thersby, Head of Safeguarding (Adult and Children) presented the Safeguarding Update for Q3. It was reported that the Safeguarding Committee had been refreshed with new terms of reference produced. Safeguarding Committee meetings are held monthly and the following risks were escalated from the Committee meeting in March; 1. Mandatory Training In line with the Intercollegiate Document for Safeguarding Children 2014 and the draft Intercollegiate Document for Safeguarding Adults all staff have been reviewed in line with their job role and new levels of safeguarding training required. This has been a significant piece of work which has altered our previous training compliance figures. The current figures noted may be subject to change: Level 1: increase from 66% to 72.6% at the end of Q3. Level 2: decrease from 53.2% to 47.3% (adults) and 50.49% (children). This training has moved to e-learning so is easier for staff to access. Level 3: (adults) this was not previously captured and is now at 11.54%. A training strategy will be developed to target this group of staff. Level 3: (children) decreased from 64% to 41.55%. This decrease is due to more staff now requiring this training following the updated document. Prevent: increase from 51.4% to 55.35%. It is anticipated that the target of 85% compliance by December 2016 will be reached. 2. Outstanding Supervision Sessions for Health Visitors Due to long term sickness within the Safeguarding Team we are not currently compliant with delivering safeguarding supervision to Health Visitors for children who are subject to child protection plans. There are currently 57 outstanding cases. Plans are in place to address this and assurance was received that all outstanding cases will be completed by the end of April 2016 and performance will be monitored closely by the Safeguarding Committee. This will remain on the risk register until all Health Visitors have received the supervision. 3. Alerts to Calderdale Adult Social Services In Q3 there were a total of 22 alerts made against CHFT. 21 of these related to the Medical Division and 1 to the Community Division. 18 of these were unsubstantiated. Further work is being done with adult social care and streamlining the process from raising allegations to feeding back concerns is ongoing. The safeguarding team are re-locating to work alongside Calderdale adult social care to

	ensure closer working will reduce inappropriate referrals. Closer working with the Discharge Team will also allow remedial action to be taken in relation to discharge related concerns. 4. Serious Case Review – Child M A Serious Case Review in relation to Child M is ongoing and there are no immediate lessons for CHFT. **OUTCOME:** The Committee RECEIVED and NOTED the content of the report and was assured that the outstanding cases of Children's Safeguarding Supervision would be completed by the end of April 2016. Assurance of closer working with Calderdale Adult Social Care to alleviate inappropriate referrals was also noted.
051/16	**UPDATE REPORT ON SPECIAL MEASURES WARD** Matron Cath Briggs was in attendance to give an update on a ward currently receiving supportive measures to improve the quality of care. The acute medical ward had been placed under special measures in October 2015. The key areas of support have focussed on the following areas: 1. Medical Model The medical workforce is currently under review to support the clinical criteria. 2. Nursing Leadership The nursing leadership has been reviewed and the workforce model has been adjusted through hard truths review using a number of indicators including national guidance, dependency and acuity and professional judgement. The Band 6 nursing leadership has been increased from 2 full time posts to 4 full time posts. The benefits of strengthening the leadership have been visible and palpable on the ward senior clinical walk rounds. Engagement and support worker posts have also been agreed and these posts are currently being appointed to. 3. Training and Education Training compliance continues to improve across the ward and is being monitored weekly. 4. Performance (falls and medication standards) An improvement plan has been implemented to decrease the number of falls and support the ward team to reduce the number of missed doses of medication. 5. Communication Weekly senior nurse meetings have taken place with the Director of Nursing, alongside regular ward meetings. Multi-disciplinary team approaches are also being reviewed. 6. Organisation and management of care. The Matron and Ward Sister are working together to implement and ensure robust processes are in place within the ward that meet the standard expected of all wards at CHFT. The special measures support has provided a framework to support improvement and quality and the ward has a clear action plan which is monitored by the senior nursing team. From April, if improvements are sustained, the weekly review meetings will be chaired by the Divisional Associate Nurse Director.

