Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 26 May 2016 from 1:30 pm

Venue: Boardroom, Sub Basement, Huddersfield Royal Infirmary

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Cllr Naheed Mather, Nominated Stakeholder MC Mr George Richardson, Publicly Elected Membership Councillor	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 28 April 2016	Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log**	Chair	**APP B**	**Review**
6	**Chairman's Report** a. Regional Chairs' Event	Chair	**VERBAL**	**Note**
7	**Chief Executive's Report:** a. Board Appointments Update	Chief Executive	**VERBAL**	**Note**
Transforming and improving patient care				
8	Consultation Process - Update	Director of Transformation and Partnerships	**VERBAL**	**Note**
Keeping the base safe				
9	Risk Register	Acting Director of Nursing	**APP C**	**Approve**
10	Strategic Plan – Year 1 ending March 2017	Company Secretary	**APP D**	**Approve**
11	Nursing and Midwifery Staffing – Hard Truths Requirement	Acting Director of Nursing	**APP E**	**Approve**
12	Health and Safety Annual Report	Executive Director of Planning, Performance Estates and Facilities	**APP F**	**Approve**

13	Fire Safety Annual Report	Executive Director of Planning, Performance Estates and Facilities	**APP G**	**Note**
14	Car Parking Charges	Executive Director of Planning, Performance Estates and Facilities	**APP H**	**Approve**
15	Director of Infection, Prevention and Control Quarterly Report	Executive Medical Director	**APP I**	**Note**
16	Integrated Board Report - Safety - Effectiveness - Caring - Responsive - Workforce - Financial Position	Chief Operating Officer Acting Director of Nursing Executive Medical Director Acting Director of Nursing Chief Operating Officer Interim Director of Workforce & OD Executive Director of Finance	**APP J**	**Approve**
Financial Sustainability				
17	Month 1 – April 2016 – Financial Narrative	Executive Director of Finance	**APP K**	**Approve**
A workforce for the future				
18	Staff Survey Action Plan	Interim Director of Workforce & OD	**APP L**	**Approve**
	Update from sub-committees and receipt of minutes & papers ▪ Quality Committee – minutes of 25.4.16 and verbal update from meeting 24.5.16 ▪ Finance and Performance Committee – minutes of 26.4.16 and verbal update from meeting 24.5.16 ▪ Audit and Risk Committee – minutes		**APP M**	**Receive**

	from meeting 20.4.16 and verbal update from meeting 26.5.16 ▪ Workforce (Well Led) Committee – minutes from meeting 21.4.16 ▪ Membership Council Meeting Minutes – 7.4.16 ▪ Charitable Funds Committee Minutes – 9.5.16			
Date and time of next meeting Thursday 30 June 2016 commencing at 1.30 pm **Venue:** Large Training Room, Learning Centre, Calderdale Royal Hospital				

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).*

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th May 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 28.4.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 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 minutes of the last Public Board of Directors Meeting held on Thursday 28 April 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 minutes of the last Public Board of Directors Meeting held on Thursday 28 April 2016.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 28.4.16.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 28 April 2016 in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Executive Medical Director
Keith Griffiths	Executive Director of Finance
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Richard Hopkin	Non-Executive Director
Philip Oldfield	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
Kathy Bray	Board Secretary
Jackie Green	Interim Director of Workforce and OD
Rosemary Hedges	Membership Councillor
David Himelfield	Huddersfield Examiner Reporter (for part of meeting)
Peter Middleton	Membership Councillor
Victoria Pickles	Company Secretary
Lindsay Rudge	Acting Director of Nursing
Caroline Wright	Communications Manager (for part of meeting)

Item

57/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

58/16 APOLOGIES FOR ABSENCE

Apologies were received from:

Dr Linda Patterson	Non-Executive Director
Mr David Longstaff	Nominated Stakeholder Membership Councillor

59/16 DECLARATION OF INTERESTS

There were no declarations of interest to note.

60/16 MINUTES OF THE MEETING HELD ON THURSDAY 31 MARCH 2016

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

61/16 MATTERS ARISING FROM THE MINUTES/ACTION LOG

CAIP – MORTALITY REVIEW – It was noted that Professor Mohammed from Bradford University was due to give a repeat presentation of his findings on Mortality to the Board and Membership Council on the 5 May 2016.

STATUS: Closed

10/16 – CALDERDALE SUPPORT AND INDEPENDENCE TEAM – The Chief Operating Officer confirmed that the line management for the enablement staff had now changed and staff had been informed.
STATUS: Closed

44/16b – CHAIRS' INFORMATION EXCHANGE – INTERMEDIATE CARE FACILITIES – The Chief Operating Officer reported that work was underway with colleagues as part of the safer patient flow workstream.
STATUS: **Closed**

12/16 – RISK REGISTER – HEATMAP CHANGES – The amendments to the Risk Register heatmap had now been undertaken.
STATUS: Closed

62/16 STAFF STORY – IMPROVEMENT WARD UPDATE

Sister Rachel Garside and Matron Catherine Briggs gave a presentation outlining the challenges faced by one of the elderly medical wards at Calderdale. It was noted that prior to her appointment there had been some problems on the ward regarding the high number of vacancies, low retention of staff, skill mix, low staff morale, high sickness levels and limited communication with medical teams and support staff. Sister Garside highlighted the team building work undertaken which had improved continuity of patient care and safety and improved relationships with all staff on the ward.

The Board heard of the positive feedback which had been received from the Care Quality Commission (CQC) and Royal College of Nursing following recent visits. The Chief Executive stressed that once the CQC and RCN reports are received it was important that the ward staff are involved in the action planning of the recommendations. The Board asked about the number of patients awaiting care home placements and it was agreed that the Chief Operating Officer would produce and circulate some analysis of the patients on the wards awaiting social services and other partner support.

ACTION: Chief Operating Officer

The Executive Director of Finance asked whether there were any further improvements which could be made. Matron Briggs suggested that it was the perception of some ward staff that patients awaiting diagnostic tests should not be allowed home until after the diagnostic test has been done. It was suggested that giving patients appointments and allowing them to go home was the right thing for some patients and should be considered if appropriate. It was noted that physiotherapy delays on the wards can cause problems for elderly patients.

The Board thanked Rachel and Catherine for their enlightening and informative presentation and congratulated the ward staff on the improvements made.

63/16 CHAIRMAN'S REPORT

a. MEMBERSHIP COUNCIL MEETING – 7.4.16

The Chairman updated the Board on the discussions held which included:-

- Electronic Patient Record (EPR) Update
- CQC Inspection initial feedback
- Consultation Process update
- Integrated Performance Report update received
- Election timetable approved
- Chairs Appraisal process approved

- Car Parking – the discussion had identified an error in modelling. Paper was being reworked following the Membership Councillors observations.

64/16 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 Nursing. The offer was being concluded and once accepted it would be formally announced.

As reported at the last meeting the Executive Director of Workforce and Organisational Development, Ian Warren was due to commence with the Trust on the 1 August 2016.

ACTION: Chief Executive

65/16 CONSULTATION PROCESS - UPDATE

The Director of Transformation and Partnerships advised that the consultation on the reconfiguration of hospital services was underway and would run to the 21 June 2016. It was noted that two public meetings had taken place: one in Halifax on the 14 April and Huddersfield on the 18 April 2016. There were also a number of drop-in events scheduled and to date these had been relatively well attended.

It was noted that following the two public meetings, the clinical commissioning groups (CCGs) were considering whether a further public event was necessary. The Board discussed the need to ensure that a broad spectrum of local people were encouraged to participate in the consultation.

Prof Peter Roberts enquired about the process after the 21 June 2016. The Director of Transformation and Partnerships advised that once all the feedback and findings have been collated the CCG will submit the findings to the Scrutiny Panel prior to a final decision being made.

OUTCOME: The Board noted the progress with the Consultation.

66/16 RISK REGISTER

The Acting Director of Nursing reported that the top risks (scored 15+) within the organisation remained the same as the previous month. The 7 **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 there were no risks with increased scores.

Risks With Reduced Score

The Board noted that: the risk relating to the potential loss of income to the Trust due to competitive procurement had been 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.

The risk relating to the clinical administration workforce had been reduced from 15 to 9 due to additional resources secured for this group of staff.

New Risks
There had been 1 new risk identified since the last report – this was relating to the failure to provide adequate care during the junior doctor's strike on 26 and 27 April 2016

Risks to be discussed at next Risk and Compliance Committee
The Board noted that the Risk and Compliance Group would discuss the following risks at the next meeting:

- Maternity Services
- Gastroenterology Rota
- Documentation

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

67/16 CARE OF THE ACUTELY ILL PATIENT

The Executive Medical Director presented the summarised Care of the Acutely Ill Patient Report. The key issues arising from the report were discussed:-

- Mortality Reviews – challenges in undertaking timely reviews had been experienced.
- SHMI and HMSR – Unchanged position - still above the national average position. The work undertaken on coding, co-morbidities and changes in demographics was discussed.
- Crude mortality – Remains within the national average and actions were being undertaken to investigate why the Trust should have acceptable Crude Mortality but above average figures for SHMI. This work included an external respiratory review and work within stroke to develop an action plan.
- Care Bundles – new process for collation of information
- Pallative Care – work was underway to ensure that were possible patients die in their place of choice.

Discussion took place as to whether it felt that this summarised report provided the Board with a sufficient level of detail. It was agreed that this should be reviewed in the future once assurance that the sub committees are working through the granularity of the issues was confirmed.

The Executive Director of Finance stressed that it was important for specific workforce issues to be addressed by the newly formed Workforce Well-Led Committee and it was agreed that this be fed back to them through the Chair, Jan Wilson, Non Executive Director.

OUTCOME: The Board received and noted the progress with the summarised Care of the Acutely Ill Patient Programme. It was agreed that the Board would review the adequacy of the summarised report in 2-3 sub-committee meeting cycles.

68/16 SAFEGUARDING UPDATE – ADULTS AND CHILDREN - ANNUAL REPORT

The Acting Director of Nursing presented the Safeguarding Annual Report. The key highlights included:-

- Policies and Guidelines – continued to be updated and developed.
- Mental Capacity Act and Deprivation of Liberty Safeguards Training had been undertaken.
- Mandatory Training in Safeguarding for all staff developed via the electronic staff record system.
- Revised, strengthen governance arrangements – monthly Safeguarding Committee to report to Quality Committee
- Partnership Working - strategy to be developed around female genital multilation.

OUTCOME: The Board received and agreed the Safeguarding Annual Report

69/16 REVIEW OF PROGRESS AGAINST STRATEGY

The Company Secretary presented the Review of Progress against year 1 of the 5 year plan to the Board. It was noted that there had been significant progress against all objectives in the plan. It was noted that as the plan for year 2 was developed any outstanding issues would be included and reported back to the Board. It was noted that the Board/Membership Council Workshop on the 10 May 2016 would discuss the strategy and particularly discuss issues around:-

- EPR
- Care of the Acutely Ill Patient
- Quality Priorities
- CQC Delivery of action plan

Rosemary Hedges raised the issue of leadership and development programme. The Chief Executive advised that work was on going within the Trust through a number of different forums regarding leadership and development together with succession planning. These forums included:-
Workforce Well-led Committee, Working Together to Get Results initiative, Investor in People and staff survey feedback, along with work that colleagues were co-producing through the Workforce Race Equality Standard Group.

The Interim Director of Workforce and OD advised that she was developing a Workforce Strategy which would pull together all these strands of work into one document and action plan. It was agreed that this would also be discussed at the Workshop on the 10 May 2016.

OUTCOME: The Board received and approved the progress against Strategy.
ACTION: Workforce Strategy to be discussed at BOD/MC Workshop – 10.5.16

70/16 MEMBERSHIP COUNCIL ELECTION – PROPOSED TIMETABLE

The Company Secretary advised the Board that the Membership Council had reviewed and agreed the proposed timetable for the Membership Council Elections at its meeting held on 7 April 2016.

It was noted that currently there would be 11 seats subject to election during the summer of 2016. The deadline for receipt of nominations was 5 July and the Electoral Reform Services were due to publish the results on the 22 August 2016.

It was noted that there were a significant number of staff seats subject to election. The Chairman emphasised that managers should ensure that staff are given support and encouraged to attend as part of their personal development although the issue of time commitments was acknowledged.

OUTCOME: The Board approved the Membership Council Election timetable.

71/16 MODERN SLAVERY AND HUMAN TRAFFICKING STATEMENT FOR ANNUAL REPORT

The Company Secretary reported that the Modern Slavery Act 2015 was designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act created 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 Board considered the draft statement and approved that this should be included within the Annual Report.

OUTCOME: The Board approved the statement for the Annual Report on Modern Slavery and Human Trafficking

72/16 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief Operating Officer introduced the Integrated Board Report as at 31 March 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 earlier that week.

The areas of specific note were:

Responsiveness:

Variance against plan - Non elective and % day case variance against plan are both improving this month. Elective and outpatient variance have both continued to decline. The overall picture, as with most acute trusts, is an increasing number of A&E attendances leading to increasing pressures on staff and beds. Targets related to this such as the 4 hour emergency care standard have been negatively impacted.

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

Caring:

Patient experience - the Trust maintains a high level of patients reporting through the Friends and Family test. The % that would recommend A&E is now red as is the % that would recommend the community service, which has been falling throughout the quarter. Further work was underway to look at the reasons behind these scores and what would be required to improve patient experience of these services.

Complaints – the total numbers of complaints had increased in month in line with the trend throughout this final quarter. The Board considered that this may be due to the increased pressures experienced by the Trust. It was noted that work continued with Divisions to improve the response times to complaints.

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.

Ulcers – All categories of pressure ulcers increased in the quarter and Categories 2 and 3 pressure ulcers are reported red. Root cause analysis of ulcers and patient falls continued.

Effectiveness:

Mortality rates – all mortality indicators are now showing red and all have risen over the past quarter. As discussed within the Care of the Acutely Ill Patient report this is the focus of significant work to understand and address this 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.

Fractured Neck of Femur performance – continues to fall and is now at less than 62% against a national target of 85% despite work undertaken. A review of the pathway was underway.

Workforce:
Sickness – Absence rates for sickness were higher than target in 4 out of 7 divisional groups. Overall the majority of the Trust's sickness absence was due to long term sickness. An attendance management team had been established and due to proactive work and through return to work interviews the level of sickness was reducing.

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.

Finance:
Finance: Month 12 elective and day case income was below plan, however overall total income was above plan and the Trust ended the year with an overall £2.03m surplus above plan. This would be reported in more detail under the Month 12 report later in the meeting.

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.

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

73/16 MONTH 12 – MARCH 2016 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 12 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 26 April 2016:-

The key issues included:-

Summary Year to Date:

- The overall deficit (including restructuring costs and 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 were 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 £20.15m against the planned £29.72m.
- 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.

Summary forecast:

- The financial position presented 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 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. 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 it original 2015/16 financial plan in both I&E and cash terms.

The Board requested that thanks be given to the Finance Team for their help in achieving the financial position for the Trust.

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

74/16 MEDICAL REVALIDATION

The Executive Medical Director presented the update to the Board on the progress with medical revalidations within the Trust. In summary, the purpose of the paper was to update on Appraisal Completion for Non Training Grade Medical Staff.

It was noted that as at 31 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.

The Executive Medical Director asked that a record of thanks from the Board be made to acknowledge the work of all staff involved, particularly the Post Graduate team in achieving this position.

OUTCOME: The Board received and approved the Medical Revalidation update position.

75/16 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 29 March 2016 and a verbal update from the meeting held on 26 April 2016 was received from Dr David Anderson. Matters arising from the April meeting included:-

- **Upper GI Haemorrage and pathway review**
- **Emergency Services flow**
- **SHMI position**
- **Care of the Acutely Ill Patient programme**
- **Stroke Care**
- **Report on Calderdale Vanguard**
- **NICE Guidelines** – work in the Trust ongoing
- **CQC Response** – Group being established to work on the Action Plan following the recent inspection.

b. **Finance and Performance Committee** – minutes of the meeting held on 29 March 2016 were received and noted and a verbal update from the meeting held on the 26 April 2016 was received from Phil Oldfield
Matters arising in the April meeting included:-

- **2015/16 Position.**
- **EPR Approach** – risks/delays.
- **CIP Performance** – challenging target for 2016/17 noted.
- **Agency spending** – report received – debate on controls scheduled for next meeting.
- **Position in marketplace** – update from Director of Transformation and Partnerships. Opportunities/proposals to be discussed at next meeting.
- **Finance Report** – examination of what should be reported to the Committee being reviewed.
- **Challenges for future** – including cashflow, CIP and Monitor control total discussed.

c. Audit and Risk Committee – a verbal update from the meeting held on 26 April 2016 was received from Prof Peter Roberts. Matters arising from this meeting included:-

- **EPR Update**
- **Payroll** – process assurances – improvement timetable to be circulated to ARC
- **Self Assessment of ARC** – Collated responses received. Action plan developed and agreed. Arrangements to be made for all Sub Committees of the Board to undertake similar exercise.
- **Documents for Annual Report** – Annual Governance Statement, ARC Annual Report – documents to be circulated for ARC approval. Compliance against Monitor Code of Governance - approved.
- **ARC Workplan** – approved.
- **Internal Audit** – significant improvement in clearing overdue audit recommendations. The three audits with limited assurance discussed:- Payroll, Non Patient Visitors, Duty of Candour.
- **LCFS** – Progress noted and Workplan 2016-17 approved.
- **Whistleblowing and expressions of concern –** 2 incidents had been reported no further information was available at the time of the meeting.

d. Workforce (Well Led) Committee – Phil Oldfield reported on the matters arising from the meeting held on 21 April 2016. This included:

- Staff Survey – Action plan to be taken to Board in May.
- Workforce Performance Report – issues discussed
- Finance Workforce Report – noted
- Status reports from Work-stream Committees – received.
- Health and Wellbeing Group - CQUIN – update on plan at next meeting.

The Chairman thanked everyone for their attendance and contributions.

76/16 DATE AND TIME OF NEXT MEETING

Thursday 26 May 2016 commencing at 1.30 pm in the Boardroom, Sub Basement, Huddersfield Royal Infirmary

The Chairman closed the meeting at 16:00 hours.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th May 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - 1 MAY 2016 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 May 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 May 2016

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 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 Gill 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.			Presentation to Board and MC 5.5.16
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 (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		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 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
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 COO confirmed that the line management for the enablement staff had now changed and staff had been informed.	28.4.16		26.5.16
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		
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			13 July 2016 Board Dev Session		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 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
	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.					
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		
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		TBC		
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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 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
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 An offer of employment for the post of Executive Director of Nursing was being concluded and once accepted it would be formally announced.	26.5.16		26.5.16
62/16 28.4.16	**STAFF STORY – IMPROVEMENT WARD UPDATE** The Board asked about the number of patients awaiting care home placements and it was agreed that the Chief Operating Officer would produce and circulate some analysis of the patients on the wards awaiting social services and other partner support.	HB		26.5.16		

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, 26th May 2016	**Sponsoring Director:** Lindsay Rudge, Deputy Director of Nursing
Title and brief summary: Corporate Risk Register - Corporate Risk Register - This paper presents to the Board the corporate risk register as at May 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 Compliance Group reviewed the risk register at it's meeting on 9 May 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:

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:

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 May 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 20 risks and the associated controls and actions to manage these. There are two new risks, 6732 re: failure to deliver cost improvement and risk 6715 regarding documentation.

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 CRR - MAY 2016.pdf

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CORPORATE RISK REGISTER REPORT

Risks as at 16th May 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
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
6721 (20): Non delivery of 2016/17 financial plan
6723 (20): Suspension of capital programme
6732 (20): Cost improvement delivery

RISKS WITH INCREASED SCORE

No risks have increased in score.

RISKS WITH REDUCED SCORE

No risks have reduced in score.

NEW RISKS

There has been two new risks and three financial risks updated from 2015/16 added to the corporate risk register.

The new risks added are:

- 6732 Failure to deliver cost improvement programme
- 6715 Poor quality / incomplete documentation

- 6721 Non delivery of financial plan 2016 / 17 (former 2015/16 risk 4706)
- 6722 Cash flow risk 2016/17 (former 2015/16 risk 6150)
- 6723 Suspension of capital programme 2016/17 (former 2015/16 risk 6027)

A risk has been added to the divisional risk registers of Medicine and Surgery and Anaesthetics regarding Gastroenterology. Due to the risk score following assessment being below 15 this risk is not for inclusion on the corporate risk register and will be managed within divisional risk registers.

CLOSED RISKS

The 2015/16 financial risks (4706, 6150, 6027) have now been closed.

RISKS TO BE DISCUSSED AT NEXT MEETING

Risk regarding Athena system, Family and Specialist Services.

	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	**Service Reconfiguration** 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	The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks. Public engagement has commenced on Cardiology and Respiratory inpatient change. A change in consultant recruitment process (that commenced during January 2016) will reduce time to appointment. 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 2016 Update: Programme of consultation meetings underway. **May 2016 Update**: Consultation continues	May-2016	Oct-2016	WEB	Anna Basford	Catherine Riley
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	**A&E** 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 April 2016 Update: Proceeding to international recruitment for hard to fill Consultant level posts. **May 2016 Update**: as April	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	**Mortality** 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	- To complete the work in progress - CQUINS To be monitored by the Trust - External review of data and plan To take place - assistance from Prof Mohammed (Bradford) 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 update** We are still awaiting final reports from the Two Invited Service Reviews. We are going To commission a Further review into stroke services. the stroke Service are developing an improvement plan to reduce their crude mortality levels.Mortality review numbers have decreased and still not showing increased levels of avoidable death.	May-2016	Aug-2016	COB	David Birkenhead	Juliette Cosgrove

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	**Staffing Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to 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 number of specialties (A&E, Ophthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service) Dual site working impacts 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: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) There is a risk that patients in the extra capacity wards (cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate	**Nurse Staffing** To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy -- flexible labour used for shortfalls (bank/ (nursing), internal / agency) and weekly report on as part of HR workstream. **Medical** Medical Workforce Group chaired by Medical Director Active recruitment activity, including international recruitment - Revised apporvals process for medical staffing to reduce the delay in commencing recruitment Interim HR resource to man\ge medical workforce issues Exit interviews for Consultants a Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements **Therapy Staffing** - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners Flexible working - aim to increase availability of fstaff through additional resources / bank staff All staff Contribute to Health Education England survey to inform future commissioning / provision of education / training	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 - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	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). March Update A summary report produced for the medical workforce and therapy workforce setting out:- • what the current staffing position is against the current establishment for both groups (where we are e.g vacancies and how we are covering e.g bank and agency workers) • what gaps exist and what risk they generate • what actions can be taken to mitigate any risks identified • what our approach to recruitment and retention is This work will 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. **May 2016**: No further update - see April	Jun-2016	Sep-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson

Major	6503	Corporate	THIS	THIS Modernisation	Dec-2015	Active	Transforming and improving patient care	**EPR** 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 Tru+A2st 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 Risk Compliance group via the Cerner Portal if required, any escalations from transformation group will be brought to Risk Compliance group by the programme leads April 2016 Update - Risk and Compliance Group to review EPR risk register in May. Risk summary (Transformation Group) to be brought to R&C monthly. **May 2016 Update:** An overview of the EPR Risks were presented at R&C Group on the 9th May. The actions/processes that have been implemented to mitigate the risk and the gaps in controls are: - Deep Dives carried out on top 3 scoring programme risks - Formation of a CHFT EPR Ops group - This is the feed into Divisional Risk Registers. - Any risks escalated to Transformation board should then come to R&C with the Transformation board Risk Summary. The board members who attend R&C agree the Board is well informed of the Risk situation with EPR	Jul-2016	Sep-2017	RC	Mandy Griffin	Mandy Griffin

Major	6658	Medical	Emergency Network	Accident & Emergency	Mar-2016	Active	Keeping the base safe	**Patient Flow** 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 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 16 update**. Safer programme established and key priorities agreed supported by programme infrastructure and regular progress reviews. Short term improvement plans in place with ability to flex capacity short term to manage peaks. 2 potential external capacity options being considered in partnership with CCG where alternative providers of Package of care and nursing home beds have been identified; CHFT active in the discussions. ECIST report received and appropriate planning commenced internally with an SRG workshop scheduled for June following by a SEB workshop.	May-2016	Sep-2016	BOD	COO Helen Barker	Bev Walker
Major	6721	Corporate	Finance	Trustwide	May-2016	Active	Keeping the base safe	**Finance** The Trust is planning to deliver a £16.1 M deficit in 2016/17. There is a risk that the Trust fails to achieve its financial plans for 2016/16 due to: - clinical activity and therefore income being below planned levels - income shortfall due to commissioner affordability - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of sustainability and transformation funding due to performance - failure to deliver cost improvements - expenditure in excess of budgeted levels - agency expenditure and premia in excess of planned and Monitor ceiling level	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify cip shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach	Further work ongoing to tighten controls around use of agency staffing.	20 5 x 4	20 5 x 4	15 5 x 3		Aug-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

Major	6722	Corporate	Finance	Trustwide	May-2016	Active	Keeping the base safe	**Finance** Risk that the Trust will not be able to pay suppliers, staff, PDC and 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 going concern.	* Agreed £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1 m to support cash in advance of progression of revenue support loan	Distressed cash support through "Revenue Support Loan" not yet formally approved by Monitor.	15	5 x 3	15	5 x 3	10	5 x 2	To progress application, subject to Monitor support, for distressed funding through Revenue Support Loan	Aug-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer
Major	6723	Corporate	Finance	Trustwide	May-2016	Active	Financial sustainability	**Capital Programme** Risk that the Trust will have to suspend or curtail its capital programme for 2016/17 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. There is a risk that Monitor will not approve the Trust's capital programme for 2016/17 due to national funding pressure also resulting a failure to develop infrastructure for the organisation	Agreed £5M capital loan from Independent Trust Financing Facility (TFF) received in April 2016 to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Discussed with Monitor and planned for distressed cash support.	Monitor approval of capital programme awaited. Approval of distressed cash support awaited.	20	5 x 4	20	5 x 4	15	5 x 3		Aug-2016	Mar-2017	FPC	Keith Griffiths	Kirst Archer
Major	6732	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	May-2016	Proposed for Acceptance	Keeping the base safe	**Cost Improvement** Risk of: not achieving £14m cost improvement (CIP) delivery due to : - failure to identify sufficient aggregate value of CIP schemes (approach being taken is that to deliver £14m CIP - schemes to the value of £16m is required). Currently £7m of schemes are fully developed with a further £7m of high level/ high risk ideas. · failure to deliver or under-performance of the CIP schemes that are identified as fully developed · inability to deliver transformational bed reduction CIP schemes due to increased demand for hospital admission or insufficient community health and social care capacity. · income CIP schemes are challenged by Commissioners and income is not paid. resulting in not achieving £14m CIP target Not achieving the Trust's financial control total for 16/17 Regulatory action by NHSI Loss of reputation	· Divisions challenged with identifying 4% of influenceable spend by end of May · CIP principles to ensure the schemes through the gateway 2 process are achievable e.g. income schemes tested with contract ADF · Turnaround Executive meeting reviews RAG rated performance status of the CIP development & delivery programme on a weekly basis. · Executive Sponsor(s) accountable for CIP scheme delivery are in place. · Programme Management Office is in place, supporting and tracking all schemes using established gateway review process and reporting to Turnaround Executive. · CIP planning is focused on development of cost reduction schemes with aim to minimise percentage of Income CIPs required to achieve £14m. Star Chambers held for schemes off-track to identify additional CIP opportunity and corrective actions / replacement schemes. · The Carter recommendations and benchmarking is being assessed in every Division to identify additional cost reduction CIP schemes with the requirement these are developed to Gateway 2 by end May. · The Safer Patient Flow work programme has been established to enable the planned reduction in beds. · Divisional monthly Board meeting reviews CIP delivery, also reviewed at monthly meetings of senior Divisional teams with Executive Directors.	A specific risk which is outside the direct control of the Trust is the demand for hospital admission and capacity of community health and social care to enable CIP bed reduction. This has the potential to impact on a number of productivity related schemes. The CCG and other external commissioners refusal/ inability to pay additional income	20	5 x 4	20	5 x 4	10	5 x 2	Consideration of external support to construct plans for and deliver the £14m Regular discussion at Calderdale and Huddersfield SRG on the actions of partners to reduce demand for hospital admission and support care closer to home capacity required to enable bed reductions. Ongoing dialogue with commissioners regarding income schemes	Jun-2016	Sep-2016	FPC	Anna Basford	Sharon Appleby

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 Update** - ongoing discussions on actions and verbal update to Serious Incident	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 March 16 Ward 5 improvements completed and ward returned (from ward 11) April 16 Business case for Resus approved at CMG May 16 Business case for Resus to go to the Trust Board for approval	Aug-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	**Incident Investigations** Risk of not conducting timely investigations into serious incidents (SIs). due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Interim resource in place in Risk Management to oversee management of Serious Incident Investigations	1. Lack of capacity to undertake investigations in a timely way and 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16	4 x 4	16	4 x 4	8	4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group 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 Update** Senior Investigations Manager in post to support serious incident investigations	May-2016	Jul-2016	QC	Director of Nursing, Julie Dawes	Juliette Cosgrove
Major	6598	Corporate	Workforce, OD & Training	Training	Jan-2016	Active	Keeping the base safe	**Training Data** 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 require1/ 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	16	4 x 4	16	4 x 4	12	4 x 3	**May 2016 update** Future dates for any essential skills training will be logged on version two of the productive drive essential skills database. Data exchange with IBM which will facilitate this will be completed by May 31st 2016. Version two of the database will be rolled out to all areas throughout June 2016 To enable compliance reporting for the listed essential skills subjects, target audience agreement must be completed for each subject. The following subjects have been agreed as organisational priorities for this process: - aseptic non touch technique (ANTT) basic life support (BLS) documentation malnutrition universal screening tool (MUST) pressure ulcer care infection prevention and control end of life (EoL) care The priority subjects will be completed by September 2016 with the further matrix subjects being completed by 31st March 2017. This work will be led by Pam Wood.	Jun-2016	Jun-2016	NA	Interim Director of Workforce and Organisational D	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 4 x 4	16 4 x 4	8 4 x 2	- CQC compliance Steering Group - Implementation CQC Compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures October Update: External support for assurance on key areas. Date of inspection confirmed. CQC handbook to all staff (October 2015) and focus groups being held with staff November update Assurance inspections commenced with actions for divisions identified Additional capacity to be brought into the corporate team to assist planning for the inspection Risks that are unlikely to be mitigated prior to inspection to be identified throughout November	May-2016	Jul-2016	WEB	Julie Dawes	Juliette Cosgrove
Major	6694	Trustwide	All Divisions	All Departments/Wards	Mar-2016	Active	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 4 x 4	16 4 x 4	8 4 x 2	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. **May 2016 update** Significant progress is being made within the divisions particularly in the management of serious and moderate harm incidents	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 4 x 4	16 4 x 4	12 3 x 4	**May Update:** Awaiting outcome of national negotiations	Jun-16	Jun-16	QC	Helen Barker	Em. Planning Officer

Major	6715	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Apr-2016	Active	Keeping the base safe	**Documentation** There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation for when deterioration occurs, poor communication and multidisciplinary working.	Monthly clinical record audits (CRAS) with feed back available form ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken Analysis and action planning is managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement.	The number of audits undertaken can be low Unable to audit an allow and act on finding in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Director of Nursing	20 4 x 5	15 3 x 5	8 4 x 2	The Trust is developing an electronic patient record that will enable reports to be run in real time, audits can be undertaken by the ward or department lead when they deem it necessary (daily, weekly, monthly) There are alerts and stops within the system to prevent the user skipping documentation.	Jul-2016	Nov-2016	QC	Lindsay Rudge	Jackie Murphy
Major	6693	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Mar-2016	Active	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	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.	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	1. PPM Programme to be competed by end October 2015 by V. Wotherspoon 2/3. Medical devices database audit by V. Wotherspoon, completion August 2016 to ensure accurate picture of devices needing maintenance and location of devices.. 4. Review final report and actions of independent assessor (due September 2015) and amend plans accordingly. 5. Newly recruited Medical Engineer to start September 2015 6. Medical Engineering team to move to Estates from end of September 2016 to ensure systems and processes for medical devices are closely monitored. APRIL update. PPM scheduling with bank resource. Increasing number of devices seen , validation of database continues. Slower progress in March due to annual leave and major influx of new devices due to end of year spend. Recruitment of additional engineer to vacant post is proving difficult, positive candidate declined position. Process re instigated.Significant amount of high risk devices now scheduled and work completed. Work continues in a positive direction. **May 2016 update.** job offer in progress for vacant post. Bank resource still helping with PPM scheduling etc (53% of inventory) devices now on	May-2016	Mar-2017	DB	Lesley Hill	V Wotherspoon

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th May 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: STRATEGIC PLAN - YEAR 1 ENDING MARCH 2017 - The Board is asked to receive and approve the Strategic Plan - Year 1 - ending March 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors and Membership Council Workshop - 10.5.16	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and approve the 5 Year and FY17 Strategic Plan..

Main Body

Purpose:

The report presents the updated 5 Year Plan on a page and 1 Year Plan for year ending 2017 for approval

Background/Overview:

Last year the Board received the 5 Year and 1 Year plan on a page. During 2015/16 the Board has received quarterly updates on the progress made against the objectives described in the plan and at its meeting in April, received the end of year position. This showed that good progress had been made against all areas of the plan and three objectives had been completed.

The Issue:

The draft objectives for 2016/17 were discussed at a workshop between the Board of Directors and the Membership Council on 10 May. The objectives were agreed with the addition of patient flow and continuation of the development of the community division being added. These have been incorporated in the updated plan attached at appendix 1.

Next Steps:

At the workshop, the Board and Membership Councillors also discussed the way in which progress against these objectives will be monitored throughout the year, including some key questions that will need to be answered to demonstrate the effectiveness of delivery. A regular progress report will be brought to the Board and Membership Council each quarter along with a more detailed report on a specific objective and these will be timetabled into the work plans for these meetings.

Recommendations:

The Board is asked to receive and approve the 5 Year and FY17 Strategic Plan.

Appendix

Attachment:

2016.17.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

5 Year Strategy

Five Year Responses and Year Ending March 2017

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5 Year Strategy

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	Our patients and the public will be involved in their treatment and we will use their feedback to develop services for the future	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape and size with the capability and capacity to deliver safe, high quality services.	We will have implemented the five year plan
	We will have commenced implementation of an agreed re-configuration of integrated hospital and community services	We will be compliant with NHS Improvement standards	We will be widely recognised as an employer of choice through growing our own and attracting talented people to join our team.	We will be financially sustainable with the ability to invest for the future
	We will meet all relevant 7 day working standards and our SHMI will be 100 or less	We will consistently achieve all national and local patient performance targets	Engaging with our people and involving them in decisions that affect the Trust will be the norm.	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust interoperable electronic patient record which is used by patients and clinicians alike	We will be fully compliant with health and safety standards		

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Year Ending 2017

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	Subject to consultation, develop DoH approved implementation plans for the 5 Year Strategic Plan. Deliver on YE 2017 including strengthening community services for 2017	Undertake a Well Led Governance Peer Review and implement any actions to support the findings and ensure ongoing compliance with NHS Improvement & CQC	Develop and implement a 5 year workforce and organisational development plan	Deliver a robust financial plan including CIP for YE 2017
	Refocus the Care of the Acutely Ill Patient action plan and implement the SAFER (patient flow) and hospital@night programmes to improve quality of care	Implement the actions resulting from the findings from the CQC inspection	Implement the colleague produced action plan in response to Investor in People accreditation; the staff survey; Friends and Family Test and Workforce Race Equality Scheme	Working with partners, including across WY, develop and implement a sustainability and transformation plan including Carter compliance
	To work as an early adopter toward the implementation of selected 7 day NHS England standards (2,5,6 and 8)	Implement year 2 of the health and safety action plan and via the estates strategy, deliver against level B quality standards	Design and deliver a leadership and succession planning development programme	Develop a full CIP programme for YE 2021
	Together with our partners deliver and implement a robust EPR system	Implement the local quality priorities (see separate page)	Delivery of the integration of finance and workforce information systems ensuring consistency of provision and integrity of data	Develop a 5 year commercial strategy for THIS and consolidate the existing PMU strategy

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Vicki Drummond, Workforce Assurance Manager
Date: Thursday, 26th May 2016	**Sponsoring Director:** Lindsay Rudge, Deputy Director of Nursing
Title and brief summary: Hard Truths - Nursing and Midwifery Staffing - This paper provides assurance to the Trust Board that nursing and midwifery staffing capacity and capability is monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; National Quality Board guidance (2013) and NICE Guidance for safe staffing of Adult Inpatient Wards (2014) and Maternity (2015).	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

This paper provides assurance to the Trust Board that nursing and midwifery staffing capacity and capability is monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; National Quality Board guidance (2013) and NICE Guidance for safe staffing of Adult Inpatient Wards (2014) and Maternity (2015).

This paper sets out the evidence base underpinning the staffing review completed April 2016 as well as analysis of the review findings. Areas in scope included Inpatient ward areas (Adult; Paediatric and Maternity); Community nursing teams (Health Visiting; Immunisation and District Nursing teams); Emergency Department and Outpatient Department. The annual non ward based nursing review is currently scheduled to begin in June 2016.

This paper provides an overview of the size and shape of the nursing and midwifery workforce. Current and potential workforce risks are highlighted, and recommendations made for investment; disinvestment or change to the workforce models.

Main Body

Purpose:

As above

Background/Overview:

This paper is the next in a series of 6 monthly reviews of the nursing and midwifery workforce

The Issue:

NA

Next Steps:

The next steps will be to undertake a non ward based nursing review which will take place in June 2016, and to review workforce models within 6 months

Recommendations:

The Board can be assured that the nursing workforce models have been reviewed, scrutinised and challenged.

A record of the rationale for all recommendations has been maintained.

Investment and disinvestment opportunities have been identified.

The Board isasked to note and support the recommendations.

Appendix

Attachment:

Hard Truths (Nurse Staffing) - May 2016 VD v15.pdf

HARD TRUTHS REPORT

NURSING AND MIDWIFERY STAFFING

Board of Directors – 26 May 2016

CONTENTS

1.0 Introduction

This paper provides assurance to the Trust Board that nursing and midwifery staffing capacity and capability is monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; National Quality Board guidance (2013) and NICE Guidance for safe staffing of Adult Inpatient Wards (2014) and Maternity (2015).

This paper sets out the evidence base underpinning the staffing review completed April 2016 as well as analysis of the review findings. Areas in scope included Inpatient ward areas (Adult; Paediatric and Maternity); Community nursing teams (Health Visiting; Immunisation and District Nursing teams); Emergency Department and Outpatient Department. The annual non ward based nursing review is currently scheduled to begin in June 2016.

This paper provides an overview of the size and shape of the nursing and midwifery workforce. Current and potential workforce risks are highlighted, and recommendations made for investment; disinvestment or change to the workforce models.

2.0 Investment Update 2015 / 2016

2.1 Nursing Spend has increased within the last 6 months which has been attributed to increased flexible capacity requirements; Registered Nurse / Midwife (RN / RM) vacancies and absence levels.

Table 1: Nurisng Spend April 2015 – March 2016

		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
SPENDING - NURSING, MIDWIFERY & HCA PAY EXPENDITURE TRENDS	Substantive Pay	6,686,415	6,823,869	6,816,697	6,559,584	6,547,506	6,644,384	6,619,964	6,624,288	6,734,747	6,863,698	7,069,233	7,030,286	81,020,670
	Agency	529,957	360,517	393,637	426,887	376,646	408,185	453,304	535,366	502,950	702,990	529,379	713,729	5,933,548
	Bank	191,559	220,812	193,404	263,564	170,477	188,524	192,080	198,510	196,215	147,462	195,592	197,849	2,356,047
	Additional Basic Pay	63,465	49,209	50,755	46,348	46,674	45,657	41,702	44,833	55,734	48,486	57,393	67,239	617,494
	Overtime	152,755	114,405	189,991	167,954	112,621	139,045	108,463	105,748	180,376	89,961	213,816	229,131	1,804,264
	Plan	7,432,092	7,435,487	7,368,281	7,305,888	7,433,279	7,455,166	7,469,825	7,528,726	7,592,309	7,724,132	7,714,245	7,737,114	90,196,544
	Total Spend	7,624,150	7,568,811	7,644,484	7,464,336	7,253,923	7,425,795	7,415,513	7,508,746	7,670,022	7,852,597	8,065,413	8,238,233	91,732,024
	Against Plan	-192,058	-133,324	-276,203	-158,448	179,356	29,371	54,312	19,980	-77,713	-128,465	-351,168	-501,119	-1,535,480

2.2 Significant focus on reducing agency spend for the nursing workforce has been completed (see section 3.0 for further detail). Despite focused efforts in both recruitment and reduction in agency spend there remains a risk that CHFT will not be able to meet the ceiling of 3% applied by Monitor.

The percentage of agency spend on RN's of the total substantive RN's continues to be monitored on a monthly basis in line with Monitor Caps.

Table 2: CHFT Nursing Agency Spend: Percentage of Substantive Spend

units	Actual For Month ending 30-Sep-15	Actual For Month ending 31-Oct-15	Actual For Month ending 30-Nov-15	Actual For Month ending 31-Dec-15	Actual For Month ending 31-Jan-16	Actual For Month ending 29-Feb-16	Actual For Month ending 31-Mar-16
£m	(4.530)	(4.543)	(4.469)	(4.591)	(4.592)	(4.798)	(4.804)
£m	(0.040)	(0.065)	(0.065)	(0.081)	(0.059)	(0.000)	(0.146)
£m	(0.316)	(0.363)	(0.426)	(0.298)	(0.639)	(0.396)	(0.345)
£m	(0.615)	(0.616)	(0.637)	(0.857)	(0.647)	(0.650)	(0.520)
£m	(0.004)	(0.003)	(0.004)	(0.004)	(0.001)	(0.001)	(0.004)
£m	-	-	-	-	-	-	-
£m	(0.322)	(0.307)	(0.327)	(0.325)	(0.328)	(0.341)	(0.340)
£m	(0.002)	(0.002)	(0.001)	(0.002)	(0.002)	(0.002)	(0.001)
£m	-	-	-	-	-	-	-
£m	(5.829)	(5.898)	(5.930)	(5.959)	(6.269)	(6.188)	(6.262)
	5.42%	6.15%	7.18%	5.00%	10.20%	6.40%	5.51%

2.3 Investment secured for critical posts from November 2015 nursing review panel and supported by Board update:

FSS

1.8 wte midwifery posts have been reinvested in Deputy Head of Midwifery post.

Band 2 recruitment to posts in GAU and Ward 4C has been completed. Due to some attrition a level of vacancy remains on ward 4C which will be recruited to by 16.5.16.

Additional band 7 paediatric sister is now in post increasing the leadership and support for paediatrics across both sites.

The workforce model was increased for paediatrics between October and February but as a level of vacancy remained this was not achieved with substantive staff at all times.

2.4 Surgery Division

2.58 wte HCA have been recruited to ward 15, with 1.0 wte in post and the additional 1.58 in the recruitment process.

Funding for a Deputy Associate Director of Nursing post supported in November 2015 has been used to support an uplift of a band 7 into a matron post to support development and manage a short term absence in this team. As the Associate Director of Nursing is new in post this supported an adjustment period to scope how this role would fit and be supported within the existing senior management team.

2.0 wte clinical educators for a fixed term to support the nursing workforce funded through a temporary reduction in supervisory time is being scoped to understand how this will fit within the existing educational strategy.

2.5 Medical Division

Non Invasive Ventilation provision to meet the British Thoracic Society guidance required significant investment and was reviewed by the investment committee following the recommendation made in the previous nursing workforce report provided to Board of Directors in November 2015.

£100K investment has been allocated to the division and is currently been utilised to provide specialist nurse cover in the areas when required and provide support and education.

6.72 wte Engagement support workers have been recruited to and will commence on wards 5, 5AD and 8.

Deputy Associate Director of Nursing for Medical Division commenced in post April 2016

Emergency Department - Investment was agreed through the investment committee. Investment for an additional 12.6 wte RN's was supported and focused recruitment has resulted in increased workforce model. As this has not been fully recruited to and with turnover a level of reliance on high cost agency use in this area has continued.

As recruitment to the additional RN's within the Emergency Nurse Practitioner role are completed service cover will increase from midnight to 2am.

Additional HCA's have been recruited whilst RN vacancies continue.

3.0 Flexible Workforce

3.1 Both registered and non registered demand increased for the nursing workforce in the last 6 months, peaking in March 2016 with requested hours for registered nurses totalling 24,438 in comparison to 15,256 in November.

The highest reason for requested flexible workforce support for registered nurses is vacancies in the clinical area, followed by supporting flexible capacity areas and short term sickness.

The highest reason for requested flexible workforce support for non registered nurses is one to one support, followed by vacancies and short term sickness.

Table 3: Reason for Flexible Workforce Support Non-Registered Nurses November 2015 – April 2016

	One to One care	Vacancies on ward	Short Term Sickness	Other	Long Tern Sick	Winter Capacity Ward	Grand Total
Total (shifts)	3446	3206	1885	1378	942	916	11773

Table 4: Reason for Flexible Workforce Support Registered Nurses November 2015 – April 2016

	Vacancies on ward	Short Term Sickness	Winter Capacity Ward	Other	Long Tern Sick	One to One care	Grand Total
Total (shifts)	6809	1892	1725	1537	598	15	12576

The useage of one to one support is expected to decrease as the engagement support workers commence in post on wards 5, 5AD and 8.

3.2 The Flexible Workforce team (FWT) has significantly increased from 4.9 wte to 12.6 wte within the last 6 months. This has included specific roles to increase leadership within the service, assurance for training and development ; compliance of the service and a move to 7 day service with extended hours now being 7am – 8pm each day.

Benefits realised through the increased team include:

- Position of Flexible Workforce members (FWM) with appraisal and training completed
- Action plan – for training of FWM to facilitate online mandatory training completion
- Minimum of 3 attendances at the daily bed meetings to review staffing pressures and requirements
- Newly developed standardised CHFT agency compliance checklist which all agencies CHFT engage complete for all new agency staff working within CHFT. This provides assurance that agency staff have had the appropriate immunisations; training; registration. In addition photo identification; references and a copy of the nurses curriculum vitae are requested and then checked by the FW team before any bookings are agreed.

- Identification checking completed consistently with the FWF team contacting clinical areas at the start of each shift to ensure each agency nurse has had their induction; signed in to the ward and had their identification check completed.

3.3 Monitor Price Caps

Monitor introduced price caps in a 3 stage process in 2015. From 1.4.16 CHFT have an agency ceiling spend of 3% of substantive pay (RN).

To meet this requirement significant work has been completed with 14 agencies to negotiate and secure reduced rates.

The FWF team continue to recruit further agencies who are on framework and work within monitor imposed caps.

Monitor imposed caps relate to imposed levels of hourly rates available to pay to agency workers. The breaches of any hourly rates are reported weekly to Monitor.

The Board of Directors is requested to note a current risk we are working with. CHFT currently work with 3 agencies who do not supply nurses within the agency capped rates. The 3 agencies remain off framework within our region (2 have tended to the framework and we await the outcome of this).

Use of high cost / off framework agencies is approved at Director level for identified critical shifts only.

The level of useage of critical shifts is monitored and reviewed by the Acting Director of Nursing weekly as a minimum. The Flexible Workforce Manager is working with Associate Directors of Nursing to develop a trajectory for reducing high cost agency use.

3.4 Recruitment

Recruitment to the Flexible Workforce is ongoing with monthly external recruitment to band 5 posts realising minimum results (1 RN / Month on average).

The Flexible Workforce Manager is scheduled to run a separate advert targeting recruitment to FWT.

A review of pay scales for FWF members is scheduled as part of the nursing workforce strategy to decrease reliance on high cost agency.

Recruitment to band 2 HCA has been completed in cohorts with significant numbers recruited in advance of winter pressures in September 2015. Further recruitment events completed in December; March 2016 and May 2016.

All newly recruited registered and non registered members of the flexible

workforce team attend the nursing workforce induction.

4.0 The Nursing and Midwifery Workforce

4.1 Vacancies

Vacancies for Registered Nurses / Midwives have increased each month from December 2015, rising to 177.77 wte (data reported via ESR) in March 2016 which is a vacancy rate of 8.8%.

The vacancy level on individual areas is considerably higher than 8.8% for RN's with one area currently experiencing a vacancy rate of 40% (Ward 5B).

The vacancy level on individual areas is managed divisionally with substantive staff transferring for periods of time to ensure stability in all areas.

Three times a day as a minimum the actual staffing position on each inpatient adult ward is reviewed against planned and areas of risk escalated. A record of mitigating actions taken is also recorded and reported via the electronic site staffing tool launched in January 2016.

Vacancies for non registered staff are reported from ESR (March 2016) as 45.27 wte. Significant recruitment to non registered roles has been completed and further work to confirm the vacancy data from ESR is underway with a task and finish group.

Turnover peaked in March 2016, following a pattern consistent with March having the highest level of turnover from the nursing workforce in comparison with the other 11 months of the year in both 2014 and 2015.

Table 5: Turnover Nursing and Midwifery Workforce

Month	Nov 15	Dec 15	Jan 16	Feb 16	March 16
Turnover % RN / RM	1.19%	1.34%	1.13 %	0.96%	1.76%
Turnover % Non Registered	0.79%	0.82%	0.54 %	0.86%	1.43%

Vacancies are expected to increase from April 2016 within the nursing workforce as a result of the increase in headroom from 20 to 22% by 16.96 wte RN / RM and 8 wte non registered staff.

4.2 Absence

Absence rates have started to reduce through focused attendance management, resulting in an absence rate of below 5% for RN in March 2016 and below 7% for non registered staff in March 2016.

Table 6: Absence Rates Nursing and Midwifery Workforce

Month	Nov 15	Dec 15	Jan 16	Feb 16	March 16
Sickness % RN / RM	5.79	5.39	5.20	5.14	4.32
Sickness % Non Registered	8.99	8.32	8.72	7.94	6.28

The Attendance Management Team have assisted in reducing the absence level through a number of actions:

- Defined action plan for all long term sickness cases
- Supported line managers in ensuring that short term absence is being managed appropriately and in a timely manner
- Held meetings and training sessions with Ward/Department Managers to ensure appropriate management of short and long term sickness
- Developed a portal on the intranet which provides support and guidance for colleagues and line managers including frequently asked questions, flow charts, information leaflets, facts and figures
- Devised ‘how to’ videos for recording sickness on eRoster, completing a sickness absence returns form and conducting a return to work meeting

4.3 Average Fill Rates

Average fill rates are monitored by the Nursing Workforce Strategy Group and by the Associate Directors of Nursing for each division.

Average fill rates have remained largely stable over the last 4 months, but this has required a level of both agency and flexible workforce support.

Table 7: Average Fill Rates Registered Nurses and Care Staff

Average Fill Rates				
	Registered Nurses		Care Staff	
	Day	Night	Day	Night
April 2016 HRI	**90.64%**	**97.30%**	**107.82%**	**123.86%**
April 2016 CRH	**89.46%**	**95.51%**	**105.79%**	**118.69%**
March 2016 HRI	**88.85%**	**92.96%**	**104.97%**	**122.21%**
March 2016 CRH	**88.15%**	**96.24%**	**101.97%**	**116.21%**
February 2016 HRI	**87.61%**	**94.6%**	**103.8%**	**123.93%**
February 2016 CRH	**85.04%**	**96.11%**	**94.85%**	**109.46%**
January 2016 HRI	89.29%	95.24%	104.71%	117.60%
January 2016 CRH	88.81%	95.78%	99.81%	113.93%
December 2015 HRI	88.02%	92.69%	102.89%	115.57%
December 2015 CRH	91.70%	95.76%	97.20%	107.61%

4.4 The Nursing Workforce Strategy Group has developed their safe staffing data within the last 6 months to provide an electronic real time solution allowing staffing levels across both sites to be visible. Areas to be rag rated and visible to the flexible workforce team to ensure priority areas are allocated nurses first. The tool also provides a record of escalated risks and mitigating actions taken.

The electronic site staffing tool has also allowed the nursing team with colleagues to review not only fill rates, but skill mix and the percentage of substantive staff in any area. A weekly report is now available for each adult inpatient area and an example can be seen in Appendix 1.

The introduction of quality dashboards which present month on month data including nurse quality indicators has enabled the nursing teams to be able to review all indicators considered to achieve safe staffing more easily.

Parameters for exception reporting of the data within the quality dashboards from divisions to the nursing and midwifery committee is due for completion June 2016.

4.5 Recruitment

Recruitment to the Nursing and Midwifery Workforce in 2015 surpassed the level of recruitment achieved in 2014

Table 8: Starters and Leavers Nursing and Midwifery Workforce

2014 Nursing Workforce Starters and Leavers

Month	Qualified Hires	Unqualified Hires	Qualified Leavers	Unqualified Leavers
January	36	14	19	3
February	9	8	11	0
March	21	4	29	8
April	23	4	14	6
May	10	3	17	8
June	17	1	24	3
July	7	4	15	4
August	16	1	30	3
September	56	5	27	5
October	38	5	20	5
November	10	1	19	12
December	10	2	24	0
Grand Total	**253**	**52**	**249**	**57**

2015 Nursing Workforce *(International recruits)

Month	Qualified Hires	Unqualified Hires	Qualified Leavers	Unqualified Leavers
January	20 (8)	8	31	1
February	13	10	21	4
March	32 (12)	1	53	14
April	17 (7)	2	28	8
May	24 (8)	1	20	8
June	15	3	28	6
July	15	5	21	9
August	16	4	20	14
September	47 (1)	7	30	9
October	45 (3)	5	18	6
November	16	26	23	6
December	15 (1)	17	24	6
Grand Total	**275 (40)**	**89**	**318**	**92**

4.6 Recruiting and retaining high calibre nurses has remained a key objective for the Nursing Workforce Strategy Group, but this has remained a challenge at CHFT mirroring the challenges experienced across the UK following the increase demand for registered nurses in the post Francis era.

Since January 2016 recruitment of nurses from the EEA has become increasingly challenging due to the increased demand impacting on the availability of nurses and the introduction of the IELTS exam from the NMC.

Currently the Nursing Workforce Strategy Group are awaiting the outcome of a paper proposing a level of overseas nurse recruitment from outside the EEA to reduce the vacancy level and contribute to a skilled and stable workforce.

