Calderdale and Huddersfield NHS
NHS Foundation Trust

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

Venue: Boardroom, Huddersfield Royal Infirmary HD3 3EA

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Mr Brian Moore, Publicly Elected Membership Councillor Ms Kate Wileman, Publicly Elected Membership Councillor	Chair	**VERBAL**	**Note**
2	**Apologies for absence:** Dr Linda Patterson, Non-Executive Director	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Receive**
4	**Minutes of the previous meeting** held on 30 June 2016	Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log**	Chair	**APP B**	**Review**
6	**Patient/Staff Story:** 'Improving food and drinks for staff and patients at CHFT' presentation by Alison Wilson, General Manager – Compliance and Divisional Support, Chris Bentley, Estates and Facilities Matron and Dr Cleasby, Deputy Chair – Calderdale CCG	Chair	**Presentation**	**Note**
7	**Chairman's Report** a. Board to Board Meeting with Mid Yorkshire Joint Board – 11.7.16 b. NHS Providers – Governance, Sustainability and Improvement Workshop – 7.7.16	Chair	**VERBAL**	**Note**
8	**Chief Executive's Report:** a. Sustainable Transformation Plan	Chief Executive	**VERBAL**	**Note**
Transforming and improving patient care				
9	Consultation Process – Update and Consultation Petition	Director of Transformation	**APP C**	**Note**

		and Partnerships/ Company Secretary		
Keeping the base safe				
10	Board Assurance Framework	Company Secretary	**APP D**	**Approve**
11	Risk Register	Executive Director of Nursing	**APP E**	**Approve**
12	Workforce Race Equality Standard (WRES) – Statement and Action Plan	Chief Executive	**APP F**	**Approve**
13	Care of the Acutely Ill Patient	Executive Medical Director	**APP G**	**Approve**
14	Director of Infection, Prevention and Control Quarterly Report	Executive Medical Director	**APP H**	**Approve**
15	Director of Infection, Prevention and Control Annual Report	Executive Medical Director	**APP I**	
16	Integrated Performance Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Finance	Chief Operating Officer “ Director of Nursing Director of Nursing Executive Medical Director Executive Director of Finance	**APP J**	**Approve**
Financial Sustainability				
17	Month 3 – June 2016 – Financial Narrative	Executive Director of Finance	**APP K**	**Approve**
A workforce for the future				
18	Medical Revalidation Annual Report	Executive Medical Director	**APP L**	**Approve**
19	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 28.6.16 and verbal update from meeting 26.7.16 ▪ Finance and Performance Committee – minutes of 28.6.16 and verbal update from meeting 26.7.16 ▪ Audit and Risk Committee – verbal		**APP M**	**Receive**

	update from meeting 21.7.16			

Date and time of next meeting
Thursday 15 September 2016 commencing at 6.00 pm – Formal Joint BOD/MC AGM
Venue: Lecture Theatre, CRH

Thursday 29 September 2016 commencing at 1.30 pm
Venue: Boardroom, HRI

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).*

Table of Contents

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th July 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 30.6.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 30 June 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 30 June 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 30 June 2016.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 30.6.16(1).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 30 June 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
Brendan Brown	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Karen Heaton	Non-Executive Director
Richard Hopkin	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
Mandy Griffin	Director of The Health Informatics Service
David Himelfield	Huddersfield Examiner Reporter (for part of meeting)
Victoria Pickles	Company Secretary
Bob Metcalfe	Membership Councillor
Barbara Schofield	Nurse Consultant in Older People (for part of meeting)

Item

97/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting. A particular welcome was extended to Brendan Brown, newly appointed Executive Director of Nursing, for his first meeting of the Board of Directors.

98/16 APOLOGIES FOR ABSENCE

Apologies were received from:

Dr David Birkenhead	Executive Medical Director
Jackie Green	Interim Director of Workforce and OD
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director

99/16 DECLARATION OF INTERESTS

There were no declarations of interest to note.

100/16 MINUTES OF THE MEETING HELD ON THURSDAY 26 MAY 2016

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

101/16 MATTERS ARISING FROM THE MINUTES/ACTION LOG

25/16a - IMPLEMENTING THE FORWARD VIEW - It was noted that input from the work undertaken with partners would be brought to the Board of Directors in September.

STATUS: Open – BoD Agenda Item September 2016

26/16b – MENTAL HEALTH – 5 YEAR FORWARD VIEW - The Chief Executive reported that joint work to expand the Trust's involvement was underway with South West Yorkshire Partnership Foundation Trust. More information would be brought to the Board as appropriate.

STATUS: Closed

30/16 - RISK MANAGEMENT POLICY – Professor Roberts confirmed that a meeting was scheduled for Friday 1 July 2016 with the Company Secretary and Head of Governance and Risk to discuss risk management in readiness for the Board Workshop on the 13 July 2016.

33/16 - QUARTERLY QUALITY REPORT – The Company Secretary confirmed that the quality priorities had been signed off by the Quality Committee at its meeting on the 28 June and it was agreed that these would be circulated to the Board and Membership Council.

ACTION: Company Secretary

87/16 - NURSING AND MIDWIFERY STAFFING – HARD TRUTHS – It was noted that the Chief Operating Officer and Executive Director of Nursing would report to the Finance and Performance Committee on the work to reduce agency costs. This followed discussion and liaison with Divisional staff to implement the necessary changes required.

102/16 PATIENT STORY 'MRS CAMPBELL'

Barbara Schofield, Nurse Consultant for Older People attended the meeting to present a story by Mrs Campbell. The Board heard about Jack, Mrs Campbell's husband who had been an active and healthy 90 year old man. Due to back pain he had been receiving medication but had become confused and unable to mobilise himself. This led to his decline and admission to rehab at Holme Valley Hospital. Further deterioration resulted in admission to Huddersfield Royal Infirmary.

The Board heard that Mrs Campbell wished to share the story so that other patients could benefit from lessons learnt by the ward staff. The presentation covered a number of issues, which described examples of both poor and good patient experience. The experience of nursing care had varied between on the wards where he had been looked after. Examples of poor care included poor patient hygiene; medications left on bedside, not taken; choice of meals; and the use of call bells.

The last point made by the family was 'being quiet doesn't make you less vulnerable'.

The Board were assured that the areas where improved care could be extended to Jack and his family had been taken on board by the ward staff concerned and they were addressing the issues raised. It was noted that the launch of 'John's Campaign' in the Trust over the next few years would change the leadership and culture throughout the organisation and it was stressed that it was important that this was multidisciplinary across the Trust, with the aim of focusing on family centred care.

The Board asked that thanks be given to Mrs Campbell and other members of Jack's family for sharing their experience with the Trust.

103/16 CHAIRMAN'S REPORT

There were no issues that the Chairman wished to raise.

104/16 CHIEF EXECUTIVE'S REPORT

a. JOINT YORKSHIRE CHAIR/CHIEF EXECUTIVE MEETING – 8.6.16

The Chief Executive reported on the event attended by himself and Jan Wilson on behalf of the Chairman. The Chief Executive of NHS Providers, Chris Hopson introduced the meeting and outlined the national context and financial challenges being faced by NHS Improvement, NHS England and Public Health England.

The main focus of the meeting was around the Sustainability and Transformation Plan in West Yorkshire. It was noted that the Board Workshop on the 13 July would be an opportunity to debate the likely significant changes which would be made to health provision in the future.

105/16 CONSULTATION PROCESS - UPDATE

The Director of Transformation and Partnerships confirmed that the Consultation process had closed during the week of the 21 June 2016. The timetable for the findings of the consultation being shared with the Clinical Commissioning Groups (CCGs) and Joint Scrutiny Panel in August was noted. It was anticipated that a joint governing body response would be agreed on the 20 October 2016 when the next steps would then be determined. Some concern was expressed by the Board that the ability for the Trust to secure the funding required could be affected due to national financial constraints if there was a delay in the decision.

The Board asked that thanks be given to all staff who had been involved in the Consultation process. It was noted that a number of colleagues have given their own time to make sure they attended events that allowed people to raise their comments and concerns.

OUTCOME: The Board noted the progress with the Consultation.

106/16 RISK REGISTER

The Executive Director of Nursing reported on the top 9 risks within the organisation. These were:-

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
6722 (20): Cash flow risk
6732 (20): Cost improvement delivery

Risks with increased score

The Board noted that Risk 6722, relating to cash flow - previously scored at 16 had increased to a score of 20 due to the Trust having to manage and prioritise supplier payments to maintain cash balance.

Risks With Reduced Score

The Board noted that Risk 6723 'suspension of capital programme' had reduced from a risk score of 20 to 16 as an internal review had determined that expenditure on the capital programme could be curtailed without significant risk to the organisation.

New Risks

One new risk has been added, Risk 6753, scored at 16. This related to the risk of 'inappropriate access to personal identifiable information and Trust data on some Trust computers'. The Director of The Health Informatics Service assured the Board

that this issue was being addressed and would be fully mitigated once the EPR system was operational.

Bob Metcalfe raised the question of whether the long term effects of the results of the EU referendum had any implications such as staff recruitment/vacancies and increased drug costs were required to be included on the Risk Register in the future. The Chief Executive acknowledged that the Trust was alert to the issues, would monitor the situation and once the Trust was fully aware of the issues would escalate as appropriate. The Board agreed that this position should be reviewed again in November 2016 and any material risk included in the Risk Register.

ACTION: Impact of recent Referendum – consideration to be given to inclusion in the Risk Register

Closed Risks

There were no closed risks on the register to report.

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:

- Athena system in Family and Specialist Services.

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

107/16 GOVERNANCE REPORT

The Company Secretary presented the Governance Report. It was noted that this report brought together a number of items that evidenced or strengthened the corporate governance arrangements and systems of internal control within the Trust.

The issues brought to the Board's attention were:-

1. Q4 Response from Monitor/NHS Improvement

The Trust received feedback from Monitor in relation to the Q4 2015/16 submission and a copy was attached at appendix 1.

OUTCOME: The Board RECEIVED the Q4 feedback.

2. Board Workplan

The Board work plan had been updated and was presented to the Board for review at appendix 2.

OUTCOME: The Board CONSIDERED and AGREED the items allocated for the meetings were correct and agreed that there were no other items they would like to add for the forthcoming year.

3. Use of Trust Seal

Four documents have been sealed since the last report to the Board in December 2015 and a copy of the register of these sealing was attached for information at Appendix 3. These were in relation to:-

- Sale of 38 Acre Street (formerly Occupational Health Building). Sold subject to contract for £125,500.00
- Renewal Lease for Park Valley Mills site (Community Midwifes and Child Health Teams) from Holmfirth Dyers Ltd. (£11,250 per annum rent)
- Sub Underlease to extend lease agreement between the SPC, Trust and WH Smith at CRH
- HRI Communities Together - Lease relating to radio apparatus being installed at HRI for the broadcast of Radio Sangam Community radio station - no rental cost.

OUTCOME: The Board RATIFY these sealings.

4. Board of Directors Declaration of Interest Register

Board members were asked to confirm that their entry on the Register at Appendix 4 was correct before publication on the Trust website. All present agreed their entries

OUTCOME: The Board AGREED the contents of the Register

5. Board of Directors Attendance Register

The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors.' The attendance register at Appendix 5 was from April to February 2016.

OUTCOME: The Board NOTED the attendance register.

6. Workforce Well Led Committee - Terms of Reference

The Board was asked to receive and approve the revised Terms of Reference for the Workforce Well Led Committee at Appendix 6.

OUTCOME: The Board APPROVED the revised Terms of Reference for the Workforce Well Led Committee.

7. Calderdale Artefacts

As reported to the Board in December 2016, arrangements were made for the transfer of the artefacts under an Exhibition Agreement on Tuesday 14 June 2016 to the Halifax Royal Infirmary Hospital Management Company based at Edgcumbe House. It was confirmed that the insurance liability for the items sat with Management Company.

The Board NOTED the letter of thanks received from the Management Company which was attached at appendix 7. The Board asked that thanks be passed to all staff involved in ensuring the completion of this task which had been on-going for approximately five years.

OUTCOME: The Board NOTED the transfer of the artefacts to the Halifax Royal Infirmary Hospital Management Company and wished to thank all staff involved.

108/16 WELL LED GOVERNANCE REVIEW ACTION PLAN UPDATE

The Company Secretary reported that all issues had been delivered, although in some areas the newly appointed Executive Director of Nursing and Executive Director of Workforce and Organisational Development would be asked to review to identify whether any further work was required.

The Chief Executive advised that at the last meeting with NHS Improvement it had been suggested that a peer review would be arranged. It was agreed that this would be discussed with NHS Improvement on 19th July given that the CQC report would be received shortly.

OUTCOME: The Board approved the progress of the Well Led Governance Review Action Plan Update.

109/16 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief Operating Officer introduced the revised Integrated Board Report as at 31 May 2016 and explained that key areas would be presented in detail by the appropriate Executive leads. It was noted that this report had been circulated and discussed in detail at the Quality Committee and Finance and Performance Committee earlier that week and the Executive Board the week previously. It was

noted that work continued on the development of specific sub-committee reports in the future.

Discussion was also taking place regarding the timeline for completion of the report and whether it was possible to move the key committee meetings to the 1st week in the month.

ACTION: Chairman/Chief Executive/Company Secretary

The key areas of specific note from the report were:

Safe

• Inpatient Falls with Serious Harm - there were 7 falls in May, which were currently being investigated. This was a further increase on what was already a peak in April. As part of the CQUIN on safety huddles implementation there is an action plan in place to reduce the number of falls.
• Never Event - There had been one Never Event reported in May relating to feeding by a dislodged NG tube. This was in the process of being investigated with NHS England with a final submission date of 11 August to the CCG. The investigation will look at Trust compliance with NPSA alert 2011/PSA002 reducing the harm caused by misplaced NG feeding tubes.
• Maternity - % Post Partum Haemorrage (PPH) 1500ml - An improvement in overall PPH rates had been recorded in May 2016, however, the Trust was still above the target. A reduction in overall PPH rates will lead to improved patient experience following delivery.
• Number of Trust Pressure Ulcers (Category 2) Acquired at CHFT - 22 against monthly target of 17. Further cluster investigations into category 3 ulcers should see improvements in Quarters 2 and 3. The report was expected at the end of June.

The Chairman asked whether the setting of targets for pressure ulcers and falls should be reviewed in the future. It was noted that the Executive Director of Nursing was undertaking work in this area and further information would be brought to the Board after the review had been undertaken.

ACTION: Executive Director of Nursing

Effective

• Total Number of Clostridium Difficile Cases - There were three cases in May, two were avoidable.
• Perinatal Deaths (0-7 days) - at 0.65% are above the 0.1% target. A New Standard Operating Procedure (SOP) for Perinatal deaths and quarterly reports had been produced. Perinatal mortality group meet monthly to review cases and feedback learning. All perinatal deaths were logged on datix as an incident and fully investigated.
• Stillbirths Rate - at 0.65% is above expected levels for the second month running. New SOP in place for stillbirth reduction and an action plan was in place which is monitored on a weekly basis. Quarterly report produced and findings discussed at stillbirth reduction group and Audit meetings.
• 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. There was an improvement plan in place to address both of these.
• Split by site, in-hospital and 30-day post-discharge deaths show that SHMI for post discharge deaths from Huddersfield Royal Infirmary (HRI) was much higher than in-hospital HRI deaths or any in Calderdale Royal Hospital. This is currently unexplained and is subject to investigation.
• Hospital Standardised Mortality Rate (1 yr Rolling Data April 15 - Mar 16) 111.6 - Trust predicts further modest reductions in the coming months.

• Mortality Reviews - The completion rate for Level 1 reviews has been declining and YTD was 34%. Recruitment of more reviewers had been discussed and a proposal to move towards a consultant delivered initial review process was agreed at the Mortality Surveillance Group and will be taken to the Divisional Patient Safety and Quality Boards for implementation.
• Crude Mortality Rate - had peaked at 1.6% for May 16. This was to be reviewed by the Mortality Surveillance Group.
• Average Diagnosis per Coded Episode - there had been an improvement in month and work continues with Surgery focusing on improving coding through the use of Bluespier. Similarly in Paediatrics work done on the Paediatric ward will be extended to the Paediatric Assessment Unit.
• Percentage Non-elective fractured neck of femur patients with admission to procedure of < 36 Hours based on discharge is 68.3% against 85% target. In May 26 of 34 people received an operation within 36 hours. There were three clinical breaches and 5 organisational breaches. RCAs are carried on all breaches.

Caring

• Only 38% of complaints were closed within timeframe against a target of 100%. This was the lowest position in the last 12 months and was subject of specific discussions as part of the divisional performance agendas.
• Friends and Family Test Outpatients Survey - 90.8% against a target of 95% would recommend the Service against 95% target. Improvement plans were in place around car parking and clinic waiting times.
• Friends and Family Test Community Survey - 87% would recommend the Service against 96.2% target. Actions were in place to address concerns around the perception of poor staff attitudes. Standards of communication and expected behaviours were discussed across the division at every meeting.

Responsive

• Emergency Care Standard 4 hours. May's position had fallen slightly to 93.47% with an increase in patients waiting over 8 hours and further corrective actions have been identified to correct the deterioration. If all actions were achieved the Trust aims to secure a quarter one position of 94% and were seeking to achieve 95% for June. The Trust was 2nd only to Harrogate in performance of surrounding Trusts for the quarter.
• % Daily Discharges - Pre 12pm. 17% against 40% target. 2 wards achieved 50% in May. 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 90 patients, discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care.
• 83.3% of patients spent 90% of their stay on a stroke ward similar to last month- action plan for stroke service improvement had been updated.
• Only 47.8% of Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 90% target - updated action plan.
• % Last Minute Cancellations to Elective Surgery - Continued pressure from Medical outliers on the Gynaecology bed base at CRH. Monthly performance of 1.35% against a target of 0.6%. Discussions taking place to set criteria for outlying into Gynaecology beds and management of patient flow (by July 16).
• RTT pathways over 26 weeks highest since July 2015 - need for further validation.
• 38 Day Referral to Tertiary had improved to 66.7% against 85% target. Action plans had been to Divisional Performance reviews in May with a requirement to achieve by July reflecting changes to reporting rules from Q3.

Workforce

• Sickness Absence rate had fallen to 4.23% against 4% target the lowest position for over 12 months with improvements across all divisions. Within this long term

sickness is 2.8% against 2.7% with the short term 1.47% against 1.3%. Surgery has improved particularly its short term sickness.
• Return to work Interviews was a key contributor to effective sickness management and was currently only running at 34.6% against 100% target. The Trust also had the highest Turnover rate when compared to surrounding Trusts.
• Mandatory Training and appraisal compliance remained a challenge. Appraisal training proposal – a paper was to be received at the Education Learning Group meeting on 22 June 2016.

It was noted that focus on face to face exit interviews to analyse the retention issues was to be discussed at Executive Board. Professor Roberts asked whether the Trust would revisit the question of bursaries and incentives to join the Trust and the need to widen the scope away from the Huddersfield and Calderdale. The Chief Executive advised that this was particularly relevant to review with the forthcoming Sustainability and Transformation Plan challenges which will affect the universities as well as health sector.

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 Emergency Department for Q1. Performance 43% against year end 70%. ED staff have identified a way to ensure that all staff have a trigger to 'think sepsis' during triage. From June 1st there is a prompt on the EDIS system which needs to be completed at triage to indicate whether patients are showing signs of sepsis. The pathway and triggers for those patients who present directly to MAU/SAU is next to be improved and engagement with colleagues in those areas had begun in June.

Activity

• Planned day case and elective activity performance is improved at 3.3% above the month 2 plan. This was driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall was 3.2% below the month 2 plan which was a continued reduction from April. This continues to be mainly driven by emergency long-stay. A&E had seen activity 7.6% above the month 2 plan which is a significant increase from month 1. Outpatient activity had seen a significant increase across first and follow-ups and is 5.3% above the month 2 plan.

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

110/16 MONTH 2 – MAY 2016 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 2 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, both held on the 28 June 2016:-

The key issues included:-

Year to date:

The year to date financial position stands at a deficit of £5.87m, an adverse variance of £0.06m from the planned £5.81m. In month, the Trust has seen a stronger performance against planned activity, catching up some of the shortfall seen in Month 1. However, to deliver activity and maintain staffing ratios across the bed base the Trust continues to rely heavily upon agency staffing at premium rates to cover both medical and nursing vacancies driving a pay overspend in both of these areas. Total agency spend in month was just under £2.5m, an increase on an already high run rate and a significant draw on limited cash resources impacting the Trust's ability to pay for other goods and services in a timely way.

The impact of this operational position is as follows at headline level:
• A negative EBITDA of £1.82m, a £0.25m adverse variance from the plan.
• A bottom line deficit of £5.87m, a £0.06m adverse variance from plan.
• Delivery of CIP of £1.26m against the planned level of £1.24m.
• Contingency reserves of £0.66m have been released in line with the planned profile.
• Capital expenditure of £2.38m, this is below the planned level of £2.52m.
• A cash balance of £1.93m in line with the planned level of £1.94m.
• A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

As was the case last month, the underlying trading position is masked by a number of one off financial benefits. Outpatient work has been high in the first two months as some specialties aim to get ahead in advance of anticipated capacity gaps later in the year and so this is not forecast to be maintained at the same level. Critical Care income has spiked by £0.46m as a result of the discharge in May of a particularly long staying patient. Finally, one off rebates totalling £0.20m have been received in relation to rates and utilities.

Forecast:
Whilst there have been one-off benefits in the year to date, the run rate on underlying expenditure is bringing ongoing pressure with a particular risk around ongoing high levels of agency expenditure. CIP has delivered as planned at Month 2 but it should be noted that the planned profile of CIP is heavily weighted into the latter part of the year and just under 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 continues to be to deliver the planned £16.1m deficit. Divisions are required to fully develop and deliver recovery plans to mitigate against the risks and pressures and offset any year to date shortfall. In addition, it is 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.

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

111/16 NURSING REVALIDATION

The Executive Director of Nursing presented the paper which provided a brief update to the Board of Directors on the progress within CHFT on the implementation of revalidation within the nursing and midwifery workforce.

From April 2016 nurses and midwives in the UK are legally expected to undertake a process of revalidation every three years in order to remain on the nursing register. All registrants are required to meet a number of minimum standards in the three years preceding the date of their application for renewal. Individuals who fail to meet the revalidation standards are not legally able to work in the profession within the United Kingdom. The revalidation process had been implemented in line with national guidance. The Trust had a monthly trajectory of colleagues who were due to complete revalidation and this paper provided assurance to the Board that the processes in place supported colleague's within the Trust to meet regulatory requirements.

The Executive Director of Nursing suggested that now the Trust had assurance there was a robust system in place; consideration should be given to removing this item from the Annual Plan. All present supported this action.

ACTION: Remove from Annual Plan.

OUTCOME: The Board received and approved the Nursing Revalidation Update

112/16 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 24 May 2016 and a verbal update from the meeting held on 28 June 2016 was received from Dr David Anderson. Matters arising from the June meeting included:-

- **Feedback from mock Cardiac Arrest simulation in Paediatrics – learning taken forward.**
- **Choose and Book – assurance given that no patients were coming to harm through delays in this system.**
- **Fractured Neck of Femur – Update received**
- **Incidents and Coroner Enquiry – dissemination of learning discussed.**
- **Mortality reductions – discussion around learning shared.**
- **CIP - quality impact on programme to be assessed.**
- **Terms of Reference – Awaiting CQC report, following which TOR and Work plan would be reviewed – October/November.**

b. **Finance and Performance Committee** – minutes of the meeting held on 24 May 2016 were received. It was noted that there were no other issues not already covered in the meeting discussed at the meeting held on the 28 June 2016.

c. Audit and Risk Committee – minutes of the meeting held on 26 May 2016 were received and noted. The next meeting was scheduled to be held on the 21 July 2016.

d. Workforce (Well Led) Committee – The minutes from the meeting held on the 14 June 2016 were received and noted. The next meeting was scheduled for 15 August 2016 and would be scheduled monthly from thereon. Arrangements were being made for Karen Heaton to Chair this Committee in the future. Thanks were given to Jan Wilson for her help in establishing and chairing this Committee.

The Chairman thanked everyone for their attendance and contributions.

113/16 DATE AND TIME OF NEXT MEETING

Thursday 28 July 2016 commencing at 1.30 pm in the Boardroom, Sub-basement, Huddersfield Royal Infirmary

The Chairman closed the meeting at 15:45 hours

Approved Minute

Cover Sheet

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	COO	**25.2.16** Report received. Likely implementation to be July 2016.	29.9.16		
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	**26.5.16** Director of Transformation and Partnerships advised that plans were being developed. Agreed that input would be brought to the September BOD Meeting.	29.9.16		
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	**26.5.16** Chair and Chief Executive to review. **30.6.16** Work was underway with SWYPFT. More information would be brought to the Board as appropriate.			
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	DoN currently reviewing information and data reporting and escalation.	29.9.16		
86/16 26.5.16	**STRATEGIC PLAN – YEAR 1 ENDING MARCH 2017** Output from MC/BOD Workshop held on 10.5.16 was received and approved. It was agreed: a. Local Quality priorities would be presented to a	CE/Co Sec	**30.6.16** The Company Secretary confirmed that the local priorities had been signed off by the Quality Committee at its meeting on the 28 June and these had been circulated to the Board and Membership Council			

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 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
	future BOD Meeting, subject to approval by the Quality Committee.					
87/16 26.5.16	**NURSING AND MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENTS** Discussion at F&P noted. Agreed that issue of recruitment would be triangulated with the Patient Flow Team through the Acting DoN and COO. This information would be presented to F&P before being finalised for the Board of Directors.	DoN/COO	**19.7.16** Patient flow and Hard Truths (Nurse staffing) details to be reported on IPR as individual entities. Nurse staffing issues within non-ward based departments ie Patient Flow Team to be escalated within Hard Truths papers going forward to the Board.			
94/16 26.5.16	**STAFF SURVEY ACTION PLAN** Concern was expressed that some timelines would be difficult to achieve and it was agreed that work should be undertaken to aim towards the timeline but it was acknowledged that some may require additional time. It was agreed that feedback on the progress from all workstreams would be brought to the BOD in September 2016.	All		29.9.16		
106/16 30.6.16	**RISK REGISTER – IMPACT OF RECENT REFERENDUM** The question of whether the long term effects of the results of the EU referendum had any implications such as staff recruitment/vacancies and increased drug costs were required to be included on the Risk Register in the future. The Chief Executive acknowledged that the Trust was alert to the issues,			? Nov 2016		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 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
	would monitor the situation and once the Trust was fully aware of the issues would escalate as appropriate. The Board agreed that this position should be reviewed again in November 2016 and any material risk included in the Risk Register.					
109/16 30.6.16	**INTEGRATED PERFORMANCE REPORT – BOD MEETING DATES** Discussion was taking place regarding the timeline for completion of the report and whether it was possible to move the key committee meetings to the 1st week in the month.	Chair/Co Sec/Board Sec		28.7.16		
109/16 30.6.16	**IPB – TARGETS** The Chairman asked whether the setting of targets for pressure ulcers and falls should be reviewed in the future. It was noted that the Executive Director of Nursing was undertaking work in this area and further information would be brought to the Board after the review had been undertaken.	Exec DoN	11.7.16 Confirmation for review of targets to be tabled at September Board IPR Action correlates with Board action 33/16	29.9.16		

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th July 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CONSULTATION PETITION - The Board is asked to RECEIVE a Petition relating to the proposed reconfiguration of hospital services.	
Action required: Note	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Transforming and Improving Patient Care	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to RECEIVE the Petition relating to the proposed reconfiguration of hospital services.

Main Body

Purpose:

This report confirms receipt by the Trust of a petition relating to the proposed reconfiguration of hospital and community services.

Background/Overview:

As part of the consultation process, a petition was received by NHS Greater Huddersfield Clinical Commissioning Group on 21 June 2016. As it is addressed to the Trust, it was agreed that the Trust Board should formally receive and note the petition.

The Issue:

In line with Standing Order 2.7 (Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.) it was agreed to include the petition on the agenda of the July Board meeting. The petition contains 160 signatures.

Next Steps:

The petition has also been formally received by NHS Greater Huddersfield Clinical Commissioning Group Governing Body and will be included in the consultation feedback

Recommendations:

The Board is asked to RECEIVE the Petition.

Appendix

Attachment:

C460_3 John Garside Petition.pdf

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
SEAN HOLDCROFT	3-7 HIGH HOUSE HD7 5FF	
SARAH HOLDCROFT.	"	
Sara marriage	68 Upperclough Linthwaite	Smarriage.
PHILIPPA ROBINSON	116 UPPER CHOUGH LINTHWAITE HD7 5PG	
P R ROBINSON	"	
John Thomas	4 Dairy Green HD7 5PJ	
RUTH ALLEN	3 DAISY GREEN HD7 5PJ	
ROB MORRISON	Stoney Shaw Upper Clough HD7 5PA	
A·C·GITBANSKI	175, HD4 7JN	

190 - Names & Address, sign.
This document/Statement, above.

16

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

	Name.	Address & Post code.	Signature.
1	R. HOWARD	3 TOP O TH HILL HD7 5UA	R Howard
2	D Handforth	8 Woods Mount	D Handforth
3	L Smith	Moor Top, Bink Platt Ln HD7 5UZ	L Smith
4	J CARTER	4 ROCKVIEW, MARSDEN HD7 6RY	
5	R C Howard	3A TOP O' THE HILL HD7 5UA	
6	Mrs Mavis	MANCHESTER RD NO 4	
7	Mr Bingle	Marsden Rd Slaithwaite HD7	
8	C. Howard	3 Top O The Hill, Slaithwaite	C A Howard
9	G. Smith	14 ARTHUR ST GOLCAR HD7	
10	GEOFF GOODWIN	14 HAWTHORNE RD SLAITHWAITE HD7 5DU	
11	Kay Bowden	5 MEALHILL HD7 5UR	K Bowden
12	Steve Lockwood	17 Chapel Hill HD7 5NJ	S Lockwood
13	HOWARD BLACKLOCK	18 CLOUGH DR HD7 5PX	H D Blacklock
14	ANNE DIXON	WINDSOR FARM, HD7 5TR	
15	RACHEL WALKER	PIONEER HOUSE HD7 5TR	R Walker
16	MATTHEW WALKER	" "	

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
David Ellison	90 upper clough Linthwaite Huddersfield HD7 5pg	D. Ellison
JOANNE ELLISON	90 UPPERCLOUGH, LINTHWAITE HUDDERSFIELD HD7-5PG	Joanne Ellison
KATHLEEN BEADLE	86, UPPER CLOUGH	K. Beadle
ROBERT BEATTIE	86 UPPER CLOUGH	
ADAM ROBERTSHAW	50 PAVILION WAY HOLMFIRTH HD9 5QW	
ALEXANDRA ROBERTSHAW	" " " HD9 5QW	
Wendy Stott	103 Clough Drive	
	51 Clough Drive	T Hoolley
G. Mellor	83 Clough Drive HD7 5PX	
R CLAY	66 Banks Rd. HD7 5LS	
A. Hargfall	59 clough Drive HD7 5PX	
M McNeill	1 BROOKSIDE SLAITHWAITE	M. GLEDHILL

181

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
S. TODD	4 LITTLE LONDON HD7 5TR	
G DRAKE	1 LITTLE LONDON HD7 5PY	
C DRAKE	1 LITTLE LONDON HD7 5PY.	
D ANDERSON	GREEN GARTH DAISY LEA LANE HD7 3LP	D. [illegible]
E. SHORT.	Heathcliffe 23. Blackmoorfoot. Lintheads HD7 5TR.	
S. Anderson.	Green Garth. Daisy Lea Lane. HD7 3RP.	
	23 Blackmoorfoot HD7 5TR	

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
PETER COLE	42 UPPER CLOUGH HD7 5PF	
Becki Oxnell	33, Longden Avenue HD4 5JE	
Myrtle Sherwood	36 Longden Avenue HD4 5JE	
Amelia Pryke	50 delves wood Rd HD4 7AS	
P A Martini	29 Longden Avenue HD4 5JD	
K Lodh	34 Longden Avenue	K Lodh
H.L. Pryke	50 Delves Wood Rd HD4 5JE HD4 7AS	H.L. Pryke
N A Pryke	50 Delves Wood Rd HD4 7AS	N A Pryke
James Oxnell	32 Longden Ave HD4 5JE	
Stephanie Lodge	53 JAGGER lane. HD8 9TF	S Lodge

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
R. BEAUMONT-MILLAR.	338 Leymoor Rd Golcar HD7 4QL	R. Beaumont-Millar
D. WHITE	No 1 Fieldhead Bungalows. HD7 5PH	
A Bowley	3 FIELDSHEAD BUNGALOWS HD7 5PH	A Bowley
F Jenkins	11 FIELDSHEAD BUNG. HD 75 PH	A. JENKINS.
M Jenkins	11 FIELDSHEAD BUNGS HD 75 PH.	M. JENKINS
P Foley	No 6 Fieldhead Bungalows HD7-5PH	P Foley
J Wyley Atwiley	2167 Upper Clough Linthwaite	HD7 5PG
Pat Stephenson	159 Lascelles Hall Rd Kirkheaton	HD5 0BE R A Stephenson
Tunebb THERESA WEBB.	5. Whitehall Rd. HD7 5PN	Tunebb
Sophie Chatha	8 Violet Terrace, HX6 2DJ	S. Chatha
K. Foley	2 FIELDHEAD BUNGALOWS LINTHWAITE	
Howard R Smith	104 & Manchester Rd Linthwaite	HD7 5QQ
BERYL SMITH	149 FIELDHEAD LINTHWAITE	HD7 5PG

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
Matthew Russell	51, Dance Park Close, Elland HX5 0PF	1
M Henderson	1 The Cedars Bramhope LS16 9EA.	2
D WHITELEY	5 HIGH HOUSE LANE LINTHWAITE HD7 5TS	3
Andrew Scase	43 Helme Village HD9 5RW	4
Thomas James Pearson	1 BLACKMOORFOOT HD7 5TR	5
James Pearson	1 Blackmoorfoot HD7 5TR	6

11

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
JULIE SHAW	15 BLACKWOOR FOOT HD7 5TR	
[illegible]	28 BLACKWOOR FOOT HD7 5TR.	
[illegible]	HD4 5BN	
[illegible]	HD4 5BN	
[illegible] Glynn	HD7 5TR	
[illegible] Glynn	HD7 5TR.	
SANDRA BRAMLEY CHRIS BRAMLEY	BD18 2NN 4 HOPE AVENUE SHIPLEY BD18 2NN	
D. HUTCHINSON	SKELMANTHORPE HD8 9DE	
P. PHILPOTT.	102. UPPER CLOUGH LINTHWAITE HD7 P.Q.	
SABIAN STEWART	38 Upper Clough Linthwaite HD7 5PF	

16

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
1 C Brook	137 Upper Clough	C Brook
2 R Brook	" " "	R Brook
3 K. Nuttall	Clough View, Stones Lane, Linthwaite, HD7 5PP.	K. Nuttall
4 P. Nuttall	" " "	P. Nuttall
5 Dave Martell	7 Blackmoorfoot HD7 5TR	
6 Emma Penn	11 Blackmoorfoot HD7 5TR.	
7 V Brookes	13 Blackmoorfoot HD7 5TR	
8 D Popel	49 Bank Rd HD7 5FP	
9 S C Eggleton.	27 Masefield Road. OL14 LX	
10 M. P. WINTER	5 BLACKMOORFOOT HD7. 5TR.	
11 A. W. WINTER	5 BLACKMOORFOOT HD7 5TR	
12 Mary Worswick.	53 Helme Village, HD9 5RW	Mary Worswic
13 Mr & Mrs Harrison	128 Upper Clough Linthwaite HD7 5PQ	
14 Mrs Harrison	128 Upper Clough Linthwaite HD7 5PQ	
15 Sally Morrison	Stoneybrook Upper Clough HD7 5PQ	Sharon
16 Mr G Garside	52 Upper Clough HD5 8PF	G Garside

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.	
Jayne Whitwam	Little London Cottage Blackmoorfoot, Linthwaite HD7 5TR	J Whitwam	1
Stuart Whitwam	Little London Cottage Blackmoorfoot, Linthwaite HD7 5TR		2
Monica Dixon	Pioneer Farm, Blackmoorfoot, Linthwaite HD7 5TR	M Dixon	3
S Crathorn	29 Elland Halifax HX5 9BU		4
J. Gladwin	7 timber Street Elland HX5 0EA		5
M. Holmes	66 Saddleworth Rd		6
R.S. [illegible]	~~[illegible]~~ 181 Stainland Road Halifax		7
R. Forrest.	4 Coronation St, Greetland HX 4 4AP.		8

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

	Name.	Address & Post code.	Signature.	
-	JOHN GARSIDE	38, UPPER CLOUGH LINTHWAITE HUDDS HD7. 5PF	John Garside	1
=	CRISTINE SYKES	32, UPPER CLOUGH, LINTHWAITE HD75PF	C. Sykes	2
-	KEITH S FIELDING	THE COTTAGE CLOUGH HOUSE LINTHWAITE HD7 5PP	K S Fielding	3
+	Simon Holroyd	16 Dearn Fold Lindley HD3 3JU	S Holroyd	4
!	CHRIS TONKS	35 LARKFIELD COURT. HD6 1AN	C Tonks	5
L	ARBEN CEKA	38 BRACKENBED FIELD UPPER CLOUGH, LINTHWAITE HD7 5PT		6
1/7	CAROLINE WOODHOUSE	34 UPPER CLOUGH LINTHWAITE HD75PF	C Woodhouse	7
?	DAVID WOODHOUSE	34 UPPER CLOUGH LINTHWAITE HD75PF	D Woodhouse	8
,	JAMES WHITTON	1 UPPER CLOUGH LINTHWAITE HD75PF		9
!!	J. BULLAS	36 NEW STREET UPPER CLOUGH LINTHWAITE HD75PF	J Bullas	10

10

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency **department** continue at Lindley H.R.I. hospital for many decades to come. It is ideally **located to** serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious **accident** on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.	
R Lockett	2 Pog Hall Linthwaite	HD7-5PL	1
H. Lockett	2 Pog Hall	"	2
K. KAYE	8 POG HALL	K KAYE HD7-5PL	3
C. Smith.	7 WHITEHALL RD HD7 5PN.		4
P JAMES.	7 Whitehall Rd HD7 5PN.		5
A. FIELDING	10 WINTER HILL LINTHWAITE HD7 5TS	A Fielding	6
L. Fielding	10 Winter Hill HD7 5TS		7
Luke Lancaster	5 Kirkwood Close Linthwaite HD7 5PJ		8
Steven Milnes	133 Upper clough Linthwaite HD7 5PG		9
JOHN REEBUCK	431 Blackmoorfoot Rd, Crosland Moor		10

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

	Name.	Address & Post code.	Signature.
1	R.M. HIRST	173, UPPERCLOUGH LINTHWAITE HD7 5PQ	R M HIRST
2	R J Hirst	44 Moor Park Ave Bea HD6 3AL	R J Hirst
3	[illegible]	84 Springdale Ave HUDS HD2 1NE	[illegible]
4	[illegible]	D. GREGSON	
5	P. Gregson	P. GREGSON	14 UPPER CLOUGH Linthwaite HD7 5PF
6	Wilfred Sykes	Walk syke Farm South Crosland. HD7 5RJ	Wilfred Sykes.
7	RICHARD SYKES	8 STONEFIELD RD CROSLAND HILL	Richard Sykes
8	Sandra Duffy	54 Upper Clough, HD7 5PF	S Duffy
9	HELEN SHAW	POST HALL BUNGALOW HD7 5PL	A Shaw
10	GEORGE SHAW	" " "	G Shaw
11	Andrea Mallen	9 HIGH HOUSE LANE HD7 5TS	A Mallen
12	Beryl Woodward	7 High House Lane HD7 5TS	B Woodward
13	Charlotte Holmes	7 Daisy Green HD7 5PJ	C Holmes
14	ANDREW DYSON	175 UPPERCLOUGH HD7 5PQ	A Dyson
15	COLIN DICKINSON	CRABTREE BARN HEY LANE HD7	Colin Dickinson
16	PAMELA "	" " " " "	Pamela Dickinson
17	GRANVILLE ROBINSON	19 BLACKMOORFOOT HD7 5TR	G Robinson
18	GLADYS ROBINSON	" " "	G E Robinson.