	The Executive Director of Nursing thanked Matron Briggs for the update. She acknowledged that a great amount of improvement work has been undertaken and the ward has been completely transformed. **OUTCOME:** The Committee NOTED the content of the report and the improvements that have been made.
052/16	**UPDATE REPORT ON THE ACTION PLAN FOLLOWING KIRKUP INQUIRY (MORECOMBE BAY INVESTIGATION)** Elaine Brotherton, Patient Safety and Quality Lead, FSS Division presented a paper which gave a 4th and final update, to The Committee, on the action plan developed in response to the recommendations of the Morecombe Bay Investigation (Department of Health 2015). The Morecombe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital. The report drew attention to serious problems in 5 main areas. The Department of Health approved a series of recommendations for development at UHMB and an action plan was produced. CHFT review the UHMB action plan and considered local deficits and areas for improvement, from this a local action plan was produced. All but one action has been completed, with the final action being partially completed with deadlines for presentation at April Maternity and Paediatric Forums, PSQB and the FSS Divisional Business Meeting. Ongoing work has been identified which includes work around maternity theatre provision and further enhancements to the maternity clinical dashboard and monitoring of process and outcome. The final action to be completed is: *'The Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups'*. To date, an audit of risk assessment of birth centre bookings and births and an audit of transfer of babies from the birth centres to NICU and transfers of mothers from the birth centre to LDRP has been completed. The Director of Nursing commented that the action plan attached to the report was not the most up to date version and that the most up to date would need to be reviewed by The Committee. **ACTION:** 1. Stephanie Jones to obtain the most up to date action plan and email out to Committee members by close of play 29 March 2016. 2. Final Action plan to be re-submitted to The Committee in April for final sign-off.
053/16	**QUALITY ACCOUNT – DRAFT REPORT** Lisa Fox, Clinical Information Manager, was in attendance to present the Quality Account in its draft format. It was noted the draft Quality Account had been scrutinised by the Membership Council and feedback from commissioners, overview and scrutiny committees and local Healthwatch would be incorporated after circulation of the draft report. The Chair asked what would happen to the monitoring of sepsis as it is not part of the

	Quality Account for 2016/17. Lisa Fox confirmed that it would be monitored through the Care of the Acutely Ill Programme. The final report will go to the auditors KPMG and will be submitted to the Board of Directors for final approval prior to being published on the CHFT website in May 2016. **OUTCOME:** The Committee RECEIVED and APPROVED the draft Quality Account.
054/16	**GI BLEEDS** The Chief Operating Officer reported that discussions are ongoing in relation to the proposal to resolve concerns relating to the upper GI bleeds service. In order to ensure a safe service consideration is being given as to how the service may be provided in the future. Discussions around this will take place with the Overview and Scrutiny Committee. **ACTION:** A paper giving further detail will be brought to a future Committee meeting.
055/16	**QUALITY COMMITTEE SELF–ASESSMENT QUESTIONNAIRE** The Committee Secretary informed members that the Quality Committee self-assessment questionnaire would be emailed out shortly and asked that completed questionnaires be returned as soon as possible. The questionnaire has been developed to gauge the committee's effectiveness by taking the views of committee members across a number of themes. Once all questionnaires have been returned they will be analysed and the finding reported back to the Committee.
CQC RESPONSE	
056/16	**CQC FEEDBACK REPORT** The Executive Director of Nursing presented a paper which provided a summary of the CQC planned inspection that took place on the 8th – 11th March 2016. The inspection commenced on the 8 March with approximately 60 inspectors. The first day included a presentation by the Chief Executive followed by clinical visits, interviews and focus groups. Initial feedback from the inspection team was that they felt welcomed and looked after. Staff spoke highly of working for the Trust and also about the Executive Team. The Dementia work, in particular the engagement support workers, was held up as exemplary and something they would like to share nationally. The following feedback was noted from each domain: • **Safe** - concerns were raised about: - A&E staffing, in particular medical staffing, referencing long term staffing as the main issue, rather than day to day staffing of the units. - Documentation and care planning in some of the areas visited. - The Gastroenterology acute bleed rota. - Positive feedback was received about the use of the Nerve centre and community documentation. • **Effective** – no concerns raised under this domain. • **Caring** – no concerns raised, with a significant number of positive examples

witnessed. The inspectors acknowledged the commitment to patient experience noted through the Estates and Facilities team.