4.7 Focused recruitment within the UK has led to 51 (wte) adult nurses due to qualify in September 2016 being secured to start as their studies complete. In addition we have 8 paediatric nurses on a holding list and recruitment events for midwifery due to complete in May.

Recruitment remains an ongoing action each month for the nursing workforce, with a variety of adverts and campaigns which has included local newspapers; Nhs Jobs; attendance at job fayres and local universities. One of our current actions is to promote the opportunities, support and benefits of joining our nursing team at CHFT through the CHFT website.

4.8 Within the last 6 months significant recruitment of non registered nurses to both permanent posts and the flexible workforce has been completed.

All new starters both registered and non registered are now invited to a nursing workforce induction to optimise their start at CHFT.

The nursing workforce has continued to utilise value based recruitment for both non registered and registered recruits. We have also completed a review of strengths based recruitment and have supported a proposal to develop this starting with recruitment to band 6 and band 7 posts in part to ensure we have the right staff in the right roles.

4.9 The Nursing Workforce Strategy Group are currently reviewing a proposal to introduce a band 4 / senior health care assistant role to support patient care within the nursing and midwifery workforce.

4.10 <u>Retention</u>

The nursing workforce has increasingly focused on retention noting that we have experienced an increasing number of leavers in 2015 (Table 8).

Face to face leavers surveys primarily to qualified nurses within the last 12months have been offered to learn more about the reasons for leaving. The most common themes have been:

- Working days and nights in the same week

- Working significantly more hours than contracted to in one week
- Being moved from base ward / area to another area to work at short notice and on a regular basis
- Lack of support / preceptorship
- Pressure from reduced staffing levels

4.11 In response to the leavers surveys:

- the rostering team have reviewed and reported on unreasonable working patterns
- Introduced development support sister role to support new starters
- Provided week long induction for new starters
- Developed preceptorship programme for 12 months
- Introduced electronic site staffing tool to review staffing levels in real time across both sites
- Commenced preceptorship database

4.12 Recently Health Education England provided "best guidance" support to retain nurses and the Nursing Workforce Strategy Group has mapped current practice against the guidance and identified actions (Appendix 2) which are under review from the Workforce and Organisational Development team as part of the Trust wide retention strategy.

5.0 Nursing Workforce Model Review Panel

5.1 In April 2016 all nursing workforce models were reviewed using the nursing workforce model review panel which was introduced in October 2015. This ensured a consistent approach was utilised across each division to complete the reviews using standardised guidance and templates.

5.2 Specialist nursing reviews and non ward based areas were predominantly out of scope as these areas will be covered through the annual non ward based nursing review due to commence in June 2016.

5.3 The panel process consisted of each Associate Director of Nursing prior to panel:

- Reviewing within their division the current workforce model for each area with colleagues including finance representatives, matron's and ward managers.
- Acuity and Dependency studies were reviewed (see appendix 3)
- Nursing quality indicators
- Professional Judgement
- Professional guidance

5.4 The review panel consisted of:

- Director of Nursing and / or Acting Director of Nursing
- Deputy Director of Nursing – Modernisation
- Assistant Director of HR
- Workforce Assurance Manager
- Finance Manager

5.5 The Associate Director of Nursing for each division at panel :

- Presented their current workforce models
- Completed a documented review which included the rationale for any changes to the workforce model or no changes
- Identified the risk if recommended changes were not supported
- Identified the expected benefits if recommended changes were supported
- Provided a divisional summary of investment and disinvestment recommended for their nursing workforce

5.6 The panel were tasked with reviewing the information provided and providing scrutiny and challenge.

Following the initial review panels held in April 2016 a summary of key areas of challenge from the panel was issued to each Associate Director of Nursing and a final review panel was then held in May 2016.

6.0 Medical Division

6.1 Emergency Department

This area on both sites has received investment following the previous panel review completed in November 2016.
Phased recruitment has resulted in a level of vacancy in both departments currently.

Additional non registered roles have been recruited to temporarily to support the workforce.

No further changes are recommended to the workforce model, but the panel requested that BEST was repeated prior to the next planned review in 6 months to inform workforce model review.

6.2 MAU (CRH)

The workforce model review resulted in a recommendation to panel for investment of an additional 2.73 wte Health Care Assistants (HCA) to increase the number of HCA's on both the early and late shift from 1 to 2.

The throughput of patients, increased need for patients to require two nurses

to assist in basic care, use of one to one support; nurse quality indicators; staff wellbeing and colleagues experience contributed to the recommendation.

The risk of not supporting the investment of £66,069 were identified as reduction in quality of care; retention of staff and delayed medication. Also a reduced patient flow leading to increased waiting times in A&E.

The panel supported increasing the workforce using increasing apprentices within the division and reviewing placement of both experienced HCA's and new apprentice HCA's to maintain safe skill mix at all times for HCA's. In order to manage this in year, the number of apprentices must exceed the existing baseline of 16.

6.3 MAU (HRI)

The workforce model review for MAU at HRI also resulted in a recommendation to panel for investment of 3.6 wte HCA's to increase the number of HCA's on both Early and Late shifts from 2 to 3 (using 1 long shift), and a temporary 4 hour twilight shift.

The layout of the ward at HRI is significantly different to that on MAU at CRH. Professional judgement has identified that the activity at HRI and acuity of patients can feel higher. The twilight shift is in part driven from an increasing reliance on nursing teams to complete patient transfers, but also the increased use of the ambulatory assessment area which is increasingly used after its budgeted staffing model of 8pm. The 4 hour twilight shift is recommended as a temporary investment until the Safer Flow Programme long term ambulatory staffing model is complete.

The risk of not supporting the investment of £88,092 were identified as reduction in quality of care; retention of staff; delayed medication and reduced patient flow leading to increased waiting times in A&E.

The panel supported increasing the workforce within existing budget using increasing apprentices within the division and reviewing placement of both experienced HCA's and new apprentice HCA's to maintain safe skill mix at all times for HCA's. This will mean the wards need to have a minimum of 22 apprentices in total at any time.

An evaluation of the increased workforce model was requested ahead of the next workforce panel review to inform a recommendation for substantive funding in 2017.

6.4 Ward 21

The panel noted that additional governance was in place to manage increased HCA useage which had resulted in a pressure due to 2 additional beds open on ward 21. These beds should be closed and do not form part of the 16/17 bed plan.

6.5 Ward 5AD

The addition of engagement support workers due to start in this area following investment supported in November 2015 will be reviewed in the next panel.

6.6 Ward 17

Ward 17 has received investment through the GI business case into the nursing establishment to reflect the changing acuity and dependency on the ward.

Additional funding was requested to support a further uplift of 1.0 wte band 5 to an additional 1.0 wte band 6.

The panel considered the current establishment which consists of 1.0 wte Band 7 and 1.0 wte Band 6 with a further 1.0 wte development Band 6 post.

The panel supported the recommendation of the uplift of 1.0 wte band 5 to 1.0 wte band 6. Although this will increase the budgeted establishment by £7K this may provide opportunity to attract external RN's into CHFT and reduce the requirement for agency shifts.

6.7 Ward 8

Ward 8 is a 21 bedded complex care ward with a significant level of vacancy currently. Additional leadership support was recommended and supported by the panel resulting in the uplift of 1.0 wte band 5 to 1.0 wte band 6.

This will provide the area with 1.0 wte band 7 and 2.0 wte band 6's.

The ward is currently overspending, whilst this change will increase budgeted and long term staffing establishment costs by £7K, it will help support reduced vacancies on the ward and therefore become an enabler to avoid the continued use of agency premiums.

The addition of engagement support workers due to start in this area following investment supported in November 2015 will be reviewed in the next panel.

6.8 Review of Ward Clerks, Nutritional Assistants and Housekeepers

These posts have been reviewed across the division, revieweing where they are required and where there is opportunity for disinvestment. A net reduction has been agreed of 3.54 wte, £71,684 across the wards. These posts have been vacant for a minimum of 6 months and no quality impact has been seen in these areas.

6.9 Areas with no recommended changes

Ward 6D, 7BC and 7AD – no change whilst awaiting outcome of stroke services review, which will include further analysis of acuity and dependency

studies.

6BC and CCU
Ward 11 and 5
Ward 2AB, 6, 5C, 12
Ward 14; 8C; 5B and 6A

6.10 Table 9: Summary of Recommended Investment and Disinvestment Supported by Panel

The costs below are based on budget setting principles and are consistent with previous hard truths reviews. These demonstrate the level of investment commitment to future years. As explained above these costs will be mitigated aginst by employing apprentices (saving £109k of the £154k investment (MAU) recommending providing apprentice levels on the wards can be increased from 16 - 22). The band 6 uplifts are expected to be within current run rate costs and act as an enabler to reduce agency spend.

Area	Disinvestment £	Investment £
MAU CRH		66,069
MAU HRI		88,092
All wards	71,684	
17		6,744
8		6,744
Total	**71,684**	**167,648**

7.0 Surgical Division

7.1 Ward 19 and Ward 20

These wards were noted to be working across the floor supporting each other well to provide care and maintain safe staffing levels.

No recommended investment.

7.2 Ward 3

No recommended investment or changes to current workforce model. The panel noted that support to roster efficiently to maintain safe staffing levels is currently being provided.

7.3 Critical Care

An initial recommendation to panel for £191,637 investment predominantly to meet D16 guidance for 24 hour supernumerary co-ordinator on the HRI site was considered.

As the Unit is currently mitigating the risk and no incidents have been

reported as a result of not having this level of cover the panel did not support the recommendation for additional investment.

The panel recommended that the risk of not fully meeting the D16 guidance was monitored and held on the divisional risk register.

7.4 Trauma Co-ordinators

Currently the service consists of 1.6wte with no uplift. The panel considered a recommendation to invest £13,532 to provide headroom.

The panel did not support the recommendation for investment and identified a requirement for the division to identify opportunities for the Hospital at Night team and Clinical Commanders to provide support.

7.5 Ward 8D

The panel considered recommended investment of £95,819 to support additional ward attenders and clinics which have resulted from service developments. Data reported suggested activity linked to the service increases had been included within the divisional budget income with no increased provision for nursing to date.

The panel did not support recommended investment at this time and it was noted further work identifying the bed base required for a surgical model required focus.

Whilst further work to identify the bed base and consider developing nursing establishment to meet service requirements in the most appropriate area 8D would continue to be supported by nursing establishments on 8AB and 8C.

7.6 Ward 15

The panel was asked to consider changing the workforce model to accommodate flexible working in this area requiring investment of £4023.

The panel did not support the requirement to fund the investment and proposed the investment was met divisionally.

The Division is reviewing fluctuating activity which supports a variation of workforce model on different days of the week as seen on Ward 15.

7.7 Ward 22

Recommended investment reviewed by the panel was for £44,618 to support increased ward attendees direct from A&E in the form of an additional co-ordinator.

The panel identified that patients from A&E or direct referrals may require ambulatory care rather than beds and further work to consider an ambulatory model and support from clinical commanders to ensure efficient flow and co-ordination was required.

The panel noted that the current ratio at night within the workforce model exceeds 1:10 ratio with 2 RN's for 23 beds. This is described and monitored through the divisional risk register. A review of the workforce model on ward 22 will be undertaken as part of the ambulatory workstream of the safer patient programme.

7.8 Surgical Assessment Unit

The panel considered a recommendation for investment of £68,390 to support ambulatory care. The initial review had identified poor patient experience and ratios of less than 1:8. Further review of the evidence did not support these findings.

The area is currently working outwith the workforce model and support to work within the model and develop a model for ambulatory care within the divisioin was recommended by the panel.

Additional investment is not supported by the panel at this time.

7.9 Clinical Educators

Additional investment to support clinical educators in the operating department was requested (£83,068).

The panel considered the request but noted the 2.0 wte clinical educators for the division had not been realised yet as recommended in the November 2015 panel review.

The operating department has educator support in place (0.4 wte) currently. The panel recommended the division considered approaching Health Education England and the local university to work in partnership to increase clinical placements which could provide additional funding opportunities.

7.10 Outreach / CVAD Team

The panel noted that the number of referrals into this service has significantly increased and requested at initial panel in April further consideration of the impact of Hospital at Night and an additional training post further ahead of a follow up meeting to review the recommended investment of £133,222 to increase the service by an additional long day on HRI site 7 days a week.

The panel recognised the change in the way we care for the acutely ill patient and requirement for more critical care beds.

The panel considered the evidence provided and identified further work required to review current service delivery with particular focus on the CVAD team and Hospital @ Night team.

7.11 Summary of Investment and Disinvestment Surgical Division Recommended

No investment or disinvestment recommended.

8.0 COMMUNITY DIVISION

8.1 Health Visiting

The health visiting service has continued to maintain the target set by NHS England of 58.7 wte.

The service is mindful of the recent transfer to Local Authority commissioning and is aware that the service will be put out to tender in 2016.

Early indications suggest the budget following tender will be between 10 and 20% lower to meet the tender requirements. Therefore 2.5 wte Registered Health Visiting vacancies have been transformed into band 4 child development support roles in readiness.

Whilst awaiting the specification of the service no further investment is recommended, but the Board is offered assurance that health visitor caseloads have been maintained at 250 – 300 per wte health visitor in line with current CPHVA recommendations.

8.2 Immunisation Team

No recommended investment is requested at this time despite the immunisation programme growing. Assessment of the current work is being completed.

Future development dependant on impact of increased activity may provide an opportunity to develop skill mix further within the team.

8.3 District Nursing

Significant work has been completed within the last 6 months which has enabled the district nursing team to have activity led workforce models.

Defining the current workforce model has provided a baseline and enabled the service to align and match resources with equitable service provision. The workforce models are built upon the average number of contacts. The current average number of contacts is 9 patients ins a 7.5 hour shift.

8.4 No acuity studies have been completed recently within the community setting and there is minimal evidence of acuity studies in the community setting available nationally, however the team are committed to developing acuity and dependency data to identify the complexities of the patients they are caring for in the community.

The team are also planning to benchmark the district nursing service in order to be responsive to future changes and challenge and to be in a position to

make robust workforce plans. Initial benchmarking has suggested that CHFT has a flatter structure with less skill mix within the team in comparison to pyramid structures in place in other organsiations.

8.5 Health Informatics have been requested to work with the division to develop staffing level reporting for the community division within the next quarter to identify measureable pressures now workforce models have been defined. This will also include developing metrics to identify time from referral to 1st contact and urgent and average response times which will inform future workforce model reviews.

8.6 Initial recommendations reviewed by the panel required investment for an additional 3.0 wte band 3 to meet the requirement of Out of Hours service requirements.

Following budgetary alignment additional investment was no longer required at this point.

8.7 The community division continues to work within a changing landscape with the development of quest and vanguard work. Changing geographical boundaries and population focused work is anticipated to impact upon workforce model requirements going forward. As the changing landscape emerges the workforce plans for community will be reviewed – we anticipate this will be more regularly than 6 monthly at times due to the pace of change.

The division anticipate a requirement to increase the nursing workforce in the community setting and plan to review workforce models across services tosupport integration of teams and reducing duplication through right person right place right time approach. The introduction of new models will require further scoping of service needs and review of current capacity within specialist services to meet the Care Closer to Home agenda

8.8 Summary of Investment and Disinvestment recommended by panel

£0

Further work is to be done to align workforce with new models of care delivery.

9.0 Families and Specialist Services Division

9.1 Ward 18

No changes to current wfm recommended. This area has 2 RN / shift for 8 beds with occupancy of 0 – 70%, but any reduction in the workforce model could result in lone working.

The increase of band 7 leadership across paediatrics from 1.0 wte to 2.0wte from the November 2015 workforce model review has increased visible leadership on ward 18.

Whilst the workforce model has comparatively high level (80%) of long days with the relatively low occupancy levels at times this has resulted in high levels of compliance with training.

9.2 Ward 3

The panel considered a recommendation to make two changes to the workforce model for ward 3:

- Increased RN provision to meet RCN (2013) recommendation
- Seasonal workforce model built to accommodate attendances based on occupancy data. Occupancy levels currently drop to around 50% for a 8/52 period in high summer.

The panel noted the innovative nature of such a change to workforce model and expected benefits as staff would be encouraged to take higher levels of annual leave in the summer period.

Caution was noted that the RCN has identified that variations in occupancy have not been as great as previously expected in seasonal attendances.

The panel supported a trial of the seasonal workforce model which will be achieved by turnover; recruitment planning and allocation of annual leave, and is cost neutral. A recommendation that this would be for full evaluation of the trial at the next review panel before permanent change to workforce model recommended.

9.3 The panel considered a recommendation to fully meet the RCN guidance "Defining Safe Staffing Levels for Children and Young Peoples Services " 2013 to implement a 24/7 supernumerary shift supervisor.

This would require an investment of £160,930. Possible development of the current band 6 roles supported by a reduction in supervisory time for 2.0 wte band 7 roles was considered.

The panel recognised the expected benefits of a supernumerary shift co-ordinator to effectively manage, train and supervise qualified and unqualified staff, but did not support the recommendation at this time for further investment. Evaluation of the second 1.0 wte band 7 role in providing additional leadership; training and supervision was recommended, and an assessment of support which could be provided by Paediatric Nurse Practitioner roles to be completed.

2.0 wte development band 6 posts are to be trialled with specific focus on co-ordinating care, rostering effectively and managing staffing appropriately on a shift by shift basis.

9.4 Acuity studies have not been completed in paediatrics due to the delayed acuity tool from the Shelford Group. The tool is now expected to be available in May 2016. The CHFT team have maintained a dialogue with the Shelford Group regarding the acuity tool and alternative tools available. The recommendation from the Shelford Group has been that CHFT await the

Shelford acuity tool.

9.5 GAU

No recommended changes to workforce model. The full effect of investment from November 2015 is not fully realised yet as level of HCA vacancy remains.

9.6 Ward 4C

No recommended changes to workforce model recommended but acuity to be reviewed when completed and bed modelling plans reviewed due to a high level of medical outliers.

Further monitoring of theatre activity is being completed, and in future this may inform a move to a twilight for RN from late shift if activity continues to be at the latter end of day.

9.7 Maternity Services

Midwifery staffing levels have been reviewed utilising birth rate + tool and the midwife to birth ratio. Following the last review panel the LDRP workforce model was increased to 12 midwives and 2 HCA's per shift. As a result CHFT have seen an increase from 89.6% to 96.4% of women receiving 1:1 care in established labour.

2015 Births totalled 5622 which resulted in a birth to midwife ratio of 1:29.4

In 2016 CHFT have an increase of 70 predicted births which will result in a birth to midwife ratio of 1:29.8 in comparison to the 2015 ratio of 1:29.4

Benchmarking across the region has been completed:

Area	Crude Midwife to Birth Ratio
CHFT	1:29.8
Hull	1:32
Barnsley	1:28
York	1:32
Scarborough	1:26

9.8 To achieve a midwife to birth ratio of 1:28 (Royal College of Midwives recommended standard) at CHFT based on predicted births 2016-2017, an additional 12.75 wte band 6 midwives would be required with financial investment costs of £516,000.

The ratio of midwives to rooms on LDRP remains comparatively good. Community midwifery caseloads remain lower than professional guidance recommends at 1:98.

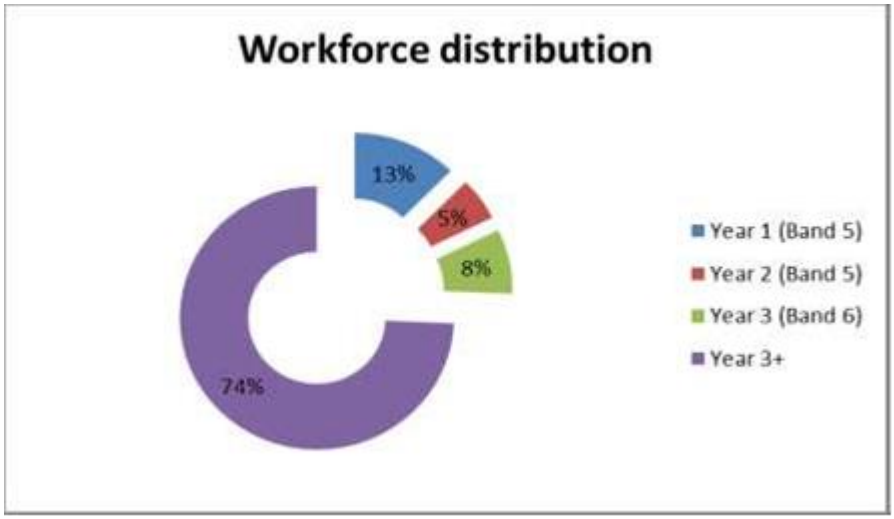
9.9 The panel supported the Head of Midwifery's recommendation to monitor the current establishment against the actual births monthly through the Nursing Workforce Strategy Group and the risk of increased birth to midwife ratio will

be registered on the risk register.

The current skill mix within midwifery has been reviewed. Currently skill mix is 88% Registered Midwife to 12% non registered.

A level of band 5 midwives within the workforce remains with the current level of band 5's being 18%. The level of band 5's is monitored within the division and an increase of 25% or above would result in further risk assessment.

Table 10: Percentage of Band 5 and Band 6 Midwives at CHFT April 2016



9.10 Through the review process the panel supported a recommendation to invest 2.0 wte midwives to maintain the birth to midwife ratio at 1:29.5, and support the level of band 5 midwives in post for a 12 month period. This will be provided within budget due to the number of band 5 midwives in post against the total number of midwives budgeted for as band 6.

The additional 2.0 wte midwives will work as educators to support the midwifery workforce to include:

- Working clinically to support staff
- To be a clinical expert to train staff
- Support the preceptorship programme
- Work with the Consultant midwife to develop training packages to improve outcomes

Key Areas of Impact anticipated through investment:

- 3rd / 4th degree tears / management of the 2nd stage of labour
- Episiotomy / Suturing
- Improving midwifery skills e.g FBS/ FSE/ quality of VE's
- Increasing normal birth rate
- Increasing waterbirths
- Increasing homebirths
- Supporting midwives with achieving core skills

Outcomes Measures to be measured following investment:

- Decrease in 3rd / 4th tears rate after normal birth
- Decrease PPH after normal birth
- Increase normal birth rate
- Increase home birth rate
- Increase waterbirths

- Improve quality of preceptorship support for midwives with 100% of midwives achieving band 6 in 18-24 months

9.11 To increase support for the midwifery workforce in community the division proposes formalising a buddy system to "an enhanced preceptorship model" for band 5 midwives new to community.

This will result in:

- Band 6 midwives will take a larger caseload and have a band 5 midwife working with them
- Band 5 midwives will be accountable for the actions she/he takes in a clinic/postnatal environment
- Band 6 midwife will be overall responsible and meet with the band 5 midwife on a regular basis (at least monthly) to provide formal documented clinical supervision
- Band 5 midwives will not be allocated on call until 2 months after commencement in community and after 1 month of shadowing midwives (3rd on call), 3 months in total.
- On call will consist of x1 band 6 midwife at all times. 2 band 5 midwives should not be allocated on call together.
- Clinical Managers will be responsible for arranging the formal allocation of band 5 midwives to work with band 6 midwife and caseload.
- The Clinical manager will also provide supernumerary support and observation on a weekly basis, ensuring that all band 5 midwives are observed monthly.
- The preceptorship document is to be reviewed to include community competencies.

9.12 The panel supported realignment of budget in antenatal clinic cross site with 0.24 wte Band 2 transferring to support at CRH antenatal clinic from HRI antenatal clinic.

9.13 NICU

A review of the NICU establishment identified a level of risk in that due to turnover and maternity leave the percentage of qualified in speciality within the workforce just reaches the 70% threshold until June 2016.

The panel noted the research post within NICU is currently developing creating an opportunity to provide clinical education within the unit. This will provide specialist education and training to band 5 nurses who are not qualified in speciality, band 3 nurses and student nurses. The post holder

would lead development and implementation of the preceptorship programme and , competency based assessments.

A current risk is that we are at the minimum of 70% qualified in speciality ratio due to mat leave until June 2016 when this figure is due to improve.

Risk reference number 6559: Risk of being unable to provide trained nurses with Specialist Neonatal skills (QIS) and knowledge to care for HDU and iCCU babies as specified in the current NHS England specification. This has been caused by retirement, maternity leave, sickness and regional training availability. This may result in the unit having an inability to care for Neonates and to transfer babies in the region.

The current workforce model, shift fill and acuity and dependency scoring against BAPPM guidelines highlights the workforce model is appropriate for current levels of activity.

9.14 OPD

The directorate management team have worked together to review safe staffing levels taking into account clinical demographics and complexity, resource, comparison with high performing Trusts OPD to develop a refined OPD workforce model.

The model will provide clinic specific workforce models with skill mix determined by the clinical interventions required. The workforce models will provide flexible working across sites and an extended working day.

We anticipate when the workforce models are fully developed that they will result in a reduction of band 5 nurses and the development of skilled band 3 clinical support workers who will provide care across all specialities.

In the November 2015 panel review a reduction 2.31 wte Band 5 nurses and an increase in band 2 practitioners was approved and this resulted in a £31,000 disinvestment.

Further work for 2016-2017 is being completed within the Outpatient Productivity PMO Scheme, but no further recommendations are supported by panel at present.

9.15 Summary of Recommended Investment and Disinvestment FSS Supported by Panel

No investment or disinvestment recommended.

10.0 CONCLUSION

The Board can be assured that the nursing workforce models have been reviewed, scrutinised and challenged.

A record of the rationale for all recommendations has been maintained.

Investment and disinvestment opportunities have been identified.

The Board isasked to note and support the recommendations.

10.1 Table 11: Summary of Investment Recommended

Division	Investment £	Disinvestment £
FSS	0	0
Medical	167,648*	-71,684
Surgical	0	0
Community	0	0
Total	167,648	-71,684

Medicine investment will be reduced to £101,912 if apprentices in the division can be increased to 28 from the existing 16 already in place and offsetting existing overspends on the wards due to agency premiums.

Appendix 1

Overall - Weekly Summary

Location	RN Early Shift Total	RN Late Shift Total	RN Night Shift Total	Bank-Agy RN Early	Bank-Agy RN Late	Bank-Agy RN Night	% RN Bank-Agency Early	% RN Bank-Agency Late	% RN Bank-Agency Night
CRH	422	405	371	26	27	89	6.2	6.7	24.0
HRI	528	486	411	49	33	75	9.3	6.8	18.2

Details - By Ward

CRH	Ward	Beds	RN Early Shift	RN Late Shift	RN Night Shift	Bank - Agency RN Early	Bank - Agency RN Late	Bank - Agency RN Night	% Bank-Agency Early	% Bank-Agency Late	% Bank-Agency Night
	2AB	31	32	30	26	4	3	6	12.5	10.0	23.1
	2CD MAU	24	35	34	26	4	3	13	11.4	8.8	50.0
	5AD	31	29	28	29	0	0	2	0.0	0.0	6.9
	5B	16	15	13	13	4	2	10	26.7	15.4	76.9
	5C	16	18	14	14	0	0	4	0.0	0.0	28.6
	6A	15	15	14	15	2	0	5	13.3	0.0	33.3
	6BC	32	28	28	27	2	4	8	7.1	14.3	29.6
	6D (Acute Stroke)	15	26	24	19	6	8	6	23.1	33.3	31.6
	7AD	26	28	27	25	0	0	5	0.0	0.0	20.0
	7BC	26	27	25	28	0	1	9	0.0	4.0	32.1
	8AB	26	22	19	16	1	1	3	4.5	5.3	18.8
	CRH A&E	0	46	55	46	2	4	3	4.3	7.3	6.5
	CRH CCU	13	24	23	20	0	0	4	0.0	0.0	20.0
	CRH ICU	5	28	27	27	0	0	0	0.0	0.0	0.0
	Ward 4C	16	17	17	14	0	0	0	0.0	0.0	0.0
	Ward 8C	16	17	13	14	1	1	8	5.9	7.7	57.1

	Ward 8D	14	15	14	12	0	0	3	0.0	0.0	25.0
	Totals					*26*	*27*	*89*			
HRI	Ward	Beds	RN Early Shift	RN Late Shift	RN Night Shift	Bank - Agency RN Early	Bank - Agency RN Late	Bank - Agency RN Night	% Bank-Agency Early	% Bank-Agency Late	% Bank-Agency Night
	1 MAU	24	35	35	34	2	1	8	5.7	2.9	23.5
	10 HRI	20	22	22	14	1	0	0	4.5	0.0	0.0
	11 HRI	24	32	31	28	1	4	5	3.1	12.9	17.9
	12 HRI	20	26	25	22	0	0	0	0.0	0.0	0.0
	14 HRI	12	14	14	14	2	3	6	14.3	21.4	42.9
	15 HRI	27	28	24	18	5	6	7	17.9	25.0	38.9
	17 HRI	24	28	26	16	1	0	0	3.6	0.0	0.0
	19 HRI	22	27	24	20	3	0	4	11.1	0.0	20.0
	20 HRI	30	31	30	18	1	1	5	3.2	3.3	27.8
	21 HRI	18	21	19	14	1	1	1	4.8	5.3	7.1
	22 HRI	23	22	22	14	1	0	1	4.5	0.0	7.1
	3 HRI	15	16	14	14	1	0	0	6.3	0.0	0.0
	4 HRI	15	7	5	6	2	3	3	28.6	60.0	50.0
	5 HRI	25	30	23	18	6	3	9	20.0	13.0	50.0
	6 HRI	23	31	26	20	9	3	7	29.0	11.5	35.0
	8 HRI	21	22	21	21	6	3	8	27.3	14.3	38.1
	HRI A&E	0	55	51	49	6	4	5	10.9	7.8	10.2
	HRI SAU	25	34	34	25	1	1	6	2.9	2.9	24.0
	ITU HRI	8	47	40	46	0	0	0	0.0	0.0	0.0
	Totals					*49*	*33*	*75*			

Appendix 2

Health Education England (HEE) recently reviewed best practice strategies for the retention of nurses within the current supply and demand challenges across England.

Table 1 Identifies key recommendations / Best Practice from HEE and current practice at CHFT. Proposed actions are also included.

Table 1: Gap Analysis: Best Practice / Current CHFT Practice

Best Practice	Current CHFT Practice	Proposed Action	Date to be Completed By
Development of clear career structure from Band 5 upwards, including advanced roles, with development opportunities to support.	Competency programme developed – not fully integrated Project group developing Band 6 and Band 7 programme Development Band 6 posts available – no formal programme	Embed programme Complete programme Develop structure for ongoing development posts;	June 16 September 16 October 16
Provision of robust preceptorship for new registrants to support their transition to practice.	Preceptorship programme (12 months commenced Sept 15) Preceptorship database commenced Dec 15 Web based preceptorship training available (minimal uptake) Preceptorship documentation under review Development support sister role (fixed term)	Evaluate and recommend format for 16/17 Develop reports from database to utilise data and present updates at Nursing and midwifery committee Promotion of role of preceptor and training Complete review and recommend format Formal evaluation of role and identify ongoing plan	June 16 July 16 Ongoing June 16 June 16

Opportunity for flexible working including retire and return, phased retirement options and part time working options	Flexible working available including part time hours and variety of shifts Phased retire and return options not currently in place	Promote and assist ward managers use flexible approach whilst maintaining safe base Develop with HR programme to introduce phased retirement and trajectory Develop retire and return option and promote	Ongoing August 16 August 16
Completion of in-depth exit interviews at an early stage following resignation to explore any potential solutions	Some evidence solution finding and interviews are not current place	Consider education for ward managers in completing interviews and identifying solutions	July 16
Availability of “fast-track” pre-registration programmes for healthcare workers who have experience and previous academic qualifications	Not currently in place – work commenced on identifying development roles leading to 2+2 nurse training placement with local providers has commenced	Review development role and monitor progression within nursing strategy group	Monthly review
Development of leadership at all levels	Current position not readily available	Develop analysis of leadership development / training and identify current position as baseline to inform future actions	August 16
Introduction of Mentor / clinical supervision to support RN	Clinical supervision available in some areas of workforce. Identified within strategy for retention 15 / 16 but not fully implemented	Update from Practice Group re implementation of clinical supervision required	June 16
Implementation of the Calderdale Framework to	Divisional review of areas where role development could be utilised	Develop workstream for role development (J Cosgrove leading) and	June 16

ensure skill mix appropriate to client group and RN not undertaking non-nursing tasks.	completed 15/16 and April 16. Consideration of implementing new role / skill mix changes completed January 2016 Task force developing this area of workstream currently Contact time review completed June 15 identifying at ward level tasks completed by RN and non registered workforce as baseline.	report monthly progress to nursing workforce group	
Promotion of work / life balance, including health promotion, employee counselling and stress management	OH team have programme of events and resources addressing promotion of work life balance and providing counselling and stress management	Promotion of availability to be considered Inclusion of benefits at recruitment events to be considered Listening events with workforce to be completed to inform reality position and monitored through divisional feedback to nursing workforce strategy group	July 16 July 16 June 16
Implementation of safe staffing levels in areas of high acuity to ensure RN do not have an unacceptable workload	Monitoring and review of safe staffing levels completed and reviewed by senior nurse x 3 per 24 hours as a minimum to ensure risks mitigated. Focused recruitment continues. Divisional review of areas of concern with divisional plan to mitigate risks completed. Acuity audits completed	Promotion of acuity results. Feedback to nurses on the process and outcome of “hard truths” reviews Training for site co to ensure use of daily site staffing tool and mitigating staffing risks Consider moving staff within defined areas to ensure expertise Consider incentives to achieve higher fill rates	June 16 June 16 June / July 16 July 16 May 16

Appendix 3

November 2015 Acuity and Dependency Audit Results

Ward	Beds	AUKUH Nov 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	Current N:B
3	15	1.10	1.20	1.65	1.61	1.14	1.37
10	20	1.10	1.50	-	1.41	1.39	1.25
15	27	1.20	1.50	1.32	1.22	1.47	1.02
19	22	1.30	1.60	1.42	1.62	1.53	1.75
20	30	1.30	1.50	1.15	1.26	1.28	1.37
22	23	1.10	1.20	-	1.17	1.19	1.23
SAU	25	1.00	0.92	1.05	1.15	1.22	1.31
SAU AMB			-	-	-	0.83	
ICU HRI	8	-	-	3.03	2.30	3.02	4.95
8AB	26	0.80	-	0.68	0.97	0.84	1.22
8D	14	-	-	-	0.91	0.89	1.29
ICU CRH	5	-	-	-	2.45	1.68	

Ward	Beds	AUKUH Nv 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	Current N:B
6D	15	1.38	1.13	1.33	-	1.18	2.10
7AD	26	1.59	-	1.54	1.55	1.60	1.50
7BC	26	1.54	1.22	1.48	1.55	7B – 1.62 7C – 1.62	1.50
21	18	1.43	1.29	1.25	1.44	1.06	1.34
HRI MAU	24	-	1.18	1.12	1.23	1.41	1.91
HRI MAU AMB		-	-	-	-	0.30	
CRH MAU	24	1.24	1.15	1.22	1.46	1.47	1.91
CRH MAU AMB		-	-	-	-	0.40	
6	23	-	1.35	1.26	0.98	1.37	1.46
2AB	31	1.28	1.24	1.24	1.14	1.26	1.31
8	21	-	1.43	1.66	1.75	1.65	1.31

Ward	Beds	AUKUH Nv 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	Current N:B
4	15	1.70	1.54	1.31	1.36	1.44	1.7
5AD	31	1.44	-	1.50	1.66	1.69	1.53
17	24	1.21	-	-	1.21	2.43	1.32
5C	16	1.42	1.42	1.59	1.59	1.57	1.42
6BC / CCU		1.13	1.32	1.48	1.80	6BC 1.29 CCU1.10	1.49
12	20	1.23	1.45	1.31	1.43	1.28	1.38
5	19	0.82	1.38	1.26	1.46	1.20	1.36
CRH CDU		-	-	-	-	1.13	
HRI CDU		-	-	-	-		

Ward	Beds	AUKUH Nov 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	Current N:B
3	25 + 10 assess beds						2.22
18	8						2.42
4C	16	-	-	-	1.02	0.97	1.50
HBC / CBC	14						2.28
NICU	24						2.35
1D	13						1.32

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Gorman, PA to Director of Planning, Performance, Estates & Facilities
Date: Thursday, 26th May 2016	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: CHFT Annual Health & Safety Report 01.04.15 - 31.03.16 - For approval	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Health & Safety Committee	
Governance Requirements: See attached	
Sustainability Implications: None	

Executive Summary

Summary:

Keeping the base safe

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

See attached

Next Steps:

See attached

Recommendations:

The Board is asked to approve this report.

Appendix

Attachment:

CHFT Annual Health and Safety Report May 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

CHFT Annual Health & Safety Report
1st April 2015 – 31st March 2016

1. INTRODUCTION

This report describes the health and safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2015/2016 (1st April 2015 to 31st March 2016) in order to meet the requirements of the Health and Safety at Work Act 1974 (HASAWA) and its supporting regulations.

2. BACKGROUND

H&SAWA provides the legal framework for health and safety and aims to protect employees, contractors and the public from the risks associated with work activities. The act, and its underpinning regulations, place responsibilities on the Trust and its employees to identify, manage and reduce health and safety related risks.

Health and safety support and advice is provided through the following departments:-

- **Estates and Facilities** – provision of health and safety advice
- **Risk Management** – management of moving and handling training, public and employees liability claims and DATIX incident reporting system. The Moving and Handling department transferred to the Medical Division on 1st April 2016.
- **Medical Engineering** – management of medical devices, including advice on safety, support and training. The Medical Engineering Department transferred to Estates and Facilities Division on 1st April 2016.

The Trust Health and Safety Committee meet monthly in order to consult with Divisions, specialist advisors and staff side representatives on incident performance, legislative changes, health and safety risks and to promote shared learning from incidents.

3. REPORT

3.1. Policies

The Trust's Health and Safety Policy was approved by the Trust Board in December 2014 and provides an overarching framework for the Trust. The policy is due to be reviewed in December 2016 which will done so in partnership with the Health and Safety Committee representatives and ultimately signed off by Trust Board.

3.2. Risk Assessments

The Management of Health and Safety at Work Regulations 1999 place a requirement on organisations to undertake suitable and sufficient risk assessments to identify significant risks to the health, safety and welfare of employees and anyone that may be affected by their activities. Specific risk assessments are completed for fire safety, moving and handling, estates engineering tasks and substances that may be hazardous to health. Risk assessment training is incorporated into the current health and safety teaching however, further work is required to embed this process into the organisation.

3.3 Incidents reported under the Reporting of Incidents Injuries and Dangerous Occurrence Regulations (RIDDOR) 2013

RIDDOR is the law that requires employers, and others in control of work premises, to report and maintain records of the types of incidents listed below to the Health and Safety Executive (HSE).

- Work-related accidents which cause death
- Work-related accidents which cause certain serious injuries ('specified injuries')
- Diagnosis of certain industrial diseases
- 'Dangerous occurrences' (incidents with the potential to cause harm)

During the reporting period a total of 19 RIDDOR injuries were reported to the HSE. However, it should be noted that two of the incidents did not meet the required criteria to be reportable to the HSE. All but one were staff related injuries and one involved a contractor working at Calderdale Royal Hospital who sadly died as a result of the injuries he sustained caused by a fall from significant height. This incident is currently under investigation with PFI providers and the HSE.

A breakdown of the causes of these incidents is illustrated in table 1 with 2014/15 comparator of the previous year.

Table 1 – RIDDOR INCIDENT CAUSES

	2014/15	2015/16
Slips, trips, falls and collisions	10	6
Infection control	1	0
Lifting accidents	3	5
Abuse etc of Staff by patients	1	2
Accident caused by some other means	4	5
Injury caused by physical or mental strain	2	0
	21	19

The above figures show a 14.3% reduction in the number of reported RIDDOR injuries since the same period last year. This is encouraging, given the previous increase in numbers from 2013/14 to 2014/15. However, the impact of the 435 lost working days as a result of these injuries should not be ignored. Slips, trips and fall incidents remain the main cause of the majority of RIDDOR incidents despite there being a 40% reduction since last year.

Table 2 illustrates the consequences of these incidents in terms of the injuries suffered using the reporting categories detailed under RIDDOR. Two incidents included in the "over 7 day's absence category" total were reported to HSE but do not meet the criteria for being reportable incidents. Both involved members of staff reporting swelling of the elbow following contact with an object. Neither of these incidents resulted in fractures nor were they reported as causing over 7 days absence from work therefore, they had been coded inaccurately.

Table 2 – RIDDOR INCIDENT INJURIES	2015/16	Injury cause
Fatality	1	Fall from height
Specified injuries	4*	Slips, trips or falls (2) Assault by patient (2)
Injuries causing over 7 days absence	14	Lifting or handling (5) Slips, trips or falls (4) Other (5)

*All of these were fractures.

Further work is required to ensure RIDDOR incidents are reported accurately and result in the appropriate level of investigation. Additional checks are recommended to ensure the accurate reporting of RIDDOR related "industrial diseases" and "dangerous occurrences" to the HSE.

3.4 Staff Related Incidents

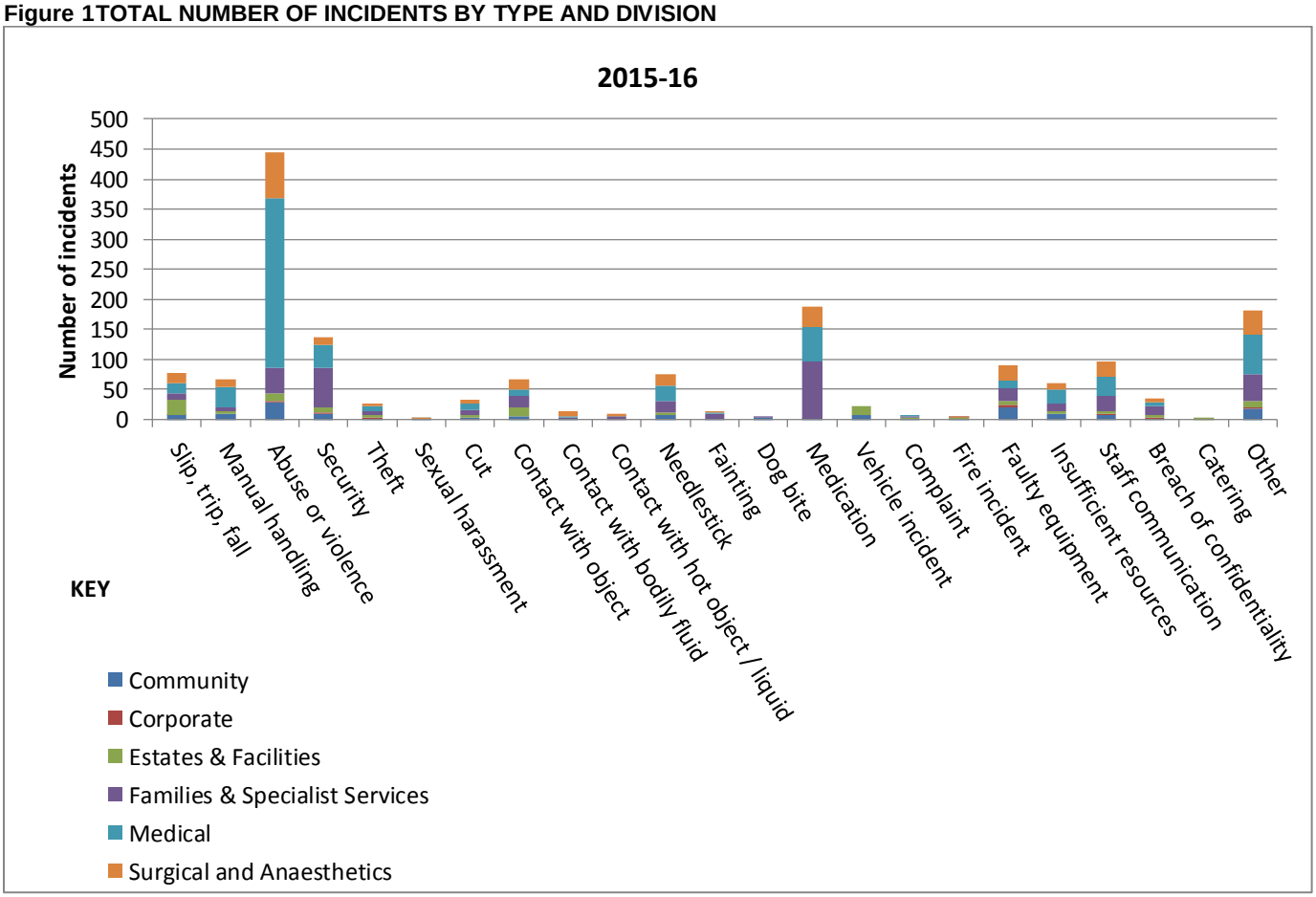
A total of 983 staff incidents occurred in 2015/16 which is a slight increase (2.1%) on last year's total. The main incidents relate to (See Figure 1):-

- Abuse of staff by patients
- Medication issues, such as discrepancies in controlled drug counts
- Security-related incidents, such as missing keys or loss of staff ID badges

There were also a number of incidents relating to the wastage of blood, plasma or platelets. These had been ordered by staff on hospital premises and were not then used. Unfortunately, as these had been at room temperature for too long they were no longer considered to be viable so they were disposed of rather than being returned for re-issue.

Incidents relating to patient abuse of staff are monitored by the Trust's Health and Safety Committee but are reported separately to the Trust Board on an annual basis.

Figure 1TOTAL NUMBER OF INCIDENTS BY TYPE AND DIVISION



3.5 Needle-stick / Splash Injuries

A sub-group of the Health and Safety Committee has been initiated to review the numbers and causes of needle-stick and splash related injuries with a view to ensuring accurate and consistent reporting and encourage learning from incidents. Further work is required from the sub-group to ensure the aims and objectives are achieved and features on the 2016/17 work plan.

3.6 Employee Injury Claims

Risk Management provide quarterly updates of Employers and Public Liability claims against the Trust to the Health and Safety Committee. During the reporting period a total of 21 employee and public liability claims were lodged against the Trust. This is a small decrease in comparison to the previous year (24 claims). During the reporting period 23 claims were settled and 13 claims were successfully repudiated.

3.7 Training

The Trust commenced a program of health and safety training in 2013 covering 4 tiers of management within the Trust as follows:-

Tier 1 - IOSH for Senior Executives
Tier 2 - Bespoke Health and Safety; Senior Managers
Tier 3 - IOSH Managing Safely; Departmental & Supervisory Staff
Tier 4 – Health and Safety Awareness; Remaining Trust Staff

Following delegate feedback a corporate decision was made to combine tier 2 and 3 into a healthcare specific training programme which commenced in 2015. Divisional attendance is illustrated in Table 3.

Table 3 – Trust Tier 2 Health and Safety Training by Division

Division	Staff Requiring Training	Staff Trained	Percentage Complete
Families & Specialist Services	63	19	30.2%
Corporate Division	35	19	54.3%
Community Division	31	24	77.4%
Medical Division	113	36	31.9%
Surgery & Anaesthetics Division	58	22	37.9%
Estates & Facilities Division	24	18	75.0%
Health Informatics Division	42	10	23.8%

Further training will be planned in the coming year to ensure all Divisions have a competent health and safety knowledge.

General health and safety awareness training now features as one of CHFT's annual mandatory training modules and is accessible for all staff.

4. GOVERNANCE ARRANGEMENTS

4.1 Reporting Arrangements

The Health and Safety Committee is chaired by an Executive Director with frequent attendance from a Non-Executive Director. The Committee meet on a monthly basis and report into the Quality Committee (a sub-committee of Trust Board) escalating any areas of concern or significant risk.

4.2 Health and Safety Committee Attendance

Divisional staff attendance has improved significantly over the last 12 months however, further work is taking place with Staff Side to ensure they are well represented.

4.3 Audits / Inspections

a) Front line ownership (FLO) audits are carried out by Ward Managers covering various ward related risks. Weekly tours take place with the involvement of the senior nursing team where health and safety / estates risks are managed appropriately. However, non-clinical areas are not given the same level of inspection. Therefore, it is recommended an inspection routine is considered for such areas to ensure health and safety risks are managed appropriately.

b) Leadership walk rounds are carried out by the Senior Executive team which are patient and staff focussed. They aim to improve patient experience, safety and promote staff engagement. Action plans are generated following each tour and progressed via the relevant division.

5. SPECIFIC RISKS

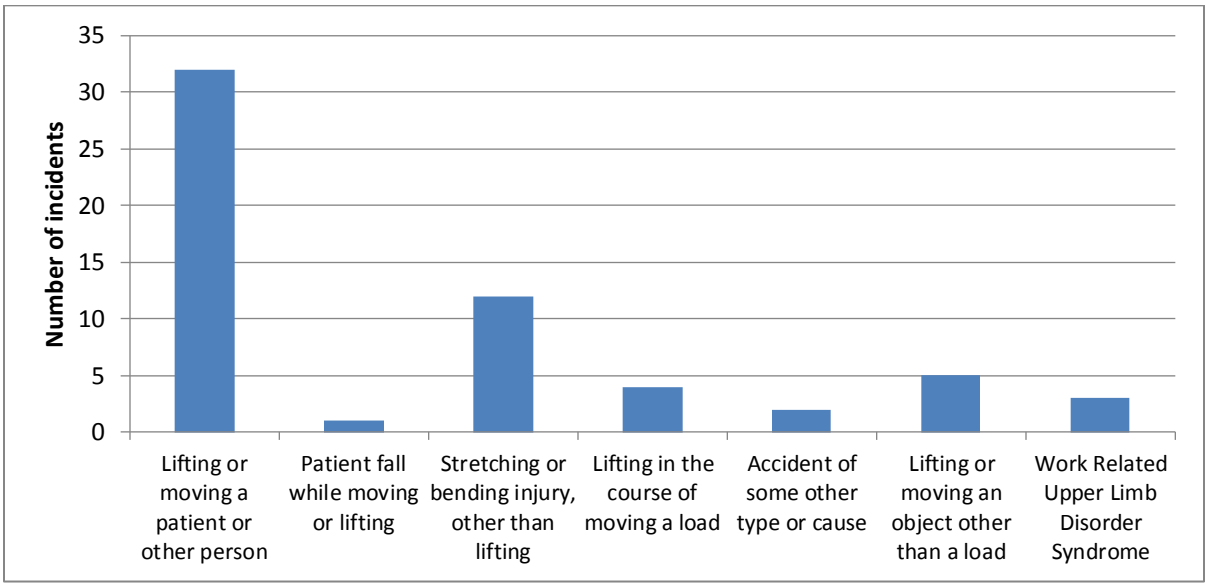
5.1 Control of Substances Hazardous to Health (COSHH)

The Trust introduced a COSHH management system in 2015 which provides an on-line library of safety data sheets and COSHH risk assessments. Whilst COSHH expertise resides in both Pharmacy and Estates and Facilities key divisional representatives will complete a one off COSHH training exercise in Quarter 1 to ensure a good understanding of the legal requirements. General COSSH awareness training will be incorporated into the annual mandatory health and safety training package.

5.2 Manual Handling

There were a total of 59 manual handling incidents reported during the 12 month reporting period. An overview of the incidents is detailed in figure 2:-

Figure 2 – Moving & Handling Incidents



The main cause of incident relates to the lifting of a patient or other persons with the main areas of occurrence being in Acute Medicine (53%).

The Manual Handling Department was based within Risk Management however, this transferred to the Medical Division on 1st April 2016. The following manual handling training is provided to CHFT staff using a cascade method of training from departmental facilitators. The following training is available from Moving and Handling:-

- 4 Day Facilitator Training
- 1 Day practical patient handling training for new starters
- ½ day refresher training for facilitators

However, the update training is inconsistent due to work pressures and the incapacity to release staff for training. Recording of training is also a concern proving it problematic to have clarity on the numbers of staff trained within their Divisions. Further work is recommended in this area to review and improve how moving and handling training is provided and recorded.

5.3 Medical Engineering

The Medical Devices Regulations 2002(11) require all medical devices to carry the CE marking which is captured within the Medical Devices Management Policy. The Medical Engineering department provide an important service to the Trust and follow the MHRA document "Managing Medical Devices Guidance for healthcare & social services organisations – April 2015" which includes:

- Checking equipment for compliance with appropriate regulations
- managing the provision of appropriate maintenance and repair for medical devices
- providing proactive advice on the procurement of suitable medical devices ensuring that devices are of good quality, comply with appropriate standards and are cost efficient, resulting in safe and appropriate equipment for healthcare use
- coordination & provision of medical devices training
- monitoring and recording of training on the 'Medical Devices Training Database'

The efficient management of medical devices is a vital factor in keeping CHFTs base safe and it is important to have accurate, safe working equipment and the staff who are trained to use it. Medical devices play an increasingly important role in the diagnosis and treatment of our patient's health and from a patient's point of view the availability of functioning equipment and authorised competent staff must be re-assuring.

The Medicines and Healthcare Regulatory Agency (MHRA) have recommended changes to the management of medical devices principally to the roles and responsibilities of the Trust board and the introduction of the Medical Devices Safety Officer MDSO. The Chief Engineer/Head of Medical Engineering now undertakes this responsibility.

During 2014/2015 there were 202 incidents involving medical equipment reported via Datix; a breakdown is provided in table 4.

Table 4 – Breakdown of Medical Device Incidents Reported on Datix

Classification	Organisational	Patient	Staff	Total
GREEN	32	160	1	193
YELLOW	0	8	1	9
ORANGE	0	0	0	0
RED	0	0	0	0
Total	**32**	**168**	**2**	**202**

Of these 4 were reported to the MHRA a summary of these are provided in Table 5.

Table 5 – Summary of Incidents Reported to the MHRA

Speciality	Number of reports	Investigations completed
General Ward based equipment	0	0
Theatre Instrumentation	2	2
X-ray Ancillary	0	0
Life support	2	2
Total	**4**	**4**

The 2 incomplete investigations have been investigated by Medical Engineering who are awaiting a response from MHRA to enable the investigations to be closed / completed.

The MHRA issued 29 Medical Device Alerts (MDAs) in the 2015/16 financial year relating to medical devices, all of which were actioned appropriately in accordance with Trust policy. In addition to MDAs the Trust also dealt with a number of manufacturers Field Safety Notices, which were applicable to the Trust, in the same manner .

Availability of equipment has improved since the introduction of the Medical Equipment library at both sites. This method of asset control means that the equipment can be checked and made ready for the next use with greater assurance and maximises the use of a limited resource. The introduction of wireless technology at each site may lead to a further step change in asset management enabling widely used but scarce equipment to be located quickly.