16

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
1 A. RIBOUTON	31 BLACKMOORFOOT HUDDERSFIELD HD7 5TR	Ribouton
2 Q Ogoli	291 A WAKEFIELD Rd. HUDDERSFIELD HD5 8AQ.	Ogoli
3 S. TOZER	8 Hubert Street Huddersfield HD3 3TS	S.Tozer.
4 F. Deria	888 Manchester Road. Linthwaite Huddersfield. HD7 5QS	
5 T Scholefield	Clough Royd, 8, Flathouse Linthwaite Huddersfield HD7 5PR	TScholefield
6 S. SOITOTHA	7, FLAT HOUSE LANE, LINTHWAITE, HUDDERSFIELD, HD7 5PR.	

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
M. Pepper	The Bulls Head HD7 5TR	
H. Woodruff	2 Hoyle Ing HD7 5RX	
A. LEYLAND	THE OLD FARMHOUSE 31 BARN VIEW RD NETHERTON HD4 7JY	
C MARSHALL	The Woodlands HD7 5TR	
B MULLARKEY	12 SKELTON CRESCENT OAKLAND HEIGHTS HUDDERSFIELD HD4 5PN	
T. MULLARKEY	"	
RICHARD IRWIN	29 OSPREY DRIVE HD4 7LG	
A FROST	32 WESTFIELD AVE HD4 5PY	
P ARMSTRONG	33 " "	
D. YOUNG	58 FARNINE VIEW HD7 5SD	
J. STOCKS	203 LANE TOP, LINTHWAITE	

15

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
M S Myers	122 Upper Clough Linthwaite HD7 5PQ	M S Myers
M.D. Boothroyd.	21, Avison Road. HD4 5TL	M.D. Boothroyd.
H. Hemingway	4 UPPER HIGHFIELD Slaithwaite HD7.	
J GREEN	2 FLATHOUSE, LINTHWAITE HD7 5PR	J Green
K. COX	4 WATERHALL RD HD7 5PN LINTHWAITE	K Cox
K Saunders	2 Newland Fold HD7 5GY Blackmoorfoot	K Saunders
R BANKS	3 NEWLAND FOLD, HD7 5GY	R Banks
R McNeill	5 NEWLAND FOLD, HD7 5GY.	
S. Castle	7 Newland Fold, HD7 5GY	
John McAvoy	1 Newland Fold, HD7 5GY	J McAvoy
PHILIP FRANCIS	127 UPPER CLOUGH, HD7 5PG	
S. SENIOR.	121 UPPER CLOUGH HD7 5PG	
D SCOTT	2 LITTLE LONDON HD7 5PY BLACKMOORFOOT	D Scott
IAN USHER	3 LITTLE LONDON HD7 5PY BLACKMOORFOOT.	
[illegible]	" " " " "	

Petition To Calderdale N.H.S. Trust & Mr Jeremy Hunt Minister Responsible For The N.H.S.- To stop dismantling Kirklees N.H.S.

We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley H.R.I. hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond.
It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard.
We demand that residents of Kirklees have full N.H.S. hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon, and all the back up services e.g. X-ray, scan, blood testing etc.
Further copies & collection contact John 01484 843600. none face book participants.

Name.	Address & Post code.	Signature.
J Peel	22 Beaumont St HD3 4RE	JM
S Dunn	11 [illegible] Grove	S. [illegible]
J.M. Shaw	4 [illegible] Rock Lane, Crimble [illegible]	[illegible]
[illegible]	37 [illegible]	[illegible]
SA Smith	59 Lockwood	SA [illegible]
J Selby	31 Lower Wellhouse HD7 4EJ	J [illegible]
M Newton	37 Stirley Hill, HD4 6TX	M Newton
N Reeves	Holmfirth HD9 5PT	[illegible]
Gavin Reeves	Holmfirth HD9 5PT.	[illegible]
David Jones	21 Blackman Drive HD6 4LP	[illegible]
F Clifford	160 Helme Lane HD9 5RJ	F Clifford

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th July 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to approve the update to the Board Assurance Framework	
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 update to the Board Assurance Framework

Main Body

Purpose:

The Board Assurance Framework has been reviewed to take account of the 1 Year Plan on a Page, approved at the Board meeting in June.
A new risk has been identified and included on the BAF:
- Failure to maintain a cash flow position

There are two risks recommended for closure:
1. Failure to deliver a robust financial and CIP plan for 2016/17
It is recommended that this risk be closed and a new risk be identified to address the financial and CIP planning process for 17/18 and beyond

2. The Trust is unable to grow due to inability to increase clinical income opportunities
It is recommended that this risk be closed and a new risk be developed to reflect the Sustainability and Transformation Plan work and the wider West Yorkshire discussions

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the update to the Board Assurance Framework

Appendix

Attachment:

16.17 Board Assurance Framework July - Board meeting.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2016/17

Contents:

compassionate care

REF	RISK DESCRIPTION	Current score	Lead	Link to RR
Transforming and improving patient care				
001	Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI.	20 =	DB	4783 2827 6313
002	Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration) while keeping the base safe	20 =	OW	6346
003	Faliure to progress service reconfiguration caused by an inability to agree a way forward across health and social care partners	20 =	AB	6131 2827 4783
004	Inability to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	12 =	DB	
005	Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care	15 =	MG	6230
006	Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust	9 =	BB	
Keeping the base safe				
007	Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety	15 =	BB	6300 6299
008	Failure to implement robust governance systems and processes across the Trust	12 =	OW	
009	The Trust does not deliver the necessary improvements required to achieve full compliance with Monitor	20 =	OW	4706
010	Failure to achieve local and national performance targets	16 =	HB	2828
011	Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care	16 =	LH	6300 5806
A workforce fit for the future				
012	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues.	20 =	BB / DB	6345
013	Failure to attract and develop appropriate clinical leadership across the Trust.	16 =	DB	
014	Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.	12 =	JE	
Financial sustainability				
015	Failure to deliver the financial forecast position for 2016/17 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity	15=	KG	6721
016	Failure to develop a robust financial plan for 2016/17 including identification of CIP		KG	CLOSED TO BE REDEVELOPED
017	Failure to progress and agree a five year strategic turnaround plan across the local health economy	15 =	AB	
018	The Trust is unable to grow due to inability to increase clinical income opportunities		AB	CLOSED TO BE REWORDED
019	Failure to maintain a cash flow	20 NEW	AB	6722

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)				1. Mortality 2. Large scale transformation	
Likely (4)			4. Seven day services	11. Estate fit for purpose 13. Clinical leadership 19. Cash flow 10. National and local targets 14. Staff engagement	15. Financial delivery 16/17 12. Staffing levels 9. Breach of monitor licence 3. Service reconfiguration
Possible (3)			6. PPI	8. Governance	5. EPR 7. Compliance with quality standards 17. Five year turnaround plan
Unlikely (2)					
Rare (1)					

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	Current	Target
1.1516	Quality Committee	Executive Medical Director	**Risk** Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI. **Impact** - Inaccurate reporting of preventable deaths - Increased regulatory scrutiny as become CQC outlier - Inability to learn lessons - Increased risk of litigation and negative publicity. - Possible increase in complaints and litigation	• Safety thermometer in use on wards • Safety huddles being implemented • Mortality review process redesigned and rolled out with clinical leads appointed to address the gaps in capacity / capability to undertake reviews • Tighter process in place in relation to SI reporting and investigation • 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 • Nervecentre roll out across the Trust • Ongoing work to improve the care of frail patients • Implementation of care bundles • Mortality reviews in respiratory and stroke not showing any themes	First line Mortality dashboard in divisions Mortality reviews provide themes to improve standards of care Coding review putting Trust in upper quartile for some areas Second line Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee Mortality review updates to Quality Committee Third line HSMR has fallen to 111.6. Predicting modest further reductions Independent review of cases by Professor Mohammed	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 Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. Mortality reviews not yet undertaken consistently Acute cerebrovascular & pneumonia outlier areas	• SHMI position has worsened • Regulation 28 reports from Coroner received	5x4 = 20	5x4 = 20	4x4 = 16

Action	Mort	Lead
Recruitment to Hospital @ Night team underway. To be completed	September	SU
Awaiting review of mortality review guidance to implement process further	End Q2	JC
Phase 1 roll out of Hospital @ Night	September	SU

Links to risk register:
Risk 4783 - Outlier on Mortality
Risk 2827 - Clinical decision making in A&E
Risk 6313 - Inability to progress service transformation

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
2.1516	Board of Directors	Chief Executive	**Risk** Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration) **Impact** - Delivery of safe clinical care - Financial sustainability - Low staff morale. - Viability and competitiveness of Trust is compromised	• Programme Management Office established to manage schemes •Turnaround governance arrangements in place including weekly Turnaround Executive • Joint EPR governance arrangements in place with BTHT • Moderisation WEB and report to F&P Committee / Board on progress with delivery of EPR • Weekly CQC steering group • Risk reporting and review arrangements • Executive team undertaking review of capacity and responsibilities Hospital Programme Board Partnership Board with CCGs	<u>First line</u> Modernisation WEB held every 6 weeks CIP plan on track for 15/16 EPR implementation programme Strategic turnaround plan development <u>Second line</u> Integrated Board Report EPR report to Finance and Performance Committee / Board Turnaround Executive scrutiny weekly Monthly report on turnaround to Finance and Performance Committee Board approval of 5 Year Strategic Plan <u>Third line</u> PRM meetings with Monitor demonstrate progress Well Led Governance Review showed some areas of good practice Gateway 1 assurance report	EPR continues to be risk with training timetable to be fully implemented New job planning framework to be agreed and implemented	Self assessed against CQC standards as requires improvement 16/17 CIP	4x4 = 16	4x5 = 20	3x3 = 9

Action	**Timescales**	**Lead**
Well Led Governance review action plan to be implemented Await CQC report to implement further actions	September August	VP BB

Links to risk register:
Risk 6346 - Capacity and capability to deliver service transformation

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
3.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Faliure to progress service reconfiguration caused by inability to agree way forward across health and social care partners **Impact** - 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 - Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums) - Potential loss of service to other areas	• Participation in Hospital Services Board by key senior staff. 20/1/16 CCGs made the decision to commence public consultation on the future configuration of hospital services. • CCGs and NHS England representatives included in roundtable discussion with Monitor • There is an agreed consensus between the CCGs and the Trust on the preferred clinical model.This has been reviewed and endorsed by Yorkshire and Humber Clinical Senate. • Monitor support for development of 5 Year Strategic plan which was approved by the Trust Board on 29th December and then updated to take account of 16/17 planning guidance. Refreshed version approved by the Trust Board in January. • ED business continuity plan developed • Additional consultant posts agreed for ED • Interim actions to mitigate known clinical risks including areas identified for service redesign where this will not impact on co-adjacencies e.g. EPAU & Gynae • Nurse led service managing Paediatrics • Critical care still being managed on both sites • Frequent hospital to hospital transfers to ensure access to correct specialties	<u>First line</u> Vanguard work in Calderdale showing an impact <u>Second line</u> 5 Year plan progress report to Finance & Performance Committee and Board Urgent Care Board and System Resilience Group in place <u>Third line</u> Recent Trauma review shows positive position for CHFT PRM meeting with Monitor tracks progress	• Difficulty in recruiting Consultants, Middle Grade and longer term locums • Estate limitations inhibit the present way of working • Consultant rotas cannot always be filled to sustain services on both sites	• High use of locums • High sickness rates among staff	5x5 = 25	4x5 = 20	3x5 = 15

Action	**Timescales**	**Lead**
Awaiting outcome of consultation. Participate in JOSC meetings.	October	ALL

Links to risk register:
Risk 6131 - large scale service change
BAF risk 2.1516

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
4.1516	Quality Committee	Executive Medical Director	**Risk** Inability to deliver appropriate services over seven days resulting in poor patient experience, greater length of stay and reduced quality of care. **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Working group set up and workshop held with senior colleagues to develop plan • Perfect week learning shared • Governance systems and performance indicators in place • Part of the West Yorkshire early implementers • Capacity brought in to support programme	First line Improvement in performance against some key indicators including pre 12 o'clock discharge and reduction in outliers Second line Integrated Board report Benchmarked against four key Keogh standards Paper received at WEB Third line Independent review of mortality cases by Professor Mohammed	• Gap analysis and action plan to be followed up • National consultant contract negotiations outcomes awaited • Work to be done on job planning • Capacity to deliver 7 day service action plan • Medicine action plan to be implemented • Hospital @ Night Phase 1 roll out to take place	• Not yet meeting a number of indicators in the IBR including green cross reduction	**Initial**	**Current**	**Target**
								4x3 = 12	4x3 = 12	2x3 = 6
Action					**Timescales**			**Lead**		
7 day service action plan to be finalised Hospital @ Night phase 1 roll out					~~October / November~~ April September			SU SU		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
5.1516	Finance and Performance Committee	Interim Director of The Health Informatics Service	**Risk** Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care **Impact** - Inability to realise the benefits - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • A detailed project plan and timelines has been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR. • Current state gap analysis completed • Go live date planned for 19 Bovember	<u>First line</u> Regular reporting showing progress against plan CHFT has met exit criteria for the majority of areas <u>Second line</u> Joint Transformation Board with BTHT meets on a monthly basis chaired at Chief Executive level. Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee <u>Third line</u> 2nd Gateway assurance report Monthly update to NHS Improvement as part of PRM reporting arrangements	• Training plan to be fully described and populated		Initial 3x5 = 15	Current 3x5 = 15	Target 1x5 = 5

Action	Timescales	Lead
Communications and Engagement plan to be implemented	Ongoing starting in September	MG
Training plan to be completed and delivered	September	MG

Links to risk register:
Risk 6230 - Non delivery of EPR
BAF risk 2.1516

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
6.1516	Quality Committee	Executive Director of Nursing	**Risk** Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust **Impact** - inability to make require service change impacting on the delivery of safe clinical care - reputational damage with stakeholders	• Patient and public involvement plan implemented for development of SOC / OBC and used as template for other engagement activity • Full engagement and consultation commissioned from CSU for movement of child development services from Princess Royal Health centre • EPAU and Gynae engagement completed with CCG scrutiny and OSC oversight • Particpation in communication and engagement strategic oversight group with CCGs. • Patient and Public involvement plan developed for the Trust and being implemented • Greater clarity on process for engagement and consultation sign off for service redesign with CCGs	First line Some PPI activity included in divisional patient experience reports to Patient Experience Group each quarter Second line Contribution to CCG Annual Statement of Involvement PPI included in Quarterly Quality Report to Board Third line OSC oversight and approval of Child Development Unit; EPAU / Emergency Gynae engagement plan; Cardio & Respiratory engagement plan.	• No identified capacity to deliver co-ordinated approach to PPI • Membership Strategy requires review and appropriate action plan putting in place	• PPI action plan to be delivered	**3x4= 12**	**3x3 = 9**	**2x3 = 6**

Action	**Timescales**	**Lead**
Membership Strategy review to be completed	September	RM
Awaiting outcome of CQC report to identify any further action to be taken	August	RM

Links to risk register:
No corporate (>15) risks

TRUST GOAL: 2 KEEPING THE BASE SAFE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
7.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale	• Quality governance arrangements revised and strengthened • Revised SI investigation and escalation process in place • Improved risk management arrangements • Weekly CQC Steering Group in place overseeing self assessment of compliance with CQC domains and delivery of 90 day plans • Use of e-rostering in place. • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Leadership walkrounds implemented • Policies reviewed	<u>First line</u> Staffing levels reported to WEB CQC Steering Group reports Clinical audit plan reviewed Assessment of compliance with NICE guidance CQC self assessment including strengths and weaknesses <u>Second line</u> Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee CQC Action plan progress reported to Quality Committee DIPC report to Board Care of the Acutely Ill Patient plan report to Board Slight improvement in HSMR <u>Third line</u> Quality Account reviewed by External Auditors and stakeholder bodies Trauma Review results PWC mock CQC inspection feedback Well Led Governance review Independent assurance on clinical audit strategy	• Mandatory training compliance • Scale of change and pace impacting on staff morale and engagement • Operational priorities impacting on capacity • Not fully compliant with NICE guidance where appropriate • Clinical audit plan to be reviewed to map to challenged services and Internal Audit recommendations • Standard of serious incident investigations needs to be improved • Some infection control concerns identified • Estate issues identified	• Internal Audit report on Medical Devices has outstanding actions • National Clinical Advisory Team recommendations not fully addressed • Self assessed as requires improvement across a small number of areas • Staff FFT response to recommendation as a place to work and place to be cared for declining • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements	**Initial** 3x5 = 15	**Current** 3x5 = 15	**Target** 2x5 = 10
Action					**Timescales**			**Lead**	
Awaiting CQC report to identify any further action to be taken					August			BB	
Links to risk register: Risk 6300 - Estates Risk 6299 - Medical devices									

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
8.1516	Board of Directors	Chief Executive	**Risk** Failure to implement robust governance systems and processes across the Trust **Impact** - Potential to affect the quality of patient care. - Reputational damage - Risk of regulatory action - Learning opportunities missed	• Quality governance review undertakend and implemented • Review of Board level sub-committees • Improved board level risk management reporting arrangements • PMO in place and improved governance in relation to CIP planning • Performance Management Framework approved and being implemented	First line Divisional governance arrangements in place with Executive attendance Improved PSQB reporting Self assessment undertaken against Board Governance Assurance Framework template Mock CQC inspection for Community Work undertaken to strengthen PSQB governance arrangements Second line Self assessment for Well Led Governance review approved by the Board Third line PRM meeting with Monitor showing progress Foresight assessment of Board governance PWC Mock CQC Inspection Well Led Governance Review identified no red flags Partnership Board meeting with CCGs	• Risk management arrangements to be strengthened at divsional level and below • Performance management framework requires further work to embed	• Well Led Governance review actions to be implemented across a small number of remaining areas • Assessment of divisional governance to align to Well Led Governance review • Self assessed against CQC as requires improvement	**Initial** 3x4 = 12	**Current** 3x4 = 12	**Target** 2x4= 9

Action	**Timescales**	**Lead**
Well Led Governance review action plan to be implemented	September	AH / VP
Awaiting outcome of CQC report to identify further actions	August	VP
Performance management framework implementation update to be brought to the Board	September	HB

Links to risk register:
Risk 6694 Divisional governance

TRUST GOAL: 2. KEEPING THE BASE SAFE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
9.1516	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• PRM meeting with Monitor • Corporate compliance register in place • Review of monthly Monitor bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • 5 Year strategic plan completed and formally adopted by the CCGs as part of the pre-consultation business case • Well Led Governance review completed	First line Clear PMO reporting from Divisions Second line Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee Well Led Governance review report to Board Board approval of 5 Year Strategic Plan Third line Bi-Monthly PRM with NHS Improvement Round table meetings being held with CCGs, NHS England and NHS Improvement CCG acceptance of 5 Year Strategic Plan EY independent assessment of 5 Year Plan	• Gap in 16/17 CIP plan to be addressed	• 16/17 CIP plan not yet finalised	Initial: 5x5 = 25	Current: 4x5 = 20	Target: 2x5 = 10

Action	**Timescales**	**Lead**
Well Led Governance Review action plan to be implemented	September	AH / VP
Development of 16/17 CIP schemes to be completed	September	AB
Awaiting outcome of CQC report to identify any further actions to be addressed	August	VP

Links to risk register:
Risk 4706 - Financial plans

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
10.1516	Finance and Performance Committee	Chief Operating Officer	**Risk** Failure to achieve local and national performance targets and levels required for STF **Impact** - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders - STF withheld and financial issues	• Strengthened performance monitoring and management arrangements • Bed modelling work and additional investment made in to bed capacity • Theatre productivity work and Theatres perfect week • New patient flow programme • CQUINS compliance monitored by Quality directorate • Bronze, silver and gold command arrangements and escalation process • External expertise brought in to support the patient flow work • System-wide gold commanders meeting in place • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Interim Head of Performance in place	First line Weekly performance review with divisions. Divisional board and PSQB reviews of performance with executive attendance Activity reporting discussed at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Work begun to develop more intuitive dashboard Second line Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff Third line Urgent Care and Planned Care Boards and System Resilience group	• System responsiveness • Appointment slot issues backlog still to be addressed • Delivery of activity remains behind plan and action plans do not set out full recovery • Achievement of 4 hour emergency care standard requires micro-management. • Gap in external reporting sign off process.	• A number of indicators remain off track including A&E target in Q1; delayed discharges. • Lack of robust system surge plans.	**Initial** 4x4 = 16	**Current** 4x4 = 16	**Target** 2x3 = 6
Action					**Timescales**			**Lead**		
Further improvement work around patient flow and discharges to be implemented					Ongoing			HB		
Links to risk register: Risk 2828										

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	Current	Target
11.1516	Quality Committee	Executive Director of Planning, Performance, Estates and Facilities	**Risk** Failure to maintain current estate and equipment and develop future estates model to provide high quality patient care **Impact** - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• System for regular assessment of Divisional and Corporate compliance • Policies and procedures in place • Quality Governance assurance structure revised • Estates element included in development of 5 Year Strategic plan • Close management of service contracts to ensure planned aintenance activity has been performed • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Development of Planned Preventive Maintenance (PPM) Programme • Audit of medical devices by independent assessor to identify any further actions needed • Health Technical Memorandum (HTM) structure in place including external Authorsing Engineers (AE's) who independantly audit Estates against statutory guidance.	<u>First line</u> CQC compliance reported in Quarterly Quality and Divisional Board reports Weekly strategic CQC meetings <u>Second line</u> Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices Monitor review of PFI arrangements Assurance provided by AE's following audits against Estates statutory requirements <u>Third line</u> PLACE assessments CQC Compliance report Assurance received from Environment Agency regarding healthcare waste implementation plans Progress made on DoH Premises Assurance Model (PAMs) to illustrate to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe.	• Capital funding scaled back which has impacted on ability to deliver estates schemes • PPM Programme not yet complete • Medical Device database needs to be reviewed to ensure accurate formation on medical devices needing maintenance. • Lack of information on what proportion ofequipment has accurate recording of location on medical devices database • Medical Devices Assessor final report and action plan not yet received meaning further actions required not yet known	• Internal Audit report on medical devices has a number of outstanding actions • Mandatory training figures remain below plan for both health and safety and fire • Action plans following CQC visit to be finalised • A number of areas for improvement identified on the PAMs model. Department making progress on the areas identified.	4x4 = 16	4x4 = 16	2x4 = 8

Action	Timescales	Lead
Awaiting CQC report to identify any further actions	August	LH
Implement actions from PAMS assessment	March	LH

Links to risk register:
Risk 6300 - estates risk
Risk 5806 - estates schemes
Risk 6299 - medical devices

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING		
								Initial	Current	Target
12.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff	• Weekly nurse staffing escalation reports; • Ongoing multifacted recruitment programme in place, including international recruitment; • Use of bank, agency and overtime in place to cover gaps with CIP plan to reduce reliance on this in the future; Escalation process in place • ED business continuity plan in place; • Vacancy review process in place; • Use of e-rostering. • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Risk assessments in place • Nursing recruitment and retention strategy	First line Staffing levels reported to WEB Report on delivery of training and education Divisional business meetings and PSQBs consider staffing levels IBR shows slight decrease in sickness levels Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee Third line Nurse staffing report on the internet CQC report .	Current hotspots are: Emergency Care; Radiology; Hisotpathology; vascular surgery; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; clinical administration Clear workforce strategy / plan required Recruitment and retention strategy for medical and therapy staffing required Continued spend on locums and agency above the Monitor cap leading to financial pressures in year.	• Medical workforce paper to Quality Committee highlighted particularly difficult areas for recruitment. • Need clear workforce plan • Need recruitment and retention strategy for medical and therapy	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
Medical staff tool to be developed and rolled out	~~May~~ September	DB
Medical and therapy plan to be developed	~~May~~ September	JE
Improved reporting on planned and actual staff in post	~~May~~ September	JE

Links to risk register:
Risk 6345 overall staffing risk

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** Initial	Current	Target
13.1516	Quality Committee	Executive Medical Director	**Risk** Failure to attract and develop appropriate clinical leadership across the Trust. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Devolved clinical structure • Work together get results programme in place • Positive feedback from Junior doctors on medical training • Performance appraisal based around behaviours • Coaching circles process • All CIP schemes have clinical lead • Development of new roles across professional groups • Good revalidation compliance • Performance Management Framework agreed including job description for clinical leads.	First line Established escalation framework to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead particpation in star chamber approach Second line Integrated Board Report Revalidation report to board Third line IIP Accreditation Internal Audit report and Turnaround Director report on PMO arrangements and inclusion of clinicians and Quality Imapact Assessment processes in governance arrangements.	• Lack of clarity in service redesign and improvement responsibilities • Need clearly articulated clinical development plan • Job plans to be reviewed to include time for clinical leadership responsibiltiies	• Well Led Governance review identified some actions relating to accountability framework between corporate and divisions • Assessment of divisional governance to align to Well Led Governance review • Acquire independent assessment of clinical leadership arrangements • Staff FFT / Survey results deteriorating • Appraisal compliance away from target	4x4 = 16	4x4 = 16	3x3 = 9

Action	**Timescales**	**Lead**
Job planning arrangements to be agreed and implemented	September	DB

Links to risk register:
No corporate (>15) risks

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
14.1516	Well Led Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Colleague engagement plan signed off by WEB • Leadership visibility increasing • Quarterly staff FFT in place • Work together get results programme in place • 'Ask Owen' button launched and being responded to • Good evidence of colleague engagement in SOC / OBC development • Celebrating success annual awards • Staff survey action plan • Health and wellbeing strategy • Implemented star award • Leadership walkaround and feedback process in place	First line Divisional leadership approach CQC preparation for self assessment shows some areas reporting GOOD in well led domain Second line Integrated Board report shows sickness absence slightly improved CQC Mock inspection feedback from focus groups Third line Staff FFT / staff survey provides some positive feedback IIP accrediation - Bronze award	• Cultural barometer indicators to be developed • Continued difficulty in engaging clinical staff	• Staff FFT response rate deteriorating along with number of staff who would recommend the Trust as a place to work • Still a number of well led indicators on the IBR showing red • Number of areas in self assessment for CQC preparation showing requires improvement • Falling number of entries into Celebrating Success	Initial 3x4 = 12	Current 4x4 = 16	Target 1x4 = 4
Action					**Timescales**			**Lead**		
Staff survery and Workforce Race Equality Scheme action plan to be implemented					September			ALL		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
15.1516	Finance and Performance Committee	Executive Director of Finance	**Risk** Failure to deliver the financial forecast position for 2016/17 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity **Impact** - financial sustainability - increased regultory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Financial recovery and cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process • Detailed income and activity contract monitoring • Bottom-up forecasting process • Star chamber process to support CIP schemes off track • Quality directorate overview of progress against delivery of CQUIN • Authorisation processes for agency spend • Standing Financial Instructions set authorisation limits	First line Divisional Board reports Second line Turnaround Executive Reports Monthly scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting Third line Monthly return to Monitor PRM meeting with Monitor Two day assurance visit from Monitor PWC report from December Turnaround Director report Well Led Governance Review Internal Audit Report on divisional performance management arrangements	• Temporary staffing remains a cost pressure due to additional capacity remaining open • There remain outstanding contract challenges on PBR contract • Remain gap between activity and agreed contract	• Agency spend levels not falling as required.	4x4 = 16	4x4 = 16	1x4=4

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through F&P and Board	Ongoing	KG

Links to risk register:
Risk 6721 - failure to achieve financial plans

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER**		**RISK DESCRIPTION**	**KEY CONTROLS**	**POSITIVE ASSURANCE &**	**GAPS IN CONTROL**	**GAPS IN ASSURANCE**	**RATING**		
								Initial	**Current**	**Target**
17.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Failure to progress and agree a five year strategic plan across the local health economy **Impact** - financial sustainability - viability of certain services - inability to compete or collaborate with other WY acute trusts	• PRM process • Roundtable discussions introduced including Monitor, CCGs and NHS England • EY appointed to develop 5 year plan. 5 Year Strategic Plan completed at end December 2015 and updated in January 2016 to take account of 16/17 planning guidance. Plan approved by Trust Board in January 2016. • Public consultation completed	<u>First line</u> WEB assessment of direction of travel <u>Second line</u> Board scrutiny and approval of 5 Year Plan. Hospital Services Programme Board discussions to ensure plan aligned with local health economy plans - this has enabled CCGs in January to confirm decision to commence public consultation on future configuration of hospital services. <u>Third line</u> PRM meetings with NHS Improvement and Roundtable discussions with CCGs. NHS I oversight of strategy development process. NHSE assurance of CCG processes and readiness to commence public consultation.		• The Five Year Strategic Plan has been agreed and submitted to NHS Improvement. An application has been made to DH for the required external funding support. However no confirmation on funding yet received. • Public consultation is completed Trust now needs to await process to progress through CCG and JOSC.	4x5 = 20	3x5 = 15	2x5 = 10
Action					**Timescales**			**Lead**		
Links to risk register: **Risk 6131 - mortality standards** **Risk 2827 - clinical decision making in A&E** **Risk 4783 - Service reconfiguration**										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY									
Ref	**OWNER**		**RISK DESCRIPTION**	**KEY CONTROLS**	**POSITIVE ASSURANCE &**	**GAPS IN CONTROL**	**GAPS IN ASSURANCE**	**RATING**	
								Initial	**Current**	**Target**
19.1617	Board of Directors	Director of Finance	**Risk** Failure to maintain a cash flow position so 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 **Impact** - financial sustainability - external scrutiny - reputational damage - ability to continue as a 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 (at 1.5% interest rate) * Profile of cash management is being raised at Divisional level * Agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner.	<u>First line</u> WEB financial performance report Cash Management Committee <u>Second line</u> Finance and Performance Committee reports <u>Third line</u> Bi-monthly PRM with NHS Improvement	Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital	Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement	5x3 = 15	5x4=20	5x3=15

Action	**Timescales**	**Lead**
Further work to raise profile of cash management across the Trust	Ongoing	KG

Links to risks register:
Risk 6722- Cash management

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CSU	Commisisoning Support Unit
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FFT	Friends and Family Test
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
PSQB	Patient Safety and Quality Board
SI	Serious incident
SHMI	Summary hospital-level mortality indicator
SOC	Strategic Outline Case
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
DB	David Birkenhead, Executive Medical Director
HB	Helen Barker, Associate Director of Operations
JC	Juliette Cosgrove, Assistant Director of Quality
BB	Brendan Brown, Director of Nursing
JE	Jason Eddleston, Deputy Director of Workforce and OD
KG	Keith Griffiths, Executive Director of Finance
MG	Mandy Griffin, Interim Director of the Health Informatics Service
AH	Alex Hamilton, Assisociate Medical Director
LH	Lesley Hill, Executive Director of Planning, Estates and Facilities
RM	Ruth Mason, Associate Director of Engagement and Inclusion
VP	Victoria Pickles, Company Secretary
CR	Catherine Riley, Assistant Director of Strategic Planning
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
OW	Owen Williams, Chief Executive

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 28th July 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Corporate Risk Register - This paper presents to the Board the corporate risk register as at July 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 12 July 2016	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Corporate Risk Register (CRR) is presented on a monthly basis to ensure that the Board of Directors are aware of key risks facing the Trust and is a fundamental part of the Trust's risk management system.

Main Body

Purpose:

To assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks identified on the corporate risk register.

Background/Overview:

The CRR is presented on a monthly basis to ensure that the Board of Directors are aware of all current 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 consider all risks that may potentially be deemed a corporate risk, with 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 July 2016 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

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

Next Steps:

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

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

Board combined risk register JUly PDF.pdf

APPENDIX H

CORPORATE RISK REGISTER REPORT

Risks as at 19 July 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 6722 (20): Cash flow risk 6732 (20): Cost improvement delivery
RISKS WITH INCREASED SCORE
No risks have increased in score.
RISKS WITH REDUCED SCORE
None
NEW RISKS
There are no new risks for addition to the Corporate Risk Register in July 2016.
CLOSED RISKS
None

CORPORATE RISK REGISTER –19 July 2016 - Summary of Risks by Risk Type

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	March 2016	April 2016	May 2016	June 2016	July 2016
		Strategic Risks						
6503	Transforming & Improving Patient Care	Non-delivery of Electronic Patient Record Programme	Chief Executive	20=	20=	20 =	20 =	20 =
		Safety and Quality Risks						
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	20=	20=	20 =	20 =	20=
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20 =	20=	20=	20=	20=
2827	Developing Our Workforce	Over –reliance on middle grade doctors in A&E	Medical Director (DB)	20 =	20=	=20	=20	=20
6299	Keeping the base safe	Failure of high risk medical devices	Director of Estates and Performance (LH)	15 =	15=	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	16 =	16=	=16	=16	=16
6300	Keeping the base safe	Clinical, operational and estates risks	Director of Nursing (BB)	16=	16=	=16	=16	=16
6594	Keeping the base safe	Radiology risk acting on diagnostic test findings	Medical Director (DB)	16=	16=	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Interim Director of Workforce and OD	16=	16=	=16	=16	=16
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (BB)	16	16=	=16	=16	=16
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	-	-	!15	=15	=15
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of THIS (MG)					16!
		Financial Risks						
6721	Financial sustainability	Non delivery of 2016/17 financial plan	Director of Finance (KG)	-	-	!20	=20	=20
6722	Financial sustainability	Cash flow risk	Director of Finance (KG)	-	-	!15	20↑	=20
6732	Financial sustainability	Not delivering cost improvement plan	Director of Finance (KG)	-	-	!20	=20	=20

		Performance and Regulation Risks						
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer	20↑	20=	=20	=20	=20
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	16=	16=	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Deputy Director of Workforce (JE)	15	15=	=15	=15	=15
		People Risks						
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), HR Director	20=	20=	=20	=20	=20

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

Trust Risk Profile as at 19 July 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 Failure to comply with monitor staffing cap = 6715 Poor quality / incomplete documentation	= 4783 Outlier on morality levels = 6345 Staffing risk, nursing and medical = 6 6 5 8 Inefficient patient flow = 6131 service reconfiguration	
Likely (4)				= 5806 Urgent estate work not completed = 6300 Clinical, operational and estates risks outcome = 6594 Radiology risk/ diagnostic tests = 6596 Serious Incident investigations = 6598 Essential Skills Training Data =6694: Divisional governance arrangements ! 6753 Inappropraite access to patient identifiable data	= 2827 Over reliance on middle grade doctors in A&E = 6503 Non delivery of EPR programme =6721 Not delivering 2016/17 financial plan =6732 Not achieving cost improvement plan
Possible (3)					= 6299 Medical Device failure levels =6722 Cash Flow risk
Unlikely (2)					
Rare (1)					

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

Risk No	Div	Dir	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	15 5 x 3	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. April 2016 Update: Programme of consultation meetings underway. May 2016 Update: Consultation continues June 2016 Update: Consultation continues **July 2016** 2 listening events held during July by joint Calderdale and Kirklees Scrutiny Committee. CCG decision to be confirmed in October 2016.	Sep-16	Oct-2016	WEB	Anna Basford	Catherine Riley
2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed 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 **July 2016 Update:** No appropriate applications from overseas consultant recruitment. Senior clinical fellow (consultant level) commences 1st August. Advert out to attempt further niddle graade recruitment	May-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected 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) May 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. June update. We have received the report relating to the Elderly Medicine service review, a meeting is being arranged to develop the plan to respond to the recommendations. We are still waiting for the report from the Respiratory Service review. The terms of reference for the Stroke service Review will be completed this month. An in depth review of deaths of people with a stroke has shown some areas for improvement in quality of care but no concerns about death being related to omissions in care or treatment. Actions arising from the review are being incorporated into the Stroke Service Improvement Plan. **July update** The Stroke Service review has been commissioned. Coding levels are improving putting us in the upper quartile for some key measures. Significant progress is being made in relation to the prevention of sepsis. Recruitment into the Hospital at Night team is underway.	Aug-2016	Aug-2016	COB	David Birkenhead	Juliette Cosgrove

6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas - lack of medical staffing as unable to recruit to 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) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams resulting in increase in clinical risk to patient safety due to reduced level of service / less specialist input and negative impact on staff morale, motivation, health and well-being and ultimately patient experience, sickness & absence, staff mandatory training and appraisal, coste pressures due to increased costs of interim	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 workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment. -revised approvals process for medical staffing to reduce delays in commencing recruitment. -HR resource to manage medical workforce issues. - Exit interviews for Consultants being conducted. -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 flexible work force through additional resources / bank staff	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	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) **July Update - Nurse Staffing** · Targeted recruitment for substantive Registered Nursing and Midwifery workforce underway. This is currently focused on local recruitment from graduate programmes and overseas recruitment · Liaison with staff who have recently left the Trust to commence, to ascertain reasons for leaving, and encourage return to the Trust · Specific recruitment to bank, night and weekend posts to commence · Focus on retention of existing staff underway and revisited with Ward leaders · Branded recruitment process under development, promoting CHFT as an exemplar employer · Development programmes for Ward Managers and Matrons to commence from September 2016 · Standard Operating procedure for use and authorisation of temporary nursing staff launched · Full workforce review of ward nursing establishments undertaken by Chief Nurse office July 2016 **July Update - Therapy Staffing** . All current vacancies are reviewed for opportunities to change skill mix prior to commencing recruitment process . Standard Operating Procedure has been produced for authorisation of temporary staffing . Work is ongoing with finance to ensure that all agency staff are within capped rate . Currently advertising for bank therapists for all professions . Work has started with Locala to recruit rotational Band 5 Physio's and OT's that will rotate across both organisations, therefore giving an increased rotational opportunity for staff	Aug-2016	Nov-2016	WLG	David Birkenhead, Brendan Brown, Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson

6503	Corporate	THIS	THIS Modernisation	Dec-2015	Transforming and improving patient care	RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable. The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception. This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised.	A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT. Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register Executive sponsorship of the programme with CEO's chairing the Transformation Board Separate assurance process in place Clinical engagement from divisions Clearly identified and protected funding as identified in the Full Business Case. All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.	- Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success. - Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live. - Sign off the Operational Readiness plan by division - Lack of divisional engagement in some areas as raised at the EPR Operational Group.	20 5 x 4	20 5 x 4	5 5 x 1	Continual monitoring of actual programme risk and issues log - Any risks escalated to the Transformation Board brought to this committee - Access to the full EPR Risk Log will be made available to R and C P11group via the Cerner Portal if required, any escalations from transformation group will be brought to R&C by the programme leads May / June 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. July Update: Dual go live with BTHFT communicated trust wide for the 19th November 2016. ST2 (System Testing) finished early July, IT1 (Integration Testing) completes this week (15th July). Feedback evidences that CHFT are in a good position both technically and operationally. There is a second risk being drafted around Operational Readiness/Engagement to help manage that aspect. No change to score.	Aug-2016	Sep-2017	RC	Mandy Griffin	Mandy Griffin
6721	Corporate	Finance	Trustwide	May-2016	Keeping the base safe	The Trust is planning to deliver a £16.1m 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. For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.	20 5 x 4	20 5 x 4	15 5 x 3	**July update:** At Month 3, 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 and deliver standards and access targets. Recruitment and retention and bed capacity issues bring risk to delivery of elective and daycase activity. Against the £14m CIP target the risk profile has been reviewed and £3.7m 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. The new Junior Doctors contract may also bring additional unplanned pressure .	Aug-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6722	Corporate	Finance	Trustwide	May-2016	Keeping the base safe	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 (at 1.5% interest rate)	Distressed cash support through "Revenue Support Loan" not yet formally approved by Monitor.	15 5 x 3	20 5 x 4	15 5 x 3	To progress application, subject to Monitor support, for distressed funding through Revenue Support Loan. **July update:** Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Further action is being taken to maximise collection of receivables and the profile of cash management is being raised at Divisional level and agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital.	Aug-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer
6723	Corporate	Finance	Trustwide	May-2016	Financial sustainability	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 NHS Improvement 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 NHS Improvement and planned for distressed cash support.	NHS Improvement approval of capital programme awaited. Approval of distressed cash support awaited.	20 5 x 4	16 4 x 4	12 4 x 3	**July update:** In early June a submission was required to be made to NHSI by the Trust, constituting a comprehensive deep dive into the capital programme. This detailed the process of prioritisation that the Trust had undertaking; level of contractually committed spend; an assessment of essential versus non essential investments, all of which was required to be cross reference to the Trust's strategies and risk register. As at mid-July 2016 NHSI have still not formally approved the Trust's capital plan and therefore availability of the required loan funding to support the £28.2m capital programme is not guaranteed at this stage.	Aug-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6658	Medical	Emergency Network	Accident & Emergency	Mar-2016	Keeping the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB.	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 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision.	20	4 x 5	16	4 x 4	9	3 x 3	April 2016 Update Safer patient flow programme launched (including partners), ECIST draft report received and being incorporated. Ambulatory programme commenced. Short term recovery plan developed by Medicine Division with key actions identified to support improved patient experience and delivery of 95% for quarter 1. Excess bed days remain very high with particular risks across the Calderdale health and social care system. Winter plans being formally evaluated and SRG holding a half day workshop to ensure common understanding of cause and agreement on effective actions to deliver sustainable improvement. Some risk of removal of winter pressures funding by CCGs from May, currently being assessed. May 2016 Safer patient flow programme further established with good clinical ward engagement and several areas achieving internally established discharge targets, however overall number of delayed discharges remains high. Weekly meetings with Medicine division focusing on further actions to mitigate risk whilst implementing sustainable changes. These include improved end of life pathway, bed before 11pm initiative , daily debrief at 7am between flow and A&E co-ordinators and exploring direct commissioning of out of hospital capacity. **July Update** Safer patient flow programme fully operational with clear governance arrangements including monthly reporting to WEB to ensure full organisational awareness and ownership. Process to cross check patients with a long wait in A&E and outliers within the mortality review process. As per the bed plan a further 14 bed reduction on the HRI site which, with current demand is requiring more focussed patient flow team input	Sep-16	Apr-2017	BOD	COO Helen Barker	Bev Walker

6753	Corporate	THIS	THIS -Operational	Jun-2016	Keeping the base safe	The Risk of:- Inappropriate access to PID and CHFT Organisational data on some Trust PC's. This risk is increased by the inability to audit access either pre or post any incident. Due to :-Data being saved under Web-station log ins on communal PCs and associated network drives (wards etc) Resulting in:-Breach of confidentiality of patient or staff internally and organisational risk from a CHFT data breach.	- Only trust staff can access the PCs under the web-station login - Only PC's that are a member of a specified group will allow the use of web-station login - Policy mandates that no Data (especially PID) to be saved to local drives - Reduction of generic logons where possible (low impact) - Sophos encryption of disk drives for encrypted local disk data	- Process to wipe the local drive on web-station PCs daily (Begin Comms after audit) - Removal of generic logons through roll out of single sign-on/VDI (Oct 2016) - Password for web-station does not change (currently set in 2010) every 3 months as per other user accounts - Ability to save information to shared network drives associated with web-station account. This information is accessible by all who use the account. - Not all PC's have Sophos Encryption installed (Ongoing)	16	4 x 4	16	4 x 4	4	4 x 1	Clarity around the extent of the problem through audit of PCs and network saved data - End of July 2016 - Understand potential completion dates for SSO and VDI - October 2016 **July Update**: Work is continuing with the Audit of the situation/PC's, once		Aug-2016	Oct-2016	RC	Mandy Griffin	Rob Birkett
6594	Family & Specialist Services	Radiology	CT & MRI	Jan-2016	Transforming and improving patient care	Acting upon radiological resultsThis risk relates to how radiology clinical results are received and acted on by the referring clinician. Although the Radiology department use the same method to inform clinical teams it has been identified that there is no consistency to the method by which clinicians and their supporting administrative teams are receipting and reviewing urgent results. 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 results	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 Update - ongoing discussions on actions and verbal update to Serious Incident Review Group on 23 May 2016. June update- actions being taken in the Divisions to implement recommendations from the Task and Finish Group. Draft process devised - with divisions for comment. Group meeting on 24th June to finalise. **July update** - agreed new process will go-live from 25th July. Cross-divisional involvement in developing and implementing this process - to be reviewed in August to ensure fully successful. Risk expected to reduce at this stage.		Jul-2016	Jul-2016	RC	David Birkenhead	Rob Aitchison/ADDs

5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	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 - Poor/unsafe flooring in ICU at HRI - Uneven floor surface on Ward 19 - Poor fitting windows on Ward 6 at HRI - Damaged floor on CCU at CRH - A&E Resus requires more space. - Poor fitting windows on MAU at HRI There is also a risk of reducing capital monies for 2016/17 improvements.	ICU- temporary repairs carried out as & when required but decant necessary for full floor replacement. Ward 19 - Staff aware of issue; decant to be planned to enable re-skimming of floor Ward 6 - temporary repairs to windows CRH CCU - Flooring which is being monitored prior to decanting ward to refurb under lifecycle. A&E - RESUS - Project to move switchboard to another location to enable expansion of Resus (with CMG) MAU HRI - Windows are of an age and difficult to open / close without significant force. temp repairs	ICU Floor - monitored by Estates until opportunity to decant ward and fully replace,. Ward 6 - Superficial repair of Ward 6 windows (carried out Site Wide); windows will be monitored by Estates. CCU CRH - Cofley monitoring CCU flooring on life-cycle replacement however monitored prior to decant. A&E Resus area requires expansion at HRI; going to CMG for approval.	16 4 x 4	16 4 x 4	6 3 x 2	April 16 Business case for Resus approved at CMG May / June 16 Business case for Resus to go to the Trust Board for approval June 16 Capital Team undertaking a review of the capital projects Vs available funding. **July 16** Capital programme to be agreed 14th July 16. once finalised the projects will be reviewed Vs funding.	Aug-2016	Mar-2017	RC	Lesley Hill	Paul Gilling / Chris Davies
6596	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 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. June Update Serious Incident Review Group met in May and agreed to meet monthly. Senior investigator in post to support investigators of serious incidents. Weekly panels being held to discuss potential serious incidents with approx 4 new incidents discussed per week. Cluster investigation underway for pressure ulcers. **July Update** SI review group discussed different approaches to sharing learning across Trust. Two reports completed one month late.	Sep-2016	Sep-2016	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6598	Corporate	Workforce, OD & Training	Training	Jan-2016	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject (the project timeline extends until February 2017). Compliance measurement will be enabled as each TA is set although this is a lengthy process within the confines of the current Learning Management System. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway.	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	16	16	12	**July update** The tender process for a new LMS is underway. In the meantime, work continues on establishing TA's with a view to applying them within the new system. This work is on plan at the moment. The ELG has now been established and will manage future inclusions onto the essential skills matrix. May 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	Aug-2016	Dec-2016	NA	Interim Director of Workforce and	Pamela Wood
6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Keeping the base safe	Clinical, operational and estates risks in:Children and young people, maternity and family planning, out patients and diagnostic imaging, A&E, Medical care, end of life care, surgery causing increased risks to patients and possible non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance), which could cause the Trust to have breach of licence. Key areas of concern identified for CQC self assessment: Medical Care - safe, responsive and well-led domain Urgent and Emergency Services - safe domain Community Services for Adults - safe domain	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified s requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is to be held to monitor progress with the action plans chaired by the Chief Executive - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, is being commissioned	- Assessments show us to be be in the "requiring improvement" category -We have had feedback from the CQC relating to some areas which require improvement- these are maternity, CDU, patient flow, record keeping and the acute gastro-intestinal haemorrhage service	16	16	8	June update The revised Acute Gastro Intestinal Haemorrhage pathway commenced on the 1st June. The CQC Response Group has received a number of reports detailing progress and outstanding risks. Improvements have been noted in the maternity service with better governance arrangements to monitor clinical risk.We are still waiting for the draft report to be shared with us. Plans are being developed in order to effectively respond to the report. **July update** We expect the report at the end of July The CQC Response Group is monitoring progress with actions in anticipation of the report. The review of the Maternity Service will take place this month. The CQC have requested an update on the actions within the Maternity Service action plan.	Aug-2016	Sep-2016	WEB	Brendan Brown	Juliette Cosgrove
6694	Trustwide	All Divisions	All Departments/Wards	Mar-2016	Keeping the base safe	Risk that the divisional governance structures are not sufficiently standardised and mature to provide assurance on quality and safety due to inconsistent divisional governance systems and processes and lack of application of agreed terms of reference and divisional and directorate Patient Safety Quality Boards (PSQB) resulting in The Quality Committee having a lack of assurance on quality and safety at divisional and directorate governance level	Divisional PSQB terms of reference used for each divisional PSQB. Supplementary governance manager resource within divisions.Quarterly quality and safety report from divisional PSQB to quality committee and hoc reports to Quality committee on specific quality issues eg, Stroke, # Neck of Femur	Consistent application of PSQB terms of reference at Divisional and Directorate level.Variable quality quarterly PSQB reports to Quality Committee.Varied model of governance support into and within Divisions. Varying structures and processes for Quality governance at Directorate and Speciality level.	16	16	8	June update Improved performance management arrangements are being implemented with Divisions receiving data in a more timely way and increasing accountability for performance. **July update** Scoping exercise underway to inform a new appraoch to quality governance / Boards within divisions..	Sep-16	Dec-2016	QC	Brendan Brown	Juliette Cosgrove

6715	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Apr-2016	Keeping the base safe	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. June update Actions re visited through clinical records group. Plan in place to address longstanding areas of non-compliance with a targeted approach to an area until significant changes are seen.Working group established led by matrons from surgical and medical divisions with band 6 nurses leading on this piece of work. Initial meeting has taken place with an action to focus on fluid balance charts initially. This is supported by the Professor of Nursing. Discharge documentation has been collated and work is being led by the discharge matron to rationalise the number of discharge documents in use. **July Update** Documentation sub group of Clinical Records Board re-established in June, meeting fortnightly and focusing on fluid balance, discharge and quality of record.	Jul-2016	Nov-2016	QC	Brendan Brown	Jackie Murphy
6299	Trustwide	All Divisions	All Departments/Wards	May-2015	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. Also being monitored by the CQC Steering Group 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	JUNE update. New starter on plan to start 18th July (pending references). Bank resource (band 3 - 1 day per week) still supporting PPM scheduling (56% of inventory) devices on schedules. Asset verification continues using existing resource (50% complete). KPI's being further developed to break out CRH, HRI and Community data to provide further detail for focus areas. These numbers are worst case, require additional short term admin resource to catch up with data entry as more work has been completed but not yet included in the statistics. **July update.** New starter confirmed to join us on Monday 18th July to help address the CRH site. Bank resource still helping with PPM scheduling (Band 3) 1 day per week (57.5% of inventory) devices on schedules. Asset verification continues using existing resource (50.2% complete). Additional short term admin resource now in place. for a couple of months (Band 2 bank resource). High risk devices with scheduled PPM's now 80.01% complete. KPI's still in development to provide further detailed breakdown. Plan still to achieve 90-95% of high risk devices PPM completed by September 2016. Figures shown are currently worst case, actuals will improve with improved KPI information.	May-2016	Mar-2017	DB	Lesley Hill	V Wotherspoon

6693	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Mar-2016	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. Assurance via Finance and Performance and Well- led Group The Trust has performed a number of challenge sessions to review all existing long term breaches of the Monitor cap. Following this one-off exercise the Trust has sought to integrate this review/challenge into the existing Divisional Business Meetings. An exercise has been carried out to write a letter to all agencies (across all staff groups) requiring agencies to comply with the Monitor cap imposed. Nursing - The Trust has a centralised escalation process in place for the authorisation of requests to secure agency workers for Nursing staff (qualified and non-qualified), through to Nursing Director. The Trust has rich information on the Nursing workforce, covering bank, overtime and agency as a monitoring tool for spend/bookings. Medical – Divisional authorisation of requests to secure agency workers/locums AHP's – Divisional authorisation of requests to secure agency workers Admin & Clerical – Divisional authorisation of requests to secure agency workers	Reportable breaches are currently signed off at Director level though the Trust could further raise the awareness and action by including this information within a report to the Executive Board. Robust escalation and management information for all non-Nursing staff groups. Routine divisional review of agency spend.	15 3 x 5	15 3 x 5	9 3 x 3	A further paper to the Weekly Executive Board that requests gaps in controls are addressed and requests a directive from the Exec Board about absolute compliance with the agency cap and framework compliance guidance. Implementation of a Trust wide management system for all temporary workforce groups (rolled out from the existing system for locums). Manage a safe bed reduction plan from the Trust's current position. Recruit to all vacant posts across all workforce groups. Implement the EPR and reduce the Trust's reliance on agency staff. June update: NHS Improvement agency spend diagnostic tool completed and submitted to Executive Board. Compliance RAG rated and actions identified with lead responsibilities. Action plan to be further refined. Compliance progress to be reported to Executive Board on a monthly basis. Additional ward based bed capacity reduced in early June with continuing review of those that remain open Recruitment from UK/EU sources being progressed. International recruitment pilot agency contracts for Consultant medical staff vacancies signed and activity plans being finalised. Business case for further international recruitment for nursing posts drafted Expanded role of the flexible workforce office to lead on all bank and agency procurement being explored and costed '. Brookson' agency engagement model for medical and nursing, A&C and other staff groups adopted with timetable for implementation to be finalised A business case to recruit additional HCA to reduce current agency reliance is to be drafted A nursing business case that offers revised nursing skill mix is to be developed. Scope and develop the internal bank for medical staff Consolidate and expand bank worker numbers for nursing and AHPs **July update** Scope alternative internal medical locum rates to reduce reliance on agency secured locums	Sep-16	Sep-2016	WLG	Coo Helen Barker, B Brown, D. Birkenhead K Griffi,	Jason Eddleston, Gary Boothby, Lindsay Rudge

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Azizen Khan, Assistant Director of HR
Date: Thursday, 28th July 2016	**Sponsoring Director:** Owen Williams, Chief Executive
Title and brief summary: Workforce Race Equality Standard (WRES) - The paper sets out the Trust position against the Workforce Race Equality Standard (WRES) for 2016. The Trust previously set out its position against the nine indicators and published these on 1 July 2015. This year the Trust is required to publish these on 1 August 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: Executive Board - 21 July 2016	
Governance Requirements: A Workforce for the Future	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached paper.

Main Body

Purpose:

Please see attached paper.

Background/Overview:

Please see attached paper.

The Issue:

Please see attached paper.

Next Steps:

Please see attached paper.

Recommendations:

The Board of Directors is asked to approve the proposed publication of the WRES baseline workforce data report.

Appendix

Attachment:

BoD 28 July 2016 - WRES 2016.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

28 JULY 2016

WORKFORCE RACE EQUALITY STANDARD (WRES)

1. Purpose

The paper sets out the Trust position against the Workforce Race Equality Standard (WRES) for 2016. The Trust previously set out its position against the nine indicators and published these on 1 July 2015. This year the Trust is required to publish these on 1 August 2016.

2. Introduction

The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES first became operational from 1 April 2015 and organisations were required to publish their position against it by 1 July 2015. There is a requirement to publish progress against the standard on an annual basis. The standard aims to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for (Black and Minority Ethnic) BME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The WRES requires organisations to develop an action plan to drive forward improvements against the indicators. The Trust developed its action plan after hearing directly from BME colleagues about their experience of working in the Trust and what they identified as key areas for improvement. The action plan was approved by the Board of Directors in late May 2016 and is now incorporated into a combined WRES/staff survey action plan which is monitored by Executive Board.

3. The WRES Indicators

The WRES comprises 9 indicators as detailed below. Indicators 1 and 9 have been revised since the last submission in July 2015 and now require additional information to be provided.

Four indicators compare workforce metrics for White and BME staff (1-4), four concentrate on staff survey responses (5-8) and one considers the composition of the Board of Directors.

1. Percentage of staff in each of the AfC Band 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.
2. Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.
3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

4. Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff.
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7. Percentage believing that the Trust provides equal opportunities for career progression or promotion.
8. In the last 12 months have you personally experienced discrimination at work from your manager/team leader or other colleagues?
9. Percentage difference between the organisations' Board voting membership and its overall workforce.

4. WRES baseline workforce data report publication

The Trust is required to publish baseline workforce data against the Workforce Race Equality Standard (WRES) on 1 August 2016. This is attached at Appendix 1.

5. Conclusion

The Board of Directors is asked to approve the proposed publication of the WRES baseline workforce data report.

Owen Williams
Chief Executive
July 2016

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation Calderdale and Huddersfield NHS Foundation Trust	**Date of report:** July 2016
Name and title of Board lead for the Workforce Race Equality Standard Ian Warren, Director of Workforce and OD	
Name and contact details of lead manager compiling this report Azizen Khan, Assistant Director of Human Resources	
Names of commissioners this report has been sent to Carol McKenna, Director of Commissioning, Greater Huddersfield CCG and Matt Walsh, Chief Officer, Calderdale CCG	
Name and contact details of co-ordinating commissioner this report has been sent to Carol McKenna, Director of Commissioning, Greater Huddersfield CCG	
Unique URL link on which this report will be found (to be added after submission)	
This report has been signed off by on behalf of the Board on (insert name and date) Board of Directors 28 July 2016	

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

Indicator 2:-

- The NHS Jobs website, the NHS recruitment tool only allows reporting for the previous 12 months and as such the data is for the period 1 July 2015 to 30 June 2016.
- Data on candidates who have been shortlisted is held in NHS Jobs. Recording of ethnicity is not a mandatory field and the Trust data is incomplete.

b. Any matters relating to reliability of comparisons with previous years

The Trust has undertaken a data cleansing exercise which has resulted in a number of posts being re-classified from clinical to non-clinical Agenda for Change Pay Bands. This means that for Band 1 posts meaningful comparisons cannot be made between 2015 and 2016 data.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

5825 (as at 31 March 2016)

b. Proportion of BME staff employed within this organisation at the date of the report

14.3%

3. Self-reporting

a. The proportion of total staff who have self–reported their ethnicity

97.3% (5665)

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

The Trust has contacted those employees where ethnicity information on the Electronic Staff Record (ESR) was absent resulting in improved ethnicity data being reported.

c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity

The Trust has plans to introduce Manager and Colleague ESR Self Service which will allow staff to update their own record.

4. Workforce data

a. What period does the organisation's workforce data refer to?

1 April 2015 - 31 March 2016

5. Workforce Race Equality Indicators

For ease of analysis, as a guide we suggest a maximum of 150 words per indicator.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 1a	Please see appendix 1a	The report for this year shows that there has been a slight decrease of BME staff in AfC Bands 4, 6 and 9 in the non-clinical group. All other groups have seen an increase in BME staff. In the clinical groups there has been an increase in BME staff across all AfC Bands. Overall the Trust has 14.3% of its workforce from a BME background compared to 12.6% in the previous year.	Links to EDS Outcome 3.1 - a fair recruitment and selection process so there is a more representative workforce at all levels. Links to the Trust's action plan - to improve recruitment processes including having a BME person as a panel member for Band 7 and senior management appointments.

2	Relative likelihood of staff being appointed from shortlisting across all posts.	BME = 0.107 White = 0.163 White 1.52 times as likely to be appointed.	BME = 0.134 White = 0.170 White 1.27 times as likely to be appointed.	The data shows that in a 12 month period (July 2015 to June 2016) the ratio of BME staff appointed after being shortlisted has decreased. An assumption has been made given the reported position in Indicator 1 that this is erroneous as a consequence of the absence of ethnicity data held in NHS Jobs, highlighted in section 1a.	Please see Indicator 1.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	BME = 0.007 White = 0.006 White 0.85 times as likely to enter the formal process.	BME = 0.004 White = 0.005 White 1.25 times as likely to enter the formal process.	The information shows that there is an increased possibility of a BME colleague entering the disciplinary process than a White colleague. In headcount terms this equates to 31 White colleagues compared to 6 BME colleagues who have been subject to a formal disciplinary investigation.	Links to EDS2 Outcome 3.4 - staff at work being free from abuse, harassment, bullying and violence from any source. Links to the Trust's action plan - to produce standards for line managers, prepare guidance for managers on tools to use to strengthen team working, and strengthen the provision of equality and diversity training to include cultural awareness training and valuing different perspectives.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	BME = 0.83 White = 0.81 White 0.98 times as likely to access non-mandatory	BME = 0.64 White = 0.66 White 1.03 times as likely to access non-mandatory	The data shows that there is a marginally higher uptake of non-mandatory training in the BME workforce.	Links to EDS2 Outcome 3.3 - about training and development opportunities being taken up and positively evaluated by staff. Links to the Trust's action plan - to provide mentoring and coaching

		training.	training.		including support to navigate training and development pathways and job shadowing and to develop a comprehensive programme for Bands 3 / 4 (Administrative staff) and Band 5 / 6 (Clinical staff) to support them in career progression / promotion
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White = 28.42% BME = 28.57%	White = 25.17% BME = 22.50%	The staff survey results show the difference between White and BME staff. The average (median) for acute Trusts is 28%. In comparison with all acute Trusts the Trust ranking is above (worse than) average.	Links to EDS2 Outcome 3.4 - staff at work being free from abuse, harassment, bullying and violence from any source. Links to the Trust's action plan - to create a safe and effective pathway for dealing with issues of discrimination and racism and set out clear guidelines about acceptable/unacceptable behaviour and language.
6	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White = 24.83% BME = 25.00%	White = 21.93% BME = 28.21%	The staff survey results show the difference between White and BME staff. The average (median) for acute Trusts is 28% therefore the Trust is below (better than) average.	Please see Indicator 5
7	KF21. Percentage believing that	White = 86.24%	White = 92.06%	The staff survey results show	Links to EDS Outcome 3.1 - a fair

	trust provides equal opportunities for career progression or promotion.	BME = 71.43%	BME = 85.71%	that the Trust is below the average (median) for acute Trusts with significant difference between BME staff and White staff. In comparison with all acute Trusts the Trust is below (worse than) average.	recruitment and selection process so there is a more representative workforce at all levels. Links to the Trust's action plan - to provide mentoring and coaching including support to navigate training and development pathways and develop a comprehensive programme for Band 3/4 (non-clinical staff) and Band 5/6 (clinical staff) to support in career progression or promotion.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White = 5.10% BME = 11.11%	White = 4.29% BME = 10.53%	The staff survey results shows the difference between BME and White staff experiencing discrimination at work however the Trust is below the average (median) for acute Trusts.	Please see Indicator 5
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	Board BME 7.1% Overall Workforce BME 14.3% Difference 7.2%	Board BME 7.1% Overall Workforce BME 12.6% Difference 5.5%	There is no change in the BME composition of the Board from 2014/2015 to 2015/2016.	Please see Indicator 1

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress?
The Trust held several focus groups with BME colleagues in the early part of 2016 and the feedback received from the groups has been directly used to support the development of the WRES action plan. BME colleagues presented the action plan to the Board of Directors in May 2016. One of the key actions was to establish a BME network. The first meeting of the BME Network will take place in September 2016.
7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.
The Trust has developed an action plan which was approved by the Board of Directors in May 2016 – attached at Appendix 1b

5.Workforce Race Equality Indicators

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

1 April 2015 - 31 March 2016

	Pay Scale	White %	BME %	Not Stated %
Non-Clinical	Under Band 1	70.0%	30.0%	0.0%
	Band 1	81.4%	17.8%	0.8%
	Band 2	83.4%	13.5%	3.1%
	Band 3	91.5%	5.5%	3.0%
	Band 4	90.4%	7.7%	1.8%
	Band 5	82.1%	17.0%	0.9%
	Band 6	87.7%	10.8%	1.5%
	Band 7	85.0%	10.0%	5.0%
	Band 8a	84.8%	9.1%	6.1%
	Band 8b	81.3%	6.3%	12.5%
	Band 8c	88.2%	5.9%	5.9%
	Band 8d	80.0%	0.0%	20.0%
	Band 9	92.3%	0.0%	7.7%
	VSM*	66.7%	22.2%	11.1%
Clinical	Under Band 1	77.8%	20.0%	2.2%
	Band 1	90.9%	9.1%	0.0%
	Band 2	84.6%	13.1%	2.3%
	Band 3	90.7%	7.6%	1.7%
	Band 4	87.3%	10.1%	2.5%
	Band 5	85.2%	12.4%	2.4%
	Band 6	90.8%	6.7%	2.5%
	Band 7	93.1%	4.7%	2.2%
	Band 8a	95.6%	2.2%	2.2%
	Band 8b	100.0%	0.0%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	100.0%	0.0%	0.0%
	Band 9	100.0%	0.0%	0.0%
	VSM*	45.5%	27.3%	27.3%
Medical	Consultant	48.2%	47.3%	4.5%
	Career Grade	18.3%	78.9%	2.8%
	Trainee Grade	46.3%	46.7%	7.1%
	Other	0.0%	100.0%	0.0%
	Overall Workforce	83.0%	14.3%	2.7%

1 April 2014 - 31 March 2015

	Pay Scale	White %	BME %	Not Stated %
Non-Clinical	Under Band 1	88.9%	11.1%	0.0%
	Band 1	82.7%	16.3%	1.0%
	Band 2	84.2%	12.1%	3.6%
	Band 3	91.7%	5.4%	2.9%
	Band 4	90.4%	8.4%	1.3%
	Band 5	84.5%	13.8%	1.7%
	Band 6	84.3%	12.0%	3.6%
	Band 7	86.1%	11.1%	2.8%
	Band 8a	87.5%	6.3%	6.3%
	Band 8b	83.3%	5.6%	11.1%
	Band 8c	89.5%	5.3%	5.3%
	Band 8d	83.3%	0.0%	16.7%
	Band 9	80.0%	10.0%	10.0%
	VSM*	80.0%	20.0%	0.0%
Clinical	Under Band 1	94.6%	5.4%	0.0%
	Band 1	82.5%	16.4%	1.1%
	Band 2	87.0%	10.4%	2.5%
	Band 3	92.0%	6.4%	1.6%
	Band 4	86.4%	9.9%	3.7%
	Band 5	87.1%	10.8%	2.1%
	Band 6	91.3%	5.8%	2.8%
	Band 7	92.9%	4.5%	2.5%
	Band 8a	98.7%	1.3%	0.0%
	Band 8b	100.0%	0.0%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	100.0%	0.0%	0.0%
	Band 9	50.0%	0.0%	50.0%
	VSM*	50.0%	10.0%	40.0%
Medical	Consultant	50.9%	44.0%	5.2%
	Career Grade	22.4%	69.7%	7.9%
	Trainee Grade	51.3%	44.8%	3.9%
	Other	100.0%	0.0%	0.0%
	Overall Workforce	84.7%	12.6%	2.7%

*VSM = Very Senior Manager. Contains staff in the roles; Chair, Chief Executive, Finance Director, Other Executive Director, Board Level Director, Non Executive Director, Clinical Director - Medical, Medical Director, Director of Nursing, Director of Public Health, and non-Medical & Dental staff with a full time salary over £98,453.

Note - Staff on Local/Senior Manager pay scales have been categorised into AfC bandings based on their full time salary.

Workforce Race Equality Standard Action Plan 2016-2017

ACTION	MEASURE	LEAD	GROUP MEMBERS	TIMESCALE
Set up a BME Network led by the CEO to oversee the implementation of these actions.	There is visible leadership to make improvements on E&D issues	Owen Williams	Michelle Augustine	30 June 2016
Design a communication plan to share key messages from focus groups across the Trust	Transparency about the work of the focus groups and what the Trust is trying to achieve and the need to work together with all colleagues regardless of race and ethnicity	Lesley Hill/Jan Wilson	Errol Brown Adele Roach	31 July 2016
Set out clear and helpful guidelines spelling out acceptable/ unacceptable behaviour and language	Fewer incidents of discrimination and racism reported through formal processes, improved staff survey results	Lesley Hill/Karen Heaton	June Thomas Teresa Stewart-Lynch	31 October 2016
Create a safe and effective pathway for dealing with issues of discrimination and racism.	People feel able to raise issues without fear and issues are dealt with fairly and effectively, with staff being able to discuss issues and seek support through a BME support network	Mandy Griffin/Richard Hopkin	Asifa Ali Lauren Holland	31 October 2016
Improve our recruitment processes including having a BME person as a panel member for Band 7 and senior management appointments	Band 7 and senior management appointments reflect the diversity of the Trust	Mandy Griffin/Karen Heaton	Tahira Shariff	30 September 2016

Strengthen the current E&D training to include cultural awareness training (so people understand cultural sensitivities) and how to challenge on issues of equality and diversity (authentic speech)	E&D training is classroom based and brings about a reduction in incidents of racism, discrimination	Lesley Hill/Jan Wilson	Tahira Shariff	31 December 2016
Provide mentoring and coaching for anyone who wants to get on and who feels that an E&D issue may be holding them back including support to navigate training and development pathways and opportunities for job shadowing	People feel that they can progress in their career regardless of race and culture, age, gender or sexuality and numbers of BME staff accessing mentoring and coaching are increased	David Birkenhead/David Anderson	Paulette Rowe Qusva Ilyas	30 September 2016
Improve cultural sensitivity in how we treat patients including taking steps to understand patients diverse needs and adjusting services to suit those needs	Patients feel that the organisations is sensitive to their cultural needs and this will be reflected in the patient satisfaction survey results	David Birkenhead/David Anderson	Asifa Ali June Thomas	31 December 2016
Create processes to monitor progress and measure the effectiveness of the steps we are taking including an ongoing forum like focus groups or listening groups to monitor issues around equality and	The Trust has solid data on the progress we are making and people feel that their voices are heard	Mandy Griffin/Karen Heaton	Asifa Ali Qusva Ilyas	31 October 2016

diversity, share experiences and identify solutions				
Develop a comprehensive programme for Bands 3/4 (Admin staff) and Band 5/6 (Clinical staff) to support them in career progression/promotion	There are opportunities offered to staff to progress and the Trust will see an increase of BME staff at Band 4 and above	Ian Warren/Karen Heaton	Mahen Jamookeeah Debi Johnson	31 December 2016
Health and wellbeing of colleagues is seen as important and options like a staff gym and healthy food options are explored	Healthy and motivated staff should reduce sickness absence particularly related to stress which in turn impacts on better and improved care for patients	David Birkenhead/David Anderson	Ezra Matebele Sameera Norat	31 October 2016
The work from the BME focus groups and in particular the action plan will be integrated into the broader workforce strategy	Improved staff survey results, achievement against CQUINS, recruitment/retention and reduction in sickness absence	Owen Williams/Karen Heaton	Azizen Khan	30 September 2016

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Senior Nurse Clinical Governance
Date: Thursday, 28th July 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient programme Report - This is a progress report against the six themes identified within the CAIP programme	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Reports are provided monthly to the Clinical Outcomes Group (COG)	
Governance Requirements: Transforming and improving patient care	
Sustainability Implications: None	

Executive Summary

Summary:

The Care of the Acutely Ill Patient (CAIP) programme, last revised in August 2015, is divided into six themes, an update is provided for all of these themes:

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

Main Body

Purpose:

This progress report is intended to keep the Board of Directors informed of the progress of the 6 themes within the CAIP programme

Background/Overview:

As per the executive summary

The Issue:

Although mortality remains a concern there has been progress made in all themes within the CAIP programme and a reduction in HSMR has been noted.

Next Steps:

Monthly monitoring of all the themes continues with reporting to COG

Recommendations:

To note the content

Appendix

Attachment:

CAIP programme summary for BoD_July 2016 final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors; July 2016

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

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

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

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

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** The latest release for SHMI is for Jan 15 - Dec 15 and is consistent with the previous release of 113. **HSMR** The latest HSMR release is for April 15 to March 16, and has shown a fall to 111.6. Our prediction is for further modest reductions in the coming months. **Mortality Reviews** The completion rate for Level 1 reviews has come back in line with previous performance levels, levelling out at 47.5% YTD, with 45% of the May deaths having had a corporate level one review. The trust is aware that colleagues in the surgical division are doing mortality reviews on a number of	The next SHMI is expected to remain at a similar level, as it reflects a delayed period of time when the HSMR was also stablised. HSMR performance is expected to continue to reduce of the coming months. The process for consultants to perform mortality reviews is being developed and the review compliance is expected to rise once this is established This will not be until the end of Q2. Review of 1st level review forms to reduce the data collected for all

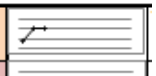
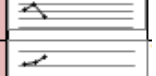
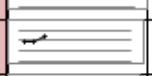
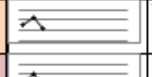
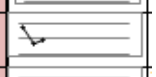
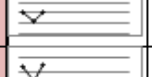
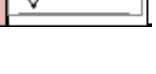
	patients in line with their own governance processes. Work has begun on how to integrate these reviews into the corporate process. A mortality Surveillance Group has been set up with the first meeting held in May. The meeting is chaired by the Medical Director **Alerting Conditions** The trust is showing as an outlier in mortality for two diagnostic groups; Acute Cerebrovascular Disease (ACD) and Pneumonia. An in depth review of 15 ACD has been carried out with some learning themes but no preventability issues noted.	deaths but to include optional speciality section. Also to work with the National programme to ensure alignment of process A review of 30 pneumonia cases is currently being undertaken. There is a Stroke Improvement Plan overseen by the Medical Director to improve the care of Stroke patients including mortality
2) Reliability in clinical care	There are five conditions where evidence-based care bundles have been developed to improve patient outcomes. These are; • Asthma • Acute Kidney Injury (AKI) • Sepsis • Chronic Obstructive Pulmonary Disease (COPD) • Community Acquired Pneumonia (CAP) There has been improvement seen in the commencing the bundles since these were included in the medical clerking documentation, however, there still remains variation in completion of the bundles.	AKI and Sepsis bundles have now been included in the Surgical Clerking documentation from the beginning of July and compliance will need to be monitored for improvement. Liaise with the clinical lead for each of the bundles to follow up improvement work. An understanding of how the elements of the care bundles fit with the new EPR and how compliance can be measured through the system.
3) Early recognition and treatment of deteriorating patients.	A new group had been set up to lead 7 day working and Hospital at Night. A project nurse has been appointed to implement the H@N. The NerveCentre is fully operational in all areas including Paediatrics	Further work looking patients who have a NEWS score of 7 or more to see what happened to those patients for any themes.

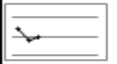
4) End of life care	An End of Life Care co-ordinator has been appointed on a 1-year secondment and supported by the ADN in the Community Division. An improvement plan and strategy has been developed DNACPR are not quite embedded yet with completion and review date staying at 75-80 with 90% having a recorded discussion.	Quality Indicators to be set and will be measured and will report to the COG bi-monthly and also the Patient Experience Group. Information to be collected on how many patients should be on the ICODD and the percentage of these patients that are actually on the ICODD
5) Caring for frail patients	A group has been identified to look at the care of frail patients. This is being led by the Surgical ADN supported by the medical ADD and DD from FSS.	Close working with CCG partners
6) Clinical coding	Improvements noted in diagnosis and co-morbidities but deterioration in signs and symptoms as primary diagnosis. Considerable variation though between Divisions and Specialties. Co-morbidity form completion continues to be low although slight overall improvement on previous audit where overall completion was 54% 4th clinician with PA for Clinical Coding identified. Additional clinical coding trainees recruited and will commence training in June/July.	Clinical engagement work needs to continue Ongoing work with Specialist Palliative Care to ensure this is documented into the case notes by the wards.

June 2016 - Dashboard

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Performance
Theme 1: Investigating Mortality and Learning from findings	Rolling 12 month SHMI (from HED Monthly – latest HSCIC publication date) January 2015- December 2015	100	113.88		113.8										113.80	
	HSMR - comparing to same time period as latest SHMI	100	116.79		116.49										116.49	
	HSMR - April 15- March 16	100	116.71	114.48	111.62										111.62	
	HSMR - Number of New Alerts		0	0	0										0	
	Number of ongoing Alerts		2	2	1											
	Number of completed Alert investigations		1	1	1											
	COPD - SHMI January 2015 - December 2015	100	117.86		120.96										120.96	
	COPD - HSMR- comparing to same time period as latest SHMI	100	129.07		133.17										129.07	
	COPD HSMR- April 15 - March 16	100	118.31	132.74	129.01										118.31	
	Heart Failure - SHMI January 2015 - December 2015	100	113.89		115.22										115.22	
	Heart Failure - HSMR comparing to same time period as latest SHMI	100	107.33		109.24										107.33	
	Heart Failure HSMR - April 15 - March 16	100	107.72	100.55	100.88										107.72	
	ACD (inc Stoke) - SHMI January 2015 - December 2015	100	144.62		140.07										140.07	
	ACD (inc Stoke) - HSMR- comparing to same time period as latest SHMI	100	127.99		131.35										131.35	
	ACD (inc Stoke) HSMR - April 15 - March 16	100	130.22	141.07	138.57										130.22	

	Number of In Hospital Deaths	NA	139	155	135									429	
	Deaths within 30 days of Discharge	NA	22	22	49									93	
	% of Deaths Occurring in Hospital	NA	86%	88%	73%									82%	
	% Crude Mortality – All Admissions	NA	1.44%	1.59%	1.32%									1.45%	
	% Crude Mortality – Weekend Discharges	NA	2.62%	3.83%	2.78%									3.1%	
	% Mortality Reviews (Month behind)	100%	50.4%	41.6%	in arrears									45.8%	

Theme 2: Reliability	Asthma - Bundle Started	95%	87%	100%	100%									95%	
	Asthma - Bundle Completed	95%	46%	50%	42%									43%	
	AKI - Bundle Started	95%	58%	62%	79%									68%	
	AKI - Bundle Completed	95%	39%	38%	48%									43%	
	Sepsis - Bundle Started	95%	88%	91%	86%									88%	
	Sepsis - Bundle Completed	95%	41%	45%	39%									42%	
	COPD - Bundle Started	95%	43%	65%	77%									61%	
	COPD - Bundle Completed	95%	85%	33%	48%									53%	
	Pneumonia - Bundle Started	95%	40%	23%	43%									36%	
	Pneumonia - Bundle Completed	95%	67%	20%	77%									75%	

Theme 3: Early recognition and treatment of	Number of Cardiac Arrests	NA	12	20	13										45	
	Number of Cardiac Arrests per 1000 bed days (Rate)	0.68	0.56	0.90	0.62										0.70	
	Unplanned Admission to ICU	43	39	50	54										143	
Theme 4: End of Life Care	DNACPR % Discussion completion	95%	89.2%	87.6%	91.0%										89.3%	
	DNACPR Review date completion %	95%	79.5%	76.4%	80.9%										78.9%	
	% of patients on the ICODD	N/A	46.7%	40.3%	37.6%										41.5%	
Theme 5: Frailty	% frailty Deaths (as a proportion of all deaths)	N/A	13.7%	7.7%	9.6%										10.5%	
Theme 6: Coding	Average Diagnosis	5.27	4.9	5.1	5.1										5.0	
	Average Charlson Score	4.43	3.8	4.6	4.4										4.4	
	Co-morbidity capture	90%	45%	51%	61%										54%	
	% Sign and Symptom	9.4%	9.1%	8.7%	9.6%										9.1%	
	% Coded with Specialist Pall Care	NA	0.8%	0.9%	0.9%										0.9%	

Report from the Director of Infection Prevention and Control to the Weekly Executive Board
1st April to 30th June 2016

Performance targets

Indicator	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	302 days since the last infection
C.difficile (trust assigned)	21	**6**	3 avoidable and 3 unavoidable cases
MSSA bacteraemia (post admission)	9	**2**	Local target – 15/16 outturn
E.coli bacteraemia (post admission)	25	**5**	Local target – 15/16 outturn
MRSA screening (electives)	95%	**95.14%**	April validated
Central line associated blood stream infections (Rate per 1000 cvc days)	1	**0.51**	Rolling 12 months
ANTT Competency assessments (doctors)	95%	**68.2%**	
ANTT Competency assessments (nursing and AHP)	95%	**78.8%**	
Hand hygiene	95%	**99.15%**	

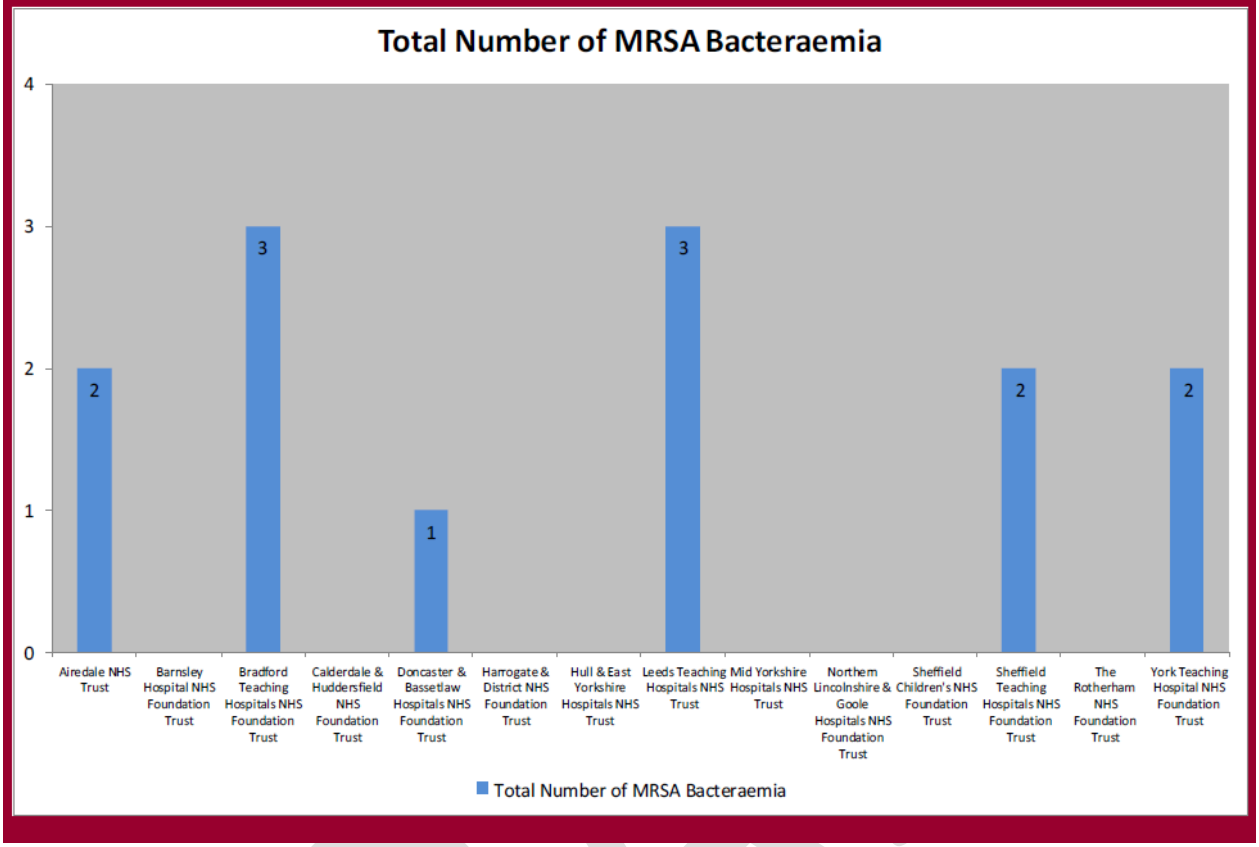
Quality Indicators

Indicator	YTD agreed target	YTD performance	Comments
MRSA screening (emergency)	**95%**	90.63%	April validated data
Isolation breaches	**Non set**	62	Compared to 75 for same time period last year
Cleanliness	**Non set**	97.4%	

MRSA bacteraemia:

To the end of June 2016, there have been **0** post admission cases **MRSA bacteraemia**:

MRSA assigned to Acute Trusts – April to June 2016



MSSA bacteraemias: there have been 2 post-admission MSSA bacteraemia cases during quarter one, against the internal objective of 9.