- **Responsive** – concerns raised about:
  - Patient flow
  - Transfer of patients
  - The need for an increased use of community services.

  Positive feedback was given about the services for patients with dementia and learning disabilities.

- **Well led**
  The inspectors were pleased to note the responsiveness of the management team to any issues raised during the inspection week. They noted a lack of proactive management and forward planning for succession planning and talent management. The unannounced follow up visit took place on Wednesday 16th March 2016, with the inspectors returning to the clinical decisions units on both sites and also the maternity services as they needed further information to consolidate their findings from the previous week.

  The inspectors also ran some additional focus groups on Tuesday 22nd March 2016, these were duplicated on both sites – one for non-consultant grade doctors and the other an open session for any staff member. They also made a further visit to the outpatient departments.

Maternity Services: There was a particular focus on maternity services. The feedback is being reviewed in detail.

Next steps:
The majority of ward and department areas who were visited during the inspection week provided feedback to the central CQC office – 119 individual feedback forms received These have been collated and are being used to develop quality improvement plans at a Trust-wide and divisional level. These will continue to be managed via the CQC steering group.

It is anticipated the final report will be received 8 to 10 weeks post visit.

OUTCOME:

1. The Committee **NOTED** the initial feedback following the inspection and the next steps.
2. The Committee **ACKNOWLEDGED** and **THANKED** all staff involved in preparing for the inspection and during the inspection for all their hard work. The Committee asked that their thanks be fed back via the Divisions.

RESPONSIVE	
057/16	**INTEGRATED QUALITY AND PERFORMANCE REPORT** The Integrated Quality and Performance Report was presented for the month of February 2016. The following highlights from the report were noted: Responsiveness • The Emergency Care Standard failed for the month and for Q4. • DTOC improved but green cross numbers remain high • 100% of patients requiring thrombolysis for stroke received this within 1 hour • Mortality remains a concern and is the focus of significant work. • ASI; problem with backlog and a deep dive has been done to look at this further. There is a plan in place to address this to deal with the urgent appointments. Caring • Complaints; a significant amount of progress has been made and we currently have the lowest amount of complaints. Effectiveness • C.difficile was worse than target for February, although we are performing well against our peers. • SHMI; has moved to 114 (unexpected range). Current data does not give us an understanding of why SHMI is so high. This is being looked into further. • Work continues on care bundles • Coding improvement noted with 50 to 70% compliance • Had one Royal College visit with another planned for April. • Hoping EPR will help with more robust metrics. • Fractured neck of femur has fallen behind; the arrival of 5 patients on one day has compounded this. Safety • Never Events; there have been 2 never events to date and 2 near misses. The never event relates to a retained swab in maternity. An investigation (themed) is ongoing and immediate action has been put in place to ensure this does not happen again. There is a clear policy in place regarding swab counts. The investigation will be complete within 40 days from when it happened, so will be approximately another 6 weeks. None of the patients involved in the two never events came to any serious harm. Workforce • Hardtruths; Medical Division are red on nurse staffing during the day however this may improve now some wards have been closed Questions raised by the Committee: Q1 (JP): The Chair questioned whether the CQC had taken an interest in our SHMI figure? A1 (DB): The CQC don't appear to be overly concerned. **OUTCOME:** The Integrated Quality and Performance Report was **RECEIVED** and **NOTED** by The Committee.
SAFETY	
058/16	**SERIOUS INCIDENT REPORT** The Serious Incident Report was presented which summarised the position as at 18 March 2016.