Since 2010, Medical Device training has been standardised and promoted across the Trust. This methodology has now been extended to Community Services. A review of training has resulted in reporting streams to Divisional Quality and Safety Boards, Operational Health & Safety Committee, The Audit Committee and Trust Board, a new training database, training strategy (including delivery methods and materials) being developed as well as a link community training.

The Trust has set targets of 70% of staff being trained prior to clinical use of a new device and a 95% target of permanent authorised staff sufficiently trained on current devices. Although the Trust has moved towards its 95% target, it currently achieves an average of 82% (A breakdown of training by Division is provided in Table 6); however, it should be noted the enormity of this task, given that in 12 months ending March 2016 there were over 24128 (a 46% increase) separate recorded training instances. Work is underway to increase the number of training instances with more Medical device training events being organised for 2016. Nonetheless, continuing progress is being maintained towards achieving the Trust's targets.

Table 6 - Medical Device Training by Divisions

Division	Percentage of staff trained in March 2015	Percentage of staff trained in March 2016
FSS	83%	86%
DATS	N/A	84%
Surgery	75%	75%
Medical	75%	68%
Corporate	91%	67%
Community	N/A	86%

6. WORKPLAN (2015/2016) PROGRESS

The following work-plan takes into account the progress made during the last 12 months and illustrates an number of actions to be further developed in the 2016/17.

	WHAT	Progress
1	Incorporate Risk Assessment methodology into the two day health and safety training.	Risk assessment training is included into the Managers / Supervisors health and safety training. Further work is recommended to incorporate risk assessment understanding into the awareness training. **Action:- To continue in 2016/17**
2	Carry out analysis of RIDDOR incidents.	RIDDOR analysis is complete however, further engagement work is necessary to ensure an improved understanding of RIDDOR reporting and to ensure all RIDDORS (industrial disease & dangerous occurrences) are recorded and reported. . **Action: To continue in 2016/17**
3.	Provide healthcare specific health and safety training for Managers / Supervisors.	Regular health and safety training sessions were provided in the year; **Action:- To continue in 2016/17.**
4	Provide generic health and safety awareness training via Workforce Organisation and Development.	Health and safety training is part of the annual mandatory training suite and available to all staff. **Action:- Complete**
5	Include health and safety monitoring within FLO Audit.	Health and safety monitoring is included in the clinical area walkabouts (by Senior Nursing Staff and Executive walkabouts). However, non-clinical areas must be checked at regular interviews. It is recommended a programme of checks is incorporated into the annual health and safety plan. **Action: To continue in 2016/17.**
6	Support Risk Management to promote the use of DATIX Incident Reporting System.	 **Action:- Complete**
7	Improve attendance at Manual Handling Training	This action is outstanding with sporadic attendance at moving and handing training **Action: To continue in 2016/17**
8	Implement COSHH framework	COSHH framework is partly implemented with Divisional & mandatory training planned in Q1 2016/17. **Action:- To continue in 2016/17.**
9	Improve divisional representation at Health & Safety Committee	Divisional representation has improved. **Action:- Complete**
10	Improve staff side representation at Health & Safety Committee	Further efforts are required to improved staff side attendance; **Action:- To continue in 2016/17**.

7. RECOMMENDATIONS

Based on the information provided and the actions carried forward the Trust Board are requested to accept the following health and safety work plan for 2016 / 17.

	WHAT	WHO	WHEN
1.	Review and update CHFT's Health and Safety Policy	Exec Director / H&S Committee	31.12.16
2.	Fully implement COSHH management and awareness training for Divisions and all staff	Health & Safety Advisor	31.3.17
3.	Embed risk assessment knowledge and understanding into the organisation.	Health & Safety Advisor / Risk Management	31.3.17
6	Improve understanding of RIDDOR Injuries, illnesses and dangerous occurrences to ensure accurate reporting and learning.	Health & Safety Advisor / Risk Management	31.12.16
7	Review moving and handling arrangements within the Trust to ensure a robust training and recording.	Medical Division / Health & Safety Advisor	31.12.16
8.	Introduce inspection programme for non-clinical areas.	Health & Safety Advisor / H&S Committee	30.6.16
9.	Introduce a Needle-stick Injury working group to investigate needle-stick & splash related incidents to embed learning within the Trust.	H&S Committee / Occupational Health / Infection Control	30.6.16
10.	Ensure robust arrangements are in place for the safe management of medical devices and provide monthly updates to the Health & Safety Committee.	Head of Medical Engineering / H&S Committee	30.6.16
11.	Provide a two day health and safety training programme for Managers / Supervisors.	Health & Safety Advisor.	30.6.16
12.	Ensure appropriate staff side representation at Health & Safety Committee	Exec Director / Ass. Director of Workforce Organisational Development	30.6.16

18th May 2016

Estates & Facilities Division
Health & Safety Department

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Gorman, PA to Director of Planning, Performance, Estates & Facilities
Date: Thursday, 26th May 2016	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: CHFT Annual Fire Safety Report 01.04.15 - 31.03.16 - For approval	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Health & Safety Committee	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

Keeping the base safe

Main Body

Purpose:

For approval

Background/Overview:

See attached.

The Issue:

See attached

Next Steps:

See attached

Recommendations:

The Board is asked to approve this report.

Appendix

Attachment:

CHFT Annual Fire Report May 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

CHFT Annual Fire Safety Report
1st April 2015 – 31st March 2016

1. INTRODUCTION

This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2015/2016 (1st April 2015 to 31st March 2016) in order to meet the requirements of the Fire Safety (Regulatory Reform) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

The Trust has made significant improvements over the last 12 months in terms of fire safety but there is further progress to be made. Improvements include an overall increase in training figures, upgrading of fire detection at both CRH and HRI and progress on HRI fire compartmentation scheme ensures the Trust is in a safer position.

Well managed space utilisation remains a priority for the Trust and all departmental moves must be carefully considered and risk assessed from a fire safety perspective. This approach ensures the changes (eg: increased fire loading / change of service) are assessed and do not impact on the fire risk of the surrounding clinical areas providing vital healthcare services. Support from the Fire Officer is available to ensure fire risk assessments are carried out to ensure all moves are completed safely.

Ongoing efforts are being made to ensure temporary storage arrangements are well managed and do not become permanent solutions over a period of time. Whilst space is at a premium all efforts must be made to reduce the storage of equipment (eg: beds / chairs etc) on corridors which are designated means of escape. Whilst patient flow is a priority all efforts must be made to ensure the Trust do not contravene our legal requirements.

2. BACKGROUND

The RRO provides the legal framework for the implementation of fire safety in organisations and the HTM provides guidance on how to manage fire safety in healthcare premises detailing the responsibilities placed on the Trust and its employees.

Fire safety advice, support and training is provided by the Fire Officer who resides in the Estates and Facilities Division. The Trust also has fire advice from an independent authorising engineer as required by HTM 05.

3. REPORT

3.1 Fire Risk Assessments

The RRO places a legal requirement on organisations to undertake suitable and sufficient fire risk assessments; all of which have been completed for CHFT. The responsibility for implementing action plans resides with local areas but it is difficult to provide assurance that all actions have been implemented and completed. An audit of CHFT's Fire Risk Assessments is being carried out in 2016/17 to measure compliance with this requirement.

A number of estates related fire risks are making good progress including the introduction of a robust fire door maintenance programme and improved fire compartmentation. However, it is important that all staff ensure good housekeeping standards are introduced locally.

3.2 Fire Alarms

There have been four fires at HRI and CRH:

- Over-heated light fitting lower ground floor Physio reception at HRI
- Over-heated air handling unit motor in the Chapel at HRI
- Kettle fire at the eye department at CRH
- Mattress fire caused by a patient smoking in bed at CRH

All incidents were investigated and any learning disseminated via the health and safety committee.

3.3 False Fire Alarms

The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and ensure actions are implemented to prevent a reoccurrence. West Yorkshire Fire and Rescue Authority began a pilot scheme on 1st April 2014 for charging organisations £350 + VAT for each unwanted fire signal (UFS). Their objective is to reduce the number of UFS thus ensuring fire tenders are available for actual fire calls. The number of fire engines available in West Yorkshire has dropped dramatically resulting in Huddersfield Fire Station with two appliances and Halifax has one appliance.

The Fire Officer and Authorising Engineer are working closely with the Fire Authority, Estates, Engie and ISS to ensure where possible the Trust are not charged. During 2015/16 CHFT did not receive any charges for unwanted fire alarms.

The number of false alarms has reduced significantly and continued efforts are being made to reduce these even further. Whilst the number of calls at CRH is higher than HRI the life cycle fire alarm upgrade programme is helping to reduce these activations.

2015/16	**Actuations**	**Fires**	**False Alarms**	**Unwanted Fire Signals**
Huddersfield	36	2	34	0
Calderdale	62	2	60	3

2014/15	**Actuations**	**Fires**	**False Alarms**	**Unwanted Fire Signals**
Huddersfield	53	4	51	4
Calderdale	100	0	100	5

2013/14	**Actuations**	**Fires**	**False Alarms**	**Unwanted Fire Signals**
Huddersfield	67	5	40	5
Calderdale	95	2	93	6

3.4 Fire Safety Training

During 2015/16 fire training was carried out via a fire safety booklet. This approach reinforced fire safety learning from the previous year and allowed valuable time for the Fire Officer to provide concentrated training for the Trust's fire response teams (Site Commanders, Estates, Engie, Portering Services, Fire Wardens, ISS) who are now fully trained to assist in the event of a fire / evacuation. The training also included hands-on fire extinguisher training.

HTM 05-01 states the use of e-learning may offer a number of benefits to an organisation. However, in all but the smallest healthcare organisations such as a small GP's practice with a single-stage evacuation plan, e-learning is not acceptable as the sole means of training staff as it fails to:-

- take account of significant findings from fire risk assessments;
- take account of changes in working practice;
- train staff in evacuation techniques, particularly those involving patient evacuation;

- provide for job-specific training;
- promote colleague engagement
- allow for questions to be raised by trainees

Therefore, this method of fire training can only be used to support training delivered by a person competent in fire safety in the healthcare environment.

The loss of face to face training at Trust induction has left a gap which enabled the Fire Officer to introduce himself to new colleagues and was important in terms of the staff engagement process whereby they could relate to an individual.

The fire training figures for 2015/16 are illustrated below in comparison with previous years:-

		2013/14	**2014/15**	**2015/2016**
Fire Safety Training	-	2460	4976	4171
Fire Warden Training	-	826	1042	1089

Fire training for 2016/17 is tailored to the needs of the staff and will be in the form of practical sessions enabling staff to practise what they know in terms of fire safety awareness and practice evacuation. This will be carried out in simulated areas for ward based staff. Training for other Departments / Community will be available in group sessions in the local working environment.

3.4.1 Fire Extinguisher Training

A total of 187 staff received training in handling fire extinguishers in 2015/16 at HRI, CRH, PRCH & PMU. This training was well received and a positive way of engaging with staff and promoting the fire safety message 24/7.

3.4.2 Fire Evacuation Drills

Due to the risk to patients there are limited options to undertake live fire evacuation training on wards. However, in 2015 a number of staff evacuations were practiced as a live hands-on event. The use of a smoke machine is used to simulate a more practical fire safety training when carrying out such evacuations drills. Further evacuation exercises are planned for the coming year.

4 GOVERNANCE

4.1 Audits

CHFT's independent fire engineer completed an audit of CHFT's premises against the RRO and HTM 05. A compliance report has been provided detailing both challenges and strengths which are captured within this report.

4.2 Health & Safety Committee

Monthly performance reports are provided to the Health and Safety Committee with quarterly updates detailing progress against the annual action plan. Monthly meetings take place which involve the Fire Safety Manager, Fire Engineer and other key stakeholders ensuring any new and emerging risks are captured and managed accordingly.

4.3 West Yorkshire Fire Authority

A regular dialogue is held between West Yorkshire Fire & Rescue Service, the Trust Fire Officer and Independent Authorised Engineer following any fire related incident or when up-grade work is planned through building control. Such contact provides the Fire Authority with assurance the Trust is making progress with fire compliance and, as such, no formal visits have been made during the last 12 months.

However, it is important the Trust does not become complacent and continues to make good progress to ensure this positive dialogue continues.

There have been a steady number of both operational and familiarisation visits to Trust premises by local Fire Crews which ensures they have a better understanding of the problems they will face in the event of a fire or evacuation on our premises. Such visits are encouraged and facilitated by the Fire Officer.

5 CAPITAL WORKS

5.1 HRI - Fire Compartmentation

The Trusts buildings are made up of a number of fire resisting compartments to reduce the spread of fire from one location to another. This fire compartmentation allows the Trust to use progressive horizontal evacuation as its primary evacuation method.

The fire compartmentation at HRI has deteriorated over many years due to works carried out by Contractors and the fire compartmentation not being reinstated following the completion of the work. A fire survey has identified the works necessary to reinstate the compartmentation back to its original design and a plan is in place to ensure all areas are reinstated. This is a significant and costly task but one which is continuing.

5.2 HRI Fire Precautions Work

Over the last 12 months there have been a number of capital schemes that have improved the fire precautions within the Trust these are:

- HRI Ward 7
- HRI Penthouse Plant rooms (on going)
- HRI Theatres and plant room (on going)

CRH does not have major capital works due to an annual life cycle programme which keeps the areas to a good standard.

5.3 Fire Detection

Improved fire detection has been installed in the majority of areas at HRI but a number of areas require better detection coverage to ensure the system is up to the required standards. The new type of smoke detector (Squad) being installed can distinguish better between smoke and other products (eg: air freshener / steam etc) so a further reduction of calls is anticipated.

CRH fire detection is being upgrade with the lifecycle programme in place and so a further reduction of calls is anticipated.

6 FIRE SAFETY WORKPLAN FOR 2016/2017

	WHAT	Who	When
1	**Fire Risk Assessments**		
1.1	Complete audit review of CHFT fire risk assessments for HRI and CRH	Independent Fire Engineer	30.9.16
1.2	Carry out an audit of fire risk assessment for Community Premises	Independent Fire Engineer	31.12.16
1.3	Annual review of fire risk assessments	Fire Officer / Independent	31.3.17

		Fire Engineer	
1.4	Ensure fire risk assessments feature on divisional PSQB dashboards.	Fire Officer / ADD	30.9.16
2	**TRAINING**		
2.1	Gain approval from WEB for 2016/17 fire training programme.	Exec Director / WEB	19.5.16
2.2	Commence roll out of fire safety training (practical sessions).	Fire Officer	23.5.16
2.3	Continue providing fire extinguishers training for key fire response staff (practical)	Fire Officer	1.6.16
2.4	Plan in evacuation training at regular intervals.	Fire Officer	1.6.16
3	**CAPITAL WORKS**		
3.1	Ensure Fire Compartmentation works runs to plan at HRI.	Fire Officer / Capital Manager	31.3.16
3.2	Ensure fire detection installation programme runs to plan at HRI	Fire Officer / Capital Manager	23.5.16
3.3	Monitor installation of CRH Fire detection system	Fire Officer / PFI Providers	1.6.16
4	**FIRE ALARM ACTIVATIONS**		
4.1	Reduce further the number of fire alarm activations across CHFT	Fire Officer & staff	31.3.17

7. RECOMMENDATIONS

The Board of Directors are requested to receive and note the contents of the annual report and agree the draft work plan for 2016 / 2017.

18th May 2016
Estates & Facilities

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Gorman, PA to Director of Planning, Performance, Estates & Facilities
Date: Thursday, 26th May 2016	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Car Park Strategy Proposal - To engage with car park users on car park strategy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Staff Management Partnership Forum	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

Car Park Strategy Proposal 19.04.16 Version 5.

Main Body

Purpose:

Car park user engagement strategy for approval

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the Car Park Strategy Version 5.

Appendix

Attachment:

Staff Car Parking Drop in Sessions.pdf

Car Park Strategy Proposal

19/04/2016

Version 5

Introduction

It is important to get car parking and travel strategy, and its communication, right to ensure fair access, good patient and staff experience and to protect organisational reputation. As such the Trust has developed its car parking policy in line with the clinical and social changes that have accentuated access issues as car ownership has broadened, thus causing the throughput of patients, staff and visitors to hospital sites to increase.

It light of the above the Trust has reviewed its car parking strategy, taking into consideration the Health Technical Memoranda HTM 07-03, transport management and car parking;2006: Income Generation: car parking charges- best practice for implementation, published by the Department for Health (Finance and Investment) and the NHS confederation report, Fair for all, not free-for-all- Principles for sustainable hospital car parking. Contained in the following report are the reccomendations for the 2016/17 car parking strategy.

Colleague and Public Engagement

We have continued to engage with all service users following the changes made in 2015/16, we have met local groups including the Calderdale Disability User Group and worked with colleagues in the Patient Advice and Complaints department to resolve car parking concerns and complaints we have used this essential feedback (key points shown below) to develop the strategy for 2016/17.

Car Parking Permit Allocation
(criteria for permit allocation, cost and green transport issues)

- Do you need your car to do your job? High priority
- If a role is difficult to recruit to, a car parking permit may help retain/maintain the role and maintain excellent services
- Is the work journey difficult (more than 2 buses/longer than 1 hour, etc.)
- Is the journey unsafe without a car- work life balance has to be considered during application
- Life outside work and tasks required to and from work require thought (child drop off/pick up/care of relatives)
- Cross site workforce have priority
- Most feel the cost of a permit is acceptable, however staff feel cheated if there are no spaces available.
- Consideration for community staff, on/off site for equipment drop off/pick up

Park and Ride/Shuttle Bus Service (staff allocation, cost and frequency) • Is more communication required as some forms replied it would be a good idea (park & ride)! • Shuttle service credit to the trust few questions regarding availability and more buses at peak times (regular activity reports undertaken by transport) • Shuttle for staff use only?
Priority Parking Areas • Positive feedback following the reallocation of permits and the introduction of the red permits, however more engagement required as some clinical colleagues unsure if they are eligible to apply
Car Parking Enforcement and Penalty Notices • All positive relating to access and space availability, unless staff had received a PCN then obviously view changed.
Patient and Visitor Car Parking • Important to maintain and segregate patient car parks, if spaces were not available and visitors could not park adverse effect on other services YAS/DNA for clinics etc. • Visitor car parks to be used in emergency and staff claim their fees back • Designated areas for short clinic appointments (blood tests/x ray) • Can show the trust and its facilities in a negative context which may have future implications on patients choosing the trust for services
Car Park Layout • Much improved at HRI • Acre Mill (unsurfaced) car park creating frustration with staff due to surface conditions (trend? plans to surface) inadequate lighting. Proper layout would maximise potential use of this area • Areas require more clear lining (hatched/double yellows) • CRH layout offers poor traffic flow • Undergrounds/Multi storey? • Designated areas for motorcycles

Colleague Engagement

It is felt that introducing a banding system linked to pay will be a fair approach and welcomed by the majority of colleagues. Colleagues with earnings up to £17,978 (Band 1 &

2) will see a reduction in their monthly charge. Colleagues with earnings from £17,979 - £19,655 (Band 3) will see no change, other bands will see a small to moderate increase and priority parking charges will also be increased.

We can also cite neighbouring Trusts who adopt a banding approach and have charges which compare to our proposed rates.

Communications and engagement should include:

- Share final agreed proposals with Staff Side
- Meet key colleagues across both sites to ensure alignment and activity arranged in line with WTGR (including payroll, estates, security etc.)
- A letter to current permit holders explaining the changes, what will happen when, and what it means for them.
- We'll use our normal communication channels to share the messages: CHFT Weekly, Trust News, Big Brief, Line Manager Bulletin, intranet banner (signposting to relevant content and FAQs etc.), poster for colleague notice boards.
- The Wednesday regular Estates drop-ins or questions by email will be promoted as other ways to engage with colleagues from Estates.
- Month long estates wide email sign-off signposting to intranet

Public Engagement

Communications and engagement will include:

- Share final proposals with key Non-Exec Directors/Membership Councillors
- Write to representatives of appropriate local groups
- Include in next Foundation News
- Announce as latest news on external website
- Tweet introduction of new hourly slot, and static rates

Qualitative information will be gathered by the F.M service team on both sites and an appropriate survey is now being constructed.

General Permit Issue

A review of permit costs has been undertaken and compared to other local Trusts (see below), and it is proposed that on site permits will be allocated by salary scales, colleagues will receive salary sacrifice if included in the scheme, the proposed increases are shown below;

- £15,251>£17,978 £20.00
- £17,979>£19,655 £22.00
- £19,656>£28,462 £24.00
- £28,463>£41,373 £26.00
- £41,374 AND ABOVE £28.00
- Priority Parking £32.00

The generated revenue from the increase will be £88,000.

Local Trust Comparators (15/16 Fees);

- Airedale various schemes starting at £4.70 per week
- Barnsley Grade dependent £14 > £33
- Bradford Royal Zone dependent due to limited space (2 year waiting list for permits) £14 > £30 > £33
- Leeds Teaching £30 > £62 (Priority Parking) Grade dependent
- Mid York's Grade Dependent
  - Afc 1 & 2 £17.80
  - Afc 3 £19.81
  - Afc 4&5 £21.41
  - Afc 6&7 £22.50
  - Afc 8&9 £28.00
- Sheffield Teaching Grade Dependent £18.01 > £21.19 > £27.54

Patient & Visitor Car Parks

The current costs for patient & visitor car parking will be increased to the following;

- Up to 2 hours £2.50 increased £2.80
- Up to 4 hours No Change
- Up to 6 hours No Change
- 6 hours and above No Change

A comparison is shown below to local trusts, tariffs shown are for 15/16 fees.

Hospital	Up to 1hr	Up to 2hrs	Up to 3hrs	Up to 4hrs	Up to 5hrs	Up to 6hrs	Up to 7hrs	Up to 24hrs
CHFT		£2.80	-	£5.00	-	£6.00	-	£7.00
St James's	£1.40	£2.80	£4.20	£5.60	£8.30	£11.00	£13.70	£16.40
Leeds General Infirmary	-	£2.80	-	£5.60	-	£11.00	-	£16.40
Chapel Allerton	-	£2.70	-	£5.40	-	£8.50	-	£12.70
Seacroft	-	£2.10	-	£4.20	-	£8.40	-	£11.00
Wharfedale	£1.00	£2.00	£3.00	£4.00	£5.00	£6.00	£7.00	£8.00
Barnsley	£1.30	£2.80	-	£4.00	-	-	-	£6.90
Mid Yorks	£1.30	£2.80	-	£4.10	-	-	-	£6.90
Sheffield	-	£2.50	-	£3.70	-	-	-	£8.40

We will still maintain the 30 minute drop off/pick up allowance and it will still form part of the chargable tariffs. We have considered a one hour charge, but this would lose considerable income to the Trust, and has been discounted. Details are in appendix 1.

The total increase in the amount that would be generated in 2016/17 is £162,896.

Car Park Enforcement

We will continue to enforce the "Car Parking Rules" as detailed in the Trust Car Parking Policy. However Traffic Officers will be trained and instructed to assess each car parking rule breach as and when it occurs and where possible, use a more pragmatic approach to establish the reason for the breach. Should the reason for the breach be clearly proven to be a response to situations of clinical urgency, the Traffic Officer will not issue a parking notice. If it is not possible to establish the reason at the time, a parking notice will be issued and the member of staff will have the opportunity to appeal through the agreed process.

Travel Sustainability & Future Developments

We have identified travel and car parking as areas where we could realise significant efficiencies in cost and CO2 reductions, whilst potentially unlocking and protecting staff time from unnecessary business or commuter travel. Therefore we propose to;

- Address any hotspot areas within our travel expense claims
- Calculate our carbon footprint and set reduction targets
- Fully utilise our current I.T systems (M.D.T etc.)
- Develop a protocol to help staff prioritise sustainable transport
- Include the environmental benefits of home working/ agile working within our existing policy
- Encourage active travel amongst our colleagues
- Assess the utilisation of the Trust's shuttle buses
- Encourage and support staff to cycle to work and work in partnership with Kirklees and Calderdale local authorities to facilitate safer cycling to work
- Understand the impact of our fleet vehicles and taxi contracts
- Promote lower emission cars via the Salary Sacrifice Scheme
- Identify through tender a robust and sustainable solution to manage our car parks
- Promote the use of the discounted Metro Cards for CHFT staff

Conclusion

The price increases proposed take into account other local charges for NHS public and visitor car parks, and bring a fairer system of charging for staff. If both increases are implemented on 1st June the total increase in income will be £224,347 in 2016/17 and £269,216 on an annual basis.

We are engaging and listening to our users to ensure "we get it right" therefore the Board are asked to support the 2016/17 strategy for car parking.

Appendix 1

Income Changes

Patients and Visitors

	£
HRI Income	£954,410
CRH Income	£901,967

	HRI			**With a 1 Hour charge**				**No 1 Hour Charge**			
Price 2016-17		% split of income		Tickets	Rates at 2015/16 prices	Income at proposed charge		Charge	Tickets		
£1.50	1 hour	29%	£280,816.63	112,327	£280,817	£168,490	-£112,327	£2.80	112,327	£314,515	£33,698.00
£2.80	2 hours	44%	£417,091.10	166,836	£417,091	£467,142	£50,051	£2.80	166,836	£467,142	£50,050.93
£5.00	4 hours	18%	£170,119.08	34,024	£170,119	£170,119		£5	34,024	£170,119	£0.00
£6.00	6 hours	4%	£35,351.54	5,892	£35,352	£35,352		£6	5,892	£35,352	£0.00
£7.00	6 + hours	5%	£51,031.65	7,290	£51,032	£51,032		£7	7,290	£51,032	£0.00
		100%			£954,410	£892,134	-£62,276			£1,038,159	£83,749
	CRH										
		% split of income		Tickets	Rates at 2015/16 prices	Income at proposed charge			Tickets		Proposed income change
£1.50	1 hour	29%	£265,386.30	106,155	£265,386	£159,232	-£106,155	£2.80	106,155	£297,233	£31,846.36
£2.80	2 hours	44%	£394,172.74	157,669	£394,173	£441,473	£47,301	£2.80	157,669	£441,473	£47,300.73
£5.00	4 hours	18%	£160,771.36	32,154	£160,771	£160,771		£5	32,154	£160,771	£0.00
£6.00	6 hours	4%	£33,409.04	5,568	£33,409	£33,409		£6	5,568	£33,409	£0.00
£7.00	6 + hours	5%	£48,227.56	6,890	£48,228	£48,228		£7	6,890	£48,228	£0.00
		100%			£901,967	£843,113	-£58,854			£981,114	£79,147
							-£121,130				£162,896

Income generated in 2016/17 would be 10 months = £135,746

Appendix 2 – Staff Charges

NEW INCOME IN 16/17 FROM STAFF	Number of people who pay as salary sacrifice	New Charge	Total new income (salary sacrifice)	Number of people who pay as non salary sacrifice	Total new income (non salary sacrifice)	TOTAL NEW INCOME
		£22				
			Change			
Band 1	11	20	-£22	12	-£24	-£46
Band 2	130	20	-£260	179	-£358	-£618
Band 3	41	22	£0	65	£0	£0
Band 4	56	24	£112	54	£108	£220
Band 5	293	24	£586	233	£466	£1,052
Band 6	218	26	£872	178	£712	£1,584
Band 7	110	26	£440	89	£356	£796
Non Review Body Band 9	0	28	£0	1	£6	£6
Non Review Body Band 8 - Range	19	28	£114	16	£96	£210
Band 8 Range A	17	28	£102	22	£132	£234
Band 8 Range B	3	28	£18	1	£6	£24
Speciality Registrar	31	28	£186	3	£18	£204
Speciality Registrar Core Train	4	28	£24	1	£6	£30
Speciality Doctor	20	28	£120	10	£60	£180
Consultant (Medical)	1	28	£6	1	£6	£12
Consultant Post 31 Oct	92	28	£552	28	£168	£720
Consultant (pre 31 Oct) - 1yr	1	28	£6	0	£0	£6
Consultant (pre 31 Oct) - 4yrs	8	28	£48	1	£6	£54
Consultant (pre 31 Oct) - 7-8y	9	28	£54	3	£18	£72
Consultant (pre 31 Oct) - 3yrs	4	28	£24	2	£12	£36
Consultant (pre 31 Oct) - 5yrs	6	28	£36	1	£6	£42
Consultant (pre 31 Oct) - 9yrs	2	28	£12	1	£6	£18
Consultant (pre 31 Oct) - 6yrs	3	28	£18	3	£18	£36
Consultant (pre 31 Oct) - 10yr	3	28	£18	2	£12	£30
Consultant (pre 31 Oct) - 11yr	2	28	£12	2	£12	£24
Consultant (pre 31 Oct) - 12yr	1	28	£6	1	£6	£12
Consultant (pre 31 Oct) - 14yr	0	28	£0	1	£6	£6
Consultant (pre 31 Oct) - 16yr	0	28	£0	1	£6	£6
Consultant (pre 31 Oct) - 18yr	0	28	£0	2	£12	£12
Senior Manager Band 1	2	28	£12	0	£0	£12
Senior Manager Band 2	2	28	£12	1	£6	£18
Senior Manager Band 3	2	28	£12	7	£42	£54
Senior Manager Band 4	6	28	£36	6	£36	£72
Senior Manager Band 5	6	28	£36	2	£12	£48
Senior Manager Band 6	3	28	£18	2	£12	£30
Senior Manager Band 7	4	28	£24	0	£0	£24
Senior Manager Band 8	9	28	£54	7	£42	£96
Senior Manager Band 9	1	28	£6	1	£6	£12
Senior Manager Band 10	3	28	£18	3	£18	£36
Senior Manager Band 11	1	28	£6	0	£0	£6
Senior Manager Band 12	1	28	£6	0	£0	£6
Senior Manager Band 15	1	28	£6	0	£0	£6
Senior Manager Band 14	0	28	£0	2	£12	£12
Senior Manager Band 17	1	28	£6	0	£0	£6
Associate Specialist New Contr	3	28	£18	2	£12	£30
STAFF GRADE	1	28	£6	3	£18	£24
Locum Consultant	3	28	£18	0	£0	£18
chair	1	28	£6	0	£0	£6
Senior Auditor Band 3	2	28	£12	0	£0	£12
	1137		£3,396	949	£2,094	£5,490
Annum			£40,752.00		£25,128.00	£65,880.00
Priorty Parkers	337	32	£3,370			
		Total	£40,440			
				GRAND TOTAL		**£106,320**
INCOME IN 16/17 IF WE START IN JUNE						**£88,600.00**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th May 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Director of Infection Prevention and Control Quarterly Report - Jan-April 2016 - The Board is asked to receive and approve the quarterly Director of Infection, Prevention and Control Report for the period January to 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 receive and approve the quarterly Director of Infection, Prevention and Control Report for the period January to April 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 receive and approve the quarterly Director of Infection, Prevention and Control Report for the period January to April 2016

Appendix

Attachment:

DIPC Quarterly Report up to 30th April 2016 2.pdf

Report from the Director of Infection Prevention and Control to the Weekly Executive Board
January to April 2016

Performance targets

Indicator	End of year target	End of year performance	April 2016	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**3**	0	199 days since the last infection
C.difficile (trust assigned)	21	**25**	2	7 avoidable and 18 unavoidable cases
MSSA bacteraemia (post admission)	12	**9**	1	Local target – 14/15 outturn
E.coli bacteraemia (post admission)	29	**25**	2	Local target – 14/15 outturn
MRSA screening (electives)	95%	**95.51%**	95.35%	March validated
Central line associated blood stream infections (Rate per 1000 cvc days)	1	**0.51**	1.07	Rolling 12 months
ANTT Competency assessments (doctors)	95%	**68.2%**	67.4%	
ANTT Competency assessments (nursing and AHP)	95%	**76.5%**	78%	
Hand hygiene	95%	**99.52%**	99.18%	

Quality Indicators

Indicator	YTD performance	April 2016	Comments
MRSA screening (emergency)	**90.80%**	90.64%	March validated data
Isolation breaches	**316**	23	
Cleanliness	**97.3**	97.4%	

MRSA bacteraemia:

To the end of March 2016, there have been **3** post admission cases **MRSA bacteraemia**: 1 unavoidable and 2 avoidable. **3** pre MRSA bacteraemia cases: 2 unavoidable, 1 avoidable and attributed to CHFT. The Objective for 2016/17 is 0.

MSSA bacteraemias: there have been 9 post-admission MSSA bacteraemia cases during 2015/16 against the internal target of 12. The internal objective for 2016/17 will be 9.

MRSA - Hospital-Acquired Infections (HAIs):

There have been 23 acquisitions this year compared to 29 for the same time period last year.
Wards are informed of any HAIs that occur within their area and are asked to carry out a ward-led investigation; these are presented to the PSQBs. If more than one case occurs in a short period of time, an outbreak meeting may be held to identify any issues / concerns and formulate an action plan in order to reduce the risk of further acquisitions. There has been a year on year reduction for the past 10 years when in 2006/07 we had 207 acquisitions.

Clostridium difficile: the target / ceiling for 2016/17 is for no more than 21 post-admission cases
Key themes from the C-diff cases are:

- Delay in isolating the patient
- Delay in obtaining stool specimen
- Completion of the Bristol Stool Chart

Work is ongoing to improve compliance with the above issues with the development and roll out of the EPR.

Escherichia-coli (E-coli) bacteraemias:

There have been 25 post-admission E-coli bacteraemia cases from April 2015 to March 2016 against the internal target of 29.
18 within the Medical Division, 7 within the Surgical Division.
Case note review has been carried out for 23/25 cases by IPCD.
25 cases: 16 Medical Division, 8 Surgical Division, 1 FSS

Reviewed 23/25

<u>Medical:</u>

Reviewed 15/16 cases.

Average time from admission to bacteraemia: 26 days.

Median time from admission to bacteraemia: 10 days.

3 patients died within 30 days (all cause 30 day mortality of 20%)

Underlying cause:

- Catheter inserted in patient with encephalitis, GCS 8, 14 days after admission
- Radiation enteritis secondary to radiotherapy for bladder cancer
- Post ERCP – stent insertion for malignant stricture / external CBD compression
- # NOF – catheterised for retention, unclear if TWOC'd
- Acute decompensated alcoholic liver disease

- Catheter related UTI – CVA in Greece, repatriation.
- Non-catheter related UTI in poorly mobile patient
- Treatment failure of splenic abscess (despite drainage and 6 weeks appropriate IV antibiotics)
- UTI – acute retention possible secondary to changes in mental health medication in community
- Catheter related UTI – 10 days post insertion.
- Related to ureteric stents inserted for recurrent stones, underlying prostatic malignancy
- Acute cholecystits developing in an in-patient, had been admitted with CAP.
- Crohn's disease flare – GI translocation
- Same patient had two bacteraemias related to a 2cm gallstone that proved very difficult to remove – had 3rd bacteraemia (pre-48 hour) in January 2016, has since been successfully stented.

No common theme: 4 patients had CA-UTI, other than that broad range associated mostly with underlying disease.

Surgical:

Reviewed 8/8 cases.

Average time from admission to bacteraemia: 7.25 days

Median time from admission to bacteraemia: 6 days.

3 patients died within 30 days (all cause 30 day mortality of 37.5%) – 2 with advanced cancer, with following emergency repair of AAA.

Underlying cause:

- Community acquired acute pyelonephritis, on cusp of 48 hours ?delay in blood culture
- Blocked ureteric stent (underlying bladder cancer, same reason for initial presentation) – 14 days
- CA-UTI – bladder cancer, post TURBT
- Ventilator associated pneumonia post emergency AAA repair
- Sigmoid tumour erosion into bowel
- Post-ERCP for acute cholecystits failed to retrieve the stone
- Palliative rectal cancer – likely GI translocation

No common theme was identified.

Given that there are a broad range of aetiologies for the post 48 hour bacteraemias, in patients who generally have underlying, advanced medical problems, there are very limited actions that can be generated to prevent them, as many of them are largely unpreventable (from the view point of an individual case note reviewer). Prevention of CA-UTI does however feature in the HCAI action plan.

All post 48 E. coli bacteraemias in 2016/7 will be subject to case note review and assessment of whether cases could be avoided or not. Common themes/areas for action and learning will feed into the HCAI Action Plan.

The internal objective for 2016/17 will be 25.

Central Vascular Access Device related bacteraemias

The internally set target for CVAD related bacteraemias is 1 per 1000 CVAD line days. The current rate is 0.47 and below target.

CVAD infections are investigated using RCA. The current improvement work includes standardising all areas to use Chlorhexidine dressings, development of a training package for patients and to include a checklist of understanding and development of a 'CVAD passport' to improve communication when patients have received shared care between different hospitals and community.

Isolation Breaches

There have been 316 isolation breaches during the last 12 months compared to 242 breaches for the previous year.

- Isolation is included in the Action plan for 2016/17.
- Work was ongoing with the roll out of the Nerve centre throughout the wards, to incorporate the Bristol stool chart and prompt the need for isolating the patients with diarrhoea; this work has now been superseded by EPR.

Audits:

39 Quality improvement environmental audits have been carried out since the beginning of April 2015 to end of March 2016.

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

- 17 of the areas achieved a green rating.
- 22 of the areas achieved an amber rating.
- No area's received a red rating.

Action plans are produced by the Ward / Department following an audit in order to address any issues or concerns identified; a follow-up audit is completed for areas that only achieve a red rating.

Commode audits: these are carried out by the IPCT on a monthly basis. Commodes on all ward areas are inspected to ascertain whether they have been cleaned according to CHFT policy and are ready for use.

Commode cleanliness audit monthly results		
Month	CRH	HRI
April 15	76%	81%
May 15-june 15	97%	92%
July 15	77%	80%
August 15	89%	87%
September 15	91%	89%
October 15	83%	87%
November 15	86%	88%
December	83%	89%
Jan 2016	87%	90%
Feb 2016	88%	79%
March 2016	96%	95%

Compliance issues include urine splashes to the commodes, including some dried urine and faeces.
Results are discussed with ward staff at the time that the audit is carried out and are included on the IPC monthly reports.

The point prevalence annual PVC audit was completed in March, highlights are as follows:-

- 237 PVC where audited which is an increase compared to 187 at the previous audit.
- Documentation is inconsistent throughout the organisation.

The point prevalence annual Urinary catheter audit was also completed in March, highlights are as follows:-

- 91 catheters overall compared with 101 last year
- Main points across all catheters, a lack of insertion details: especially when inserted by medics
- No evidence of catheter passports being brought in by patients.
- Lack of securing devices to prevent trauma.
- Daily reason for continued catheterisation not documented.

Overall all daily cares are documented well across all areas.
Storage of catheters is now standardised and good.

Hand hygiene: the weekly hand hygiene audits continue with staff being encouraged to report actual practice so that any problems may be identified and actions put in place.

Link Infection Prevention & Control Practitioners (LIPCPs):

The IPCT continue to provide 4 workshops per year for the LIPCPs for each ward area and department, plus one aimed specifically at community staff, in order to address specific IPC issues and provide relevant information and support.

Training: The IPCT continue to deliver both planned and ad hoc sessions to all levels of CHFT staff.
Newly introduce 'beyond the basics' training for Clinicians which is being evaluated positively.

ANTT (Aseptic Non-Touch Technique) training for Assessors:
The IPCT took over this training in October 2015, since which over 70 new assessors have been trained. CHFT employs a 'train the trainer' approach. All staff who are involved in patient care and carry out procedures such as removing peripheral venous cannulae (PVCs), emptying urinary catheters, venepuncture and cannulation, wound dressings etc., are required to be assessed as competent for ANTT.

An e-learning package has been purchased and will be rolled out in the next few weeks; this will be initially for all junior doctors and ANTT assessors.

Competency is now at 76.5% for nursing staff (previously 70%) and 68% (previously 62%) for Doctors.

IPCNs: The team have currently 2 WTE IPCNs vacant posts as a result of unexpected retirement and resignation. Whilst recruitment to these posts has been successful there will be continuing impacts on the team due to the need training needs of the successful candidates. It has been agreed that due to staffing over the summer period on-call will be covered at weekends only.

IPCNs continue to work both proactively and reactively, dealing with potential and actual outbreaks and situations as they arise; informing ward staff of results which require further action such as isolating the patient and maintaining enhanced precautions; carrying out planned training sessions and ad hoc sessions upon request; audit and surveillance; reviewing and updating IPC policies.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 26th May 2016	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: IPR Report - The Board is asked to receive and approve the Integrated Board Report for April 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (19.5.16) Quality Committee (24.5.16)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Trust has remained busy with AED attendances and admissions high and excess bed days above the norm for this period. The impact is that the Trust continues to rely on additional capacity and flexible staffing.

The Medicine Division has a high number of Consultant vacancies some of which are filled with agency locums and other rota gaps covered by substantive colleagues.

There were 2 days of industrial action in April where emergency cover was withdrawn requiring Consultants to cover wards and AED.

Flow across the Health and Social care system remains a challenge with a daily mismatch between admissions and discharges compounded by the timing of these which often occur later in the day

Package of Care capacity remains limited, 2 further Nursing homes are closing in Calderdale and Social Worker staffing is limited.

Several specialties are being supported with improvement including Invited Service Reviews in Stroke, Respiratory Medicine and Complex care.

Professor Mohamed Mohammed has presented on mortality for a second time to the senior leadership team.

Complaints into the Trust remain high for the period and reflect the pressures on capacity and flow in quarter 4.

There remains a focus on the data capture for Friends and Family Test however greater focus is now being given to the output of the responses and action plans being developed in each area reflecting a 'you said, we did' approach.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Integrated Board Report for April 2016

Appendix

Attachment:

IPR Report.pdf

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

Quality and Performance Report

April 2016

Contents

RAG Key	
Achieving target	
Between target and threshold	
Worse than target or Threshold	

Executive Summary

The report covers the period from April 2015 to allow comparison with historic performance. However the key messages and targets relate to April 2016 for the financial year 2016/17.

Area	Domain
Safe	• **Inpatient Falls with Serious Harm** have peaked with 6 in month - higher than any month in 15/16 and equivalent to 20% of last year's total. To enable improvements the appointment of a specialist falls lead to enable traction, compliance and success with the Falls quality improvement initiatives is underway. • **Maternity - Major PPH - Greater than 1000mls** continues to be over 8% target at 10.2%. Only achieved in two months in 15/16. Developing an SOP to improve objectivity in measuring post-partum blood loss following vaginal and caesarean birth. • **Number of Trust Pressure Ulcers (Category 2)** Acquired at CHFT - 30 against monthly target of 17. Further cluster investigations into category 3 ulcers should see improvements in Quarters 2 and 3. • **Alert Safeguarding Referrals made by the Trust** - highest number (20) since July 2015 (29).
Effective	• **Total Number of Clostridium Difficile Cases -** There was one avoidable case of Clostridium difficile and one case is pending ribotyping results. The RCA investigation identified a number of issues and the learning is to be shared with the clinical teams with bespoke IPC training to be provided to ward staff. • **Local SHMI - Relative Risk** (1yr Rolling Data October 14 - September 15) 113.88 - The two diagnostic groups that are negative outliers are Acute Cerebrovascular Disease and Pneumonia. Split by site, in-hospital and 30-day post-discharge deaths show that SHMI for post discharge deaths from HRI is much higher than in-hospital HRI deaths or any in CRH. This is currently unexplained and is subject to investigation at present. • **Hospital Standardised Mortality Rate** (1 yr Rolling Data Mar 15 - Feb 16) 114.48 - Trust predicts further modest reductions in the coming months. • **Mortality Reviews** - The completion rate for Level 1 reviews has been declining, and for March deaths was 38.1%. Recruitment of more reviewers has been much discussed and a proposal to move towards a consultant delivered initial review process was tabled at the Mortality Surveillance Group, and will be taken to Divisional PSQB's for discussion. • **Crude Mortality Rate** - Gradual increase over the last 6 months to 1.43% against internal target of 1.32%). • **Average co-morbidity score** 3.7 against 4.4 target. Clinical engagement continues around the importance of complete and accurate documentation and development of existing documentation to assist coding process e.g. inclusion of co-morbidity form. Co-morbidity form completion remains poor at 48% despite the form being present within case notes 82% of the time. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge is** 68.4% against 85% target
Caring	• **Only 30% of complaints were closed within timeframe against a target of 100%.** This is a deterioration on March performance and is subject of specific discussions with Divisional teams at the weekly performance meeting There is a small cohort of responses that are now over 2 months past due date that are receiving specific attention. • **Friends and Family Test Outpatients Survey** - 90.5% would recommend the Service against 95% target. The new car parking payment system at Acre Mills and improved communication between staff and patients in clinic will address the 2 key themes and improve the position. • **Friends and Family Test Community Survey** - 87.5% would recommend the Service against 96.2% target. Feedback to service users using the "You said, we did" method is being developed and will be in place by Q2.

Background Context

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The report covers the period from April 2015 to allow comparison with historic performance. However the key messages and targets relate to April 2016 for the financial year 2016/17.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours.** April's position has improved to 93.87% the highest since December despite attendances continuing above 450 daily with the exception of the 2 days of Industrial Action. The Safer Patient Flow Programme launched at a breakthrough event and local improvement initiatives have been agreed with clinical teams. Reflecting the need for additional immediate improvement a weekly ECS recovery meeting has agreed a series of actions including daily debrief with AED and patient flow coordinators, bed before 11 project, EOL fasttrack within 24hours and an evening transfer team. • **% Daily Discharges - Pre 12pm.** 16.4% against 40% target. A daily senior matrons' huddle monitoring the 'tests of change' is in place. A month on month improvement of 10% is expected from March to achieve 40% by the end of Q1. • **Green Cross Patients (Snapshot at month end)** remains high at 93 patients, within month this number has been greater with particular delays noted in social worker assessment, Nursing home placement and Package of Care. • **83.7% of patients spent 90% of their stay on a stroke ward** which was a slight improvement on previous month which was 18 out of 57 stroke patients. Overall bed pressures were the main causative factors including delayed discharges. • **Only 47.8% of Stroke patients were scanned within 1 hour of hospital arrival (where indicated)** against 90% target, the worst position of the last 12 months. A review of the reasons has been undertaken and shared with the clinical teams for actions to be developed which includes stroke nurses now also seeing all possible stroke patients to help ensure early diagnosis for imaging. • **RTT pathways over 26weeks** was high in April reflecting some backlogs from elective activity reductions and the requirement for more focussed validation, this is reducing in May and is reviewed weekly. • **2WW Breast Symptomatic underachieved at** 90% against 93% target. This is a very low volume KPI with single patient breaches impacting on target achievement. • **38 Day Referral to Tertiary has further deteriorated in April at** 41.18% against 85% target which is the lowest position in last 12 months. Each Division is taking an updated action plan to their May Performance reviews with a requirement to achieve by July reflecting changes to reporting rules from Q3.
Workforce	• **Sickness Absence rate is** currently 4.6% against 4% target the lowest position for several months with the Medicine Division seeing significant improvement. Within this long term sickness is 3.1% against 2.7% with the short term 1.49% against 1.3%. • **Return to work Interviews** are a key contributor to effective sickness management and are currently only running at 33.1% against 100% target. • **Mandatory Training and appraisal** compliance remains a challenge. • **Hard Truths compliance** was over 90% for day and night qualified staff and over 100% for unqualified.
Efficiency/ Finance	• **Average Length of Stay - Overall Trust length of stay** (LOS) reduced in April, but was still higher than target with excess bed days un seasonably high. • **Spend on agency staff in April** remains high and an improvement trajectory challenge has been set for each Division. • **Theatre Utilisation** was red across all metrics in month reflecting the acute demand and Industrial Action.
CQUIN	• **Sepsis - % of patients Screened (admission Units)** - On plan to hit 3 out of 4 Q1 targets, risk in achieving 90% of patients screened in ED for Q1. Performance 53% against year end 70%. Urgent meetings with ED leads in place to decide on remedial action.
Activity	• **Activity** at all points of delivery is on target for the month of April with the exception of elective inpatients which is currently 14.5% (107 spells) undertrading, however this masks variances at specialty level which cannot be explained by the Industrial Action in month.

Background Context

Additional capacity was open in some areas through April requiring additional staffing, where shifts not covered through bank or agency. Redeployment of existing staff was required and fill rates in some areas reduced.

Vacancy rates in Nursing and Medical staffing remain high particularly in the Medicine Division.
A Task and Finish group has been established to focus improvement on flexible workforce use and a self assessment using NHSI toolkit has been undertaken.

There has been an increase to staffing in the HR department focussed on absence management with Clinical Divisions.

Surgical bed capacity released from Medicine from the 2nd week in April impacting on elective activity and Theatre utilisation.

Industrial Action for 2 days in April required the cancellation of all elective inpatient and a percentage of day case activity.

There remained high numbers of patients fit for non acute care but unable to be discharged.

Carter Dashboard

		Current Month Score	Progress Against Previous Month	Standard (Plan)	NHS Good Practice
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.0%	96.9%	↑	96%
	Inpatient Complaints per 1000 bed days	2.1	2.72	↑	TBC
EFFECTIVE	Average Length of Stay - Overall	5.32	5.45	↑	5.17
	Delayed Transfers of Care	2.90%	3.30%	↑	5%
	Green Cross Patients (Snapshot at month end)	93	98	↑	40
	Local SHMI - Relative Risk (1yr Rolling Data)	113.88	112.41	↓	100
	Theatre Utilisation (Trust)	84.18%	83.82%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.71%	0.96%	↑	0.6%
	Emergency Care Standard 4 hours	93.87%	89.30%	↑	95%
	% Incomplete Pathways <18 Weeks	96.2%	95.7%	↑	92%
	62 Day Gp Referral to Treatment	91.9%	89.4%	↑	85%
SAFE	% Harm Free Care	94.16%	93.04%	↑	95.0%
	Number of Outliers (Bed Days)	769	883	↑	495
	Number of Serious Incidents	3	3	↔	TBC
	Never Events	0	1	↑	0

MOST IMPROVED

Improved: Emergency Care Standard 4 hours. April's position has improved to 93.87% the highest since December despite attendances continuing above 450 daily with the exception of the 2 days of Industrial Action.

Improved: Sickness Absence rate is 4.6% against 4% target the lowest position for several months with the Medicine Division seeing significant improvement. Long term sickness is 3.1% against 2.7%, short term 1.49% against 1.3%.

Improved: Friends and Family Test A & E Survey - % would recommend the Service has reached the 90% target for the first time since July 2015. Similarly response rate has improved from 8.37% to 13.27% just below the threshold for the green rating (14%). Staff capturing accurate mobile numbers to increase the success with the text messaging service.

MOST DETERIORATED

Deteriorated: Inpatient Falls with Serious Harm have peaked with 6 in month - higher than any month in 15/16 and equivalent to 20% of last year's total.

Deteriorated: Only 30% of complaints were closed within timeframe against a target of 100% and continues a downward trend.

Deteriorated: Only 47.8% of Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 90% target, the worst position of the last 12 months.

ACTIONS

Action: To enable improvements the appointment of a specialist falls lead to enable traction, compliance and success with the Falls quality improvement initiatives is underway.

Action: This is now subject to specific discussions with Divisional teams at the weekly performance meeting. There is a small cohort of responses that are now over 2 months past due date that are receiving specific attention.

Action: A review of the reasons has been undertaken and shared with the clinical teams for actions to be developed which includes stroke nurses now also seeing all possible stroke patients to help ensure early diagnosis for imaging.

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Progress Against Previous Month	Standard (Plan)	NHS Good Practice
Doctors Hours per Patient Day				
Care Hours per Patient Day	Available from Q2			
Absence Rate	4.60%	4.62%	↑	4.0%
Turnover	14.5%	16.40%	↑	
Vacancy	494.92	484.70	↓	
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	82.0%			
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4	64.0%			

OUR MONEY	Current Month Score	Progress Against Previous Month	Standard (Plan)	NHS Good Practice
Income vs Plan (£m)	£0.26		●	
Expenditure vs Plan (£m)	-£0.63		●	
Liquidity (Days)	0			
I&E: Surplus/(Deficit) (£m)	-£0.3		●	
CIP (£m)	-£0.05		●	
FSRR	2		●	
Temporary Staffing as a % of Trust Pay Bill	0.0%			

Performance Key: ⇧ Direction of arrow indicates direction of performance. Up arrow = Improvement, Down arrow = Deterioration on previous period. Colour of arrow indicates Achievement/non achievement of Standard.