MRSA - Hospital-Acquired Infections (HAIs):

There have been 7 acquisitions this year compared to 6 for the same time period last year.

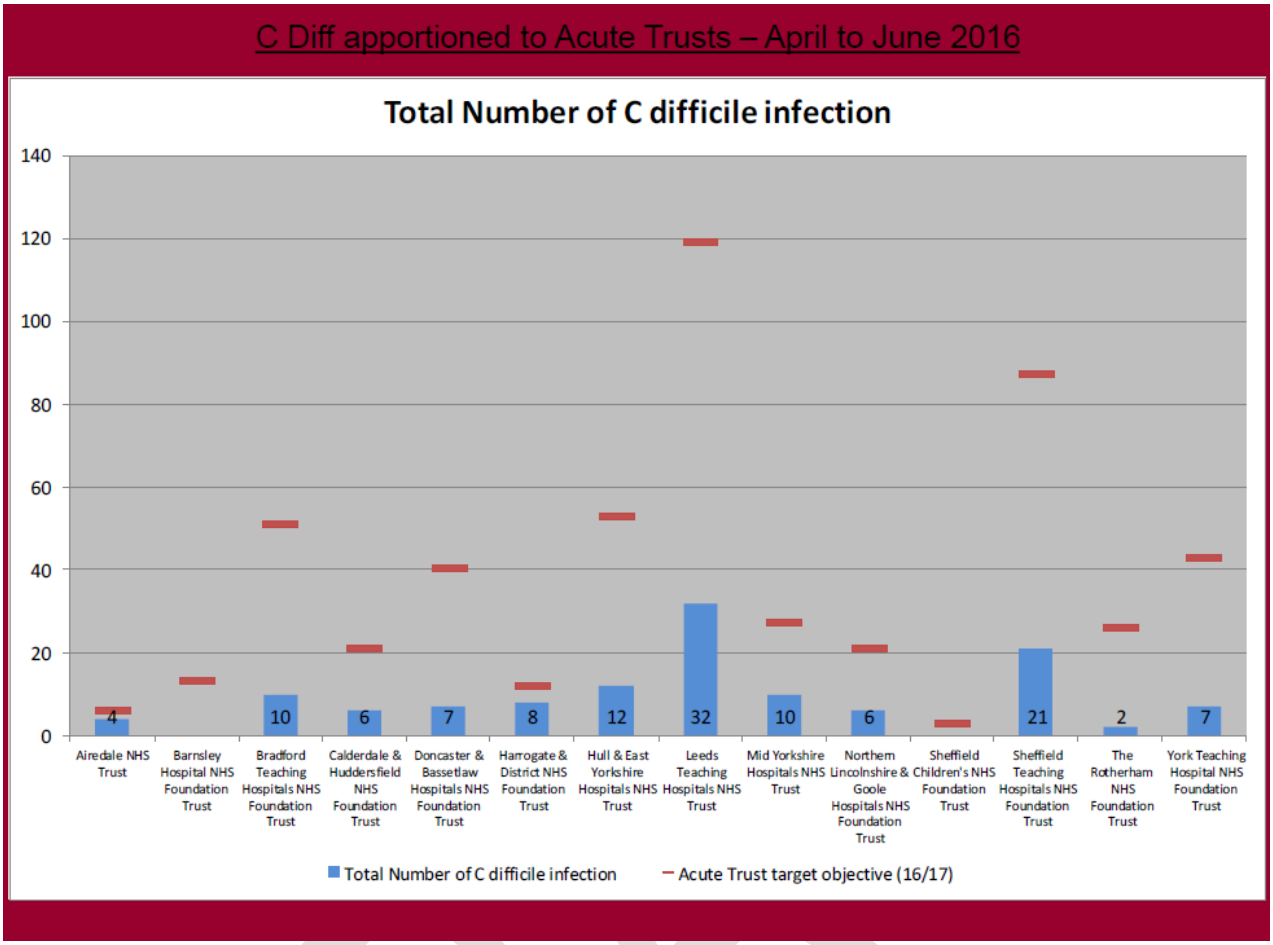
Wards are informed of any HAIs that occur within their area and are asked to carry out a ward-led investigation; these are presented to the PSQBs. These will be monitored throughout the year.

Clostridium difficile: the ceiling for 2016/17 is for no more than 21 post-admission cases

Key themes from the C-diff cases are:

- 2 of the cases had the same strain and were nursed in close proximity to each other; a recommendation has been made by the IPCT to remove one of the beds which would make this area compliant with HBN 04-01 Adult in-patient facilities & HFN 30 Infection Control in the built environment.
- Delay in obtaining stool specimen
- Completion of the Bristol Stool Chart

Work is ongoing to improve compliance with the above issues.



Escherichia-coli (E-coli) bacteraemias:

There have been 5 post-admission E-coli bacteraemia cases against the internal objective of 25.

Outbreaks & Incidents:-

3 patients have tested positive for Zika virus following return from foreign travel.

There have been **2** incidents in Day surgery at HRI following exposure to Chickenpox:-

- Case 1 – the patient had attended for surgery on the 16th June, developed rash on the 18th of June and rang out of courtesy to inform day surgery. Lookback exercise complete with no follow-ups required.
- Case 2 – child brought in for operation, whilst in theatre obvious chickenpox rash noted. Risk assessment completed on all patients in waiting list; same resulted in postponing 3 operations due to high risk status.

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.

Isolation Breaches

There have been 62 isolation breaches during the last 3 months compared to 75 breaches for the previous year.

- Isolation is included in the Action plan for 2016/17; work has commenced with MAUs to identify patients being admitted with a previous history of infection.

Audits:

17 Quality improvement environmental audits have been carried out since the beginning 1st April 2015 to end of June 2016.

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

- 7 of the areas achieved a green rating.
- 7 of the areas achieved an amber rating.
- 3 of the areas the report is pending.
- 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**
Jan 2016	87%	90%
Feb 2016	88%	79%
March 2016	96%	95%
April 2016	90%	94%
May 2016	90%	94%

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.

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:

There are 83 new assessors have been trained since October 2015.
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. All FY1 will be assessed prior to commencing on the wards in August. FY2 will have to provide evidence of previous ANTT assessment or they will have to be assessed within one month of starting in the Trust.

Competency rate is now at 80.25% for nursing staff (previously 76.5%) and 68.3% (previously 68%) for Doctors; Trust overall 76%. Plans to improve performance includes:- ANTT competency matrix on all divisional PSQBs; additional support provided to ANTT assessors by the IPCNs; new assessors identified and trained on ward/departments are being supplied with their individual clinical area matrix so that they can target those staff who are not ANTT assess, this is proving to have a positive effect.

IPCNs: The team have currently 2 new starters which impacts on the team due to the training and support required. 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.

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 28th July 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Quarterly DIPC report - The Board is asked to receive the report on the position of healthcare associated infections	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board	
Governance Requirements: Keeping tthe base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the report on the position of healthcare associated infections

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 the report on the postion of healthcare associated infections

Appendix

Attachment:

Quarterly DIPC Report July 2016 final.pdf

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 28th July 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Annual DIPC Report - The Board is asked to receive the report on the 2015/16 position of healthcare associated infections	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive board	
Governance Requirements: keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the report on the 2015/16 position of healthcare associated infections

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 the report on the 2015/16 position of healthcare associated infections

Appendix

Attachment:

DIPC Report 2015-16 final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2015-16

Executive Summary

This report provides information about the infection prevention and control arrangements and activity during the period April 2015 to March 2016, with an assessment of performance against national targets for the year. The Director of Infection Prevention and Control (DIPC) who leads the infection prevention and control team reports directly to the Chief Executive.

Key points:

The Health and Social Care Act (2008) sets out a code of practice for the prevention and control of infections. Compliance is demonstrated through a self-assessed a HCAI programme of work for 2015/16 that includes the 10 criteria identified in the code and incorporates the Trust Healthcare Associated Infection (HCAI) action plan.

- There were 3 trust apportioned MRSA bacteraemia reported against a ceiling target of zero.
- There were 25 trust apportioned *Clostridium difficile* toxin (CDT) positive cases this year against a ceiling target of 21. All were subject to Root Cause Analyses (RCA) – 7 were identified as potentially avoidable owing to 'lapses in care' identified at RCA. Lapses in care principally related to antibiotic prescribing out with policy and poor documentation. Areas for improvement feed into the Trust HCAI action plan. There were 9 trust apportioned Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, which is a 25% reduction from 2014/15.
- The trust reported 25 E.coli bacteraemia infections demonstrating a reduction on last year's performance of 29. Analysis of all cases has not demonstrated a common underlying cause.
- A decontamination failure was investigated as a Serious Incident (SI). A look back exercise involving 22 patients did not demonstrate any evidence of patient harm as a result of this. Several measures have been implemented as a result of the investigation into this SI, including the implementation of a decontamination committee.
- There were 8 wards affected (either closed or restricted) with viral gastroenteritis, resulting in 76 bed days lost.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of hand hygiene compliance for the year was 99%.
- The Trust participated in the mandatory 3 month orthopaedic surgical site infection surveillance (SSIS).

- Two patients were identified as carrying Carbenpenemase-producing enterobacteriacae (CPE) from the Trust screening programme.
- All core policies, as required by the Hygiene Code 2008(DH 2010), have been reviewed and have been published on the Trust Intranet and Internet sites. 15 policies have been approved at Executive Board during 2015/16.

Contents

1. Infection Control Arrangements

The Infection Prevention and Control Team (IPCT) provide specialist advice and training on matters relating to the identification, prevention and management of hospital acquired infection within the Trust. The team works to an agreed annual programme, approved by the Infection Control Committee (ICC) and the Executive Board.

The IPCT is also supported by two antibiotic pharmacists (1 WTE) who are led by a Consultant Microbiologist with responsibility to improve antibiotic prescribing.

The IPCT comprises of an Infection Prevention and Control Doctor, Lead Infection Prevention and Control Nurse, Senior Infection Prevention and Control Nurses, Infection Prevention and Control Nurses, support and administration staff.

- Two staff successfully completed the Infection Control Certificate last year
- There have been significant staffing pressures throughout 2015/16; these will be resolved during 2016/17

The Director of Infection Prevention and Control (DIPC) is both the Medical Director and a Consultant Microbiologist. The specific role and responsibility of the DIPC is to:

- oversee local control of infection policies and their implementation;
- be responsible for the Infection Prevention and Control Team within the healthcare organisation;
- report directly to the Chief Executive and the Board and not through any other officer;
- have the authority to challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions;
- assess the impact of all existing and new policies and plans on infection and make recommendations for change;
- be an integral member of the organisation's clinical governance structures;
- Produce an annual report on the state of healthcare associated infection in the organisation and release it publicly via the Calderdale and Huddersfield NHS Foundation Trust website.

Reporting arrangements

- Infection prevention is the responsibility of everyone in the organisation;

- The Infection Prevention and Control Doctor oversees the implementation of the Infection Prevention annual programme through the their chairmanship of the Infection Control Committee (ICC) and reports directly to the DIPC;
- The Infection Prevention and Control nursing team is managed by the Lead Nurse;
- The DIPC is a member of the Executive Board and Trust Board of Directors and reports directly to the Chief Executive;
- Through reports received at the ICC and Executive Board the DIPC is able to challenge infection prevention and control practice.

Infection Control Committee

The ICC meets quarterly and is chaired by the Infection Prevention and Control Doctor. It has senior nursing representatives from each clinical division, Facilities and Estates, occupational health, decontamination, Public Health England and representatives from both CCGs. Its remit is as follows:

- To ensure that Calderdale and Huddersfield NHS Foundation Trust provides a safe environment, in terms of infection risk and within the sphere of current knowledge, for patients, staff and visitors.
- To oversee the organisation and development of infection control services across the Trust, including surveillance, audit, education and the development and review of policies.

The ICC reports to the Quality Board and onward to the Quality Board which reports to the Executive Board and Board of Directors.

Preventing Infection and Improving Prescribing Group (PIIP) (formally Healthcare Associated Infection (HCAI) Operations Group and the Antimicrobial Management Team)

This group develops and ensures delivery of the actions of the Trust HCAI Action Plan, which incorporates the antimicrobial stewardship plan. It meets monthly with medical and nursing representatives from each of the divisions, pharmacy, the health informatics team and estates and facilities. It is chaired on a rotational basis by the Consultant Lead for antimicrobial prescribing and the Lead Infection Control Nurse or Infection Prevention and Control Doctor.

Board to Ward

Board to ward reporting is achieved primarily through the HCAI dashboard which is compiled on a monthly basis. The DIPC reports monthly to the Executive Board (EB) and Board of Directors (BOD) on a number of key indicators and performance of HCAI; this information is cascaded via the Trust EB Briefing and is reported in the staff newsletter, Trust News. A quarterly DIPC report is provided for the Executive Board and Board of Directors and is also widely shared with the HCAI Clinical Champions, members of the PIIP group and the CCGs. A narrative of any off target indicators is provided in the integrated board report, detailing actions being taken to get us back on plan. Target indicators are also discussed at divisional PSQBs (Patient Safety Quality Board) which are attended by a representative from the IPCT; they are displayed on ward notice boards and mentioned at Trust 'Big Brief' on a monthly basis.

Healthcare Economy-Wide Meetings

The economy-wide group met on a quarterly basis with representation from the Trust, Public Health England (PHE), South West Yorkshire Partnership Trust (SWYT), Locala and representatives from the Clinical Commissioning Groups (CCG). This group was designed to ensure that there was a co-ordinated approach to improvement with respect to HCAI and facilitated communication and the sharing of best practice. These meetings will not continue in the same format during 2016/17; however the Lead IPCN for each organisation will continue to meet on a monthly basis.

Infection Prevention and Control representative at relevant groups

To provide infection and prevention advice and ensure liaison between the IPCT and key groups, representation is provided at the following:

- Infection Control Performance Board (disbanded September 2015)
- Healthcare economy wide meetings
- Divisional patient safety quality boards
- Medical devices and clinical product review
- IV Strategy Group
- Community Infection Control Committees
- Sisters Meetings
- Nursing and Midwifery Committee
- Nursing and Midwifery Practice group
- Water management and air quality group
- Estates and Facilities Capital planning group

Infection Control Budget 2015/16

The Infection Control Team has a budget of £413,000 per annum. Of this £35,000 is for non-pay including ICNet licensing, training expenses as well as travel and mobile phone costs. The Lead Nurse is both the budget holder and budget manager. Excess costs associated with outbreaks are funded separately from within the Trust.

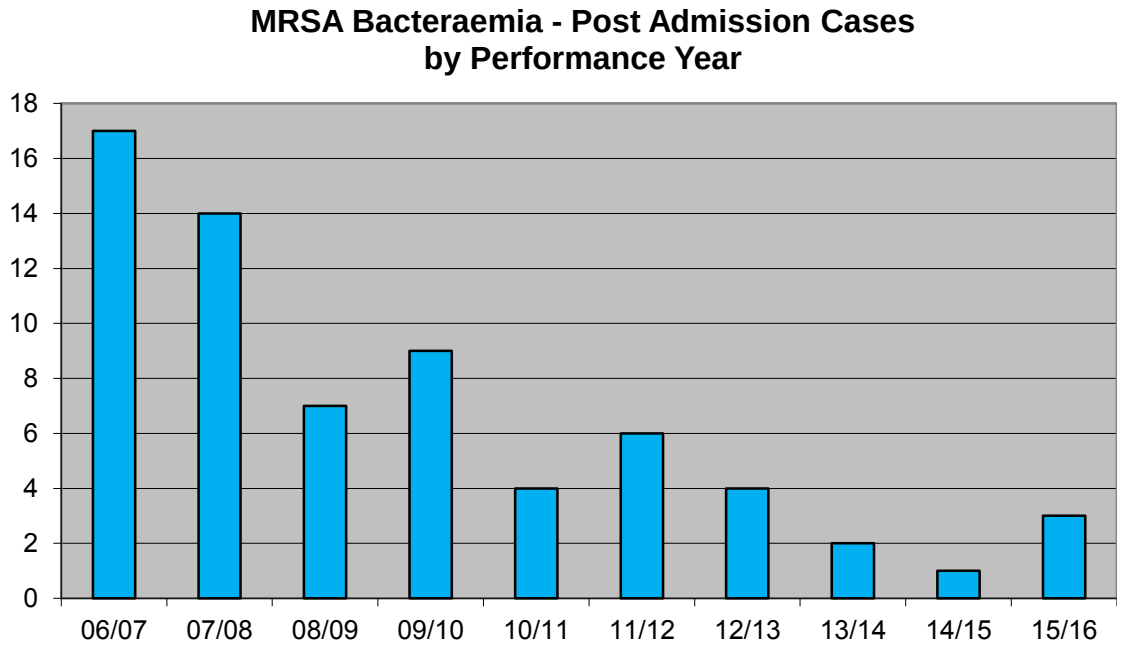
2. Mandatory reporting of HCAI

Mandatory reports are made to Public Health England (PHE) these are reporting of:

- Staphylococcus aureus bacteraemia (MRSA & MSSA)
- *Escherichia coli* bacteraemia
- *Clostridium difficile*
- Orthopaedic Surgical site surveillance

Meticillin-resistant Staphylococcus aureus

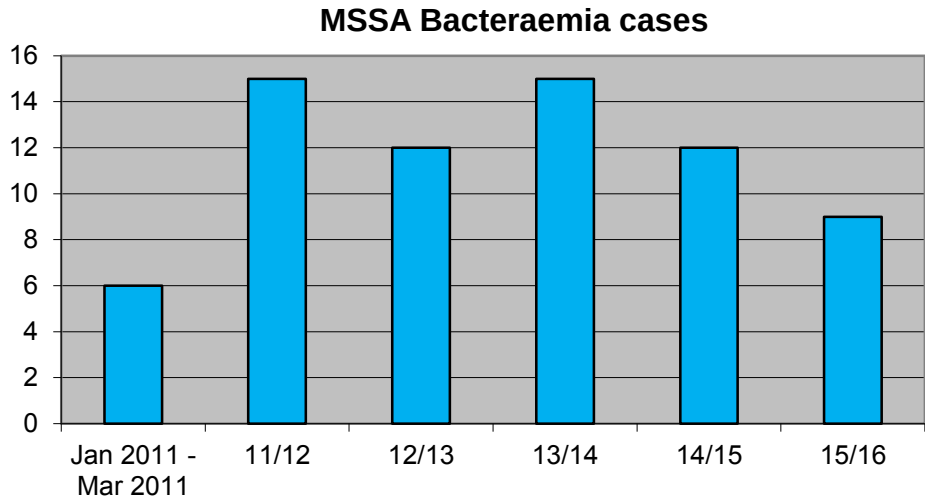
MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia are reported nationally and the Trust had seen a significant reduction over the last few years, so we are obviously disappointed to have seen an increase from 1 case in 2014/15 to 3 cases in 2015/16. All cases are subject to a Post Infection Review to identify if there were any lapses in care to aid prevention of further cases. 1 cases were deemed to have been avoidable at PIR. Actions were generated and incorporated within the Trust HCAI action plan.



Meticillin-sensitive Staphylococcus aureus

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemia are reported nationally but there is no national set target. A local target was set using the 2014-15 out turn of 12 cases. Nine cases were recorded.

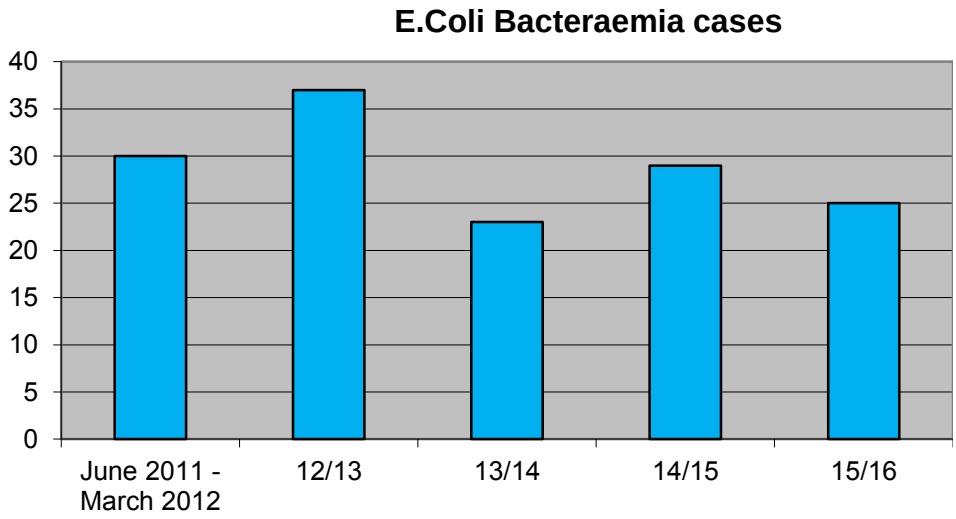
The chart below shows the number of post admission MSSA bacteraemia.



E.coli Bacteraemia

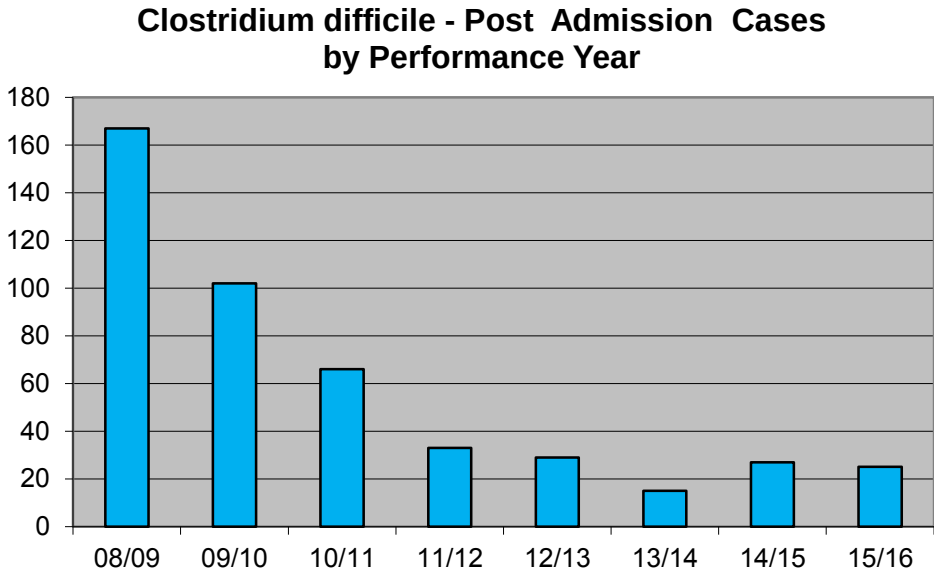
There is no national set target for post 48 hour E.coli bacteraemia. An internal target for E.Coli bacteraemia was set using the 2014-15 out turn of 29 cases. There were a total of 25 cases in 2015/16. A case note review was carried out for each case. In total, 5 were related to the presence of a urinary catheter. The remaining 20 cases for a multitude of different reasons. Actions to reduce the incidence of CA-UTI will be incorporated in the HCAI action plan for 2016/17.

The chart below shows the number of post admission cases.



Clostridium difficile

Clostridium difficile (*C. difficile)* is one of the major causes of infective diarrhoea. The target set for the trust in 2015-16 was a ceiling of 21. In the last year there was an increase in cases compared to the previous year. All the cases were subject to investigation by way of root cause analyses (RCA). Following RCA investigations of the 25 cases, 7 showed lapses in care which had action plans implemented. In the remaining 18 cases there were no lapses in care that had contributed to the infection. The slight increase in C. difficile cases from 2013/14 to 2014/15 are in keeping with a national rise in the number of reported cases of *Clostridium difficile* infection.



3. Health and Social Care Act (2008)

The Health and Social Care Act (2008) sets out a code of practice for health and adult social care on the prevention and control of infections. The main purpose of the code is to make the registration requirement for cleanliness and infection control clear to providers of health and social care services so they know what is needed to comply.

The Trust developed the HCAI programme of work for 2014/15 around the 10 criteria and was able to demonstrate self-assessed evidence of compliance in all criteria. The Trust received an inspection from the Care Quality Commission in March 2016, we are awaiting the report.

Compliance criteria	What the registered provider will need to demonstrate
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
Criterion 3	Provide suitable information on infections to service users and their visitors
Criterion 4	Provide suitable accurate information on infections to any persons concerned with providing further support or nursing/medical care in a timely fashion
Criterion 5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people
Criterion 6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
Criterion 7	Provide or secure adequate isolation facilities
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for individual's care and provider organisations, that will help to prevent and control infection
Criterion 10	Ensure, so far as reasonably practicable, that care workers are free from and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care

4. Preventing Healthcare Associated Infections

Surgery and Anaesthetics Division

This year the Division of Surgery have seen an improvement in the number of hospital acquired *Clostridium difficile* with the end of year figure at 5. Two were found to be avoidable. Key learning has been identified through root cause analysis around isolation and sample taking. This has been shared through directorate meetings and at the divisional Patient safety and Quality Board.

The year-end ANTT position is at 73.56% of staff competency assessed. Although we have seen improvements with some staff groups we have had a real challenge with others. Compliance concerns with ANTT practice in theatres had been identified and an improvement plan was put in place. We worked closely with the infection prevention and control team to provide additional training and support into theatres on both sites and have seen improvements in practice. Work is ongoing to ensure that these improvements are sustained.

Hand hygiene compliance position at year end is 98.7%. Work is ongoing to ensure that this figure is an accurate reflection of current practice. Issues with hand hygiene and PPE compliance were identified in both main theatres and the matron for operating services has been working with the service managers to improve compliance, closely supported by the clinical director for operating services.

As part of our CQC preparation, department and ward areas were supported to de-clutter and work closely with cleaning services. This process highlighted a number of issues which the matrons continue to focus on. We continue to peer review areas as part of the senior nursing 'clinical Wednesdays'. The matrons within surgery are contributing to the redesign of the Front line ownership tool to ensure that learning from the pre CQC inspections is captured within the tool.

Medical Division

The Medicine division has continued to progress its infection control agenda to support the trust's action plan and continues to monitor performance in its infection control practice and management.

Medical and nursing staff has demonstrated improved compliance with infection controlled practices thus improving patient care and management. There have been 2 MRSA bacteraemia cases within the division, both of which were subject to post

infection reviews from which learning in both the acute trust and community have been identified and implemented.

Thematic reviews of the cases of *C.difficile* have highlighted the need to improve practices relating to obtaining stool samples from diarrhoeal patients. Challenges continue for staff to comply with side room isolation although an action plan around this has been implemented and improved compliance is expected – this will be closely monitored.

The Division continues to attend the trust infection control committee. Infection Prevention and Control is an agenda item on Divisional Boards and Patient and Safety Quality Boards where performance is monitored and challenged. Action plans to improve the performance around ANTT compliance are in place and are on track – standards are expected to continue to rise, and again, this will be subject to close monitoring.

Matrons FLO audits continue to be submitted on the 15th of every month to match with safety the thermometer process. Infection prevention and control remains a fundamental part of the matron's role and the senior nursing team working in partnerships with mangers at ward level. The infection control agenda has also remained a key focus of "back to the floor, clinical Wednesdays" working in partnership with Domestic teams, Estates Staff and Infection Control teams to improve standards.

Families and Specialist Services

The Families and Specialist Services Division maintains its commitment to working on continuous improvement. Link Infection Control and Prevention Practitioners are active within all services, with succession plans in place across most areas.

Our Link Infection Control and Prevention Practitioners work in collaboration with Matrons and Clinical Leads to ensure clear leadership and to continuously promote excellence in infection control. We recognise that staff engagement is crucial to success and so all areas maintain up to date infection control notice boards. Frontline Ownership (FLO) audits and spot checks made by Matrons, Ward and Departmental Managers and Clinical Leads; where non-compliances have occurred, investigations are carried out and learning shared. Outcomes and performance are discussed at Divisional and Directorate Board meetings and clinical forums.

We have sustained our position in having no cases of MRSA bacteraemia.

Designated clinical colleagues in the Division have again provided immunisation of the flu vaccine to the divisional team and others to contribute to meeting the Trusts target. A new comprehensive flu immunisation training programme for midwives was implemented in 2015-2016. As a result, Trust performance in terms of rates of supporting administration of the 'flu' vaccine to pregnant women benchmarks well across the region.

Table 1: Number of pregnant women having a flu vaccine administered by the maternity service 2014-2016

2014/15	Cald	Hudds	Total	**2015/16**	Cald	Hudds	Total
October	0	0	0	October	50	94	144
November	8	41	49	November	29	29	58
December	6	9	15	December	16	21	37
January	7	2	9	January	5	14	19
February	0	0	0	February	7	9	16
March	0	0	0	March	0	1	1
Total	21	52	**73**	Total	107	168	**275**

Vaccine uptake by pregnant women across Greater Huddersfield CCG is higher than the regional average and Calderdale CCG was one of only two CCG's in the region to increase uptake this year.

	2014-15 %	2015-16 - %	comparison %
National	44.1	42.3	-1.8
West Yorks Region	49	41.6	-7.4
Calderdale CCG	48.2	49.6	+1.4
Greater Hudd CCG	51.6	48.9	-2.7

5. Untoward Incidents

In January 2016 a potential failure of the nasendoscope decontamination process was identified. This affected nasendoscopes used on the Acre Mill site only. This incident was managed through a series of incident control meetings which were supported by Public Health England. The risk of transmission of infection between patients was considered to be extremely low, but as a precaution a limited look back exercise was undertaken. No evidence of cross transmission of infection was found.

This incident was investigated as a serious incident (SI). A number of recommendations were made as a result of this, the majority of which have been implemented in full, with only one outstanding action which is to convene a decontamination committee – this will meet for the first time on 27th June 2016 and on a monthly basis thereafter. Other actions included an improved process for decontamination within the Acre Mill site, with improved documentation, training and audit.

6. Antimicrobial Prescribing

Antimicrobial Management Team:
The Trust Antimicrobial Management Team (AMT) comprises the Trust Antimicrobial Stewardship lead, Infection control doctor, Consultant Microbiologist, Senior Clinicians from Medicine, Surgery and Families and Specialist Services divisions, Antimicrobial Pharmacists and the Divisional Clinical Pharmacy Services Manager. The Team meet regularly at the Preventing Infection Improving Prescribing Group (PIIP) following a merger with the HCAI Operations Group, with the aim of facilitating dissemination of information to the wider team.

Antibiotic Prescribing Guidelines:
Adult antibiotic prescribing guidelines have all been updated and approved by Medicines Management Committee (MMC) and are available on the Trust Intranet. There have been challenges due to national supply problems with several antibiotics; alternative guidelines are available on the Intranet for this situation.

The AMT was also involved in the revision of primary care antibiotic guidelines approved by the Southwest Yorkshire area prescribing committee (Oct 2015)

NICE Guidance:
Nice Medicines Practice Guideline (NG15) on "Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use" was published, the team has assessed the Trusts adherence to the guideline using the baseline assessment tool. CHFT is compliant in all areas except one aspect relating to training which is being addressed.

Quality Improvement work:
Several projects have been supported by the antimicrobial management team through engagement with junior doctors Quality improvement work around antibiotic prescribing, principally undertaken within Surgery & Anaesthetics and Medical Divisions.

- Medicine - Ward 5, HRI – Audit of Antimicrobial Stewardship "Start Smart – then Focus". Over 95% were compliant with Trust guidelines and had an indication prescribed and 83% had a documented stop date.
- Surgery- Audit of Surgical Wards (3, 10, 15, 22 & SAU), closely supported by vascular surgeons. This was trialling the use of a visual sticker to prompt review of 5 key areas including antibiotics for every patient every day on ward rounds. The audit showed a global improvement using the sticker. This has led to the development of the "Every Patient Every Day" tool which has been

cascaded out across the surgical division, and is being re-audited and evaluated.

A celebration event was held, where the work was presented and certificates given to the Junior Doctors involved, a report was also presented in the trust Newsletter.

Following Datix incidents, a poster for penicillin allergy and empiric antibiotics in surgery was drafted. These have been laminated and installed in key prescribing wards.

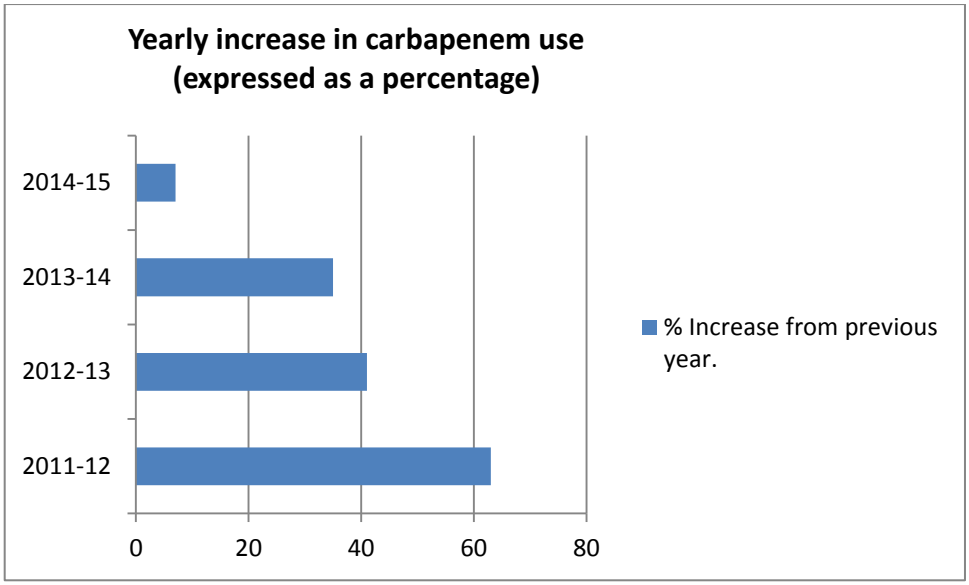
Outpatient Parenteral Antibiotic Therapy (OPAT) antibiotics:
An OPAT service is provided for Kirklees and Calderdale patients for up to 12 antibiotic administrations per day in each community area. A multi-disciplinary health economy-wide project group has continued to meet regularly. There is now a single OPAT pathway to guide clinicians on assessing suitable patients. The service has adapted and more than 20 antibiotics and methods of administration have been used for OPAT patients. Patients have a weekly "virtual" review by a multi-disciplinary team led by a Consultant Microbiologist.

The service has accepted 1199 patients from April'13-Oct'15 leading to a potential saving of 8088 bed days with 484 admissions avoided.

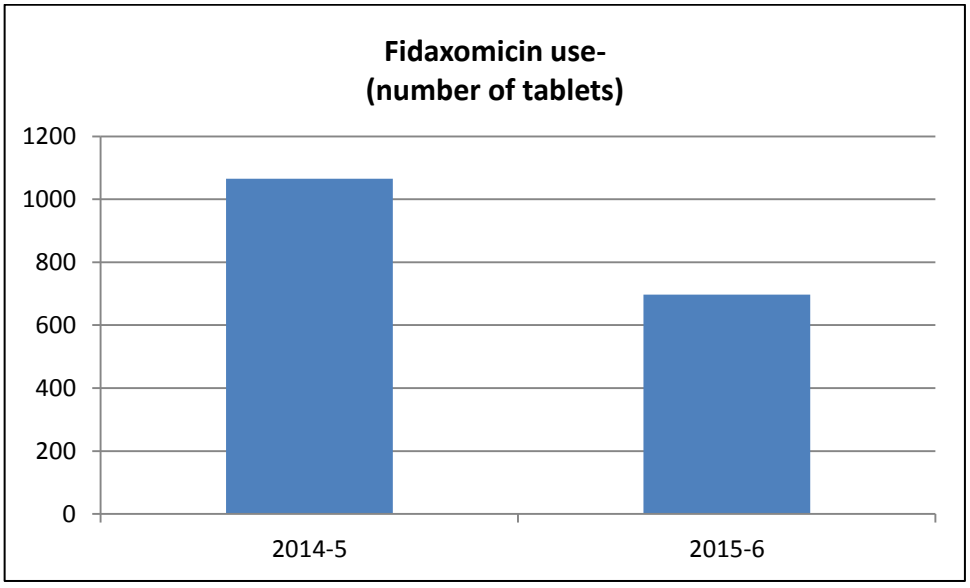
The Trust has also participated in an NIHR funded study, 'CIVAS' which was evaluating patient preferences for and cost effectiveness of intravenous community antibiotics. We have met our recruitment target for this.