	There are currently 26 open serious incidents none of which relate to pressure ulcers. Of these 26: • 7 are under investigation and are within timescale • 6 are awaiting review by the CCG • 10 are pending closure by the CCG • 3 are overdue (further details of these were referenced within the report). A number of actions have taken place to improve the position, which were detailed within the report. A total of 5 serious incidents were reported to the CCG in January and February all within the agreed timescales. Up to the 18 March 2016 3 serious incidents have been reported to the CCG, one of which is being de-logged. There are two open never events involving retained swabs. The Governance and Risk Team have implemented a plan to ensure there are no outstanding serious incident reports by the end of March 2016. There is an improved process now in place which aligns with the new incident reporting policy to ensure incidents are completed and reported to the CCG within the timescale. Following a recent review of pressure ulcer serious incidents, it was found that a substantial number did not meet the serious incident criteria and they were subsequently down-graded. In light of this the Trust will submit a request to the CCG to de-log 57 pressure ulcers from StEIS (Strategic Executive Information System). Lessons learned from closed incidents were detailed within the report. It was noted an Investigation Manager has now been appointed and will commence post at the end of April 2016. This post will support Divisions through the investigation process and help improve performance going forward. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report.
059/16	**REPORT FROM THE PATIENT SAFETY GROUP** The Executive Director of Nursing presented a summary report from the Patient Safety Group following the last meeting held on the 3 March 2016, along with the minutes from the meeting. Serious Incidents: As previously reported a substantial amount of work has been undertaken to reduce the number of outstanding red incidents to ensure they are closed down within the agreed timescales and this was acknowledged by the Patient Safety Group. Orange incidents are known to be a concern and at the time of the meeting there were 80 outstanding, the majority of which fell within the Medical Division. The Division are working closely with the Governance and Risk Team to review all the incidents to ensure a plan is in place for each incident which will include a timeline for completion. A deep dive into staffing incidents is to be carried out as data suggested peaks in months when capacity has not been as its maximum level. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the highlights from the Patient Safety

	Group meeting.
COMPLIANCE	
060/16	**RISK REGISTER (CORPORATE)** The Corporate Risk Register was presented as at the 18 March 2016. The following highlights were noted from the report: 1. Top Risks 6131 (20): 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 6503(20): Delivery of Electronic Patient Record Programme 6658 (20): Patient flow (replaces 2828) 2. Risks with increase score The revised patient flow risk (risk 6658 - new reference) has increased from a previous score of 16 to 20. 3. Risks with reduced score Risk 6346 which relates to capacity and capability of delivering service transformation was reviewed by the Risk and Compliance Group and the score was reduced to 12 in light of the CQC visit having taken place. 4. New risks There were 4 new risks added to the register: • 6658: replaces 2828 – inefficient patient flow • 6665: replaces 6507 – delay to patient communication due to voice recognition functionality • 6693: lack of compliance with Monitor cap rules • 6694: Divisional governance arrangements 5. Closed risks • 2828 – patient flow – replaced by 6558 • 6057 – clinical admin and voice recognition – replaced by 6665 Questions raised by the Committee: Q1 (DA): Where does maternity sit in relation to the risk register? A1 (JD): The register will be refreshed depending on the response from the CQC. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the Risk Register.
EFFECTIVENESS	
061/16	**REPORT FROM THE CLINICAL OUTCOMES GROUP** The Medical Director apologised that no report had been provided from the Clinical Outcomes Group this month, however the report that went to the Board of Directors in February 2016 was received. No further discussion took place.