Safe - Key messages

Area	Issue	Corrective actions	Impact & Accountability
Falls / incidents and Harm Free Care	**Inpatient Falls with Serious Harm** The current number of patients who have had a fall resulting in harm exceeds planned trajectory which was based on the 10% reduction from 2014/15 . There were 6 falls in April that resulted in fractures, which are currently being investigated as part of the SI/orange panel processes. This is a significant increase on previous months. Early indications show the majority of the falls were unwitnessed. **Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)** Only 1 incident was sent outside of the agreed timeframe as a result of the CCG declining review. A de-log had been requested and the report was not progressed whilst we waited for the response for that request. All remaining incidents were submitted within the agreed timeframe but Datix had not been updated as appropriate. The response rate was 80% .	To enable improvements the appointment of a specialist falls lead has been approved who will lead an agreed Falls quality improvement initiatives. In Quarter 1 work has commenced in line with a new local CQUIN to seek to reduce rates of falls by the introduction of safety huddles into areas with high falls rates. The falls multidisciplinary collaborative meeting is recommencing in June which will engage clinicians across the trust to engage in a strategic approach to reviewing current practice and in managing a reduction in falls .	There will be a reduction in falls by the end of Q1 2016 in the areas identified for safety huddle implementation as part of the CQUiN. Improvement will be seen across the Trust following the reimplementation of collaborative work commencing June 2016. **Accountable: Deputy Director of Nursing**
Maternity	Despite an improving trend during the last 3 months, the major PPH rate is still above the target set of 8%. One element of this may be related to the way in which blood loss at birth is measured.	Develop SOP to improve objectivity in measuring post-partum blood loss following vaginal and caesarean birth Critically examine recent published systematic reviews to establish up-to-date incidence of PPH and to refresh (if appropriate) CHFT target rates and improvement trajectory. This should include improvement trajectories for active and physiological third stage, and vaginal and caesarean birth .	Target for SOP 31 May 2016, Lead Jill Bellerby Target for improved trajectories 31 May 2016, Lead Julie Goddard **Accountable: ADN for FSS**
Pressure Ulcers	Current performance being monitored against 15/16 thresholds. There is further investigation into the causes of the category 3 & 4 cases. New targets are to be set going forward.	Further cluster investigations into category 3 ulcers to increase learning. Report expected at the end of June. Implementations of safety huddles into areas of high incidents commenced this quarter.	Improvement expected with Q2 and Q3. Improvement trajectories will be set in Q2. **Accountable : Assistant Director of Quality**
Duty of Candour	There was one non-complaint case with sharing the outcome. This related to a patient who had died and due to the sensitivity around time scales the letter was delayed.	The process around what to do in these cases is going to be reviewed to ensure the letter is sensitively written and therefore may not need to be delayed. This is not expected to be a regular occurrence.	Performance expected back on track - May 16 **Accountable : Head of Risk and Governance.**

Safe - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Annual Target	Monthly Target
Falls / Incidents and Harm Free Care																	
All Falls	2033	197	145	160	139	138	175	185	168	194	187	167	156	**152**	**152**	Not applicable	
Inpatient Falls with Serious Harm	29	1	3	3	2	2	4	3	0	2	3	3	2	**6**	**6**	<=12	<=1
Number of Falls per 1000 bed days	-	9.1	6.6	7.8	6.8	7.4	8.3	8.1	7.7	8.9	7.9	7.2	6.7	**6.9**	**6.9**	TBC	TBC
% Harm Free Care	93.63%	93.87%	95.04%	94.69%	93.96%	92.19%	93.46%	93.30%	93.29%	92.27%	93.47%	93.25%	93.04%	**94.16%**	**94.16%**	>=95%	95.00%
Number of SI's	78	9	4	15	5	5	7	13	10	2	2	3	3	**3**	**3**	Not applicable	
Number of Incidents with Harm	1751	159	114	201	89	111	176	159	203	97	147	139	156	**158**	**158**	Not applicable	
Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	-	61.00%	21.00%	50.00%	100.00%	100.00%	90.00%	0.00%	0.00%	21.00%	33.00%	28.00%	100.00%	**80.00%**	**80.00%**	100.00%	100.00%
Maternity																	
Elective C-Section Rate	9.00%	7.50%	11.46%	7.50%	8.50%	7.50%	9.60%	9.60%	9.60%	9.60%	9.60%	9.60%	9.60%	**9.60%**	**8.70%**	<=10%	10.00%
Total C-Section Rate	23.90%	**24.60%**	**24.20%**	**21.90%**	**24.20%**	**25.30%**	20.40%	28.30%	22.60%	25.70%	22.60%	23.10%	23.60%	**22.20%**	**22.20%**	<=22.5%	22.50%
Major PPH - Greater than 1000mls	10.40%	7.73%	9.38%	14.60%	**9.60%**	9.50%	7.60%	11.60%	11.00%	9.60%	11.20%	11.80%	10.60%	**10.20%**	**10.20%**	<=8%	8.00%
% PPH ≥ 1500ml - all deliveries	3.78%	3.70%	3.30%	6.90%	**4.80%**	2.30%	3.30%	4.20%	3.50%	2.90%	4.00%	2.80%	3.60%	**2.90%**	**2.90%**		
Antenatal Health Visiting Contact by 32 Weeks	91.80%	94.00%	74.00%	96.00%	98.00%	85.00%	113.00%	95.00%	100.00%	77.00%	95.00%	87.00%	100.00%	**103.00%**	**103.00%**	>=90%	90.00%
Pressure Ulcers																	
Number of Trust Pressure Ulcers Acquired at CHFT	498	52	42	61	65	53	32	35	41	20	24	29	44	**39**	**39**	<=300	25
Number of Trust Pressure Ulcers Acquired at CHFT per 1000 bed days	-	2.4	1.9	2.8	3.1	2.5	1.5	1.6	1.9	0.9	1.0	1.3	1.9	**1.6**	**1.6**	**TBC**	TBC
Number of Category 2 Pressure Ulcers Acquired at CHFT	403	37	36	51	53	46	26	25	38	13	21	22	35	**30**	**30**	<=204	17
Number of Category 3 Pressure Ulcers Acquired at CHFT	86	12	6	9	10	7	6	9	3	6	3	7	8	**8**	**8**	<=96	8
Number of Category 4 Pressure Ulcers Acquired at CHFT	9	3	0	1	2	**0**	0	1	0	1	0	0	1	**1**	**1**	0	0
Percentage of Completed VTE Risk Assessments	95.30%	95.20%	95.20%	95.20%	95.90%	95.60%	95.20%	95.20%	95.30%	95.40%	95.40%	95.10%	95.10%	**95.01%**	**95.01%**	>=95%	95.00%
Safeguarding																	
Never Events	2	0	0	0	0	0	0	0	0	0	0	1	1	**0**	**0**	0	0
Total Duty of Candour shared within 10 days	-	87.50%	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	86.00%	91.00%	**85.71%**	**85.71%**	100%	100%
Alert Safeguarding Referrals made by the Trust	157	7	23	18	29	12	8	16	6	7	12	8	11	**20**	**20**	Not applicable	
Alert Safeguarding Referrals made against the Trust	99	7	8	9	10	6	4	9	6	8	7	12	13	**7**	**7**	Not applicable	

Effectiveness - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Infection Control	There was one avoidable case of Clostridium difficile in April on ward 2A CRH, and one case is pending ribotyping results. The RCA investigation identified a number of issues:- delay in isolation, not using soap and water when undertaking hand hygiene, staff none compliant with BBE.	The learning is to be shared with the clinical teams with bespoke IPC training to be provided to ward staff.	The trust is below the trajectory for the number of avoidable cases in year. **Accountable : Lead Consultant for Infection Control**
Average Diagnosis per Coded Episode/ Average co-morbidity score	CHFT depth of coding and average co-morbidity score is less than plan due to missed or undocumented relevant diagnoses/complexities/comorbidities within the coding source documentation. It may also be due to incomplete coding documentation at the time of coding or as a result of the terminology, content and quality of what is written within the case notes. Since May 2015 coding depth and average co-morbidity score have gradually improved although not to national upper quartile levels. There is variable improvement across specialties for each KPI – noticeable deterioration in some Medical Division specialties since	Clinical engagement continues around importance of complete and accurate documentation. Pilot of coding process at CRH has been rolled out to HRI endoscopy areas. Recruitment process continues to achieve full coding team establishment. Project support has been identified to support the interfacing of the 3M Encoder with Cerner Millennium. To improve clinical coding and the link to clinical colleagues 5 doctors are to have 1 PA.	Expect to see continued improvement month on month across each average diagnoses and average co-morbidity, with a trajectory to hit targets in 2016/17 **Accountable: Head of Clinical Coding**
Fracture Neck of Femur - Best Practice Guidance	31 patients admitted in April, 30 were eligible for BPT. 38 patients discharged in April. Only 26 got to theatre in 36 hours. 7 trauma cases were treated in CRH on elective lists to allow for additional capacity. 2 patients needed THR. and it was not possible to organisation surgeon capacity at HRI. Insufficient trauma capacity was unavailable to the service in April.	Future trauma service model developed – *by Mid June* Fallow laminar flow lists offered to T&O for first refusal – *Immediate effect* Review experienced middle grade job plans to create additional trauma capacity and review option to create #NoF specific lists – *end of June* Capacity and demand analysis of Orthopaedic Trauma to identify shortfall in capacity – *Completed in June* Discuss with Orthopaedic Consultants to reserve the morning part of the trauma list for #NoF cases – *May consultant meeting* Ensure equipment is available at the right location for cases – *Immediate action* Continued improvement in escalation – with greater visibility (explore use of Trauma board or Knowledge Portal or both for trauma demand and planning) – *Immediate Action* Improve the quality of RCA's – *Immediate action* All potential breaches to be discussed with Divisional management before the patient breaches – *Immediate effect*	In May there have been 6 breaches for #NoF with a total of 18 patients giving a current MTD position of 67%. Additional trauma lists have been put in place for the remaining week in May. Unless #NoF levels rise to 40 for May it is not possible to achieve performance of 85%. It is unlikely that there will be such demand on the service. It is likely that the demand for the service will be approximately 31 given demand figures in April. It is therefore possible that the service could achieve a performance between 70 and 80% for the month of May should demand be as expected. When measuring performance based on admission the Division is working hard to ensiure goood performance in May. However, it is unlikely due to previous sub-optimum performance the Division will be able to secure a good performance on discharge patients against this target given a LoS typically between 16 - 23 days. For the discharged indicated the Division is working hard to ensure the June positiion is improved. **Accountable : GM for T&O**

Effectiveness - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Hospital Mortality	Local SHMI - Relative Risk (1yr Rolling Data October 14 - September 15) There has been no further quarterly SHMI data issued by HSCIC since the last IPR. However we continue to scrutinise the data closely. The two diagnostic groups that are negative outliers within our SHMI data currently are Acute Cerebrovacular Disease and Pneumonia, and both stroke and respiratory are subject to service review at present. Hospital Standardised Mortality Rate (1 yr Rolling Data March 15 - Feb 16) The latest HSMR release is for March 15 to Feb 16, and has shown a fall to 114.5. Our prediction is for further modest reductions in the coming months. Mortality Reviews As has been noted before, the completion rate for Level 1 reviews has been declining, and for March deaths was 44%. Recruitment of more reviewers has been much discussed, but feedback from Divisions shows that the current system of a nursing-dominated review team is not sustainable. Crude Mortality Rate For March 15 to Feb 16 the crude in-hospital death rate at CHFT was 1.35%, which is close to the average for English acute Trusts of 1.32%.	Meantime further analysis by Professor Mohammed Mohammed, splitting our SHMI data by site, and also into in-hospital and 30-day post-discharge deaths, shows that the SHMI for post discharge deaths from HRI is much higher than in-hospital HRI deaths or any in CRH. This is currently unexplained and is subject to investigation at present. Mortality Reviews A new proposal for a review programme taking into account the move to national standardisation, and also moves towards a consultant delivered initial review process was tabled at the Mortality Surveillance Group, and will be taken to Divisional PSQB's for discussion. This is, however, bound up to a degree with the proposed consultant job planning framework.	**Accountable : Associate Medical Director**
Still Births	There were 3 stillbirths in April meaning the rate for the month was 0.66%. Two of these cases were due to known abnormalities incompatable with life. The remaining stillbirth was reviewed and care was found to have been satisfactory.	Review of all still births undertaken using the National Patient Safety Agency (NPSA) Toolkit to identify learning opportunites.	Ongoing Monitoring of stillbirth rate. **Accountable : ADN FSS**

Effectiveness - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/Monthly
Infection Control																	
Number of MRSA Bacteraemias – Trust assigned	3	1	0	0	1	0	1	0	0	0	0	0	0	**0**	**0**	0	0
Total Number of Clostridium Difficile Cases - Trust assigned	25	2	0	1	1	3	3	4	2	1	3	3	2	**2**	**2**	<=21	< = 2
Avoidable number of Clostridium Difficile Cases	5	1	0	1	0	0	1	1	1	0	0	0	0	**1**	**1**	0	0
Number of MSSA Bacteraemias - Post 48 Hours	9	0	2	1	0	2	0	1	0	1	1	1	0	**1**	**1**	<=12	1
Number of E.Coli - Post 48 Hours	26	1	3	5	3	3	0	5	4	1	0	1	0	**2**	**2**	<=26	2.17
MRSA Screening - Percentage of Inpatients Matched	99.52%	94.66%	97.00%	95.74%	96.78%	93.60%	95.29%	96.00%	95.55%	96.08%	96.08%	96.37%	95.11%	**95.35%**	**99.52%**	>=95%	95%
Mortality																	
Stillbirths Rate (including intrapartum & Other)	0.41%	0.68%	0.21%	0.21%	0.41%	0.00%	0.64%	0.80%	0.20%	0.42%	0.42%	0.68%	0.22%	**0.66%**	**0.66%**	<=0.5%	0.5%
Perinatal Deaths (0-7 days)	0.16%	0.23%	0.21%	0.21%	0.21%	0.00%	0.43%	0.00%	0.00%	0.21%	0.21%	0.00%	0.22%	**0.00%**	**0.00%**	<=0.1%	0.1%
Neonatal Deaths (8-28 days)	0.04%	0.00%	0.00%	0.00%	0.00%	0.22%	0.00%	0.00%	0.00%	0.00%	0.21%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%	0.1%
Local SHMI - Relative Risk (1yr Rolling Data)	109.10	112.41	112.41	112.41	113.88	113.88	113.88	**in arrears**	**in arrears**	**in arrears**	**in arrears**	**in arrears**	**in arrears**	**113.88**	**113.88**	<=100.0	100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	113.00	111.52	112.89	114.33	116.16	116.43	116.41	116.49	116.38	116.82	116.62	114.48	**in arrears**	**in arrears**	**114.50**	<=100.0	100
Mortality Reviews	48.80%	69.80%	40.50%	20.20%	21.10%	75.20%	50.80%	60.70%	56.80%	60.30%	63.40%	37.90%	38.10%	**48.80%**	**48.80%**	100.00%	100%
Crude Mortality Rate	1.34%	1.62%	1.41%	1.19%	1.08%	1.18%	1.22%	1.21%	1.33%	1.41%	1.53%	1.46%	1.49%	**1.43%**	**1.43%**	<=1.32%	1.32%
Coding and submissions to SUS																	
Completion of NHS numbers within acute commissioning datasets submitted via SUS	99.94%	99.96%	99.97%	99.94%	99.94%	99.93%	99.94%	99.93%	99.93%	99.94%	99.93%	99.95%	99.95%	**99.92%**	**99.92%**	>=99%	99%
Completion of NHS numbers within A&E commissioning datasets submitted via SUS	99.04%	99.10%	99.20%	99.10%	99.10%	98.80%	99.10%	98.80%	99.00%	99.10%	98.50%	98.60%	98.89%	**98.99%**	**98.99%**	>=95%	95%
% Sign and Symptom as a Primary Diagnosis	9.63%	9.51%	969.00%	9.57%	10.03%	**9.43%**	10.81%	10.08%	9.65%	9.46%	8.99%	8.90%	9.37%	**9.14%**	**9.14%**	<=9.4%	9.40%
Average co-morbidity score	3.48	3.27	3.1	3.32	3.15	3.27	3.36	3.51	3.59	3.82	3.62	3.94	3.84	**3.77**	**3.77**	>=4.4	4.40
Average Diagnosis per Coded Episode	4.34	3.97	3.71	3.94	3.98	4.11	4.35	4.39	4.53	4.74	4.68	4.84	4.89	**4.94**	**4.94**	>=5.3	5.30
CHFT Research Recruitment Target	933	49	45	46	45	62	68	85	109	114	93	96	96	**in arrears**	**in arrears**	>=1008	92
Best Practice Guidance																	
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	69.40%	73.33%	56.52%	76.74%	66.67%	63.16%	55.56%	73.81%	79.49%	86.00%	71.79%	70.70%	61.29%	**68.40%**	**68.40%**	>=85%	85%
IPMR - Breastfeeding Initiated rates	79.80%	82.51%	80.00%	79.20%	77.30%	76.10%	80.20%	80.20%	83.90%	77.60%	79.50%	77.60%	78.30%	**77.50%**	**77.50%**	>=70%	70%
Readmissions																	
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	7.85%	9.52%	8.30%	8.30%	7.77%	6.35%	7.13%	8.73%	7.09%	6.60%	6.78%	7.81%	7.08%	**7.29%**	**7.29%**	<=7.97%	7.97%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	7.95%	7.87%	9.31%	8.96%	8.34%	7.21%	6.45%	7.35%	6.95%	7.06%	7.51%	8.07%	8.06%	**7.08%**	**7.08%**	<=7.05%	7.05%
% 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	4.20%	3.30%	5.90%	4.30%	2.70%	3.30%	2.60%	6.30%	3.40%	5.70%	5.70%	3.30%	2.75%	**in arrears**	**in arrears**	<=10%	10%

Caring - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Friends & Family Test A&E	A much improved position has been achieved in month increasing from a response rate of 8.37% to 13.27%. This is just below the threshold for the green rating (14%). Staff in the department have been working together to improve this, with increased use of postcards and greater vigilance in capturing accurate mobile numbers to increase the success with the text messaging service. The impact has been more successful to date on the HRI site, which is now achieving a green rating.	The team will continue with the good practice introduced during April 16, with a focus now on the CRH site. The teams are also aware that text messages are not sent to children under 16 and therefore will target this patient group with the postcard.	Given the level of improvement achieved in month, it is anticipated that the target is now achievable by the end of May 16. **Accountable : Emergency Network Matron**
Friends & Family Test - Outpatients	In April 90% of patients recommended outpatient services against a target of 95%. Most common themes relating to car parking and waiting times in clinics.	Outpatient group meets weekly to review and respond to feedback. Local patient survey has been developed and was tested in March, this will now be completed monthly and coordinated by the OP Managers, to measure impact of improvements made including – car parking. Following Feedback from patients and FFT a new car parking system is to be installed at Acre Mill. The Trust is currently out of tender, anticipated installation July/August 2016. Clinic delays - Clinic Delays slips have been introduced in all OP departments. The slips are completed where trends in delays in clinic are evident, and are returned to the OP PMO for detailed analysis of clinic start/finish times and clinic templates. Recommendations for change taken to the Clinical Division Access Meetings.	Improvement anticipated from July 2016. **Accountable : Outpatients Matron**
Friends & Family Test - Community	Areas of focus for the division are around improving response rate, improving quality of care so that feedback scores improve and feeding back to service users on the actions that have been taken as a result of the feedback that has been received. in clinics	Each service is reviewing the way that patient experience information is being collected to ensure that more responses are received from service users and a true reflection of service performance can be measured. Methods such as the use of web forms on smart phones and mobile devices, focus groups and questionnaire design are being investigated in order to improve response rate. The response rate is expected to improve by end Q1. Each of the three areas that have been identified as receiving negative comments have been asked to develop an action plan to address the areas identified in the responses from the FFT feedback. This is being monitored through the divisional PSQB structure. Division has a CQUIN for 16/17 to improve the % would recommend rate in OP Physio.	Feedback to service users using the "You said, we did" method is being developed and will be in place by Q2. **Accountable: ADD Community**
Friends & Family Test - Maternity	Women wanted more information during the induction of labour, and didn't understand that it is a slow process . Women also want to have allocated times for post natal visiting in the community. Waiting times for appointments & discharges.	Information sheet produced to explain induction of labour, and the facilities available to women and their partners. Further PN clinics planning to be offered in central locations, morning and afternoon appointments offered. Work ongoing to improve the clinic templates, and reduce waiting times. Work ongoing to improve the efficiency of discharges from the wards.	End of Q2 **Accountable: Maternity Matron**

Caring - Complaints Key messages

Area	Issue	Corrective Actions	Impact and Accountability
% Complaints closed within target timeframe	45 complaints were closed in April, which is a 18% decrease from March. The split by Division is SAS 12, Medicine 20, FSS 13 and Community 0. Of the 45 complaints closed 66% were closed with agreed timescales; this is a 21% increase from February, the focus remains closing overdue complaints. The total number of overdue complaints is 59 this is an increase of 40% from March. Whilst the majority of these complaints (44 complaints) are in the 0-1 month overdue bracket, a number of complaints have are now in the 2-3 and 3-4 month overdue. 5 out of 6 of these complaints are within the Division of Medicine.	Weekly meeting with Divisions and Complaints Team continue to improve responsiveness of complaints by weekly performance report, with guidance given for older more complex complaints; further attention will be given to the complaint that are within the 2-3 and 3-4 month overdue.	Throughout the rest of Q1 the priority will be to clear backlogs. During Q2 we will then be in a position to move forward with plans to close all complaints within target time. **Accountable : Head of Risk and Governance**

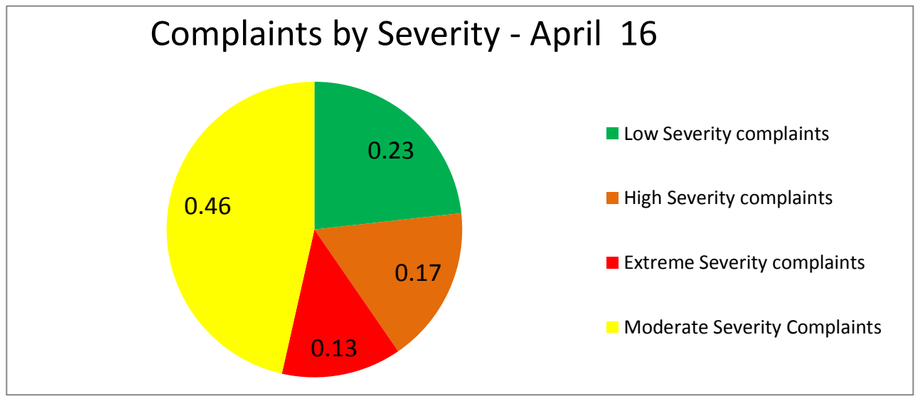
Complaints Background

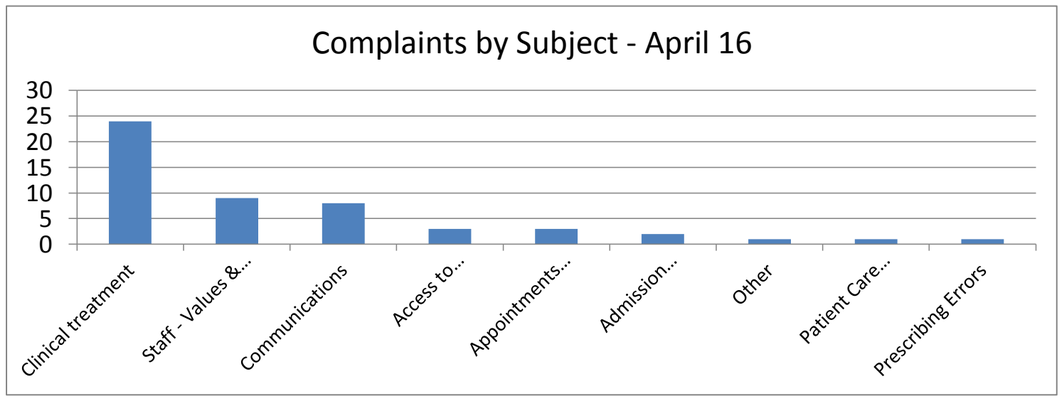
The Trust received 52 new complaints April 2016, a decrease of 20% from February 2016, and reopened 9 complaints; receiving a total of 61 complaints in April 2016.
As a quality metric the Trust is now monitoring the number of reopened complaints to understand the quality of the orginal response and identify areas where improvements in complaints handling maybe required. The total number of open complaints has increased to 136, with 59 of these being overdue. The 59 overdue complaints split by Division is SAS 14, Community 2, Medicine 29, and FSS 14.

The top 3 Complaints subjects were:
Clinical Treatment
Staff – Values and Behaviours
Communication
These subjects were also the top three in March 2016; however, there has been a further increased in the number of complaints regarding Staff – Values and Behaviours.

Severity: The Trust received 7 new red complaints in April which is an increase of 10% from March 2016. Red complaints include both complaints that may have a related clinical incident as well as those where the patient experience has been very poor.

PHSO Cases:
The Trust received 4 new Ombudsman / PHSO case received in April 2016. The PHSO have requested the records for all 4.
1 PHSO complaint was closed in April 2016, which was partially upheld.





Caring - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
Complaints																	
% Complaints closed within target timeframe	48.45%	32.61%	47.22%	55.68%	61.11%	56.41%	51.85%	61.11%	39.68%	39.73%	47.73%	43.94%	45.45%	**30.00%**	**30.00%**	100.00%	100.00%
Total Complaints received in the month	641	58	51	58	50	41	48	52	58	49	55	51	65	**52**	**52**	To be confirmed	
Complaints re-opened		Not collected for 15/16												**9**	**9**	To be confirmed	
Inpatient Complaints per 1000 bed days		2.27	2.11	2.42	2.23	1.77	2.27	2.35	2.36	2.24	2.26	2.05	2.72	**2.10**	**2.10**	To be confirmed	
Friends & Family Test																	
Friends & Family Test (IP Survey) - Response Rate	28.60%	25.80%	21.40%	21.94%	26.50%	28.10%	24.40%	31.10%	32.90%	34.30%	32.10%	33.50%	30.70%	**31.29%**	**31.29%**	>=28.0%	28.00%
Friends & Family Test (IP Survey) - % would recommend the Service	96.90%	97.20%	96.90%	97.37%	96.60%	97.10%	96.50%	96.70%	96.70%	96.40%	97.10%	97.00%	96.94%	**97.04%**	**97.04%**	>=96.0%	96.00%
Friends and Family Test Outpatient - Response Rate	13.50%	14.40%	13.90%	13.60%	13.80%	13.50%	13.30%	13.20%	13.10%	12.90%	13.60%	13.70%	13.20%	**13.50%**	**13.50%**	>=5.0%	5.00%
Friends and Family Test Outpatients Survey - % would recommend the Service	89.60%	88.00%	87.90%	88.40%	89.50%	89.20%	89.20%	90.20%	90.50%	91.60%	90.50%	89.70%	90.70%	**90.50%**	**90.50%**	>=95.0%	95.00%
Friends and Family Test A & E Survey - Response Rate	8.50%	**6.80%**	**10.00%**	**8.60%**	**5.70%**	**2.70%**	9.50%	12.10%	9.20%	9.10%	10.20%	9.70%	8.37%	**13.27%**	**13.27%**	>=14.0%	14.00%
Friends and Family Test A & E Survey - % would recommend the Service	86.90%	90.70%	90.50%	91.10%	**91.10%**	84.80%	86.20%	86.80%	81.60%	85.40%	86.50%	84.80%	84.59%	**90.02%**	**90.02%**	>=90.0%	90.00%
Friends & Family Test (Maternity Survey) - Response Rate	30.80%	18.20%	18.90%	26.30%	27.50%	29.60%	42.60%	30.90%	40.80%	33.60%	30.30%	30.70%	34.47%	**26.99%**	**26.99%**	>=22.0%	22.00%
Friends & Family Test (Maternity) - % would recommend the Service	96.30%	94.00%	89.30%	95.30%	97.80%	95.20%	98.80%	95.00%	97.00%	96.50%	97.80%	96.80%	97.82%	**96.32%**	**96.32%**	>=96.9%	96.90%
Friends and Family Test Community - Response Rate	11.60%	8.00%	8.00%	6.00%	7.00%	7.00%	6.00%	2.00%	14.00%	10.00%	11.00%	10.00%	10.00%	**13.20%**	**13.20%**	>=3.4%	3.40%
Friends and Family Test Community Survey - % would recommend the Service	88.80%	91.00%	89.00%	90.68%	92.00%	90.00%	92.00%	91.00%	85.00%	86.00%	87.00%	86.00%	85.80%	**87.50%**	**87.50%**	**>=96.2%**	96.20%
Maternity																	
Proportion of Women who received Combined 'Harm Free' Care	72.43%	77.78%	77.80%	67.70%	70.40%	60.90%	73.50%	76.92%	76.92%	70.73%	91.84%	66.00%	78.95%	**in arrears**	**in arrears**	>=70.9%	70.90%

Caring - What our patients are saying

Some of the positive feedback we have received

Endoscopy HRI - Everyone was very caring and professional. One part of the procedure was tricky and the theatre team supported me very well. Excellent service all round.

Day Surgery - HRI - Friendly, efficient staff from beginning to end. Made to feel at ease by all staff. Thank you.

HRI 15 - Everything first class from when I first arrived to being discharged. Nothing too much effort and every task performed with dignity.

CRH 4C - My care has been superb from entering Day Care, to my operation, to my care on the ward, on all counts. I have felt safe and secure.

A&E - HRI - My father had a fall and was seen almost immediately. Doctor and Nurses kept me informed. Every staff member was courteous and professional.

A&E - CRH - Treatment and care were fantastic. Seen quickly and all staff friendly and polite. Given necessary medication and tests promptly. Great, thanks.

CRH 2CD - Treatment and care were spot on and my dignity was maintained throughout my stay. I was able to leave after 2 days after thorough investigations (CT and MRI scans).

Where can we improve

Appointment times should be staggered as there is too much waiting, ie 4 hours to wait before going to theatre. Car parking charges.

Make discharge less chaotic. Too many visitors per bed for too long a period when in 4 bed bays.

I was admitted just before the weekend so the fact that the Consultants and some of the scans were not available for 2 to 3 days was a source of frustration.

One of my appointments was booked with a Doctor who did not deal with my problem so he arranged for me to be re-booked with another Consultant, which then became a first appointment again. This next appointment came 3 months later but was cancelled 2 weeks before. This may be an administrative problem, but it should not happen.

Staff were very noisy at night, making it difficult to sleep (bed near Nurses' station).

If anything, it would be good if a female Nurse could help with toilet needs. I'm mobile, so I was ok but most found it really embarrassing with a male Nurse. Having quite a wait to see Urologist for treatment when you're in constant pain.

Reduce waiting times and increase available parking.

Responsive - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Emergency Care Standard 4 hours	Improving patient flow through the Emergency Department and the hospital through to discharge into the community is essential . Increased number of patients waited over 8 hours for an inpatient bed. Lack of compliance with achieving 'bed before 11'- this prevents good capacity and demand management The number of patients with a LOS over 10/50/100 days has increased. High number of patients waiting for social assessment and Pacakage of Care (POC)	*Immediate actions* Review of Patient flow team with clear roles and responsibilties Development programme with AED Coordinators to ensure responsibilities clear Daily debrief with key coordinators and Directorate leaders Establishment of robust EOL pathway with clear escalation Trial of twilight transfer team *Continuous Improvement* Safer Patient Flow Programme launched. This includes : 1. Introduce Internal Professional Standards - which includes launch of 'bed before 11' . 2. Launch of the Ambulatory Emergency Care Collaborative - National Programme to deliver improvements in patient experience, reduce LOS, improve patient flow and aid the delivery of the 4 hour ECS. 3. Escalation through SRG to improve system response to delays. 4. Review options for CHFT to provide social care in the community. ECIST review completed and SRG workshop scheduled for 14th June 16	If all actions achieved we will deliver the required performance by the end of Quarter 1, for the month of May we will achieve 94%. **Accountable : ADD Medicine**
Patient Flow	<u>Pre 12 o'clock Discharges</u> The pre 12 o'clock discharges remained in line with last months performance however below the target level of 40% <u>Green Cross</u> The number of patients with a LOS on or over 10/50/100 days has increased. Lack of internal professional standards. Increasing delays due to lack of social assessments and POC . <u>Number of Outliers (Bed Days)</u> Increase LOS from 5.6 to 5.9 days is driving the increase in outliers. This is predominantly due to lack of social work capacity for assessment and social care provision in the community which is impacting on patients within the hospital bed base but also patients in intermediate care and the reablement service.	<u>Pre 12 o'clock Discharges</u> 1.Relaunch of 'bed before 11' commenced. ADN leading by supporting ward sisters with small tests of change to improve compliance. The performance target is 40%. May 16 performance improved with 2 wards now achieving 50%. 2. Divisional Director engaging with consultants with a focus on identification of next day discharges , robust discharge planning, timely completion of TTO's and criteria led discharge. <u>Green Cross</u> 1.Focused MDT discharge planning for all patients over 50/100 days in place. 2. Introduction of internal professional standards. 3. Discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care. 4. Escalation through SRG to improve system response to delays <u>Number of Outliers (Bed Days)</u> 1.Discharge coordinators are pre-screening patients so ensure a coordinated approach prior to social care assessment which prevents delays. 2.Dedicated consultant and junior medical team to support outliers. 3. Escalation to SRG to ensure wider visibility of the reality. 4. Safer Patient Flow Programme (all projects)	<u>Pre 12 o'clock Discharges</u> A daily senior matrons huddle monitoring the 'tests of change' is in place. We expect a month on month improvement of 10% from March to achieve full compliance with the target of 40% the end of Q1. **Accountable : ADN Medicine** <u>Green Cross & Outliers</u> There is no resilience within the system and therefore a reduction of 5% can only be expected in the number of patients on a green cross pathway per month. To be discussed as a key improvement target at SRG **Accountable: Discharge Matron**

Responsive - Key messages

Area	Issues	Corrective Actions	Impact and Accountability
Stroke	**Thrombolysis within one hour** Performance reflects 2 patients who were thrombolyised and then discharged in the month of March. The one that failed the target was due to delay in decision due to medical complexity **Scanned within 1 hour where indicated** Many of the patients who were missed as a 1 hour scan despite meeting the urgent imaging criteria were due to being a late diagnosis of stroke. **90% stay on stroke ward** 83.7% of patients spent 90% of their stay on a stroke ward. This is a slight improvement on last months performance . There was a total of 57 stroke patients within April of which 18 patients did not spend 90% of their time on a stroke ward. The principle reason for this is due to the bed pressures and patients on the rehabilitation wards having a prolonged stay in hospital due to the lack of POC. **% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival** Direct Admission – Patients who were not directly admitted on to the stroke ward from A+E are mainly due to late diagnosis or lack of beds on ASU.	**Thrombolysis within one hour** Learning from this around education to nursing staff around the checking of the thrombolysis drugs. Also we need to have clear communication with CT scan. From the 31st May there will be the introduction of the bleep alert system so Doctors, nurses, CT Scan and porters will all be aware that a patient is arriving and they are ready to deal with these patients. **Scanned within 1 hour where indicated** The stroke audit and data officer has done an audit on this matter that has been shared with weekly stroke group. All scans that meet the criteria to be completed within the hour. This should improve the imaging times in future, the stroke nurses are now also seeing all possible stroke patients to help avoid late/wrong diagnosis' of patients. **90% stay on stroke ward** Actions to get back on plan On going management through patient flow meetings. Close monitoring through the weekly stroke improvment group. **% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival** The stroke team are working with patient flow to prevent outliers. They are also ensuring any outliers that do occur are moved to the appropriate ward ASAP. The stroke nurses are also now personally reviewing all possible stroke patients to help make sure that a larger percentage of stroke patients are provided with the appropriate diagnosis the first time, which should have a positive influence on	Thrombolysis within one hour June 2016 Scanned within 1 hour where indicated June 2016 % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival July 2016 **Accountable : GM IMS Directorate**

Responsive - Key messages

Area	Issues	Corrective Actions	Impact and Accountability
Referral To Treatment	There are increased waiting times for patients who are not clinically urgent due to capacity constraints caused by: Bed capacity and reduced surgical activity in preceding months Consultant sickness Consultant vacancies Junior Doctor strike The impact of this is that generally patients have waited longer than normal for their inpatient operations causing a deterioration in the incomplete target and the above 26 week waits. Reduced capacity within the surgical management team due to the re-planning of surgical work as a result of the bed capacity constraints has led to a reduction in capacity for validation. Increased waiting times due to outpatient capacity shortfalls have also led to a deterioration in the 18 week position and are caused by a reduction in capacity.	Fill vacancies asap – Panels to be held in June for a number of the posts. Provide full cover for sickness at the earliest opportunity Increase length of short term cover to enable recovery of lost capacity Increase operating for new hand surgeon by picking up cases from other surgeons, and thereby reduce waiting times. Ensure an paediatric all day ENT weekend list is scheduled each month. Improve identification of capacity gaps Aim to reduce fallow lists to no more than 1 per week Ensure scheduling meeting is effective, by improved pre-work with specialties. Ensure all long waiting pathways are validated	It is expected that most capacity gaps within the Division will be covered in June which will stop the deterioration of the current position. Validation capacity is now back on track. As a result an improvement is expected in June with performance targets being met in August due to the timelag on the 18 week pathway. **Accountable : ADD Surgery**
Cancer	**Bowel Cancer Screening** Half breach in April due to patient having a high BP which needed to be resolved before treatment but future risks for May where a failure to escalate risks has been identified during weekly performance review meeting **Breast Symptomatic** There were a total of 15 breaches, out ofthe 150 patients seen. In the main breaches related to patients cancelling their appointment , leaving insufficent time to rebook in	**Bowel Cancer Screening** Formal escalation policy developed Improvement to tracking of patients. GMs reminded about attendance at cancer meetings to support trackers **Breast Symptomatic** Ensure capacity in the system to allow earlier booking within the 14 day period.	June 2016 **Accountable : GM for General Surgery** June 2016 **Accountable : GM for General Surgery**

Responsive - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
Accident & Emergency																	
Emergency Care Standard 4 hours	93.88%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%	94.87%	95.26%	91.49%	89.44%	89.30%	**93.87%**	**93.87%**	>=95%	95.00%
A and E 4 hour target - No patients waiting over 8 hours	1351	73	88	78	55	57	60	72	69	84	192	250	273	**108**	**108**	M	M
A&E Ambulance Handovers 30-60 mins (Validated)	103	29	3	3	4	2	3	7	6	1	13	12	20	**10**	**10**	0	0
A&E Ambulance 60+ mins	23	1	0	0	0	1	2	0	0	2	8	2	7	**0**	**0**	0	0
A&E Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0	0
Patient Flow																	
% Daily Discharges - Pre 12pm	19.47%	19.27%	20.20%	20.40%	22.09%	20.89%	20.53%	19.33%	17.43%	19.74%	17.77%	18.51%	16.84%	**16.40%**	**16.40%**	>=40%	40.00
Delayed Transfers of Care	5.13%	7.30%	6.30%	6.20%	7.04%	7.45%	5.30%	4.60%	4.50%	4.50%	3.35%	3.38%	3.30%	**2.90%**	**2.90%**	<=5%	5.00%
Green Cross Patients (Snapshot at month end)	98	72	91	90	96	62	71	91	91	79	91	115	98	**93**	**93**	<=40	<=40
Number of Outliers (Bed Days)	8878	813	791	813	859	628	598	508	730	781	1035	989	883	**769**	**769**	<=495	<=495
Stroke																	
% Stroke patients spending 90% of their stay on a stroke unit	83.00%	88.89%	81.25%	80.39%	66.67%	73.40%	74.60%	97.80%	84.60%	80.00%	94.40%	81.30%	83.70%	**in arrears**	**in arrears**	>=90%	90.00%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	60.67%	51.80%	57.70%	59.30%	53.10%	48.40%	83.00%	65.40%	60.00%	66.70%	58.30%	56.70%	67.60%	**in arrears**	**in arrears**	>=90%	90.00%
% Stroke patients Thrombolysed within 1 hour	55.20%	21.95%	20.00%	12.50%	50.00%	28.57%	80.00%	50.00%	80.00%	50.00%	57.10%	100.00%	80.00%	**in arrears**	**in arrears**	>=55%	55.00%
% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	68.42%	0.00%	64.00%	75.00%	56.52%	75.00%	90.91%	72.00%	75.00%	66.70%	78.94%	50.80%	47.80%	**in arrears**	**in arrears**	**>=90%**	90.00%
Maternity																	
Antenatal Assessments < 13 weeks	91.60%	94.52%	93.10%	91.48%	**92.10%**	91.10%	90.40%	92.40%	92.10%	91.60%	88.10%	89.80%	93.80%	**90.15%**	**90.15%**	>90%	90.00%
Maternal smoking at delivery	9.90%	10.57%	11.30%	12.00%	11.30%	**10.20%**	9.80%	9.30%	8.50%	8.20%	7.80%	10.20%	9.70%	**10.40%**	**10.40%**	<=11.9%	1109.00%
Cancellations																	
% Last Minute Cancellations to Elective Surgery	0.67%	0.72%	0.74%	0.50%	0.71%	0.51%	0.76%	0.43%	0.59%	0.75%	0.62%	0.69%	0.96%	**0.71%**	**0.71%**	<=0.6%	0.60%
Breach of Patient Charter (Sitreps booked with 28 days of cancellation)	2	0	0	0	0	0	0	1	0	0	0	1	0	**0**	**0**	0	0
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0	0

Responsive - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
18 week Pathways (RTT)																	
% Non-admitted Closed Pathways under 18 weeks	98.47%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%	98.44%	98.32%	98.39%	98.17%	**98.42%**	**98.42%**	>=95%	95.00%
% Admitted Closed Pathways Under 18 Weeks	91.92%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	91.63%	92.04%	92.21%	91.86%	91.96%	**92.12%**	**92.12%**	>=90%	90.00%
% Incomplete Pathways <18 Weeks	95.70%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%	95.95%	95.80%	95.70%	**96.16%**	**96.16%**	>=92%	92.00%
18 weeks Pathways >=26 weeks open	139	348	251	246	197	174	137	98	94	126	152	127	139	**186**	**186**	**0**	0
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0	0
% Diagnostic Waiting List Within 6 Weeks	99.54%	99.85%	99.80%	99.89%	99.93%	99.48%	98.56%	99.82%	99.94%	99.65%	98.48%	99.71%	99.52%	**99.71%**	**99.71%**	>=99%	99.00%
Cancer																	
31 Days From Diagnosis to First Treatment	99.81%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%	100.00%	99.12%	99.30%	100.00%	99.09%	100.00%	**99.03%**	**99.03%**	>=96%	96.00%
Two Week Wait From Referral to Date First Seen	97.34%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%	98.73%	96.84%	97.06%	98.86%	99.27%	98.95%	**95.04%**	**95.04%**	>=93%	93.00%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	95.82%	93.33%	93.75%	94.92%	94.87%	98.60%	98.47%	94.85%	95.89%	94.05%	96.85%	96.55%	96.55%	**90.00%**	**90.00%**	>=93%	93.00%

Responsive - Monitor Dashboard

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
Clostridium Difficile																	
Total Number of Clostridium Difficile Cases - Trust assigned	25	2	0	1	1	3	3	4	2	1	3	3	2	**2**	**2**	<=21	< = 2
Avoidable number of Clostridium Difficile Cases	5	1	0	1	0	0	1	1	1	0	0	0	0	**1**	**1**	0	0
Accident & Emergency																	
Emergency Care Standard 4 hours	93.88%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%	94.87%	95.26%	91.49%	89.44%	89.30%	**93.87%**	**93.87%**	>=95%	95%
Referral To Treatment Pathways																	
% Admitted Closed Pathways Under 18 Weeks	91.92%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	91.63%	92.04%	92.21%	91.86%	91.96%	**92.12%**	**92.12%**	>=90%	90%
% Non-admitted closed Pathways under 18 weeks	98.48%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%	98.44%	98.32%	98.39%	98.17%	**98.42%**	**98.42%**	>=95%	95%
% Incomplete Pathways <18 Weeks	95.70%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%	95.95%	95.80%	95.70%	**96.16%**	**96.16%**	>=92%	92%
Cancer																	
62 Day Gp Referral to Treatment	91.19%	**89.38%**	**92.31%**	**90.00%**	**88.95%**	**93.94%**	88.24%	91.77%	95.00%	93.98%	91.04%	94.53%	89.40%	**91.94%**	**91.94%**	>=85%	85%
62 Day Referral From Screening to Treatment	95.74%	85.71%	100.00%	100.00%	**100.00%**	100.00%	100.00%	95.65%	88.24%	96.67%	94.44%	100.00%	100.00%	89.47%	**89.47%**	>=90%	90%
31 Day Subsequent Surgery Treatment	99.15%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=94%	94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%	98%
31 Days From Diagnosis to First Treatment	99.81%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%	100.00%	99.12%	99.30%	100.00%	99.09%	100.00%	**99.03%**	**99.03%**	>=96%	96%
Two Week Wait From Referral to Date First Seen	97.34%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%	98.73%	96.84%	97.06%	98.86%	99.27%	98.95%	**95.04%**	**95.04%**	**>=93%**	93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	95.82%	93.33%	93.75%	94.92%	94.87%	98.60%	98.47%	94.85%	95.89%	94.05%	96.85%	96.55%	96.55%	**90.00%**	**90.00%**	>=93%	93%
Data Completeness																	
Community care - referral to treatment information completeness	50.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=50%	50%
Community care - referral information completeness	98.06%	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%**	**98.06%**	>=50%	50%
Community care - activity information completeness	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%	**100.00%**	**100.00%**	>=50%	50%

Workforce - Monitor Key messages

Area	Issue	Corrective Action	Impact and Accountability
Sickness and Absence	1. Long term absence is above target at 3.11%. 2. Short term absence is below target at 1.49% 3.Return to work interviews are not consistently undertaken.	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. Cases moving from short term to long term are monitored and reviewed by the end of the 2nd week each month. How to conduct a return to work interview video - 16 May 2016 Identify departments who constantly conduct return to work interviews - 30 June 2016 NHS staff health and wellbeing CQUIN plan for health and wellbeing initiatives - 30 June 2016 Information document 'what to expect from a formal review meeting' produced for colleagues - 31 May 2016.	December 2016 **Accountable : Director of Workforce and OD.**
Appraisal	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. 4. Appraisals scheduler completed or submitted for 2016/2017	Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 30 June 2016. Produce clearer rules for the use of the appraisal scheduler in each division – 15 May 2016. Confirm with DDs, ADDs and appraisal leads activity plans submissions - 31 May 2016 Review the current appraiser training offer and increase the opportunities to participate – 15 June 2016.	30 June 2016 **Accountable : Director of Workforce and OD**.
Mandatory Training	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. There is an absence of a sanction for non-compliance. 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.	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. Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 May 2016. Establish what alternative delivery methods are available within the DH requirement to provide PREVENT training – Paper to be submitted to Exec board by 2 June 2016 Reviewing Mandatory Training Compliance requirement in light of EPR implementation - 9 June 2016	30 June 2016 **Accountable : Director of Workforce and OD.**

Workforce Information - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
Sickness YTD																	
Sickness Absence rate (%) **Target date** - 31 Dec 2016	4.60%	4.42%	4.57%	4.53%	4.49%	4.44%	4.38%	4.44%	4.52%	4.58%	4.61%	4.62%	4.60%	*	**4.60%**	4.00%	***
Long Term Sickness Absence rate (%) **Target date** - 31 Dec 2016	3.11%	3.02%	3.16%	3.15%	3.14%	3.11%	3.05%	3.05%	3.09%	3.12%	3.13%	3.12%	3.11%	*	**3.11%**	2.70%	***
Short Term Sickness Absence rate (%) **Target date** - 31 Dec 2016	1.49%	1.40%	1.41%	1.37%	1.34%	1.33%	1.33%	1.39%	1.43%	1.45%	1.49%	1.50%	1.49%	*	**1.49%**	1.30%	***
Sickness Monthly																	
Sickness Absence rate (%)		4.42%	4.71%	4.45%	4.36%	4.23%	4.13%	4.76%	5.08%	5.03%	4.95%	4.71%	4.34%	*	**4.60%**	4.00%	***
Long Term Sickness Absence rate (%)		3.02%	3.29%	3.15%	3.11%	2.95%	2.79%	3.02%	3.34%	3.42%	3.15%	3.05%	2.96%	*	**2.96%**	2.70%	***
Short Term Sickness Absence rate (%)		1.40%	1.42%	1.30%	1.25%	1.28%	1.33%	1.73%	1.74%	1.61%	1.81%	1.66%	1.38%	*	**1.38%**	1.30%	***
Attendance Management KPIs																	
Sickness returns submitted per month (%) **Target date** - 30 April 2016	76.00%											100.00%	100.00%	*		100.00%	***
Return to work Interviews (%) **Target date** - 31 Dec 2016	38.00%											43.15%	33.10%	*		100.00%	***
Number of cases progressing/not progressing from short term absence to long term absence												***	9 / 556	*			***
Long Term Sickness cases with a defined action plan **Target date** - 30 April 2016												100.00%	100.00%	*		100.00%	***
Number of short term absence cases managed at each stage in the formal procedure												***	344	*			***
Number of visits to dedicated intranet web pages.												1261	1514	*			***
Staff in Post																	
Staff in Post Headcount	5820	5795	5779	5731	5697	5701	5753	5701	5732	5724	5755	5809	5820	**5820**			***
Staff in Post (FTE)	5090.64	5016.37	5004.32	4963.08	4933.58	4944.57	4993.82	4963.35	5000.02	4993.44	5027.39	5081.93	5090.64	**5083.45**			***
Staff Movements																	
Turnover rate (%)		1.65%	1.37%	1.37%	1.32%	1.24%	2.40%	0.97%	1.18%	0.99%	1.13%	0.64%	0.82%	**0.73%**			***
Turnover rate (%)(Rolling 12m)	14.47%	14.00%	14.62%	15.24%	15.73%	15.80%	16.69%	16.46%	16.33%	16.44%	16.51%	16.40%	14.88%	**14.47%**			***
Vacancies																	
Vacancies (FTE)**	484.70	Data unavailable for this period										387.12	484.70	**494.92**			***

*	Data One month behind
**	Vacancy information is updated monthly and is based on the funded establishment in ESR, this is fed by the establishment
***	Indicator in development

Training - Key measures

	Renewal Period	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/Monthly
Mandatory Training																		
Fire Safety	1 Year Refresher	73.38%	Packages launched 01 Jun 2015		19.00%	26.70%	31.50%	34.40%	60.80%	61.80%	63.50%	68.70%	73.10%	73.40%	**7.52%**	7.52%	100.00%	8.00%
Information Governance	1 Year Refresher	84.24%			73.20%	73.30%	70.30%	70.90%	72.20%	72.90%	76.50%	79.10%	82.30%	84.20%	**5.68%**	5.68%	100.00%	8.00%
Infection Control	1 Year Refresher	85.07%			8.50%	22.10%	31.40%	39.20%	49.30%	58.40%	66.70%	73.00%	80.90%	85.10%	**6.07%**	6.07%	100.00%	8.00%
Manual Handling	2 Year Refresher	86.73%			8.10%	21.40%	31.30%	39.30%	58.60%	65.40%	72.00%	77.40%	83.10%	86.70%	**88.36%**	88.36%	100.00%	100.00%
Health & Safety	3 Year Refresher	84.60%			7.90%	21.10%	31.10%	38.50%	48.60%	58.40%	66.50%	73.00%	80.40%	84.60%	**86.80%**	86.80%	100.00%	100.00%
Equality & Diversity	3 Year Refresher	85.89%			18.90%	29.00%	37.70%	46.10%	56.00%	63.30%	70.40%	75.80%	82.40%	85.90%	**87.61%**	87.61%	100.00%	100.00%
Safeguarding	3 Year Refresher	78.34%			4.00%	12.20%	19.60%	25.20%	57.90%	61.00%	66.00%	69.80%	73.60%	78.30%	**81.09%**	81.09%	100.00%	100.00%
Dementia	3 Year Refresher	81.88%							8.40%	32.90%	54.10%	65.20%	76.60%	81.90%	**84.90%**	84.90%	100.00%	100.00%
Conflict Resolution	3 Year Refresher	77.63%			Packages launched 01 Oct 2015				7.40%	27.80%	47.70%	58.70%	70.80%	77.60%	**81.73%**	81.73%	100.00%	100.00%
Prevent	No Renewal	61.59%	16.00%	21.20%	32.70%	33.60%	35.50%	37.50%	39.90%	43.40%	51.40%	51.80%	54.80%	61.60%	**63.71%**	63.71%	100.00%	100.00%
Appraisal																		
Appraisal	1 Year Refresher	78.57%	1.50%	4.10%	7.24%	10.74%	14.46%	25.17%	33.42%	45.70%	56.50%	60.10%	74.10%	78.57%	**6.71%**	**4.60%**	100.00%	8.00%

Staffing - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/Monthly
Hard Truths																	
Hard Truths Summary - Nurses/Midwives														**90.51%**	**90.51%**	100%	100%
Hard Truths Summary - Day Care Staff														**103.59%**	**103.59%**	100%	100%
Hard Truths Summary - Night Nurses/Midwives														**94.84%**	**94.84%**	100%	100%
Hard Truths Summary - Night Care Staff														**120.13%**	**120.13%**	100%	100%
FFT Staff																	
FFT Staff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4															**82.00%**		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4															**64.00%**		

Financial Position

FINANCIAL POSITION

YEAR TO DATE POSITION: M01

	M01 Plan £m	M01 Actual £m	Var £m	
Total Income	**£29.68**	**£29.94**	**£0.26**	
Total Expenditure	**(£30.42)**	**(£31.05)**	**(£0.63)**	
EBITDA	**(£0.74)**	**(£1.11)**	**(£0.37)**	
Non Operating Expenditure	(£2.12)	(£2.05)	£0.07	
Deficit excl. Restructuring	**(£2.86)**	**(£3.16)**	**(£0.30)**	
Restructuring Costs	£0.00	£0.00	£0.00	
Surplus / (Deficit)	**(£2.86)**	**(£3.16)**	**(£0.30)**	

YEAR END 2016/17

	Plan £m	Forecast £m	Var £m	
Total Income	**£371.32**	**£373.00**	**£1.69**	
Total Expenditure	**(£361.97)**	**(£364.46)**	**(£2.49)**	
EBITDA	**£9.35**	**£8.55**	**(£0.80)**	
Non Operating Expenditure	(£25.45)	(£24.65)	£0.80	
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**	
Restructuring Costs	£0.00	£0.00	£0.00	
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**	

KEY METRICS: YEAR TO DATE M01

Year To Date

	M01 Plan £m	M01 Actual £m	Var £m	
I&E: Surplus / (Deficit)	(£2.86)	(£3.16)	(£0.30)	
Capital	£1.23	£0.95	£0.28	
Cash	£1.94	£1.92	(£0.02)	
Borrowing	£36.95	£36.95	£0.00	
CIP	£0.64	£0.59	(£0.05)	
Financial Sustainability Risk Rating	2	2		

KEY METRICS: YEAR END 2016/17

Year End: Forecast

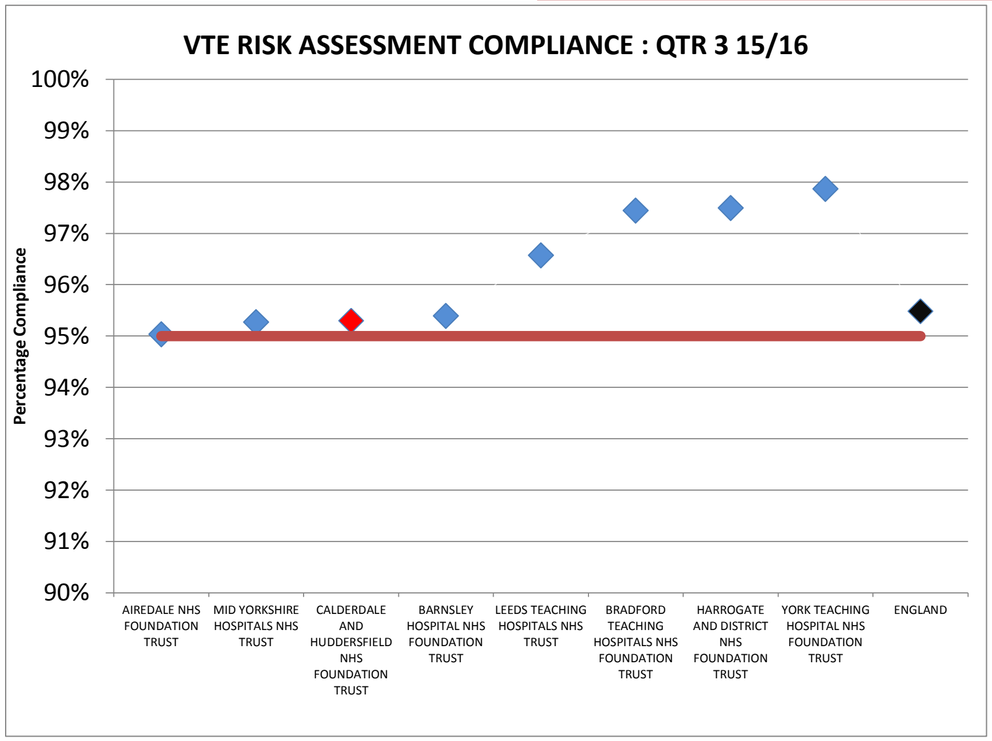
	Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£16.10)	(£16.10)	£0.00	
Capital	£28.22	£28.22	£0.00	
Cash	£1.95	£1.95	£0.00	
Borrowing	£67.87	£67.87	£0.00	
CIP	£14.00	£14.00	£0.00	
Financial Sustainability Risk Rating	2	2		