Monitoring antibiotic usage:
Inpatient antibiotic usage is monitored and discussed quarterly. In particular, we have closely monitored our carbapenem (Meropenem and Ertapenem) use due to continued national concerns regarding Carbapenemase producing Organisms (CPOs). There has been a 41% increase in the use of carbapenems at CHFT since 2013. This is compared to a 37% increase nationally since 2010. Contributing to this is the increase in Ertapenem for patients on OPAT. Review of patients on carbapenems has been a focus of the consultant microbiologist-led antibiotic ward rounds to ensure appropriate use and timely step-down/de-escalation. As a result, we are seeing a reduction in the year-on-year increase.

The PHE-led regional surveillance survey identified 4 CPOs from CHFT (76 in Yorkshire and Humber) over October 2014-March 2016. All CHFT isolates were identified on screening.



Using DEFINE data on regional antimicrobial prescribing, we were identified as high users of Fidaxomicin compared to other Trusts in the Yorkshire Region in Feb 2015. This antibiotic is used for the treatment of *C.difficile* Infection



We reviewed our clinical guidelines on the use of Fidaxomicin and there has been a 35% reduction in use, and this along with reducing the quantity dispensed (to minimise wastage), has achieved a cost saving of £29k without any impact on patient care.

Monitoring antibiotic resistance:

This is done annually from laboratory reported data. Resistance data from *E. coli, Pseudomonas aeruginosa* and *Klebsiella pneumoniae* isolates from blood-cultures to various antibiotics is collected. CHFT resistance rates remain stable and lower than the reported national rates. E. coli resistance to antibiotics co-amoxiclav and piperacillin-tazobactam has shown a slight increase compared to previous years and this continues to be monitored. Carbapenem resistance in enterobacteriacea from blood-cultures has not been reported so far.

Education and Training:

Education and Training is provided in a number of ways and aimed at different professional groups including Medical staff (Trust-wide Junior Doctor Inductions, Anaesthetic registrar teaching, Orthopaedic registrar teaching, Trust-wide consultants, clinical audit meetings), multi-disciplinary events (Health-care associated infections (HCAI) champions events, Infection Control Link Practitioners Workshops), the pharmacy team and to our potential future staff (third and fifth year Medical students)

Antibiotic Awareness Week - November 2015:

This year's theme focussed on recruiting Antibiotic Guardians across the Trust, staff members and members of the public were invited to choose one simple pledge about how they will make better use of antibiotics and help save these vital medicines from becoming obsolete. The antibiotic pharmacists and microbiologists worked in collaboration with the infection control staff, and "Pledge Walls" were created in the Learning Centres on both Trust sites. There was an article in the Trust newsletter and an antibiotic quiz to further raise awareness.

Safety of Antibiotic Prescribing:

Root Cause Analysis

There is Microbiologist and/or Pharmacist attendance at *C. difficile* root cause analysis (RCA) and MRSA post infection review (PIR) meetings. Learning related to antibiotic prescribing from these RCAs is disseminated, as required.

Electronic Prescribing:

The Consultant Microbiologists and Antibiotic Pharmacist have advised the team developing the Electronic Patient Record.

Audits:

MRSA Suppression treatment – January 2016 showed all patients audited had appropriate suppression treatment prescribed promptly and good use was made of the Infection Control Nurses PGDs (Patient Group Directive).

Clinical Indication/Stop review for antibiotic prescribing audit in November 2015 showed adherence to indication specified on inpatient prescription chart 75.6% and stop/review 62.6%. Historical data collected in May 2011 showed adherence to indication specified on inpatient prescription chart 59% and stop/review 63%. Between 2011 and 2015 adherence to Indication specified has shown a sustained improvement from 50% to 90%, however stop/review specified has fluctuated from 63-80.5%.

Candidaemia audit this looked at the management of candidaemia from 2011-2014 at CHFT and findings were presented at the pathology audit meeting in 2015. The laboratory standards were met but we were not compliant with clinical standards. Since this audit CHFT guidelines on the management of candidaemia have been approved.

Antimicrobial Ward Rounds:
The Consultant Microbiologists continue to carry out both regular (ICU, W3, W12) and targeted (supported by infection control and pharmacy) ward rounds. We prioritise review of complex patients, and those on carbapenems, fidaxomicin/with clostridium difficile or on prolonged courses of intravenous antibiotics.

Key Challenges in 2015-6:
There have been challenges due to national supply problems with several antibiotics, alternative guidelines have been developed for if this situation occurs.

Antimicrobial Pharmacist – there has been a six month gap in full time cover as one postholder (0.5wte) left the Trust. A new pharmacist has been recruited (0.5wte), and is currently on maternity leave.

7. Decontamination

The Choice Framework for Policies and Procedures (CFPP) is a suite of best practice guidance that has replaced the Health Technical Memorandum (HTM) and details principles on the management and decontamination of surgical instruments.

A safe decontamination service contributes to successful clinical outcomes and the wellbeing of patients and staff. The trust is required by law to comply with essential levels of safety and quality which are assessed by the CQC. These levels are set in law through registration requirements, one of which covers cleanliness and infection control.

CFPP draws on current advice to provide comprehensive guidance on the management and decontamination of surgical instruments used in acute care, which includes clear definitions of what constitutes Essential Quality Requirements (EQR) and Best Practice (BP).

The Trust receives its decontamination service from a third party provider, BBraun Sterilog Yorkshire Limited. They use British and European Standards to demonstrate compliance with the essential requirements of the Medical Devices Directive (MDD 2007/47/EC) and have a quality system in place, ISO13485 against which they are independently audited by the British Standards Institute (BSI). This therefore offers assurance to the Trust that the service delivered is safe and achieves recognised standards.

Within the Decontamination Services Agreement (DSA) there are key performance indicators (KPIs) associated with logistics, quality outcomes and turnaround times that are embedded to ensure the delivered service continues to meet the Trust needs and expectations. The KPI's also ensure national and international guidelines and recommendations are met.

BBraun Sterilog Yorkshire Limited is recognised as having validated processes and as such is fully compliant against all guidelines as detailed via the National Decontamination programme where independent verification by the British Standards Institute (BSI) confirms compliance by a six-monthly review audit and certificated accordingly.

The operating reporting structure for the remainder of the contract term is as follows:

a) Joint Management Board (JMB) (strategic) comprising of the three partnering Trusts & Braun, currently Chaired by C&HFT.
b) Project Board (PB) (strategic) comprising of the partnering Trusts and Chaired as above.
c) Technical Review Committee (operational) comprising representatives of the three Trusts & Braun with the Contract Manager Chairing the committee.
d) Service Review Meeting (operational) comprising CHFT stake holders & Braun and is Chaired by the Decontamination Manager.

Day to day service delivery is monitored within the organisation to ensure the service maintains a fit for purpose status.

Endoscopy

The centralised endoscopy units at HRI and CRH have been designed and built to meet all relevant and current standards of build including Mechanical and Electrical services.

These state of the art units provide a first class, decontamination compliant, JAG certificated service to our patients who can be confident the level of care delivered is supported by a rigorous audit regime associated with the service delivery.

The environment in which decontamination is carried out should be one that minimises both the risk of recontamination of flexible scopes and the possibility of generating aerosols. This implies the use of a separate room or rooms for the accommodation of clean (output) and dirty (input) work. These rooms are built into the endoscopy units and are used for this purpose only and access restricted to those staff performing decontamination duties or maintenance regimes.

The policy and guidance specifically designed for flexible endoscope reprocessing CFPP 01 – 06 is driven by the aim of ensuring progressive improvement in decontamination performance both in centralised facilities and at a local level giving a continuous reduction in infection rates from both conventional (virus, bacterial fungi and spores) and prion infection disease.

The guidance provides options to flexible endoscope decontamination practices within which choices may be made and a progressive improvement programme established. Coordinated use of the guidance across the quality inspection processes will help the Trust to achieve a satisfactory level of risk control

together with equivalent compliance with the "Essential Requirement" of the Medical Devices Regulations.

Additionally, further independent monitoring carried out by the Joint Advisory Group (JAG) which is recognised as a pathway of quality improvement, where acceptable standards for endoscopy units are continually met, and assurance that endoscopy training and quality are consistently achieved and therefore the patient experience and outcomes are of the standard expected.

A planned project to replace the equipment associated with decontamination i.e. Automated Endoscope Reprocessors, (AER's) Reverse Osmosis water treatment plants (RO) and Drying Cabinets is planned to take place in 2017. The project will take account of the need to ensure that effective measures to reduce disruption to patient care during the replacement programme are understood and managed via the provision of an on-site temporary decontamination facility that meets current standards.

ENT

ENT Naso-endoscope reprocessing is carried out at the Huddersfield Royal Infirmary (Acre Mill) via a state of the art unit using automated processes with independent validation at the heart of the process. Calderdale Royal Hospital currently reprocess locally in the ENT OPD area where manual cleaning takes place after each patient use followed by a daily high level disinfection via the Endoscopy unit daily, which complies with the essential quality requirements of the CFPP guidance for this flexible scope type.

Review of Services

A review of reusable medical device decontamination compliance is being undertaken during 2016 and a decontamination committee responsible for overseeing compliance to assure a consistency of approach across the Trust is being established, and will meet for the first time on 27th June 2016.

8. Cleaning Services

The provision of cleaning services continues to be delivered by both an in-house service at HRI, Broad Street Plaza and Beechwood Community Health Centre and an outsourced service under the PFI (Private Finance Initiative) agreement by ISS Facilities Healthcare Services at CRH and Princess Royal Community Health Centre (PRCHC). A 24-hour Rapid Response Team continues to be provided at CRH and HRI for out of hours cleaning at both sites.

The Infection Prevention Quality Improvements audits continue to be successful in driving improvements across the Trust. This was updated 2015-2016 driven by changes to PLACE (Patient led Assessments of the Care Environment) and CQC guidance.

The Front line Ownership (FLO) whereby nursing staff at three different levels assess compliance with 10 key infection control areas quickly using a standardised tool, continues to be used and has been adapted as needs required. Ward and Department Managers assess their areas weekly and report their finding to their Matron. Matrons provide a further monthly check. This helps to identify issues quickly and strengthens the assurance process.

Performance management systems are in place with key performance indicators produced on a monthly basis in line with the national specification for cleanliness. The monthly scores are displayed in each ward/department's infection control notice board for public viewing.

Through the service performance report any concerns raised relating to cleaning are reported at the Estates and Facilities Quality and Safety Board and for the CRH site at the PFI Service Performance meeting.

The Trusts Service performance team also monitors cleaning on both the HRI and CRH site using an adapted version of the FLO. Schedule 2 monitoring audits are also performed by the Service Performance Team at CRH in accordance with the PFI concessions agreement but do not audit against the 49 elements.

The Facilities Matron continues to work closely with all disciplines including cleaning services across both hospital sites and is the link between clinical and non-clinical teams. The matron attends the Trust Infection Control Committee as the Estates and Facilities representative.

Hydrogen Peroxide Vapour (HPV), a powerful bio-decontamination agent which reduces the biomass in the built environment, has continued to be used. The service continues to be funded this financial year and for 2016-2017. The reactive service remains to be operated in house by cleaning services staff on both hospital sites primarily to provide high level decontamination of isolation rooms. HPV is used in the final decontamination of a clinical area after discharge of an infected patient to ensure the room is safe for the next patient.

HRI received accreditation in October 2015 as a training centre to deliver British Industry of Cleaning Science (BICSc) cleaning methods and safe systems of work. Four members of cleaning services gained a BICSc licence to practice allowing them to deliver and assess BICSc training to all members of cleaning services. This will ensure a consistent method of cleaning is delivered to all areas at HRI. Working with BICSc HRI will implement Cleaning Industry Management Standards (CIMS) as their quality management system. All functional areas have been risked assessed using guidance from the PAS 5748 document and resource requirements measured against ISSA productivity rates, this has developed a workforce planner in the department that ensures a measured amount of resource is used in all areas and they are cleaned to the minimum cleaning frequency and meet the required standards to ensure a clean, safe environment is produced and maintained.

A revised combined audit system is to be developed through 2016/17 and providers are now being sought to deliver this system: this will ensure CHFT are utilising the latest innovations to measure its cleaning standards.

9. Estates

The trust continued with environmental improvements during 2015/2016 to both public and clinical areas; improvement works include:

- Improving disabled access to the Day Surgery Unit (DSU)
- Decommissioning of the underground diesel oil tanks in line with environmental guidelines
- Window replacement above A&E and Main Entrance
- Redecoration works of main corridors and departments in vibrant colours in line with wayfinding policy
- Improving segregation of the laundry and improved access to the sewing room

In addition, work has continued on the site infrastructure in order to provide a safe environment that is compliant with HTM requirements, improvement works include:

- Emergency Lighting
- Refurbishment of staff residence
- Roof repairs
- Repairs to the building façade
- Structural Repairs

Ward Upgrades Programme

The Ward refurbishment programme continued with works being completed on ward 7 at HRI, to create a mixed gender Oncology Out Patients Department and Chemotherapy Unit.

In addition, replacement flooring and redecoration was carried out in the A&E department to provide an improved patient environment.

Theatre Upgrade Programme

The Theatre upgrade programme continued with theatre 3, which was completed in July 2015. The upgrade of theatre 1 also started in January 2016 and is due to complete in May 2016.

Fire Compartmentation

The Trust embarked on a 4 year programme to improve fire compartmentation throughout HRI, starting with the high risk areas.

Estates

The estates team has worked through the action plan following the independent compliance audit for engineering services in 2015/16 to ensure full compliance with CQC requirements.

Waste management continues to be well managed across both CRH and HRI Sites. A trial has started "Bag to Bedside" to reduce bins in clinical areas in so reducing clutter and noise. Improvements to segregating waste streams have also continued. Work was completed on the stores yard at HRI to aid the segregation of waste.

The Water and Air management group ensure scrutiny and ensure clinical governance arrangements for both systems. Audits are continuing by the associated Authorising Engineers to ensure compliance with HTM standards.

Patient-led Assessments of the Care Environmental (PLACE)

PLACE assessments allow members of the public to go into hospitals as part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The results are reported publicly to help drive improvements in the care environment. The Divisions continue to review and further improve performance across all criteria which will be reflected in the PLACE assessment for 2016/17. The findings from the PLACE inspection for 2015/16 were:-

Huddersfield Royal Infirmary (HRI)

Site	Cleanliness (%)	Food (%)	Privacy, Dignity and Wellbeing (%)	Condition, Appearance and Maintenance (%)
HRI	99.11	83.58	90.80	93.80
National Average	97.57	88.49	86.03	90.11
Variance	+1.54	-4.91	+4.77	+3.69

Calderdale Royal Hospital (CRH)

Site	Cleanliness (%)	Food (%)	Privacy, Dignity and Wellbeing (%)	Condition, Appearance and Maintenance (%)
CRH	98.00	74.22	89.44	94.93
National Average	97.57	88.49	86.03	90.11
Variance	+0.43	-14.27	+3.81	+4.82

10. Infection Prevention and Control Audit Programme

The audit programme for 2014/15 was completed and all action points were taken to the HAI Operational group (now known as the PIIP group) for follow-up. This programme included:

- Urinary Catheter annual prevalence audit
- Peripheral Venous Cannula prevalence audit
- Isolation audit
- Commode audit
- Sharps disposal

The Infection Prevention and Control Team (IPCT) are involved in the Quality Improvements audits which are undertaken on an unannounced basis in all clinical areas. The development of this process has interlinked services to provide a cohesive joined-up service; this is led by the Service Performance team.

The annual Hand Wash Roadshow (HWRS) was carried out across the Trust in the acute settings of Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) during the 7th to the 18th September 2015 by the IPCT. All wards and departments across both hospital sites were visited to highlight good hand hygiene technique and frequently missed areas when performing hand hygiene. Staff were shown hand / skin care by the use of a hydrometer. Agar plate sampling of unwashed hands was also undertaken. The aim of the IPCN team is to highlight areas of good practice and by the use of visual aids, provide information and feedback to staff of agar plate sample results and the adherence to the principle of bare below the elbows (BBE), as specified in the Hand Hygiene policy.

In this year's roadshow, 369 staff were reviewed at HRI and 391 at CRH, a total of 760 staff. The overall compliance with BBE across the trust was 81 %.

11. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2015/16:

Section A	Infection Control Arrangements Policy
Section B	Notifiable Diseases Policy
Section C	Standard IC Precautions Policy
Section D	Meningococcal Disease Policy
Section F	Decontamination & Disinfection Policy
Section G	Aseptic Technique Policy
Section H	Hand Hygiene Policy
Section K	Isolation Policy
Section M	Management of Clinical Sharps Injuries inc BBV Policy
Section P	Care of the Deceased Patient Policy
Section R	Specimen collection Policy
Section S	TB Policy
Section T	MRSA inc PVL Policy
Section W	Bed management Policy
Section X	Pet Policy
Section Z	Blood Culture Policy

12. Education and training

Annual updates on Infection Prevention and Control are mandatory for all staff and are delivered via an online training package that includes questions to assess knowledge and understanding.

The Bi-annual face-to-face update sessions continue with 1578 staff having attending 'Beyond the basics' and 434 'Right from the start'.

Mandatory face to face training for permanent medical staff has been introduced. This is delivered on a monthly basis by the Infection Prevention and Control doctor, in addition to bespoke sessions for clinical teams upon request.

The IPC team consider training and education a core activity key to the success of ensuring a knowledgeable workforce and effective infection prevention on clinical practice; this includes both clinical and non-clinical staff. Content is tailored to the needs of specific staff groups that are identified through the training strategy as well as audit and surveillance outcomes.

Face to face bespoke training is delivered by the IPC team as and when requested by wards and departments, enabling maximum opportunity for local learning to be fed back into training. IPC support is provided as and when required on wards and departments.

The Trust has a well-established Link Infection Prevention Control Practitioners in each clinical area, including community settings. Quarterly educational workshops are held for link workers to enhance the knowledge and skills in order to fulfil the role. Link workers perform regular audits of infection control standards. On-going support is provided to the link practitioners' as well as ward and department managers.

A training programme for third and fifth year student doctors was supported by the IPC Team.

Training for IPC Specialists: - the IPC Team members have attended national and local conferences and courses to facilitate their continuing pro

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 28th July 2016	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Board Report - The Board is asked to receive and approve the Integrated Board Report for June 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 and Quality Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Domain
Safe
• Harm Free Care - Performance decreased this month. A number of pieces of work looking to reduce at falls and pressure ulcer reduction have commenced.
• Maternity - % PPH 1500ml - Previously month's Improvements not sustained during June, continues to be monitored closely.

Effective
• Hospital Acquired Infections - There were no avoidable HAIs in June.
• Perinatal Deaths (0-7 days) - at 0.41% are above the 0.1% target. A New SOP for Perinatal deaths and quarterly reports have been produced. Perinatal mortality group meet monthly to review cases and feedback learning. All perinatal deaths are logged on datix as an incident and fully investigated.
• Local SHMI - Relative Risk (1yr Rolling Data January 15 - December 15) 113.88 - The two diagnostic groups that are negative outliers are Acute Cerebrovascular Disease and Pneumonia. There is an improvement plan in place to address both of these. A new piece of work with CCG is in place to undertake joint mortality reviews on patients who die within 30 days of discharge.
• Hospital Standardised Mortality Rate (1 yr Rolling Data April 15 - Mar 16) 111.6 - Trust predicts further modest reductions in the coming months.
• Mortality Reviews - The completion rate for Level 1 reviews has improved and is in line with previous performance levels of just under 50%. More consultant level one reviewers are being recruited and the programme is anticipated to be consultant led in the future.
• Crude Mortality Rate - has dropped considerably to 1.32% for June 16.
• Average Diagnosis per Coded Episode - Improvements in month continue.
• Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge improved to 75% against 85% target. In June 18 of 24 people received an operation within 36 hours. There were 3 clinical breaches and 3 organisational breaches. RCAs are carried on all breaches.

Caring
• Only 33% of complaints were closed within timeframe against a target of 100%. This is the lowest position in the last 12 months but is a consequence of focused effort on reducing overdue complaints. 70 complaints were close in June which is the highest for a number of months.
• Friends and Family Test Outpatients Survey - % would recommend is stabilising at 90- 91% against a target of 95%. Improvement plans are in place around car parking and clinic waiting times.
• Friends and Family Test Community Survey - 85% would recommend the Service against 96.2% target. A more in death survey is now being developed to gain further insight into the drivers behind these responses.

Responsive
• Emergency Care Standard 4 hours. June's position saw 95.07% patient seen within 4 hours, the best position for a number of months. The Trust secured a quarter one position of 94.1% and are seeking to achieve 95% month in month for Q2
• % Daily Discharges - Pre 12pm. 23% in month against 40% target. However the anticipated month on month improvement of 10% per month has not been seen and the 40% is remains challenging. Currently undergoing small tests of change to improve compliance
• Green Cross Patients (Snapshot at month end) remains high at 94 patients, discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care.
• Stroke – improvements noted in all indicators and ongoing work to achieve full compliance continues.90% stay on stroke ward now at 87.50% and 100% of stroke patients were thrombolysed within an hour.
• % Last Minute Cancellations to Elective Surgery - Improved to 0.56%
• RTT pathways over 26weeks lowest in 6 months. Father reduction needed and validation continues.

• 38 Day Referral to Tertiary has deteriorated to 38% against 85% target. Action plans being worked through with a requirement to achieve by July reflecting changes to reporting rules from Q3.

Workforce
• Sickness Absence rate continues to fall to 4.1% against 4% target the lowest position for over 12 months with improvements across all divisions. Within this long term sickness is 2.9% against 2.7% with the short term 1.24% against 1.3% target also the lowest position in the last 12 months.
• Return to work Interviews are a key contributor to effective sickness management and are running at an improved position on last month of 44% but still some way short of 100% target.
• Mandatory Training and appraisal compliance remains a challenge. Appraisal training proposal paper received at the Education Learning Group in June 2016.

Efficiency/ Finance
• Year to date: Financial position stands at a deficit of £5.02m, a favourable variance of £0.15m from the planned £5.17m. In month, the Trust has seen a strong performance against the clinical activity contract, driven primarily through non elective, A&E and outpatients. However to deliver activity and access standards and maintain nurse staffing ratios the Trust continues to rely heavily upon agency staffing to cover clinical vacancies driving a continued pay overspend. Total agency spend in month was £2.3m, a slight fall on last month but above the NHSI trajectory.
• Theatre Utilisation has stabilised around 83% with room for further improvement due to insufficiently filled lists and large number of patient cancellations.

CQUIN
• Sepsis - % of patients Screened (admission Units) - On plan to hit 3 out of 4 Q1 targets, risk in achieving 90% of patients screened following an admitted to an admission unit in Q1. . ED staff have identified a way to ensure that all staff have a trigger to 'think sepsis' during triage. The pathway and triggers for those patients who present directly to MAU/SAU is next to be improved and engagement with colleagues in those areas is underway.

Activity
• Planned day case and elective activity performance has worsened and is 1.2% above the month 3 plan. This continues to be driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall is 2.6% above the month 3 plan which is an increase in admissions from May. The over-performance is mainly within emergency short stay but an increase in long stay admissions has also been seen. A&E has seen activity 2.4% above the month 3 plan which is a continued over-performance but a reduction from that seen in month 2. Outpatient activity has continued to see a further significant increase across first and follow-ups and is 6.7% above the month 3 plan.

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 June 2016

Appendix

Attachment:

IPR Board Report June 2016.pdf

Board Report

June 2016

Executive Summary

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

Area	Domain
Safe	• **Harm Free Care - P**erformance decreased this month. A number of pieces of work looking to reduce at falls and pressure ulcer reduction have commenced. • **Maternity - % PPH ≥ 1500ml - Previously month's** Improvements not sustained during June, continues to be monitored closely.
Effective	• **Hospital Acquired Infections -** There were no avoidable HAIs in June. • **Perinatal Deaths (0-7 days) -** at 0.41% are above the 0.1% target. A New SOP for Perinatal deaths and quarterly reports have been produced. Perinatal mortality group meet monthly to review cases and feedback learning. All perinatal deaths are logged on datix as an incident and fully investigated. • **Local SHMI - Relative Risk** (1yr Rolling Data January 15 - December 15) 113.88 - The two diagnostic groups that are negative outliers are Acute Cerebrovascular Disease and Pneumonia. There is an improvement plan in place to address both of these. A new piece of work with CCG is in place to undertake joint mortality reviews on patients who die within 30 days of discharge. • **Hospital Standardised Mortality Rate** (1 yr Rolling Data April 15 - Mar 16) 111.6 - Trust predicts further modest reductions in the coming months. • **Mortality Reviews** - The completion rate for Level 1 reviews has improved and is in line with previous performance levels of just under 50%. More consultant level one reviewers are being recruited and the programme is anticipated to be consultant led in the future. • **Crude Mortality Rate** - has dropped considerably to 1.32% for June 16. • **Average Diagnosis per Coded Episode -** Improvements in month continue. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge improved to 75**% against 85% target. In June 18 of 24 people received an operation within 36 hours. There were 3 clinical breaches and 3 organisational breaches. RCAs are carried on all breaches.
Caring	• **Only 33% of complaints were closed within timeframe against a target of 100%.** This is the lowest position in the last 12 months but is a consequence of focused effort on reducing overdue complaints. 70 complaints were close in June which is the highest for a number of months. • **Friends and Family Test Outpatients Survey** - % would recommend is stabilising at 90- 91% against a target of 95%. Improvement plans are in place around car parking and clinic waiting times. • **Friends and Family Test Community Survey** - 85% would recommend the Service against 96.2% target. A more in death survey is now being developed to gain further insight into the drivers behind these responses.

Background Context

June was another busy month for non-elective activity; a position reflected across West Yorkshire. AED attendances are high with evening surges increasing in frequency and there is an increasing pressure in General Surgery where non-elective demand is exceptionally high.

Despite the non-elective pressures in AED conversion rates to admission are below plan, this conversion rate improvement correlates with ECS delivery.

The system DTOC group has expanded its scope to ensure focus on the non reportable delays which remain high and continue to drive high bed occupancy rates.

Elective activity continues with some peaks and troughs in admission profiles resulting in bed pressures early in the week .

Despite continuation of elective activity the waiting list is growing, work on validation has commenced to ensure data quality is robust and pre EPR capacity increases are being planned to ensure no performance risk. In several specialties demand continues to increase most noticably Ophthalmology, ENT, Cardiology the latter 2 more pronounced in Calderdale GPs

Improvement plans are in place for several areas of risk and the new Divisional PRM process went live in June with good initial feedback around process and discussion. All Divisional action plans will be monitored by the Executive through this route to enable triangulation.

Dr Mohamed Mohamed has been commissioned to undertake some specific work with the Trust around mortality

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours.** June's position saw 95.07% patient seen within 4 hours, the best position for a number of months. The Trust secured a quarter one position of 94.1% and are seeking to achieve 95% month in month for Q2 • **% Daily Discharges - Pre 12pm.** 23% in month against 40% target. However the anticipated month on month improvement of 10% per month has not been seen and the 40% is remains challenging. Currently undergoing small tests of change to improve compliance • **Green Cross Patients (Snapshot at month end)** remains high at 94 patients, discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care. • **Stroke -** Improvements noted in all indicators and ongoing work to achieve full compliance continues.90% stay on stroke ward now at 87.50% and 100% of stroke patients were thrombolysed within an hour. • **% Last Minute Cancellations to Elective Surgery -** Improved to 0.56% • **RTT pathways over 26weeks** lowest in 6 months. Father reduction needed and validation continues. • **38 Day Referral to Tertiary has deteriorated to 38%** against 85% target. Action plans being worked through with a requirement to achieve by July reflecting changes to reporting rules from Q3.
Workforce	• **Sickness Absence rate continues to fall to** 4.1% against 4% target the lowest position for over 12 months with improvements across all divisions. Within this long term sickness is 2.9% against 2.7% with the short term 1.24% against 1.3% target also the lowest position in the last 12 months. • **Return to work Interviews** are a key contributor to effective sickness management and are running at an improved position on last month of 44% but still some way short of 100% target. • **Mandatory Training and appraisal** compliance remains a challenge. Appraisal training proposal paper received at the Education Learning Group in June 2016.
Efficiency/ Finance	• **Finance:** Year to date: Financial position stands at a deficit of £5.02m, a favourable variance of £0.15m from the planned £5.17m. In month, the Trust has seen a strong performance against the clinical activity contract, driven primarily through non elective, A&E and outpatients. However to deliver activity and access standards and maintain nurse staffing ratios the Trust continues to rely heavily upon agency staffing to cover clinical vacancies driving a continued pay overspend. Total agency spend in month was £2.3m, a slight fall on last month but above the NHSI trajectory. • **Theatre Utilisation has stabilised around 83% with** room for further improvement due to insufficiently filled lists and large number of patient cancellations.
CQUIN	• **Sepsis - % of patients Screened (admission Units)** - On plan to hit 3 out of 4 Q1 targets, risk in achieving 90% of patients screened following an admitted to an admission unit in Q1. . ED staff have identified a way to ensure that all staff have a trigger to 'think sepsis' during triage. The pathway and triggers for those patients who present directly to MAU/SAU is next to be improved and engagement with colleagues in those areas is underway.
Activity	• Planned day case and elective activity performance has worsened and is 1.2% above the month 3 plan. This continues to be driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall is 2.6% above the month 3 plan which is an increase in admissions from May. The over-performance is mainly within emergency short stay but an increase in long stay admissions has also been seen. A&E has seen activity 2.4% above the month 3 plan which is a continued over-performance but a reduction from that seen in month 2. Outpatient activity has continued to see a further significant increase across first and follow-ups and is 6.7% above the month 3 plan

Background Context

Additional beds were closed for most of June, some small peaks required a short injection of capacity but Divisions worked hard to close this quickly.

Staffing remains a challenge with increased focus on good roster management and in hours planning. A decision to centralise all Flexible workforce capacity was agreed and the implementation of this is being expedited.

Standard Operating Protocols (SOPs) have been developed to increase controls on agency usage and a full review of all posts with agency attributed has been undertaken.

The vacancy control process has been improved with clinical, operational and financial input reviewing requests weekly so a maximum of 7days between decision points and identifying trends where delays occur

Within the Community services division two senior clinicians have been supporting the SAFER patient flow programme and are leading pieces of transformation work that will support reducing hospital admission, reducing length of stay and improving flow through the medical and rehabilitation wards.
The division is looking at better ways of communication and is going to introduce a divisional twitter account over the next month.

The development of Hospital @ Night and 7/7 services continues but has required a refocus on engagement to ensure fully inclusive

Outpatients are busy with actions related to the CIP scheme on clinic utilisation delivering results as activity across first and follow-ups is above the month 3 plan. Divisions continue to drive through the implementation of their CIP plans including active involvement in the Safer programme and development of responses to the Carter review.

A system Transformation Board has been established with CIP & QIPP plans shared and priorities identified. Ensuring robust clinical and operational input to CCG QIPP schemes is essential and is being developed through clear Terms of Reference. The connection with Local Authority plans still requires development to ensure no duplication or unintended consequences.

In summary June has seen a significant improvement in Performance for the organisation with the overall Performance Score moving from 56% in May to 64% (see page 5).
The Trust achieved all of its Regulatory Targets in month with the following areas moving from Red to Green:
Total Number & avoidable number of Clostridium Difficile Cases
Emergency Care Standard 4 hours
62 Day Referral From Screening to Treatment

4 of the 6 domains improved their Performance Score in month most notably 'Responsive' which now has a Green rating.

A number of indicators had their best performance for some months including the Emergency Care Standard where we delivered the first green month since December15. Several Stroke metrics and cancelled operations.

Performance Summary

CHFT

Most recent month's performance

RAG Movement

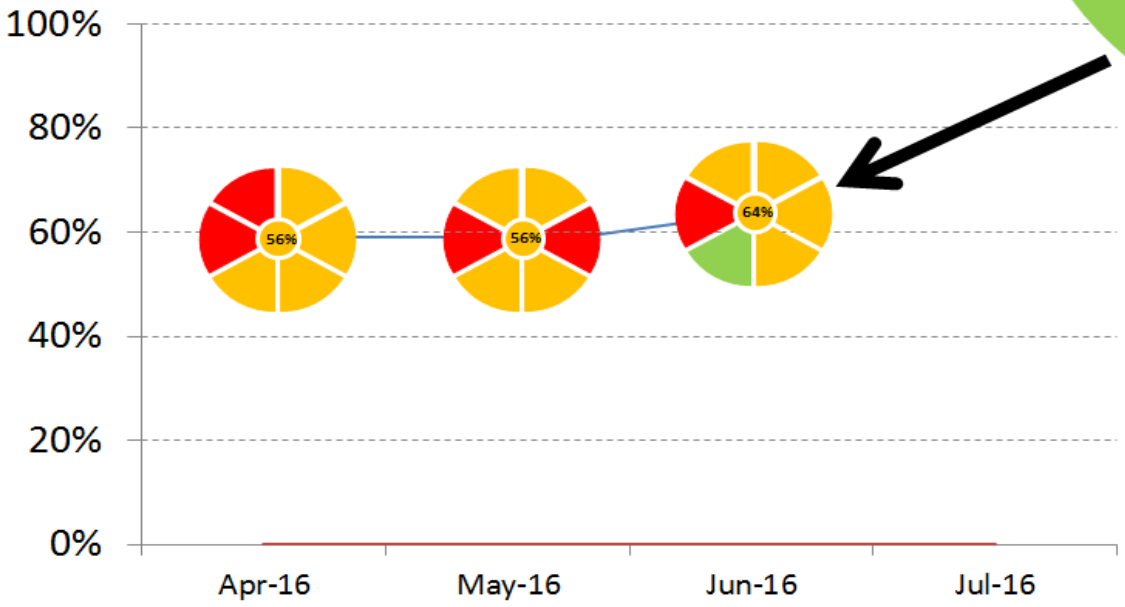
Within the **Effective** domain an improved performance within number of CDiff cases, number of E.Coli - Post 48 Hours, Stillbirths rate, Crude mortality rates and Emergency Readmissions for GH CCG have resulted in an improved AMBER rating.

Within the **Responsive** domain improved performance in the Emergency Care Standard, % Stroke patients spending 90% of their stay on a stroke unit, % Stroke patients Thrombolysed within 1 hour and 62 Day Referral From Screening to Treatment have resulted in a GREEN rating.

Regulatory Targets

CDiff Cases	Cancer 62 day Referral to Treatment
Avoidable CDiff	Cancer 62 day Screening to Treatment
ECS 4 hours	Cancer 31 day targets x3
RTT Incomplete Pathways	Cancer 2 Week Referral to Date first seen
Data Completeness Community Care x3	Cancer 2 week Breast Symptoms

Total performance score by month



June Score by Domain

Safe	56%
Effective	56%
Caring	70%
Responsive	80%
Workforce	36%
Efficiency & Finance	65%
Performance Score	**64%**

Other Key Targets

VTE Assessments	FFT targets x7
Never events	FFT A&E 88.56% (90%)
MRSA	FFT OP 90.6% (95%) Community 85% (96%)
SHMI 113.88 (100)	Stroke % admitted 4 hours 68.75% (90%)
HSMR 111.62 (100)	Diagnostics 6 weeks
Emergency Readmissions GHCCG 7.69% (7.05%)	Net surplus/ (deficit) 0.15
% Complaints closed 33% (100%)	Sickness 4.14% (4%)

Carter Dashboard

TREND ARROWS:
Red or Green depending on whether target is being achieved
Arrow upwards means improving month on month
Arrow downwards means deteriorating month on month.

		Current Month Score	Previous Month	Trend	Target
	#REF!	#REF!	#REF!		#REF!
CARING	Inpatient Complaints per 1000 bed days	2.1	2.2	↑	TBC
	Average Length of Stay - Overall	5.0	5.4	↑	5.17
	#REF!	#REF!	#REF!		5%
EFFECTIVE	Green Cross Patients (Snapshot at month end)	94	90	↓	40
	#REF!	111.60	#REF!		100
	Theatre Utilisation (TT) - Trust	83.85%	85.60%	↓	92.5%
	#REF!	#REF!	#REF!		0.6%
RESPONSIVE	#REF!	#REF!	#REF!		95%
	% Incomplete Pathways <18 Weeks	96.3%	96.0%	↑	92%
	62 Day GP Referral to Treatment	94.7%	88.4%	↑	85%
	#REF!	#REF!	#REF!		95.0%
SAFE	#REF!	#REF!	#REF!		495
	Number of Serious Incidents	4	6	↑	0
	Never Events	0	1	↑	0

MOST IMPROVED

Improved: Performance against the 4 hour standard has improved and reached the 95% target for the first time this year.

Improved: Sickness Absence rate have futher reduced to 4.14% against 4% target the lowest position for several months. Short term sickness is now below target at 1.24% against 1.3%.

Improved: Number of Outliers - Noticable improvement on the previous two months performance, with 838 outliers as opposed to 1363 the previous month. Still some way to target but improvement being seen.

MOST DETERIORATED

Deteriorated: Harm Free Care - the % of patients free of harm (not experienced either a fall, old or new pressure ulcer, a UTI (+catheter) or a VTE) has decreased this month. Poorer performance was driven by increases in the number of old pressure ulcers - (ulcers that are present on admission as opposed to being hospital acquired).

Deteriorated: Theatre Utilisation has deteriorated in month. This is impacted by on the day cancellations for both clinical and non clinical reasons.

Deteriorated: Vacancies - The vancancy increase is mainly attributable to additional posts that have recently been approved but recruitment has only just commenced. There are 10 Medical and Dental posts plus 18 Nursing.

ACTIONS

Action: Safety Huddles are being implemented across the hospital to ensure there is an increased awareness of patient who are at risk of harm. Surgical division has a plan in place to look at the Catheter related infections.

Action: Individual and Sub Specialty team discussions have taken place and there is a a refreshed Service Improvement Group with involvement of Membership Councillor to support us with our service improvement approach.

Action: Recruitment has commenced for all posts.

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	Available from Q2			
Sickness Absence Rate	#REF!	#REF!		4.0%
Turnover rate (%) (Rolling 12m)	#REF!	#REF!		12.3%
Vacancy	#REF!	#REF!		NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	82.00%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4	64.00%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	£1.31	£0.53	●
Expenditure vs Plan var (£m)	£1.41	-£0.78	●
Liquidity (Days)			
I&E: Surplus/(Deficit) var (£m)	£0.15	-£0.06	●
CIP var (£m)	£0.69	£0.02	●
FSRR	2	2	●
Temporary Staffing as a % of Trust Pay Bill			

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th July 2016	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 3 - FINANCIAL NARRATIVE - The Board is asked to approve the Month 3 Financial Narrative - June-July 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 26.7.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 3 Financial Narrative - June-July 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 3 Financial Narrative - June-July 2016

Appendix

Attachment:

FP TRUST Month 3.pdf

EXECUTIVE SUMMARY: Trust Financial Overview as at 30th Jun 2016 - Month 3

YEAR TO DATE POSITION: M3

	M3 Plan £m	M3 Actual £m	Var £m
Total Income	**£92.46**	**£93.77**	**£1.31**
Total Expenditure	**(£91.25)**	**(£92.66)**	**(£1.41)**
EBITDA	**£1.21**	**£1.11**	**(£0.10)**
Non Operating Expenditure	(£6.37)	(£6.13)	£0.25
Deficit excl. Restructuring	**(£5.17)**	**(£5.02)**	**£0.15**
Restructuring Costs	(£0.00)	£0.00	£0.00
Surplus / (Deficit)	**(£5.17)**	**(£5.02)**	**£0.15**

YEAR END 2016/17

	Plan £m	Forecast £m	Var £m
Total Income	**£371.52**	**£375.00**	**£3.48**
Total Expenditure	**(£361.96)**	**(£365.92)**	**(£3.96)**
EBITDA	**£9.56**	**£9.09**	**(£0.47)**
Non Operating Expenditure	(£25.66)	(£25.14)	£0.52
Deficit excl. Restructuring	**(£16.10)**	**(£16.06)**	**£0.05**
Restructuring Costs	(£0.00)	£0.00	£0.00
Surplus / (Deficit)	**(£16.10)**	**(£16.06)**	**£0.05**

KEY METRICS

	Year To Date			Year End: Forecast		
	M3 Plan £m	M3 Actual £m	Var £m	Plan £m	Forecast £m	Var £m
I&E: Surplus / (Deficit)	(£5.17)	(£5.02)	£0.15	(£16.10)	(£16.06)	£0.05
Capital	£4.10	£3.67	£0.43	£28.22	£27.61	£0.61
Cash	£1.94	£1.91	(£0.03)	£1.95	£1.90	(£0.05)
Borrowing	£44.00	£48.97	£4.97	£67.87	£67.51	(£0.36)
CIP	£1.78	£2.47	£0.69	£14.00	£14.04	£0.04
Financial Sustainability Risk Rating	2	2		2	2	

Year to date: The year to date financial position stands at a deficit of £5.02m, a favourable variance of £0.15m from the planned £5.17m. In month, the Trust has seen a strong performance against the clinical activity contract, driven primarily through non elective, A&E and outpatients. However, as has been the case in recent months, to deliver activity and access standards and maintain nurse staffing ratios the Trust continues to rely heavily upon agency staffing to cover clinical vacancies driving a continued pay overspend. Total agency spend in month was £2.3m, a slight fall on last month but above the NHSI trajectory and a significant draw on limited cash resources contributing to the need to bring forward borrowing.