	OUTCOME: The Committee **RECEIVED** and **NOTED** the content of the report.
CARING	
062/16	**REPORT FROM THE PATIENT EXPERIENCE AND CARING GROUP** The last meeting of the Patient Experience and Caring Group was cancelled and therefore no report was received.
WELL LED	
063/16	**UPDATE FROM THE WORKFORCE AND WELL BEING GROUP** It was noted that the responsibilities of the Workforce and Well Being Group responsibilities had been transferred to the Board of Directors. However the Quality Committee would continue to receive the minutes from this group as it is important for the Committee not to lose sight of its work, particularly in relation to staffing. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report.
HEALTH AND SAFETY ISSUES RELATING TO QUALITY OF CARE	
064/16	**UPDATE FROM THE HEALTH AND SAFETY COMMITTEE** The Executive Director of Planning, Performance, Estates and Facilities gave a verbal update following the last meeting of the Health and Safety Committee. The following highlights were noted; • The last meeting of the Health and Safety Committee was well represented by all Divisions and by staff side. It is hoped this high attendance will continue going forward. • Manual Handling: there are still issues with regards to the service and in particular the number of manual handling trainers and no information held on the database. A meeting between Juliette Cosgrove and Lesley Hill had already taken place, but it was agreed a further meeting would be beneficial. A decision will need to be made as to whether the service remains within the remit of the Risk Team or whether it be moved to sit with Health and Safety or Education. • The Health and Safety Executive are carrying out an investigation following the sad death of a contract worker at Calderdale Royal Hospital
ITEMS TO NOTE	
065/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** • Never Events – Julie Dawes to update • Draft Quality Account • Patient Safety Group: red incidents cleared
066/16	**QUALITY COMMITTEE WORKPLAN 2016/17** **OUTCOME:** The Committee **RECEIVED** the Work Plan for 2016/17 and were asked to **NOTE** the reports required going forward.

067/16	**ANY OTHER BUSINESS** The following documents were **RECEIVED** by The Committee for information: • Safeguarding Committee Terms of Reference • Research and Innovation Committee Terms of Reference • 2015 Audit of Audit Policy
DATE AND TIME OF NEXT MEETING	
Tuesday 26 April 2016 2pm – 5pm Discussion Room 2, Learning and Development Centre, Huddersfield Royal Infirmary	

MINUTES APPROVED:

APP A

Minutes of the Finance & Performance Committee held on Tuesday 29 March 2016 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnerships
Lesley Hill	Executive Director of Planning, Performance and Esates & Facilities
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Gary Boothby	Deputy Director of Finance
Mandy Griffin	Acting Director of Health Informatics Services
Andrew Haigh	Chair (In Part)
Brian Moore	Membership Councillor
Betty Sewell	PA (Minutes)

ITEM

041/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed Gary Boothby, Deputy Director of Finance to the meeting.

042/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead, Executive Medical Director
Julie Dawes, Executive Director of Nursing
Keith Griffiths, Director of Finance
Victoria Pickles, Company Secretary

043/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

044/16 MINUTES OF THE MEETINGS HELD 23 February 2016

The minutes of the last meeting were approved as an accurate record subject to the following amend:-

Page 4 - The action against the Minute 032/16 was deleted as the recommendation not to have a separate Commercial Plan had been accepted by the Committee.

The Chair of the Committee confirmed that following the review of the Action Log, item 054 on the agenda would be covered first.

045/16 ACTION LOG AND MATTERS ARISING

Action Log

264-267/12/15: Review of Admissions Criteria - The Chief Operating Officer confirmed that a report would be submitted at the next meeting. It was requested that this report should be circulated electronically prior to that meeting – **HB**

054/16 **EPR Update**

The Acting Director of Health Informatics Services reported that the Future State Validation was carried out week commencing 29 February. The Design is planned to be completed by the end of March 2016 but at the moment we are running a week behind, the Build is planned to be completed by the 25 April. The financial position was reviewed and the Committee were asked to note the report.

The Chief Executive brought the Committee up to date with regard to in depth and difficult conversations which have taken place over the last few weeks. Following the Future State Validation work, discussions took place with all three parties, Bradford Teaching Hospital, CHFT and the provider Cerner with regard to data migration and if the 'go-live' dates would be achievable. It was noted that a recommendation would be going to the Transformation Board which will mean that our 'go-live' date would now be 15 October with the Bradford 'go-live' moving from September to mid-November. In terms of our planning and the financial and mitigation planning this should not make too much of a difference, but the cost profile could be affected.