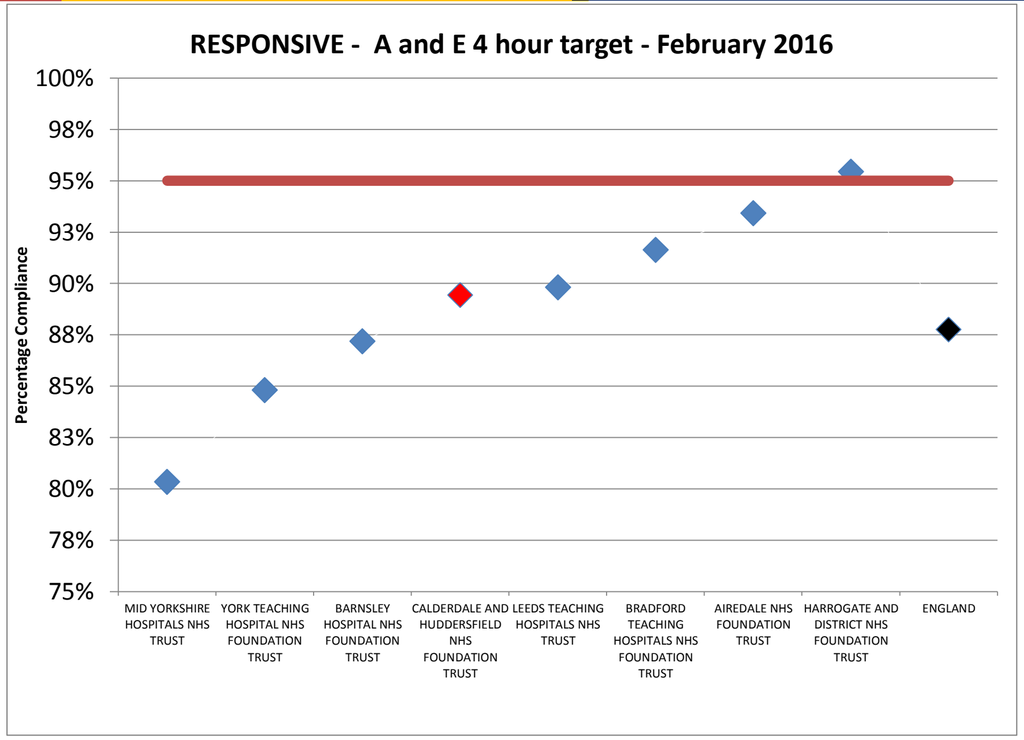
RAG KEY: (Excl: Cash)
- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

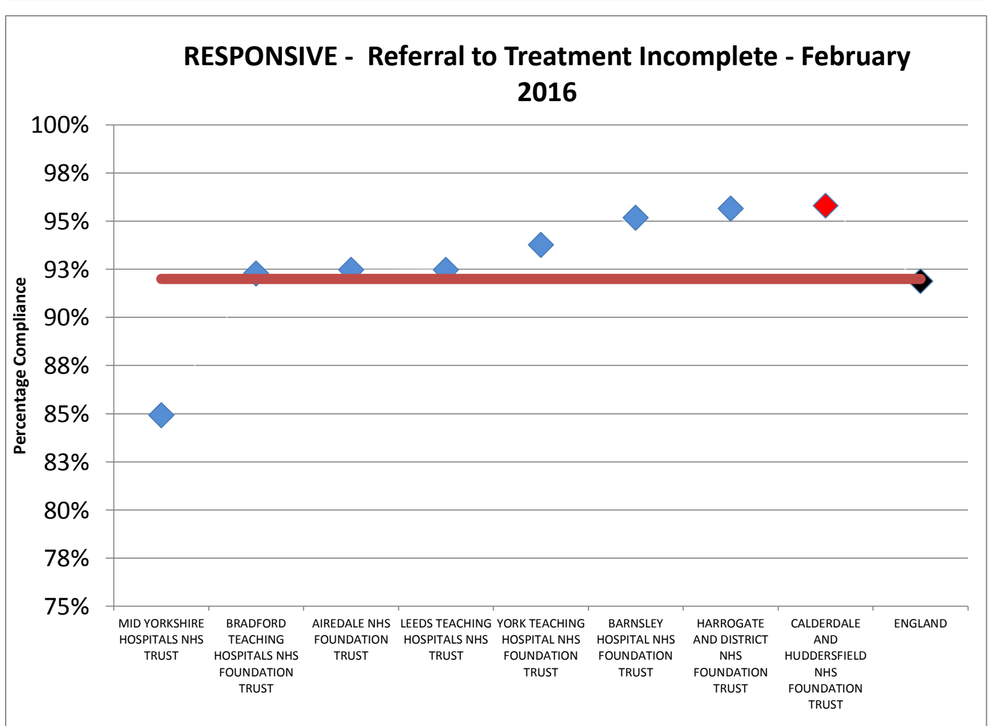
NB. In addition to the above rules, if Capital expenditure <85% of planned then Red, (per Monitor risk indicator)

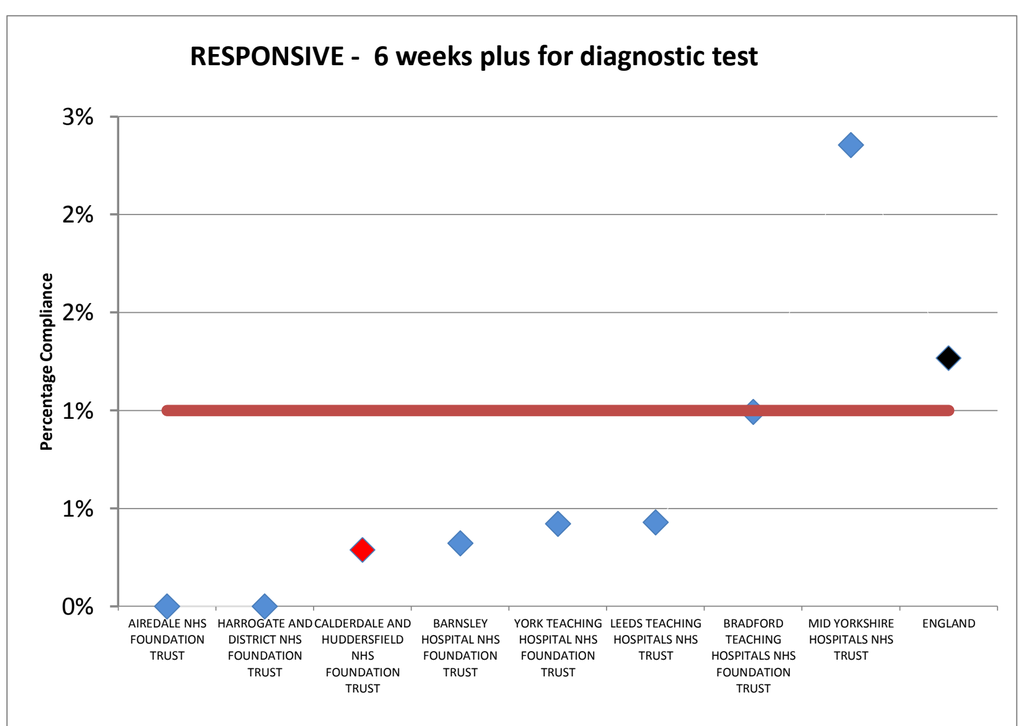
RAG KEY - Cash:
- At or above planned level or > £18.6m (20 working days cash)
- < £18.6m (unless planned) but > £9.3m (10 working days cash)
- < £9.3m (less than 10 working days cash)

Benchmarking - Selected Measures

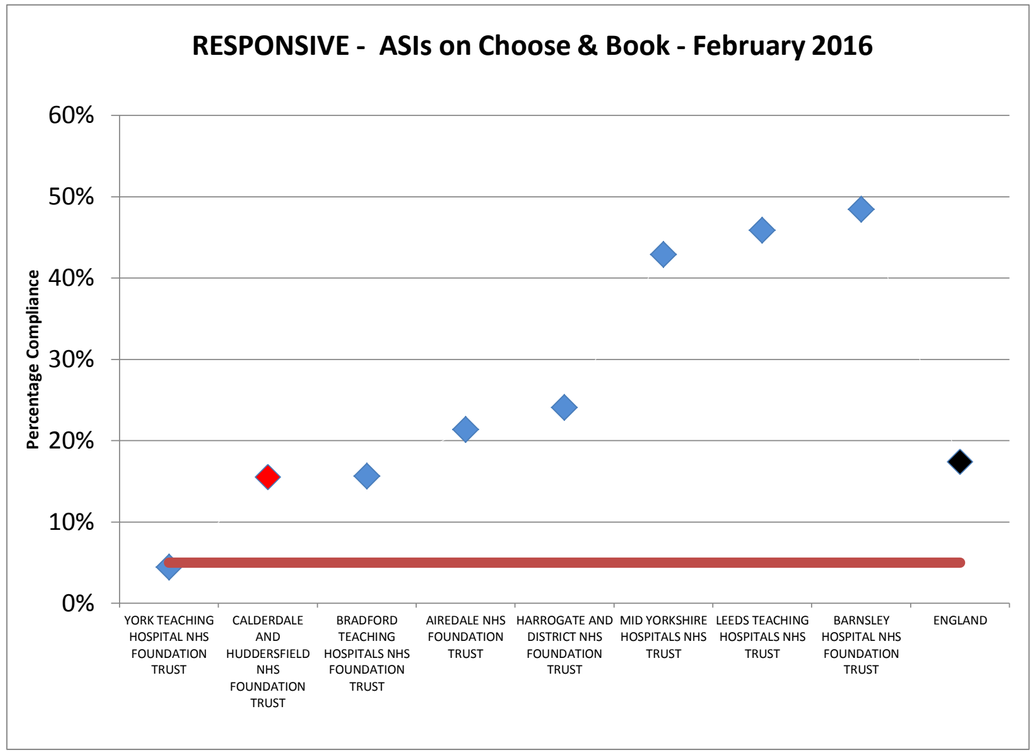


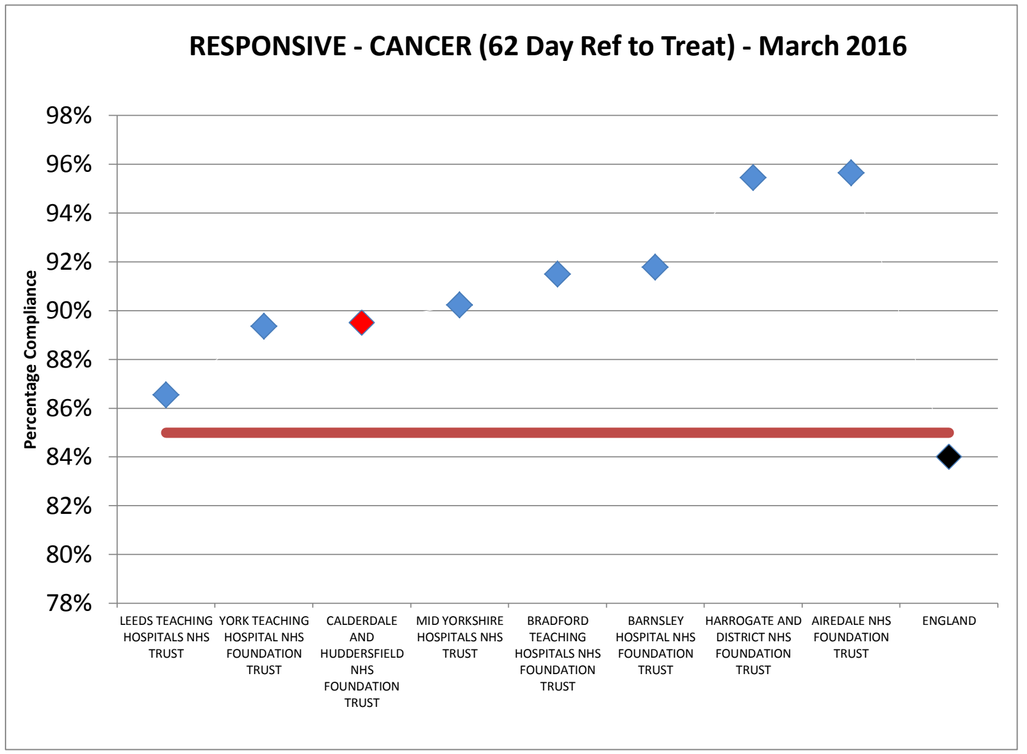


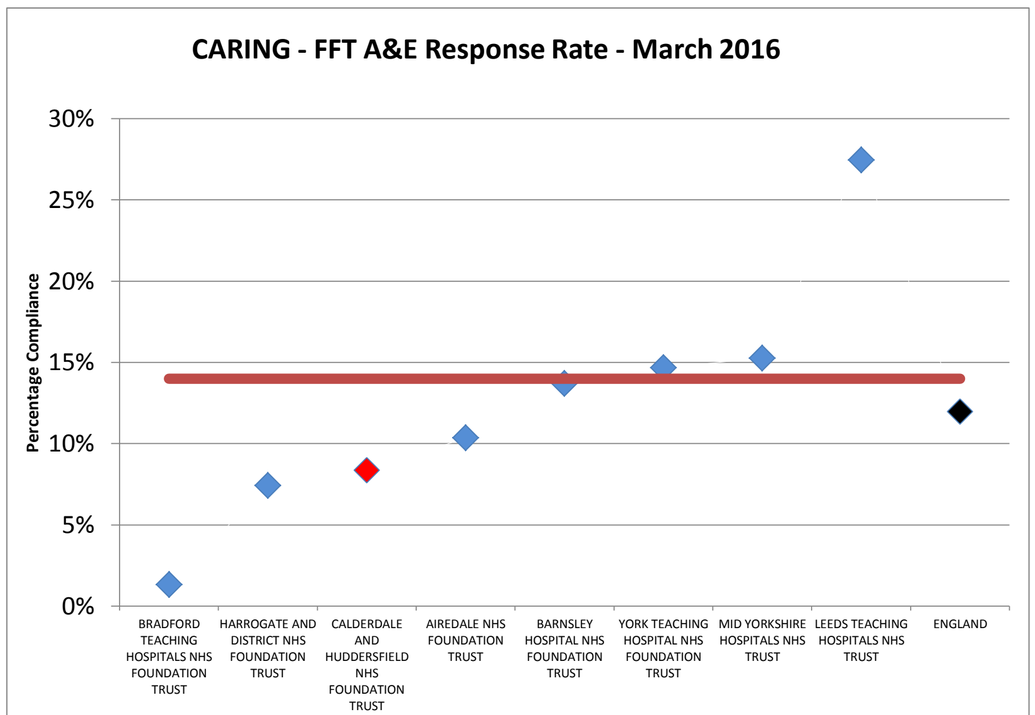


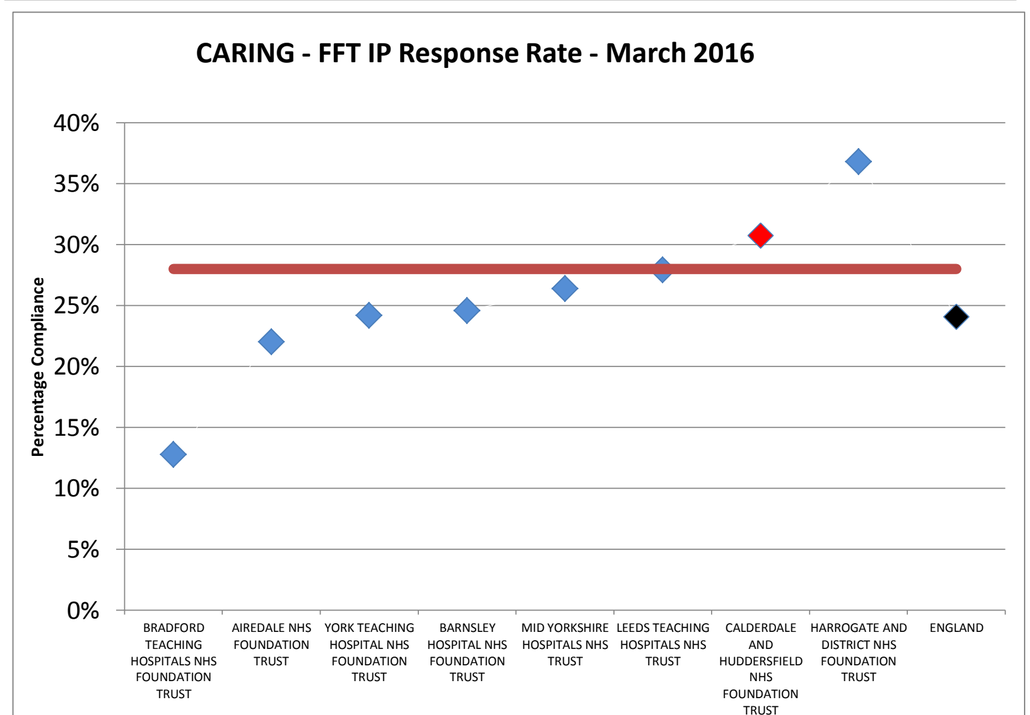


Benchmarking - Selected Measures







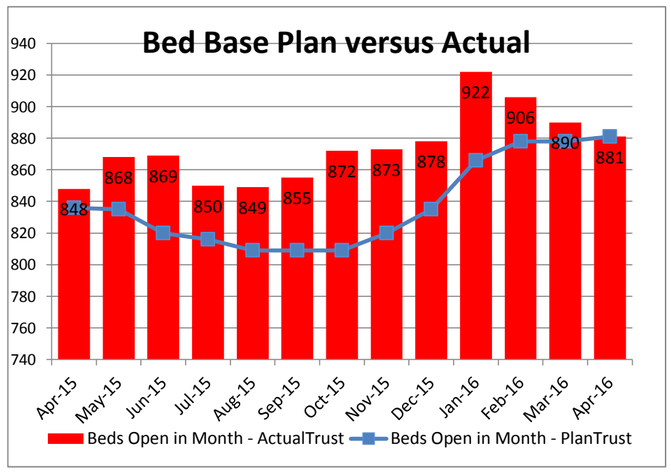


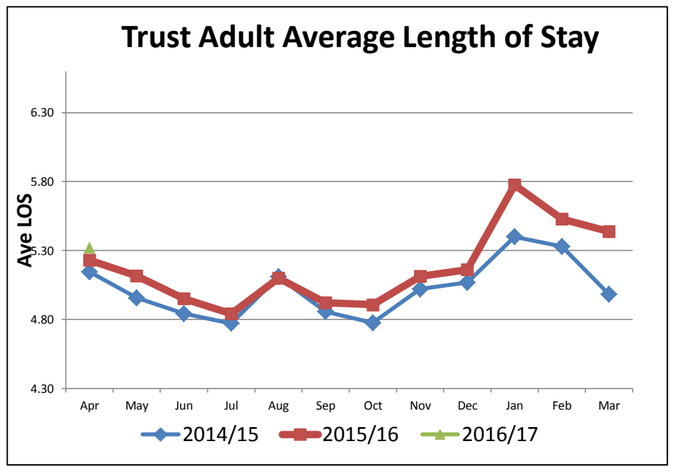
Efficiency & Finance - Efficiency Key Messages

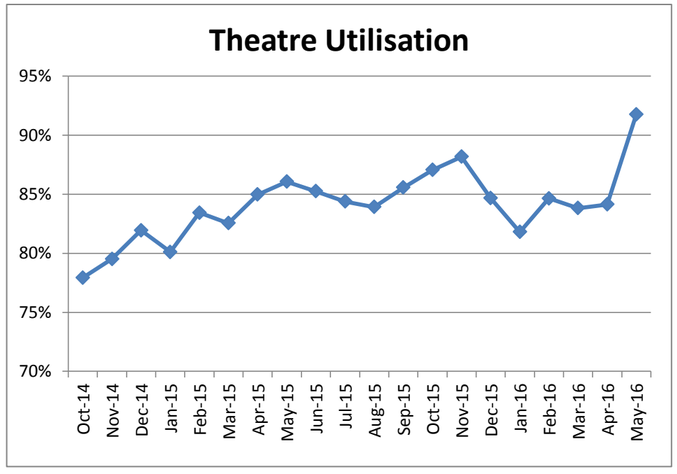
Area	Issue	Corrective Actions	Impact and Accountability
Theatre Utilisation	Bed capacity restricted at the start of the month Insufficiently filled lists Large number of patient cancellations .	Review pre-assessment call out service to confirm patient is ready for surgery, confirm the date and ensure no clinical reasons for cancellation are known at that point Review all unfilled lists in the weekly scheduling meeting Theatre productivity slots on this month's consultant audit session to talk to consultant groups about the importance of theatre utilisation and share the most recent data. 1-2-1 consultant discussions where needed Continued involvement from the service improvement team . Refreshed service improvement group. Involvement of membership councillor to support us with our service improvement approach Ensure planned session lengths are correct in bluespier.	May is currently tracking at 92% utilisation for all theatres across the Trust, broken down as follows: CRH 89% (April 87%) DSU 85% (April 75%) HRI main 108% (April 87%) SPU 89% (April 80%) The Division will be working hard with clinical specialties to maintain that position for the remainder of the month. **Accountable: GM for Theatres**
Surgical Activity Variance	The service experienced capacity shortages due to: **Daycase / elective** Bed retraction 29 SPELLS Jnr Dr Strike 47 SPELLS Vacancy / sickness 8 wte 120 SPELLS **Outpatients** 500 outpatient slots lost due to junior doctor strike	Fill vacancies asap – Panels to be held in June for a number of the posts. Provide full cover for sickness at the earliest opportunity Increase length of short term cover to enable recovery of lost capacity Increase operating for new hand surgeon by picking up cases from other surgeons, and thereby reduce waiting times. Improve identification of capacity gaps Aim to reduce fallow lists to no more than 1 per week Ensure scheduling meeting is effective, by improved pre-work with specialties.	There is a continued capacity gap in General Surgery due to consultant absence. It is anticipated that the service will be able to deliver contract activity from June onwards. T&O have no current capacity gaps however, there may performance has been affected by capacity. Additional list capacity has been found with a plan to implement in the last week of May leading to performance being back on track in June. ENT have a capacity gap due to vacancy. A locum was in place to support this service, but has now left the organisation. Due to the size of the loss in April it will not be possible to recover the lost activity from April in May. A recovery plan is being developed to look at how lost capacity can be regained across these specialties. Other specialties are either currently on track or over performing in May. **Accountable: ADD Surgery**

Efficiency & Finance - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
Did Not Attend Rates																	
First DNA	6.80%	6.91%	6.83%	6.65%	7.86%	7.07%	6.52%	6.64%	6.55%	7.22%	6.37%	6.26%	6.80%	**6.60%**	**6.60%**	<=7%	7.00%
Follow up DNA	7.70%	7.96%	8.44%	7.66%	8.65%	7.91%	8.19%	7.54%	7.21%	7.63%	6.79%	6.60%	7.17%	**6.48%**	**6.48%**	<=8%	8.00%
Average length of stay																	
Average Length of Stay - Overall	5.17	5.23	5.11	4.95	4.85	5.11	4.88	4.91	5.11	5.16	5.78	5.53	5.45	**5.32**	**5.32**	<=5.17	5.17
Average Length of Stay - Elective	2.85	2.64	2.75	2.87	2.72	2.90	2.82	2.73	2.89	2.80	3.25	2.92	3.07	**2.54**	**2.54**	<=2.85	2.85
Average Length of Stay - Non Elective	5.63	5.77	5.59	5.41	5.31	5.57	5.34	5.36	5.62	5.60	6.24	5.96	5.79	**5.85**	**5.85**	<=5.63	5.63
Day Cases																	
Day Case Rate	85.00%	85.22%	84.64%	85.15%	85.14%	84.52%	84.74%	84.55%	84.30%	86.34%	86.35%	87.90%	88.50%	**86.40%**	**86.40%**	>=85%	85.00%
Failed Day Cases	1440	131	137	**121**	132	116	147	136	119	93	103	112	93	**138**	**138**	120	120
Elective Inpatients with zero LOS	1630	152	118	171	163	136	152	132	142	122	135	110	97	**117**	**117**	136	136
Beds																	
Beds Open in Month - Plan	10011	836	835	820	816	809	809	809	820	835	866	878	878	**881**	**881**	Not applicable	
Beds Open in Month - Actual	10480	848	868	869	850	849	855	872	873	878	922	906	890	**881**	**881**	Not applicable	
Theatre Utilisation																	
Theatre Utilisation (TT) - Main Theatre - CRH	86.05%	87.57%	87.28%	87.10%	86.18%	85.64%	89.70%	88.07%	88.30%	85:93%	80.13%	81.36%	83.99%	**87.41%**	**87.41%**	>=92.5%	92.50%
Theatre Utilisation (TT) - Main Theatre -HRI	94.92%	91.46%	95.08%	96.08%	93.73%	89.87%	93.13%	96.00%	99.25%	95.01%	92.02%	101.14%	88.36%	**89.04%**	**89.04%**	>=92.5%	92.50%
Theatre Utilisation (TT) - HRI DSU	78.04%	75.69%	75.67%	76.41%	76.50%	75.31%	79.83%	81.42%	82.36%	76.33%	76.58%	79.92%	78.00%	**75.08%**	**75.08%**	>=92.5%	92.50%
Theatre Utilisation (TT) - HRI SPU	82.73%	80.30%	84.46%	83.48%	85.03%	**84.41%**	81.97%	80.01%	81.94%	80.94%	82.01%	83.98%	84.68%	**79.95%**	**79.95%**	>=92.5%	92.50%







Activity - Key measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	YTD % Change
GP referrals to all outpatients																
02T - NHS CALDERDALE CCG	41514	3445	3419	3586	3514	3194	3681	3693	3368	2989	3555	3437	3651	**3743**	**3743**	8.7%
03A - NHS GREATER HUDDERSFIELD CCG	38568	3075	3069	3456	3357	2921	3465	3423	3206	2862	3171	3241	3367	**3296**	**3296**	7.2%
03J - NHS NORTH KIRKLEES CCG	2816	227	199	256	227	193	222	243	224	198	246	296	299	**279**	**279**	22.9%
02R - NHS BRADFORD DISTRICTS CCG	3047	241	252	251	280	232	271	273	265	213	283	244	250	**240**	**240**	-0.4%
03R - NHS WAKEFIELD CCG	437	41	34	41	36	26	40	37	29	25	35	48	52	**56**	**56**	36.6%
02W - NHS BRADFORD CITY CCG	520	22	42	37	35	58	53	66	41	49	39	40	37	**24**	**24**	9.1%
01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	206	5	10	3	17	8	22	23	19	9	25	35	30	**42**	**42**	740.0%
03C - NHS LEEDS WEST CCG	78	7	3	10	6	6	10	6	3	5	7	4	11	**5**	**5**	-28.6%
02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG	61	4	4	**9**	5	7	3	5	7	5	6	2	6	**6**	**6**	50.0%
03G - NHS LEEDS SOUTH AND EAST CCG	18	**3**	**2**	**2**	**3**	**0**	2	0	4	2	0	1	0	**0**	**0**	-100.0%
02V - NHS LEEDS NORTH CCG	18	3	2	2	**3**	0	2	0	4	2	0	1	0	**0**	**0**	-100.0%
Other	978	76	62	79	97	64	74	71	96	82	103	90	99	**65**	**65**	-14.5%
Total	88261	7148	7099	7730	7579	6711	7846	7841	7263	6442	7471	7438	7803	**7758**	**7756**	8.5%
% Change on Previous year	3.5%	-0.9%	1.2%	9.4%	-2.0%	6.1%	4.9%	0.9%	7.1%	4.0%	16.3%	1.0%	-3.0%	**8.5%**	**8.5%**	
Activity																
% of spells with > 5 ward movements (No Target)	0.06%	0.08%	0.06%	0.07%	0.03%	0.03%	0.09%	0.06%	0.06%	0.06%	0.02%	0.16%	0.04%	**0.06%**	**0.06%**	0.0%

ACTIVITY VARIANCE AGAINST CONTRACT																
Day Case activity variance														**9**	**9**	
Day Case activity variance %age														**0.3%**	**0.3%**	
Elective Inpatient activity variance														**-107**	**-107**	
Elective Inpatient activity variance %age														**-14.5%**	**-14.5%**	
Non Elective activity variance														**-69**	**-69**	
Non Elective activity variance %age														**-1.6%**	**-1.6%**	
Outpatient activity variance														**-96**	**-96**	
Outpatient activity variance %age														**-0.3%**	**-0.3%**	
Accident and Emergency activity variance														**-212**	**-212**	
Accident and Emergency activity variance %age														**-1.7%**	**-1.7%**	

Please note further details on the referral position is available within the appendix.

CQUIN - Key Messages

Area	Issues	Corrective Actions	Impact and Accountability
CQUINS	There are several CQUINs which have not yet been assigned a target / threshold. A large proportion of them are establishing baseline measures in Q1.		
Staff Wellbeing:	At present the Staff Wellbeing is on plan to hit all Q1 Targets however a risk is being raised in achieving the third element, regarding 75% of front line staff receiving the Flu Vaccination. Previous year saw year end at 53%. The final payment is staged, 0-50% vaccinated = £0	The campaign planning is already underway, with a number of event scheduled over Q1/Q2 to engage with the vaccinators from last year and address what barriers there were.	The Campaign starts in September 16 and Ends in December 16,. Performance will be monitored weekly during this stage. **Accountable: Director of Workforce**
Sepsis	At present the Sepsis CQUIN is on plan to hit 3 out of 4 Q1 Targets, a risk is being raised in achieving 90% of patients screened in ED for Q1. Performance is reducing on last years' year end of 70%. The lead for the work is looking over the cases to further understand why this is.	The risk to performance has been noted and urgent meeting s with ED leads in place to decide on remedial action.	The Q1 payment is staged. 0-50% = £0 50% - 90% = £16,235.06 >90% = £32,470.12 It is not anticipated that the 90% target will be met, But corrective action will ensure over 50%.
Antimicrobial Resistance	At present this CQUIN is in on plan to hit all Q1 Targets however a risk is being raised in achieving the third and fourth quarter performance. Each Quarter will see performance targets rise by 25%. The risk to achieving the 1% reduction is not known as baseline data is currently being gathered.	Sampling criteria has been established at the team are underway with collecting the baseline data. Once this is understood, the barriers to compliance can be addressed. Regular meetings have been set up to drive this forward.	Further detail around internal trajectories will be known at the end of Q1 **Accountable: Director of Pharmacy**

CQUIN - Key measures

	£ Annual Value	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Target	Threshold/ Monthly
Staff Well Being																
Well Being Iniatives	£649,402.30	Plan in Development for three Iniatives - Mental Health, Physical Health, MSK access													Qrtly Written Rpt to Commissioner	
Healthy Food for Visitors	£649,402.30	submit national data collection returns by July													Qrtly Written Rpt to Commissioner	
Flu Vaccination Uptake	£649,402.30	Campaign Starts in September 16												**in arrears**	>75%	>75%
Sepsis																
% of patients Screened (admission Units)	£129,880.46	53.00%												**53.00%**	>90%	90.00%
% of patients receiving Antibiotic in timeframe and undertake Antibiotic Review (admission units)	£194,820.69	in arrears												**in arrears**	Yr End = To be agreed post Q2	Q1 = Baseline Data Only
% of patients Screened (Inpatients)	£129,880.46	in arrears												**in arrears**	>90%	Q1 = Baseline Data Only
% of patients receiving Antibiotic in timeframe and undertake Antibiotic Review (inpatients)	£194,820.69	in arrears												**in arrears**	>90%	Q1 = Baseline Data Only
Antimicrobial Resistance																
Antibiotic Consumption - All	£259,760.92	in arrears												**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Antibiotic Consumption - Carbopenum	£129,880.46	in arrears												**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Antibiotic Consumption - piperacillin -tazobactam	£129,880.46	in arrears												**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Empiric review of antibiotic prescriptions within 72 hours	£129,880.46	in arrears												**in arrears**	>90%	Q1 = >25%
Safety Huddle (SH) Roll Out																
Number of Wards with SHs in place	£1,168,924.14	2												**2**	**8**	2
Ulcer perfomance on SH ward		#N/A												**#N/A**	TBC - Post Q1 data	Q1 = Baseline Data Only
Falls perfomance on SH ward		#N/A												**#N/A**	TBC - Post Q1 data	Q1 = Baseline Data Only
Self Administration of Medication																
% of patients assessed for self medication	£389,641.38	67.00%												**67.00%**	**>=50%**	50.00%
Hospital at Night																
Roll out of System	£1,168,924.14	Technical specification complete, testing started													Qrtly Written Rpt to Commissioner	
Community Experience																
Service Users experience of Community Care	£519,521.84	Reporting tool in development													TBC - Post Q1 data	Q1 = Tool Dev

Appendices

Appendix - Efficiency Key Measures

BEDS

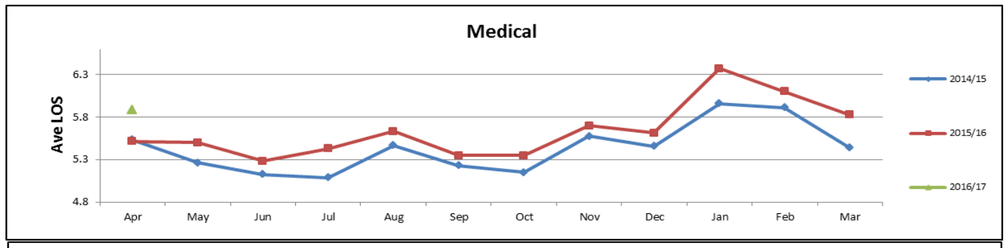
Divisional Breakdown of Bed Base - Plan versus Actual - 2016 / 2017

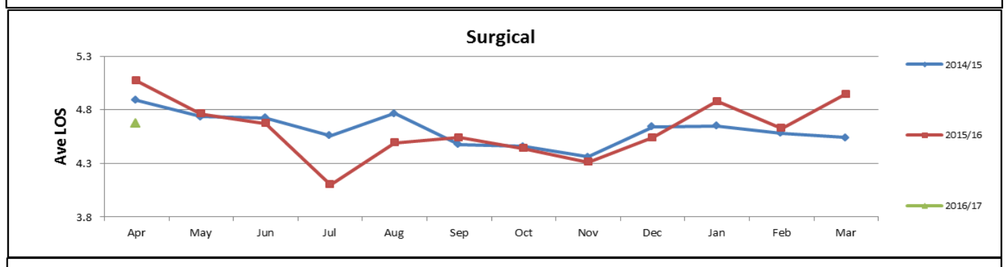
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Surgical Bed Base Plan	213	213	213	193	193	193	193	193	193	193	193	193
FSS Bed Base Plan - Adult	16	16	16	16	16	16	16	16	16	16	16	16
Paediatrics	43	43	43	43	43	43	43	43	43	43	43	43
Mother	63	63	63	63	63	63	63	63	63	63	63	63
Cots (inc NICU)	80	80	80	80	80	80	80	80	80	80	80	80
FSS Bed Base Plan - TOTAL	202	202	202	202	202	202	202	202	202	202	202	202
FSS Bed Base Actual	202											
Medical Bed Base Plan core	451	451	451	451	451	451	451	451	451	451	451	451
Flex	15	15	15	0	0	0	15	25	39	46	39	39
Medical Bed Base Plan - TOTAL	466	466	466	451	451	451	466	476	490	497	490	490
Medical Bed Base Actual	470											
TRUST Bed Base Plan - TOTAL	881	881	881	846	846	846	861	871	885	892	885	885
TRUST Bed Base - ACTUAL	881											
Beds Above (+ve) / Below (-ve) Plan	0											

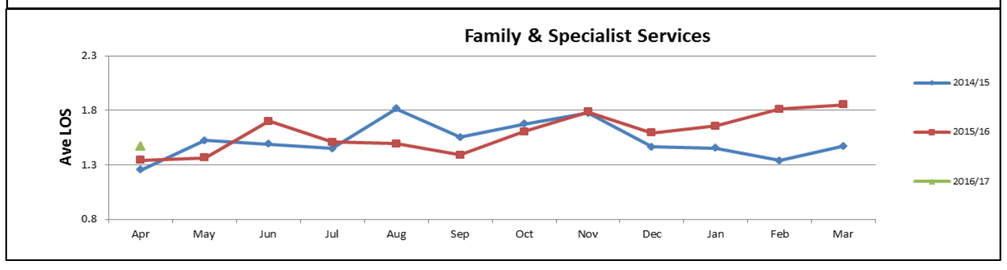
AVERAGE LENGTH OF STAY

- Trust length of stay (LOS) reduced in April, but still was higher than the March 2015 figure. This reduction relates to the Surgical and FSS divisions.
- It is the elective LOS that has reduced markedly
- Regards medical LOS IP LOS in month was 5.9 days, remaining high (plan is 5.6 days).

- Contributing factors as follows -
- Increase in Medical green x patients – from 88 to 93 as at 30 April 2016 (profile is set at 70)
- Significant number of outliers increases inefficiency .. avg 25 per day in April 2016
- High bed occupancy levels – 98% in month.
- Lack of nursing home / intermediate care beds
- Pressures within primary care



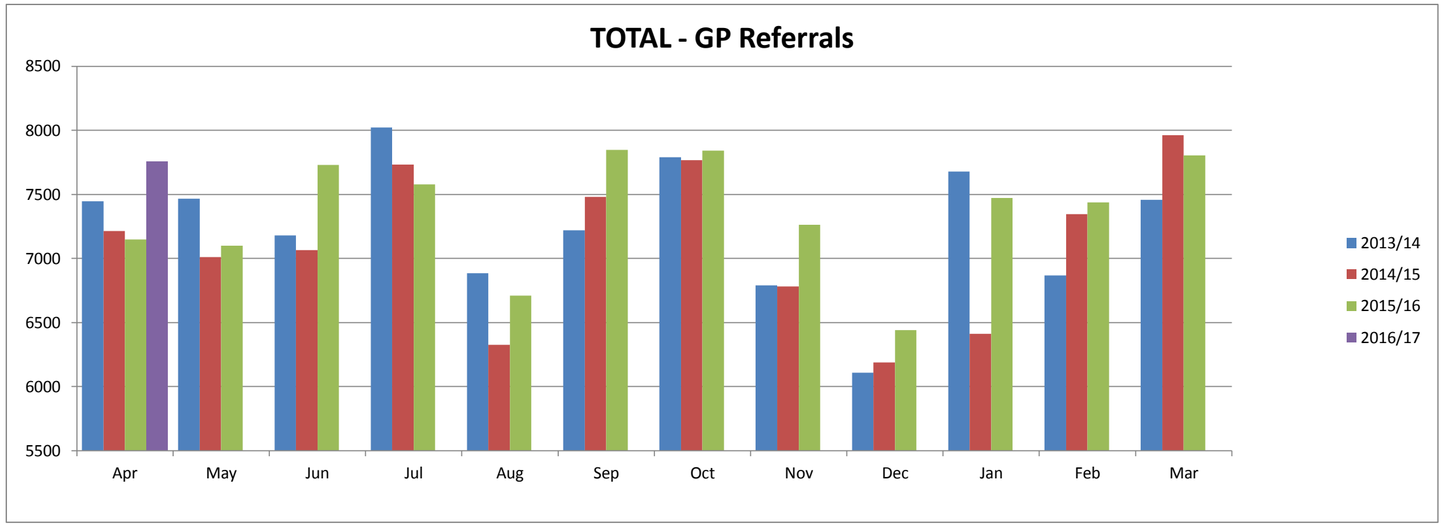




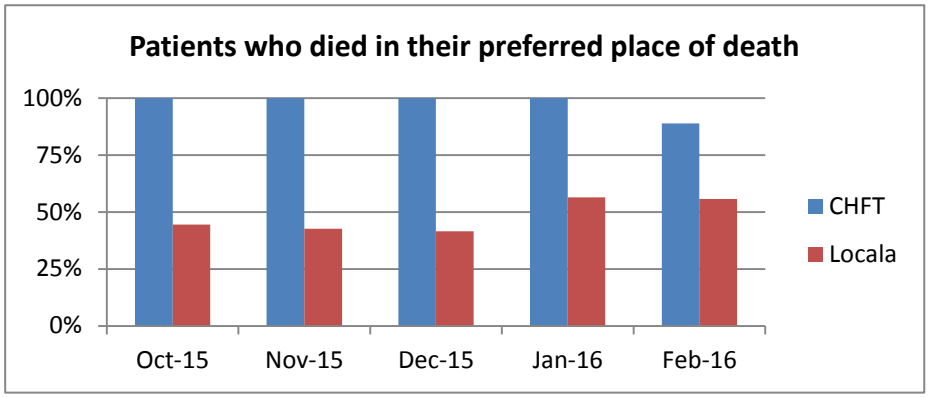
Appendix - Referrals

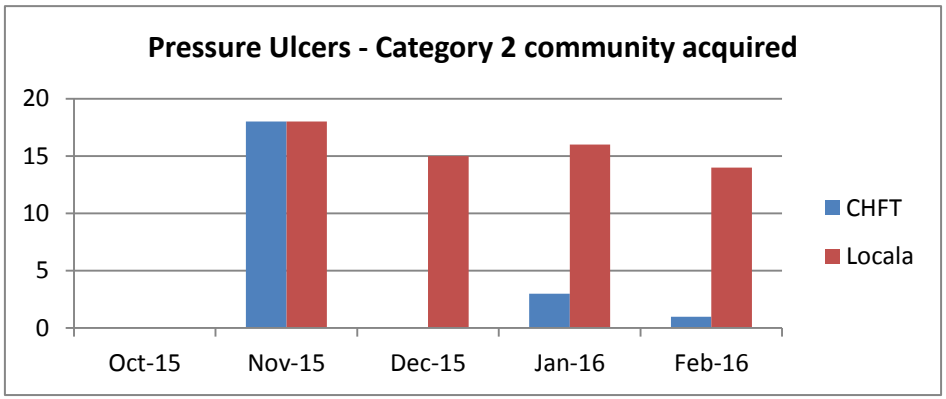
KEY MESSAGES

- GP Referrals up 8.4% in April 2016 compared with April 2015
- With one more working day in April 16 one expects an increase in referrals of 5.0% only. Easter in April 15 impacts also.
- Non GP referrals (37% of all referrals) up 3.8% YTD
- NHS Calderdale GP referrals increase of 8.7% (298) principally due to Orthopaedics 23% (142), Cardiology 24% (55) and Cardiology 30% (38)
- NHS Greater Huddersfield GP referrals increase of 7.2% (221) principally due to Gastroenterology 40% (57) and Cardiology 29% (33)
- There have been notable GP referral increases in April 16 compared with April 15 for NHS North Kirklees, NHS Wakefield and particlularly NHS Heywood, Middleton and Rochdale.
- At April's Finance and Performance committee (F&PC) a scoping paper proposing an approach to understanding movement in market share was provided. The first stages of this proposal is being worked through with the intention of a first stage report to be provided at Mays F&PC.



Appendix - Community



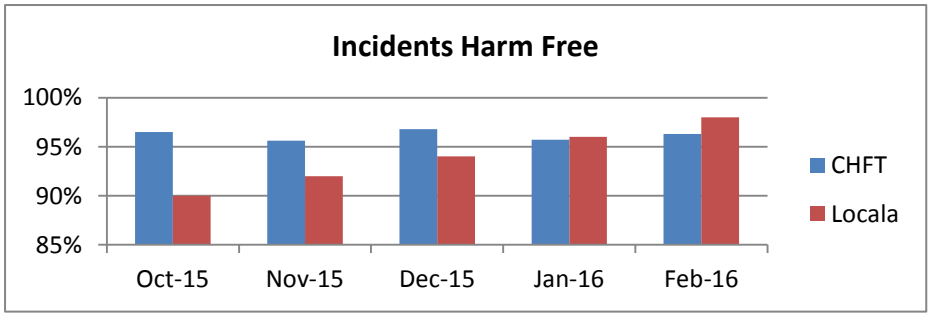


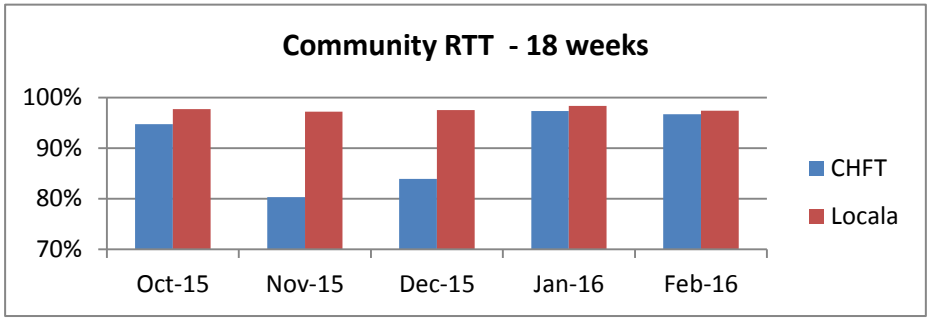
Patients who died in their preferred place of death

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
CHFT	100.0%	100.0%	100.0%	100.0%	88.9%
Locala	44.4%	42.6%	41.5%	56.4%	55.7%

Pressure Ulcers - Category 2 community acquired

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
CHFT		18	0	3	1
Locala		18	15	16	14





Incidents Harm Free

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
CHFT	96.5%	95.6%	96.8%	95.7%	96.3%
Locala	90.0%	92.0%	94.0%	96.0%	98.0%

RTT 18 weeks

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
CHFT	94.7%	80.3%	83.9%	97.3%	96.7%
Locala	97.7%	97.2%	97.5%	98.3%	97.4%

Appendix - Responsive Key Measures

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Target	Threshold
Outpatient Total Waiting List																
GP/GDP sourced referrals	110,129	9181	9462	9213	8978	8993	9452	9533	9112	8728	8921	9258	9298	**9505**	Not applicable	
Other sourced referrals	104,065	8742	9060	9340	9285	8994	8850	8537	8428	8296	8107	8389	8037	**8515**	Not applicable	
Total	214,194	17923	18522	18553	18263	17987	18302	18070	17540	17024	17028	17647	17335	**18020**	Not applicable	
Elective Total Waiting List																
18 week pathway	53944	4233	4187	4363	4374	4344	4418	4570	4593	4573	4763	4732	4794	**4738**	Not applicable	
Non 18 week pathway	55985	4336	4415	4551	4572	4565	4640	4719	4729	4792	4833	4877	4956	**4944**	Not applicable	
Not on Active List	2284	184	240	216	234	186	192	181	207	170	155	166	153	**207**	Not applicable	
Unavailable	3607	311	319	361	370	354	287	227	289	373	231	231	254	**238**	Not applicable	
Total	115,820	311	319	**361**	370	354	287	227	289	373	231	231	254	**238**	Not applicable	
Referral to Treatment (RTT)																
RTT Total incomplete waiting list	19,390	19,027	19,247	19,002	18,981	18,655	18,799	19,525	19,282	19,201	19,355	19,625	19,390	**19,337**	Not applicable	
RTT Waiting 18 weeks and over (backlog)	833	947	799	866	845	1052	764	820	758	873	783	825	833	**743**	Not applicable	
18 weeks Pathways >=26 weeks open	134	348	251	246	197	174	137	98	94	126	152	127	139	**186**	Not applicable	
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	Not applicable	
% Non-admitted Closed Pathways under 18 weeks	98.47%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%	98.44%	98.32%	98.39%	98.17%	**98.42%**	>=95%	95.00
% Admitted Closed Pathways Under 18 Weeks	91.92%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	91.63%	92.04%	92.21%	91.86%	91.96%	**92.12%**	>=90%	90.00%
% Incomplete Pathways <18 Weeks	95.70%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%	95.95%	95.80%	95.70%	**96.16%**	>=92%	92.00%
18 weeks Pathways >=26 weeks open	139	348	251	246	197	174	137	98	94	126	152	127	139	**186**	0	0
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0	0
% Diagnostic Waiting List Within 6 Weeks	99.54%	99.85%	99.80%	99.89%	99.93%	99.48%	98.56%	99.82%	99.94%	99.65%	98.48%	99.71%	99.52%	**99.71%**	>=99%	99.00%

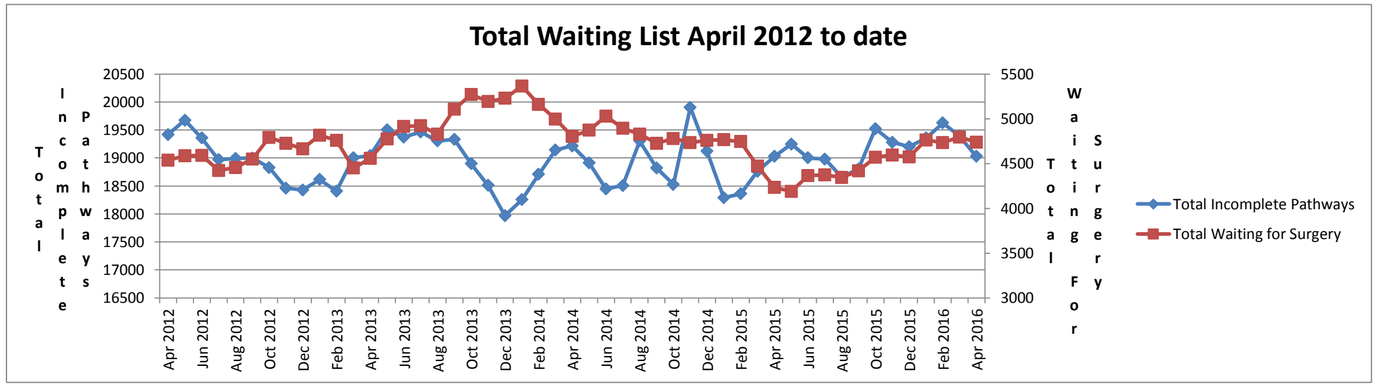
RTT KEY MESSAGES:

Total number of patients on waiting list (including outpatients, diagnostics, surgery) = 19337

Total number of patients waiting for surgery = 4738 -

Total number of patients waiting over 18 weeks = 743

Main specialties where highest level of 18+ week waiters:
General Surgery =292 Trauma & Orthopaedics = 156



Appendix - Cancer - By Tumour Group

	15/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD	Target	Threshold/ Monthly
62 Day Referral to Treatment																	
Breast	98.75%	100.00%	100.00%	100.00%	100.00%	100.00%	81.82%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	85.00%
Gynaecology	85.71%	66.67%	88.89%	100.00%	100.00%	100.00%	50.00%	100.00%	100.00%	84.62%	75.00%	77.78%	70.00%	**100.00%**	**100.00%**	>=85%	85.00%
Haematology	91.27%	66.67%	80.00%	100.00%	85.71%	71.43%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%	60.00%	**100.00%**	**100.00%**	>=85%	85.00%
Head & Neck	74.58%	0.00%	33.33%	72.73%	75.00%	100.00%	100.00%	71.43%	100.00%	66.67%	66.67%	-	80.00%	**100.00%**	**100.00%**	>=85%	85.00%
Lower GI	92.70%	100.00%	84.62%	100.00%	96.15%	100.00%	100.00%	83.33%	80.00%	84.62%	100.00%	93.33%	100.00%	**80.00%**	**80.00%**	>=85%	85.00%
Lung	85.02%	70.83%	88.24%	75.86%	91.67%	100.00%	83.33%	90.48%	100.00%	85.71%	61.54%	100.00%	92.31%	**100.00%**	**100.00%**	>=85%	85.00%
Sarcoma	70.00%	-	-	-	0.00%	0.00%	50.00%	-	-	-	100.00%	100.00%	100.00%	**-**	**-**	>=85%	85.00%
Skin	95.83%	100.00%	100.00%	92.31%	76.19%	100.00%	95.65%	100.00%	94.44%	90.00%	95.45%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	85.00%
Upper GI	87.97%	81.82%	84.62%	**100.00%**	87.50%	100.00%	88.89%	70.59%	100.00%	100.00%	92.86%	57.14%	37.50%	**71.43%**	**71.43%**	>=85%	85.00%
Urology	89.60%	**91.89%**	**100.00%**	**66.67%**	**79.41%**	**85.71%**	92.50%	93.75%	88.57%	95.92%	97.06%	96.77%	90.91%	**90.70%**	**90.70%**	>=85%	85.00%
Others	95.24%	100.00%	-	66.67%	**100.00%**	-	0.00%	100.00%	100.00%	100.00%	66.67%	-	-	**-**	**-**	>=85%	85.00%
14 Day Referral to Date First Seen																	
Brain	98.73%	100.00%	100.00%	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	93.00%
Breast	97.81%	98.41%	100.00%	96.84%	93.17%	98.53%	97.52%	98.32%	98.77%	97.96%	98.43%	99.25%	97.12%	**99.23%**	**99.23%**	>=93%	93.00%
Childrens	96.85%	100.00%	100.00%	100.00%	100.00%	-	100.00%	-	100.00%	-	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	**>=93%**	93.00%
Gynaecology	96.83%	100.00%	100.00%	97.96%	94.87%	90.67%	97.59%	98.78%	94.95%	91.82%	97.37%	98.99%	100.00%	**96.81%**	**96.81%**	>=93%	93.00%
Haematology	97.89%	100.00%	100.00%	93.75%	90.91%	100.00%	90.48%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**90.00%**	**90.00%**	>=93%	93.00%
Head & Neck	98.54%	98.06%	100.00%	98.29%	97.94%	**95.08%**	100.00%	97.73%	99.12%	98.92%	98.51%	97.96%	100.00%	**77.00%**	**77.00%**	>=93%	93.00%
Lower GI	98.98%	100.00%	99.14%	99.31%	96.83%	98.18%	99.24%	97.44%	98.77%	99.41%	100.00%	100.00%	100.00%	**90.58%**	**90.58%**	>=93%	93.00%
Lung	99.14%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	91.67%	95.00%	100.00%	100.00%	**96.30%**	**96.30%**	>=93%	93.00%
Sarcoma	98.68%	100.00%	100.00%	100.00%	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**91.67%**	**91.67%**	>=93%	93.00%
Skin	93.26%	84.92%	95.15%	91.32%	93.29%	83.33%	96.61%	100.00%	90.41%	93.67%	100.00%	99.41%	97.58%	**98.21%**	**98.21%**	>=93%	93.00%
Testicular	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%	**100.00%**	**100.00%**	>=93%	93.00%
Upper GI	97.59%	93.48%	97.10%	98.94%	96.00%	95.18%	95.70%	100.00%	99.02%	98.15%	100.00%	99.00%	98.81%	**98.97%**	**98.97%**	>=93%	93.00%
Urology	99.07%	98.88%	100.00%	98.95%	100.00%	97.00%	100.00%	100.00%	99.08%	100.00%	96.67%	99.07%	99.30%	**100.00%**	**100.00%**	>=93%	93.00%

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th May 2016	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 1 - FINANCIAL NARRATIVE - APRIL MAY 2016 - The Board is asked to approve the Month 1 Financial Narrative - April/May 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 - 24.5.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 1 Financial Narrative - April/May 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 1 Financial Narrative - April/May 2016

Appendix

Attachment:

FP Month 1 Finance Report.pdf

EXECUTIVE SUMMARY: Trust Financial Overview as at 30th Apr 2016 - Month 1

YEAR TO DATE POSITION: M01

	M01 Plan £m	M01 Actual £m	Var £m	
Total Income	**£29.68**	**£29.94**	**£0.26**	
Total Expenditure	**(£30.42)**	**(£31.05)**	**(£0.63)**	
EBITDA	**(£0.74)**	**(£1.11)**	**(£0.37)**	
Non Operating Expenditure	(£2.12)	(£2.05)	£0.07	
Deficit excl. Restructuring	**(£2.86)**	**(£3.16)**	**(£0.30)**	
Restructuring Costs	£0.00	£0.00	£0.00	
Surplus / (Deficit)	**(£2.86)**	**(£3.16)**	**(£0.30)**	

YEAR END 2016/17

	M12 Plan £m	M12 Actual £m	Var £m	
Total Income	**£371.32**	**£373.00**	**£1.69**	
Total Expenditure	**(£361.97)**	**(£364.46)**	**(£2.49)**	
EBITDA	**£9.35**	**£8.55**	**(£0.80)**	
Non Operating Expenditure	(£25.45)	(£24.65)	£0.80	
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**	
Restructuring Costs	£0.00	£0.00	£0.00	
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**	

KEY METRICS

	Year To Date			Year End: Forecast			
	M01 Plan £m	M01 Actual £m	Var £m	Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£2.86)	(£3.16)	(£0.30)	(£16.10)	(£16.10)	(£0.00)	
Capital	£1.23	£0.95	£0.28	£28.22	£28.22	£0.00	
Cash	£1.94	£1.92	(£0.02)	£1.95	£1.95	(£0.00)	
Borrowing	£36.95	£36.95	£0.00	£67.87	£67.87	£0.00	
CIP	£0.64	£0.59	(£0.05)	£14.00	£14.00	(£0.00)	
Financial Sustainability Risk Rating	2	2		2	2		

Year to date: The year end financial position stands at a deficit of £3.16m, an adverse variance of £0.30m from the planned £2.86m. Operational pressure has been borne in month in a number of areas: the Junior Doctor's 48 hour strike; the slower than planned retraction of Medical patients from Surgical capacity; and medical staffing vacancies in key Medical and Surgical specialties. In addition, the Trust continues to rely upon agency staffing at premium rates to cover both medical and nursing vacancies driving a pay overspend in both of these areas but are non recurrent.