The impact of this operational position is as follows at headline level:

- EBITDA of £1.11m, an adverse variance of £0.10m from the plan.
- A bottom line deficit of £5.02m, a £0.15m favourable variance from plan.
- Delivery of CIP of £2.47m against the planned level of £1.78m.
- Contingency reserves of £0.75m have been released against pressures.
- Capital expenditure of £3.67m, this is below the planned level of £4.10m.
- A cash balance of £1.94m in line with the planned level of £1.91m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

In the year to date, the activity over performance has driven overall income recovery in excess of plan by £1.31m. This, coupled with strong CIP delivery in the first quarter, has been sufficient to offset the pay expenditure pressures. Further pressure has been borne in the first quarter as a result of the Junior Doctors' strike action which impacted operational performance and consequently financial performance by £0.5m. Of the £2m contingency reserves, £0.75m has been released in the year to date, offsetting this pressure but reducing the potential to mitigate against the greater outstanding risks in the remainder of the year.

Forecast: Whilst the year to date position is favourable, the expenditure run rate brings ongoing pressure with particular risk around high agency expenditure and the cash challenge. CIP has delivered in excess of plan in the year to date but this is a timing difference which is not forecast to continue, indeed the higher risk schemes are forecast to commence delivery in the last 6 months. EPR implementation and the introduction of the new Junior Doctors' contract bring further uncertainty and risk. By design, they are not within the control total and therefore the I&E and cash implications are subject to ongoing conversations with NHSI. Acknowledging these risks, the year end forecast position continues to be to deliver the planned £16.1m deficit. Divisions are required to deliver recovery plans to mitigate against the risks and pressures. In addition, it is assumed that the Trust will achieve the conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the plan.

Trust Financial Overview as at 30th Jun 2016 - Month 3

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

YEAR TO DATE POSITION: M3

CLINICAL ACTIVITY

	M3 Plan	M3 Actual	Var
Elective	2,207	1,879	(328)
Non-Elective	12,856	12,777	(79)
Daycase	9,257	9,407	150
Outpatient	85,062	88,416	3,354
A&E	37,440	38,489	1,049
Other NHS Non-Tariff	390,467	414,120	23,653
Other NHS Tariff	28,995	31,422	2,427
Total	566,284	596,510	30,226

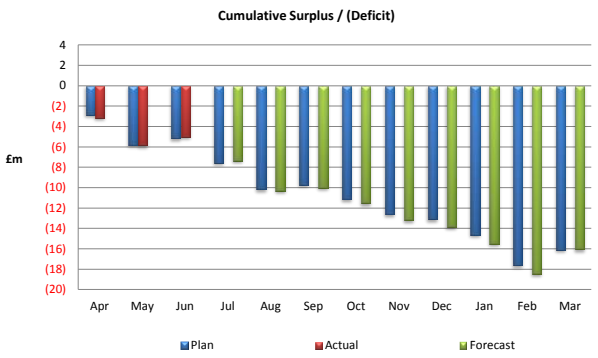
TRUST: INCOME AND EXPENDITURE

	M3 Plan	M3 Actual	Var
	£m	£m	£m
Elective	£5.64	£5.02	(£0.62)
Non Elective	£21.74	£22.24	£0.50
Daycase	£6.62	£6.67	£0.05
Outpatients	£10.87	£11.47	£0.60
A & E	£4.14	£4.30	£0.16
Other-NHS Clinical	£31.93	£32.96	£1.03
CQUIN	£1.68	£1.74	£0.06
Other Income	£9.83	£9.36	(£0.47)
Total Income	**£92.46**	**£93.77**	**£1.31**
Pay	(£60.11)	(£61.01)	(£0.90)
Drug Costs	(£8.73)	(£8.64)	£0.09
Clinical Support	(£7.68)	(£7.85)	(£0.17)
Other Costs	(£11.72)	(£12.16)	(£0.44)
PFI Costs	(£3.01)	(£3.01)	£0.00
Total Expenditure	**(£91.25)**	**(£92.66)**	**(£1.41)**
EBITDA	**£1.21**	**£1.11**	**(£0.10)**
Non Operating Expenditure	(£6.37)	(£6.13)	£0.25
Deficit excl. Restructuring	**(£5.17)**	**(£5.02)**	**£0.15**
Restructuring Costs	(£0.00)	£0.00	£0.00
Surplus / (Deficit)	**(£5.17)**	**(£5.02)**	**£0.15**

DIVISIONS: INCOME AND EXPENDITURE

	M3 Plan	M3 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£4.47	£4.76	£0.29
Medical	£5.98	£5.82	(£0.16)
Families & Specialist Services	(£1.12)	(£1.31)	(£0.19)
Community	£1.09	£0.91	(£0.19)
Estates & Facilities	(£6.72)	(£6.61)	£0.12
Corporate	(£6.11)	(£6.12)	(£0.01)
THIS	£0.10	£0.10	£0.00
PMU	£0.57	£0.51	(£0.06)
Central Inc/Technical Accounts	(£2.42)	(£2.83)	(£0.41)
Reserves	(£1.01)	(£0.25)	£0.76
Surplus / (Deficit)	**(£5.17)**	**(£5.02)**	**£0.15**

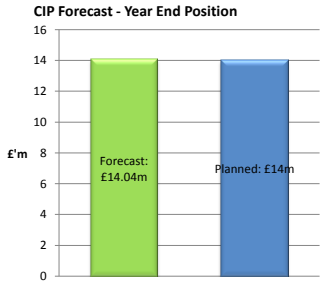
TRUST SURPLUS / (DEFICIT)



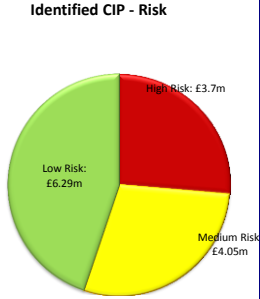
KEY METRICS

	Year To Date			Year End: Forecast			
	M3 Plan	M3 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£5.17)	(£5.02)	£0.15	(£16.10)	(£16.06)	£0.05	
Capital	£4.10	£3.67	£0.43	£28.22	£27.61	£0.61	
Cash	£1.94	£1.91	(£0.03)	£1.95	£1.90	(£0.05)	
Loans	£44.00	£48.97	£4.97	£67.87	£67.51	(£0.36)	
CIP	£1.78	£2.47	£0.69	£14.00	£14.04	£0.04	
	Plan	Actual		Plan	Forecast		
Risk Rating	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14m



Total Forecast £14.04m

YEAR END 2016/17

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	8,787	7,989	(797)
Non-Elective	51,619	51,255	(364)
Daycase	36,895	37,211	317
Outpatient	338,922	344,227	5,305
A&E	148,571	148,178	(393)
Other NHS Non- Tariff	1,556,020	1,603,885	47,865
Other NHS Tariff	115,305	121,547	6,243
Total	2,256,117	2,314,292	58,174

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£22.48	£21.05	(£1.43)
Non Elective	£87.09	£88.67	£1.57
Daycase	£26.37	£26.62	£0.25
Outpatients	£43.43	£44.79	£1.36
A & E	£16.43	£16.58	£0.15
Other-NHS Clinical	£129.03	£131.67	£2.64
CQUIN	£6.79	£6.93	£0.14
Other Income	£39.90	£38.69	(£1.21)
Total Income	**£371.52**	**£375.00**	**£3.48**
Pay	(£237.12)	(£240.22)	(£3.11)
Drug Costs	(£35.59)	(£36.63)	(£1.05)
Clinical Support	(£30.17)	(£30.59)	(£0.43)
Other Costs	(£47.05)	(£46.45)	£0.59
PFI Costs	(£12.04)	(£12.02)	£0.02
Total Expenditure	**(£361.96)**	**(£365.92)**	**(£3.96)**
EBITDA	**£9.56**	**£9.09**	**(£0.47)**
Non Operating Expenditure	(£25.66)	(£25.14)	£0.52
Deficit excl. Restructuring	**(£16.10)**	**(£16.06)**	**£0.05**
Restructuring Costs	(£0.00)	£0.00	£0.00
Surplus / (Deficit)	**(£16.10)**	**(£16.06)**	**£0.05**

DIVISIONS: INCOME AND EXPENDITURE

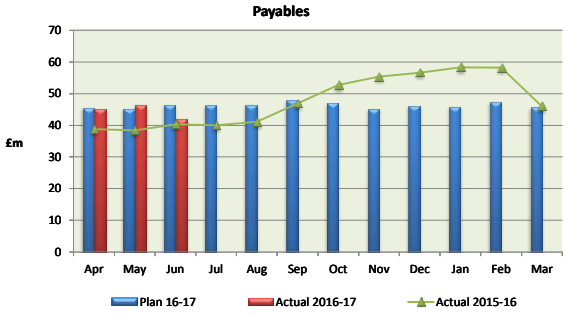
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£19.52	£19.52	(£0.00)
Medical	£22.07	£22.07	£0.00
Families & Specialist Services	(£2.51)	(£2.51)	£0.00
Community	£4.42	£4.42	(£0.00)
Estates & Facilities	(£26.69)	(£26.69)	£0.00
Corporate	(£24.34)	(£24.34)	(£0.00)
THIS	£0.47	£0.47	(£0.00)
PMU	£2.62	£2.62	£0.00
Central Inc/Technical Accounts	(£9.63)	(£10.11)	(£0.47)
Reserves	(£2.03)	(£1.51)	£0.52
Surplus / (Deficit)	**(£16.10)**	**(£16.06)**	**£0.05**

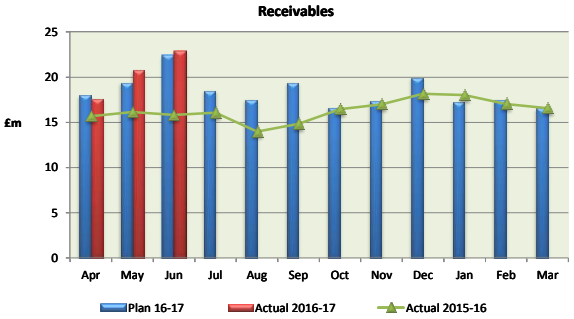
Trust Financial Overview as at 30th Jun 2016 - Month 3

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

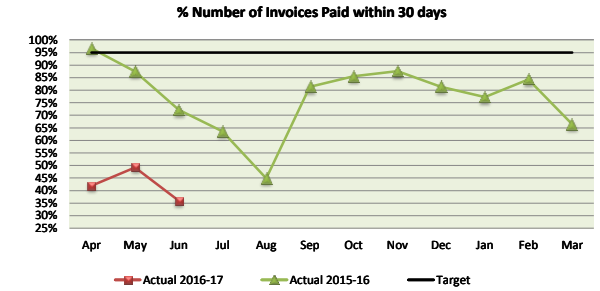
WORKING CAPITAL

	M3 Plan £m	M3 Actual £m	Var £m	M3
Payables	(£46.58)	(£41.94)	(£4.64)	
Receivables	£22.41	£22.95	(£0.54)	



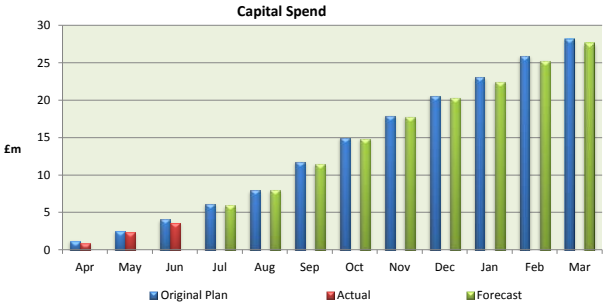


BETTER PAYMENT PRACTICE CODE



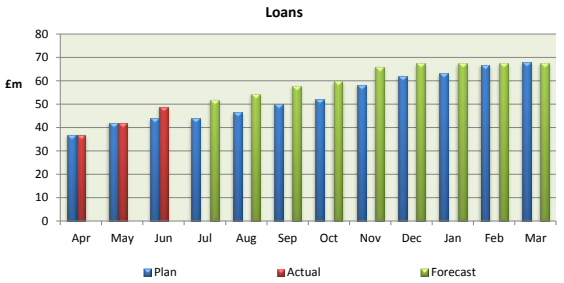
CAPITAL

	M3 Plan £m	M3 Actual £m	Var £m	M3
Capital	£4.10	£3.67	£0.43	

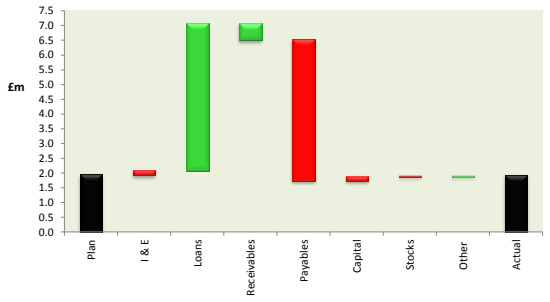


CASH

	M3 Plan £m	M3 Actual £m	Var £m	M3
Cash	£1.94	£1.91	(£0.03)	
Loans	£44.00	£48.97	£4.97	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £5.02m versus a planned deficit of £5.17m.
- Elective activity remains behind plan but is offset by higher than planned Outpatient, A&E and Daycase activity.
- Capital expenditure year to date is £3.67m against a planned £4.10m.
- Cash balance is virtually on plan with £1.91m against a planned £1.94m.
- The Trust has drawn down loans earlier than planned. The total loan balance is £48.97m against a planned £44.00m.
- CIP schemes delivered £2.47m in the year to date against a planned target of £1.78m.
- 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 plans being put in place at Divisional level against ongoing pressures and risks.

- Cash is forecast very close to plan at £1.90m.
- 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 £0.61m below plan at £27.61m.
- The year end FSRR is forecast to be at level 2 as planned.

RAG KEY: (Excl: Cash)	Green	Actual / Forecast is on plan or an improvement on plan
	Yellow	Actual / Forecast is worse than planned by <2%
	Red	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:	Green	At or above planned level or > £21.2m (20 working days cash)
	Yellow	< £21.2m (unless planned) but > £10.6m (10 working days cash)
	Red	< £10.6m (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 Var	Plan YTD Spells	Actual YTD Spells	Spells var YTD
DAYCASE	DAYCASE	2,391	2,398	7	6,846	6,886	40
	DAYCASE ENDOSCOPY	842	879	37	2,410	2,521	111
DAYCASE Total		3,233	3,277	44	9,257	9,407	150
ELECTIVE	ELECTIVE	691	611	-80	1,978	1,654	-324
	ELECTIVE ENDOSCOPY	80	64	-16	229	225	-4
ELECTIVE Total		771	675	-96	2,207	1,879	-328
NON-ELECTIVE	EMERGENCY SHORT STAY	1,957	2,075	118	5,932	6,023	91
	EMERGENCY LONG STAY	1,609	1,604	-5	4,861	4,750	-111
	EMERGENCY THRESHOLD	0	0	0	0	0	0
	NON-ELECTIVE LONG	331	342	11	974	991	17
	NON-ELECTIVE SHORT	368	353	-15	1,089	1,013	-76
NON-ELECTIVE Total		4,265	4,374	109	12,856	12,777	-79
A&E	A&E	12,480	12,781	301	37,440	38,489	1,049
A&E Total		12,480	12,781	301	37,440	38,489	1,049
OUTPATIENT	OUTPATIENT FIRST	8,253	9,042	789	23,626	25,074	1,448
	OUTPATIENT PROCEDURE FIRSTS	2,046	2,383	337	5,859	6,386	527
	OUTPATIENT FOLLOW-UP	15,164	15,557	393	43,424	43,806	382
	OUTPATIENT PROCEDURE FOLLOW-UPS	4,244	4,718	474	12,153	13,150	997
OUTPATIENT Total		29,707	31,700	1,993	85,062	88,416	3,354
OTHER NHS TARIFF	CHEMOTHERAPY	657	643	-14	1,880	1,891	11
	DIRECT ACCESS & OP	5,769	6,414	645	16,843	18,862	2,019
	MATERNITY PATHWAY	935	936	1	2,804	2,796	-8
	OTHER NHS TARIFF	2,565	2,804	239	7,468	7,873	405
OTHER NHS TARIFF Total		9,925	10,797	872	28,995	31,422	2,427
OTHER NHS NON-TARIFF	CRITICAL CARE - ADULT	337	358	21	1,012	1,215	203
	CRITICAL CARE - NICU	506	572	66	1,496	1,724	228
	CHEMOTHERAPY SUPPORTIVE DRUGS	0	0	0	0	0	0
	DIAGNOSTIC TESTS & IMAGING	120,382	129,689	9,307	355,603	375,727	20,124
	OUTPATIENTS LOCAL PRICE	4,168	4,793	625	11,934	13,476	1,542
	PASS THROUGH DEVICES	48	59	11	144	162	18
	PASS THROUGH HCDS	0	0	0	0	0	0
	REHABILITATION	1,761	1,914	153	5,343	5,867	524
	OTHER NHS NON-TARIFF	5,192	5,554	362	14,935	15,949	1,014
OTHER NHS NON-TARIFF Total		132,394	142,939	10,544	390,467	414,120	23,653
Grand Total		192,774	206,543	13,768	566,284	596,510	30,226

Overall activity has continued to see a strong performance in month 3 and is ahead of plan against all points of delivery with the exception of elective inpatients and cumulatively with the exception of elective and non-elective inpatients.

• Planned day case and elective activity has worsened slightly in month 3 with activity 1.3% (52 spells) below plan. This is driven by continued over-performance within day case activity, albeit at a lower level, with elective activity remaining consistently below plan. Day case continues to over-perform mainly within Gastroenterology, due to extra middle-grade locum capacity until the end of July and Interventional Radiology due to a shift in casemix from elective. General surgery endoscopy continues below plan due to vacant medical posts with Oral Surgery seeing a decrease due to lack of capacity from Bradford. Elective under-performance continues to largely be driven by medical vacancies within General Surgery and ENT. Paediatric elective activity is also below plan but with no capacity issues and is therefore expected to recover although this is not yet seen. Trauma and Orthopaedics (T&O) elective activity is just below plan in month. The impact of the Junior Doctors' 48hr Strike and slower than planned retraction of medical patients from T&O beds seen in April has not been recovered and so cumulatively elective continues to be materially below planned levels.

• Non-elective activity overall is 2.6% (109 admissions) above the month 3 plan which is an increase from month 2 across both long and short stay. Cumulatively activity is just below planned levels due to long stay and obstetric/midwifery short stay.

• A&E has seen activity 2.4% (301 attendances) above the month 3 plan which is a continuation of the over-performance in month 2 but to a lesser degree. Cumulatively activity is 2.8% (1,049 attendances) above plan.

• Outpatient activity has seen a further significant increase across first and follow-ups and is 6.7% (1,993 attendances) above the month 3 plan. The most significant over-performances are within T&O, ENT, Dermatology, Ophthalmology and Gynaecology. This is in part due to a drive to reduce ASIs. Dermatology have had an additional 3rd Locum driving this which wont continue. Locally priced outpatients are also 15% (625 attendances) above plan due to Neurology and an additional Locum which again is not anticipated to continue.

ACTIVITY & CAPACITY (2)

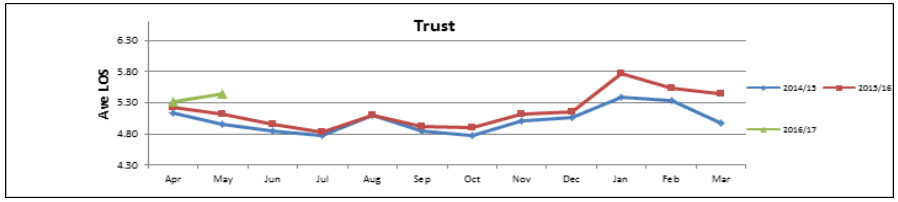
CAPACITY

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	213										
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	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	476										
TRUST Bed Base Plan - TOTAL	881	881	881	846	846	846	861	871	885	892	885	885
TRUST Bed Base - ACTUAL	881	891										
ds Above (+ve) / Below (-ve) Plan	0	10										

Trust Average Length of Stay (LOS)



- Direct access and unbundled outpatient imaging has continued to see a large over-performance within MRI and Ultrasound. .

- Diagnostic testing has seen a further significant increase and is 7.7% (9,307 tests) above the month 3 plan. This continues to be driven by a large increase within Biochemistry and Haematology.

- Adult Critical Care is 6.2% (21 bed days) above the month 3 plan which is a reduction to the previous month where over-performance was solely driven by a long-stay, 6-organ supported patient. Cumulatively activity is still above plan.

- NICU has seen activity 13% (66 bed days) above the month 3 plan which is a further increase. Cumulatively activity is now 15.2% (228 bed days) above plan.

- Rehabilitation is 23.9% (153 bed days) above the month 3 which is a further large increase. This continues to be driven by Calderdale due to social care capacity pressures with Greater Huddersfield seeing a decrease.

- Overall Trust level bed numbers are 3 below the month 3 plan which is a reduction of 13 beds when compared to May. The reduction is due to closure of 4 Surgical beds ahead of plan and 13 Medical beds, bringing the Medical bed capacity only 1 above plan. FSS continue to be at planned levels.

- The average Trust length of stay (LOS) for May was 5.03 which is a decrease from May when LOS was 5.45 days. The decrease is across all Divisions but more notable within Medical where there has been a decrease from 6.1 to 5.5 days. This has been driven by a reduction in the level of green cross patients, reduced outliers thereby inproving efficiency and reduced occupancy. The increase in length of stay is within medical patients which has increased by 0.18 days from 5.88 to 6.06. Whilst emergency admissions have increased, LOS has decreased therefore leading to the reduced bed numbers referenced above.

INCOME

Summary of Operating Income

Income category	In-Month Plan (£'m)	In-Month Actual (£'m)	In-Month Variance (£'m)	Year-to-date Plan (£'m)	Year-to-date Actual (£'m)	Year-to-date Variance (£'m)
NHS Clinical Contract Income	25.59	26.58	1.00	75.69	77.76	2.07
Other-NHS Clinical Income	4.20	4.08	-0.12	6.94	6.66	-0.29
Sub-Total NHS Clinical Income	**29.79**	**30.67**	**0.88**	**82.63**	**84.41**	**1.79**
Other Non-NHS Clinical Income	0.53	0.6	0.05	1.57	1.56	-0.01
Total Clinical Income	**30.31**	**31.25**	**0.93**	**84.20**	**85.97**	**1.77**
Other Non-Clinical income	2.78	2.6	-0.14	8.26	7.80	-0.46
Total Operating Income	**33.09**	**33.88**	**0.79**	**92.46**	**93.77**	**1.31**

Summary of Clinical Contract Income - by Point of Delivery

Point Of Delivery	In-Month Plan (£'m)	In-Month Actual (£'m)	In-Month Variance (£'m)	Year-to-date Plan (£'m)	Year-to-date Actual (£'m)	Year-to-date Variance (£'m)
DAYCASE	2.31	2.32	0.00	6.62	6.67	0.05
ELECTIVE	1.97	1.82	-0.15	5.64	5.02	-0.62
NON-ELECTIVE	7.21	7.62	0.40	21.74	22.24	0.50
A&E	1.38	1.45	0.07	4.14	4.30	0.16
OUTPATIENT	3.80	4.15	0.35	10.87	11.47	0.60
OTHER NHS TARIFF	1.99	2.03	0.04	5.83	5.88	0.05
OTHER NHS NON-TARIFF	6.35	6.60	0.26	19.16	20.43	1.26
CQUIN	0.58	0.60	0.02	1.68	1.74	0.06
Grand Total	**25.59**	**26.58**	**1.00**	**75.69**	**77.76**	**2.07**

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

Commissioner	In-month Plan (£'m)	In-month Actual (£'m)	In-month Variance (£'m)	Year-to-Date Plan (£'m)	Year-to-Date Actual (£'m)	Year-to-Date Variance (£'m)
NHS Calderdale CCG	11.51	11.98	0.47	34.01	34.63	0.62
NHS Greater Huddersfield CCG	10.39	10.44	0.05	30.70	31.09	0.39
Other CCG's	1.60	1.83	0.23	4.75	5.15	0.40
NHS England	2.09	2.33	0.24	6.22	6.88	0.66
Total Commissioners	**25.59**	**26.58**	**1.00**	**75.69**	**77.76**	**2.07**

Operating Income

There is a £0.79m favourable variance from the month 3 plan within operating income which is an improved position from the position seen in month 2. Cumulatively income is £1.31m above plan.

NHS Clinical Income

Within the £0.79m in-month favourable income variance, NHS Clinical income relates £0.88m. Cumulatively NHS Clinical income is £1.79m above plan. Non-pay spend on pass-through drug and devices is driving clinical income of £0.03m above plan both in-month and cumulatively. The remaining favourable income variance is mainly due to Clinical Contract PbR income.
The Clinical Contract PbR income position is driven by over-performances within Non-elective, A&E, Outpatients, Rehabilitation and Diagnostic testing & imaging. The above areas are partially offset by reduced elective income due to the under-performance as described earlier.

The Clinical Contract Income position by Commissioner reflects an over-performance against the month 3 plan for all of the Trust's Commissioners, however this is most material within Calderdale CCG. This position is mainly driven by over-performances within emergency admissions, in particular within long-stay, A&E attendances, outpatients and rehabilitation. Calderdale emergency admissions have seen a large increase again plan when compared with month 2. Calderdale Day case and Elective activity overall is in line with plan.
The Greater Huddersfield CCG position overall is in line with plan in month 3 which is a decrease from the month 2 over-performance. The position is also driven by over-performances within emergency admissions but mainly within short stay. Long stay in line with the activity plan but variances at specialty level are driving income above planned levels. This is off-set by under-performances within Rehabilitation and High Cost Drugs and Elective activity.
The over-performance within the NHS England contract is driven by adult critical care, NICU, high cost drugs and Oral Surgery outpatients.

Other income

Overall other income is £0.09m below the planned level for month 3 and £0.57m cumulatively. This is mainly due to lower than planned income within Injury Cost Recovery Unit (ICRU) income which can fluctuate month on month, the Trust's Pharmacy Manufacturing Unit (PMU) and Donated Asset Income. The Trust also planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, showing below plan within non-NHS Clinical income off-set by over-performance within NHS Clinical income.

INCOME (2)

Summary of Commissioner Contract Position (versus Commissioner Contract)

Commissioner	In-month			Year-to-Date		
	Contract (£'m)	Actual (£'m)	Variance (£'m)	Contract (£'m)	Actual (£'m)	Variance (£'m)
NHS Calderdale CCG	11.19	11.98	0.78	33.10	34.63	1.53
NHS Greater Huddersfield CCG	10.09	10.44	0.35	29.82	31.09	1.26
Other CCG's	1.59	1.83	0.24	4.70	5.15	0.45
NHS England	2.24	2.33	0.09	6.65	6.88	0.23
Total Commissioners	**25.12**	**26.58**	**1.46**	**74.28**	**77.76**	**3.48**

Contractual Sanctions

Contract Sanction	Performance In Month	Gross Sanction		Adjusted for STF		Net Contract Sanction Applied	
		In Month £'000	YTD £'000	In Month £'000	YTD £'000	In Month £'000	YTD £'000
MRSA	0 Post MRSA Bacteraemia cases	0.0	0.0	0.0	0.0	0.0	0.0
Clostridium Difficile	5 breaches YTD	0.0	0.0	0.0	0.0	0.0	0.0
Ambulance Handovers	14 breaches of 30-60 minutes	2.6	7.4	-2.6	-7.4	0.0	0.0
Ambulance Handovers	1 breach of 60+ minutes	0.0	1.0	0.0	-1.0	0.0	0.0
A&E % of attendance discharged or admitted within 4 hours of arrival in A&E	95.1%	0.0	42.6	0.0	-42.6	0.0	0.0
Cancelled Operations	All within target	0.0	0.0	0.0	0.0	0.0	0.0
RTT	All within target	0.0	0.0	0.0	0.0	0.0	0.0
Never Events	1 breach in May - tbc	0.0	tbc	0.0	0.0	0.0	tbc
Duty of Candour	2 breaches - Apr & May tbc	20.0	20.0	0.0	0.0	20.0	20.0
TOTAL		**22.6**	**71.0**	**-2.6**	**-51.0**	**20.0**	**20.0**

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 3 position represents £1.46m above the Commissioner Contract value and £3.48m cumulatively. This is driven by emergency admissions, outpatients, A&E, rehabilitation and critical care all above the Commissioner contract value. This presents a risk regarding the Commissioner affordability of this level of over-performance, however no financial risk is reflected within the Q1 position.

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 3 performance has seen 2 Duty of Candour breaches giving a sanction of £0.02m, with April and May still undergoing validation and so is subject to an increase. The main STF risk relates to EPR 'go live' and RTT performance, mitigations and system resilience conversations are in train.

CQUIN

The performance and income against each CQUIN scheme within the Contract is measured against quarterly targets. At the end of Q1, it is anticipated that the Sepsis scheme will achieve only 3 out of the 4 targets, 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 3 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.

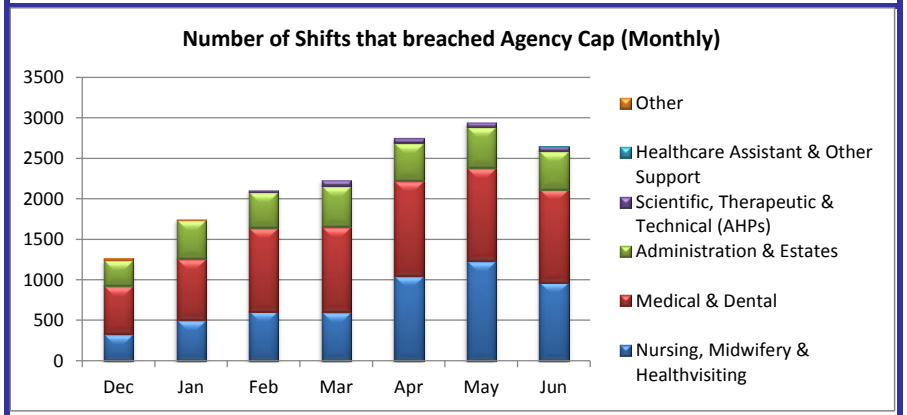
Commissioner Contractual Challenges

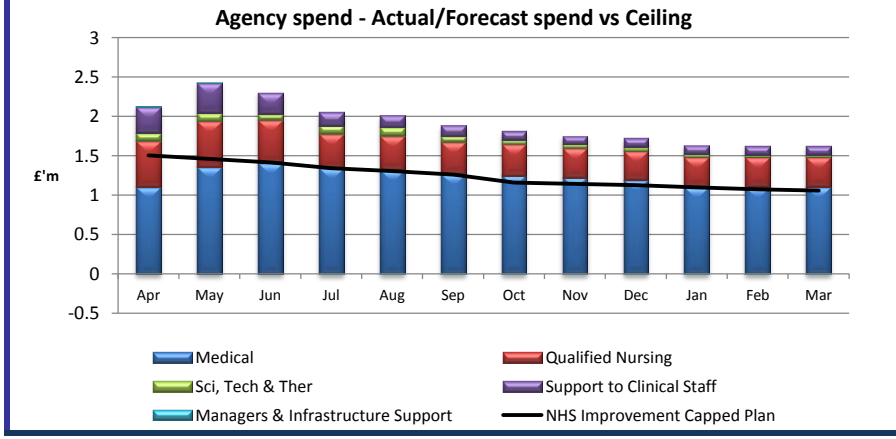
The NHS Standard Contract enables Commissioners to formally make monthly contractual challenges. No challenges have yet been made in relation to 2016/17 and there is currently no risk relating to this included within the year-to-date position.

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	41	84	97	207	91	521
Staff in post (WTE)	622	1,138	496	1,631	1,138	5,024
% Vacancies	6%	7%	16%	11%	7%	9%





For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement (NHSI). The Trust is under close scrutiny by NHSI on this measure due to both the level of spend in 2015/16 totalling £19.93m and the ongoing high run rate. A straight extrapolation of the year to date agency spend would suggest a potential to spend £27.5m in 2016/17, threatening both compliance with the ceiling but also delivery of the overall control total deficit and has cash implications. Capped hourly rates for agency staff were also introduced by NHSI in 2015/16 and from July 2016 performance is being monitored against the additional measure of wage cap paid to the individual as well as the overall price cap and use of approved procurement frameworks.

Vacancies

In overall terms at the end of Month 3 the Trust was carrying 521 vacancies, a rate of 9% of the total establishment and a slight increase from last month. The highest vacancy rates continue to be in directly patient facing staff groups, medical and nursing staffing at 16% and 11% respectively (both of which have increased by 1% in-month), which are essential to delivery of activity and maintenance of safe and high quality services. In order to suppress the unaffordable use of agency staff, recruitment to these posts is a priority.

Agency rate cap

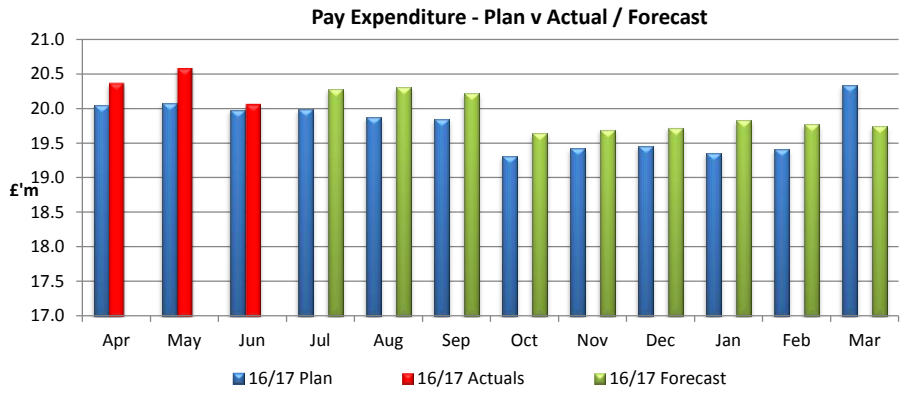
During monitoring period, since last December the capped rate has been reducing on a stepped basis with the latest reduction being applied from April 2016 and further rate reductions coming in from July 2016.

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 increased again in May. Reliance on agency nursing reduced in June and this is expected to improve further in July as use of the highest rate nursing agency (Thornbury) has now ceased except for in exceptional circumstances.

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 3, against a trajectory of £1.41m, actual spend is £2.31m. Divisional forecasts, which in themselves are reliant upon operational actions and a greater level of constraint going forwards, project a **full year spend of £22.96m** illustrated by staff group on the graph opposite. This demonstrates an improvement on the straight line extrapolation of quarter 1 performance (at £27.5m referenced above) but is still significantly in excess of the £14.95m ceiling.

EXPENDITURE - PAY



	Pay Expenditure including Agency								
	M3 YTD Budget	M3 YTD Actual							M3 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	10.68	10.69	7.60	2.08		0.29	0.34	0.37	0.01
Junior Medical	6.83	6.92	4.59	1.80		0.06	0.18	0.29	0.09
Qualified nursing, midwifery and health visiting staff	18.61	19.14	16.70	1.70	0.12		0.48	0.14	0.53
Sci Tech & Ther	6.47	6.74	6.28	0.29	0.04		0.09	0.05	0.26
Support to Nursing staff	4.63	5.26	4.46	0.22	0.39		0.15	0.04	0.63
Support to clinical staff	1.72	2.40	1.49	0.75	0.13		0.01	0.01	0.68
Non Clinical									0.00
Managers and infrastructure support	10.07	9.83	9.50	0.04	0.04		0.16	0.10	-0.24
Any Other Spend	0.06	0.04	0.04						-0.02
Pay Reserves	1.03								-1.03
TRUST TOTAL	**60.11**	**61.01**	**50.66**	**6.87**	**0.72**	**0.36**	**1.41**	**0.99**	**0.90**

Pay costs are £0.90m higher than the planned level in the year to date, although the absolute spend level has reduced in month. It should be noted that £2.0m of contingency reserves are planned against pay in equal instalments across the first six months of the financial year. Three months of this contingency, £1.0m, has been released against the pay position, meaning that the underlying divisional year to date pay overspend was £1.90m.

As has been the case through this year it is the 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 £1.16m in the quarter with a £1.92m spend on agency staffing in these staff groups. The escalation protocols for booking of nursing agency shifts have been reviewed and further strengthened by the new Director of Nursing and use of the highest cost agency (Thornbury) has been ceased in all but exceptional circumstances from late June.

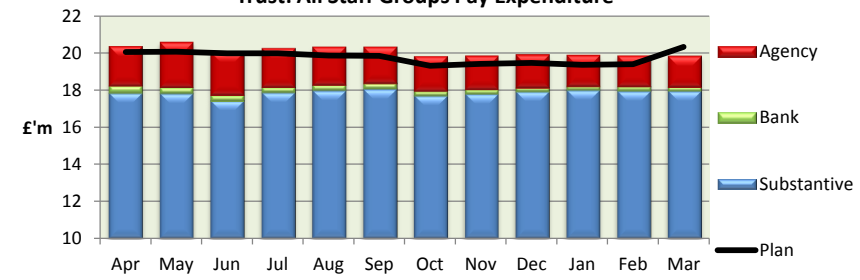
Recruitment difficulties also remain an issue in certain Medical and Surgical specialties for medical staff. This is driving additional costs through the requirement to use agency locum staff in key areas. The overspend against medical staffing at a net £0.10m as the use of agency is offset in part by these unfilled staffing gaps. The absolute cost of medical agency is however high at £3.88m in the year to date, 56% of the overall agency spend. There is a balance to be struck in engaging medical staffing between the high cost of employment against the potential performance standards and income lost through staffing gaps. The assessment of the risk of switching off this agency cover is being made on a case by case basis by Divisions to inform strategic decisions to be taken at Trust level.

Focussed management activity is co-ordinated 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. The impact of these strategies needs to be expedited as ground is being lost on a daily basis against the Trust's ability to manage what is one of the most significant risks to delivery of the financial plan.