It was noted, for connectivity, that the action from the last Finance & Performance Committee (033/16) relating to the penalties set out within the contract and the contingency plan, should 'go-live' be delayed will be going to the next Audit & Risk Committee and then will be presented to the next Finance & Performance Committee.

It was acknowledged that unfortunately now we are the first to 'go-live' we will not be able to learn lessons. However, there will be no compromise and everything possible will be done to ensure a successful implementation.

The Acting Director of Health Informatics Services informed the Committee that she had advised the Board Secretary to schedule a separate Board meeting to discuss EPR in April. It was also agreed that a Board Development session would be used for an EPR presentation/demonstration.

045/16 **MATTERS ARISING**

193/08/15: Market Share Update – The Director of Transformation & Partnerships referenced the paper and commented that it did not include the forecast activity for 15/16. It was noted that further information is required from the CCGs but with the information currently available, following 3 years of growth, the Trust saw a decline in GP referrals in 14/15 largely attributed to dermatology and in 15/16 the Trust has seen a 3.3% growth in GP referrals. Compared with our peer trusts locally, CHFT benchmarked 2nd with Bradford achieving a 14.6% growth in GP referrals. The second part of the paper looked at the commissioned activity by Commissioners and it was noted that in 14/15 there had been an overall referral reduction for all Commissioners of 32%. CHFT have seen a decrease in our market share for outpatients of 4% from Calderdale and 7% from Huddersfield which seems to have gone to a number of our peer organisations as well as Spire and BMI.

It was agreed that more granularity is required to get a clearer picture and for the next meeting the Director of Transformation & Partnerships would provide an update with a view to providing either a paper or presentation to be included on the agenda

for the Finance & Performance Committee in May.

ACTION: To look at how other organisations report market share, pull together a scoping of key questions we want to address, discuss with HIS internally and look for external support to assist with the analysis of the data, if required - **AB**

271/12/15: Carter Review Update – The Director of Transformation & Partnerships reported that the purpose of the paper was to outline the Trust's approach to responding to the recommendations and opportunities presented following the efficiency review across the NHS by Lord Carter of Coles.

It was noted that the actions so far included the establishment of a Task & Finish group which would be Director led and would drive a programme of work with the Divisions to get clinical engagement to understand the reasons for clinical variations. The FSS Division have a plan to review all services and workshops are being scheduled. Within Surgery, this is being supported by some of the Prof. Briggs work which is being extended. The PMO team would monitor the programme plan which will then report into the Turnaround Executive.

The Committee noted the recommendations of the report.

029/02/16: Bed Plans Summary Report – The Chief Operating Officer provided a paper which gave some assurance with regard to proposed initiatives to achieve a reduced bed base for the Trust. The paper described the process which would move from a transactional piece of work to a transformational programme of change that focuses on engagement with clinical leadership driving the changes.

Discussions took place with regard to the challenges to manage the services and reconfigure the bed base at 2 sites. It was noted that the Chief Operating Officer would be Chairing weekly meetings to establish momentum within the specialties. To ensure decision makers are in the right place at the right time, the Chief Operating Officer would be working closely with the Medical Director around the medical workforce.

The Committee agreed that the paper did not give assurance that this plan would be sufficiently different from previous years and that it required greater granularity and a clear timeline of deliverables to provide a plan that would be robust. The reliance on core staffing levels without agency staff is variable.

ACTION: The action from the above discussions was for a further update to be presented at the next F&P Committee to encompass more detail with regard to those schemes which are covered by CIP and where they are in terms of Gateway, to look at the wider options, capacity and staffing levels - **HB**

It was noted that the Bed Plan will be progressed and monitored at the Turnaround Executive going forward.

FINANCE AND PERFORMANCE

046 & 047/16 **MONTH 11 PERFORMANCE SUMMARY**

The Director of Transformation & Partnerships reported an increase in activity against plan in A&E and non-elective in Month 11. A reduction in elective is associated with the postponement of elective work to provide capacity for non-elective patients.