The combined impact of these operational pressures have driven this headline position:

- A negative EBITDA of £1.11m, an £0.37m adverse variance from the plan.
- A bottom line deficit of £3.16m, an £0.30m adverse variance from plan.
- Delivery of CIP of £0.59m against the planned level of £0.64m.
- Contingency reserves of £0.33m have been released in line with the planned profile.
- Capital expenditure of £0.95m, this is below the planned level of £1.23m.
- A cash balance of £1.92m in line with the planned level of £1.94m.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

The underlying trading position in Month 1 is subject to greater pressure than the year to date deficit reveals due to a number of one off financial benefits in month. There has been a catch up in Cardiology discharges in April following delays in March caused by Catheter Lab issues. In addition, Dermatology and Neurology outpatient work has been high in month as these specialties aim to get ahead in advance of anticipated capacity gaps later in the year. Finally, there has been a particularly long staying patient discharged from Critical Care. In income terms, these factors offset the shortfall driven by the strike action and underperformance on planned activity.

Forecast: Going forwards, the underlying elective activity performance is a risk to planned income. This sits alongside a material risk against the continued use of agency staffing. CIP has delivered as planned at month 1 but it should be noted that the planned profile of CIP is heavily weighted into the latter part of the year and half of the £14m required is flagged as 'high risk'. In addition the £2m contingency reserves are planned across the first six months of the year and will therefore bring limited respite against these risks.

Whilst acknowledging these risks, the year end forecast position at this early stage is to deliver the planned £16.1m deficit. Divisions are required to design and deliver recovery plans to mitigate against the risks and pressures. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit.

Trust Financial Overview as at 30th Apr 2016 - Month 1

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT IN APRIL 2016

YEAR TO DATE POSITION: M01

CLINICAL ACTIVITY

	M01 Plan	M01 Actual	Var
Elective	736	629	(107)
Non Elective	4,229	4,160	(69)
Daycase	3,086	3,095	9
Outpatients	28,353	28,257	(96)
A & E	12,331	12,119	(212)

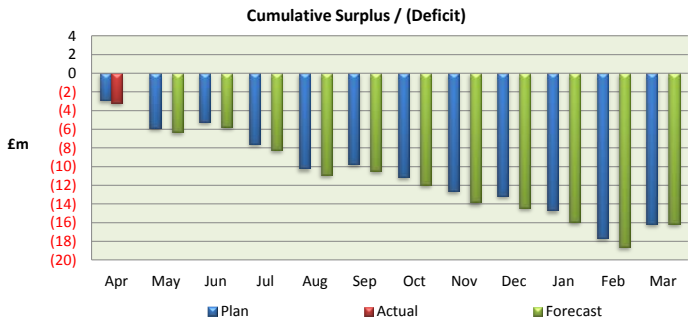
TRUST: INCOME AND EXPENDITURE

	M01 Plan	M01 Actual	Var
	£m	£m	£m
Elective	£1.88	£1.57	(£0.31)
Non Elective	£7.14	£7.17	£0.03
Daycase	£2.20	£2.15	(£0.05)
Outpatients	£3.62	£3.65	£0.02
A & E	£1.36	£1.35	(£0.02)
Other-NHS Clinical	£9.66	£10.40	£0.74
CQUIN	£0.55	£0.56	£0.01
Other Income	£3.26	£3.10	(£0.16)
Total Income	**£29.68**	**£29.94**	**£0.26**
Pay	(£20.05)	(£20.37)	(£0.32)
Drug Costs	(£2.95)	(£3.06)	(£0.11)
Clinical Support	(£2.49)	(£2.59)	(£0.09)
Other Costs	(£3.93)	(£4.04)	(£0.11)
PFI Costs	(£1.00)	(£1.00)	£0.00
Total Expenditure	**(£30.42)**	**(£31.05)**	**(£0.63)**
EBITDA	**(£0.74)**	**(£1.11)**	**(£0.37)**
Non Operating Expenditure	(£2.12)	(£2.05)	£0.07
Deficit excl. Restructuring	**(£2.86)**	**(£3.16)**	**(£0.30)**
Restructuring Costs	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£2.86)**	**(£3.16)**	**(£0.30)**

DIVISIONS: INCOME AND EXPENDITURE

	M01 Plan	M01 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£1.43	£1.27	(£0.16)
Medical	£1.92	£1.84	(£0.08)
Families & Specialist Services	(£0.42)	(£0.44)	(£0.02)
Community	£0.40	£0.36	(£0.05)
Estates & Facilities	(£2.24)	(£2.30)	(£0.06)
Corporate	(£2.02)	(£2.01)	£0.01
THIS	£0.03	£0.04	£0.00
PMU	£0.18	£0.12	(£0.06)
Central Inc/Technical Accounts	(£1.81)	(£2.02)	(£0.22)
Reserves	(£0.33)	£0.00	£0.33
Surplus / (Deficit)	**(£2.86)**	**(£3.16)**	**(£0.30)**

TRUST SURPLUS / (DEFICIT)

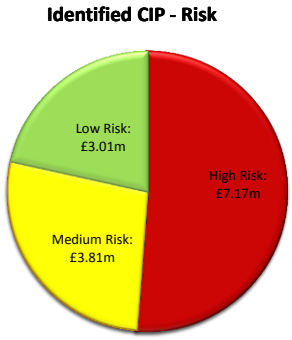


KEY METRICS

	Year To Date M01 Plan	Year To Date M01 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£2.86)	(£3.16)	(£0.30)	(£16.10)	(£16.10)	(£0.00)
Capital	£1.23	£0.95	£0.28	£28.22	£28.22	£0.00
Cash	£1.94	£1.92	(£0.02)	£1.95	£1.95	(£0.00)
Loans	£36.95	£36.95	£0.00	£67.87	£67.87	£0.00
CIP	£0.64	£0.59	(£0.05)	£14.00	£14.00	(£0.00)
Financial Sustainability Risk Rating	Plan 2	Actual 2		Plan 2	Forecast 2	

COST IMPROVEMENT PROGRAMME (CIP)

Total Planned: £14m



Total Forecast £14m

YEAR END 2016/17

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	8,787	8,647	(140)
Non Elective	51,619	51,382	(237)
Daycase	36,895	36,355	(540)
Outpatients	338,922	339,116	194
A & E	148,571	148,043	(528)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£22.48	£22.04	(£0.44)
Non Elective	£87.09	£87.93	£0.84
Daycase	£26.37	£25.74	(£0.63)
Outpatients	£43.43	£43.85	£0.42
A & E	£16.43	£16.40	(£0.03)
Other-NHS Clinical	£129.03	£131.71	£2.68
CQUIN	£6.79	£6.90	£0.11
Other Income	£39.70	£38.43	(£1.27)
Total Income	**£371.32**	**£373.00**	**£1.69**
Pay	(£237.12)	(£239.29)	(£2.17)
Drug Costs	(£35.59)	(£36.42)	(£0.84)
Clinical Support	(£30.17)	(£29.98)	£0.19
Other Costs	(£47.05)	(£46.74)	£0.31
PFI Costs	(£12.04)	(£12.02)	£0.02
Total Expenditure	**(£361.97)**	**(£364.46)**	**(£2.49)**
EBITDA	**£9.35**	**£8.55**	**(£0.80)**
Non Operating Expenditure	(£25.45)	(£24.65)	£0.80
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**
Restructuring Costs	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**

DIVISIONS: INCOME AND EXPENDITURE

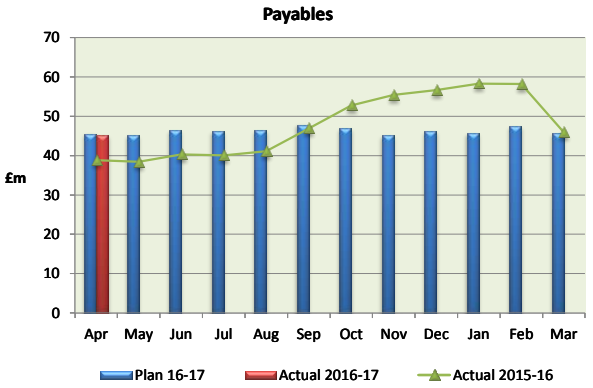
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£18.99	£18.99	(£0.00)
Medical	£21.62	£21.62	(£0.00)
Families & Specialist Services	(£3.09)	(£3.09)	(£0.00)
Community	£4.82	£4.81	(£0.01)
Estates & Facilities	(£26.88)	(£26.85)	£0.03
Corporate	(£24.17)	(£24.17)	(£0.00)
THIS	£0.41	£0.41	£0.00
PMU	£2.39	£2.39	£0.00
Central Inc/Technical Accounts	(£10.02)	(£9.78)	£0.24
Reserves	(£0.16)	(£0.43)	(£0.26)
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**

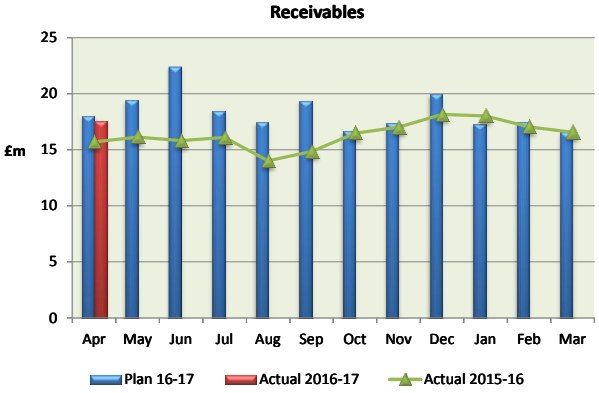
Trust Financial Overview as at 30th Apr 2016 - Month 1

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT IN APRIL 2016

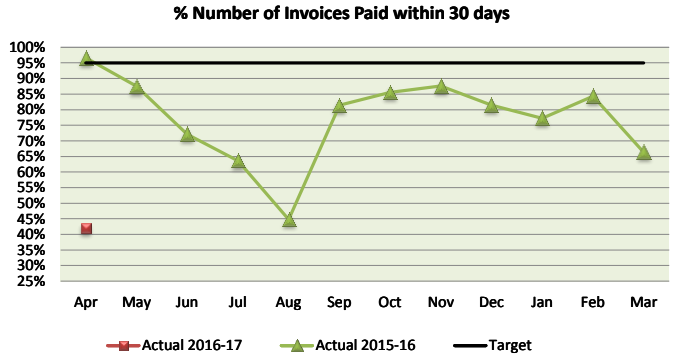
WORKING CAPITAL

	M01 Plan £m	M01 Actual £m	Var £m	M01
Payables	(£45.55)	(£45.16)	(£0.39)	
Receivables	£17.98	£17.59	£0.39	



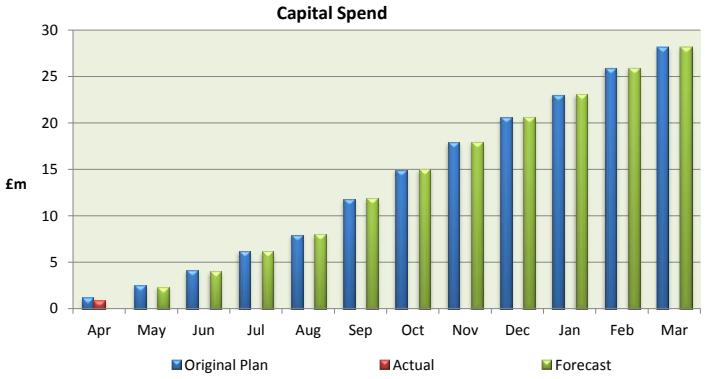


BETTER PAYMENT PRACTICE CODE



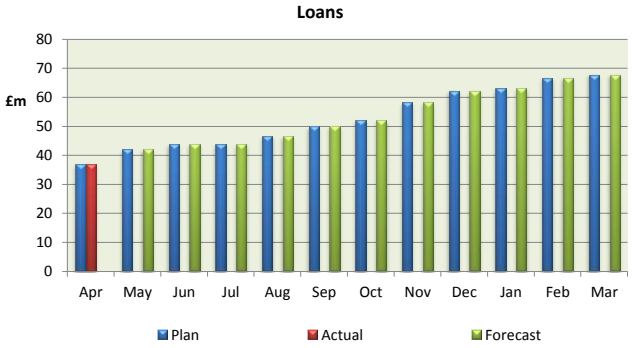
CAPITAL

	M01 Plan £m	M01 Actual £m	Var £m	M01
Capital	£1.23	£0.95	£0.28	

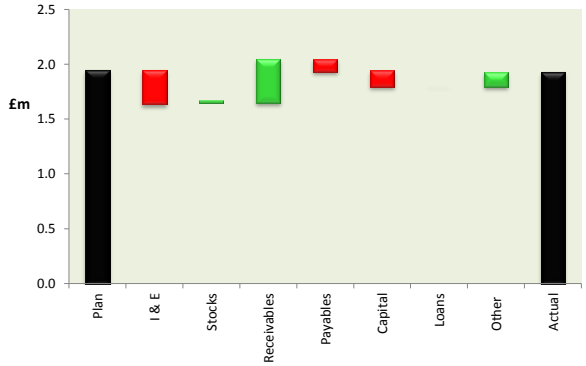


CASH

	M01 Plan £m	M01 Actual £m	Var £m	M01
Cash	£1.94	£1.92	(£0.02)	
Loans	£36.95	£36.95	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £3.16m versus a planned deficit of £2.86m.
- Elective activity is behind plan in month.
- Capital expenditure year to date is £0.95m against a planned £1.23m.
- Cash balance is virtually on plan with £1.92m against a planned £1.94m.
- As planned, the Trust borrowed a further £5m in month from the Independent Trust Financing Facility (ITFF).
- CIP schemes delivered £0.59m in the year to date against a planned target of £0.64m.
- The Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

SUMMARY FORECAST

- The forecast year end deficit is £16.10m against a planned £16.10m.

This position assumes full delivery of the planned £14.0m CIP and recovery of the £0.3m Month 1 shortfall in the overall position against plan.

- Cash is forecast on plan at £1.95m.
- The Trust cash position relies on the Trust borrowing £37.63m in this financial year to support both Capital and Revenue plans.
- Forecast Capital expenditure is as planned at £28.22m .
- The year end FSRR is forecast to be at level 2 as planned.

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)

ACTIVITY & CAPACITY

CLINICAL ACTIVITY

Activity summary by Point of Delivery

Point of Delivery	Detailed Point of Delivery	In-month			Year-to-date		
		Plan Spells	Actual Spells	Spells Variance	Plan Spells	Actual Spells	Spells Variance
DAYCASE	DAYCASE	2,282	2,266	-16	2,282	2,266	-16
	DAYCASE ENDOSCOPY	803	829	26	803	829	26
DAYCASE Total		**3,086**	**3,095**	**9**	**3,086**	**3,095**	**9**
ELECTIVE	ELECTIVE	659	536	-123	659	536	-123
	ELECTIVE ENDOSCOPY	76	93	17	76	93	17
ELECTIVE Total		**736**	**629**	**-107**	**736**	**629**	**-107**
NON-ELECTIVE	EMERGENCY SHORT STAY	1,958	1,949	-9	1,958	1,949	-9
	EMERGENCY LONG STAY	1,596	1,574	-22	1,596	1,574	-22
	EMERGENCY THRESHOLD	0	0	0	0	0	0
	NON-ELECTIVE SHORT	359	320	-39	359	320	-39
	NON-ELECTIVE LONG	317	317	0	317	317	0
NON-ELECTIVE Total		**4,229**	**4,160**	**-69**	**4,229**	**4,160**	**-69**
A&E	A&E	12,331	12,119	-212	12,331	12,119	-212
A&E Total		**12,331**	**12,119**	**-212**	**12,331**	**12,119**	**-212**
OUTPATIENT	OUTPATIENT FIRST	7,874	7,919	45	7,874	7,919	45
	OUTPATIENT PROCEDURE FIRSTS	1,953	1,939	-14	1,953	1,939	-14
	OUTPATIENT FOLLOW-UP	14,475	14,171	-304	14,475	14,171	-304
	OUTPATIENT PROCEDURE FOLLOW-UPS	4,051	4,228	177	4,051	4,228	177
OUTPATIENT Total		**28,353**	**28,257**	**-96**	**28,353**	**28,257**	**-96**
OTHER NHS TARIFF	CHEMOTHERAPY	627	609	-18	627	609	-18
	DIRECT ACCESS & OUTPATIENT IMAGING	5,659	6,158	499	5,659	6,158	499
	MATERNITY PATHWAY	935	928	-7	935	928	-7
	OTHER NHS TARIFF	2,488	2,597	109	2,488	2,597	109
OTHER NHS TARIFF Total		**9,709**	**10,292**	**583**	**9,709**	**10,292**	**583**
OTHER NHS NON-TARIFF	CRITICAL CARE ADULT	291	418	127	291	418	127
	CRITICAL CARE NICU	474	607	133	474	607	133
	DIAGNOSTIC TESTS & IMAGING	119,407	126,381	6,974	119,407	126,381	6,974
	OUTPATIENTS LOCAL PRICE	3,978	4,344	366	3,978	4,344	366
	PASS THROUGH DEVICES	48	52	4	48	52	4
	PASS THROUGH HCDS	0	0	0	0	0	0
	REHABILITATION	1,761	1,929	168	1,761	1,929	168
	OTHER NHS NON-TARIFF	4,892	4,885	-7	4,892	4,885	-7
OTHER NHS NON-TARIFF Total		**130,851**	**138,616**	**7,765**	**130,851**	**138,616**	**7,765**
Grand Total		**189,294**	**197,168**	**7,874**	**189,294**	**197,168**	**7,874**

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

• Overall activity is behind plan against all points of delivery with the exception of day case (driven by endoscopy) and other tariff and non tariff income (driven by disgnostic testing).

• Planned day case and elective activity performance is 2.54% (98 spells) below the month 1 plan. This is driven by under-performance within elective activity with day case activity levels maintained at plan overall. Elective under-performance is mainly within General Surgery, Trauma and Orthopaedics (T&O) and ENT. This is largely driven by the impact of the Junior Doctors' 48hr Strike seen during April, a slower than planned retraction of medical patients from T&O beds and a number of Senior Dr vacancies and sickness. The latter capacity issue currently presents a risk of delivery in future months. Day case activity, whilst at plan overall, has also seen under-performance within T&O and ENT also due to the reasons outlined above, but this has been off-set by over-performances within Pain Management, Ophthalmology and Oral Surgery. Day case endoscopy is at plan levels overall but with under-performance within General Surgery due to lack of capacity through vacancies and sickness, off-set by a corresponding over-performance within Gastroenterology. This is due to one-off middle grade capacity during April and so will not be maintained at this monthly level moving forward.

• Non-elective activity overall is 1.63% (69 admissions) below the month 1 plan. This is mainly driven by emergency long-stay and non-elective obstetric and midwifery admissions. The under-performance in emergency long-stay is predominantly within Paediatrics with an over-performance seen within Cardiology. The Cardiology position reflects the impact of reduced Catheter lab capacity within March, resulting in increased length-of-stay (LOS) of some patients and their subsequent discharge in April. This is not, therefore representative of Cardiology emergency activity levels moving forward.

• A&E has seen activity 1.72% (212 attendances) below the month 1 plan.

• Outpatient activity overall is broadly in line with the month 1 plan. Outpatient first attendances are however 1.2% (259 attendances) below plan mainly driven by General Surgery. Oral Surgery has over-performed. Outpatient follow-up attendances are 2.7% (163 attendances) above plan mainly driven by Dermatology procedures. The increase within Dermatology is due to the service 'getting ahead' prior to a substantive consultant leaving the Trust within the coming weeks and so will not be maintained at this level in future months.

ACTIVITY & CAPACITY (2)

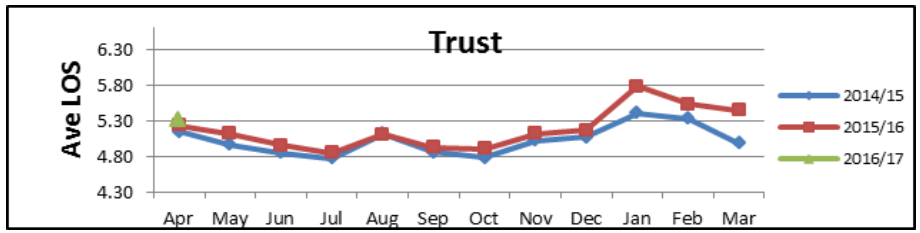
CAPACITY

Beds Plan vs Actual

Divisional Breakdown of Bed Base - Plan versus Actual - 2016 / 2017

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Surgical Bed Base Plan	213	213	213	193	193	193	193	193	193	193	193	193
Surgical Bed Base Actual	209											
FSS Bed Base Plan - Adult	16	16	16	16	16	16	16	16	16	16	16	16
Paediatrics	43	43	43	43	43	43	43	43	43	43	43	43
Mother	63	63	63	63	63	63	63	63	63	63	63	63
Cots (inc NICU)	80	80	80	80	80	80	80	80	80	80	80	80
FSS Bed Base Plan - TOTAL	202	202	202	202	202	202	202	202	202	202	202	202
FSS Bed Base Actual	202											
Medical Bed Base Plan core	451	451	451	451	451	451	451	451	451	451	451	451
Flex	15	15	15	0	0	0	15	25	39	46	39	39
Medical Bed Base Plan - TOTAL	466	466	466	451	451	451	466	476	490	497	490	490
Medical Bed Base Actual	470											
TRUST Bed Base Plan - TOTAL	881	881	881	846	846	846	861	871	885	892	885	885
TRUST Bed Base - ACTUAL	881											
Beds Above (+ve) / Below (-ve) Plan	0											

Trust Average Length of Stay (LOS)



• Direct access and unbundled outpatient imaging has seen an over-performance against plan in month 1 within MRI and Ultrasound. There has been a significant increase in the mobile MRI usage through increased referrals, the main causes of which are currently being reviewed. Ultrasound has also seen an increase in demand, with the requirement of additional agency capacity in order to deliver this.

• Diagnostic testing is 5.8% (6,974 tests) above the month 1 plan which is driven by a large increase within Biochemistry and Haematology.

• Adult Critical Care is 44% (127 bed days) above the month 1 plan. This is solely driven by a long-stay, 6-organ supported patient admitted in November 2015 and discharged from the Trust in May 2016. Due to the exceptional nature of this, a level of bed day activity has been reflected within the April position.

• NICU has seen a large over-performance against the month 1 plan of 28% (133 bed days) but it is not anticipated that this will continue at these levels.

• Rehabilitation is 9.5% (168 bed days) above the month 1 plan which is driven by an increase within Calderdale. A further 28 bedded care home has closed within Calderdale which will be impacting upon this.

• Overall Trust level bed numbers are within the month 1 plan, however as referenced earlier the first week of April saw Medical patients occupying a level of Surgical beds. The level of beds has seen a decrease of 9 beds, from 890 to 881 from March 2016 to April 2016.

• The average Trust length of stay (LOS) for April was 5.32 days. This has remained higher than the LOS during March 2016, but has seen a steady decrease throughout April due to a reduced elective LOS within Surgical and FSS divisional activity. The Medical inpatient LOS has remained high at a LOS of 5.9 days vs a plan of 5.6 days. This has been mainly driven by increased numbers of 'green cross patients' and as referenced earlier, reduced nursing home / intermediate care beds and primary care pressures.

INCOME

Summary of Operating Income

Income Category	In-month			Year-to-date		
	Plan (£'m)	Actual (£'m)	Variance (£'m)	Plan (£'m)	Actual (£'m)	Variance (£'m)
NHS Clinical Contract Income	25.06	25.44	0.39	25.06	25.44	0.39
Other NHS Clinical Income	1.37	1.40	0.03	1.37	1.40	0.03
Sub-total NHS Clinical Income	**26.42**	**26.84**	**0.42**	**26.42**	**26.84**	**0.42**
Other Non-NHS Clinical Income	0.52	0.53	0.01	0.52	0.53	0.01
Total Clinical Income	**26.94**	**27.37**	**0.43**	**26.94**	**27.37**	**0.43**
Other Non-Clinical Income	2.74	2.57	-0.17	2.74	2.57	-0.17
TOTAL OPERATING INCOME	**29.69**	**29.95**	**0.26**	**29.69**	**29.95**	**0.26**

Summary of Clinical Contract Income - by Point of Delivery

Point of Delivery	In-month			Year-to-date		
	Plan (£'m)	Actual (£'m)	Variance (£'m)	Plan (£'m)	Actual (£'m)	Variance (£'m)
Day case	2.20	2.15	-0.05	2.20	2.15	-0.05
Elective	1.88	1.57	-0.31	1.88	1.57	-0.31
Non-elective	7.15	7.17	0.03	7.15	7.17	0.03
A&E	1.36	1.35	-0.02	1.36	1.35	-0.02
Outpatient	3.62	3.65	0.02	3.62	3.65	0.02
Other NHS Tariff	1.95	1.98	0.03	1.95	1.98	0.03
Other NHS Non-tariff	6.34	7.00	0.67	6.34	7.00	0.67
CQUIN	0.55	0.57	0.01	0.55	0.57	0.01
Grand Total	**25.06**	**25.44**	**0.39**	**25.06**	**25.44**	**0.39**

Summary of Clinical Contract Income - by Commissioner (versus CHFT Plan)

Commissioner	In-month			Year-to-date		
	Plan (£'m)	Actual (£'m)	Variance (£'m)	Plan (£'m)	Actual (£'m)	Variance (£'m)
NHS Calderdale CCG	11.26	11.23	-0.02	11.26	11.23	-0.02
NHS Greater Huddersfield CCG	10.14	10.29	0.14	10.14	10.29	0.14
Other CCGs	1.59	1.66	0.06	1.59	1.66	0.06
NHS England	2.07	2.26	0.20	2.07	2.26	0.20
Total Commissioners	**25.06**	**25.44**	**0.39**	**25.06**	**25.44**	**0.39**

Operating Income

Despite the majority of specialties and points of delivery being below plan, there is a £0.26m favourable variance from the month 1 plan within operating income.

NHS Clinical Income

Within the £0.26m favourable income variance, NHS clinical income shows a favourable variance of £0.42m (offset by other non-clinical income). Non-pay spend on pass-through drug and devices are driving £0.17m of the clinical income variance above plan. The remaining £0.25m favourable income variance is mainly due to Clinical Contract PbR income.

The Clinical Contract PbR income position is driven by under-performance within planned day case and elective activity of £0.36m which, as described within the activity section, is due to a mixture of the junior doctors strike impact, surgical bed capacity and medical workforce capacity pressures. This is then off-set by small over-performances across a range of services, mainly NICU, Outpatients, Diagnostic testing and imaging, maternity pathway and rehabilitation income. More materially is the over-performance within adult ctiical care relating to the long-stay 6-organ supported patient admitted in November 2015 and discharged in May 2016. As previously highlighted, due to the exceptional nature of this, a level of income relating to this has been reflected within the month 1 position. The value of this is £0.27m but is non-recurrent in nature.

The Clinical Contract Income position by Commissioner reflects an underlying under-performance against the month 1 plan for the Trust's 2 main Commissioners, NHS Calderdale CCG and NHS Greater Huddersfield CCG. This is in the main due to under-performances within planned day case and elective activity as per above. The NHS Greater Huddersfield CCG position is then inclusive of the adult critical care patient income. There has been an over-performance within the NHS England contract driven by pass-through drugs and device and NICU activity.

Other income

Overall other income is £0.16m below the planned level for month 1. This is mainly due to lower than planned income within Injury Cost Recovery Unit (ICRU) income and the Trust's Pharmacy Manufacturing Unit (PMU).

INCOME (2)

Summary of Commissioner Contract Position (versus Contract)

Commissioner	In-month			Year-to-date		
	Contract (£'m)	Actual (£'m)	Variance (£'m)	Contract (£'m)	Actual (£'m)	Variance (£'m)
NHS Calderdale CCG	10.96	11.23	0.27	10.96	11.23	0.27
NHS Greater Huddersfield CCG	9.86	10.29	0.43	9.86	10.29	0.43
Other CCGs	1.56	1.66	0.10	1.56	1.66	0.10
NHS England	2.21	2.26	0.05	2.21	2.26	0.05
Total Commissioners	**24.59**	**25.44**	**0.85**	**24.59**	**25.44**	**0.85**

Commissioner Contract Position

The 2016-17 Contract with the Trust's Commissioners reflects a lower level of activity and income to the Trust plan in the main due to the CCG QIPP plans, Trust CIP plans and a differing view of baseline activity levels. The month 1 income position represents £0.85m above the month 1 Commissioner Contract value. This is mainly driven by emergency admissions, outpatients, maternity pathway, high cost drugs, rehabilitation and adult critical care all above the Commissioner contract value.

Contractual Sanctions

The Commissioner Contract includes all NHS Standard Contract Operational Standards and any applicable financial sanctions. Some of these are included within the Sustainability Transformational Fund (STF) performance trajectories and so will not be subject to 'double jeopardy' within the Commissioner Contract.
Month 1 performance has seen 10 ambulance handover breaches at a value of £2k but due to the link to the STF, this is not reflected within the month 1 income position.

CQUIN

The performance and income against each CQUIN scheme within the Contract is measured against quarterly targets. At month 1, the Sepsis scheme is flagging as a risk as only 3 out of the 4 Q1 targets will be met, specifically relating to achievement of 90% of patients screened within ED. This element of the CQUIN recognises partial payment of achievement of 50-70% and therefore places £0.02m of Q1 CQUIN funding at risk. The Commissioner Contract includes agreement that the Commissioners will not automatically make a cash adjustment for non-delivery and so no risk of this is currently included within the month 1 income position. Further risks on forecast achievement of the Staff Well Being Flu Vaccination and Antimicrobial Resistance CQUINs are also being flagged with actions being put in place to address this.

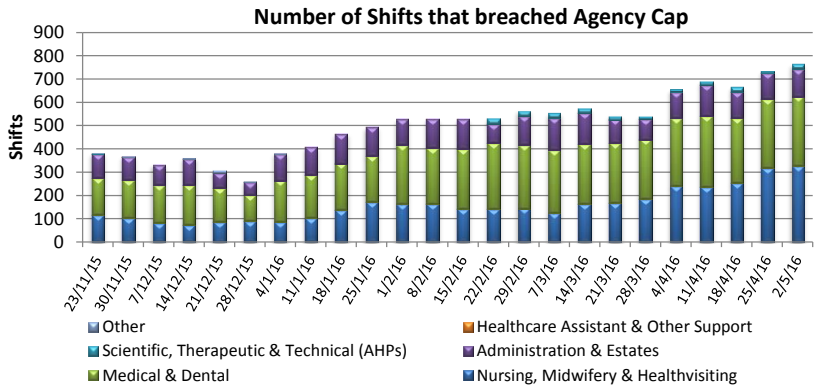
Commissioner Contractual Challenges

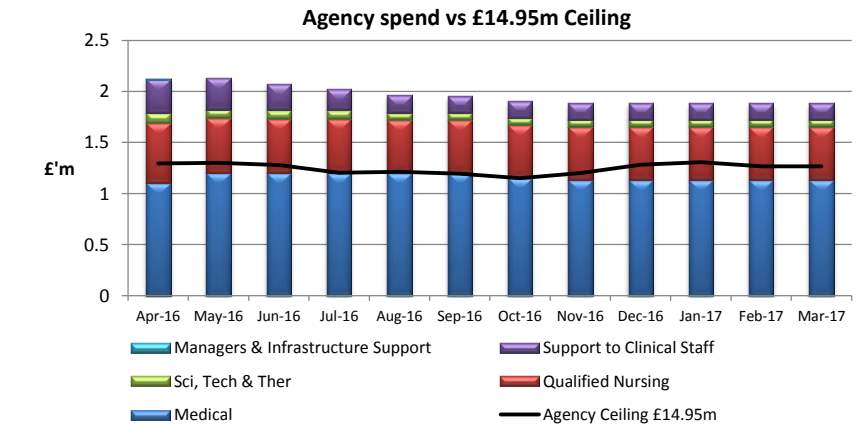
The NHS Standard Contract enables Commissioners to formally make monthly contractual challenges. No challenges have yet been made in relation to 2016/17 and there is currently no risk relating to this included within the month 1 income position.

WORKFORCE

Vacancies

	Sci, Tech & Theraputic	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	50.27	78.92	85.13	177.2	100.4	491.92
Staff in post (WTE)	617.29	1178.63	515.74	1664.67	1107.12	5083.45
% Vacancies	8%	6%	14%	10%	8%	9%





For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. This is in the context of actual expenditure incurred in 2015/16 of £19.93m. The Trust must do all that it can to aim to achieve this target which will be extremely challenging. A simple extrapolation of the month 1 agency spend would suggset a potential to spend £25.6m in 2016/17. Capped hourly rates for agency staff were also introduced by NHSI in 2015/16 which are tightened to lower rates from April 2016 and there is a requirement for all agency staff to be booked through approved procurement frameworks. This sits alongside an increased number of medical and nursing staffing vacancies. In the Medical specialties, the consultant vacancy rate is approximately 30%.

Vacancies

In overall terms at the end of Month 1 the Trust was carrying 492 vacancies, a rate of 9% of the total establishment. It is of note that the highest vacancy rates were in directly patient facing staff groups, medical and nursing staffing at 14% and 10% respectively, which are essential to delivery of activity and maintenance of safe and high quality services.

Agency rate cap

Price caps were introduced to support providers to control and reduce expenditure on agency staffing. Since November 2015 a weekly return has been completed showing the number of shifts that have breached either the rate cap or been booked outside a recognised framework of suppliers. During this period the actual rate cap has been reduced with the latest reduction being applied from April 2016.

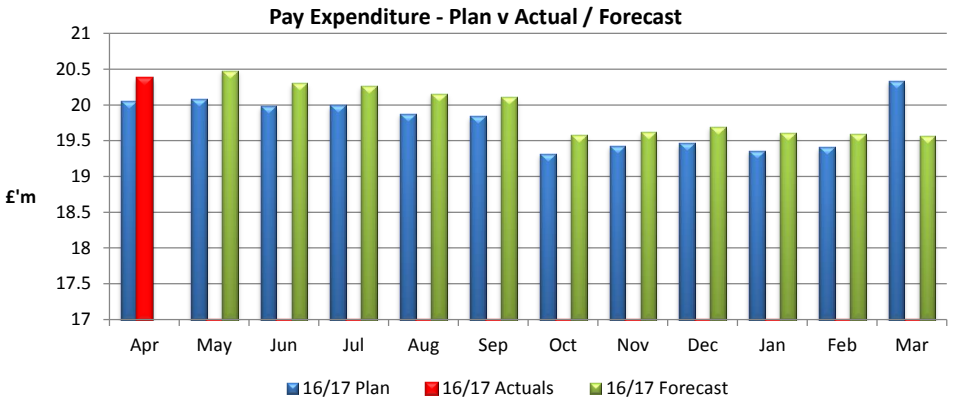
The number of breaches reported in April increased, partly as a result of the reduced cap rate threshold but on a level playing field from April onwards the number of breaches has continued to increase through early May. In the week commencing 2 May the Trust reported 764 breaches of which 600 were due to the rate paid, 31 due to the use of off framework agencies and 133 breached both the price and framework guidelines.

Agency ceiling

In respect of the £14.95m agency ceiling, the Trust has designed a trajectory against which to measure month on month performance. For Month 1, against a trajectory of £1.29m, actual spend is £2.13m. Divisional forecasts, informed by recent run rates, project a full year spend of £23.60m illustrated by staff group on the graph opposite.

Agency spend must be reduced if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding. This provides a significant risk for the Trust.

EXPENDITURE - PAY



	Pay Expenditure including Agency								
	M1 YTD Budget	M1 YTD Actual							M1 YTD Variance
	Total Budget	Total Actual	Substantive Pay	Agency	Bank	Locum	Overtime / WLI	Additional Basic Pay / Extra Sessions	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Clinical									
Consultants	3.58	3.49	2.45	0.53		0.13	0.13	0.24	-0.10
Junior Medical	2.28	2.30	1.52	0.58		0.07	0.06	0.07	0.02
Qualified nursing, midwifery and health visiting staff	6.18	6.46	5.59	0.58	0.00		0.23	0.05	0.28
Sci Tech & Ther	2.15	2.25	2.08	0.10	0.01		0.04	0.02	0.10
Support to nursing staff	1.57	1.75	1.45	0.07	0.14		0.07	0.02	0.18
Support to clinical staff	0.58	0.80	0.49	0.25	0.04		0.01	0.01	0.22
Non Clinical									0.00
Managers and infrastructure support	3.35	3.30	3.19	0.01	0.01		0.06	0.03	-0.04
Any Other Spend	0.02	0.01	0.01						-0.01
Pay Reserves	0.34	0.00							-0.34
TRUST TOTAL	**20.05**	**20.37**	**16.79**	**2.13**	**0.21**	**0.20**	**0.60**	**0.44**	**0.32**

Pay costs are £0.31m higher than the planned level. It should be noted that the £2.0m of contingency reserves are planned against pay in equal instalments across the first six months of the financial year. One month of this contingency, £0.33m, has been released against the pay position, meaning that the underlying divisional pay overspend at Month 1 was £0.67m.

As the number of beds open in April was in line with the planned level, unlike the situation seen last financial year, this is not a driver of the additional spend. Rather, it is the carrying of high vacancy levels in clinical staff groups that is causing reliance on agency staffing with the associated premium rates that drives the overspend.

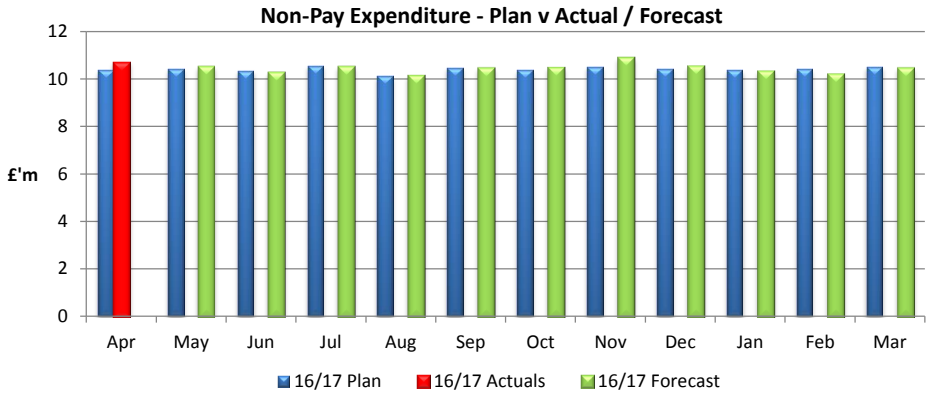
The largest area of overspend by staff group is nursing, the combined overspend against qualified nursing and support to nursing (Healthcare Assistants) is £0.46m in the month. £0.65m was spent on agency staffing in these staff groups. £0.16m additional pressure was seen as a result of a bonus scheme to reward substantive staff for working additional shifts with the aim of avoiding the higher agency premiums. The success of this scheme is being reviewed.

Recruitment difficulties also remain an issue in certain Medical and Surgical specialties for medical staff. This is driving additional costs through the requirement to engage agency locum staff in key areas as well as adversely impacting activity and income levels where staffing cover has not been successfully secured. The overspend against medical staffing at a net £0.08m is lower than nursing in month as the use of agency is offset in part by these unfilled staffing gaps. The cost of agency does however remain high at £1.11m.

Focussed management activity is underway under the leadership of the Chief Operating Officer to manage the need to meet staffing requirements through non-substantive means, balancing clinical safety and standards with achieving best value. The visibility and profile of agency usage is being raised in the Trust with weekly reporting to the Turnaround Executive group. New recruitment and retention strategies are being developed; 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.

Even with these actions being progressed, the use of agency staffing ranks as one of the main risks to delivery of the Trust's financial plan.

EXPENDITURE - NON PAY



	M01 Plan £m	M01 Actual £m	Var £m	
Drug Costs	(£2.95)	(£3.06)	(£0.11)	
Clinical Support	(£2.49)	(£2.59)	(£0.09)	
Other Costs	(£3.93)	(£4.04)	(£0.11)	
PFI Costs	(£1.00)	(£1.00)	£0.00	
Total Operating Expenditure	**(£10.37)**	**(£10.69)**	**(£0.31)**	
Non Operating Expenditure	(£2.12)	(£2.05)	£0.07	
Restructuring Costs	£0.00	£0.00	£0.00	
Total Non Operating Expenditure	**(£2.12)**	**(£2.05)**	**£0.07**	
Total Expenditure	**(£12.49)**	**(£12.73)**	**(£0.24)**	

Drug costs

Year to date expenditure on drugs was £0.11m above the planned level. The spend on 'pass through' high cost drugs is £0.13m above plan, this comprises pass through costs from the contracts with the main commissioners as well as the Cancer Drugs Fund and a Hepatitis C drug for which the Trust receives funding directly from NHS England.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.20m above the plan. This overspend reflects activity related factors such as outpatient test costs and a considerable increase in MRI usage driving hire costs and outsourced reporting charges. In addition Estates & Facilities division have an overspend particularly on non pay driven in part by additional minor works costs linked to the CQC inspection and a level of slippage on CIP delivery as utilities savings did not commence from the start of April as planned.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.07m below the planned level.

This is driven entirely by lower than planned depreciation charges as a result of pro-active work that has been pursued to review asset values and lives. The adoption of a different valuation method for the PFI site has reduced the asset value upon which depreciation is chargeable. This sits alongside a review of equipment lives and an extension of the assessed life of recent large IT investments in particular which spreads the depreciation changeable over a longer period at a lower rate. The lower depreciation charges impact the year to date and forecast position and contribute towards CIP delivery.

Other elements of non operating expenditure are in line with plan. Restructuring costs for the year are planned at nil and no such costs have been incurred in the year to date and none are forecast at present.

SUSTAINABILITY & TRANSFORMATION FUND

Terms and Conditions

In planning for receipt of the STF the Trust has signed up to the following terms and conditions:

Objective	Conditions / Measurement
Deliver agreed control total Provider deficit reduction / surplus increase	Q1: Agreement of milestone-based recovery plan with NHS Improvement AND agreed control total for 2016/17. Agreement to capital control total. Plans to include milestones for Carter implementation (including reporting and sharing data in line with the national timetable) and compliance with the NHS Improvement agency controls guidance. Q2 to Q4: Delivery of plan milestones AND capital and revenue control totals.
Access standards	Q1: Agreeing with NHS England and NHS Improvement a credible plan for maintaining agreed performance trajectories for delivery of core standards for patients, including the four-hour A&E standard, the 18-week referral to treatment standard, 62 day cancer referral to treatment standard, 6 week diagnostic access and ambulance performance target. Q2 to Q4: Delivery of agreed performance trajectories.
Transformation	Q1 to Q3: Local Sustainability and Transformation Plans (STPs) – to work with commissioners and develop an integrated five-year plan in line with the national STP timetable. Q4: STP agreed with NHS England and NHS Improvement. Providers will also have the option to volunteer to join an accelerated 2016/17 transformation cohort.
Seven day services	As a condition of the overall fund being approved, the NHS has to demonstrate tangible progress towards a credible plan for achieving seven-day services for patients across the country by 2020. Recipients of funding will be expected to continue to make progress towards achieving seven-day services in 2016/17.

Deliver agreed control total
2016/17 plans were submitted to NHSI in line with their deadlines. The I&E plan is for delivery of the £16.1m control total as set for the Trust by NHSI. The Trust has highlighted to NHSI the level of risk that this plan carries, particularly around the implementation of the new EPR system. As yet the Trust has not received formal approval of the planned capital investment of £28.2m.

At the end of Month 1 the forecast is to deliver the £16.1m planned deficit in line with the control total.

Carter implementation
The Carter dashboard and data supplied through the Carter initiative is being used alongside internal SLR/PLICS data to identify and progress savings opportunities.

Access standards
At this stage the Trust is not highlighting any material risk against performance of the planned trajectories as submitted to Monitor in the course of the first quarter.

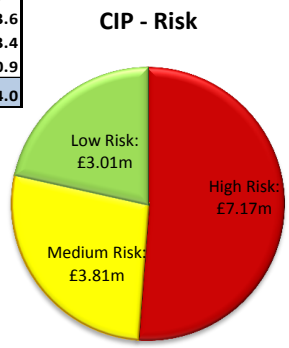
Transformation
The Trust will work with commissioners and develop an integrated five-year plan in line with the national STP timetable. This is very much linked to the work that has already been completed locally to develop the 5 year transformation strategy which the commissioners currently have out to public consultation.

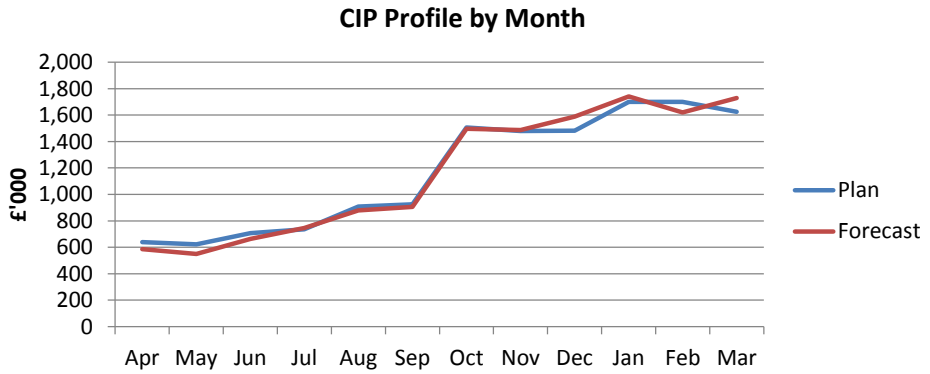
Implementation of the 5 year transformation strategy is dependent upon both the outcome of public consultation and approval of the required funding support from Treasury.

Seven day services
Investment was made in 2016/17 in the Hospital at Night project which will operate in support of seven day services. Further opportunity would come as part of the service reconfiguration under the 5 year transformation strategy.

COST IMPROVEMENT PROGRAMME

Division	16/17 Forecast CIP by Risk rating			
	Low £'m	Medium £'m	High £'m	Total £'m
Corporate Services	0.5	0.1	0.3	**0.9**
Estates & Facilities	0.6	0.3	0.2	**1.1**
Health Informatics	0.0	0.0	0.4	**0.4**
Medicine	0.8	1.1	1.5	**3.4**
PMU	0.0	0.0	0.2	**0.2**
Surgery & Anaesthetics	0.4	0.9	2.2	**3.6**
Families & Specialist Services	0.5	0.7	2.3	**3.4**
Community	0.2	0.7	0.0	**0.9**
Grand Total	**3.0**	**3.8**	**7.2**	**14.0**





	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Plan	640	623	708	737	908	925	1,506	1,479	1,482	1,700	1,700	1,625
Forecast	585	550	664	746	879	905	1,497	1,487	1,590	1,741	1,621	1,728

In month 1, £0.59m of CIP has been delivered against a plan of £0.64m. This shortfall of £0.05m is reported within the overall month 1 deficit.

The delivery of CIP has been profiled based on a combination of known scheme delivery dates but also with sufficient lead and development time for schemes currently at opportunity stage rather than well progressed. Whilst this presents a risk and the in-month CIP challenge increases from £0.64 to £1.63 by month 12, full CIP delivery is currently forecast.

CIP Update at 18th May 2016

The Trust has a well established governance process for the development of CIP schemes from the initial idea scoping stage, to Gateway 1 (GW1) where schemes are required to have a project brief including stage 1 QIA and executive sponsor. Schemes progress to Gateway 2 (GW2) only when there is a full project workbook including stage 2 QIA panel sign off and full PMO and executive sponsor approval.

For these reasons GW2 approved schemes are better developed and therefore carry less risk. However, all schemes are assigned a risk rating. There are schemes that have full GW 2 clearance that still hold risk and require action, and equally there are ideas still being scoped that are deemed low risk and likely to fully materialise.

As of 18th May 2016, £14m of scheme opportunities have been identified. Of those schemes that have passed through gateway 2, £1.3m are deemed high risk. These include:

- Theatre productivity £0.42m
- Bed efficiency £0.22m
- OP productivity £0.21m

Of the remaining schemes at scoping and GW 1 stage, £1.7m are deemed to be of low or medium risk.

Summary

Work is urgently required to develop schemes through to GW 2 but also to ensure that risks of non-delivery are mitigated and schemes are delivered. A further challenge is to increase the value and volume of ideas as delivery of the £14m target within plan will need all current ideas to progress and be fully delivered in year and for at least the current suggested value.

SERVICE LINE REPORTING

SLR SERVICE LINE REPORTING DASHBOARD

SERVICE LINE REPORTING

Month 12 (12 months to Mar'16)

Calderdale and Huddersfield NHS
NHS Foundation Trust

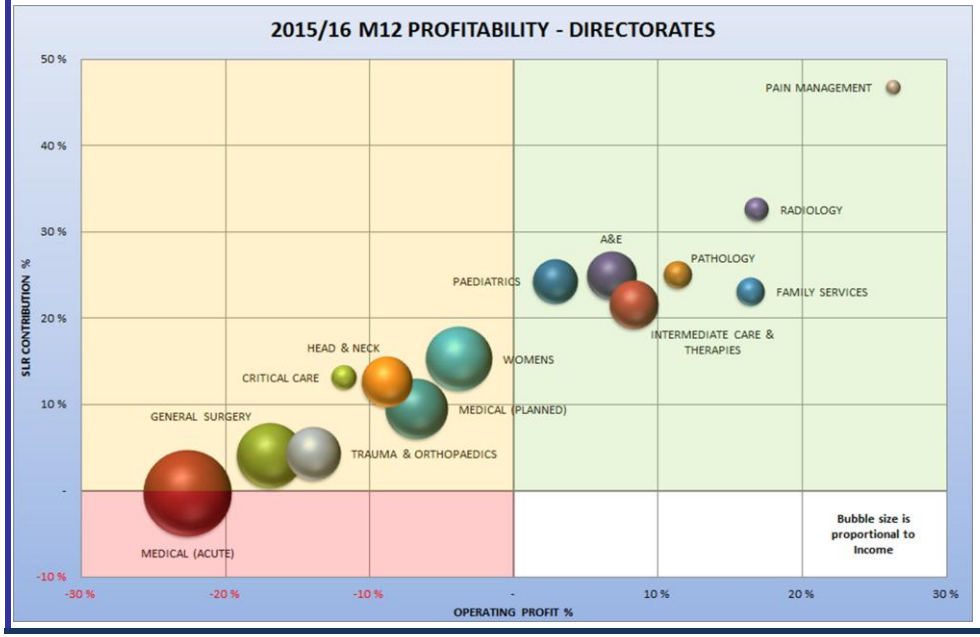
Show Selections

Income: £350,250,048 **Cost: £371,161,024** **Profit/(Loss): (£20,910,976)** **Episodes / Attendances: 838,575**

Switch to Cyclic View | SLR Relative Profitability (Bubble Charts) | Cost Pools Analysis

SLR Summary

Division	Total SLR Income	Direct	Indirect	SLR Contribution	Cont %	Overhead	Total Cost	Operating Profit / (Loss)	Operating Profit %	Loss / Profit % of Income
MEDICAL	126,014,162	111,269,657	5,961,657	8,782,847	7.0%	25,136,258	142,367,573	(16,353,411)	-13.0%	
SURGICAL	97,409,887	83,872,303	6,168,421	7,369,164	7.6%	20,042,872	110,083,596	(12,673,708)	-13.0%	
FSS	69,885,240	53,264,933	2,188,560	14,431,747	20.7%	13,121,657	68,575,150	1,310,090	1.9%	
COMMUNITY	28,924,782	22,711,121	187,442	6,026,218	20.8%	3,421,412	26,319,976	2,604,806	9.0%	
CORPORATE	21,563,931	2,257,898	2,164,418	17,141,615	79.5%	14,694,869	19,117,186	2,446,745	11.3%	
Pharmacy Manufacturing Unit	6,452,045	497	13,074	6,438,474	99.8%	4,683,973	4,697,544	1,754,502	27.2%	
TOTAL	**350,250,048**	**273,376,410**	**16,683,573**	**60,190,066**	**17.2%**	**81,101,041**	**371,161,024**	**(20,910,976)**	**-6.0%**	



The view opposite illustrates relative profitability of the Trust's divisions and clinical directorates at a summary level.