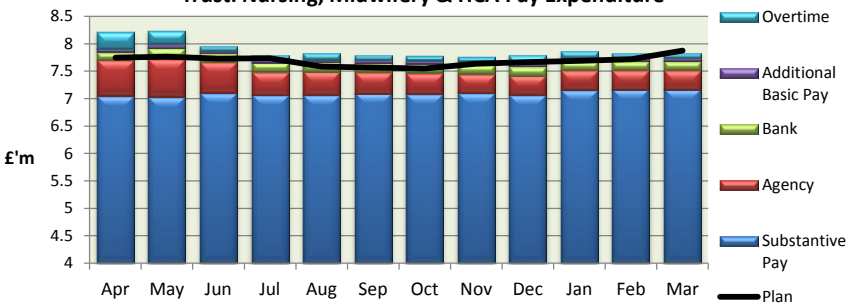
EXPENDITURE - PAY

Actual & Forecast Pay Expenduture

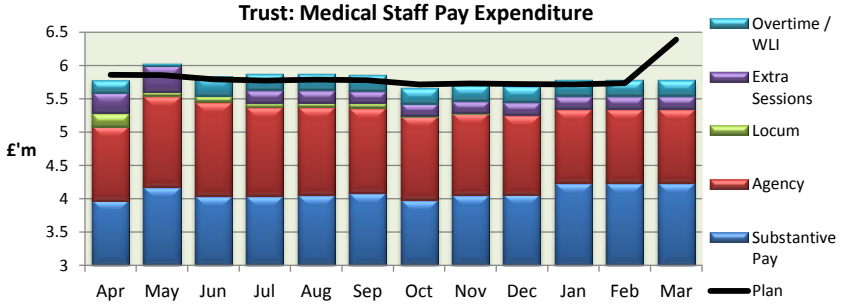
Trust: All Staff Groups Pay Expenditure



Trust: Nursing, Midwifery & HCA Pay Expenditure

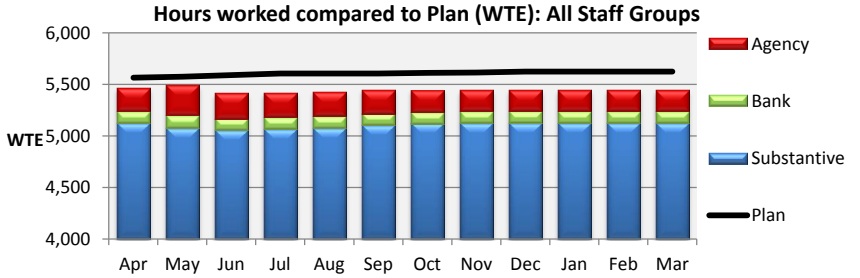


Trust: Medical Staff Pay Expenditure

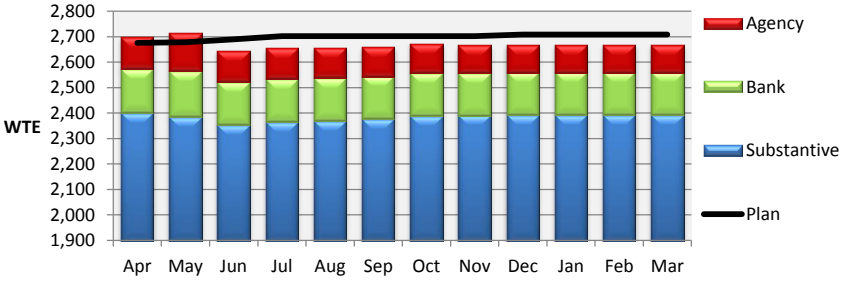


Actual & Forecast Staffing WTE

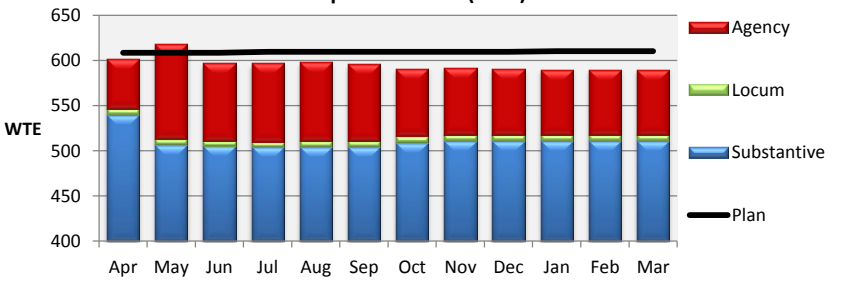
Hours worked compared to Plan (WTE): All Staff Groups



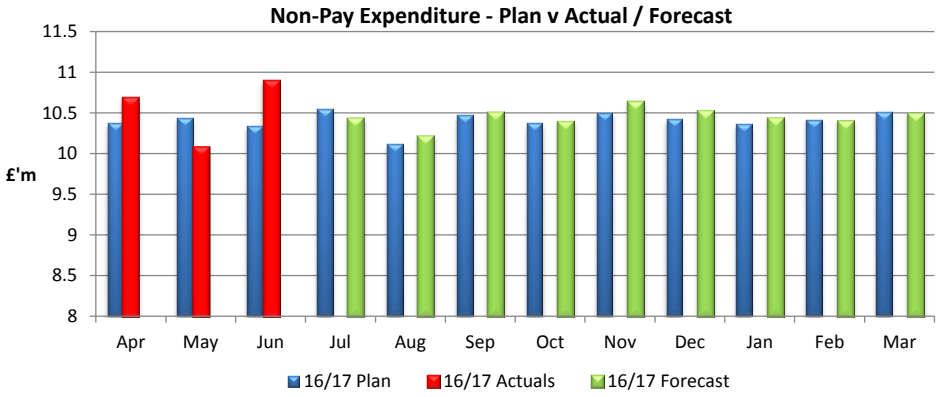
Hours worked compared to Plan (WTE): Nursing, Midwifery & HCA



Hours worked compared to Plan (WTE): Medical Staff



EXPENDITURE - NON PAY



	M3 Plan £m	M3 Actual £m	Var £m	
Drug Costs	(£8.73)	(£8.64)	£0.09	
Clinical Support	(£7.68)	(£7.85)	(£0.17)	
Other Costs	(£11.72)	(£12.16)	(£0.44)	
PFI Costs	(£3.01)	(£3.01)	£0.00	
Total Operating Expenditure	**(£31.14)**	**(£31.66)**	**(£0.52)**	
Non Operating Expenditure	(£6.37)	(£6.13)	£0.25	
Restructuring Costs	(£0.00)	£0.00	£0.00	
Total Non Operating Expenditure	**(£6.37)**	**(£6.13)**	**£0.25**	
Total Expenditure	**(£37.51)**	**(£37.78)**	**(£0.27)**	

Drug costs

Year to date expenditure on drugs was £0.09m below the planned level. Within this, the income and corresponding spend on 'pass through' high cost drugs is £0.27m below plan. Underlying drug budgets are therefore overspent by £0.18m.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.61m 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, this remains under review by the FSS division to ensure that the best balance is being maintained between access times and value for money in delivery of the service.

The year to date overspend has increased from the level seen last month, primarily for technical reasons. The annual plan includes £2.0m of contingency reserves which was planned as pay spend of £1m in the first quarter. There has been a release of £0.75m contingency reserves to the bottom line in the year to date position, a provision has been made against the balance of the available contingency, £0.25m, for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.25m below the planned level. As was the case last month, this is driven mainly by lower than planned depreciation charges. 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.

This benefit is supplemented by the £0.06m gain on disposal, realised last month, against the sale of the old Occupational Health building which was surplus to Trust requirements. 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.

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
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. The latest correspondence from NHSI with regard to the STF indicates that 70% of the funding will be based upon delivery of financial performance. At the end of Month 3, the Trust has delivered the year to date financial performance in line with plan / control total and as such it is assumed that this element of the Quarter 1 STF (70% of £2.83m) will be secured as planned.

The Trust is currently spending on agency staffing at a rate which would breach the NHS Improvement ceiling level of £14.95m for the year, in addition to the breaches against the hourly capped rates. This is contrary to the NHSI agency controls and will bring additional scrutiny from the regulator but the assumption is that it will not preclude the Trust from receipt of the STF if the control total is delivered.

As yet formal approval of the planned capital investment of £28.2m has not been received but in early June a submission was required to be made to NHSI by the Trust, constituting a comprehensive deep dive into the capital programme. This detailed the process of prioritisation that the Trust had undertaking; level of contractually committed spend; an assessment of essential versus non essential investments, all of which was required to be cross reference to the Trust's strategies and risk register.

Carter implementation
Carter data is being used with SLR/PLICS data to identify and progress savings opportunities.

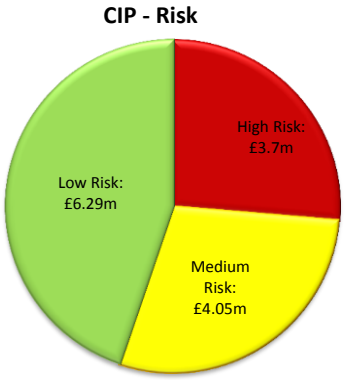
Access standards
The latest guidance from NHSI clarifies that 30% of the STF is contingent upon achieving access standards. The Trust has achieved the access standards against the trajectories set for the first quarter and so expects to secure the first tranche of the STF as planned (30% of £2.83m). At this stage the Trust is not highlighting any other material risk against performance of the planned trajectories as submitted to NHSI although this is finely balanced with the need to maintain productivity, e.g. RTT performance through the remainder of the year, alongside EPR implementation and the challenge to reduce agency staffing.

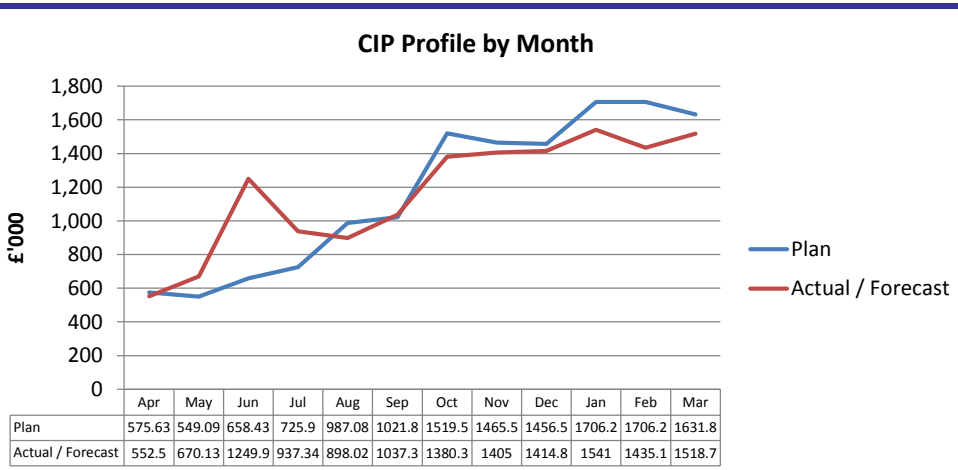
Transformation
The Trust will work with commissioners on the five-year plan in line with the STP timetable. This is linked to the work that has already been completed to develop the 5 year transformation strategy. Implementation of this strategy relies upon the outcome of public consultation and Treasury funding.

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

COST IMPROVEMENT PROGRAMME

16/17 Forecast CIP		
Income & Expenditure Category	Forecast Total £'m	Plan Total £'m
Pay	**6.21**	8.50
Drugs	**0.35**	0.30
Blood	**0.03**	0.06
Clinical supplies & services	**0.90**	0.93
Other Costs (excl. depreciation)	**0.98**	1.10
Depreciation on owned assets	**0.70**	0.00
Profit on Disposal of assets	**0.06**	0.00
Utilities	**0.25**	0.17
Clinical Income	**3.67**	2.57
Other income	**0.89**	0.37
Grand Total	**14.04**	**14.00**





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	575.63	549.09	658.43	725.9	987.08	1021.8	1519.5	1465.5	1456.5	1706.2	1706.2	1631.8
Actual / Forecast	552.5	670.13	1249.9	937.34	898.02	1037.3	1380.3	1405	1414.8	1541	1435.1	1518.7

In the year to date, £2.47m of CIP has been delivered against a plan of £1.78m.

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 which have complex interdependencies. Whilst this presents a risk as the in-month CIP challenge trebles from quarter 1 to quarter 4, full CIP delivery is currently forecast.

CIP Update July 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. The risk levels have been reviewed in month and as a result of both identification of new lower risk elements to close the planning gap and also this overall review, the high risk proportion of the £14m has reduced considerably to £3.7m.

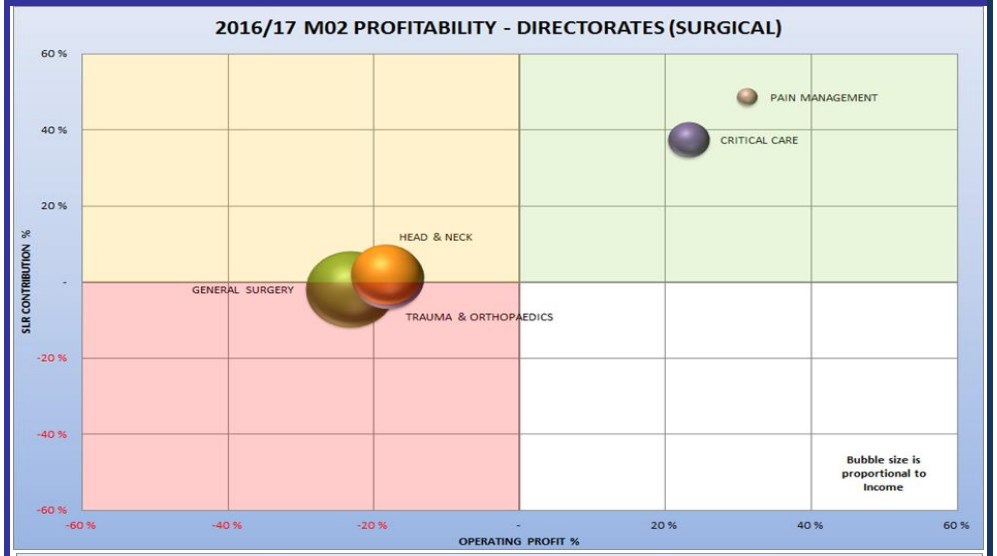
As of mid July, £14.1m of scheme opportunities have been identified with £14.0m at Gateway 2 (includes GW2 approved and GW2 ready). The latest forecast actual delivery against existing schemes slightly exceeds the £14m target.

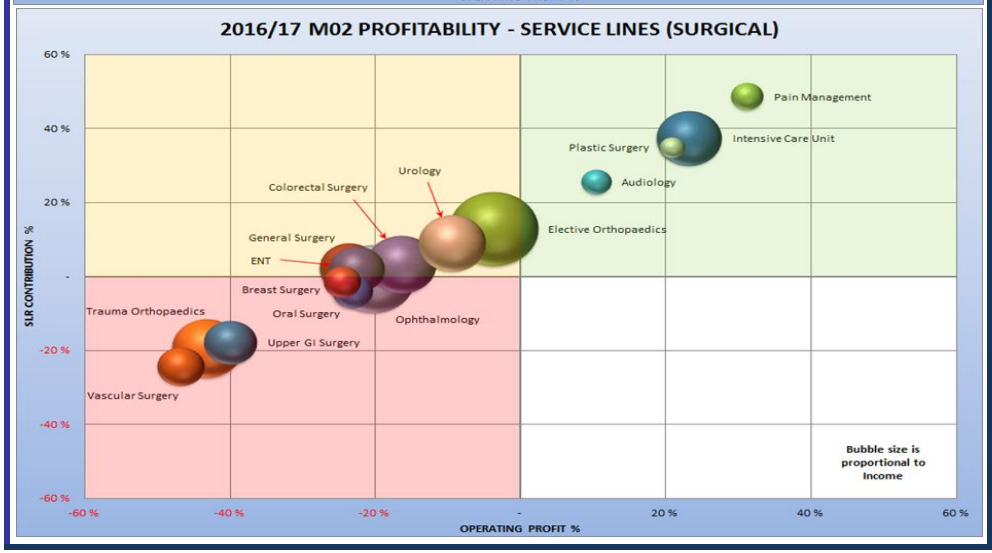
Summary

Work is now required to ensure that the step up in monthly delivery in the latter part of the year can be secured, this is where the highest risk schemes are due to commence delivery, for example the complex portfolio focussing on operational productivity through improved patient flow . An ongoing shift in focus is needed to the development of longer term, more strategic transformational ideas to deliver the scale of future savings that will be required. This will be supported by the Lord Carter work and may also be aligned with future reconfiguration of services and consideration of region wide opportunities.

SERVICE LINE REPORTING

SERVICE LINE REPORTING - SURGICAL DIVISION





The Carter Report identified top ten specialities with an opportunity value identified using the 'model hospital approach'.

This month this report is focussing on the Surgery Division. For Surgery the areas within the overall top ten included:
General Surgery
Orthopaedics
Critical Care
Ophthalmology

Actions

Phase 1: A data pack has been provided for each speciality including - Carter Report, Model Hospital Summary, 14/15 Reference cost comparison at POD level, 15/16 SLR position at speciality, POD, top ten HRG's, profit by consultant and LOS comparison by Consultant to the average benchmark.

Speciality and where appropriate sub speciality Carter review sessions have been held including General Manager, Clinical Director, speciality leads (Consultant) , Matron, PLICS Team, Finance and extended invite to other clinicians

Key lines of enquiry have been identified and documented from each session in relation to rationale where no opportunity identified, areas where an opportunity exists, consideration against the CIP opportunities already achieved or proposed for 16/17 and then finally areas where further opportunities may exist.

Phase 2: This is the next phase and will specifically focus on clinical variation which may lead to further opportunities

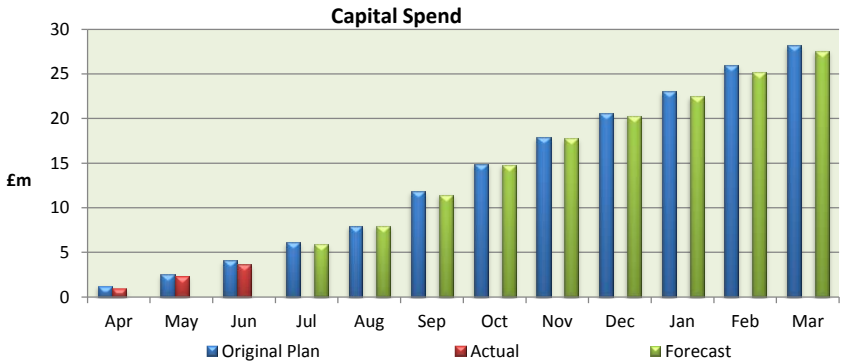
Engagement by the division to date has been strong and positive and in addition to service specific areas of focus, some common themes have been identified with regard to the opportunities afforded by single site working. In addition this analysis has reinforced that the current CIP portfolios are looking in the right direction but have not exhausted the possibilities.

Progress made in other Divisions will be reported in forthcoming months.

CAPITAL

CAPITAL - TOTAL

	M3 Plan £m	M3 Actual £m	Var £m	M3
Capital	£4.10	£3.67	£0.43	



CAPITAL - BY SCHEME

	Year To Date M3 Plan £m	Year To Date M3 Actual £m	Year To Date Var £m	Year End: Forecast Plan £m	Year End: Forecast Forecast £m	Year End: Forecast Var £m
Theatre refurbishment	£0.69	£0.71	(£0.03)	£2.60	£2.60	£0.00
Ward upgrades	£0.06	£0.00	£0.06	£2.40	£0.40	£2.00
Other Estates	£0.43	£0.16	£0.27	£5.97	£5.97	£0.00
Total Estates	**£1.18**	**£0.87**	**£0.31**	**£10.97**	**£8.97**	**£2.00**
Electronic Patient Record	£0.60	£0.86	(£0.27)	£4.74	£6.74	(£2.00)
Other IT	£1.26	£1.31	(£0.05)	£2.94	£2.94	£0.00
Total IT	**£1.86**	**£2.18**	**(£0.32)**	**£7.67**	**£9.67**	**(£2.00)**
Equipment	£0.70	£0.06	£0.64	£7.22	£6.61	£0.61
PFI Lifecycle	£0.36	£0.36	£0.01	£1.46	£1.46	£0.00
Other	£0.00	£0.20	(£0.20)	£0.91	£0.91	£0.00
Total Other	**£1.06**	**£0.62**	**£0.44**	**£9.58**	**£8.97**	**£0.61**
Total Capital	**£4.10**	**£3.66**	**£0.43**	**£28.22**	**£27.61**	**£0.61**

Capital expenditure in the year to date is £3.66m which is £0.43m below the planned level of £4.10m.

Against the Estates element of the total, year to date expenditure is £0.87m against a planned £1.18m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £0.71m, this is coupled with spend on backlog maintenance including pipe work at HRI, A&E windows and the continuation of fire compartmentation work. The ward refurbishment was planned to commence in May, it has now been decided that this will not be fully progressed but some more limited work will be done to aid patient flow, resulting in a year to date underspend of £0.06m against this element of the plan.

IM&T investments total £2.18m against a plan of £1.86m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects and replacement of PCs and laptops. The primary reasons for the £0.32m overspend versus plan is due to EPR related spend; £0.27m due to pressures on overtime, £0.18m on EDMS to bring scanning work forwards in readiness for the EPR go live date. These cost are offset in part by £0.1m underspend on wired network which hasn't commenced in line with planned timescales.

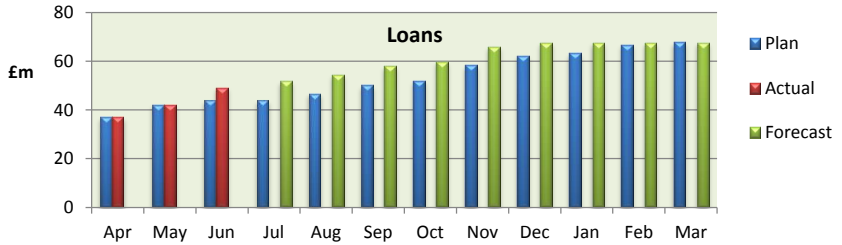
Expenditure on replacement equipment in the year to date is also lower than plan.

In overall terms the capital expenditure is currently expected to be £27.61m, £0.6m below the planned full year value of £28.22m. There will be switch in categories of spend between IT and Estates. EPR is now forecast to increase against the original plan by £2m with this being offset by the ward refurbishment not proceeding in full. This forecast is as per the submission made to NHSI in June but has not as yet explicitly been agreed by the regulator as approved with the necessary cash backing. However, after an internal review of our cash, operational, and legislative compliance requirements, the Trust has decided to proceed with our plans. This follows the completion of a full risk assessment.

CASH

CASH & BORROWING

	M3 Plan £m	M3 Actual £m	Var £m	M3
Cash	1.94	1.91	(£0.03)	
Loans	£44.00	£48.97	£4.97	



CASH FLOW

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	#REF!
	Non cash flows in operating deficit	(0.20)
	Other working capital movements	(3.81)
	Sub Total	**#REF!**
Investing activities	Capital expenditure	0.44
	Movement in capital creditors	(1.79)
	Sub Total	**(1.35)**
Financing activities	Drawdown of external DoH cash support	5.15
	Other financing activities	0.04
	Sub Total	**5.18**
	Grand Total	**#REF!**

KEY METRICS

RECEIVABLES:

As at Month 3 16/17 Aged Debt was as follows

Days	30-60	61-90	91-120	121-180	180-360	360+	Total
£m	0.60	0.12	0.34	0.41	0.38	0.47	**2.33**
No Invoices	384	245	154	238	403	533	**1,957**

PAYABLES:

£m	**0.83**	Value of approved invoices not paid at month end
No Invoices	**948**	No. of approved invoices not paid at month end

At the end of June 2016 the Trust had a cash balance of £1.91m against a planned position of £1.94m, a slight adverse variance of £0.03m. The overspend on pay and agency staffing drives an immediate outflow of cash above planned levels, whilst there is a time lag on receipt of income for clinical contract overtrades from commissioners. The pressure that this had placed on the Trust's ability to pay other suppliers has caused a number of companies to move towards suspending provision of goods. The Trust has therefore drawn down borrowing in early June at £5.1m excess of the planned level in order to rectify the timing difference on cash inflow versus outflow and catch up payments to suppliers. This is an additional 'hidden' cost to the high use of agency as the Trust will bear additional interest at 3.5% on this borrowing and if the position does not improve will bring pressure to the overall availability of cash by quarter 4 assuming no increase to borrowing. Discussions with NHSI to convert our loan from a Working Capital Facility to a Revenue Support loan continue, in order to reduce interest charges.

Operating activities

Operating activities show a adverse £3.86m variance against the plan. The adverse cash impact of the I&E position of £0.05m (£0.15m favourable I&E variance offset by £0.20m non-cash flows in operating deficit) is in addition to a £3.81m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers.

Total aged debt based on invoices raised is £2.33m, whilst outstanding creditors approved for payment to suppliers stood at £0.83m at month end. The catch up on payments to suppliers in month has had a negative impact on the performance against the Better Payment Practice Code as expected with a backlog of overdue invoices being processed for payment; in month 36% of invoices have been paid within 30 days against the 95% target. The Trust has reached agreement with lead commissioners on earlier cash settlement of activity overtrades in future months which should aid cash flow to suppliers.

Investing activities (Capital)

The favourable cash impact of the £0.43m under spend is offset by a £1.79m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £5.18m favourable variance from the original plan which is £5.15m due to additional cash support through borrowing being brought forward to June in advance of the planned timescale, and £0.04m other financing activities made up of a number of small variances.

FINANCIAL SUSTAINABILITY RISK RATING

	Plan YTD	Actual YTD
Capital Service Cover		
Revenue Available for Capital Service	1.17	1.10
Capital Service	4.60	4.80
Capital Service Cover metric	0.25	0.23
Capital Service Cover rating	1	1
Liquidity		
Working Capital for FSRR	(22.22)	(17.08)
Operating Expenses within EBITDA, Total	(91.25)	(92.66)
Liquidity metric	(21.92)	(16.59)
Liquidity rating	1	1
I&E Margin		
Normalised Surplus/(Deficit)	(5.17)	(5.08)
Adjusted Total Income for FSRR	92.47	93.84
I&E Margin	(5.59%)	(5.41%)
I&E Margin rating	1	1
I&E Margin Variance		
I&E Margin	(5.59%)	(5.59%)
I&E Margin Variance From Plan	0.36%	0.18%
I&E Margin Variance From Plan rating	4	4
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.)

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 £3.9m 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 NHSI, maintaining FSRR level 2 will not in itself change the regulatory implications in terms of the regime that it in place.

New compliance regime

With the creation of NHSI merging together the functions of Monitor and the Trust Development Authority, consultation is underway on a new Single Oversight Framework for both NHS Trusts and FTs. Further information will be provided on this in future months once the consultation has finalised. The proposed new financial rating metrics incorporate most of the existing metrics and also bring in measures of 'Change in cost per weighted activity unit', as a measure of financial efficiency and monitor total agency spend versus the provider's ceiling as a measure of financial control.

FORECAST

YEAR END 2016/17

	Plan	Forecast	Var
	£m	£m	£m
Elective	£22.48	£21.05	(£1.43)
Non Elective	£87.09	£88.67	£1.57
Daycase	£26.37	£26.62	£0.25
Outpatients	£43.43	£44.79	£1.36
A & E	£16.43	£16.58	£0.15
Other-NHS Clinical	£129.03	£131.67	£2.64
CQUIN	£6.79	£6.93	£0.14
Other Income	£39.90	£38.69	(£1.21)
Total Income	**£371.52**	**£375.00**	**£3.48**
Pay	(£237.12)	(£240.22)	(£3.11)
Drug Costs	(£35.59)	(£36.63)	(£1.05)
Clinical Support	(£30.17)	(£30.59)	(£0.43)
Other Costs	(£47.05)	(£46.45)	£0.59
PFI Costs	(£12.04)	(£12.02)	£0.02
Total Expenditure	**(£361.96)**	**(£365.92)**	**(£3.96)**
EBITDA	**£9.56**	**£9.09**	**(£0.47)**
Non Operating Expenditure	(£25.66)	(£25.14)	£0.52
Deficit excl. Restructuring	**(£16.10)**	**(£16.06)**	**£0.05**
Restructuring Costs	(£0.00)	(£0.00)	(£0.00)
Surplus / (Deficit)	**(£16.10)**	**(£16.06)**	**£0.05**

KEY METRICS

	Plan	Forecast	Var
	£m	£m	£m
I&E: Surplus / (Deficit)	(£16.10)	(£16.06)	£0.05
Capital	£28.22	£27.61	£0.61
Cash	£1.95	£1.90	(£0.05)
Borrowing	£67.87	£67.51	(£0.36)
CIP	£14.00	£14.04	£0.04
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 STF which is intrinsic to delivery of the planned deficit. The forecast assumes that the Divisions will deliver recovery plans to mitigate against the risks and pressures. The scale of the required recovery plans assumed to be delivered by each division is illustrated here.

	CIP variance from target	Other pressures	Total recovery required
	£m	£m	£m
Surgery & Anaesthetics	(£0.41)	(£0.37)	£0.79
Medical	£0.68	(£1.81)	£1.14
Families & Specialist Services	(£0.42)	(£0.11)	£0.53
Community	(£0.07)	(£0.57)	£0.65
Estates & Facilities	£0.14	(£0.14)	£0.00
Corporate	£0.10	(£0.16)	£0.06
THIS	(£0.05)	£0.05	£0.00
PMU	£0.02	(£0.02)	£0.00
Central Inc/Technical Accounts	£0.06	(£0.50)	£0.44
Total Divisional	**£0.04**	**(£3.64)**	**£3.60**
Reserves	£0.00	£0.00	(£2.00)
Total Trust	**£0.04**	**(£3.64)**	**£1.60**

The extent of the recovery required at Divisional level totals £3.6m which incorporates the pressure driven by high agency usage. This can be mitigated in part by contingency reserves but their use to offset these pressures removes their availability for use against other outstanding risks, these being:

- **Electronic Patient Record implementation**

Disruption to clinical productivity bringing costs and/ or income loss; any delay to the go live bringing additional pressure whether through charges levied by Cerner or internal costs; complexity of the project driving additional costs.

- **Planned activity delivery and commissioner affordability**

Contract income is forecast to exceed plan and further exceed commissioner contracts. There is a risk that the funding available in the health economy is insufficient to deal with this pressure.

- **Junior Doctor's contract and CQC response**

Both of the above are uncertain in terms of impact but present potential risk in this financial year.

It was acknowledged in discussion with NHSI at the time of setting the plan that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live' and similarly the Junior Doctor's contract. The other risks are emerging 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	15
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.	20

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% Rare	1-5% Unlikely	6-20% Possible	21-50% Likely	>50% Almost Certain	

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

I&E

At Month 3, 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 and deliver standards and access targets. Recruitment and retention and bed capacity issues bring risk to delivery of elective and daycase activity. Against the £14m CIP target the risk profile has been reviewed and £3.7m 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. The new Junior Doctors contract may also bring additional unplanned pressure .

Capital

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

Cash

Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Further action is being taken to maximise collection of receivables and the profile of cash management is being raised at Divisional level and agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital. Delays in the flow of STF cash (now advised to be September for Q1 performance) adds to our cash flow problems and increases interest charges.

Action required:

- **Raising awareness of cash position across the organisation**
- **Focus on recruitment, retention and bed retraction to considerably reduce agency staffing usage**
- **Progression of CIP plans to full £14m+ and development of longer term transformational plans**
- **Delivery of planned clinical activity**
- **Operational plans to mitigate EPR implementation risks**
- **Delivery of conditions to secure £11.3m Strategic Transformation Funding**

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Burton, Medical Education Manager
Date: Thursday, 28th July 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Revalidation and Appraisal of Non Training Grade Medical Staff - The paper updates the Board on the position regarding revalidation and appraisal of non training grade medical staff at the end of the last appraisal revalidation year (31st March 2016)	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: See attached	
Sustainability Implications: None	

Executive Summary

Summary:

See attached

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

See attached

Next Steps:

See attached

Recommendations:

See attached

Appendix

Attachment:

Revalidation - Board of Directors - July 2016.pdf

BOARD OF DIRECTORS - THURSDAY 28TH JULY 2016

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation since the introduction of revalidation in December 2012. The report will also discuss the 2015/16 appraisal year (1st April 2015 – 31st March 2016).

Summary of key points:

- As at 31st March 2016, 309 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust.
- In the 2015/16 revalidation year (1st April 2015 – 31st March 2016) 94 non training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC).
- Based on headcount, 93.5% of non-training grade appraisals were completed and submitted in the appraisal year. 5.5% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust, maternity leave etc).

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

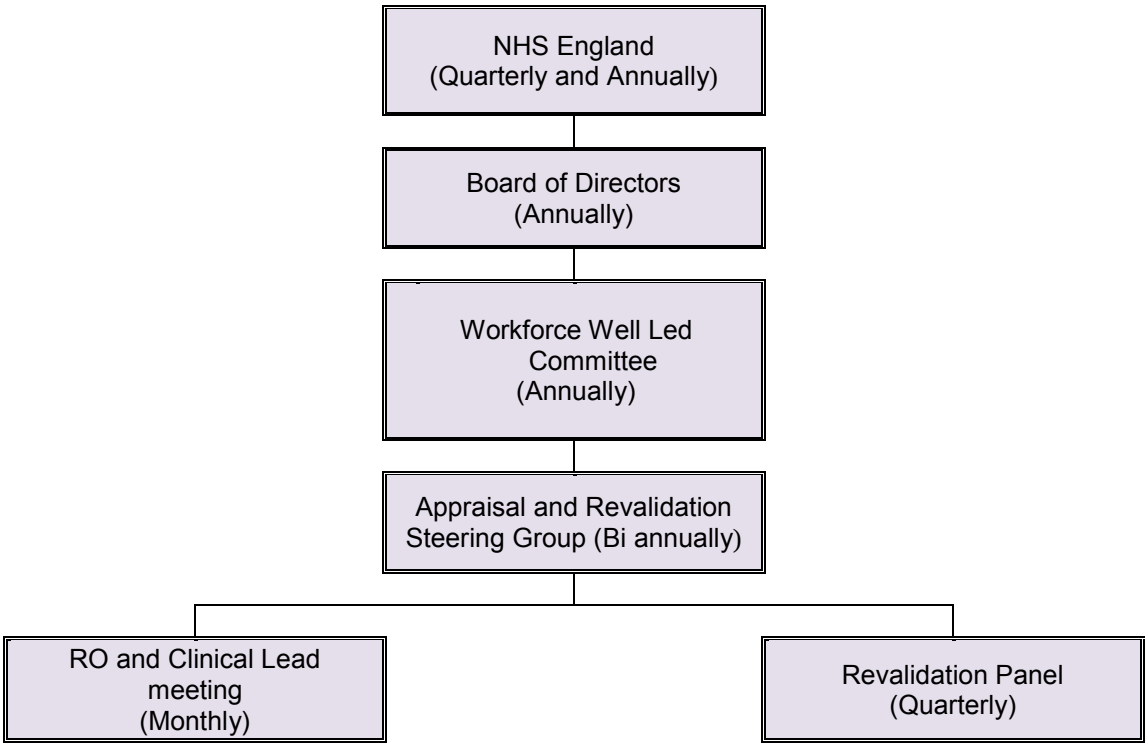
2.2 The Trust has a statutory duty to support the Responsible Officer (Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



3.2 GMC Connect

GMC Connect is the General Medical Councils database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

The database is managed by the Revalidation Office on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers. A calibration exercise between ESR and GMC Connect is undertaken quarterly.

3.3 Revalidation and Appraisal Steering Group

The Revalidation and Appraisal Steering Group panel meet bi-annually and continue to support the Responsible Officer with the revalidation agenda within the prescribed terms of reference.

4. Medical Appraisal and Revalidation Performance Data

Revalidation Cycles

4.1 The first revalidation cycle started in January 2013 and all non training grade doctors will have completed their first revalidation cycle by 31st March 2017. During this period all doctors to whom the Trust is the designated body will have a recommendation made about their fitness to practise by the Trust's Responsible Officer (the Medical Director).

4.2 In the 2015/2016 revalidation year (Year 3) the Responsible Officer has made recommendations for doctors as follows: (see also Appendix A - Audit of Revalidation Recommendations)

Revalidation Cycle (Year 3)	Positive Recommendations	Recommendation Deferred **
Year 3, Quarter 1 (April 2015 – June 2015)	19	0
Year 3, Quarter 2 (July 2015 – September 2015)	36	0
Year 3, Quarter 3 (October 2015 – December 2015)	19	0
Year 3, Quarter 4 (January 2016 – March 2016)	18	2 – the reason for the deferrals were insufficient CPD and QI information
Total:	**92**	**2**

** There were also 6 doctors for whom a positive recommendation could not be made at the time the Revalidation Panel met due to insufficient evidence being presented. However, they were able to provide, prior to their revalidation date, the missing information. This met the panel's requirements so a positive recommendation could be made.

Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are required to complete five appraisals within the revalidation cycle.

4.4 The appraisal year runs from 1st April – 31st March. The table below shows the compliance rate at the end of the 2015/2016 appraisal year on 31st March 2016 (see also Appendix B – Audit of all missed or incomplete appraisals).

Grade	Number of doctors with prescribed connection to CHFT	Completed Appraisals (1a)	Completed Appraisals (1b)	Approved incomplete or missed appraisal (1b)	Unapproved incomplete or missed appraisal
Consultants (permanent)	211	181	23	4	3
Staff Grade, associate specialist, specialty doctor (permanent)	63	49	8	6	0
Temporary or short term contract holders (all grades)	35	25	3	7	0
Total	**309**	**255**	**34**	**17**	**3**

(Doctors with a GMC prescribed connection to CHFT as at 31st March 2016)

1a: Completed appraisals: appraisal meeting between 1st April 2015 and 31st March 2016 for which the appraisal outputs have been agreed between appraiser and appraisee.

1b: Approved or incomplete or missed appraisals: accepted reason for appraisal not taking place (eg joined the Trust within the last 6 months, prolonged leave, maternity leave, sabbatical etc).
Unapproved incomplete or missed appraisal: appraisal expected to be submitted with. No agreement for appraisal to be postponed/delayed.

4.5 The appraisal completion rate is based on the number of doctors with a GMC prescribed connection to the Trust. Whilst appraisals were submitted for 93.5% of non-training grades there were 5.5% of doctors for whom an appraisal was not expected.

5. Trained Appraisers

5.1 There are currently 79 trained appraisers (Consultant and Specialty Grades). The minimum number of appraisees a trained appraiser is required to appraise each year is 5 (the maximum is 10). An audit of appraisers in December 2016 showed that only 19% of trained appraisers were meeting this minimum standard. The revised Trust Appraisal Policy allows for appraisers to be allocated to appraises. This will enable a more equitable allocation and ensure our appraisers are undertaking sufficient appraisals to retain their skills.

6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal
- The appraiser
- The appraisal discussion

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Revalidation Panel quality assurance group. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information). (see Appendix C - Quality assurance audit of appraisal inputs and outputs (1st Aril 2015 - 31st March 2016)

6.2 The Clinical Appraisal and Revalidation lead also routinely quality assures sample of appraisals submitted.

6.3 Access, security and confidentiality

Appraisal folders, supporting information and all correspondence relating to the appraisal and revalidation processes are stored on the Trust network drive. Access to the network drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation, the Assistant Director of Human Resources and the Revalidation Office administrative support. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.5 Clinical Governance

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data (Dr Foster) and attendance at audit.

7. Action Plan

a) Electronic Appraisal Systems

The Trust has is currently involved in a tendering exercise exploring the possibility of the introduction of a self-service electronic appraisal system. The systems have quality assurance checks incorporated.

b) Appraisal Policy for Non Training Grade Medical Staff

A revised policy is to be introduced across the Trust. The main changes are:

i) Allocation of appraisers to appraisees.
ii) In future appraisals must not be completed in March. This is to be introduced to avoid the end of year rush to have appraisals completed.

c) Quality Assurance

At the request of the Trust, NHSE Regional Revalidation team undertook an Independent Verification visit to review our systems and processes for revalidation. The visit was positive with no major concerns. An action plan was identified and issues are being addressed.

8 Action Required of the Board

The Board of Directors is asked to:

(i) receive this report.