Following in-depth discussions which took place with regard to referrals and the demand levels from the CCGs, it was noted that elective activity is there but that the Trust is under pressure with regard to capacity. Non-elective is driven by out of hospital, community and the social care system and it was recognised that these are issues which we need to start addressing.

It was noted that the Chief Operating Officer would also work with the Surgical Division with regard to clinical variations and elective demand.

The Chair summarised discussions by confirming that there was work still to be done in understanding bed planning, the implications from the Carter review and clinical variations for day cases. Also, to understand what is happening in the wider community, which builds on the earlier action for market data.

048 & 049/16 **MONTH 11 INCOME & EXPENDITURE AND FINANCIAL NARRATIVE**

The Assistant Director of Finance reaffirmed our position, which was stated earlier, that against the original plan the elective and day case procedures have decreased and non-elective work has increased which has had a consequence on the pay spend particularly, agency. At Month 10 the forecast was for a significant impact of elective cancellations but this was not as great as expected with some improvement versus last month's forecast. Income is secure to the end of the year due to the clinical income agreement with Commissioners. With regard to expenditure, the number of beds open peaked in January and declined in February but pay spend has remained at the peak level. An additional paper which is discussed at the Workforce Well-led Committee was referenced, the report shows a week on week performance against the Agency Cap and we continue to be above that cap, as the cap rates reduced in February for medical staffing, the breaches have increased. The year-end agreement has helped improve our year end forecast from last month and the Trust is on track to deliver the £21m deficit. It was noted that the Joint Venture profit and re-valuations recognised are non-cash and only bring in a benefit to I&E.

It was also noted that there is a pressure with Cash and we are managing payments to suppliers due to the lower level of cash coming into the Trust from other NHS organisations which we are actively pursuing. Subsequent to this report the Trust has drawn down £12.9m as planned from the ITFF and we continue to manage payments. Due to the system pressures within the NHS as a whole, cash management will need to be tighter and cash shortage is likely to become a recurring theme next year. It was agreed that the F&P Committee should dedicate time to the scrutiny of the Cash Management Group.

It was noted by the Committee that many NHS organisations are still not achieving their revised forecast and it cannot be under-estimated the work which has been undertaken by the whole organisation to deliver the £21m forecasted deficit and our delivery of CIP.

STRATEGIC ITEMS

050 & 051/16 **TURNAROUND PROGRAMME UPDATE & 2016/17 CIP SCHEME POSITION**

The Chief Executive reported that the Trust are working to develop a CIP position for 16/17 that will deliver a minimum of £14m. The schemes which have been identified to date total £12.8m, the composition has changed favourably with a higher proportion within the pay/non-pay categories. Part of the discussions which will take place at Turnaround Executive will be to identify where else we can go following the FSS Star Chamber, Carter and clinical variations.

It was noted that it is likely we will experience a challenge at the next PRM with Monitor on the 19 April and we need to show progress and a refocussed management effort, now the Trust are post-CQC visit. It was also noted that a letter had been submitted to Monitor rejecting the Control Total and that one of the reasons detailed in that correspondence was the increase in CNST, they have agreed to review their mid-year analysis. In addition, we highlighted that a number of initiatives we would like to drive through are dual-site dependant and we would have issues implementing whilst we are working within this model and in the consultation phase.

In summary the 16/17 CIPs are aiming to stretch to £16m with the current total at £12.8m with movement and risk, it was recognised that it is getting harder to take savings out especially whist we are going through the consultation process.

ACTION – The Deputy Director of Finance referenced further correspondence received from Monitor and It was requested that this should be circulated to the members of the Committee taking part in the next PRM - **GB**

052/16 **2016/17 ANNUAL FINANCIAL PLAN**

The Deputy Director of Finance presented a further draft of the Financial Plan to enable the Committee to give further scrutiny prior to submitting to Board for approval, the headlines and actions are noted as follows:-

Activity – This draft plan is not yet agreed with Commissioners and detailed conversations continue to take place. The Divisions have signed up to this activity plan and the workforce and expenditure budget is model on this activity. In terms of movement from the previous version, A&E has been revisited and shows an increase of 2.2%, but following conversations non-elective remains unchanged.