Unlike budget reporting Service Line Reporting (SLR) aims to identify the full cost of providing the service including all supporting clincial activity, e.g. Diagnostic tests and the call of the service upon other functions such as estates and facilities and corporate services. The principle is that income is matched against the full cost of delivering the service.

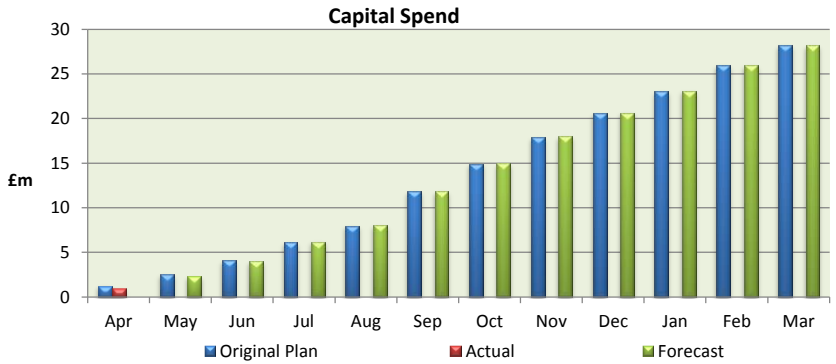
The illustration opposite shows that the areas with the gratest losses are predominantly the largest services at the Trust: Acute Medicine, General Surgery and Orthopaedics.

At CHFT SLR is built up from patient level costing (PLICS) information, combining information from clinical information systems and financial systems, aggregated up to service level. The detailed PLICS information is being used to support the analysis for the Carter productivity review. This information is widely accessible to managers to interrogate their own services and understand clinical variation and cost drivers. This is increasingly being used to stimulate discussions with clinicians with greater clinical engagement being a key goal. SLR/PLICS information is now routinely being presented with divisional reporting packs. This is aimed at generating further discussiion and identification of opportunities.

CAPITAL

CAPITAL - TOTAL

	M01 Plan £m	M01 Actual £m	Var £m	M1
Capital	£1.23	£0.95	£0.28	



CAPITAL - BY SCHEME

	Year To Date M01 Plan £m	Year To Date M01 Actual £m	Year To Date Var £m	Year End: Forecast Plan £m	Year End: Forecast Forecast £m	Year End: Forecast Var £m
Theatre refurbishment	£0.28	£0.03	£0.25	£2.60	£2.60	£0.00
Ward upgrades	£0.00	£0.00	£0.00	£2.40	£2.40	£0.00
Other Estates	£0.07	£0.06	(£0.01)	£5.97	£5.97	£0.00
Total Estates	**£0.35**	**£0.09**	**£0.24**	**£10.97**	**£10.97**	**£0.00**
Electronic Patient Record	£0.20	£0.18	£0.03	£4.74	£4.74	£0.00
Other IT	£0.45	£0.48	(£0.03)	£2.94	£2.94	£0.00
Total IT	**£0.65**	**£0.65**	**£0.00**	**£7.67**	**£7.67**	**£0.00**
Equipment	£0.11	£0.02	£0.09	£7.22	£7.22	£0.00
PFI Lifecycle	£0.12	£0.12	£0.00	£1.46	£1.46	£0.00
Other	£0.00	£0.07	(£0.07)	£0.91	£0.91	£0.00
Total Other	**£0.23**	**£0.21**	**£0.02**	**£9.58**	**£9.58**	**£0.00**
Total Capital	**£1.23**	**£0.95**	**£0.27**	**£28.22**	**£28.22**	**£0.00**

Capital expenditure in the year to date is £0.95m which is £0.28m below the planned level of £1.23m.

Against the Estates element of the total, expenditure is £0.09m against a planned £.0.28m. The main area of spend in month was on backlog maintenance including and the continuation of work to improve privacy and dignity within the radiology department. The Theatre refurbishment programme has continued and the programme of works is on track, the expenditure was less than planned in month, but is expected to be on plan for next month.

IM&T investments total £0.65m against plan of £0.65m. The main individual areas of spend in month is against Singal Sign on, the continuation of the Electronic Patient Record (EPR), and EDMS projects.

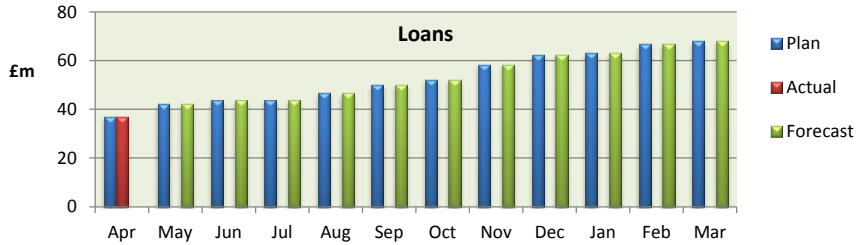
Expenditure on replacement equipment in the year to date is also lower than plan.

In overall terms the capital expenditure is expected to come in line with plan in the full year at this stage. The plan submitted to NHSI in April allows for £28.22m of capital investment. This has not explicitly been agreed by NHSI at this stage.

CASH

CASH & BORROWING

	M01 Plan	M01 Actual	Var	M01
	£m	£m	£m	
Cash	1.94	1.92	(£0.02)	
Loans	£36.95	£36.95	£0.00	



CASH FLOW

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	(0.30)
	Non cash flows in operating deficit	(0.05)
	Other working capital movements	1.12
	Sub Total	**0.77**
Investing activities	Capital expenditure	0.28
	Movement in capital creditors	(1.25)
	Sub Total	**(0.96)**
Financing activities	Drawdown of external DoH cash support	0.00
	Other financing activities	0.17
	Sub Total	**0.17**
	Grand Total	**(0.02)**

KEY METRICS

RECEIVABLES:

As at Month 1 16/17 Aged Debt was as follows

Days	30-60	61-90	91-120	121-180	180-360	360+	Total
£m	0.61	0.39	0.38	0.33	0.41	0.43	**2.55**
No Invoices	392	213	139	239	326	483	**1,792**

PAYABLES:

£m	**4.55**	Value of approved invoices not paid at month end
No Invoices	**3,843**	No. of approved invoices not paid at month end

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 opposite.

Operating activities

Operating activities show a favourable £0.77m variance against the plan. The adverse cash impact of the I&E position of £0.35m (£0.30m adverse I&E variance plus £0.05m non-cash flows in operating deficit) offset by favourable working capital variances from plan.

The working capital variance demonstrates the holding back of payments to suppliers in order to manage the overall cash position, partly due to overdue invoices from other NHS organisations. This includes invoices for: Cancer Drug funding relating to March and year end over performance with NHS England; and Overseas patient income and Self management Support team costs from NHS Calderdale CCG, at a total value of £0.56m.

Total aged debt based on invoices raised is £2.55m whilst outstanding creditors approved for payment to suppliers stood at £4.55m at month end. The impact of this is seen in the performance against the Better Payment Practice Code, in month 42% of invoices have been paid within 30 days against the 95% target. This is a decrease on the 66% seen last month. Essentially the cash position of the Trust is now being protected by delaying payments to suppliers. The overspend and cash flow linked to agency spend are key drivers as is timely receipt of debtors.

Investing activities (Capital)

The favourable cash impact of the £0.28m under spend is offset by a £1.25m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £0.17m favourable variance from the original plan. The £5m capital loan to support the EPR deployment was drawn down from the Independent Trust Financing Facility (ITFF) in April as planned. This is against a pre-approved £30m loan facility that the Trust has had in place since 2014/15 and of which £17m has already been called upon prior to 2016/17 and attracts interest at the rate of 2.35%.

The balance of the capital programme of £23.2m coupled with the I&E deficit will lead to the requirement for further DH cash support in 2016/17 totalling £32.6m. The requirement for this commences from May 2016, at which point the Trust will call upon the Working Capital Loan facility in advance of progression to an Interim Support Loan in year. Cash flows against the £11.3m Strategic Transformation Funding are assumed as quarterly payments in arrears.

FINANCIAL SUSTAINABILITY RISK RATING

	Plan YTD	Actual YTD
Capital Service Cover		
Revenue Available for Capital Service	(0.75)	(1.11)
Capital Service	1.32	1.32
Capital Service Cover metric	(0.57)	(0.84)
Capital Service Cover rating	1	1
Liquidity		
Working Capital for FSRR	(25.63)	(25.64)
Operating Expenses within EBITDA, Total	(30.42)	(31.05)
Liquidity metric	(25.27)	(24.78)
Liquidity rating	1	1
I&E Margin		
Normalised Surplus/(Deficit)	(2.86)	(3.16)
Adjusted Total Income for FSRR	29.69	29.95
I&E Margin	(9.62%)	(10.54%)
I&E Margin rating	1	1
I&E Margin Variance		
I&E Margin	(9.62%)	(9.62%)
I&E Margin Variance From Plan	0.36%	(0.92%)
I&E Margin Variance From Plan rating	4	3
Overall Financial Sustainability Risk Rating	2	2

Financial Sustainability Risk Rating

The Financial Sustainability Risk Rating (FSRR) is used by Monitor as a means of assessing the Trust's financial strength. The rating takes into account four metrics:

Liquidity: days of operating costs held in cash or cash-equivalent forms (cash in the bank less payables plus receivables, on the presumption these can be immediately converted into cash)

Capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations (a measure of the Trust's ability to afford its debt - in this sense payments against debts include PDC payments, interest and loan repayments and PFI interest, PFI contingent rent and PFI capital repayments. The obligations against the PFI always made this a hard measure for CHFT even when achieving a surplus.)

Income and expenditure (I&E) margin: the degree to which the organisation is operating at a surplus/deficit (measured excluding 'exceptional' costs such as impairments and restructuring costs)

Variance from plan in relation to I&E margin: variance between a foundation trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year (again measured excluding 'exceptional' costs, e.g. impairments, restructuring costs)

Trust Performance

The Trust's year to date performance on the overall FSRR and the individual metrics is shown below. Based on the current year end forecast this FSRR position would be the same at year end.

The overall FSRR stands at level 2, based upon the average of the scores against the metrics above calculated as follows:
1 + 1 + 1 + 3 = 6 / 4 = 1.5 rounded to an overall rating of 2

As a guide, if the adverse variance from plan (excluding restructuring costs) for the full year were to exceed £3m then the score against this metric would drop to a score of 2, bringing the overall FSRR down to level 1.

Regulatory implications

Given that the Trust is already under the scrutiny of Monitor and continues to run a deficit, maintaining FSRR level 2 will not in itself change the regulatory implications in terms of the regime that it in place. However, maintaining the Income and Expenditure Margin – Variance from Plan at a level 3 or above is an indicator of performance in itself.

FORECAST

YEAR END 2016/17

	Plan £m	Forecast £m	Var £m	
Elective	£22.48	£22.04	(£0.44)	
Non Elective	£87.09	£87.93	£0.84	
Daycase	£26.37	£25.74	(£0.63)	
Outpatients	£43.43	£43.85	£0.42	
A & E	£16.43	£16.40	(£0.03)	
Other-NHS Clinical	£129.03	£131.71	£2.68	
CQUIN	£6.79	£6.90	£0.11	
Other Income	£39.70	£38.43	(£1.27)	
Total Income	**£371.32**	**£373.00**	**£1.69**	
Pay	(£237.12)	(£239.29)	(£2.17)	
Drug Costs	(£35.59)	(£36.42)	(£0.84)	
Clinical Support	(£30.17)	(£29.98)	£0.19	
Other Costs	(£47.05)	(£46.74)	£0.31	
PFI Costs	(£12.04)	(£12.02)	£0.02	
Total Expenditure	**(£361.97)**	**(£364.46)**	**(£2.49)**	
EBITDA	**£9.35**	**£8.55**	**(£0.80)**	
Non Operating Expenditure	(£25.45)	(£24.65)	£0.80	
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**	
Restructuring Costs	£0.00	£0.00	£0.00	
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**	

KEY METRICS

	Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£16.10)	(£16.10)	(£0.00)	
Capital	£28.22	£28.22	£0.00	
Cash	£1.95	£1.95	(£0.00)	
Borrowing	£67.87	£67.87	£0.00	
CIP	£14.00	£14.00	(£0.00)	
Financial Sustainability Risk Rating	2	2	0	

The year end forecast position at this early stage is to deliver the planned £16.1m deficit. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit.

There are a number of risks against the delivery of the planned deficit position, the most significant of which are as follows:

Electronic Patient Record implementation
The risk here is multifold; the operational impact through implementation has the potential to disrupt clinical productivity bringing costs and/ or income loss; any delay to the go live date will bring additional pressure whether through charges levied by the system provider Cerner or internal project management costs; and the complexity of the project means that additional unforeseen costs may arise, for example dual running and system resilience costs.

Agency staffing usage
As highlighted in the workforce and expenditure sections of this report, recruitment and retention issues in particular are driving a higher agency staffing run rate than the budgeted level. There is a balance to be struck between maintaining safe staffing levels and delivering planned clinical activity at best value.

Planned activity delivery
Linked to the staffing gaps in key Medical and Surgical specialties, there is a risk of a shortfall against the planned elective and day case activity impacting income.

CIP delivery
The full £14m CIP requirement is not yet identified at a sufficiently detailed level to satisfy the Gateway 2 criteria and £7.17m of the overall £14m is flagged as high risk at this stage. The planned CIP profile is significantly weighted towards the latter part of the financial year.

Divisions are required to design and deliver recovery plans to mitigate against the risks and pressures emerging in their respective areas of service. In addition there will need to be Trust wide action to address these risks and maintain rigorous budgetary control.

The capital expenditure is forecast to be on line with plan at this stage at £28.2m and cash borrowing levels are also forecast to be as per plan with £37.63m of total loans to be drawn down in year.

RISKS

Financial Risks

Risk description	Score
The Trust is planning to deliver a £16.1 M deficit in 2016/17. There is a risk that the Trust fails to achieve its financial plans for 2016/16 due to: - clinical activity and therefore income being below planned levels - income shortfall due to commissioner affordability - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of sustainability and transformation funding due to performance - failure to deliver cost improvements - expenditure in excess of budgeted levels - agency expenditure and premia in excess of planned and Monitor ceiling level	20
Risk that the Trust will have to suspend or curtail its capital programme for 2016/17 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. There is a risk that Monitor will not approve the Trust's capital programme for 2016/17 due to national funding pressure also resulting a failure to develop infrastructure for the	20
Risk that the Trust will not be able to pay suppliers, staff, PDC and 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 going concern.	15

Risk Scoring Matrix

Impact							
>£5m	5	5	10	15	20	25	
>£1m	4	4	8	12	16	20	
>£0.5m	3	3	6	9	12	15	
>£0.1m	2	2	4	6	8	10	
<£0.1m	1	1	2	3	4	5	
	0	1	2	3	4	5	Likelihood
		<1%	1-5%	6-20%	21-50%	>50%	
		Rare	Unlikely	Possible	Likely	Almost Certain	

Score	
1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15-25	Extreme Risk

I&E

At Month 1, the year end forecast position is to deliver the planned £16.1m deficit. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit.

Based on current levels of vacancies and recruitment profiles it is likely to be extremely challenging to significantly reduce agency expenditure whilst striving to maintain safe staffing levels. Recruitment and retention and bed capacity issues bring risk to delivery of elective and daycase activity. Against the £14m CIP target £7.17m remains as high risk. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase for which the plans do not make any specific financial allowance.

Capital

As at mid-May 2016 Monitor have not formally approved the Trust's capital plan and therefore avaiability of the required loan funding to support the £28.2m capital programme is not guaranteed at this stage.

Cash

The Trust is having to manage and prioritise payments to suppliers in order to maintain required cash balances. Further action is being taken to maximise collection of receivables and the profile of cash management is being raised at Divisional level. Confirmation has been received of approval of the planned loan drawdown for May 2016.

Action required:

- **Focus on recruitment and retention and reduction of agency staffing usage**
- **Progression of CIP plans to full £14m + and close monitoring of delivery**
- **Delivery of planned clinical activity**
- **Operational plans to mitigate EPR implementation risks**
- **Delivery of conditions to secure £11.3m Strategic Transformation Funding**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Linda Cordingley, Executive Assistant to Chief Executive
Date: Thursday, 26th May 2016	**Sponsoring Director:** Owen Williams, Chief Executive
Title and brief summary: Staff Survey Action Plan - The paper sets out the key findings from the focused work with colleagues on the actions to address the feedback through the 2015 staff survey.	
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: A workforce for the future	
Sustainability Implications: None	

Executive Summary

Summary:

The paper sets out the key findings from the focused work with colleagues on the actions to address the feedback through the 2015 staff survey.

A number of focus groups and structured 1:1 interviews took place involving a total of 82 colleagues. A summary report from this work is attached at Appendix A.

The key themes which emerged were:

Colleague health and wellbeing
Talent management/leadership and management development
Communication, information and feedback
Reward and recognition

Participants expressed a wish to be involved in implementing one or more of these specific actions and will work with the identified lead. There was also an overarching theme of the need for consistent ward to board visibility and accessibility, and Board leadership of the four key themes.

The engagement activity identified specific actions to address these key themes (Appendix B).

Main Body

Purpose:

The paper sets out the key findings from the focused work with colleagues on the actions to address the feedback through the 2015 staff survey.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note the findings of the work and approve the action plan. Progress will be monitored by the Workforce (Well-Led) Committee and it is recommended that an update on progress will be brought back to the Board in September.

Appendix

Attachment:

Staff Survey Action Plan.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS - 26 MAY 2016

STAFF SURVEY ACTION PLAN

1. PURPOSE

The paper sets out the key findings from the focused work with colleagues on the actions to address the feedback through the 2015 staff survey.

2. INTRODUCTION

In March 2016, the Board of Directors received the results of the Trust's findings from the 2015 national NHS Staff Survey alongside the Investors in People (IIP) assessment report. The two reports highlighted areas of good practice on which we need to build as well as areas for the Trust to focus on to improve the experience of staff across the organisation. It was agreed to develop a response to these findings, co-produced with colleagues and bring this back to the Board.

3. APPROACH

The approach to developing the action plan is consistent with one of our core values:

'We work together to get results'

We co-create change with colleagues, creating solutions which work across the full patient journey

We invited 435 colleagues to participate. The invitees comprised colleagues who have completed the Work Together, Get Results (WTGR) 2-day programme and those who participated in the IIP assessment.

Seven focus groups were held supplemented by structured 1:1 interviews. A total of 82 colleagues participated (60 in focus groups and 22 in 1:1 interviews).

We used the WTGR engaged leaders' toolkit in the focus groups and in the 1:1 interviews. The WTGR toolkit creates the conditions where success for the Trust and for colleagues is fully aligned. Engaged colleagues feel fully motivated and are likely to be more creative, take greater responsibility and create better working relationships with those around them. Specifically we used the 3Rs tool (reality + response = results). The tool helps to organise our thinking and create a narrative of what we are trying to do.

The engagement with colleagues was structured around the following questions:

- Which three themes from the staff survey matter the most to you? (reality)
- How would you like things to be in the future? (result)
- What must we do – what are the three most important actions? (response)

A summary report from the focus groups and 1:1 interviews is attached at Appendix A.

4. KEY THEMES

From the engagement activity, we identified four key themes:

1. Colleague health and wellbeing

   Colleagues wanted to see better access and information to mental and physical health and wellbeing support.

2. Talent management/leadership and management development

   More visible career progression and development opportunities and consistency in good line management practice.

3. Communication, information and feedback

   Ensuring colleagues have access to information which enables them to make an effective contribution and to have a voice in the organisation.

4. Reward and recognition

   Ensuring colleagues who are performing consistently and well are identified and recognised and managers know how to show staff their work is appreciated.

   There was also an overarching theme of the need for consistent ward to board visibility and accessibility, and Board leadership of the four key themes.

   There was one priority which did not fall within one of the four key themes – ensure provision of up-to-date equipment and that clear procurement guidance for clinical and non-clinical managers is available. This will picked up separately and the lead has been identified as Keith Griffiths, Director of Finance.

   The engagement activity identified specific actions to address these key themes (Appendix B). Focus group and 1:1 interview participants expressed a wish to be involved in implementing one or more of these specific actions and will work with the identified lead.

5. RECOMMENDATION

The Board is asked to note the findings of the work and approve the action plan. Progress will be monitored by the Workforce (Well-Led) Committee and it is recommended that an update on progress will be brought back to the Board in September.

Owen Williams
Chief Executive

Vicky Pickles
Company Secretary

Azizen Khan
Assistant Director of Human Resources

Christine Bouckley
Colleague Health and Wellbeing Lead

Jason Eddleston
Deputy Director of Workforce and OD

Linda Cordingley
Staff Survey Lead

Appendix A

STAFF SURVEY FOCUS GROUP AND 1:1 INTERVIEWS

SUMMARY REPORT

KEY ISSUES IDENTIFIED (REALITY)

'Which 3 themes from the staff survey matter the most to you?'

Recognition and value of staff by managers and the organisation (27)
Support from immediate managers (19)
Staff recommendation of the organisation as a place to work or receive treatment (18)
Staff suffering work-related stress in last 12 months (15)
Staff agreeing that their role makes a difference to patients/service users (12)
Effective team working (10)
Staff satisfied with the opportunities for flexible working patterns (10)
Reporting good communication between senior management and staff (9)
Staff satisfaction with resourcing and support (6)

(Responses scoring less than 5 votes have been omitted)

WHAT WE ARE COMMITTED TO (RESULT)

'How would you like things to be in the future?'

- Culture shift
- Resources
- Empowerment – Managers
- Flexible Working
- IT
- Appraisal Quality
- Health & Wellbeing

Increase staffing
Recognising and valuing staff
Saying thank you to people
Celebrating successes and sharing good practice
Setting clear career pathways
Training and development
Giving staff a voice no matter what role or grade
Training staff to support their colleagues through difficult times
Opportunities to try new things outside of role as part of development
Giving people someone to go to / mentor
Staff gym
No blame culture
Positive attitudes towards all colleagues and make people feel valued
Clear communication which is easy to understand
Good quality appraisals for all staff
Staff are clear about their roles and how it fits in and delivers against the pillars
Work / life balance is encouraged by senior management
Work demands are reasonable
Staff want to come to work and are proud of CHFT
Everyone works together across all services
The right and appropriate staffing levels are in place
Support for new colleagues especially newly qualified with an identified preceptor who has protected time for the role
Health and wellbeing experts to support staff with a broad range of initiatives
Quicker and streamlined process for recruiting staff
Agile and flexible working with clear guidelines and rules about working in your own time
Development opportunities for all staff particularly those who are good team workers and can motivate others
Experienced staff are retained
Better career pathways and prospects where internal staff are encouraged to apply for promotion
Managers are visible and come and talk to staff routinely
Excellent staff survey results and patient satisfaction surveys.

WHAT WE NEED TO DO NOW (RESPONSE)

'What must we do – what are the 3 most important actions?'

Culture Shift

- Reward and recognition – at team and directorate level not just corporate level to make staff feel valued
- Celebrate success
- Someone for people to talk to
- Greater visibility of senior management – within divisions as well as corporately
- Recruit to behaviours and use these to hold people to account
- Campaign around valuing different perspectives
- Workplace rules "from the top"
- Redesign how we communicate – meetings ban at certain times email / phone off times (not expected to be available 24/7)
- Director commitment and then all to reasonable hours
- Identify role models for work life balance (champions)
- No unreasonable timescales
- Exec team seen to have lunch
- Less "chasers" and more "do-ers"
- Refocus OD work – follow through and deliver/use of more coaching circles
- Clear communications strategy
- Celebrate success
- Refresh listening groups
- Improve communication by managers talking to staff face to face and listen to their concerns/issues and recommendations
- Introduce a myths and rumours books on wards and departments which staff can use to ask anonymous questions of managers
- Everyone uses the "Hello my name is …" campaign
- Have a new Must-Do which is to 'smile and be respectful' and use 'please and thank you' with everyone

Resources

- Workshop for senior managers on changing culture of the Trust about working evenings and weekends and review use of email communication
- Right person doing the job (Admin review +ves and –ves)
- Release time in roles linked to recruitment and retention
- Workforce development/new, different roles
- Having tools of the trade – e.g. thermometers / scales
- Mentoring programme for all staff
- Leadership development programme / passport
- Probationary period for management training
- Recruitment and selection to get the right managers
- Management / colleague relationship skills
- Protected time for meetings and training
- Succession resource planning

- Personal development and training
- Create better networks
- Navigator for services – point of contact for patients
- Development programme for clinical staff and admin and clerical staff
- Annual timetable for all wards and departments with protected time for staff identified to do mandatory training
- Preceptors given protected time to support new staff
- Review and implement changes to improve recruitment to posts
- Series of events more locally delivered to celebrate successes of teams
- Clear roles and understanding how these link to patient care
- Training for line managers on how to engage with their teams

Empowerment

- Set out clear guidelines on flexible working for managers and staff
- Being able to make decisions locally
- Say hello / smile
- Thank you messages / cards
- Be really clear about staffing levels and include time for development
- Release time in roles linked to recruitment and retention
- Mentoring programme for all staff
- Leadership development programme / passport
- Probationary period for management training
- Management / colleague relationship skills
- Personal development and training
- Support for struggling teams – development
- Clear career progression routes

Flexible Working

- Produce clear guidelines – options, examples, stories

IT

- Put conferencing systems into community settings / meetings room – SKYPE / webinars
- Video Big Brief / TV screens for briefings / communications
- EPR and THIS more integrated into core functions – so they know about what we need to do – integrate into divisional boards / link person for division / area
- People being involved in creating the changes
- Scope what IT is required to make us more efficient
- What is available?
- Internet café approaches on site
- Use ESR to capacity
- Increase staff appetite for use of IT – use to empower, engage

Appraisal Quality

- Example of good tool – tried and tested in community – keen to share
- Go see opportunities for all staff – internally and externally
- Daily handovers of issues as opposed to time-out sessions
- Introduce performance management standards for line managers

Health and Wellbeing

- Robust strategy
- More mental health support
- Health and wellbeing handbook / roadshows
- Offer health and wellbeing benefits like relaxation classes, exercise classes on site
- Staff gyms and showers on both sites which will reduce stress and absenteeism
- Have better staff rest facilities for example a quiet area, games room and outdoor sitting areas.

Appendix B

Staff Survey Action Plan 2016/2017

IDENTIFIED RESPONSE	ACTION	ACTION LEAD	DELIVERY TIMESCALE
COLLEAGUE HEALTH & WELLBEING			
Create a robust health and wellbeing strategy	Test draft colleague health and wellbeing strategy and calendar of events (2016 Year of Health and Wellbeing) with staff survey focus group and 1:1 interview participants Produce health and wellbeing handbook and roadshow calendar Design communications plan to maintain visibility of events Identify role models/champions for work life balance and increase existing network of 50 workplace wellbeing champions to 100	Ian Warren / Karen Heaton	30 September 2016
Provide more colleague mental health support	Review mindfulness pilot programme and establish future plan Working in partnership with chaplaincy to support mental wellbeing retreat days and events Review managing stress training for managers and staff Review and develop mental health first aid training programme	Brendan Brown / David Anderson	30 June 2016
Offer health and wellbeing benefits	Explore the direct provision and external partnership provision of physical and mental health & wellbeing relaxation and exercise classes on site Explore the direct provision and/or external partnership provision of gym facilities Explore the opportunities for improved provision for rest facilities, use of outdoor spaces, provision of changing rooms and showers Effectively communicate provision across the Trust	Lesley Hill / David Anderson	30 September 2016

TALENT MANAGEMENT/LEADERSHIP AND MANAGEMENT DEVELOPMENT			
Improve access to personal and professional development opportunities	Enhance the quality of appraisals Offer 'go see' opportunities (internal and external) for all staff Identify clear career progression routes Design a comprehensive leadership and management development programme Create structured development programmes for all clinical and non-clinical colleagues Use coaching circles as a learning and development tool Offer mentoring and coaching programmes for all staff Explore the options for protected learning and development time Preceptors given protected time to support new starters	Ian Warren / Peter Roberts	31 August 2016
Strengthen the provision of equality and diversity training to include cultural awareness training and valuing different perspectives	Review current programmes available through the West Yorkshire Equality and Diversity network Review and develop the existing Embracing Diversity training programme	Anna Basford / Jan Wilson	30 September 2016
Set out clear guidelines on flexible working for managers and staff including consideration of meetings ban at certain times, email/phone off times (not expected to be available 24/7)	Clarify flexible working options with case study examples and staff/manager stories Create and deliver workshops for senior managers on changing the culture of the Trust about working evenings and weekends and review use of email communication	Lesley Hill	31 July 2016

Recruit to values/behaviours and use these to hold colleagues to account	Extend 'recruit to values' programme to all staff groups	Anna Basford / Keith Griffiths	31 July 2016
Implement changes to internal processes to improve recruitment to posts	Refine vacancy control mechanisms Implement StepChange recruitment process recommendations	Ian Warren	30 September 2016
Introduce standards for line managers	Design performance/management standards/competencies for managers at every level in the Trust Utilise standards/competencies to recruit and select to manager posts Prepare guidance for managers on tools to use to strengthen team working	Helen Barker / Phil Oldfield	31 August 2016
COMMUNICATION, INFORMATION AND FEEDBACK			
Implement a clear trust-wide communications strategy	Revise the current internal communications plan to describe requirements at corporate, divisional and directorate level	Brendan Brown / Richard Hopkin	31 July 2016
Everyone use the "Hello my name is …" campaign	Implement an everyday behaviour campaign to develop working practice	David Birkenhead	30 June 2016
Review delivery of team brief to include time for improved communication by managers talking to staff face-to-face and listening to their concerns and recommendations	Revise team brief policy and re-introduce team brief training for all line managers across the Trust building in these principles. Implement a corporate framework for listening groups/drop in sessions	Helen Barker	31 July 2016
Increase staff appetite for use of IT – use to empower and engage and inform	Put conferencing systems into community settings/meeting rooms – to increase use of webinars and limit travel between sites Video Big Brief/TV screens for briefings/communication Scope what IT is required to make us more efficient and implement employee and manager self-serve	Mandy Griffin	30 September 2016

	Open up access to internet cafés on Trust sites Scope use of the Electronic Staff Record (ESR) to its full potential and explore alternatives to the Oracle Learning Management system in ESR		
REWARD AND RECOGNITION			
Have a new must-do which is to 'smile and be respectful' and use 'please and thank you'	Add the 'must-do' value to those the Trust already has in place and communicate	David Birkenhead	30 June 2016
Promote the use of thank you messages/cards	Revise design and ensure supply available across all teams with short guidance note	Keith Griffiths	31 May 2016
Enhance 'Celebrate Success' opportunities	Develop plan to embed celebrating success across divisions	Lesley Hill	30 June 2016

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th May 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 25.4.16 and verbal update from meeting 24.5.16
- Finance and Performance Committee - minutes of 26.4.16 and verbal update from meeting 24.5.16
- Audit and Risk Committee - minutes of 20.4.16 and verbal update from meeting 26.5.16
- Workforce (Well Led) Committee - minutes of 21.4.16
- Draft Membership Council Meeting - minutes of 7.4.16
- Charitable Funds Committee - minutes 9.5.16

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 25.4.16 and verbal update from meeting 24.5.16
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- Workforce (Well Led) Committee - minutes of 21.4.16
- Draft Membership Council Meeting - minutes of 7.4.16
- Charitable Funds Committee - minutes 9.5.16

Appendix

Attachment:

COMBINED SUB CTTEE MINS.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Quality Committee held on Tuesday 26 April 2016 in Discussion Room 2, Learning and Development Centre, Huddersfield Royal Infirmary.

PRESENT

Andrea McCourt	Head of Governance and Risk
David Anderson	Non-Executive Director /Committee Chair
David Birkenhead	Medical Director
Jan Wilson	Non-Executive Director
Jackie Murphy	Deputy Director of Nursing, Modernisation
Joanne Middleton	Associate Nurse Director, Surgery and Anaesthetic Services
Julie O'Riordan	Divisional Director, Surgery and Anaesthetic Services
Juliette Cosgrove	Assistant Director of Quality
Karen Barnett	Assistant Divisional Director, Community Services
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Lindsay Rudge	Acting Director of Nursing
Lynn Moore	Membership Council Representative
Tracy Fennell	Associate Nurse Director, Medical Division

IN ATTENDANCE/OBSERVERS

Stephanie Jones	Committee Secretary/PA to Director of Nursing
Michelle Augustine	Secretary
Bev France	Head of Workforce Development (Item 073/16)

ITEM NO	
068/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
069/16	**APOLOGIES** Anne-Marie Henshaw — Associate Nurse Director/Head of Midwifery, FSS Division Diane Catlow — Interim Associate Nurse Director, Community Services Helen Barker — Chief Operating Officer Jason Eddleston — Deputy Director of Workforce and Organisational Development Keith Griffiths — Executive Director of Finance Kirsty Archer — Deputy Director of Finance Martin DeBono — Divisional Director, FSS Division Sal Uka — Divisional Director, 7 Day Service/Hospital at Night Stuart Baron — Deputy Director of Finance Victoria Pickles — Company Secretary
070/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note.

071/16

MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 29 March 2016 were approved as a correct record.

072/16

ACTION LOG

All the items on the action log due this month were agenda items under Matters Arising/Main Agenda.

ACTION

- **Regulation 28 Cases:** The Committee requested that it receive an update report outlining all four Regulation 28 cases. The report should include an updated action plan, what stage each case is currently at and any themes/lessons learnt and how they have been shared across the organisation.
  ACTION: Regulation 28 Divisional Leads

MATTERS ARISING / MAIN AGENDA ITEMS

073/16

UPDATE REPORT ON MANDATORY TRAINING, ESSENTIAL SKILLS AND INDUCTION

Bev France, Head of Workforce Development was in attendance to present an update on the new approach to Mandatory Training, Essential Skills and Induction, which was implemented on the 1 June 2015.

ACTION:

Mandatory Training: It was noted that Appendix 1 which detailed compliance data for the financial year 2015/16 split by Division, was not included within the papers.
Stephanie Jones to obtain Appendix 1 and email out to the Committee.

Overall Trust compliance was noted for the following mandatory training for 2015/16:

Mandatory Training	Compliance for 2015/16
Information Governance	84.24%
Equality and Diversity	85.89%
Infection Control	85.07%
Moving and Handling	86.73%
Health, Safety and Welfare	84.60%
Safeguarding	78.34%
PREVENT	61.59%
Fire Safety	73.38%
Dementia Awareness	81.88%
Conflict Resolution	77.63%

Appendix 2: detailed the operational challenges/risks that face the Trust and what action has been taken to mitigate them.

Appendix 3: detailed the mandatory training communication plan.

The current system to record mandatory training, OLM, is linked to the ESR but has limited functionality and difficulty has been experienced in obtaining data required. Consideration is being given to moving onto a different system, but this will incur resource and cost implications. The next step would be to invite companies to give a demonstration of their system and then an optional appraisal will be drawn up and submitted to the Weekly Exec Board (WEB).

Compliance in relation to Prevent is noted to be a concern at 61.59% for 2015/16. The Prevent package is produced by the Department of Health and there is a requirement that

	it is delivered in a classroom environment. There is potential that it may move to an e-learning package and the Department of Health are holding discussions around this. Essential Skills: Pam Wood, NVQ Co-ordinator, will take the lead on essential skills over the next 10/11 months. It is hoped the Trust will be in a position to report on compliance and to clearly understand which group of staff will be required to undertake essential skills training. **<u>Questions/comments raised by the Committee:</u>** Q1 (LR): Lindsay Rudge expressed her support for a new system to record training as the current system is not fit for purpose. Q2 (JW): Jan Wilson queried the rough costs attached to purchasing a new system? A2 (BF): Bev France confirmed a rough ball park figure would be around £175K. Another Trust a similar size to CHFT purchased it around 18 months ago. **OUTCOME:** The Committee **NOTED** the content of the paper and **SUPPORTED** the actions detailed within the report.
074/16 **ACTION:**	**<u>EMERGENCY SERVICES DEPARTMENT REPORT</u>** Tracy Fennell, Associate Director of Nursing, Medical Division, presented a report to provide The Committee with an update on the organisation's plan to sustainably deliver against the required EC monthly, quarterly and yearly standard. It was noted that 2015 saw one of the worst years from a performance perspective. The 4th quarter for 2015/16 was particularly challenging for the Trust's Emergency Department with a failure to meet the standard of 95%, only achieving 90.07%. In this particular quarter the Trust had seen an overall increase in attendances through its Emergency Departments of 4213 patients in comparison to the same period in 2014/15. This represents a 12.7% increase. Medical and non-elective in-patients also continue to remain above the planned level at 4.7% YTD. **<u>Response</u>** The Division has put a number of measures in place to improve capacity and demand, improve patient flow and the overall quality of care in the Emergency Department. A Safer Patient Flow Programme has been developed with an overall aim to improve patient experience, avoid admission, increase the number of ambulatory pathways as well as access routes and to enable capacity to be released to ensure there are beds available for those who require admission from the Emergency Department. Additional inpatient beds, for the Medical Division, have been funded for 2016/17 following a bed modelling conclusion that the core bed base is not sufficient for the needs of the present population set at 95% occupancy. **<u>Questions / comments raised by The Committee:</u>** Q1 (JC): Assistant Director of Quality, Juliette Cosgrove, requested that in future reports The Committee would like to see more information on patient experience, for example patients who have waited longer than 8 hours. The Committee need to understand the impact on patient experience, outcomes, mortality and the management response. A1 (TF): Associate Nurse Director, Tracy Fennell, agreed to include this the next report

	due in July 2016. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report. A further report will be received by The Committee in July 2016.
075/16	**STROKE SERVICES REPORT: ABILITY TO ACHIEVE LEVEL 'A' RATING** The Weekly Exec Board (WEB) had requested that the Quality Committee give consideration to the Trust's ability to achieving a 'A' SSNAP rating in relation to Stroke. Tracy Fennell, Associate Director of Nursing, Medical Division, reported that a weekly Stroke meeting had been set up, with its main area of focus being: • quality • how the Stroke service can be redesigned • review of internal and external reports to see what they are telling us • review of how the rehabilitation facility can be remodelled as it is currently not being utilised properly • SSNAP data not being collected efficiently – needs to be reviewed • not enough SALT services • potentially looking at an external review with the support of the Medical Director The Division acknowledged there is a great deal of work to be done in order to get where the Trust needs to be, but it is hoped the work outlined above would assist in achieving a higher SSNAP rating. David Birkenhead, Medical Director reported the key issues in terms of HSMR/SHMI: • Crude mortality for stroke is the second highest in the UK. • SSNAP audit to move from a C within 6 months to a B within 12 months; the work undertaken by the weekly Stroke Group will support this • Likely to commission an external review by the Royal College of Physicians; will take 2/3 months to collect and analyse the data followed by a 2 day visit. **OUTCOME:** The Committee **RECEIVED** the verbal update and **NOTED** the work being undertaken by the Weekly Stroke Group.
076/16	**VANGUARD COMMUNITY: UPDATE REPORT** Karen Barnett, Assistant Divisional Director for Community Services, presented a paper to give an update on the Calderdale Vanguard Programme and the involvement of the Community Division in the development of the locally integrated community teams. Karen explained the aims of the Programme which has been developed with 7 partners to be the vehicle to meet the 5 year strategic aim. The partners consist of CHFT, Pennine GP Alliance Board, Locala CIC Board, South West Yorkshire Partnership Foundation Trust, The Third Sector/VCS, Calderdale CCG and Calderdale MBC. There are four elements to the programme and CHFT is represented on each of the groups: • Prevention and healthy lifestyles • Supported self-management • Integrated community model • Integrated health and social care first point of contact The enabler groups are:

	• Workforce and OD • Estates • IT • Transport • Communication and Engagement • Equality and marketing Focussed work is ongoing in relation to self-management. The main work will focus on the integrated community model, which will involve working closely with Pennine GP Alliance with practice and community nursing working together. There will be a big emphasis on adult care, but also working with children and young people. **Questions/comments raised by The Committee:** Q1 (JW): What is the management structure? A1 (KB): Karen confirmed that although there had been debate around the management structure it had not yet been fully decided. Q2 (JC): In terms of measures (i.e. frailty / ill heath), when will the data be available? A2 (KB): Karen reported that workstream leads had been tasked with looking at KPIs and high level KPIs will form part of the Community dashboard going forward.
ACTION:	Futures reports on the Programme's progress will be brought to The Committee on a quarterly basis. Next report due 26 July 2016. Stephanie Jones to add to The Committee Work plan for 2016/17 **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report.
077/16	**COMPLIANCE WITH NICE GUIDANCE; QUARTERLY UPDATE** Juliette Cosgrove, Assistant Director of Quality, presented a report to update The Committee on the position of the work being undertaken to ensure the NICE guidelines working towards full compliance are regularly reviewed, and that non-compliant guidelines are validated. It was reported that better governance arrangements are in place and the chair of the Mortality Group had met with all guideline leads and annual reviews are taking place. Data presented shows that 62% of NICE guidelines are fully compliant, 18% are partially compliant and are working towards full compliance and 8% are partially compliant and with no further action. 12% are still awaiting response. Juliette questioned how often The Committee would like to receive an update on NICE compliance. The Medical Director requested that a report should be brought back to The Committee in 3 months' time with particular focus on those guidelines that are not fully compliant and particularly why they have not delivered.
ACTION:	Further update to be received by The Committee in July 2016. Stephanie Jones to update the 2016/17 Work Plan. The Committee felt it would be useful to understand whether some of the guidelines are not compliant due to commissioning decisions. Juliette Cosgrove seemed to think they are more to do with local decisions.
ACTION:	Discussions to take place with the CCGs.

	OUTCOME: The Committee **RECEIVED** and **NOTED** the content of the report. The Medical Director asked that The Committee acknowledge all the hard work that Martin DeBono and Juliette Cosgrove had done.
078/16	**UPDATE REPORT ON THE ACTION PLAN FOLLOWING THE KIRKUP INQUIRY: FINAL ACTION PLAN FOR SIGN OFF** Karen Spencer, Matron Midwifery, presented the final action plan for The Committee to sign off. Juliette Cosgrove, Assistant Director of Quality, said that because of the concerns raised by the CQC in relation to maternity, there will be the need to look back at the action plan in light of concerns raised by the CQC. **OUTCOME:** The Committee **APPROVED** the sign off of the Action Plan which will be integrated into the CQC report.
079/16	**REGULATION 28 LETTER FROM HM CORONER: (GI BLEED PROTOCOL)** Tracy Fennell, Associate Director of Nursing, Medical Division, informed The Committee of a new Regulation 28 letter received from HM Coroner on 23 March 2016. The Division had prepared an action plan in response to the letter from HM Coroner which was presented to The Committee for information. Tracy confirmed that work is ongoing, in conjunction with the Surgical Division, to create a more robust GI bleed process, with GI bleeds being admitted straight to A&E at HRI and once stable will be treated on Ward 17. This will go live from 1 June 2016. YAS and CCGs have been notified. Jackie Murphy, Deputy Director of Nursing said in terms of communication, the pathway will need clearly communicating to the clinical workforce as some clinician believe this transition has already commenced. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the paper.
CQC RESPONSE	
080/16	**CQC REPORT** Juliette Cosgrove, Assistant Director of Quality, reported that the Trust had not received any further requests for information from the CQC and it was thought they will now be in the process of writing up their report. The Trust has received some initial feedback from the CQC and an improvement plan is being developed on the back of this. A specific plan will be developed for Maternity Services. Both of these plans will be overseen by the CQC Response Group. Lindsay Rudge, Acting Director of Nursing, said it would be pertinent for teams to review the data they submitted to the CQC and they need to test their data out. Karen Barnett, Assistant Divisional Director, Community Services, reported that the CQC are currently on site looking at Looked After Children Services. **OUTCOME:** The Committee **NOTED** the approach being taken to address any issues and

	the milestones leading to the full publication of the CQC rating.
RESPONSIVE	
081/16	**INTEGRATED QUALITY AND PERFORMANCE REPORT** Karen Barnett, Assistant Divisional Director, Community Services, presented the Integrated Quality and Performance Report for March 2016. It was reported that the report had been discussed in detail at the Weekly Exec Board (WEB), where the Divisions were challenged and assurance received. The following highlights were noted from the report: Response: • Number of medical beds; impact on 18 weeks and large waits • Some more cancellations/OPD appointments following the junior doctors strike Caring: • FFT; there have been some low scores and the reasons for this are being further investigated Complaints: • Divisions have undertaken a great deal of work to ensure complaints are on-track. Performance in relation to complaints was progressing well, however there has since been a decline in performance with those complaints over 1 month overdue moving to 2 months overdue. Meetings are taking place with the Divisions to address this. Safety: • A great deal of work around pressure ulcers has been undertaken; particularly in relation to monitoring, process and learning from themes emergency from pressure ulcers. • Duty of Candour needs to get back on tract Effective: • SHMI continues to be higher than expected levels; there is lots of work ongoing to try and pull this back. CAIP programme continues with its 6 themes and work has been done on stroke and respiratory which are areas that are outlying. • Coding; some improvements have been seen, but the Trust is still not in a comfortable position. • C.diff; 2 new cases were reported in the last month • # Neck of Femur; performance had reached 85% however a decline in performance over the last month was noted. It is understood the decline is due to an increase in activity. The Division are looking at alternative ways of approaching it and the consideration of having an extended day to allow more capacity is being looked into. **Questions/comments raised by The Committee:** Q1 (LR): How are the Division tracking those patients who don't get to theatre within the 36 hours? a1 (JM): Jo Middleton, Associate Nurse Director, Surgical Division confirmed all cases have an RCA carried out and she is currently in the process of reviewing all the RCAs. Q2 (DB): Do we know what the range is? A2 (JO'R): The majority of cases are done within 48 hours and compliance has been around 80% to 85% most months. Those beyond are often due to clinical delays or don't get done at all for clinical reasons. It was noted that Professor Mohamed Mohammed will present his work to the Trust on the

	5 May 2016, 3pm – 5pm in the Boardroom, HRI. It was agreed this invite could be extended to members of The Committee **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report.
SAFETY	
082/16	**SERIOUS INCIDENT REPORT** Andrea McCourt, Head of Governance and Risk, was in attendance to present the Serious Incident Report. As at the 19 April 2016 there were 5 new open serious incidents and one pressure ulcer serious incident and one further information request for a serious incident report already submitted to the CCG. It was noted a request had been made to the CCG for 3 serious incidents to be de-logged. A second never event was noted for Maternity. It was confirmed both investigations into the two never events are being led by the same investigator. A number of actions have already been put in place to avoid a repeat incident. It was noted that case summaries will become a regular part of the serious incident report going forward, which will include identified themes and what action is being taken. Pressure Ulcers; following in internal review a request has been made to the CCG to de-log a number of pressure ulcers. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report.
083/16	**REPORT FROM THE PATIENT SAFETY GROUP** A report from the work of the Patient Safety Group was presented to the Committee, which included the draft minutes of the last meeting held on 7 April 2016. The following highlights from the meeting were noted: • A review of 2014/15 staffing incidents had been undertaken and the details were recorded in the Patient Safety Group minutes of the 7 April 2016. Going forward this will be picked up via Red Flags. • Serious Incidents; previously discussed under Item 082/16. • Reviewing Safer Staffing Guidance and how it is reported across all sectors to include Community. • Carter Review; recommendations around the number of care hours per day The Committee were asked to note item 056/16 Serious Incident Report section of the minutes for information. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report and the minutes of the last Patient Safety Group.

COMPLIANCE	
084/16	**RISK REGISTER (CORPORATE)** Andrea McCourt, Head of Governance and Risk, was in attendance to present an update on the Risk Register. The following highlights were noted: • Risk Register; 1 new risk added relating to the junior doctors strike. Reduced risks and closed risks were discussed. • 2 more risks will be added following the Finance and Performance meeting; these relate to agency staffing and EPR. • Clinical outcomes: SHMI/HSMR already discussed under Item 081/16. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report
EFFECTIVENESS	
085/16	**REPORT FROM THE CLINICAL OUTCOMES GROUP** David Birkenhead, Medical Director, presented a report from the Clinical Outcomes Group, which included the minutes from their meetings on 15 February and 31 March 2016. As the majority of its work had already been discussed earlier in the meeting no further discussion took place. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report and the minutes of the meeting.
CARING	
086/16	**REPORT FROM THE PATIENT SAFETY GROUP** Juliette Cosgrove, Assistant Director of Quality, presented a report from the Patient Experience Group, which included the minutes from its meeting on 16 February 2016. The meeting was dedicated to receiving the Q3 Divisional reports which cover complaints, patient feedback, compliance, quality and improvement plan, equality and diversity, PPI and engagement and learning and improvements. The following matters were asked to be brought to the attention of the Quality Committee: • Comprehensive reports were received from all divisions (these will be incorporated in the Divisional PSQB reports to quality committee) • The provision and access to hearing loops is not available consistently across the Trust. *Post meeting: all loops have been checked and any repairs needed were carried out. A number of portable loops have been ordered to distribute to all wards at HRI* **OUTCOME:** The Committee **RECEIVED** and **NOTED** the content of the report and the minutes of the meeting.

WELL LED	
087/16	**UPDATE FROM THE WORKFORCE AND WELL BEING GROUP** The minutes of the Workforce (Well Led) Committee were received for information. No further discussion took place. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the minutes of the meeting.
HEALTH AND SAFETY ISSUES RELATING TO QUALITY OF CARE	
088/16	**UPDATE FROM THE HEALTH AND SAFETY COMMITTEE** Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities presented a verbal update from the Health and Safety Committee. The minutes of their meeting held on 23 March 2016 were received for information. The following highlights were noted: • Medical device training; an increase in performance which has previously been seen has since declined. • Medical devices (risk register); work ongoing to ensure all medical devices are identified for maintenance is now at 75%. It is hoped that this will be up to between 90 to 95% by September 2016 for high risk devices. There are 17,500 devices on the register. • The purchase of kettles/toasters etc. direct from retailers is not permitted due to fire hazards. • Manual handling; a review of manual handling is currently underway. Going forward the team will sit under Tracy Fennell in the Medical Division. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the verbal update and minutes of the meeting.
ITEMS TO NOTE	
089/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** • Regulation 28 Letter from HM Coroner in relation to GI Bleed Service moving to HRI from 1 June 2016. • Stroke Service update • Calderdale Vanguard Programme update • NICE guidance; current position on compliance
090/16 **ACTION:**	**QUALITY COMMITTEE WORKPLAN 2016/17** **OUTCOME:** The Committee **RECEIVED** the Work Plan for 2016/17 and were asked to **NOTE** the reports required for the next meeting on 24 May 2016. Stephanie Jones to work with Lindsay Rudge and Jackie Murphy to update the work plan.

091/16	**ANY OTHER BUSINESS** There were no other items of business discussed.
DATE AND TIME OF NEXT MEETING	
Tuesday 24 May 2016 2pm – 5pm Boardroom, HRI	

MINUTES APPROVED:

Minutes of the Finance & Performance Committee held on Tuesday 26 April 2016 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships
Keith Griffiths	Director of Finance (In part)
Lesley Hill	Executive Director of Planning, Performance and Esates & Facilities
Richard Hopkin	Non-Execuitve Director
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
Brian Moore	Membership Councillor
Lindsay Rudge	Acting Director of Nursing
Betty Sewell	PA (Minutes)

ITEM

060/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee introduced and welcomed Richard Hopkin, Non-Executive Director to the Committee.

061/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Helen Barker, Chief Operating Officer
David Birkenhead, Executive Medical Director
Andrew Haigh, Chair
Victoria Pickles, Company Secretary

062/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

063/16 MINUTES OF THE MEETINGS HELD 29 March 2016

The minutes of the last meeting were approved as an accurate record.

064/16 ACTION LOG AND MATTERS ARISING

Action Log

193/08/15: Market Share Data – The Director of Transformation & Partnerships outlined the purpose of the paper. It was noted that a scoping exercise using reports used by Mid-Yorks., Airedale and Bradford had been undertaken and it confirmed that referral data is not routinely available and, therefore, is not routinely reported. In terms of moving forward the aim is to use the activity data which is available but should be mindful of the limitations of this data. The activity data will then be triangulated with analysis of other parameters to enable us to drill down to specialty level to identify the top 5 specialties as a starting point.

Following discussions it was agreed by the Committee that the sample dashboard produced by Airedale was the favourite layout and that this would be developed for the next Committee meeting. It was also requested that Anna Basford should approach an external organisation for assistance with regard to providing additional information over and above what is proposed within the paper.

ACTION: To provide the analysis in a dashboard format for the May meeting - **AB**

052/03/16: Annual Financial Plan – The Chief Executive reported that at the extra-ordinary Board Meeting held 7 April 2016, the decision was taken to accept the Control Total. Confirmation was subsequently sent to Monitor to advise them of this decision but also to register the Board's on-going concern. It was intimated within the correspondence that if EPR implementation became a factor Monitor would not take punitive measures in relation to the contingency put in place, this still has to be confirmed.