Dr David Birkenhead
Medical Director/Responsible Officer
July 2016

Appendix A

Audit of Revalidation Recommendations (1st Aril 2015 - 31st March 2016)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Revalidation Recommendations made between 1st April 2014 and 31st March 2015

	Number
Recommendations completed on time (within the GMC recommendation window)	94
Late recommendations (completed but after GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**94**
Primary reason for late/missed recommendations For late or missed recommendations only one primary reason may be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctors revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for responsible officer role	0
Other	
TOTAL SUM OF LATE AND MISSED RECOMMENDATIONS	**0**

Appendix B

Audit of all missed or incomplete appraisals audit (1st Aril 2015 - 31st March 2016)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Doctors Factors (Total)	Number
Maternity leave during the majority of the 'appraisal due window'	2
Sickness absence during the majority of the 'appraisal due' window'	2
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 months of appraisal due date	11
New starter more than 3 months from the appraisal due date	0
Postponed due to incomplete portfolio/insufficient reporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	2
Other doctors factors (describe)	0
Appraiser Factors (Total)	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by the appraiser within 28 days **	34
Lack of time of appraiser	1
Other appraiser factors (describe)	0
Organisational Factors (Total)	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

** NHS England request that we report on the numbers of appraisals not signed by the appraiser within 28 days of the appraisal being completed. However, these appraisals were still recorded as completed since they were submitted within the appraisal year.

Appendix C

Quality assurance audit of appraisal inputs and outputs (1st Aril 2015 - 31st March 2016)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Total number of appraisals completed		**289**
	Number of appraisal portfolios sampled **94**	Number of the sampled appraisal portfolios deemed acceptable against standards **90**
Appraisal Inputs	**Number audited**	**Number acceptable**
Scope of work: Has a full scope of practice been described?	94	94
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	94	90
Quality Improvement Activity: Is quality improvement activity compliant with GMC requirements?	94	92
Patient feedback exercise: Has a patient feedback exercise been completed?	94	94
Colleague feedback exercise: Has a colleague feedback exercise been completed?	94	94
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	94	94
Is there sufficient supporting information from all the doctors roles and places of work?	94	94
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)	94	94
Appraisal Outputs		
Appraisal Summary	94	94
Appraiser statements	94	92
Personal Development Plan	94	94

Appendix D

Audit of concerns about a doctor's practice (1st Aril 2015 - 31st March 2016)
Non training grade medical staff

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months	**2**	**2**	**1**	**5**
Capability concerns (as the primary category) in the last 12 months	1	0	0	1
Conduct concerns (as the primary category) in the last 12 months	1	0	1	2
Health concerns (as the primary category) in the last 12 months	0	2	0	2

This page has been left blank

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th July 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 the updates and minutes from each of the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:
- Quality Committee - minutes of 28.6.16 and verbal update from meeting 26.7.16
- Finance and Performance Committee - minutes of 28.6.16 and verbal update from meeting 26.7.16
- Audit and Risk Committee - verbal update from meeting 21.7.16

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 the updates and minutes from each of the sub-committees:
- Quality Committee - minutes of 28.6.16 and verbal update from meeting 26.7.16
- Finance and Performance Committee - minutes of 28.6.16 and verbal update from meeting 26.7.16
- Audit and Risk Committee - verbal update from meeting 21.7.16

Appendix

Attachment:

Combined update minutes.pdf

Minutes of the Quality Committee held on
Tuesday 28 June 2016 in the Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

David Anderson	Non-Executive Director / Committee Chair
Rob Aitchison	Assistant Divisional Director, FSS Division
Sharon Appleby	Transformation Programme Manager
Helen Barker	Chief Operating Officer
David Birkenhead	Medical Director
Andrew Bottomley	General Manager for Trauma and Elective Orthopaedics
Brendan Brown	Executive Director of Nursing
Diane Catlow	Associate Nurse Director, Community Division
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Tracy Fennell	Associate Director of Nursing, Medical Division
Carole Hallam	Senior Nurse Clinical Governance, Corporate Nursing
Andrea McCourt	Head of Governance and Risk
Joanne Middleton	Associate Nurse Director, Surgery and Anaesthetic Services
Lynn Moore	Membership Council Representative
Vicky Pickles	Company Secretary
Lindsay Rudge	Associate Director of Nursing
Sue Shaw	Lead Resuscitation Officer
Alison Wilson	Head of Compliance and Divisional Support, Estates and Facilities
Jan Wilson	Non-Executive Director

IN ATTENDANCE / OBSERVERS

Michelle Augustine	Clinical Governance Secretary

ITEM NO	
106/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
107/16	**APOLOGIES** Kirsty Archer — Deputy Director of Finance Karen Barnett — Assistant Divisional Director, Community Division Stuart Baron — Deputy Director of Finance Elaine Brotherton — Patient Safety & Quality Lead - FSS Division Juliette Cosgrove — Assistant Director of Quality Martin DeBono — Divisional Director, FSS Division Tracy Fennell — Associate Nurse Director, Medical Division Keith Griffiths — Executive Director of Finance Carole Hallam — Senior Nurse Clinical Governance Anne-Marie Henshaw — Associate Nurse Director/Head of Midwifery, FSS Division Lesley Hill — Executive Director of Planning, Performance, Estates and Facilities Julie O'Riordan — Divisional Director, Surgery and Anaesthetic Services Jackie Murphy — Deputy Director of Nursing, Modernisation Sal Uka — Divisional Director, 7 Day Service/Hospital at Night Bev Walker — Assistant Divisional Director, Medical Division
108/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note.

109/16	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on Tuesday, 24 May 2016 were approved as a correct record.
110/16	**ACTION LOG AND MATTERS ARISING** **Mock paediatric cardiac arrest** Sue Shaw, Lead Resuscitation Officer, was in attendance to give an update on the mock paediatric cardiac arrest simulations which took place at Calderdale Royal Hospital on 23 June 2016. A presentation was given summarising the aims of the simulation, clinical standards, human factors, participant and faculty debrief and the next steps, which included: – To review the composition of the resuscitation team and update the CHFT policy – To raise awareness of how to summon the paediatric emergency team – To raise awareness of the paediatric key when using the FR3 defibrillator – To highlight the need for increased resources (Bleeps/FR3's) to Divisions – To repeat the simulation to assess impact of corrective feedback and actions taken. – Faculty to recognise the impact of their actions whilst undertaking a simulation. (laptop/replenishing emergency trolley). In summary, the simulation was a well led paediatric exercise by the Paediatric Resuscitation Simulation Lead. This method of simulation and assessment of the organisation's systems appears to be effective. This was a prompt response to a cardiac arrest call and discrepancies noted. Comments and questions raised by the Committee: Q1 (BB): Did the simulation take place on a ward with other relatives and was consideration given to them? A1 (SS): Leaflets were handed out to relatives, regarding the simulation training. The ward apologised for the inconvenience of the exercise, and requested comments, but no feedback was received. Q2 (JC): Where are the actions from this report being managed and reported to? A2 (SS): A meeting is being held with paediatrics later today to review the simulation findings and progression of actions. The resuscitation committee will not be meeting for another three months. An issue was noted, and it was asked whether the problems with mobile and DECT phone signals at Calderdale were related to problems with the bleep system. **ACTIONS: Alison Wilson to follow up and provide some assurance on the issue of the bleep system and DECT phones** **Rob Aitchison to place issue on division's risk register** **OUTCOME**: The Committee received and noted the content of the report and supports the approach and learning and will receive an update on actions at the meeting on 26th July 2016. **Regulation 28 cases** See item 115/16 **Update on special measure ward 5AD** Tracy Fennell, Associate Director of Nursing for Medical Division, presented a report updating the Committee on ward 5AD which was identified as requiring special measures. The report gave an overview of the ward and outlined the supportive actions and interventions in place to support improvement. The ward has worked through a clear action plan, and has a weekly meeting in place to support this. Improvements have been made and

have been sustained; therefore review meetings have been moved to monthly. Recommendations going forward are to continue with the monthly review and support meeting, but to move the ward from special measures.

OUTCOME: The Committee received and noted the content of the report and the removal of ward 5AD from special measures.

Update on Gastrointestinal (GI) bleed service
Helen Barker, Chief Operating Officer, previously circulated the paper to the Committee, outlining arrangements for a new Gastrointestinal (GI) Bleed pathway for patients presenting with an upper GI bleed, and accepted the new pathway for management of GI bleeds. The new pathway was implemented on 1st June 2016.

OUTCOME: The Committee received and noted the content of the report

Visible leadership report
ACTION: To be deferred to the next meeting.

Emergency services report
See item 112/16

Fractured neck of femur performance
Andrew Bottomley, General Manager for Trauma and Elective Orthopaedics presented a paper describing the resource required to deliver a trauma service.

The orthopaedic service has not delivered the first requirement of best practice guidance for fractured neck of femur (getting patients to theatre in 36 hours). This also impacts on waits for other trauma operations.

Actions for the surgical division include:
- to agree the volume of change in trauma theatre availability – June 2016
- to agree timescale for implementation, before or after theatre 6 is available – July 2016
- Orthopaedic directorate to job plan and arrange for appropriate cover of operating lists – August 2016

Questions and issues raised by the Committee:

Q1 (TF): What is being done with the turnaround time of theatres?
A1 (AB): Foureyes has been used to look at orthopaedic theatre lists and productivity was good

Q2 (LR): How are you tracking the impact of other trauma operations? The report describes #NOF, but equality is needed in theatre space.
A2 (AB): Surgeons are part of the resource for flexible sessions, and one of the extra theatres will be used. There are hand trauma lists on Monday afternoons and upper limb trauma lists on Tuesday afternoons, as well as reserved slots, as electives do not get booked in.
A2 (JMidd): There is no impact on mortality.

The Committee queried when the implementation dates will be decided on, and it was stated that this can be done fairly quickly. This will be built into the division's Patient Safety and Quality Board and the Quality Committee will receive regular updates as necessary.

OUTCOME: The Committee received and noted the content of the report

	Appointment slot utilisation Rob Aitchison, Assistant Divisional Director for the FSS Division presented a report to provide assurance that patients have not come to harm due to delays in allocating appointments for new referrals and/or being seen after the appointment due date for follow-up. Due to capacity and demand shortfalls the Trust has a number of patients awaiting allocation of appointments. These patients fall into two groups: – The first appointment waiting list for new referrals generated outside or within the Trust – The follow-up holding list for patients continuing care on an existing pathway. The report describes the different processes in place for both lists, and the recommendations needed from divisions: – New Referrals - Clinical Divisions are working with the CCGs to develop capacity and demand plans that minimise appointment slot issues and delays in allocating appointments. – Follow-Up Appointments - Validation and clinical assessment processes have been put in place to ensure that patients waiting for appointments do not come to harm. Divisions need to ensure that they are owning and managing this process. The appointment centre function will continue to provide overarching coordination of this process including escalation to Divisional teams where this is not robustly taking place. <u>Questions and issues raised by the Committee:</u> Q1 (JC): Which are the highest areas of risk in specialities? A1 (RA): Katharine Fletcher, General Manager for Outpatients and Records has set up access meetings with divisions and has seen an improvement. Surgery, ophthalmology and cardiology were the highest areas of risk. A1 (HB): This is reviewed every week and communication is sent to Divisional Directors and Associate Divisional Directors and was raised formally at WEB last week. Q2 (JC): To what extent is validation happening for every patient? A2 (RA): This is limited at the moment. Part of the process for escalation to teams has happened, but need to take next steps. The focus from the CQC is ensuring patients do not come to harm, rather than the number of patients waiting. Q3 (DA): Is there a clinical review of patients who have waited more than 3 months? A3 (RA): This work is underway in divisions. **<u>OUTCOME</u>**: The Committee received and noted the content of the report and updates will be reported through the divisional Patient Safety and Quality Board report.
CQC	
111/16	**<u>CQC REPORT</u>** Juliette Cosgrove presented an update on actions being progressed by the CQC Response Group in advance of receiving the final report, and the approach taken to address any issues. The next step in the CQC process is receiving the draft report for factual accuracy checking. It is anticipated that the report will be received in the next few weeks (end of July). This will be a lengthy document and the Trust will have 10 working days to turn it around. Support is being provided by Capsticks for this process, which will provide an opportunity for the Trust to challenge the accuracy and completeness of the evidence on

	which the ratings are based. Any factual accuracy comments that are upheld can result in a change to one or more rating. A suggested timetable for the 10 days has been produced, and core service leads and deputies are being identified, and a workshop for those involved in the process is scheduled for 7th July 2016. It was stated that once the report has been received, the Committee will have a role in the sign-off of the action plans. It was also mentioned that South West Yorkshire Partnership NHS Foundation Trust have also received their CQC report, which will be reviewed at the CQC Response Group this week. **OUTCOME:** The Committee noted progress to date, is aware that the draft report is anticipated within the next few weeks and supports the approach being taken to deliver and monitor the action plan.
RESPONSIVE	
112/16	**EMERGENCY SERVICES QUARTERLY UPDATE** Tracy Fennell, Associate Director of Nursing for Medical Division presented a paper on how the Safer Programme is impacting on quality and improving the sustainable delivery of the Emergency Care Standard (ECS). The report focusses on improvements needed within the Emergency department, patient flow, patients delayed in their clinical pathway and patients delayed on their discharge pathway. The paper updates on the improvement work that is being undertaken by the senior nursing and management team within Emergency medicine, with a focus on two specific key performance indicators which are not presently being delivered at the required standard: – Time to initial assessment - standard set to ensure patients are seen and assessed within 15 minutes for all patients arriving by ambulance, and – Re-attendance within 7 days – standard set to ensure patients receive good quality care where the need to re-attend would therefore be unnecessary. The present performances of the standards were outlined in the report with work continuing to ensure improvements are made and sustained. **OUTCOME:** The Committee noted the content of the report.
113/16	**QUALITY AND PERFORMANCE REPORT** Helen Barker, Chief Operating Officer, presented the new format of the Quality and Performance report for May 2016. The following highlights were noted from the report: Safe – Inpatient falls with serious harm – there were seven falls in May which are currently being investigated. This is a further increase on what was already a peak in April. Work is being taken forward on this by the Falls specialist. Effective – Infection Control – There were three Clostridium Difficile cases in May, two were avoidable. – Average diagnosis per coded episode/average co-morbidity score - This continues to improve, but there are still issues in paediatrics and surgery. An improvement has helped improve the Trust's quality of documentation and led to a small improvement on the Trust's overall HSMR.

	– Stillbirths – rate remains above expected levels, work ongoing in division. – Fractured Neck of Femur – Three clinical breaches and five organisational breaches. The division plans to increase scheduled theatre time and further work underway regarding timeliness of all trauma capacity. – Hospital Mortality – HSMR showing trend to improve and expecting to improve slowly but remains an issue of concern for the Trust. The next SHMI is expected to remain at a similar level as it reflects a delayed period of time. Mortality review compliance should rise once the new process for involving all consultants in mortality reviews is established. Professor Mohammed Mohammed will be at the Trust for a day a month to lead the work. A lot of effort has been put into data collections and improved audit position for the Royal College review into stroke services. The SSNAP (Sentinel Stroke National Audit Programme) score has improved from a D to a B, but may not be sustained. <u>Caring</u> – Friends and Family Test A&E – Anticipated that the target will continue to improve. – Friends and Family Test Outpatients – Group continues to meet weekly to review. Improvement anticipated from July 2016. – Friends and Family Test – Community – The % not recommended is expected to reduce by the end of August 2016. – Friends and Family Test – Maternity – Work ongoing to improve clinic templates, reduce waiting times and the efficiency of discharges. <u>Responsive</u> – Emergency Care Standard 4 hours – the number of patients seen in 4 hours continues to be a challenge. – Cancer – two breaches in relation to bowel cancer screening. – There is no improvement in End of life patients being able to die in their chosen place of death. <u>Workforce</u> – Sickness absence – Long term absence is above target at 2.73%, short term absence is above target at 1.48% and return to work interviews are not consistently undertaken or recorded. – Vacancies – international recruitment continuing for nursing posts, international recruitment programme agreed for consultant posts, facing high turnover rate – currently 14.9%. – Improvement work ongoing with staff survey and Workforce Race Equality Standard (WRES) – Appraisals - Challenge with appraisals – currently looking for 90% completion in this calendar year. Working with divisions to ensure appraisal plans in place by the end of this month. – Mandatory training - Challenge of ensuring mandatory training is delivered and impacted on EPR implementation. <u>CQUIN</u> – Sepsis – There is a need to improve in this area, with particular attention to the screening element of sepsis for patients. – Antimicrobial resistance – performance with 72 hour reviews has exceeded expectations so far in Q1 and achievement is expected for at least the first three quarters. **<u>OUTCOME</u>:** The Committee noted the content of the report.

SAFETY	
114/16	**PATIENT SAFETY GROUP UPDATE** Juliette Cosgrove, Assistant Director of Quality, presented the report from the Patient Safety Group meetings to the Committee, which included the minutes of the meetings held on 5 May and 2 June 2016. The following highlights from the meeting were noted: • Concerns with falls exceeding trajectory • Venous Thromboembolism (VTE) work ongoing - concerns with how well measuring compliance with first risk assessment and investigation into incidents associated with VTE. Governance facilitators have been asked to do investigations and work with VTE lead. Changed way of investigating, which has been raised with divisions. • Progress on incident reporting – there has been an increase in reporting • Paediatric mock cardiac arrest drills • Work undertaken with Pressure Ulcers and to understand the reasons to reduce. **OUTCOME:** The Committee received and noted the content of the report and the minutes of the last Patient Safety Group.
115/16	**REGULATION 28 SUMMARY UPDATE** Andrea McCourt, Head of Governance and Risk, presented a review of all four regulation 28 letters received in the Trust since 2014: • Case 2356 - death following complication as a result of surgery • Case 2175 - death following fall, fracture and bronchopneumonia • Case 2371 - deteriorating patient following insertion of a central line • Case 2542 - GI bleed, patient died after transfer from CRH to HRI A summary of the issues identified in each case and the position regarding the action plans were included in the report, as well as the common themes, which were documentation of both nursing and doctor's records, and issues with the investigation skills / completeness of reports / action plans. The action plans and coroners letters for all four cases were attached to the report, and an outstanding action for the Quality Committee was to ensure that the action plan for case 2175 matched the coroners concerns, and this was confirmed. Key points to note are: • If the Trust writes a good quality investigation report and action plan, then a regulation 28 can be avoided. • Trust incident reporting systems have not always identified incidents where an inquest led to a regulation 28, meaning that these are identified externally and the incident investigation has not commenced until notified by the Coroner that a case is going to an inquest and a report is required. This can be some time after the incident. • Action plans need streamlining or good co-ordination – there may be an action plan arising from an incident investigation and then a separate Trust wide action plan in response to the regulation 28 – this makes tracking of action plans complicated. • Regulation 28 action plans are not routinely shared within Patient Safety Quality Boards (PSQB), and is recommended as best practice.

	It was noted that the process for responding to Regulation 28 letters is that the Quality Committee would receive the letter, investigation report and action plan from the coroner and seek assurance regarding the delivery of actions. PSQBs should share Regulation 28 letters and associated action plans within their meetings once reviewed at the Quality Committee. The incident relating to case 2371 still requires closure on DATIX. **OUTCOME**: The Quality Committee is satisfied with the process for the four cases in this report and that action plans have been implemented.
116/16	**INCIDENT 121228 REPORT AND ACTION PLAN** Andrea McCourt, Head of Governance and Risk, presented the paper relating to an orange incident in April 2015 relating to care provided by both the medical division (A&E HRI) and the surgical division (SAU and ICU). The patient's death was reported to the Coroner and was the subject of a 4 day inquest in May 2016. A summary of the incident was detailed in the report and the investigation found there was generally a lack of understanding of the impact of routine medication for mental health conditions; and there needs to be a more comprehensive understanding of atypical pain responses patients with a brain injury and who lack capacity to ensure optimal care is delivered. At Inquest the Coroner concluded that the patient died from the effects of a head injury sustained during an altercation in May 2014 and a lack of antibiotics on 9 May 2015. The Trust has written to the Coroner, in response to his request, setting out the lessons learned. Since the inquest, significant work has been undertaken by the Trust's Safeguarding Group and the Health and Safety Committee who have established two working groups which these two groups will oversee. An action plan relating to the recommendations is being developed by Amanda McKie (Matron for Complex Care) and Vicky Thersby (Head of Safeguarding), and will be brought back to the Quality Committee. **ACTION: Action plan for 121228 to be brought back to the meeting in August 2016.** Questions and issues raised by the Committee: LR - There was one action requested from the coroner with regard to improving communication with partners and multi-agencies – this has been satisfied, received and signed off by the Safeguarding Committee. **OUTCOME:** The Committee received and noted the content of the report.
117/16	**SERIOUS INCIDENT REPORT** Andrea McCourt, Head of Governance and Risk, presented the report relating to serious incidents in May 2016: – There were five new incidents for May – three relating to falls, one relating to care/treatment omissions, and one relating to an outbreak. – Six case summaries for incidents investigated and submitted to the Clinical Commissioning Group (CCG) were enclosed for review and learning. They have been signed off by the Trust, and are included for divisions to share at their Patient Safety and Quality Board meetings. – Summaries of the three completed serious incident reports submitted to the Commissioners in May were also included. **ACTION: That all case summaries are included on divisional Patient Safety and Quality Board meeting agendas.**

COMPLIANCE	
118/16	**BOARD ASSURANCE FRAMEWORK** Vicky Pickles, Company Secretary presented the Board Assurance Framework which lists the risks and detail of responsibility of the Quality Committee for providing assurance to the Board. An updated version will be available at the next meeting in July. **ACTION: An updated Board Assurance Framework to be made available for the next meeting.**
119/16	**CORPORATE RISK REGISTER** Andrea McCourt, Head of Governance and Risk, presented the risk register report and the new risk added in May: Risk 6753 – scored at 16 – relating to the risk of inappropriate access to personable identifiable information and Trust data on some Trust computers. A previous risk relating to junior doctor industrial action, has been reduced from a score of 16 to 12 and removed from the corporate risk register, due to ongoing negotiations and ballot planned for July 2016. The risk will be reviewed once the outcome of the ballot is known. It was reported that the register still has some actions with Julie Dawes' name instead of Brendan Brown, which will be rectified for the next meeting. **OUTCOME:** The Committee received and noted the content of the report.
EFFECTIVENESS	
120/16	**CLINICAL OUTCOMES GROUP REPORT** Carole Hallam, Senior Nurse Clinical Governance, presented the report highlighting issues discussed at the last two meetings held on 18 April and 16 May 2016: – Clinical Effectiveness and Audit Group (CEAG) - Mortality reporting has now been removed from the group (formerly Clinical Effectiveness and Mortality) since the development of the Mortality Surveillance Group. Assurance is being reviewed on compliance with NICE Guidelines with the CEAG chair and the Clinical Guidelines leads. – Care of the Acutely Ill Patient (CAIP) action plan – an update on all elements including mortality, reliability, deteriorating patients, end of life care, frailty and clinical coding were summarised. It was reported that Frailty will now be led by Joanne Middleton, Associate Nurse Director, Surgery and Anaesthetic Services. It was stated that the work on frailty from the SAFER programme should also be recognised, and to ensure that there are no duplications of work. **OUTCOME:** The Committee received and noted the content of the report.
121/16	**MORTALITY SURVEILLANCE GROUP** Carole Hallam, Senior Nurse Clinical Governance, presented the report summarising the inaugural monthly meeting of the Mortality Surveillance Group (MSG) held on 11th May, with a subsequent meeting held on 13th June. The primary role of the group was summarised, as well as the key issues discussed:

	– Mortality Data - currently shows that Hospital Standardised Mortality Ratio (HSMR) is beginning to come down and now at 111. The next Summary Hospital-level Mortality Indicator (SHMI) is due to be released. – Current Mortality Outlier Alerts - include stroke and pneumonia deaths. A mortality case note review has been completed for stroke. Although there were no preventability issues. The findings from the report have been shared with the Stroke Group and there are a number of actions to improve quality of care added to their action plan. – A mortality case note review of pneumonia patients is currently underway, and the aim is for it to be completed by the middle of July 2016. – Mortality Case Note Reviews – the monthly performance of these reviews has fallen since January 2016 to an average of 40% of mortality cases being reviewed. The majority of the reviewers are senior nurses but the new process would suggest this should be consultant led. Consultant led mortality reviews have been agreed and will be included in job plans with Supporting Professional Activities (SPA) time. – Learning from Mortality reviews – the monthly learning themes remain fairly consistent with timeliness of senior review, medications timings and recording of fluid balance being the top themes. The terms of reference of the MSG were also included, which need approval by the Committee. <u>Questions raised by the Committee:</u> Q1 (HB): Is there a robust specialty process for the new mortality review process? A1 (CH): There is not a formalised process – need to ensure that this is embedded. Q2 (JW): Does anything seen as an action plan go back to person doing it? A2: (CH): There is a process where the preventability Hogan scores are reviewed, and anything that is a Hogan 3 is reviewed and sent to clinical team and put onto DATIX. It then goes back to the clinical team to investigate action plan. There are a lot of quality issues rather than preventability issues. **<u>OUTCOME</u>:** The Committee agreed the terms of reference and noted the content of the report.
CARING	
122/16	**<u>PATIENT EXPERIENCE AND CARING GROUP REPORT</u>** Juliette Cosgrove, Assistant Director of Quality, presented the report from the Patient Experience and Caring Group meeting held on 25 May 2016. The meeting was dedicated to receiving the Quarter 3 Divisional reports, which cover: - Complaints - Patient feedback - Compliance - Quality improvement plan - Equality and diversity - PPI & engagement - Learning and improvements The following matters were identified as items to be escalated to the Quality Committee: - Comprehensive reports were received from all divisions (these will be incorporated in the Divisional PSQB reports to quality committee) - A recent survey of bereaved relatives highlighted sensitive and open communication between clinicians and families as requiring improvements.

	- There has been a drop in the complaints performance, now noted over the last 2 months. There are supportive arrangements in place to ensure that complaints management remain high on agendas - the corporate complaints team hold weekly quality assurance meetings with Divisions and Divisions have an escalation process. A meeting is being held today and will have some changes on how reports are sent out to divisions. The meeting is receiving good quality divisional reports, and will ensure that Patient Safety and Quality Board (PSQB) meetings are sighted on. **OUTCOME:** The Committee received and noted the content of the report.
WELL LED ORGANISATION	
123/16	**WORKFORCE (WELL-LED) COMMITTEE REPORT** The minutes of the Workforce (Well-led) Committee meeting held on Tuesday 14 June 2016, was circulated for information.
124/16	**QUALITY IMPROVEMENT PRIORITIES 2016/2017** Juliette Cosgrove, Assistant Director of Quality, presented a paper on the overview of the proposed quality priorities for the Trust for 2016/17. This includes both locally and nationally agreed priorities and includes CQUIN's (Commissioning for Quality and Innovation) and priorities identified within the 2015/16 Quality Account. The full list of priorities were attached, all of which have an identified lead. **OUTCOME:** The Committee received and approved the list of priorities and process for delivery.
125/16	**QUALITY IMPACT ASSESSMENT (QIA)** Sharon Appleby, Transformation Programme Manager, presented a paper on the 2016/2017 Cost Improvement Programme (CIP) Programme Quality Impact Assessment (QIA). − A total of 101 schemes are at GW2 and will be monitored to deliver efficiency savings of £12.1m. 73 schemes have been assessed by 11 panels. − The schemes have been moving to delivery phase from April 2016. − No adverse quality impacts have been identified year to date − Cumulative impact on Workforce is being developed using information in the CIP tracker − The Operational Productivity Scheme consists of several projects that have currently been assessed in isolation. A holistic view is being taken with the Project Board and future quality assessments of this scheme. The current and key future actions were also summarised. The Committee welcomed the report providing assurance on the QIA process. The Project Management Office (PMO) were commended for the work done. **OUTCOME:** The Committee received and noted the content of the report.
126/16	**QUALITY COMMITTEE ANNUAL REPORT** Andrea McCourt, Head of Governance and Risk, presented the Quality Committee's draft 2015/2016 Annual Report for review and comment before being presented to the Audit Committee in July 2016. The report describes the activities of the Committee during

	2015/16, describing how the Committee met the duties within the terms of reference, and is a key part of ensuring governance arrangements within the Trust is effective. Following discussion, it was agreed that there would be further work looking at representation and the committee structure within the Trust. **OUTCOME:** The Committee recommended the annual report for presentation to the Audit and Risk Committee.
127/16	**QUALITY COMMITTEE REVIEW OF TERMS OF REFERENCE AND WORK PLAN** Andrea McCourt, Head of Governance and Risk, presented a draft copy of the Quality Committee Terms of Reference and the work plan for the coming year. It was agreed that the sub-groups of the Quality Committee need to be reviewed and the terms of reference will be reviewed in October. **ACTION: Terms of reference to be reviewed in October 2016**. Workplan **OUTCOME:** The Committee received the Work Plan for 2016/17 and were asked to note the reports required for the next meeting on 26 July 2016. **ACTION: All papers required for the next meeting on 26 July to be submitted to Michelle Augustine for circulation by Monday, 18th July 2016**
HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE	
128/16	**HEALTH AND SAFETY COMMITTEE UPDATE** Alison Wilson, Head of Compliance and Divisional Support for Estates and Facilities, gave an update from the Health and Safety Committee meeting held on 15th June 2016. A copy of the minutes and the annual health and safety report will be circulated with the minutes: – Review moving and handling arrangements within the Trust to ensure a robust training and recording. – Incidents reported under Reporting of Incidents Injuries and Dangerous Occurrence Regulations (RIDDOR) - further work with the governance and risk department required with accurate reporting on DATIX. – Implementing Control of Substances Hazardous to Health (COSHH) framework – Alison Wilson, Christine Bouckley (Head of Occupational Health and Well Being) and Jean Robinson (Lead Infection Prevention and Control Nurse) will be meeting to look at tool used by Health and Safety Executive (HSE) which can be used at CHFT to ensure compliance with COSHH. Findings will be reported at the Health and Safety Committee and this Committee. It was stated that a piece of work will need to be carried out regarding regular HSE risk assessments. Alison agreed to arrange a meeting between herself, Juliette Cosgrove, Brendan Brown to discuss.
ITEMS TO RECEIVE AND NOTE	
129/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** ▪ Process for sharing learning from adverse events ▪ Fractured Neck of Femur – progress on addressing performance ▪ Assurance of quality impact on CIP

	▪ Learning from mock paediatrics cardiac arrest ▪ Appointment slots – availability and impact ▪ Mortality review process
130/16	**ANY OTHER BUSINESS** There was no other business.
DATE AND TIME OF NEXT MEETING	
Tuesday 26 July 2016 2:00 - 5:00 pm Boardroom Sub-Basement, Huddersfield Royal Infirmary	

MINUTES APPROVED:

Minutes of the Finance & Performance Committee held on Tuesday 28 June 2016 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnerships
Keith Griffiths	Director of Finance
Lesley Hill	Director of Planning, Performance and Esates & Facilities
Richard Hopkin	Non-Execuitve Director
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Gary Boothby	Deputy Director of Finance
Mandy Griffin	Interim Director of Health Informatics
David McGarrigan	Associate Director of Estates & Facilities
Brian Moore	Membership Councillor
Lindsay Rudge	Deputy Director of Nursing
Betty Sewell	PA (Minutes)
Lisa Williams	Assistant Director, Corporate Services

ITEM

093/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed David McGarrigan, Associate Director of Estates & Facilities and Lisa Williams, Assistant Director, Corporate Services to the meeting.

094/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Andrew Haigh – Chair
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing
Jan Wilson – Non-Executive Director
Lesley Hill – Director of Planning, Performance, Estates & Facilities
Victoria Pickles – Company Secretary

095/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

096/16 MINUTES OF THE MEETINGS HELD 24 MAY 2016

The minutes of the last meeting were approved as an accurate record.

097/16 MATTERS ARISING AND ACTION LOG

069/16: Authorisation process for agency/locum staff – The Chief Operating Officer explained that with the recent arrival of Brendan Brown, Director of Nursing to the Trust the report will be enhanced and additional information will be included in the report which will be brought to the next meeting.

072/15: CHNST/NHSLA - Learnings from claims – CNST will be included on the WEB agenda within the next couple of weeks – **action closed**.

Shared Learning - The Chief Executive confirmed that a report will be circulated to a wider distribution to be discussed at a future Chief Executive – **action closed**.

033/16: EPR Update – The Interim Director of Health Informatics explained that the cost analysis has not been completed and that the report would be available for the July meeting.

264&267/15: Review of Admission Criteria – Item to be covered at the next meeting.

193/15: Market Share Data – The Assistant Director for Corporate Services introduced the paper, the report provided market share data covering the last three years. Overall the market has grown from our contracted Commissioners, although the Trust has seen a decline in market share, more significantly in Greater Huddersfield. The four main specialty areas showing the most significant negative movement based upon volume and materiality, are, Trauma & Orthopaedics, General Surgery, ENT and Pain Management and the reasons were discussed. It was noted that included in the Calderdale activity is the MSK service which the Trust is commissioned for in Calderdale, the provider in Huddersfield is Locala and, therefore, variation in volume is expected.

Discussions took place with regard to MSK pathway redesign as a potential area of focus and it was agreed that looking at changing models of care pathways should be encouraged.

The contents of the report were noted by the Committee, it was a useful piece of work which has enhanced the desire and the need to work differently with regard to our elective work and how we could utilise our future estate. It was agreed that Market Share should be included quarterly in the Divisional performance meetings.

073/16: Lord Carter Review Update - The Director of Transformation and Partnerships reported that all the recommendations relevant to the Trust are being picked up and are being progressed within the organisation. The report detailed the work the Divisions are doing with Finance using SLR/PLICS data to identify and progress savings opportunities. Clinical Engagement Workshops are also being held with all Divisions not only to look at further opportunities but to recognise our 5 year journey.

It was recognised that the report evidenced encouraging progress which will continue to be monitored by Turnaround Executive and will be included on the WEB agenda, a further update to the Finance & Performance Committee will be received in September.

ACTION: A further update to include the scoping of savings to be presented to Finance & Performance Committee in September - **AB**

FINANCE AND PERFORMANCE

098/16 MONTH 2 FINANCE REPORT

The Director of Finance reported that the financial performance for the month and YTD are broadly on track, this was noted by the Committee.

The main discussion focussed around the very challenging cash position. It was noted that the Better Payment Practice Code (BPPC) has worsened and the Cash Committee are working to re-prioritise payments to suppliers. It was also reported that early draw down of loans has been necessary to fund working capital.

In addition, a detailed statement with regard to our capital plans has been requested and submitted to NHS Improvement (NHSI). The original plan submitted was for £28.2m, a number of small adjustments have been made, however, further challenge is anticipated.

NHSI are also requesting specific evidence with regard to agency spend, we have received correspondence from NHSI which detailed our monthly phased agency expenditure in line with the national monthly profile, and careful consideration needs to be given to our response.

ACTION: A separate Cash Flow report was requested for next month with projections to the end of 17/18, setting out the risks and mitigations and the impact on the Trust if we cannot manage the cash targets. The report should include the uniqueness of our Trust with other NHS bodies across the patch **– KG/GB**

The issue of agency was discussed and the Director of Finance updated the Committee following the Turnaround Executive meeting held yesterday. It was noted that we have seen a reduction of approx. £30k per week spent on agency staffing over the last few weeks and all areas of agency spend is being scrutinised. Improvement in retention and recruitment for substantive staff was also discussed and is being reviewed by the Director of Nursing. A reduction has been seen in non-medical/nursing agency staffing which includes agency staff being used for the EPR project. It was also noted that a decision was made to replace our existing provider for our e-rostering tool and it was agreed to fast-track this procurement.

The Chief Operating Officer also reported that weekly meetings are taking place at divisional level and at the last monthly Performance Review meetings, divisions were tasked to evidence what decisions would be required to live within their control totals. It was agreed for the next Finance & Performance Committee meeting a paper would be presented which outlines the choices available to the Trust with regard to safe staffing levels from a quality and service view point along with the associated risks. Recommendation would then be taken to the Board for discussion and agreement.

ACTION: A paper outlining the choices for the Trust with regard to safe staffing levels from a quality and service view point along with the associated risks – **HB**

It was also noted that CIP schemes are progressing to Gateway 2 with a large number of schemes which are high risk, however, we remain on plan to deliver the £16m deficit.

099/16 NHS IMPROVEMENT CAPITAL PLAN 16/17 REVIEW

This item was covered within the Finance section of the agenda.

STRATEGIC ITEMS

100/16 TURNAROUND PROGRAMME UPDATE

In addition to what has been previously noted the Chief Executive reported that more rigour and discipline had been applied this year and it was agreed that there is probably a higher level of confidence that the schemes will deliver.

101/16 EPR JOINT GOVERNANCE STRUCTURE & HIGHLIGHT REPORT

The Interim Director of Health Informatics submitted a Joint Governance Structure which describes the governance for the EPR programme, the Committee noted the contents of the paper.

The Chief Operating Officer and the Interim Director of Health Informatics will hold discussions outside this forum with regard to cross-referencing the operational position.

Highlight Report

It was noted that data migration had gone particularly well from a CHFT perspective and the project is about to enter into System testing 2 prior to the final stage of testing. With regard to project forecast, assumptions have been made with regard to dual go-live. We are still on track for dual go-live mid-November, however, work to improve Bradford's data has taken place over the last few weeks and the outcome will not be known for at least two weeks.

It was noted that clean data represents a risk for the dual launch date and clarification is essential to ensure this risk has been sufficiently mitigated as of the 1st July, this should be formerly acknowledged.

The feasibility of staff being available for EPR training was discussed, it was noted that there are proposals which are being reviewed such as delaying the mandatory training programme for this year, also Divisions have been tasked to produce a planned trajectory for appraisals to be completed by the end of December, this could be extended to January in order to ensure EPR training is supported.

It was also noted that learnings have been taken from a recent visit to West Suffolk and training will be bolstered to ensure staff have the confidence to use the system. Logistics and the capacity of training rooms was highlighted as the biggest risk and the possible use of external venues is being investigated.

Post meeting note:

As regards the financial position of EPR; the technical deployment costs across both CHFT and BTH are predicted to be £4m away from plan in real terms, which is potentially off-set by a c. £2m VAT refund and planned contingencies. The residual impact on the CHFT component is c. £600k which is being built into the revised forecast. The main reason for the cost increase is the deferred go-live date (from September to November).

As regards the costs of the operational impact on the service over the go-live period,

e.g., training, PBR income loss, capacity etc., these are being reassessed on the basis of the new go live date and the 'dual' nature of the go live programme.

GOVERNANCE

102/16 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported on the areas which are a particular focus for the Finance & Performance Committee as follows:

Effectiveness

- Improvement in month across diagnostic coding per episode
- #NoF access to theatre within 36 hours has deteriorated, the rest of the best practice tariff is being attained.
- The decision has been made not go ahead with the Theatre 6 work at HRI which will allow extra capacity

Responsive

- The Emergency Care Standard has failed in May, however, we are hoping to secure 94% in June and for the quarter.
- Lower A&E attendance level in April, however, we have seen a significant increase in May/June, this is not translating through into admissions.
- Detox position remains good but transfer to care list is still high.
- Stroke – problem in attaining the best practice tariff in May due to pathway issues with a higher number of long term patients in stroke beds.
- Safer Programme working – a paper will come back to Finance & Performance Committee in September along with a monthly update to WEB. It is important to do everything we can as we go into the winter months.

CQUIN

- Sepsis CQUINN will be a challenge for Qtr 1. A Development Matron post has been approved within medicine which will be a specific lead dedicated for delivery of this CQUIN.

It was noted that the Community Division had additional KPIs, 2 or 3 will be chosen to evidence delivery of significant change by the end of September, particularly in Calderdale, as the CCG will be making a decision in September as to whether they will go out to competitive tender.

103/16 MONTH 2 COMMENTARY TO NHS IMPROVEMENT

The Committee received the paper which provides the Management Commentary on the financial position of the Trust at the end of May 2016 for submission to NHS Improvement.

The Committee noted the contents.

104/16 WORK PLAN

The Work Plan will be reviewed by the Chair and the Committee Secretary outside this forum.

The Work Plan was noted by the Committee.

105/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

The Chair of the Committee called out the following items:-

- Market Share Data Report update
- Carter Update
- Cash Flow
- Agency Spend choices – back to Board next month
- Connection between Capital and the Risk Register

106/16 ANY OTHER BUSINESS

No items were raised and the meeting was closed.

DATE AND TIME OF NEXT MEETING

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

This page has been left blank