Income – The plan shows an increase of £11.2m, some of this increase relates to tariff uplifts and some relates to the full year effect on activity, appointments made in year and also additional activity growth.

Workforce – The actual workforce at Month 11 stands at 5492 and the 16/17 Plan shows an increase to 5636. With regard to nursing and midwives the plan does not allow for agency staff and this has been financially modelled by funding the

established posts. This will be a financial challenge for the Trust and this is seen as the biggest challenge within our plans for next year.

The Chief Executive commented that the values are quite significant and it was noted that the Chief Executive's within West Yorkshire had agreed that information regarding agency and locum rates are shared and that he should be informed immediately if anyone claims they can get a better rate elsewhere.

Discussions then took place with regard to agency staff controls and costs and further information with regard to where that would leave us if the Monitor cap rate was applied was requested.

ACTION: To circulate electronically the information - **GB**

ACTION: To ensure greater clarity for the Committee it was agreed that the decision making and authorisation process for the request of all levels of agency and locum staff should be circulated - **HB**

ACTION: To provide a Standard Agency Report for F&P to ensure visibility on agency numbers – **GB/KA**

Budget Setting –

- The budget setting position stands a £33.4m deficit with a CIP of £14m included.
- This position aligns in overall terms with the draft plan submitted to Monitor in February and Year 1 of the 5 Year Strategic Plan
- The plan is based on agreed budget setting principles
- Developments approved at Commercial & Investment Strategy Committee included

It was noted that meetings have taken place where Executive and Divisions are in line with this plan, however, it was felt that there had been a degree of insufficient challenge looking at agency.

The Chief Operating Officer commented that there is anxiety around the Monitor cap and that there had been a risk called out in relation to medical staffing.

ACTION: To look at the criteria driving the extra technical posts and medical posts – **KA**

Capital – There is a planned capital spend of £28.2m and Monitor will scrutinise in detail due to the scale of cash support required.

Cash – The plan is for external cash support requirement of £50m which is based upon capital and I&E plans as outlined.

The Chair of the Committee stated that the recommendation from this Committee for the Board would be that in terms of the overall numbers and direction of the plan this should be supported, however, there would be a clear caveat that there are risks

and further work has been requested on capital, we should provide more detail on staffing and bed establishment which tie back to CIP schemes and also look at where costs can be taken out and also to look at plans for winter.

053/16 CAPITAL PROGRAMME

The Deputy Director of Finance reported that at Month 11 the Trust was £3.6m underspent with a forecast underspend of £700k at year end.

TREASURY MANAGEMENT

055/16 CASH FLOW 13 WEEK FORECAST

The Deputy Director of Finance reiterated the challenges with regard to the cash position, the paper detailed the 13 week cash flow forecast and as previously reported payments to suppliers are being managed to ensure the requirement of the £1.9m balance.

With the importance of cash management and the governance of this Committee, the granularity of the paper was questioned. It was agreed that a review of the report would be undertaken.

GOVERNANCE

056/16 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the following from the IPR:-
Hard Truths – there are a number of areas running at Red
Workforce – attendance management is showing Green for some Divisions with regard to appraisals, this is based on their plan and in some cases they did not achieve their target, therefore should not have been approved and will be reversed.
Stroke – showing 2 months in arrears, but this has improved during February.

Discussions took place with regard to the level of report that should be submitted to this Committee, it was the intention of the Chief Operating Officer to review areas of Responsiveness and Workforce that tie into finances, but this is work in progress.

057/16 WORK PLAN

The Work plan was noted by the Committee.

058/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- Budget - Board
- EPR – Board (Private Session)

059/16 ANY OTHER BUSINESS

The Chief Executive reported that an Impact Report following the CQC inspection would be tabled at a future Committee meeting.

The meeting was closed.

DATE AND TIME OF NEXT MEETING

Tuesday 26 April 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.