The Chief Executive also reported that part of the Control Total comes with conditions. It was noted that following helpful conversations with Monitor our A&E trajectory has been scaled back so as not to put funding at risk, a retrospective note will go to the Board. This arrangement is subject to agreement from our CCGs.

The Deputy Director of Finance confirmed that the Annual Financial Plan had been submitted to Monitor in line with accepting the Control Total and we have planned receipt of the Control Total from an I&E point of view in months 3, 6, 9 and 12, and cash in months 4, 7, 10 and 12, in line with the West Yorkshire patch.

FINANCE AND PERFORMANCE

065/16 MONTH 12 PERFORMANCE SUMMARY

The Director of Transformation & Partnerships reported the continuation of a trend during March with further deterioration on planned elective daycase activity. At the year end, daycase activity was 8% below plan, in terms of non-elective an increase in demand in March gave a 3.6% increase above plan at year end. A&E saw an increase in demand, both in month and at year end. Outpatients ended the year below plan by 1.3%. With regard to referrals, there has been growth in referrals within Huddersfield but more significantly within Calderdale, which feeds into the financial position.

It was noted that due to the repetition of information, the financial reports are being reviewed to look at the overlaps to try to get a more streamlined report covering all the financial papers. It was agreed that templates will be drawn up to be discussed and agreed outside this forum.

ACTION: To produce a revised template to include prior year, budget and trend analysis to be available for the next meeting – **GB/KA**

066 - 068/16 MONTH 12 INCOME & EXPENDITURE AND FINANCIAL NARRATIVE

The Director of Finance reported that we had formally reported a £20m trading deficit plus £1m restructuring costs which were recognised by Monitor as an exceptional item. It was noted that looking at the I&E statements in entirety we have an adverse variance at EBITDA level compensated by technical benefits against

non-operating items and profit plus investment asset valuation gains on the JV. These gains below the line are not representative of the underlying trading position of the Trust and reliance on these are not sustainable.

Richard Hopkin queried what the fixed asset impairments represented. It was explained that these are non-cash movements as a result of the annual revaluation exercise. In this case they relate mainly to properties that the Trust is taking out of use such as Princess Royal Hospital, which are, therefore, deemed to have a lower value in use. These valuations are not considered in Monitor's assessment of Trust performance.

The Committee received all the financial reports.

069/16 AGENCY STAFFING REPORT

The Deputy Director of Finance presented a paper which had been tabled at the Workforce Well Led Committee on the 21 April. The report detailed the pay expenditure for 2015/16 highlighting the £19.93m which was spent on agency staff. A further breakdown of Divisions and groups of staff was detailed within the report which shows £10.9m was spent on Medical staff and £12.6m was spent within the Medicine division. The report goes on to show an extract of the weekly report which shows the number of shifts that breached the agency cap, and during w/e 28 March there was a total of 540 breaches, this shows the scale of the challenge.

In terms of 2016/17, Monitor set an overall agency cap for the Trust of £14.95m, which is an increase from the original suggested £13m cap which the Trust challenged. The 2016/17 plans assume a slightly higher spend and in order to deliver the financial plan, agency spend must be reduced.

It was acknowledged that we need to do something different as a Trust as this is the biggest financial challenge for next year. A working group has been set up to look at both the procurement process and what is driving the need for agency staff.

Discussions took place with regard to the approval process for agency staff, it was noted that we should have a weekly understanding of where we are, year to date, and this data should be made available. It was also noted that this issue should be sighted at Turnaround Executive or at another weekly forum to enable micro-management.

ACTION: To provide an agency report every month to this Committee and to ensure weekly information is made available to enable micro-management – **GB/KA**

To provide a specific decision making/approval process to the Committee to enable understanding - **HB**

STRATEGIC ITEMS

070/16 & 071/16 TURNAROUND PROGRAMME UPDATE & 2016/17 CIP SCHEME POSITION

The Chief Executive reported that the Trust is now focussed on 2016/17 to deliver a minimum CIP plan of £14m. Schemes totalling £14.4m have been identified to date and the recent Star Chambers have helped this position. It is recognised that we cannot just focus on a 16/17 year end and CIP pipelines need to be developed

which extend over a much longer period. It was acknowledged that in order to deliver the £14m plan we need to develop schemes amounting to £16m. It was noted that Monitor require a greater portion of schemes to be cost out against income based schemes. Work continues with Divisions to identify both a minimum 4% of addressable spend and the opportunities from the Carter Report.

In terms of cost out schemes, it was recognised that reconciliation is required with both the 1 & 5 Year Workforce Plan modelling with what is identified within the CIP scheme, Anna Basford, Gary Boothby and Jackie Green will meet to look to reconcile. It was noted that some of the pay schemes which have been identified are not at Gateway 2.

The Star Chamber process has been brought in to try to get us back on track together with a combination of ideas generation and getting more schemes transferred to Gateway 2, it was recognised that getting schemes to Gateway 2 has been slower due to operational and clinical leads having had other pressures. It was noted that a new Dashboard for 2016/17 has been produced which will make every area and portfolio clear and will be RAG rated and there will be particular focus at Turnaround Executive on the areas which are red RAG rated.

It was noted that a greater level of scrutiny and rigour is being applied and an improvement should be seen by the end of May. It was also noted that CIP should be elevated on the Risk Register.

The Assistant Director of Finance (KA) called out the interplay with regard to CIP/STF and how this feeds back into planning. CIP plans have been heavily weighted in the plans at the back-end of the year, which will help with the delivery and securing of STF in the first two quarters but there is more risk in the latter part of the year and we will need to be clear as we report month on month.

The Director of Finance expanded on the above comment by stating that we cannot afford to be off plan.

072/16 2016/17 ANNUAL FINANCIAL PLAN

This item was discussed earlier as part of the action log, the Chief Executive gave thanks to Finance colleagues who had to change the Financial Plan and assumptions at very short notice.

073/16 CARTER REVIEW

Director of Transformation & Partnerships presented an update, the paper noted the national milestones and that we are on track to deliver against these milestones. It also confirms a detailed plan by each Division looking at specialties identified by Carter, clinical variations, they are also holding workshops to understand the variance in cost base which will give them the opportunity to try to identify further CIP programmes. Each Division are aware that they need to ensure we have been rigorous and have undertaken a deep dive fully into these opportunities; they are working to a deadline of the end of May for this piece of work.

In terms of the over-arching pieces of work which are being undertaken, some relate to a change in culture and some relate to the dashboard/matrix, Helen Barker is

leading the dashboard work. One other area is the nursing workforce and how we benchmark, a lot of work has been undertaken around fill rates and application of rostas and work is on track.

ACTION: To provide a further update to the Finance & Performance Committee in June which will include feedback from the Divisional workshops and a position with regard to the 'Carter Review Dashboard' – **AB/HB**

074/16 EPR HIGHLIGHTS

The Acting Director of Health Informatics reported that one of the key milestones would be to finish the build by the 13 May until this is reached we will not be able to start system testing. We are on track to commence testing from 16 May which means that we are still delayed by 7-9 weeks. It was noted that go-live is still under negotiation but hopefully by early June we should have a clearer position. The Committee noted the report including the financial position for March 2016.

EPR UPDATE

The Acting Director of Health Informatics presented a paper which highlighted as part of the contractual position, the potential penalties the Trust could incur should the project be delayed or halted, the paper was also presented to the Audit & Risk Committee on the 20 April 2016. It was highlighted to the Committee that the contract makes provision for Cerner to reasonably recover some of their costs in the event of a delay, there are no fixed costs and costs are subject to negotiation. A meeting with Cerner will take place later today to establish a way forward, as currently it is likely that we will incur costs which hopefully will not be substantial. The second point highlighted to the Committee was in connection to the contingency plans which in the short-term does not give any cause for concern and will not include any additional costs but this will need to be reviewed if we run into extensive delays.

The Chief Executive confirmed that along with other colleagues he had met with the UK Managing Director of Cerner and Bradford with regard to the immediate challenges and the longer term scenarios. It was noted that we should be mindful with regard to costs including the resistance by our Clinicians to disregard the Nerve Centre application which may incur associated costs to get compatibility with Cerner's products.

It was recommended that a deep-dive into the financial impact should be undertaken to enable the Committee to keep financial focus on the project. It was also agreed that the risk should be higher on the Corporate Risk Register.

ACTION: To provide a report with regard to the financial impact should we experience a delay with the implementation of the EPR system, the report should focus on finances but should include a plan for the possible re-deployment of the EPR Team - **MG**

TREASURY MANAGEMENT

075/16 CASH FLOW 13 WEEK FORECAST

The Deputy Director of Finance presented a paper which provides details of the planned 2016/17 cash on a monthly basis and the closing balance at the end of

every month. It also reflects the need for £37.6m cash support in 2016/17 and the phasing of that support.

With regard to funding being in place, it was noted that in the short term we have drawn down from our pre-capital loan in April. From May we will need support and in the first instance, Monitor have advised us to draw on the Working Capital Loan facility which was approved last year, at an interest rate of 3.5%, the plan is predicated on moving to an Interim Support loan at the lower rate of 1.5%.

With a greater focus on cash, it was agreed that there would be no harm in getting an independent view to look again at cash flow.

In terms of capital plans, the capital process is discussed monthly at the Capital Management Group and Capital Investment & Strategy Group meetings.

GOVERNANCE

076/16 INTEGRATED PERFORMANCE REPORT

The Integrated Performance Report (IPR) was tabled for information and the Committee noted the contents, it was noted that the IPR will be discussed in detail at the Board Meeting.

077/16 WORK PLAN

The Work plan was noted by the Committee.

The Chair commented that in terms of going forward EPR, CIP, Agency Spend and Cash are moving up the agenda and Market Opportunities needs further understanding. It was noted that the Committee will need to start to focus on winter planning and how this is managed. It was also noted that the reconfiguration and the scenario of fewer beds and how we track the reduction will need to have a focus.

It was agreed that items would need to be prioritised and discussed on a rolling basis and a review of the Work plan would be undertaken.

078/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

EPR
CIP
Agency Spend
Cash
Change of reporting

079/16 ANY OTHER BUSINESS

No items were raised and the meeting was closed.

DATE AND TIME OF NEXT MEETING

Tuesday 24 May 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

APPENDIX A

Minutes of the Audit and Risk Committee Meeting held on Wednesday 20 April 2016 in Acre Mill, 3rd Floor commencing at 10:45pm

Prof Peter Roberts	Chair, Non-Executive
Phil Oldfield	Non-Executive Director

IN ATTENDANCE

Gary Boothby	Deputy Director of Finance
Jillian Burrows	Senior Manager, KPMG
Michael George	Internal Audit Manager
Adele Jowett	Local Counter Fraud Specialist (for part of meeting)
Peter Middleton	Membership Councillor
Victoria Pickles	Company Secretary
Kathy Bray	Board Secretary (minutes)
Jason Eddleston	Deputy Director of Workforce and OD (for part of meeting)
Claire Wilson	Assistant Director of Human Resources (for part of meeting)
Dave Lang	THIS Programme Director (for part of meeting)
Andrew Haigh	CHFT Chairman (observer for part of meeting)

Item

016/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Julie Dawes, Executive Director of Nursing and Operations
Keith Griffiths, Executive Director of Finance
Richard Hopkin, Non Executive Director
Helen Kemp-Taylor, Head of Internal Audit
Andrea McCourt, Head of Governance and Risk
Clare Partridge, External Audit

017/16 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

018/16 MINUTES OF THE MEETING HELD ON 20 JANUARY 2016

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

019/16 EPR ASSURANCE – UPDATE

Dave Lang, THIS Programme Director, attended the meeting to discuss the assurance around the implementation of the Electronic Patient Record. Discussion took place regarding the actions undertaken to address the recommendations made in the Gateway 1 review. It was noted that the Gateway 2 review had now been received. Andrew Haigh confirmed that the EPR Assurance Group was due to meet with GE representatives who had undertaken the Gateway reviews in May to review the work to date and look at the focus of future work.

The contents of the paper circulated to the Committee the previous day were noted. Discussion took place regarding whether any cost drift had been identified with the slippage of the implementation. Dave Lang reported that no significant cost drift was expected and any additional costs to date have been associated with the Trust bringing in extra resources to meet the timeline.

Dave Lang reported that there was rigorous testing of the system and that work continued with Internal Audit to ensure that mitigation strategies are in place around the Gateway Reviews. Arrangements were being made to ensure that there was shared risk assurance analysis and risk taking between Cerner, Bradford and CHFT.

OUTCOME: The Committee NOTED the assurance relating to the implementation of the

EPR.

020/16 ACTION LOG AND MATTERS ARISING

40/15g Payroll Report – Jason Eddleston, Deputy Director of Workforce and OD (W&OD) and Claire Wilson, Assistant Director of HR attended the meeting to present the action plan following the 2015/2016 payroll internal audit. It was acknowledged by W&OD that the internal audit report findings were disappointing. The Deputy Director of W&OD advised that the findings had been carefully considered and that the action plan developed was a robust response to the recommendations set out in the report. The response includes

- the appointment of an experienced NHS payroll and pensions manager with effect from 1.4.16;
- the appointment of an experienced NHS deputy payroll manager with effect from 1.4.16;
- weekly meetings between Finance and W&OD leads to monitor progress in implementing the action plan;
- reports on progress in implementing the actions to the Director of Finance and Interim Director of W&OD; .
- regular update to Executive Board.

The Committee discussed the apparent lack of effective controls in the payroll process, financial consequences to the Trust, impact on other organisations for which the Trust provides services and legal liabilities. The Committee requested assurance that remedial work was underway and that action deadlines will be met.

The Deputy Director of W&OD stated that process issues are to be addressed by the newly appointed leadership team in the service. The Committee was informed that a move towards a full electronic record system was envisaged and discussions are already planned with a private provider.

The concerns and risks together with challenges generated by a move to ESR self-service were discussed. The Committee requested that an assessment be made of the application of existing payroll controls in a self-service model.

Jillian Burrows, External Auditor, reported that they were working with the finance department on an audit of payroll as part of the Annual Report and Accounts and these findings would be brought back to the ARC in due course.

It was agreed that Workforce and OD, in liaison with Internal Audit will produce a project timetable for the Audit and Risk Committee, highlighting the wider picture, actions planned and timelines and this would be circulated to ARC members before the next meeting.

ACTION: JE/CW
OUTCOME: Assurance paper to be circulated to Committee members before the next ARC Meeting.
STATUS: OPEN

54/15 Review of Standing Financial Instructions/Scheme of Delegation – It was noted that following the appointment of the Deputy Director of Finance, further joint work would be undertaken with the Company Secretary to ensure that the additional amendments required following the government directive re financial limits are made. This would be completed and circulated to the Committee.

ACTIONS: VP/GB
OUTCOME: To be circulated to ARC before next meeting
STATUS: Ongoing

021/16 COMPANY SECRETARY'S BUSINESS

a. REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES

The Audit and Risk Committee were asked to receive the updated Regulatory Compliance Register and note that no breaches have arisen in meeting the deadlines.

OUTCOME: The Audit and Risk Committee received and noted the contents of the Regulatory Compliance Register.

b. BOARD ASSURANCE FRAMEWORK

The Committee received the updated Board Assurance Framework. It was noted that this was the position at the year end and would be presented to the Board in May. The 2016/17 BAF would also be developed for discussion at the May Board.

OUTCOME: The Committee received and noted the Board Assurance Framework.

c. SELF-ASSESSMENT OF AUDIT AND RISK COMMITTEE EFFECTIVENESS

To bring the Committee into line with a new annual process of self-assessment, a revised template had been circulated and a total of eight responses had been received. The Company Secretary presented the feedback on this self-assessment together with an updated Action Plan including the outstanding actions from the previous self-assessment. It was noted that all sub-committees of the Board would undertaking a similar exercise.

Peter Middleton expressed concern that clinical audit was not included in the ARC agenda. The Company Secretary advised that the Internal Audit Plan had been taken to Executive Board who had asked that it be submitted alongside the clinical audit plan. This would be received by the Executive Board in May.

OUTCOME: The Audit and Risk Committee received and noted the comments and approved the actions to address the feedback.

d. REVIEW OF ANNUAL GOVERNANCE STATEMENT AND ARC ANNUAL REPORT

As part of the annual reporting arrangements the Committee members will be circulated the Annual Governance Statement and Audit and Risk Committee Annual report outside of the meeting. The Committee members were asked to review the draft documents when received. These documents will be formally approved as part of the Annual Report and Accounts at the meeting in May. It was also noted by the Committee that there is a new requirement to provide an organisational statement on modern slavery and human trafficking.

ACTION: Company Secretary to circulate to members early next week.

OUTCOME: The Audit and Risk Committee were asked to give comment by return to the Company Secretary on the Annual Governance Statement and the Audit and Risk Committee Annual Report.

e. REVIEW OF COMPLIANCE AGAINST THE MONITOR CODE OF GOVERNANCE

As part of the annual reporting process the Trust is required to provide a report stating compliance against the Monitor Code of Governance on a comply or explain basis. A draft assessment of compliance was attached for review by the Committee.

OUTCOME: The Audit and Risk Committee approved the draft assessment of compliance with the Monitor Code of Governance.

f. ARC ANNUAL WORKPLAN

The Committee reviewed and agreed the updated annual work plan.

OUTCOME: The Audit and Risk Committee received and approved the content of the annual work plan.

022/16 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

a. Review Waiving of Standing Orders

The Deputy Director of Finance presented a report detailing the waving of Standing Orders for the period 1 January to 31 March 2016. During this quarter, 8 contracts were placed following a waiver of Standing Orders, at a total cost of £337,319.95. No amendments to earlier single sources were made this quarter.
There were no areas of concern to escalate to the Board.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the report.

b. Review of Losses and Special Payments
In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the period 1 January to 31 March 2016. Discussion took place regarding the most material issue of Pharmacy wastage amounting to £33,000 which related to the drug licenses and it was felt that these had been addressed by Pharmacy. There were no areas of concern to escalate to the Board.

OUTCOME: The Committee **RECEIVED** the report.

023/16 INTERNAL AUDIT

a. Outstanding Internal Audit Recommendations – As discussed at the previous meeting, the Committee were satisfied that further work was being undertaken to complete the outstanding recommendations following internal audit discussions with trust managers. It was noted that there was one outstanding issue related to community midwifery and since the preparation of the paper this had been resolved.

The Committee agreed that it was not necessary for any leads to be invited to attend the next meeting but it reserved the right to call leads in future should any underperformance occur.
OUTCOME: The Committee **RECEIVED** the report.

b. Review Internal Audit Progress Report
The Internal Audit Manager reported that since the last report to the Audit & Risk Committee in January 2016, the following reports 9 had been issued to and discussed with management:-

Report No	Report	Opinion
24/2016	Payroll	Limited
16/2016	Service Line Reporting	Significant
23/2016	Charitable Funds	Full
22/2016	Safeguarding	Significant
19/2016	Estates & Facilities Management - Catering	Significant
20/2016	Non Patient Visitors	Limited
21/2016	Duty of Candour	Limited
06/2016	Central Alerting System	Significant
25/2016	Compliance with ISO Standards	Full

The reports with limited assurance were discussed in detail:-

1. 24/2016 - Payroll Report – It was agreed that this item had been discussed in sufficient detail at the beginning of the meeting.

2. 20/2016 - Non Patient Visitors – The purpose of the audit was to review compliance with the Trust's policy for dealing with Non-Patient Visitors. The audit also considered awareness of the policy on the wards and found that there was no awareness of the

policy. However, the staff spoken to demonstrated a good awareness of the issues and said they would escalate a request for a non-patient visitor, to visit the ward. The Trust could rely on compliance if the staff who might encounter a non-patient visitor were aware of the requirements of the policy to notify the Communications Team who would note and monitor attendances.

3. 21/2016 - Duty of Candour - The Trust was concerned that it might not be responding to incidents where patients are adversely affected by treatment, in full compliance with its responsibilities under the Health and Social Care Act. Internal Audit put together an audit programme to respond to this concern, considering how incidents are dealt with by Division.

The audit identified that in 15% of cases the Trust did not respond to incidents within 10 days of them occurring and in a further 28% there was no record of when the Trust responded. Throughout the cases examined it was common for insufficient data to be recorded about the contact with the patient or their family. Actions were being undertaken to address the record keeping.
OUTCOME: The Committee **RECEIVED** the report.

c. ANNUAL AUDIT PLAN 2016-17 – The Internal Audit Manager presented the Annual Plan for 2016-17 which had been aligned to the Trust's strategy. It was noted that a changed approach to follow-up audits on actions undertaken was proposed as had been discussed by the Committee in the past. It was noted that the plan had been discussed at the Weekly Executive Board and that the plan would be refined and the scope of audits finalised as the work progressed through the year.

Discussion took place regarding the Vanguard work and it was agreed that this would be included in internal audit work in the future.
OUTCOME: The Committee **RECEIVED and APPROVED the Annual Audit Plan for 2016-17**

024/16 LOCAL COUNTER FRAUD SERVICES

a. LCFS Progress Report - The Local Counter Fraud Officer presented the updated progress report, the contents of which were received and noted. It was noted that networking with managers and budget holders within the Trust continues and since the last Committee meeting a new incident had been identified and this was in the early stages of being investigated.
OUTCOME: The Committee **RECEIVED and NOTED** the report.

b. LCFS Risk Assessment 2016-17 – The Local Counter Fraud Officer explained that she had worked with other Trusts to widen the remit of the Trust's work and this had been included in the risk assessment and linked into the workplan.
OUTCOME: The Committee **RECEIVED and NOTED** the report.

c. Anti-Fraud, Bribery and Corruption Workplan 2016-17 – The Committee received and approved the workplan for 2016-17.
OUTCOME: The Committee **RECEIVED and APPROVED** the report.

025/16 EXTERNAL AUDIT

a. Technical Update

Gillian Burrows, External Auditor presented the Technical Update and its contents were received and noted. There were no specific issues to draw to the Board's attention

OUTCOME: The Committee **RECEIVED and NOTED** the report.

026/16 INFORMATION TO RECEIVE

The following information was received and noted:-

a. Quality Committee Minutes – 26.1.16, 23.2.16
b. Risk & Compliance Group Minutes – 12.1.16, 9.2.16, 6.3.16
c. THIS Management Board – 11.1.16, 8.2.16, 16.3.16

027/16 WHISTLEBLOWING AND EXPRESSIONS OF CONCERN

The Company Secretary reported that she was aware that two separate expressions of concern had been received. The concerns were being investigated in-line with the Trust's whistleblowing procedure. At this stage the details of these two cases were not known.

028/16 ANY OTHER BUSINESS

There was no other business to note.

029/16 MATTERS TO CASCADE TO BOARD

- **EPR Update**
- **Payroll** – process assurances – improvement timetable to be circulated to ARC
- **Self Assessment of ARC** – Collated responses received. Action plan developed and agreed. Arrangements to be made for all Sub Committees of the Board to undertake similar exercise.
- **Documents for Annual Report** – Annual Governance Statement, ARC Annual Report – documents to be circulated for ARC approval. Compliance against Monitor Code of Governance - approved.
- **ARC Workplan** – approved.
- **Internal Audit** – significant improvement in clearing overdue audit recommendations. The three audits with limited assurance discussed:- Payroll, Non Patient Visitors, Duty of Candour.
- **LCFS** – Progress noted and Workplan 2016-17 approved.

DATE AND TIME OF NEXT MEETING

Thursday 26 May 2016 at 10.45 am - 3rd Floor Acre Mills Outpatient Building.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 21 April 2016, 3.00 pm – 4.00 pm in the Parentcraft Room, Calderdale Royal Hospital.

PRESENT:	
Helen Barker	Chief Operating Officer
Gary Boothby	Deputy Director of Finance
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Rosemary Hedges	Membership Councillor
Anne-Marie Henshaw	Associate Director of Nursing, Families and Specialist Services
Andy Lockey	Director of Medical Education
Phil Oldfield	Non-Executive Director, (Deputy Chair)
IN ATTENDANCE:	
Samantha Lindl	Personal Assistant, Workforce and Organisational Development
Vicki Drummond	Workforce Assurance Manager

25/16	**WELCOME AND INTRODUCTIONS:** The Deputy Chair welcomed members to the meeting.
26/16	**APOLOGIES FOR ABSENCE:** David Birkenhead, Executive Medical Director Julie Dawes, Executive Director of Nursing Victoria Pickles, Company Secretary Lindsay Rudge, Deputy Director of Nursing Ashwin Verma, Divisional Director, Medical Jan Wilson, Non-Executive Director
27/16	**DECLARATION OF INTERESTS:** No declarations of interest were received.
28/16	**MINUTES OF MEETING HELD ON 19 FEBRUARY 2016:** The minutes of the meeting held on 19 February 2016 were approved as a true record with the following amendment:- RH provided apologies.
29/16	**ACTION LOG (items due this month)** <u>Terms of Reference</u> To be resubmitted to the next Board of Directors meeting for further approval. **ACTION:** VP This will be actioned at the April Board of Directors meeting.

	The Committee noted the following actions were outstanding:- Identify a Medical Director deputy. JE to liaise with DB. **ACTION:** DB Identify a Clinical Director to participate as a member of the Committee. JE to liaise with DB. **ACTION:** DB Identify an Allied Health Professionals (AHP) representative to participate in the work of the Committee JE confirmed that Nicola Sheehan, Head of Therapies will be a member of the Committee. **ACTION:** SL to confirm meeting dates to NS Terms of Reference to be amended **ACTION:** SL <u>Sub-group structure</u> Identify reporting arrangements for equality and diversity. JE to liaise with VP. **ACTION:** VP <u>Visible Leadership: Process and Outcome of First Visits</u> To identify dates for reports to be received by the Committee. **ACTION:** VP <u>Human Resources Management Group</u> Please see agenda item 36/16 <u>Workforce (Well Led) Committee Work Plan 2016 / 2017</u> Visible leadership updates to be incorporated into the work plan. **ACTION:** SL
	MATTERS ARISING / MAIN AGENDA ITEMS
30/16	**2015 STAFF SURVEY ACTION PLAN:** JE reported that Owen Williams had commissioned a number of focus groups and 1-1 interviews for colleagues to inform the content of the staff survey action plan. Colleagues who have completed the 2-day Work Together Get Results (WTGR) programme or who had participated in the Investors in People (IIP) assessment were invited to participate. The fieldwork will be completed by 22 April 2016. A report to the Board of Directors is expected in May 2016. **OUTCOME:** JE to provide an update at the next meeting of the Committee.
31/16	**INTEGRATED PERFORMANCE REPORT – WORKFORCE:** JE provided a briefing on the workforce elements of the Integrated Performance Report (IPR):- <u>Attendance Management:</u> Year to date - 4.61% (2014 / 2015 outturn 4.26%)

Short Term Absence - 1.48%
Long Term Absence - 3.13%
A series of key performance indicators (KPIs) have been designed including a 4% absence rate by 31 December 2016 (2.7% long term, 1.3% short term).

Action to get on plan:

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 / 1-1 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.

<u>Appraisal:</u>
78% of colleagues had an appraisal in 2015/2016.

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:

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.

<u>Mandatory Training:</u>
Year-end performance of 95% of colleagues commencing their journey
41% of colleagues have completed all 10 elements
77% of colleagues have completed 8 or more elements
22% of colleagues have completed 7 elements or less.

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: 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. RH asked if increasing sickness absence is as a result of low staff morale. JE advised there are a number of factors at play and that through the staff survey action planning the Trust is looking to improve the staff experience. JE explained that there is a need to manage attendance at work whilst ensuring good leadership operates in the Trust and that colleague health and wellbeing is a priority. HB suggested benchmarking sickness absence as well as turnover in the IPR. **ACTION:** JE to include benchmarking data in the report in June 2016. PO queried the refresher process for the 10 mandatory training programme elements. JE confirmed that the 10 elements comprised a mix of annual, 2-yearly and 3-yearly refresher training. Work is progressing to determine the reporting format for 2016/2017. AL asked if the doctors in training on-line passport developed by Health Education Yorkshire and Humber (HEYH) has been mapped to the Trust's mandatory training programme. **ACTION:** JE to share the position with the Committee at its June 2016 meeting. AMH expressed a concern about the extent of on-line training adopted in the Trust and its impact on the opportunities available for colleagues to network. AMH specifically highlighted that a PREVENT e-learning module may work against the aims of that particular training programme. AMH asked for consideration of more classroom based training. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
32/16	**FINANCE AND PERFORMANCE REPORT – WORKFORCE:** GB provided a summary on the closing year end pay expenditure position as follows:- • pay budget shows a pressure of £2.41m • total agency spend of £19.9m (£12.6m in Medicine and a £10.9m spend on medical staff) • excess cost for junior medical staff of £4.26m (incurred £8.0m agency expenditure). Monitor agency rule breaches are reported on a weekly basis. This comprises

	situations where agency workers are engaged through 'off framework' agencies and where the price cap is exceeded. GB reported that in the week ending 23 November 2015 when Monitor rules were introduced 383 breaches occurred. This has increased to 540 breaches at 28 March 2016. Breaches are expected to continue in 2016 / 2017 with Monitor setting a total agency spend ceiling of £14.95m. The Trust has built in a spend of £16m in its annual plan. It was noted neighbouring acute Trusts have taken the decision to reduce clinical activity rather than breach the cap. HB reported that a task and finish group has been established to identity where there are gaps in rotas and look at how the Trust can reduce agency spend through potential initiatives. **ACTION:** GB/JE to consider a combined narrative incorporating agency usage in the IPR report **ACTION:** HB / GB/JE to report how reductions in agency spend will be achieved. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
33/16	**CQC INSPECTION UPDATE:** In the absence of JD / LR the Committee was advised that post-CQC inspection visit a response group will meet every 2 weeks to focus on identified development areas and / or on issues raised by the CQC inspectors. The CQC report is anticipated in June 2016. **OUTCOME:** The Committee **NOTED** the update.
34/16	**REPORT FROM COLLEAGUE ENGAGEMENT, HEALTH AND WELLBEING GROUP:** JE confirmed that the implementation of the staff survey action plan will be overseen on a monthly basis by the Colleague Engagement, Health and Wellbeing group. **ACTION:** JE to report progress to the Committee at its meetings. JE advised that a national CQUIN for NHS Staff and Wellbeing has been published. The CQUIN is in 3 parts – the introduction of health and wellbeing initiatives (physical activity schemes, access to physiotherapy services, mental health initiatives), healthy food for NHS staff, visitors and patients and improving uptake of flu vaccinations for frontline clinical staff (75%). **ACTION**: JE to bring a report to the June 2016 Committee meeting. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the position statement provided.
35/16	**REPORT FROM EDUCATION AND LEARNING GROUP:** AL reported that a workshop is scheduled for 10 May 2016 to identify the content of the Trust's Education and Learning Strategy. The workshop will be attended by the

	members of the Education and Learning Group. AL advised that Health Education England (HEE) has published a Quality Framework that the Group can utilise to develop the Strategy and associated workplan. **ACTION**: AL to report progress at the June 2016 Committee meeting. The Education and Learning Group will meet monthly. The newly appointed Director of Workforce and OD will have Board responsibility for all training, education and learning activity. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
36/16	**REPORT FROM HUMAN RESOURCES MANAGEMENT GROUP:** JE informed the Committee that this group is not established. The Terms of Reference have been developed and the membership identified. JE stated that he is in discussion Jackie Green, Interim Director of Workforce and OD and Ian Warren, Director of Workforce and OD (designate) about the operation of the group. HB asked that careful attention be paid to ensuring that new groups are not established where existing groups can extend their remit. JE advised that the Committee sub group structure was developed in a way that uses established groups and this this Committee was the only new group created to support the Committee. **ACTION:** JE to provide an update at the next meeting of the Committee.
37/16	**REPORT FROM MEDICAL WORKFORCE GROUP:** The Committee received papers from the meeting of the Medical Workforce Group held on 14 March 2016. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
38/16	**REPORT FROM NURSING WORKFORCE GROUP:** VD highlighted the following:- • work continues reviewing vacancies which have been impacted upon by increased service demand and the 2% 'headroom' uplift in budgets • discussions with the Dean of School at Huddersfield University about the funding changes from 2017 for pre-registration education of nurses, midwives and AHPs. It was noted that this will result in a reduction of nurses so attention is required on identifying how the Trust sponsor nurses differently in order to maintain an available supply • a Hard Truths review informing workforce models will be presented to the Board of Directors in May 2016. PO asked how much of the nursing agency spend relates to the open extra capacity. . **ACTION:** PO to raise this at Finance and Performance Committee.

	OUTCOME: The Committee **RECEIVED** and **NOTED** the report.
39/16	**BOARD ASSURANCE FRAMEWORK:** The updating of the framework was discussed and it was agreed to test with VP the role of the Committee in ensuring it was appropriately maintained. **ACTION:** PO / JW / JE to liaise with VP. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the report.
40/16	**CORPORATE RISK REGISTER:** The role of the Committee in receiving the Corporate Risk Register is to be clarified. **ACTION:** PO / JW / JE to liaise with VP. The Committee **RECEIVED** and **NOTED** the workforce risks from the Corporate Risk Register.
41/16	**ANY OTHER BUSINESS:** The Role of the Minute Taker was deferred in the absence of JW. **ACTION:** SL to include on the June 2016 agenda.
42/16	**WORKFORCE WELL LED COMMITTEE WORK PLAN 2016 / 2017:** The Committee **RECEIVED** the Workforce (Well Led) Committee Work Plan for 2016/2017 for information. **ACTION:** SL to include the ESR, E-rostering and Recruitment and Retention plan April 2016 workplan items on the June 2016 agenda.
/16	**MATTERS FOR ESCALATION:**
DATE AND TIME OF NEXT MEETING: Tuesday 14 June 2016, 3.00 pm – 5.00 pm, Discussion Room 2, Learning and Development Centre, Huddersfield Royal Infirmary	

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON THURSDAY 7 APRIL 2016 IN THE LARGE TRAINING ROOM, LEARNING CENTRE, CALDERDALE ROYAL HOSPSITAL

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Wayne Clarke	Public elected – Constituency 2
George Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Brian Richardson	Public elected – Constituency 6
Kate Wileman	Public elected – Constituency 7
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8
Jennifer Beaumont	Public elected – Constituency 8
Chris Bentley	Staff-elected – Constituency 13 (Reserve Register)
Dawn Stephenson	Nominated Stakeholder – SWYPFT
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Cath O'Halloran	Nominated Stakeholder – University of Huddersfield

IN ATTENDANCE:

Helen Barker	Chief Operating Officer
Gary Boothby	Deputy Director of Finance
Kathy Bray	Board Secretary
Lisa Fox	Clinical Information Manager
Mandy Griffin	Director of The Health Informatics Service
Karen Heaton	Non Executive Director
Richard Hopkin	Non Executive Director
Ruth Mason	Associate Director of Engagement & Inclusion
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Victoria Pickles	Company Secretary
Jan Wilson	Non-Executive Director

23/16 APOLOGIES:

Apologies for absence were received from:

Di Wharmby	Public elected – Constituency 1
Peter Middleton	Public elected – Constituency 3
Dianne Hughes	Public elected – Constituency 3
Grenville Horsfall	Public elected – Constituency 5
Mary Kiely	Staff-elected – Constituency 9
Eileen Hamer	Staff elected – Constituency 11
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Naheed Mather	Nominated Stakeholder – Kirklees Metropolitan Council
Sharon Lowrie	Nominated Stakeholder – Locala

Owen Williams	Chief Executive
David Birkenhead	Executive Medical Director

Juliette Cosgrove	Assistant Director for Quality
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Phil Oldfield	Non-Executive Director

The Chair welcomed everyone to the meeting. A welcome was also extended to Gary Boothby, newly appointed Deputy Director of Finance who would present the finance report in the absence of the Executive Director of Finance.

24/16 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

25/16 MINUTES OF THE LAST MEETING – 19 JANUARY 2016

The minutes of the last meeting held on 19 January 2016 were approved as an accurate record.

26/16 MATTERS ARISING

40/15b - Code of Conduct - The Chairman reported there was no policy statement within the Trust about doctors talking over patients in a different language. Enquiries had been made regarding ascertaining the original complaint and no record could be found of an official complaint being recorded. The Executive Medical Director and Executive Director of Nursing had been asked to consider including this matter within an appropriate Trust policy in the future.

STATUS: Closed

5/16c - Food and Nutrition Event – 27.10.15 – The Chairman confirmed that this had been raised at the Board of Directors meeting on the 28 January 2016.

STATUS: Closed

6/16b - Board Appointment Update – The Chairman confirmed that a letter of thanks would be sent to Julie Hull in recognition of all her help and support and wishing her well for the future from the Membership Council and the Board of Directors.

STATUS: Closed

17/16 - Membership Strategy refresh - Ruth Mason advised that this issue had been discussed at the Membership Council Development Session held on Monday 4 April 2016 when Vanessa Henderson had given a presentation identifying the stock take undertaken on the Trust membership. It was agreed that the creation of a Task and Finish Group would be considered following the evaluation of the feedback from this Development Session.

Rev Wayne Clarke thanked Ruth and Vanessa for the good presentation and felt that this formed a sound base for the membership to move forward.

STATUS: Closed

All other matters arising were included within the agenda.

27/16 ELECTRONIC PATIENT RECORD (EPR) UPDATE

Mandy Griffin, Director of The Health Informatics Service attended the meeting to give an overview of the information which had previously been shared with the Membership Councillors present at the MC Development Session held on Monday 4 April.

The Membership Council heard how the implementation of the Electronic Patient Record, expected in the Autumn/Winter of 2016, would affect everyone - patients, carers and staff - both at the hospital and within the community. The system would harness information into one system which would be readily available remotely and provide real time information. Security of the system, should a breakdown occur, and audit tracking were discussed.

Discussion took place regarding the fact that a patient portal would be established and that Membership Councillor input would be required at a future date to help develop this further.

The Chair thanked Mandy for the presentation and it was noted that the next update on this issue would be at the Annual General Meeting in September 2016.

OUTCOME: The Membership Council noted the progress made with the EPR implementation and would receive a further update at the Joint AGM Meeting on 15.9.16

28/16 CHAIRMAN'S REPORT

a. Consultation Process

It was noted that the Consultation period was now underway and was scheduled to close on the 21 June 2016. The Chairman reported on the locality meetings which had already taken place at Shelley, Slaithwaite and Sowerby Bridge. It was noted that two public meetings had been scheduled for 6.00 pm on:-

Thursday 14 April 2016 – North Bridge Leisure Centre, Halifax
Monday 18 April 2016 – John Smith Stadium, Huddersfield

A further update would be given at the July Membership Council meeting.

ACTION: MC Agenda - July 2016

b. Board Appointment Updates

The Chairman updated the Membership Council on a number of Board changes:-

- Ian Warren has been appointed Director of Workforce and Organisational Development and would join the Trust in August 2016.
- An assessment centre and interviews for the Executive Director of Nursing post would be on Tuesday 12 April and Wednesday 20 April 2016. It was noted that Lynn Moore would be representing the Membership Council at the formal interviews.
- Karen Heaton and Richard Hopkins, Non-Executive Directors who had taken up post on the 1 March to briefly introduced themselves.

Karen Heaton advised that she was currently Director of HR at Manchester University and she had worked over the past 3 years as an Independent Member with the Prison Services Pay Review Body.

Richard Hopkin advised that he had a finance background and locally worked with Age UK and was Treasurer on the Community Foundation for Calderdale. He was a member of a housing board 'Derwent Living'.

c. Update from Chairs' Information Exchange

The Council received the minutes from the meeting held on 21 March 2016. These were available within the meeting papers at Appendix B1. The issues arising included:-

- The Chairman advised that the issue of Intermediate Care Facilities in the system had been raised at the Board of Directors Meeting on 31 March 2016 and the Chief Operating Officer was investigating options.

- The issue of ensuring that all disciplines of staff are depicted on the pictures throughout the Trust had now been addressed.

d. CQC Inspection Feedback

The Chairman 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 fed back to the Trust in approximately 8 weeks' time. It was noted that initial feedback received had indicated that they had identified some areas of good practice within the Trust particularly around dementia care, together with some areas of concern which were being addressed. Staff had reported that this had been a good experience.

e. Review of Formal Meeting Attendance Register

Unfortunately Appendix B2 had not been included within the papers. It was agreed that the Board Secretary would circulate this to the Membership Council on Monday 11 April and ask for any amendments to be identified prior to its publication in the Annual Report and Accounts.

ACTION: Board Secretary – completed 11.4.16

CONSTITUTION

29/16 MEMBERSHIP COUNCIL REGISTER

The updated register of members was received for information. It was noted that resignations had been received earlier in the week from Ken Batten and Julie Hoole. The two vacant seats would remain empty and be included in the elections to be held later in the year.

30/16 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The updated Register of Interests/Declarations was received. Any amendments were requested to be notified to the Board Secretary as soon as

possible. It was requested that the members with outstanding declarations listed at the end of the Register ensure that a response is forwarded to the Board Secretary as soon as possible.

31/16 TRUST PERFORMANCE

In order to allow the Chief Operating Officer to attend another meeting later that evening, the Chairman confirmed that this item would be moved up the agenda.

a. Integrated Performance Report

The Chief Operating Officer gave an overview of the key themes from the February IPR report which showed a mixed picture with continued deterioration in patient flow related metrics. The areas of specific note were:

Responsiveness

- The Emergency Care Standard was missed 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 (referrals to Leeds/Bradford) where revised actions plans are in development
- DTOC improved but green X numbers remain high
- There was one 28 day breach relating to critical care access
- 100% of patients requiring thrombolysis for stroke received this within 1 hour.

Caring

- 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 and further work was underway.

Effectiveness

- C Difficile was worse than target in February with a further 3 cases being reported.
- Mortality remains a concern and is the focus of significant work
- Fractured neck of femur performance in relation to Theatre within 36 hours remains slightly worse than the required standard and this was due to the level of demand for access to theatre within 36 hours.
- Emergency readmissions had increased and will be reviewed as part of Patient flow action plan. Discussion took place regarding the actions underway to investigate this.

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.

• A further Never Event had been reported in February. Both Never Events in February related to retained swabs in maternity and these were being investigated. No detrimental harm had come to the patients involved.
• Our efficiency in responding in a timely manner to complaints (under the Duty of Candour) had deteriorated in month.

Well led
• Work continues by the Divisions and the Sickness/Absence team.
• Mandatory Training compliance was improving. 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.
• Appraisals – A drive was underway to complete the bulk of appraisals at the beginning rather than end of the year.

b. MONTH 11 – FEBRUARY 2016 FINANCE REPORT

In the absence of the Executive Director of Finance, **t**he Deputy Director of Finance presented the finance month 11 report as at the 29 February 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 Performance and Finance Reports were received and noted.

32/16 UPDATE FROM BOARD SUB COMMITTEES

a. Nominations and Remuneration Committee (MC) Update

As previously discussed it was noted that the two Non Executive Director appointments had been made from 1 March 2016 (Karen Heaton and Richard Hopkin).

The Committee had not met since the 7 December 2015 and those minutes had been previously circulated.

b. Audit and Risk Committee

The next Audit and Risk Committee was not scheduled until 20 April 2016.

c. Electronic Patient Record (EPR)

Rev Wayne Clarke updated the Membership Council on his representation on the EPR Transformation Board. He reported that unfortunately due to work commitments he had been unable to attend some EPR meetings. It was therefore suggested that deputies from the Membership Council might be identified to attend these meetings in Wayne's absence. The Chairman agreed that an email be circulated to ask for expressions of interest from interested Membership Councillors.

ACTION: Board Secretary

d. Finance and Performance Committee

Brian Moore advised that all issues discussed at the Finance and Performance Committee had been included in the Integrated Performance Report presented by Gary Boothby earlier in the meeting.

e. Quality Committee

Lynn Moore advised that all performance issues discussed at the Quality Committee had been included in the Integrated Performance Report presented by Helen Barker earlier in the meeting.

Areas of focus by the Committee included:- Integrated Board Report including fractured neck of femur, special measure wards, patient safety group review of risks and review of Morecambe Bay Maternity report to note any issues of learning by the CHFT. Review of the contents of the draft Quality Accounts.

f. Charitable Funds Committee

Kate Wileman advised that work was in progress regarding the Charitable Funds Committee contribution towards mental health support for victims of the Calderdale floods.

g. Workforce Well-Led Committee

Rosemary Hedges advised that unfortunately she had been unable to attend the meeting held on the 19 February 2016. It was noted that the next meeting was scheduled for the 21 April 2016.

h. MC/BOD AGM Task and Finish Group

Ruth Mason reported that a Task and Finish Group comprising of herself, Victoria Pickles, Vanessa Henderson, Caroline Wright and Kathy Bray had met to discuss the arrangements for the joint Annual General Meeting to be held on the 15 September 2016 at Calderdale.

The following format had been proposed and this was supported by the Membership Councillors present:-

- A small 'health fair' approach would be taken around the theme of technology with a strapline 'IT's vital to your health' – given the proximity to the launch of our new electronic patient record – with two areas of focus:
  1. Recent successes and developments – Nervecentre; Bing; new website; appointments over Skype etc
  2. The new EPR – what it will mean for patients and the patient portal including the demonstration videos
- A presentation given by the Director of Health Informatics / Clinical Leads for EPR on the Trust's technology journey
- The formal AGM meeting.

OUTCOME: The Membership Council approved the AGM/Health Fair approach

33/16 PROPOSED TIMETABLE FOR ELECTIONS

Ruth Mason presented a paper which outlined the election timetable for 2016, together with vacant seats.

It was noted that the resignation of Ken Batten and Julie Hoole would increase the number of possible vacant seats to 11.

Arrangements had been made for the Electoral Reform Services to oversee the process again during 2016 and those present noted and approved the proposed timetable which they had supplied.

Membership Councillors eligible for re-election were encouraged to re-stand for election.

OUTCOME: The Membership Council approved the proposed timetable for the 2016 Elections

34/16 CHAIR/NON EXECUTIVE DIRECTOR APPRAISAL PROCESS

A paper proposing the appraisal process for the Chair and Non-Executive Directors was received and noted.

Rev Wayne Clarke drew the Membership Councillors' attention to the fact that the questionnaire template had been amended in line with feedback received from the process last year.

It was agreed that the Board Secretary would circulate the template for the Membership Councillors to complete and return by 22 April 2016. As Membership Councillors who were present last year would recall Dr David Anderson, Senior Independent Non Executive Director had again agreed to collate all responses from the Membership Council and Board of Directors and he would present a report to the Membership Council at its meeting on the 6 July 2016. The Chairman reported that a report would also be prepared for this meeting following the Non Executive Director appraisals which were taking place over the next 2-3 months.

It was requested that if any Membership Councillors had any views on the Non Executive Directors which they would like to be considered in this process that they should contact Rev Wayne Clarke before the 10 May 2016.

ACTION: BOARD SECRETARY/ALL
OUTCOME: The Chair/NED Appraisal Process was approved.

35/16 MC SELF APPRAISAL OF EFFECTIVENESS PROCESS

Ruth Mason presented a re-drafted questionnaire to be completed by Membership Councillors. The collated responses would be fed back to the Membership Council at the Development Session in July 2016. Rev Clarke suggested that before the questionnaire is circulated it be amended to provide clarity around the Public Membership Council Meetings and Divisional Reference Groups.

ACTION: Ruth Mason
OUTCOME: The questionnaire was approved subject to amendment

36/16 QUALITY ACCOUNTS 2015/16

Lisa Fox, Clinical Information Manager attended the meeting and advised that the Quality Committee had received and approved the first draft of the Quality Accounts. This document would be presented to the Audit and Risk Committee and the Board of Directors within the Annual Report and Accounts. The document would also be published as a stand-alone document on NHS Choices.

Any Membership Councillors who would like to have sight of the first draft should contact the Board Secretary, otherwise the Membership Council would be able to access the 92 page document when it is presented to the Board of Directors in May 2016.

OUTCOME: Any Membership Councillors interested in having sight of the first draft to contact the Board Secretary.

37/16 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Membership Council Calendar – updated calendar received and contents noted.

38/15 ANY OTHER BUSINESS

a. Car Parking Strategy

Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities presented a paper outlining proposals for a revision to the public car parking charges. Apologies were made for the late circulation of this paper. It was noted that this paper had been considered by the Executive Board.

The Membership Council discussed the main two areas of change – the introduction of a new 60 minutes charge rate of £1.50 and a small increase from £2.50 to £2.80 for 2 hours parking. The majority present agreed that the introduction of a 1 hour parking charge would be of benefit to visitors.

Concern was expressed regarding the 2 hour parking increase and it was requested that further information be provided to the Membership Council regarding the realisation of the cost improvement of £270k which had been quoted. It was noted that this sum was partly made up from changes to staff parking charges which had not yet been finalised.

Brian Moore expressed disappointment and disapproval that this item had not been presented to the Estates and Facilities DRG where it should have been discussed before coming to the Membership Council.

Before the Membership Council would support the proposal going forward to the Board of Directors on the 26 May 2016 it was requested that further information on the finances, together with modelling impacts be re-worked.

ACTION: Lesley Hill

39/15 DATE AND TIME OF NEXT MEETING

Wednesday 6 July 2016 - Membership Council Public Meeting commencing at 4.00 pm in the Boardroom, Sub Basement, Huddersfield Royal Infirmary.

The Chair thanked everyone for their contribution and closed the meeting at 6.35 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Monday, 9 May 2016

Present: Andrew Haigh, Keith Griffiths, David Birkenhead, David Anderson

In attendance: Zoe Quarmby, Lyn Walsh, Carol Harrison

Apologies: Lindsay Rudge, Philip Oldfield, Kate Wileman

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Minutes of the last meeting
The minutes of the last meeting held on 17 February 2016 were agreed as a true and correct record.

Action (1):
Carol to upload these to board paper site as a fast track item for the next Board of Directors meeting.

3. Matters arising
~ *Calderdale Community Foundation* – Andrew presented the correspondence and paper produced by the Foundation and asked that the Committee noted its contents. It was pleasing that they were heading in the right direction and that there was some activity. Andrew would continue to provide the Committee with updates.

4. Future Expenditure from Abraham Ormerod fund
It was agreed at the last meeting that a paper would be drawn up re ideas for future expenditure with input from Zoe (Capital), Andrew H (Community) and David Birkenhead/Trust Rep (Vanguard/Trust) and brought to the next meeting.
The paper was not available for this meeting; the action point is carried forward to the next meeting.

Action (2):
Finance to consolidate report on future expenditure and bring to the next meeting.

5. Fundraising – local opportunities
In the absence of Phil, Andrew presented his comprehensive report on fundraising which provided the Committee with a great deal of information and food for thought.

Prior to the meeting, David B had spoken to Ruth Mason whose views were that, in the current climate, it would be very difficult to attract donations or the right person to fundraise. It was agreed that we would not pursue at this time.
Keith felt that this should not mean that we do nothing and he wanted to build on good Public Relations. He mentioned possibly funding Research or something unusual. It was agreed that further discussion is required when the Right Care, Right Time, Right Place consultation process is complete.
It was agreed to try to raise the Charity profile by updating the link to the Charity on the Trust website. Andrew agreed that we should have a meeting with THIS to discuss. He also agreed to speak to his contact, Dr Cath O'Halloran, at the University of Huddersfield with regard to work experience for a student around the topic of fundraising.

Action (3):
Lyn/Carol to arrange meeting with THIS and Andrew re link to Charity from Trust website.

Action (4):
Andrew to speak to University of Huddersfield re placement re fundraising.

6. Huddersfield Giants Fundraising Scheme
Andrew mentioned that he'd had an enquiry from Andrew Watson about the Trust being involved with the above lottery and asked if the Committee wanted him to ask for more details. This was agreed.

Action (5):
Andrew to speak to Andrew Watson about the Fundraising Scheme and report his findings.

7. Consolidation of Funds
Keith presented this paper which instigated a lengthy discussion around the pros and cons of consolidating the current funds into a much smaller number based on division, site, specialty or even the Trust as a whole.
There was no agreement reached at this time with regard to long term options but, in the short term, it was agreed an e-mail will be drafted from the Committee that will start the processes which were discussed relating to the short term options described in the paper; this will encompass three year plans, divisional and inactive funds as well as the funds with smaller balances. It was noted that this will be a sensitive issue that needs careful handling.
Inactive Funds exercise – Keith said he would agree on a definition outside of the meeting.
Keith also said he would arrange a meeting with Vicky Pickles to discuss the best ways of communicating any changes that could be made to the wider stakeholder audience and to promote Charitable Fund donations received as a Trust wide team effort.

Action (6):
Finance to Draft Email for review.

Action (7)
Keith to arrange to meet with Vicky Pickles re communication.

8. Accounts Overview 2015/16
Lyn presented a summary of the financial year 2015/16 and this was noted.

9. Terms of Reference review
Lyn presented the Terms of Reference which had been reviewed and amended by Vicky Pickles. The Committee was happy with the amendments and accepted these as the new Terms of Reference.

10. Minutes from the Staff Lottery Committee meeting held on 5 April 2016
These were noted.

11. Any other business
Keith asked for a list of fund balances per Division for him to forward to the Divisional Directors.

Action (8):
Carol to provide Keith with lists of divisional fund balances.

12. Date and time of next meeting
The next meeting will be on Monday, 22 August 2016 at 1.30 pm in Meeting Room 2, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
22 August 2016
Action Log - 2016/17

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Minutes of last meeting	9.05 - 1	Submit minutes to bPaper section on intranet for Andrew for next BOD meeting.	**CH**	10.05.16	Completed
Calderdale Comm. Foundation	9.05 - 2(17.02 - 2)	Consolidate report on future expenditure and bring to next meeting	**Finance**	9.05.16	
Fundraising - local opportunities	9.05 - 3	Arrange meeting with THIS re link to Charity from Trust website- AH/LW/CH to attend	**LW**	22.08.16	
Fundraising - local opportunities	9.05 - 4	Speak to Uni. of Huddersfield re placement re fundraising	**AH**	22.08.16	
Huddersfield Giants Fundraising Scheme	9.05 - 5	Speak to Andrew Watson about the Fundraising Scheme and report findings	**AH**	22.08.16	
Consolidation of Funds	9.05 - 6	Finance to draft email for review	**Finance**	asap	
Consolidation of Funds	9.05 - 7	Speak to Vicky Pickles re communication	**KG**	22.08.16	
Any other business	9.05 - 8	Provide Keith with list of fund balances by division for DDs	**CH**	10.05.16	Completed

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